

SB

74

(FILE 2)

<TARGET><BILL>SB 74</BILL><SUBJECT>SB 74 (FILE
2)</SUBJECT><COMM>HFIN29</COMM></TARGET>



ALASKA STATE LEGISLATURE
HOUSE FINANCE COMMITTEE

State Capitol, Room 519

Rep. Mark Neuman, Co-Chair

Rep. Steve Thompson, Co-Chair

Tuesday, March 22, 2016

1:30 PM

SB 74-MEDICAID REFORM;TELEMEDICINE;DRUG DATABASE
Fraud, False Claims, Penalties

Testifying:

Stacie Kraly, Chief Attorney General, Civil Division, Department of Law, in person
Andrew Peterson, Chief, Medicaid Fraud Control Unit, Department of Law, on the phone

Lynn Keilman-Cruz, Health Program Manager, Division of Senior and Disabilities Services, Department of Health and Social Services, on the phone

Doug Jones, Medicaid Program Integrity Manager, Department of Health and Social Services, on the phone

Also present from the Dept. of Health and Social Services and available for questions:

Valerie Davidson, Commissioner, in person

Jon Sherwood, Deputy Commissioner, in person

Margaret Brodie, Director, Health Care Services, on the phone

Duane Mayes, Director, Division of Senior and Disabilities Services, on the phone

Sean O'Brien, Director, Division of Public Assistance, in person

Bills Previously Heard or Scheduled:

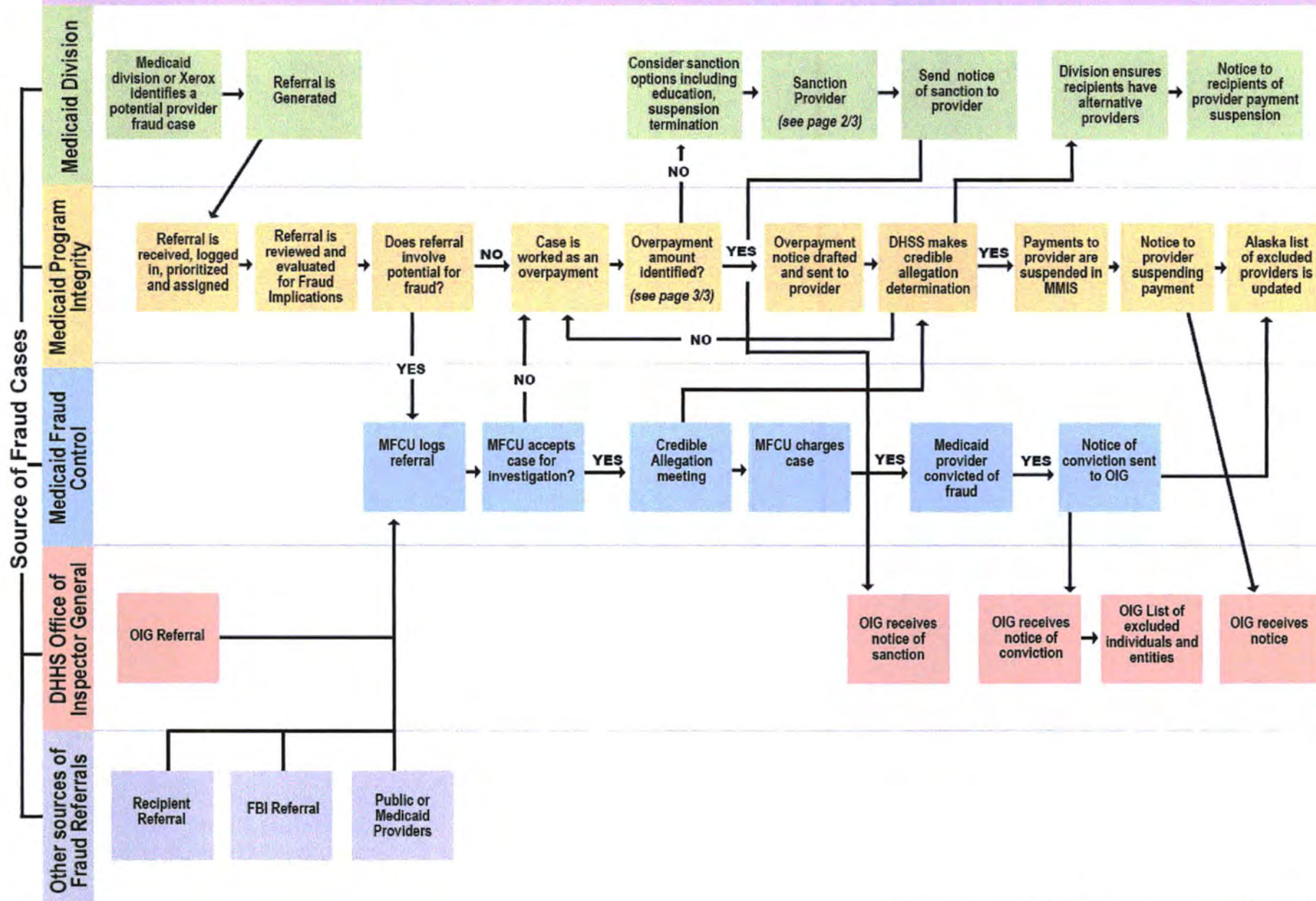
4:00 PM: (part of the 1:30 PM meeting)

