Nevada agency focuses on waste, abuse and fraud in Medicaid

By Sean Whaley, Nevada News Bureau

CARSON CITY – It isn't just fraud, but waste and abuse of Medicaid funds that state officials are taking aim at as the cost of the health insurance program for children, seniors and the disabled continues to climb.

Charles Duarte, administrator of the Nevada Division of Health Care Financing and Policy, which oversees the Medicaid program, said efforts to identify fraud, waste and abuse have been stepped up since 2005 when only two staff in his office were dedicated to these important tasks.

Now there are nine staff devoted to such reviews, and auditors can also be brought in when there is reason to believe an in-depth analysis is needed, he said.

Called the Surveillance and Utilization Review Section (SURS), the team is another line of defense against abuses of the Medicaid program along with the attorney general's Medicaid Fraud Control Unit and the investigations and recovery activities within the state Division of Welfare and Supportive Services.

"If you are looking at it as a pyramid it is really waste that is the big component, and then abuse and then fraud," Duarte said.

His staff closed 290 cases in fiscal year 2008, a number that reached 817 in fiscal year 2011.

"So the numbers of cases we have currently being reviewed and investigated has grown dramatically over the last five years,"

he said. “And as a result, we have been able to recover, on average, about $2 million to $3 million each year with regard to improper payments.”

Medicaid is big business in Nevada and nationally.

Nevada’s Medicaid budget for this 2012 fiscal year is $1.6 billion, with just more than $500 million coming from the state general fund. The federal government is paying 55 percent of the cost of the Nevada Medicaid program this year. Other local funds are also used to support the program.

The budget continues to grow as more Nevadans become eligible for services. In August 2009 there were just over 230,000 recipients. Two years later in August 2011 there were just over 300,000 recipients, an increase of 30 percent.

The federal government focused on Medicaid fraud in 2006 with a new law creating the Medicaid Integrity Program, identified as the “first comprehensive federal strategy” to prevent and reduce fraud, waste and abuse in the $300 billion per year program.

Concerns over Medicaid fraud have caught the attention of state lawmakers as well.

Assemblyman Cresent Hardy, R-Mesquite, proposed legislation in the 2011 legislative session to study the effectiveness of current Medicaid fraud prevention efforts and identify ways to improve efforts to combat the problem.

A contractor, Hardy testified that he identified two Medicaid fraud cases in two years in his business. Assembly Bill 286, which had bipartisan support, did not win final approval, however.

“That’s what I wanted to look at and see how prevalent it was, and get the businesses involved to see if we could educate them in how to maybe identify this,” he said. “Because

everybody that takes it illegally is taking it out of the mouths or the hands of those who really need it.”

Hardy said Duarte and other state officials need the tools to do their jobs.

“I really do believe we should be doing more to fight this thing, both at the state level and at the federal level,” he said.

Even without the review, state officials say Medicaid fraud is a priority.

Duarte’s staff spends much of its time analyzing data looking for “statistical outliers” or deviations in the normal parameters of billing activity, to identify potential areas of concern.

“And so we do a lot of the work up front for other branches of state government that may be involved either in prosecution or recipient-level fraud,” Duarte said. “So we’re the front line with regard to those types of reviews.”

There is also a deterrence effect from the reviews, he said.

“The word gets around,” Duarte said.

Some cases are resolved with education of a provider or group of providers, he said. But repeat offenders could be audited to recoup excess payments. If there is criminal intent, then the case is referred for potential prosecution, Duarte said.

There is also prospective review, such as checking the status of a provider seeking to do business with the Medicaid program in Nevada, he said. There have been cases where a business has been shut down for bad acts, but the same individuals establish a new company in an effort to continue to provide Medicaid services, Duarte said.

Fraud cases can involve a variety of activities, including

providers who bill for services that are not even provided, he said.

In 2010 for example, the agency cut off all payments to Ujima Youth Services, which operated group homes at several locations in Reno, after an audit showed the company's records did not support the amount that was billed to Medicaid. The Secretary of State's Office shows there is no longer any active business entity by that name in Nevada.

"You want folks to have an appreciation that we appreciate their tax dollars and how (they are) being used," he said. "It's really an issue of stewardship on our part and on the part of the federal government."