# OPTIONS FOR THE DISTRIBUTION OF RECOVERED FUNDS

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### OBJECTIVE

Multiple government and non-governmental entities participate in the recovery of improper payments made as the result of fraud, waste, and abuse in the Medicaid program.

### KEY FACTS

(1) In federal fiscal year 2013, CMS estimated that $14.4 billion of Medicaid spending was made in improper payments.

(2) In Texas, more than $25 billion in General Revenue was appropriated for the Medicaid program in the 2016–17 biennium.

(3) Medicaid Fraud Control Units (MFCU) investigate and prosecute Medicaid provider fraud and patient abuse or neglect in health care facilities and board and care facilities.

- Forty-nine states and the District of Columbia operate a MFCU.
- Typically, the MFCUs are a part of the state Attorney General's office and must be separate and distinct from the state Medicaid agency, according to federal law.

### STATUTORY REFERENCES

Government Code Chapter 531.102

TAC Title 1, Chapters 371 and 353

42 CFR Part 455 Program Integrity: Medicaid

42 CFR Part 1007, State Medicaid Fraud Control Units

Improper Medicaid payments are payments to medical providers for the wrong amount or that should not have been made due to an unintentional or deliberate error. Knowingly submitting incorrect information for a Medicaid payment is an example of fraud. Recovering improper payments is the responsibility of federal and state governments, as well as the managed care organizations (MCO) contracted to provide Medicaid covered services. Due to the large amount of state and federal spending dedicated to the Medicaid program and the increasing number of states using MCOs to provide medical services, the Centers for Medicaid and Medicare Services (CMS) issued new guidelines in April 2016 for states to monitor MCOs' efforts to detect and prevent fraud, waste, abuse (FWA). The guidelines allow states flexibility to coordinate with MCOs for the recovery of overpayments.

## THE ROLE OF THE INSPECTOR GENERAL AND MEDICAID RECOVERY EFFORTS

The Office of Inspector General (IG) is central to ensuring the integrity of Medicaid and other Texas health and human service programs, as well as recovering any misused funds. In 2003, the Texas Legislature created the IG to strengthen the efforts of the Health and Human Services Commission (HHSC) to detect and prevent FWA in state health and human service programs. The IG coordinates and devotes resources to health and human services cases that have the strongest supportive evidence, the greatest financial risk, and greatest potential for the recovery of money.

## MEDICAID IMPROPER PAYMENT RECOVERIES

The new federal guidelines require state contracts with MCOs to identify the process, timeframes, and documentation required for reporting the recovery of overpayments and for recoveries retained by the state. The guidelines allow states to continue to use individual approaches to how recovered funds are distributed. In practice, funds can be distributed among or exclusively to the following: state government, MCOs, or third-party entities.

Historically in Texas, a MCO notifies the IG of suspected FWA. If the amount to be recovered is greater than $100,000 and the IG assumes responsibility for the investigation and recovery efforts, then the MCO will receive any recovered amounts less the cost of the investigation. If an MCO is the sole entity conducting an investigation, it is entitled to retain any money recovered. However, new legislation changes how recovered funds are distributed. House Bill 2379 enacted in 2017 requires that any recovered amounts from fraud and abuse by a MCO to be shared with one half of the recovery retained by the MCO and the other half by the IG.

## RECOVERY DISTRIBUTIONS VARY BY STATE

States governments' approaches to distribute recovered funds generally fall into two categories: funds are returned to one entity (state or MCO) regardless of the entities participating in the recovery efforts or funds are distributed among entities that participated in the investigation. Some states distinguish between recovered funds resulting from fraud and those recovered from an unintentional error. Figure 1 shows how nine states distribute recovered funds among state government entities and MCOs. The selected states have Medicaid managed care enrollment rates ranging from 60 to 100 percent.

Figure 1: Other States' Recovery and Distribution of Medicaid Funds

| STATE | Retains funds from Audit and/or Overpayment | | | Retains funds from Fraud, Waste, and Abuse | | | Notes | |
|---|---|---|---|---|---|---|---|---|
| | MCO | State | Share | MCO | State | Share | Overpayment/Audit | Fraud, Waste, and Abuse |
| North Carolina | ✓ | | | | | ✓ | Full financial disclosure is required and will be reflected in next rate setting. | State shares recoveries with counties that assisted investigating fraudulent spent funds. |
| Tennessee | ✓ | | | | ✓ | | MCO receives permission from state to retain overpayments. | MCO must report fraud investigations. IG investigates only enrollee fraud and abuse. The state MFCU investigates provider fraud and abuse. |
| Missouri | ✓ | ✓ | | ✓ | ✓ | | State retains recoupment if costs have been reported in cost report, while the MCO retains it if cost have not been submitted in cost report. | If MCO reports suspected fraud to state, MCO may recover funds after conducting cost/benefit analysis about its recovery and state closes case. |
| New Jersey | ✓ | | ✓ | ✓ | ✓ | ✓ | MCO keeps recoupment unless joint investigation with state, then funds are returned to state. | Investigating entity receives recoveries. Entities share recoupment with a joint investigation. |
| Pennsylvania | ✓ | ✓ | ✓ | | ✓ | | MCO and state keep recoupment from their own investigations; share recoveries from joint investigations. | MCO fraud refers cases to state and state will recoup. |
| New Mexico | ✓ | | | ✓ | | | Contractual language allows MCOs to keep recovered overpayments. | MCO refers to law enforcement and retains recoupment. |
| New York | ✓ | | | ✓ | | | Contractual language allows MCOs to keep recovered overpayments, but report amount to state. | MCO retains funds from FWA recoupment and reports it to state on financial statements. |
| Ohio | ✓ | | | ✓ | ✓ | | MCO retains funds but amount could influence rate setting/reconciliation process. | MCO must report fraud to state to retain recoveries, unreported recoveries revert to the state. |
| Massachusetts | ✓ | | | ✓ | | | MCO must report to state overpayments more than $75,000. | MCO must report to state any amount of fraud or abuse recovery. |

Source: Centers for Medicare and Medicaid Services Program Integrity Reports (2015–2016); State Medicaid MCO Contracts

## FACTORS INFLUENCING THE RECOUPMENT OF FUNDS

Collaboration between the IG and MCOs is a critical and an ongoing effort that is part of a comprehensive plan to prevent and detect FWA. While MCOs share responsibility with the IG to ensure state funds are used efficiently, other factors may influence an MCO's decision to recoup improper payments. These include, but are not limited to, impacts to provider networks, rate setting process, and profit calculation (experience rebate). MCOs must maintain adequate networks of medical providers within a certain geographic area. In some areas of the state, the supply of certain types of medical professionals may be limited, thereby causing an MCO to balance the needs of an underserved population and taking action against a provider. Moreover, the amount of recoupment identified may be less than the cost to pursue its recovery. The financial impact of identifying FWA can influence an MCO's future contractual payments from the state. If an MCO makes fraudulent payments to providers when no services were actually delivered, then no payments should have occurred. Tracking whether services were actually delivered is important because future rate setting calculations are based on historical data about the amount and type of services used. If fraudulent payments are used in future calculations, then the rate setting calculations will not be based on accurate utilization data and result in inaccurate funding to the MCO. Additionally, an increase in MCO income from recovered payments may result in an MCO returning money to the state because MCO's are required to pay "experience rebates" to the state when their profits exceed a certain threshold.

## USEFUL RESOURCES

Centers for Medicare and Medicaid Services - Guidelines for Addressing Fraud, Waste, and Abuse in Medicaid
https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/GuidelinesAddressingfraudabuseMedMngdCare.pdf