Preliminary Spring Revenue Forecast

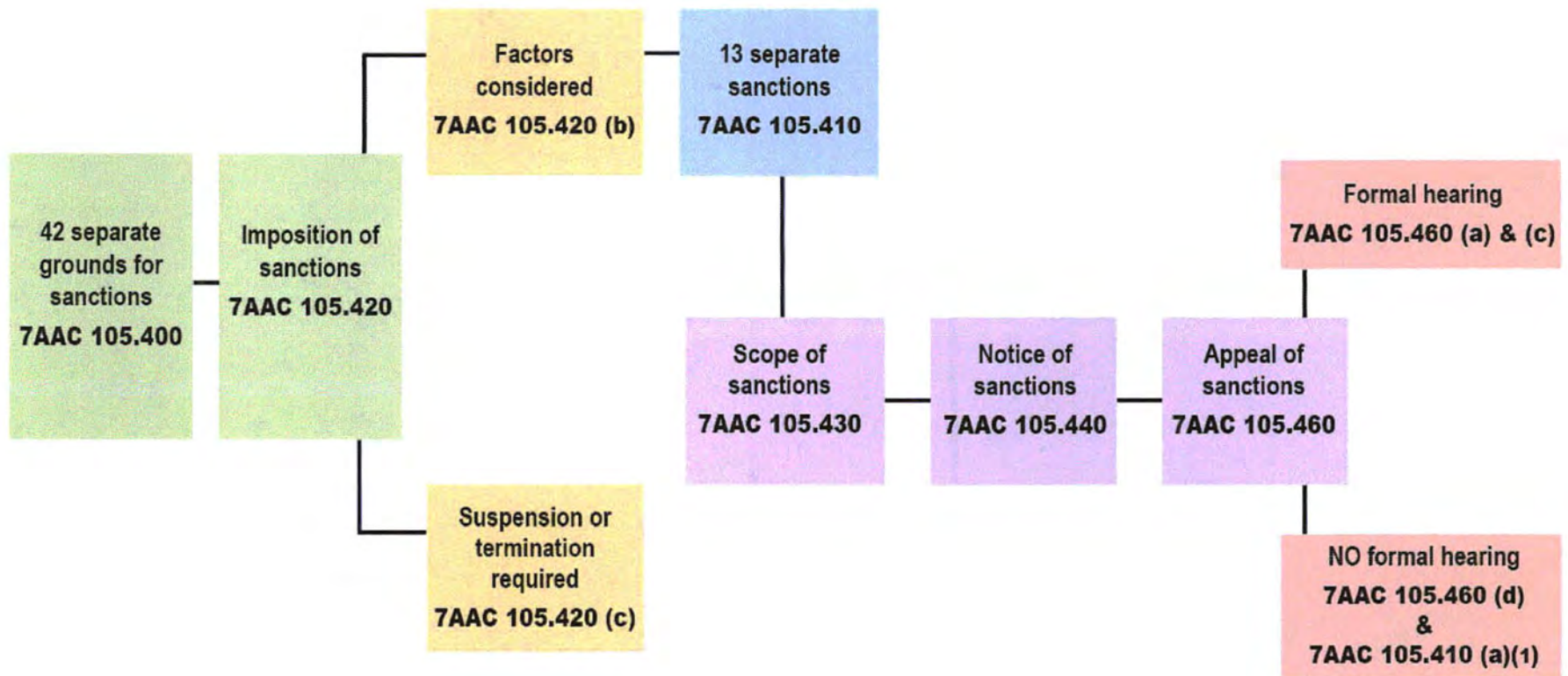
Department of Revenue

HB 143-AIDEA BONDS, LOANS, FUND; AEA LOAN *public testimony*

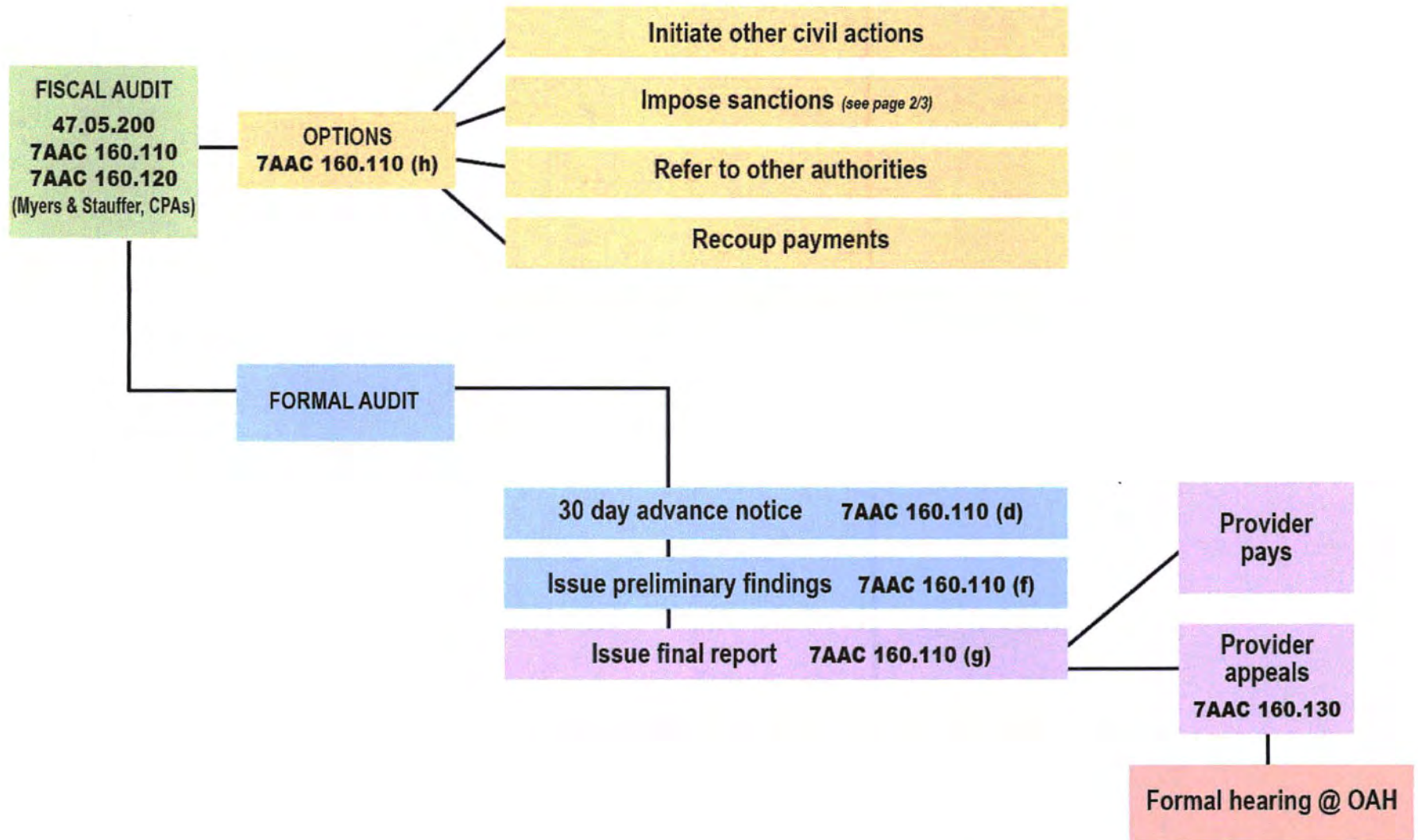
Overview of a Medicaid Fraud Case



Overview of Medicaid Sanction Process



Overview of Medicaid Provider Audit / Overpayment



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31 U.S. Code § 3729 - False claims

Current through Pub. L. 114-38 (<http://www.gpo.gov/fdsys/pkg/PLAW-114publ38/html/PLAW-114publ38.htm>). (See Public Laws for the current Congress (<http://thomas.loc.gov/home/LegislativeData.php?n=PublicLaws>.)

US Code (/uscode/text/31/3729?qt-us_code_temp_noupdates=0#qt-us_code_temp_noupdates)
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(a) LIABILITY FOR CERTAIN ACTS.—

(1) IN GENERAL.—Subject to paragraph (2), any person who—

- (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
- (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
- (C) conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G);
- (D) has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property;
- (E) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;
- (F) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge property; or
- (G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an

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obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government,

is liable to the United States Government for a civil penalty of not less than \$5,000 and not more than \$10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 ([/uscode/text/28/2461](https://www.uscode.com/text/28/2461)) note; Public Law 104-410 (<http://www.gpo.gov/fdsys/pkg/PLAW-104publ410/html/PLAW-104publ410.htm>)^[1]), plus 3 times the amount of damages which the Government sustains because of the act of that person.

(2) REDUCED DAMAGES.—If the court finds that—

(A) the person committing the violation of this subsection furnished officials of the United States responsible for investigating false claims violations with all information known to such person about the violation within 30 days after the date on which the defendant first obtained the information;

(B) such person fully cooperated with any Government investigation of such violation; and

(C) at the time such person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under this title with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation,

the court may assess not less than 2 times the amount of damages which the Government sustains because of the act of that person.

(3) COSTS OF CIVIL ACTIONS.—

A person violating this subsection shall also be liable to the United States Government for the costs of a civil action brought to recover any such penalty or damages.

(b) DEFINITIONS.—For purposes of this section—

(1) the terms "knowing" and "knowingly"—

(A) mean that a person, with respect to information—

(i) has actual knowledge of the information;

(ii) acts in deliberate ignorance of the truth or falsity of the information; or

(iii) acts in reckless disregard of the truth or falsity of the information; and

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(B) require no proof of specific intent to defraud;

(2) the term "claim"—

(A) means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that—

(i) is presented to an officer, employee, or agent of the United States; or

(ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government—

(I) provides or has provided any portion of the money or property requested or demanded; or

(II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and

(B) does not include requests or demands for money or property that the Government has paid to an individual as compensation for Federal employment or as an income subsidy with no restrictions on that individual's use of the money or property;

(3) the term "obligation" means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment; and

(4) the term "material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

(c) EXEMPTION FROM DISCLOSURE.—

Any information furnished pursuant to subsection (a)(2) shall be exempt from disclosure under section 552 of title 5 (/uscode/text/5/552).

(d) EXCLUSION.—

This section does not apply to claims, records, or statements made under the Internal Revenue Code of 1986.

(Pub. L. 97-258 ([http://thomas.loc.gov/cgi-bin/bdquery/L?d097:./list/bd/d097pl.lst:258\(Public_Laws\)](http://thomas.loc.gov/cgi-bin/bdquery/L?d097:./list/bd/d097pl.lst:258(Public_Laws))), Sept. 13, 1982, 96 Stat. 978 (<http://uscode.house.gov/statviewer.htm?volume=96&page=978>); Pub. L. 99-562, § 2 ([http://thomas.loc.gov/cgi-bin/bdquery/L?d099:./list/bd/d099pl.lst:562\(Public_Laws\)](http://thomas.loc.gov/cgi-bin/bdquery/L?d099:./list/bd/d099pl.lst:562(Public_Laws))), Oct. 27, 1986, 100 Stat.

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[1] So in original. Probably should be "101-410".

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UPDATED

OIG Guidelines for Evaluating State False Claims Acts

Note: These guidelines are effective March 15, 2013, and replace the guidelines effective on August 21, 2006, found at 71 FR 48552.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



UPDATED OIG GUIDELINES FOR EVALUATING STATE FALSE CLAIMS ACTS

Note: These guidelines are effective March 15, 2013, and replace the guidelines effective on August 21, 2006, found at 71 FR 48552.

Purpose of Updating Guidance

On August 21, 2006, the Office of Inspector General (OIG) issued guidelines on how the Inspector General would determine whether a State law meets the requirements of section 1909(b) of the Social Security Act (Act). See 71 FR 48552, Aug. 21, 2006. These guidelines replace those 2006 guidelines to reflect the amendments to the Federal False Claims Act (FCA) that have gone into effect since the effective date of section 1909 of the Act. These new guidelines provide more specificity regarding OIG's reviews when evaluating a State law and are based on OIG's experience in reviewing over 28 different State laws. The guidelines in this notice are based on the FCA in effect on the date of the publication of this notice. Future amendments to the FCA could further affect OIG's evaluation of State laws.

OIG Procedures for Reviewing State False Claims Acts

OIG will accept requests for review of State laws that have been enacted and that are in effect to determine whether they meet the requirements of section 1909 of the Act. To request OIG review of a State law, the State Attorney General's office should submit a complete copy of the State law and any other relevant information to the following address: Assistant Inspector General for Legal Affairs, Office of Inspector General, Office of Counsel to the Inspector General, Cohen Building, Mail Stop 5527, 330 Independence Avenue, SW, Washington, DC 20201. Submissions by telecopier, facsimile, or other electronic media will not be accepted. OIG will review the State law under these guidelines and in consultation with the U.S. Department of Justice (DOJ) and will inform the State Attorney General's office in writing whether the State law meets the requirements of section 1909 of the Act. OIG will also accept submissions of draft legislation for informal review and discussion.

For Further Information Contact: **Katie A. Arnholt** or **Susan E. Gillin**, Office of Counsel to the Inspector General, (202) 619-2078.

