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Federal government gives $10 million to 200 dead people

Kellan Howell

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The federal government paid almost $10 million in medicaid benefits to 200 dead people, according to a new report from the Government Accountability Office.

And that's just the tip of the iceberg.

In just four states in fiscal year 2011, the most recent year in which complete and reliable data was available, investigators found 8,600 cases where individuals were receiving double Medicaid benefits from two or more different states, totaling about $18.3 million. Auditors also found about 90 healthcare providers with suspended or revoked licenses still receiving Medicaid benefits to the tune of $2.8 million.

Watchdogs say the findings, which represent just a small slice of $310 billion in annual Medicaid payments, indicate a much bigger scale of fraud, waste, and abuse that results in hundreds of millions of taxpayer dollars being wasted every year.

"It's a gigantic problem. What the latest GAO report finds is a drop in the bucket of at least $20 billion annual Medicaid fraud," said Chris Edwards, a budget analyst at the Cato Institute.

For wasting billions of taxpayer dollars on fraudulent Medicaid payments for individuals who were dead, beneficiaries being paid in multiple states and phony health care providers, the Centers for Medicare and Medicaid Services wins this week's Golden Hammer, a weekly distinction awarded by The Washington Times that highlights examples of waste, fraud and abuse of taxpayer dollars.

“This is unacceptable. Medicaid is supposed to provide our most vulnerable with vital medical services, but continued waste and fraud undermines this important goal,” said Rep. Fred Upton, Michigan Republican, Chairman of the House Energy and Commerce Subcommittee on Oversight and Investigations in a Tuesday hearing discussing Medicaid fraud.

In 2014 CMS reported an estimated improper payment rate of 6.7 percent, which amounted to about $17.5 billion for the Medicaid program, an increase of nearly $3 billion from the prior year. In addition, Medicaid has been on the GAO’s “high risk” list since 2003.

Although CMS has taken steps to make the Medicaid enrollment process more rigorous and data-driven, investigators wrote in the report that significant gaps still exist in beneficiary-eligibility verification and data sharing processes.

For example, although CMS does require states to review electronic data maintained by the federal government to verify beneficiaries’ eligibility for Medicaid, CMS did not require states to review beneficiary files more than once a year to check if individuals had died.

“As a result, states may not be able to detect individuals that have moved to and died in other states, or prevent the payment of potentially fraudulent benefits to individuals using these identities,” auditors wrote in the report.

In a response letter to the GAO report, Jim Esquea, Department of Health and Human Services assistant secretary for legislation wrote that the department has “taken a number of steps to address provider and beneficiary eligibility fraud” since 2011.

Mr. Esquea wrote that the department has provided states with direct access to Medicaid’s enrollment database in April 2012 to compare with state enrollment records to determine whether or not an individual is in fact living, and eligible for benefits.

The department has also issued regulations since 2011 to implement risk-base screenings of new enrolling Medicaid providers and revalidate all current providers under the Affordable Care Act.

The GAO acknowledged in the report that several anti-fraud measures have gone into affect since 2011 under the Affordable Care Act, but improper payments are still costing millions of taxpayer dollars every year.

Experts say that the main problems CMS faces with Medicaid is that it’s federal-state set up, where states administer money that is provided by the federal government, taking away any incentive for the states to be frugal with the money.

“The states run the program and they have very strong incentives to maximize the federal matching payment and minimize the state payment,” said Joe Antos, a health policy expert with the American Enterprise Institute.

The a solution would be to create a per-patient grant system for beneficiaries that would prevent healthcare providers from claiming fraudulent expenses, Mr. Antos said.

“In other words get away from this matching rate program where the states have huge incentives to cheat and instead if you want to keep the structure the way it is, give them the money and more authority to run their programs but don’t give them a blank check to the taxpayer’s wallet,” Mr. Antos said.

Another approach would be to revamp the system to create a voucher program, an idea that has been touted by many Republicans, including Wisconsin Rep. Paul Ryan.

Experts say a voucher program would allow the bulk of Medicaid’s consumers, mostly healthy people who are unable to pay for their medical expenses, to use the health care funding in ways that would actually benefit them.

But lawmakers say Medicaid fraud has been an issue for decades and they don’t see any signs of it getting any better. Reform, too, is a slow process.

“So when you say, will we be here again in two years? Probably, we’ll probably be here in 10 years, because this kind of a problem takes ever vigilance by this committee,” said Oversight subcommittee member Rep. Diana DeGette, Colorado Democrat, at the Tuesday hearing.

The GAO report reviewed Medicaid data for Arizona, Florida, Michigan and New Jersey.