Background

Section 1909 of the Act, added by section 6031 of the Deficit Reduction Act of 2005 (Pub. L. 109-171), creates a financial incentive for States to enact legislation that establishes liability to the State for false or fraudulent claims to the State Medicaid program. This incentive takes the form of a decrease in the Federal medical assistance percentage with respect to any amounts recovered under a State action brought under a qualifying law. For a State to qualify for this incentive, the State law must meet certain requirements listed in section 1909 of the Act, as determined by the Inspector General of the Department of Health and Human Services in consultation with the U.S. Attorney General.

Medicaid, authorized under Title XIX of the Act, 42 U.S.C. 1396-1396w-5, is a joint Federal and State program that pays for medical and related benefits provided to certain low-income families and individuals. States that participate in Medicaid administer their own programs within broad Federal guidelines and receive matching funds from the Federal Government, called the Federal medical assistance percentage. The Federal medical assistance percentage for a State generally varies between 50 and 83 percent, depending on the State's per capita income for a particular year.

Individuals or entities that submit false or fraudulent claims under State Medicaid programs may be civilly liable under the FCA, 31 U.S.C. 3729-3733. Under the FCA, any person who knowingly submits, or causes to be submitted, a false or fraudulent claim for payment or approval under the State Medicaid program is liable to the Federal Government for three times the amount of the Federal Government's damages plus penalties of \$5,500 to \$11,000 for each false or fraudulent claim. Under the qui tam provisions of the FCA, private persons, known as relators, may file lawsuits in Federal court against individuals and entities that defraud the Federal Government by submitting false or fraudulent claims under State Medicaid programs. DOJ is required to investigate the relator's allegations and may

intervene and take over the prosecution of the action. If DOJ chooses not to intervene, the relator has the right to conduct the action. With respect to recoveries in cases in which DOJ has intervened, the relator is generally entitled to between 15 and 25 percent of the proceeds of the action or settlement of the claim depending on the extent to which the relator substantially contributed to the case. In cases in which DOJ has declined to intervene, the relator is generally entitled to between 25 and 30 percent of the proceeds of the action or settlement of the claim.

Many States have enacted their own false claims acts that establish civil liability to the States for individuals and entities that submit false or fraudulent claims under the State Medicaid programs. Generally, these laws include qui tam provisions that reward relators with a share of the recovery in cases of Medicaid fraud. If a State obtains a recovery as a result of a State action relating to false or fraudulent claims under the State Medicaid program, it must share the recovery with the Federal Government in the same proportion as the Federal medical assistance percentage. For example, if the Federal medical assistance percentage for a State is 60 percent, then the State would retain 40 percent of the recovery and the Federal Government would be entitled to the remaining 60 percent of the recovery.

Section 1909 of the Social Security Act

To encourage States to pursue civil Medicaid fraud, Congress added section 1909 to the Act, effective on January 1, 2007. Under this section, if a State has in effect a State false claims act that meets certain enumerated requirements, as determined by the Inspector General in consultation with the Attorney General, the Federal medical assistance percentage will be decreased by 10 percentage points with respect to any amount recovered under a State action brought under such a law. Under section 1909(a) of the Act, if a State has a qualifying law, the State's share of any recovery in an action under such a law will be increased by 10 percentage points. For example, if the State's Medicaid share is 50 percent, the State would be entitled to 60 percent of the amount of the recovery, while the Federal Government would be entitled to 40 percent.

Section 1909(b) of the Act sets forth the requirements that a State law must meet to qualify for the incentive. Under this section, the Inspector General must determine, in consultation with the U.S. Attorney General, whether a State has in effect a false claims act that meets the following requirements:

1. The law must establish liability to the State for false or fraudulent claims described in 31 U.S.C. 3729 with respect to any expenditure described in section 1903(a) of the Act.
2. The law must contain provisions that are at least as effective in rewarding and facilitating qui tam actions for false or fraudulent claims as those described in 31 U.S.C. 3730-3732.
3. The law must contain a requirement for filing an action under seal for 60 days with review by the State Attorney General.
4. The law must contain a civil penalty that is not less than the amount of the civil penalty authorized under 31 U.S.C. 3729.

Section 1909(c) of the Act provides that a State that has a law in effect that meets the requirements of section 1909(b) of the Act will be considered in compliance with such requirements so long as the law continues to meet such requirements. A State will not qualify for the 10-percentage-point increase in its share of recoveries until after the Inspector General, in consultation with the U.S. Attorney General, has determined that the State's law satisfies the requirements of section 1909(b) of the Act.

Section 1909 of the Act does not require a State to have in effect a false claims act or to enact a false claims act. A State may choose not to enact a false claims act or may choose to enact a false claims act that does not meet the enumerated requirements. However, a State that does not have a qualifying law in effect will not be eligible for the 10-percentage-point increase in its share of Medicaid fraud recoveries.

Amendments to the FCA

Congress has amended the FCA three times since the enactment of section 1909 of the Act: on May 20, 2009, in the Fraud Enforcement and Recovery Act of 2009; on March 23, 2010, in the Patient Protection and Affordable Care Act; and on July 21,

2010, in the Dodd-Frank Wall Street Reform and Consumer Protection Act. These three acts, among other things, amended the bases for liability in the FCA, expanded the rights of *qui tam* relators, and added an express requirement that civil penalties include adjustments under the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Pub. L. 104-410).

For purposes of OIG's review of State false claims acts, OIG will interpret the references in section 1909 of the Act with reference to the FCA to incorporate the amendments in the Fraud Enforcement and Recovery Act, the Patient Protection and Affordable Care Act, and the Dodd-Frank Wall Street Reform and Consumer Protection Act, as well as any future amendments to the FCA. Therefore, to qualify for the incentive, a State false claims act must fulfill the requirements of section 1909 of the Act with reference to the FCA as amended at the time of OIG's review.

For States with false claims acts approved by OIG before the amendments to the FCA in the Fraud Enforcement and Recovery Act, the Patient Protection and Affordable Care Act, and the Dodd-Frank Wall Street Reform and Consumer Protection Act, OIG provided a 2-year grace period during which the approved States would continue to be deemed compliant with the requirements of section 1909 of the Act and the States would continue to qualify for the incentive. The date of the expiration of the 2-year grace period was set forth in individual letters to each affected State. After the expiration of its 2-year grace period, a State will no longer qualify for the incentive unless its law: (1) is amended and resubmitted to OIG for review and (2) either is approved by OIG or is pending review by OIG.

OIG anticipates that if any provision of the FCA relevant to OIG's reviews under section 1909 of the Act is amended in the future, it will grant similar 2-year grace periods to any States with laws approved by OIG at the time of such amendment. In such event, OIG would review each OIG-approved State law and then notify in writing any State that, as a result of the amendment to the FCA, no longer satisfies the requirements of section 1909 of the Act. The specific dates for the grace period would be in the written notice.

OIG Guidelines for Evaluating State False Claims Acts

Section 1909 of the Act sets forth four requirements a State law must meet to qualify for the 10-percentage-point decrease in the Federal medical assistance percentage with respect to any amounts recovered under a State action brought under the State law. After consulting with DOJ, OIG has developed guidelines to use in determining whether a State law meets the enumerated requirements. The guidelines are intended to highlight the FCA provisions relevant to OIG's determination of whether a State law meets the requirements of section 1909 of the Act. OIG will closely review any variation from these provisions of the FCA in the State law.

A. Liability for False or Fraudulent Claims

Under section 1909(b)(1) of the Act, the State law must establish liability to the State for false or fraudulent claims described in 31 U.S.C. 3729, with respect to expenditures related to State Medicaid plans. When evaluating a State law to determine whether it meets the requirements of section 1909(b)(1) of the Act, OIG will consider whether the law provides for the following:

1. Liability to the State for false or fraudulent claims with respect to Medicaid program expenditures, including:
 - knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval;
 - knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim;
 - knowingly making, using, or causing to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the State or knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the State; and conspiring to commit any of the violations described above.
2. Definitions for the terms "knowing" and "knowingly" meaning that a person, with respect to information: (a) has actual knowledge of the information, (b) acts in deliberate ignorance of the truth or falsity of the information, or (c) acts in reckless disregard of the truth or falsity of the information. In addition, no specific intent to defraud should be required.

3. A definition for the term "claim" meaning, with respect to any Medicaid program expenditure, any request or demand, whether under contract or otherwise, for money or property and whether or not the State has title to the money or property, that (a) is presented to an officer, employee, or agent of the State, or (b) is made to a contractor, grantee, or other recipient if the money or property is to be spent or used on the State's behalf or to advance a State program or interest and if the State (i) provides or has provided any portion of the money or property requested or demanded or (ii) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.
4. A definition of the term "obligation" meaning an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship; from a fee-based or similar relationship; from statute or regulation; or from the retention of any overpayment.
5. A definition of the term "material" meaning to have a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

If a State law includes provisions that limit the application of the above-described liability provisions and definitions, OIG will consider whether, because of those limitations, the State law fails to fully establish liability to the State for the false or fraudulent claims described in 31 U.S.C. 3729.

B. Rewarding and Facilitating Qui Tam Actions

Under section 1909(b)(2) of the Act, a State law must contain provisions that are at least as effective in rewarding and facilitating *qui tam* actions for false or fraudulent claims as those described in 31 U.S.C. 3730-3732. When evaluating a State law to determine whether it meets these requirements, OIG will consider whether the law provides for the following:

1. A relator may bring a civil action for a violation of the State law for the relator and for the State, which shall be brought in the name of the State.
2. When a relator brings an action under the State law, no person other than the State may intervene or bring a related action based on the facts underlying the pending action.
3. If the State proceeds with the action, the relator shall have the right to continue as a party to the action.

4. If the State elects not to proceed with the action, the relator shall have the right to conduct the action. When the relator proceeds with the action, the court, without limiting the status and rights of the relator, may permit the State to intervene at a later date.
5. If the State is authorized to elect to pursue its claim through an alternative remedy available to the State, the relator shall have the same rights in such alternative proceeding as the relator would have had if the action had continued under the State false claims act.
6. If the State proceeds with the action, the relator shall receive at least 15 to 25 percent of the proceeds of the action or settlement of the claim, depending upon the extent to which the relator substantially contributed to the prosecution of the action. Such payment shall be made from the proceeds of the action or settlement of the claim.
7. If the State does not proceed with the action, the relator bringing the action or settling the claim shall receive an amount that the court decides is reasonable for collecting the civil penalty and damages, which shall be least 25 to 30 percent of the proceeds of the action or settlement of the claim. Such payment shall be made from the proceeds of the action or settlement of the claim.
8. A relator who receives a percentage of the proceeds of the action or settlement of the claim shall also receive an amount for reasonable expenses that the court finds to have been necessarily incurred, plus reasonable attorneys' fees and costs. All such expenses, fees, and costs shall be awarded against the defendant.
9. If the State law limits *qui tam* actions as a result of public disclosures, such limitation must not be broader than the following: The court shall dismiss an action or a claim under the State law, unless opposed by the State, if substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed (a) in a State criminal, civil, or administrative hearing in which the State or its agent is a party; (b) in a State legislative or other State report, hearing, audit, or investigation; or (c) from the news media; unless the action is brought by the State Attorney General or the relator is an original source of the information.
10. If the State law limits *qui tam* actions as a result of public disclosures, it must provide a definition of "original source" that is not narrower than the following: an individual who either (a) prior to a public disclosure, has voluntarily disclosed to the State the information on which allegations or transactions in a claim are based, or (b) has knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions, and who has voluntarily provided the information to the State before filing an action.

11. Any employee, contractor, or agent shall be entitled to all relief necessary to make that employee, contractor, or agent whole if that employee, contractor, or agent is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done by the employee, contractor, agent, or associated others in furtherance of an action under the State law or other efforts to stop one or more violations of the State law. Relief shall include reinstatement with the same seniority status that employee, contractor, or agent would have had but for the discrimination; two times the amount of back pay; interest on the back pay; and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. The relator must be allowed to initiate a civil action for such retaliation for at least 3 years after the date when the retaliation occurred.
12. A statute of limitations not shorter than the following, whichever is later: (a) 6 years after the date on which the violation of the State law was committed or (b) 3 years after the date when facts material to the right of action are known, or reasonably should have been known, by the office of the State charged with responsibility to act in the circumstances, but in no event more than 10 years after the date on which the violation occurred.
13. If the State elects to intervene and proceed with an action brought by a relator, the State may file its own complaint or amend the complaint of the relator to clarify or add detail to the claims in which the State is intervening and add any claims with respect to which the State contends it is entitled to relief. For statute of limitations purposes, any such State pleading shall relate back to the filing date of the complaint of the relator, to the extent that the claim of the State arises out of the conduct, transactions, or occurrences set forth, or attempted to be set forth, in the prior complaint of that relator.
14. In any action brought under the State law, the State shall be required to prove all essential elements of the cause of action, including damages, by a preponderance of the evidence.

The State law may include additional restrictions on the relator's procedural rights, limitations on or reductions in the relator's award, jurisdictional bars, and other *qui tam* provisions that do not conflict with the requirements of section 1909(b)(2) of the Act. If such provisions are more restrictive than the provisions of the FCA, OIG may determine that a State law is not as effective in rewarding and facilitating *qui tam* actions as the FCA. OIG will make such determinations on a case-by-case

basis and in consultation with DOJ. Examples of such provisions OIG may consider include:

- any limitation on the rights of the relator that is broader than the limitations on the rights of the relator in the FCA,
- any limitation on or reduction in the relator's share of the proceeds of the action or settlement that is broader than the limitations on or greater than the reductions in the relator's share under the FCA,
- any requirements placed on the relator that are more onerous than the requirements placed on the relator under the FCA,
- any requirement that the relator pay defendant's attorneys' fees and expenses that is broader than the requirement under the FCA, and
- any jurisdictional bar that is broader than the jurisdictional bars under the FCA.

C. Seal Provisions

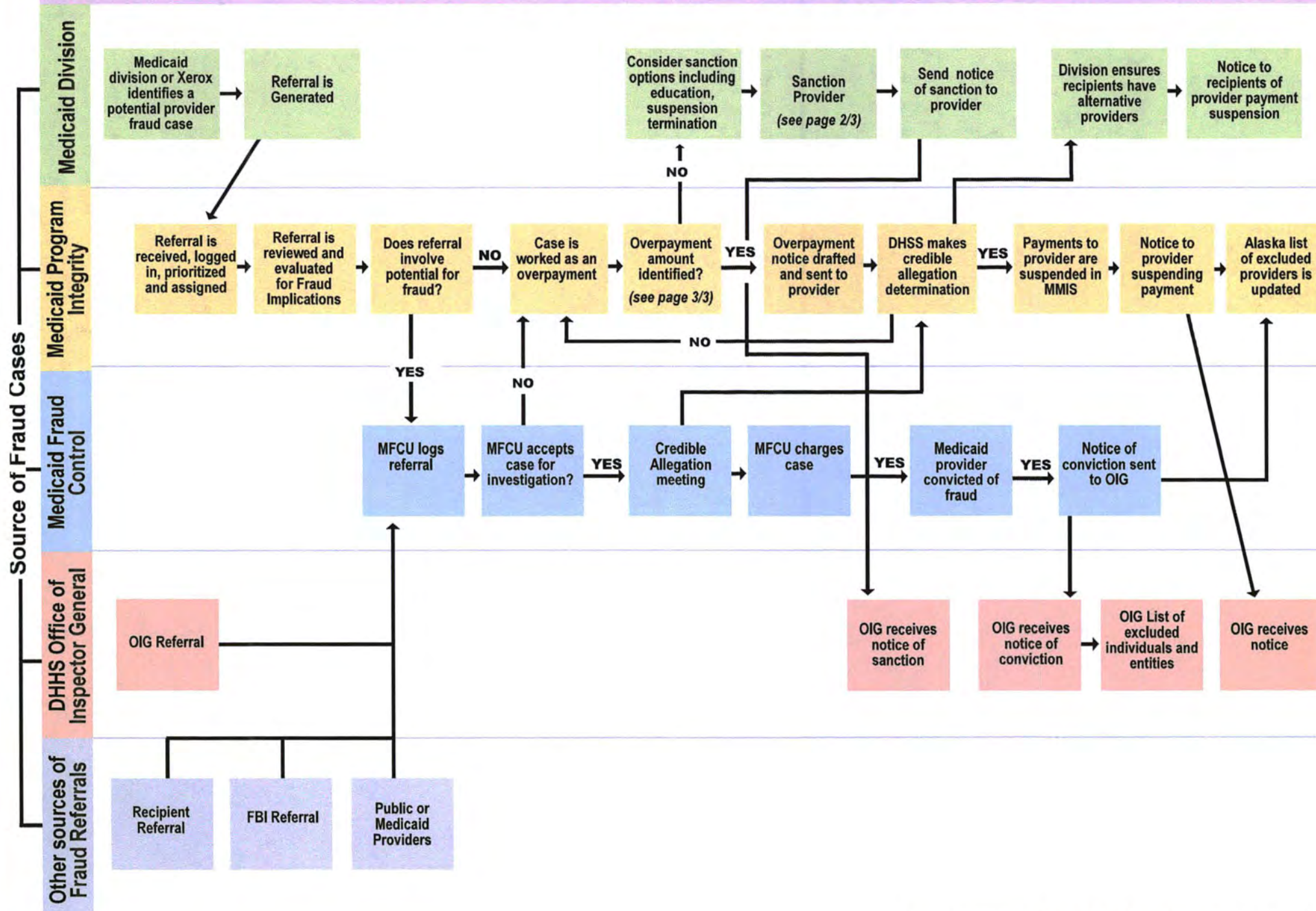
Under section 1909(b)(3) of the Act, a State law must contain a requirement for filing an action under seal for 60 days with review by the State Attorney General. When evaluating whether a State law meets the requirements of section 1909(b)(3) of the Act, OIG will consider whether the law requires the complaint to be filed in camera and to remain under seal for at least 60 days.

D. Civil Penalty Provisions

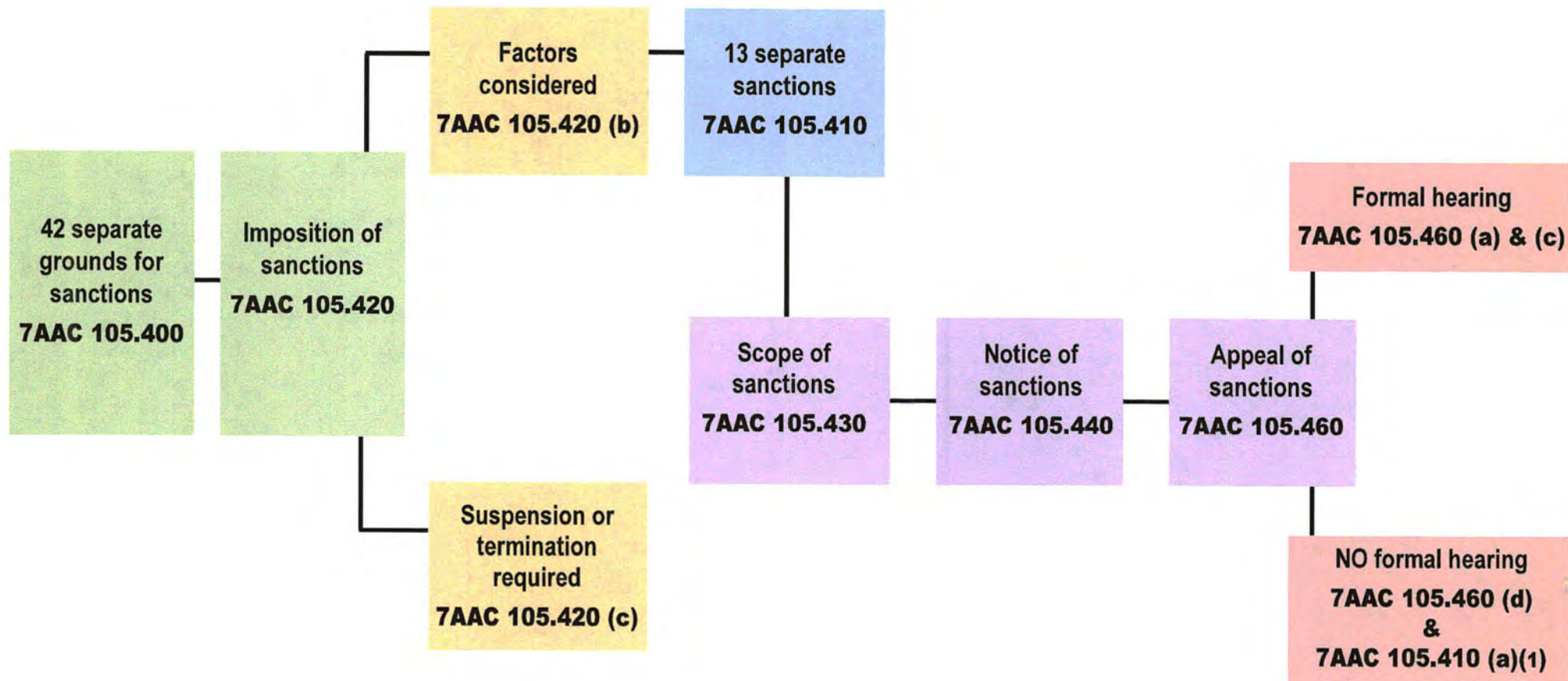
Under section 1909(b)(4) of the Act, the State law must contain a civil penalty that is not less than the amount of the civil penalty authorized under 31 U.S.C. 3729. When determining whether a State law meets the requirements of section 1909(b)(4) of the Act, OIG will consider whether the law establishes liability for (1) at least treble damages and (2) civil penalties of at least \$5,000 to \$10,000 as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Pub. L. 104-410). As of the date of this Notice, the civil penalties under the FCA, as adjusted by the Federal Civil Penalties Inflation Adjustment Act, are \$5,500 to \$11,000. Therefore, a State law must provide for civil penalties of at

least \$5,500 to \$11,000. If the civil penalties under the FCA are further adjusted by the Federal Civil Penalties Inflation Adjustment Act at a future date, then a State law must provide for civil penalties of at least those adjusted amounts to satisfy the requirements of section 1909(b)(4) of the Act.

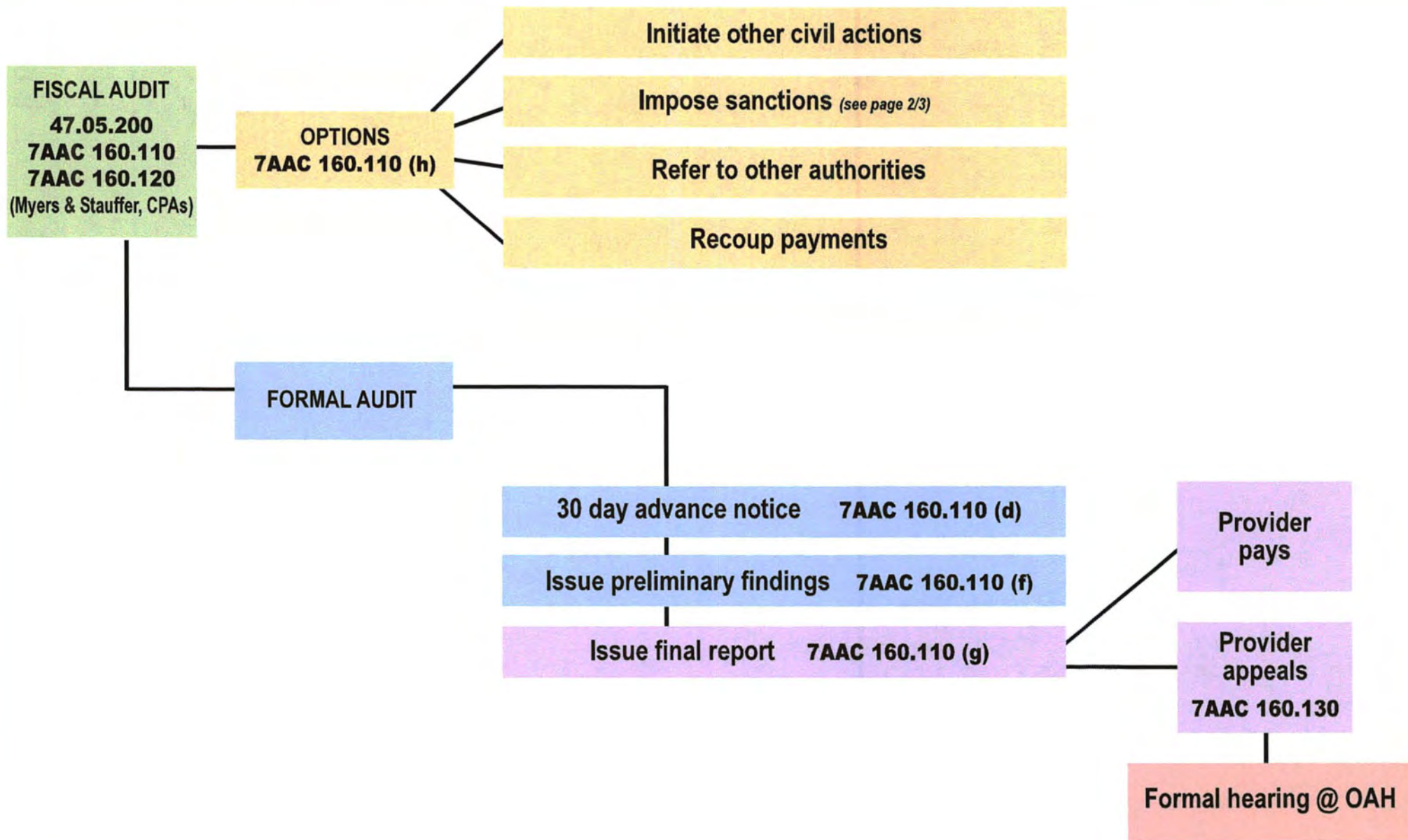
Overview of a Medicaid Fraud Case



Overview of Medicaid Sanction Process



Overview of Medicaid Provider Audit / Overpayment



STOP THE SCAM

1500-Voter Survey, October 2014, MOE +/- 2.5%

Voters Know Welfare Fraud is a BIG Problem

THEY'RE RIGHT.

WELFARE SCAMS ARE WIDESPREAD AND COSTLY.

What percent of voters believe at least 10% of Medicaid spending is wasted due to fraud and abuse?

74%

DID YOU KNOW:

Nationally, taxpayers spend \$420 billion every year on Medicaid for 60 million people.

What percent of voters believe at least 25% of all food stamp spending is wasted due to fraud and abuse?

54%

DID YOU KNOW:

Nationally, taxpayers spend \$80 billion every year on food stamps for 48 million people.

Why do you think welfare fraud and abuse is a problem?

- 47% It is a moral problem where people abuse the system at the expense of help for the truly needy
- 34% It reflects the government's inability to responsibly manage social programs
- 13% It is a fiscal issue straining government budgets and adding additional burdens to taxpayers
- 6% Don't know

FACT: BETWEEN 5% AND 25% OF WELFARE SPENDING HAS BEEN FOUND TO BE WASTED OR FRAUDULENT



In Pennsylvania, more than 160,000 individuals were fraudulently receiving Medicaid benefits, including a millionaire lottery winner.



In Massachusetts, Michael S. is receiving Medicaid benefits despite owning a 2011 BMW 550xi, a 2011 Audi R8 and a 2010 Toyota Land Rover.



In Illinois, more than 8,000 dead people, including those who died as early as 1989, were still enrolled in Medicaid. More than 300,000 people were found and removed from the program because they were no longer eligible.

STOP THE SCAM

The Proven Solution to End Welfare Fraud

STOP THE SCAM INITIATIVES ARE SAVING BUDGETS.

Illinois is expected to save approximately \$350 million every year through Stop the Scam E-Verification Best Practices.

Pennsylvania has saved nearly \$300 million in the first ten months its Stop the Scam initiative was in effect.

THE STOP THE SCAM SOLUTION IS

EASY AS 1-2-3

1 VERIFY

Enhanced data-matching technology that checks federal, state and commercial databases to confirm income, residency, identity, employment, citizenship status and more.

2 MONITOR

Regular and automatic reviews of current welfare rolls screened against updates to databases to ensure welfare recipients are still eligible.

3 PROSECUTE

Publicly prosecute individuals who knowingly abuse the welfare system to recover lost benefits, deter future abuse and change the culture of the welfare program.





April 2, 2015

Stop the Scam

HOW TO PREVENT WELFARE FRAUD IN YOUR STATE

AUTHORED BY

Jonathan Ingram | *Research Director*



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EXECUTIVE SUMMARY

The cost of welfare fraud and abuse is substantial. Not only do welfare scams result in millions of taxpayer dollars paid out to ineligible, undeserving fraudsters, they also steal limited resources away from truly needy individuals and families. Put simply, welfare fraud is a fiscal and moral crime.

No state is immune. From New York to Nebraska, reviews of states' welfare systems found individuals receiving taxpayer-funded welfare benefits without having their identity, assets, and even residency verified. Other reviews found individuals who no longer qualified for welfare benefits continuing to receive them—including millionaire lottery winners and even individuals who had died years prior.

Welfare scams drain state budgets, put the truly vulnerable at greater risk, and anger voters. But there is a simple solution to stop the scam.

Anti-fraud initiatives that embrace data-matching technology have attracted bipartisan support in states like Illinois and Pennsylvania, and have resulted in hundreds of millions of taxpayer dollars in savings. The three-step solution ensures individuals applying for welfare benefits are who they say they are and eligible to receive benefits; tracks welfare recipients already enrolled in programs to ensure they are still eligible; and prosecutes welfare fraudsters to the full extent of the law to deter future scams and recover funds paid out to perpetrators.

States across the country should look closely at the Stop the Scam solution to fix their welfare programs and guarantee only those who truly qualify and are in need of taxpayers' help will receive it. To do anything less is irresponsible and immoral.

OVERVIEW

Across the nation, government welfare programs are plagued with wasteful spending. The U.S. Government Accountability Office designates Medicaid, states' largest welfare program, as high risk because it is "particularly vulnerable to fraud, waste, abuse and improper payments" and has inadequate oversight to prevent wasteful spending.¹ Indeed, the U.S. Department of Health and Human Services (HHS) reports an improper payment rate of nearly 10 percent.²

Other welfare programs have similarly high rates of fraud. Although the federal government does not maintain a national estimate of improper payments in cash assistance programs, state-by-state reviews have identified excessive rates of waste, fraud and abuse. Worse yet, these only account for fraud that is actually identified. Taxpayers are likely paying even more for welfare fraud that continues to go undetected.

Although fraud prevention efforts traditionally focus on provider fraud, states have significant room to improve program integrity to ensure welfare recipients are actually eligible for the benefits they receive.

The federal government estimates that eligibility determination errors account for the vast majority of improper payments made by the Medicaid program.³ Eligibility errors and insufficient documentation also account for the majority of improper payments for other welfare programs, according to state reviews of those programs. Taxpayers are not the only ones hurt by this welfare fraud. Every dollar spent on individuals who are ineligible for welfare benefits is one less dollar available for the truly needy and most vulnerable—the very people welfare programs were created to help.

Taxpayers' compassion and sacrifice should not be allowed to be abused. The solution is simple: better screening at the front door, periodic checkups of the welfare rolls, and prosecution of those found to be defrauding taxpayers. These three steps help ensure applicants are actually eligible before receiving welfare benefits, that individuals receiving welfare benefits are still eligible, and that those who knowingly defraud taxpayers are prosecuted to the full extent of the law.

Using this three-step approach, states can stop the scam and root out welfare fraud.

ELIGIBILITY ERRORS ARE WIDESPREAD

A number of state and federal audits have revealed just how pervasive these welfare eligibility problems are:

ARKANSAS

In 2014, the Arkansas Department of Human Services removed nearly 5,000 Medicaid expansion enrollees, representing approximately three percent of enrollment, after learning they were ineligible for benefits.⁴ The state had not bothered to verify those applicants' eligibility before enrolling them in Medicaid.⁵ In fact, some enrollees were receiving both Medicaid and federal ObamaCare subsidies.⁶

An earlier audit found more than 12 percent of individuals in higher-cost Medicaid cases were ineligible for the program.⁷ Another 24 percent lacked appropriate documentation to establish eligibility.⁸

ILLINOIS

An Inspector General report released in 2010 found that 34 percent of randomly selected Medicaid files contained eligibility errors.⁹ The vast majority were discovered in the areas of income and other basic eligibility requirements, such as residency and household composition.¹⁰

A subsequent report by the state's Auditor General in 2013 found that the state consistently failed to ensure the program's integrity.¹¹ Some files were missing evidence that income had ever been verified.¹² For others, state workers did not bother to collect paystubs at all and simply "verified" applicants' wages verbally or through handwritten notes.¹³ Other files did not even have evidence the state verified Social Security numbers, citizenship or residency.¹⁴ In fact, some files were missing applications altogether.¹⁵

Those problems were just for the eligibility checks the state actually performed. The Auditor General's report also noted that between 15 percent and 20 percent of Medicaid cases were overdue for annual determination.¹⁶ The delays for these cases ranged anywhere from three months to more than five years.¹⁷ A follow-up audit of the program identified more than \$12 million in improper payments made on behalf of enrollees who had died years earlier.¹⁸

MINNESOTA

A 2014 legislative audit of the state's Medicaid agency found that the state had not adequately verified eligibility before enrolling applicants into welfare programs.¹⁹ As a result, nearly 17 percent of individuals in the audited sample were ineligible for benefits.²⁰ Even more cases required additional verification, which the state failed to perform. More than half of the audited files, for example, required additional verification of identity information, including Social Security numbers. Most of those cases remained unresolved.²¹

In other cases, the state did not bother to verify applicants' income at all, enrolling individuals who were ineligible at the time of application.²² Even though the state had actual income information available through state-operated databases, it did not crosscheck applicants' reported income against that data.²³ By matching applicants to information in those existing state databases, auditors were able to identify several applicants who had under-reported income, in many cases by up to \$70,000 per year.²⁴ In other cases, the state did not perform regular checkups of eligibility, allowing individuals to remain on the program after becoming ineligible due to significant income increases or moving out of state.²⁵



NEBRASKA

An audit in 2013 of the Nebraska Health Insurance Premium Payment (HIPP) program—a component of the state’s Medicaid program—found that the state lacked appropriate documentation in every reviewed case file, calling into question the entirety of expenditures made under the program.²⁶ More than three-quarters of the audited cases had received incorrect payments, with auditors identifying several cases of apparent fraud.²⁷ One individual, for example, received more than \$29,000 from the Medicaid program despite being clearly ineligible for the HIPP program.²⁸ In all, state auditors found that at least a quarter of all audited expenditures were improper.²⁹

NEW YORK

A 2006 federal audit found that eight percent of New York’s Medicaid payments were made on behalf of individuals who were ineligible, but nevertheless enrolled in the program.³⁰ Approximately 29 percent of payments were made on behalf of enrollees whose case files did not contain the required documentation supporting their eligibility determinations.³¹

A follow-up audit in 2013 found a significant number of cases for which case files had missing or invalid Social Security numbers, individuals were enrolled in the same program multiple times, or the files lacked any documentation to support the eligibility determination at all.³²

OHIO

A state and federal review of Ohio’s Medicaid spending in 2008 found that nearly 10 percent of Medicaid payments were improper.³³ Nearly all of these improper payments were caused by errors and insufficient documentation in eligibility determinations.³⁴

Auditors also found a payment error rate of roughly 20 percent for Ohio’s TANF cash assistance program, caused primarily by eligibility and documentation errors.³⁵ Nearly seven percent of audited payments went to individuals who were ineligible for the TANF program, while more than 13 percent went to individuals whose case files were missing the documentation required to establish eligibility.³⁶

THE STOP THE SCAM SOLUTION: EASY AS 1, 2, 3

States can combat these problems with a straightforward process that does a better job of screening at the front door, regularly checks eligibility information of individuals already on welfare, and publicly prosecutes those who knowingly defraud taxpayers.

1) BETTER SCREENING AT THE FRONT DOOR

One of the most important things states can do to improve program integrity is to perform better screening when applicants initially apply for welfare. A number of states accept self-attestation for income, residency, household size, and a variety of other eligibility requirements. Other states continue to approve welfare eligibility even if their own data shows discrepancies with what applicants self-report depending on the size of those differences. Even among those states that regularly check eligibility, verification tools are rarely used in a consistent and comprehensive manner.

States should use enhanced data-matching technology to verify and crosscheck income, residency, identity, employment, citizenship status, and other eligibility criteria for all welfare enrollees and applicants. Independent vendors are now able to utilize dozens of federal, state, and commercial databases in order to verify eligibility information.

If states find discrepancies between information provided by applicants and information in their databases, they can suspend eligibility determinations until those discrepancies are resolved. States can then give

applicants an opportunity to provide sufficient evidence to establish categorical and financial eligibility.

By regularly checking this information and requiring proof of eligibility, states can ensure applicants for taxpayer-funded welfare benefits are who they say they are, and that only applicants who are truly eligible will receive benefits.

2) PERIODIC CHECKUPS

Once the front door is secure, states must take a more proactive role in making sure individuals receiving welfare are still eligible for benefits. They can accomplish this by extending the same data-matching technology to those already on the program and automatically crosschecking that information regularly.

A number of states currently use a "passive" or "administrative" redetermination process, whereby states re-determine eligibility without requiring additional verification that individuals are still eligible to receive the welfare benefits they collect. In many cases, enrollees simply receive a letter telling them that their eligibility will continue until they inform the state they are no longer eligible. Federal law only requires states to perform these checks once a year and does not require any kind of active monitoring of income or other categorical requirements.

Federal data shows that individuals in poverty typically remain there for only a short time. Nearly half of individuals who fall into poverty for at least two months will leave poverty within four months, with the vast majority exiting poverty within a year.³⁷ The median length of time individuals spend in poverty is just six to seven months.³⁸ By reducing the amount of time between these periodic checkups, states can catch costly eligibility errors sooner.

Although ObamaCare regulations typically limit states to performing redeterminations only once each year, federal law provides states with a workaround that grants additional authority to begin the redetermination process whenever the state receives information that could have an effect on an individual's eligibility. By utilizing periodic checkups, states will receive this kind of information sooner and will be able to start the redetermination process earlier. States performing these checkups will also be checking far more information, as ObamaCare regulations generally accept self-attestation for eligibility.

When states receive information indicating a change in eligibility through periodic checkups, they can start the official redetermination process for those enrollees to ensure scarce welfare resources go only to the truly needy and not to those scamming the system.

3) PUBLIC PROSECUTION AND OVERSIGHT

States can deter eligibility fraud by publicly prosecuting individuals who knowingly scam the system. All cases of fraud and misrepresentation should be referred to the appropriate authorities for prosecution and benefit recovery. States would be able to use traditional collection tools, including garnishing wages or tax refunds, in order to recover the value of fraudulently-obtained benefits. States should uphold the sacred trust that comes with the collecting and spending of taxpayer dollars by collecting any fraudulent welfare payments and removing individuals from other public programs if they have committed fraud.

State lawmakers should also hold regular oversight hearings to ensure they are receiving regular updates on the progress of these anti-fraud initiatives. This proactive approach allows policymakers to adjust to any challenges in anti-fraud efforts and push for additional reforms as needed.



STOP THE SCAM

Checklist | Best Practices to Stop Welfare Fraud

| | BEST PRACTICE | Is My State Doing This? |
|-----------------------------------|---|--------------------------|
| IDENTITY VERIFICATION | 1 Verify and confirm identity of all applicants before granting benefits. | <input type="checkbox"/> |
| | 2 Check a nationwide best-address and driver's license data source to verify individuals are residents of the state. | <input type="checkbox"/> |
| | 3 Check a comprehensive public records database that identifies potential identity fraud or identity theft that can closely associate name, Social Security Number, date of birth, phone and address information. | <input type="checkbox"/> |
| | 4 Check immigration status information maintained by U.S. Citizenship and Immigration Services. | <input type="checkbox"/> |
| | 5 Check death register information maintained by the Social Security Administration. | <input type="checkbox"/> |
| | 6 Check prisoner information maintained by the Social Security Administration. | <input type="checkbox"/> |
| | 7 Check national fleeing felon information maintained by the FBI. | <input type="checkbox"/> |
| EARNINGS & ASSESSTVS VERIFICATION | 8 Check for unearned income with the IRS. | <input type="checkbox"/> |
| | 9 Check employer quarterly reports of income and unemployment insurance payments. | <input type="checkbox"/> |
| | 10 Check earned income information maintained by the Social Security Administration. | <input type="checkbox"/> |
| | 11 Check wage reporting and similar information maintained by bordering states. | <input type="checkbox"/> |
| | 12 Check earnings information maintained by the Social Security Administration in its Beneficiary and Earnings Data Exchange (BENDEX). | <input type="checkbox"/> |
| | 13 Check earnings and pension information maintained by the Social Security Administration in its Beneficiary Earnings Exchange Record System (BEERS). | <input type="checkbox"/> |
| | 14 Check employment information maintained by the state. | <input type="checkbox"/> |
| | 15 Check employment information maintained by the U.S. Department of Health and Human Services in its National Directory of New Hires database. | <input type="checkbox"/> |
| | 16 Check a database of all persons who currently hold a license, permit, or certificate from any state agency the cost of which exceeds \$500. | <input type="checkbox"/> |
| | 17 Check income and employment information maintained by the state's and the U.S. Department of Health and Human Services' Office of Child Support Enforcement | <input type="checkbox"/> |
| | 18 Check earnings and pension information maintained by the state. | <input type="checkbox"/> |
| | 19 Check a nationwide public records data source of physical asset ownership; such as real property, automobiles, watercraft, aircraft and luxury vehicles, or any other vehicle. | <input type="checkbox"/> |
| ADDITIONAL BENEFITS VERIFICATION | 20 Check public housing payment information maintained by the Department of Housing and Urban Development. | <input type="checkbox"/> |
| | 21 Check child care services information maintained by the state. | <input type="checkbox"/> |
| | 22 Check utility payments information maintained by the state under the Low Income Home Energy Assistance Program. | <input type="checkbox"/> |
| | 23 Check emergency utility payment information maintained by the state or local entities. | <input type="checkbox"/> |
| | 24 Check supplemental security income information maintained by the Social Security Administration in its SSI State Data Exchange (SDX) database. | <input type="checkbox"/> |
| | 25 Check state veterans' benefits information against the federal Public Assistance Reporting Information System (PARIS) database maintained by the U.S. Department of Health and Human Services. | <input type="checkbox"/> |
| | 26 Check any existing real-time database of persons currently receiving benefits in other states, such as the National Accuracy Clearinghouse. | <input type="checkbox"/> |

A PROVEN TRACK RECORD

These award-winning reforms have a proven track record in other states of helping ensure taxpayer money is being spent appropriately on welfare benefits.³⁹ In Pennsylvania and Illinois, welfare agencies use enhanced data-matching technology to verify income, residency, identity, employment, citizenship status, and other criteria for all applicants and existing enrollees. Those found ineligible by this process are kept off or removed from the program. Eligibility is suspended until discrepancies are resolved and suspected cases of fraud are referred for prosecution.

The Pennsylvania Department of Public Welfare (DPW) launched its Enterprise Program Integrity initiative in 2011.⁴⁰ In its first 10 months of operation, the state identified more than 160,000 ineligible individuals who were receiving benefits, including individuals who were in prison and even millionaire lottery winners.⁴¹ This resulted in nearly \$300 million in taxpayer savings in the first 10 months.⁴²

In January 2013, Illinois followed Pennsylvania's lead and began its own program integrity initiative. The state hired an independent third-party vendor to verify income, residency, and other criteria of all new applicants and the state's existing 2.7 million Medicaid enrollees.⁴³

During the first year of operation, Illinois' independent vendor identified eligibility errors in half of the cases it had reviewed.⁴⁴ A delayed program launch and early contract challenges by the state's public employee unions resulted in the vendor being unable to review all the cases it intended to complete. By the end of the first year, the state had removed roughly 300,000 individuals from the program as a result of the initiative.⁴⁵ In the second year, the state removed an additional 400,000 individuals.⁴⁶ State officials projected that the enhanced program integrity initiative would save taxpayers \$350 million per year.⁴⁷ Based on the results of the second year, taxpayers can expect to save between \$390 million and \$430 million per year, with greater savings accumulating over time as the state moves more enrollees into managed care plans.⁴⁸⁻⁵³

These reforms are now being expanded to all state-administered welfare programs in Illinois, including Medicaid, food stamps, and cash assistance. By stopping fraud in one program, states are able to prevent related fraud in other programs.

STOP THE SCAM INITIATIVES HAVE BIPARTISAN SUPPORT

These approaches enjoy large bipartisan support. In Illinois, more than 80 percent of members in the House of Representatives and 77 percent of members in the Senate—including large majorities of each party—supported legislation to have an independent vendor strengthen the state's welfare integrity.⁵⁴⁻⁵⁵

In Pennsylvania, more than 64 percent of members in the House of Representatives and 70 percent of members of the Senate voted to establish program integrity initiatives.⁵⁶⁻⁵⁷ Similar bills are pending in other states. In Massachusetts, for example, 23 Republicans and 20 Democrats have proposed implementing a similar program integrity initiative.⁵⁸

Public polling confirms these strategies are popular with voters as well. Nearly 80 percent of likely voters support such measures, compared to just 11 percent who oppose them.⁵⁹ This support spans the political spectrum. Roughly 69 percent of Democrats and 87 percent of both Republicans and Independents support enhanced verification measures to root out welfare fraud.⁶⁰

Voters view welfare fraud as a moral problem, where people scam the system at the expense of help for the truly needy.⁶¹ Voters view anti-fraud measures as one of the best ways to protect resources for people who truly need help and for other state priorities.⁶² These reforms also help ensure individuals do not stay on welfare any longer than necessary, keeping them from becoming dependent on government or trapped in poverty.⁶³



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CONCLUSION

With welfare programs often making up states' largest and fastest-growing budget line items, ensuring taxpayer resources are spent only on those actually eligible for benefits is a critical priority. States should take a three-step approach to protect the truly needy from fraudsters syphoning off scarce resources.

First, states need better screening at the front door to ensure those applying for welfare are actually eligible before they are enrolled. Second, states need more frequent checkups to monitor eligibility for those already enrolled in the program so individuals do not stay on welfare longer than they should. Lastly, states need to more comprehensively prosecute those found to be defrauding public programs.

This three-step solution is politically popular and proven to save taxpayers substantial sums. And this Stop the Scam solution makes sure limited resources are going only to those who are truly in need of targeted, temporary help.

Stopping welfare scams must become a priority for all states. Taxpayers and those in honest need of help deserve nothing less.

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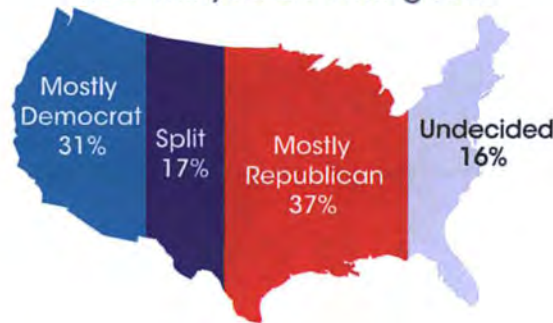
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46. Although the state had removed more than 686,000 individuals from the program, nearly 289,000 people had returned at some point during the year, including those who became eligible again after changes in eligibility information after being removed from the program. Altogether, this left a net cancellation of more than 397,000 enrollees. See, e.g., Division of Medical Program, "Medicaid redetermination data: Report updated on January 8, 2015," Illinois Department of Healthcare and Family Services (2015), <https://www.dropbox.com/s/gdrp79u4te7c13o/IMRPReport-1-8-2015.PDF>.
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48. Author's calculations based upon data provided by the Illinois Department of Healthcare and Family Services and the U.S. Department of Health and Human Services. Savings estimates were produced using average monthly disenrollment data, average monthly per-person Medicaid spending data, and average enrollment duration data, with each dataset disaggregated by eligibility category. Savings estimates were reduced to account for disenrolled individuals whose benefits were reinstated within three months and the average monthly cost of the contract with the state's third-party vendor assisting with eligibility verification. This estimate accounts for a fixed 12-month period, which somewhat understates actual savings over time. For example, while this estimate captures the full savings from individuals disenrolled in the first month, it only captures one-month of savings for those disenrolled in the 12th month. While savings in a fee-for-service system would depend largely on utilization rates for those who were disenrolled, Illinois has now shifted most Medicaid enrollees into managed care plans, which are paid a fixed, capitated rate for each enrollee, regardless of utilization rates. Moving forward, Illinois will be able to better track savings from these reforms.
49. Data on the number of individuals disenrolled under the Illinois Medicaid Redetermination Project, disaggregated by enrollment category, was provided by the Illinois Department of Healthcare and Family Services. See, e.g., Division of Medical Services, "Number of full benefit recipients on cases canceled under Phase II of IMRP," Illinois Department of Healthcare and Family Services (2015), https://www.dropbox.com/s/lbfc3cw16y9evdi/IMRP_Phase%20II_disaggregated.pdf.
50. Data on the average per-person Medicaid spending in Illinois, disaggregated by enrollment category, was collected through the Medicaid Statistical Information System. See, e.g., Centers for Medicare and Medicaid Services, "Medicaid Statistical Information System State Summary Datamart: Fiscal year 2012 quarterly cube," U.S. Department of Health and Human Services (2014), <http://msis.cms.hhs.gov>.
51. Data on the average Medicaid enrollment duration in Illinois, disaggregated by enrollment category, was collected through the Medicaid Statistical Information System. See, e.g., Centers for Medicare and Medicaid Services, "Medicaid Statistical Information System State Summary Datamart: Fiscal year 2012 monthly cube," U.S. Department of Health and Human Services (2014), <http://msis.cms.hhs.gov>.
52. Data on the average number of individuals disenrolled who were reinstated within three months was provided by the Illinois Department of Healthcare and Family Services.
53. Data on the average monthly cost of the Maximus contract during Phase I and Phase II was provided by the Illinois Department of Healthcare and Family Services.
54. Approximately 67 percent of Democrats and 94 percent of Republicans in the Illinois House of Representatives voted to implement an enhanced eligibility verification system. See, e.g., Clerk of the House of Representatives, "House roll call: Senate Bill 2840," Illinois General Assembly (2012), http://www.ilga.gov/legislation/votehistory/97/house/09700SB2840_05242012_018000T.pdf.
55. Approximately 75 percent of Democrats and 96 percent of Republicans in the Illinois Senate voted to implement an enhanced eligibility verification system. See, e.g., Secretary of the Senate, "Senate concurrence: Senate Bill 2840," Illinois General Assembly (2012), http://ilga.gov/legislation/votehistory/97/senate/09700SB2840_05242012_019000C.pdf.
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Voters' Impressions of Welfare Fraud and Abuse

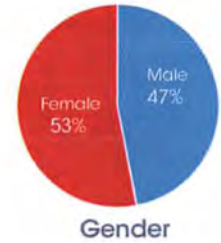
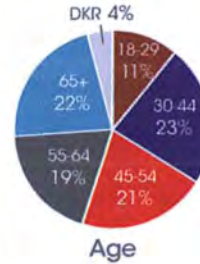
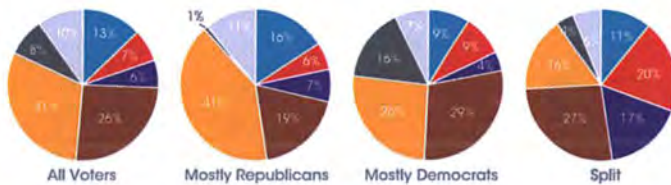


In the upcoming November election, who will you be voting for?



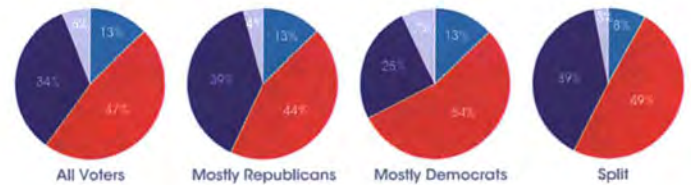
Which of the following statements comes closest to your opinion on why your state should reduce welfare spending by eliminating fraud? If you don't believe welfare fraud to be an issue, please say so.

- People shouldn't stay on welfare any longer than necessary, to make sure they don't become dependent on government and trapped in poverty
- Reducing welfare fraud is the best way to protect resources for the people who truly need help
- It's unfair to allow those who are not truly needy to receive government handouts
- Welfare fraud takes scarce tax dollars away from other spending priorities
- Fraud forces government to keep raising our taxes
- Welfare fraud is not a problem
- Don't know / refused

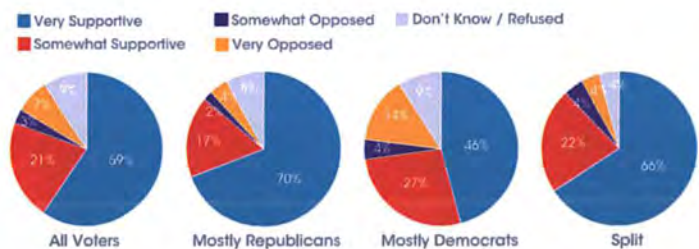


Why do you think welfare fraud and abuse is a problem?

- It is a moral problem where people abuse the system at the expense of help for the truly needy
- It reflects the government's inability to responsibly manage social programs
- It is a fiscal issue straining government budgets and adding additional burdens to taxpayers
- Don't know / refused



Both Illinois and Pennsylvania used an independent audit to check eligibility in real time, reducing fraud and saving taxpayers hundreds of millions of dollars. Would you support elected officials in your state using a similar audit to reduce fraud and abuse of welfare programs in your state?



Results for this poll are based on live telephone interviews conducted among a multi-state sample of 1,500 adults who were likely to vote in the November 2014 general election. Data for this survey research was collected by Advantage, Inc.

Interviews were conducted via a computer-assisted telephone interviewing system by professional interviewers who are extensively trained in interviewing practices, including techniques designed to achieve the highest possible respondent cooperation.

The surveys were conducted October 11-13, 2014. The margin of sampling error is plus or minus 2.53 percentage points. The margin of sampling error may be higher for certain subgroups.

Data is sampled using weighted demographic information from the U.S. Census Bureau's Current Population Survey Voting and Registration Supplement. Demographic information for actual voters in prior Congressional elections was used to construct sample target weights.

The Foundation for Government Accountability paid for all costs associated with this survey.

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