2017 HOUSE HUMAN SERVICES

HB 1227

2017 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1227
1/18/2017
27097

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Shirley Lachmeier

Explanation or reason for introduction of bill/resolution:

Relating to Medicaid fraud; and to provide penalty.

Minutes: See Attachment 1

Chairman Weisz: called the committee to order and opened the hearing on HB # 1227.

Rep. Kathy Hogan, District 21: in support of HB 1227. (See Attachment 1). 00:50-04:55

Chairman Weisz: Are there any questions from the committee?

Representative Skroch: Is there a fiscal note attached?

Rep. Kathy Hogan: The fiscal note is attached to HB 1226 which would establish the unit. I will go through that fiscal note at the time that you hear that bill.

Representative Westlind: Do you have a dollar amount?

Rep. Kathy Hogan: No, not yet because we don't have a fraud unit and don't have a real tracking mechanism yet. In the document I share about this. It gives you some similar size states so you get a sense of how other states have implemented fraud programs.

Representative Porter: Why can't you just have one bill instead of 3 that do the same thing? Could this be one bill?

Rep. Kathy Hogan: By the time we realized there would be 3 bills, we were too late to merge them. You got two of the three bills. The second bill went into judiciary because it has to do with some criminal and federal penalties. Once we found out, we tried to merge them but it was too late.

Representative Porter: Is the legislation that you are bringing forward the minimum requirements for the satisfaction of the Federal Government? Is it ten times more than what is necessary to meet federal requirements? Where did this language originate in these three bills to be asked to be made into law?

Rep. Kathy Hogan: I will have to ask the Attorney General who was involved in drafting that language to answer that question. Our intent was a small unit to begin because we don't know the scope of the problem. That was the intent that come out of government operations.

Chairman Weisz: Is there further testimony in support of HB 1227? Seeing none, we continue. A Further testimony in support of HB 1227? Further testimony in opposition of HB 1227?

Chairman Weisz: Counties used to be in charge of doing recoveries of fraud and then they got a percentage; isn't that correct prior to 1997?

Maggie Anderson: Dept. of Human Services: I don't know but I can give you 2010 information if you want it. I do know from the 2010 performance audit that was done in the department where the formal public welfare fraud units were mentioned as a finding in the audit that they did exist.

Chairman Weisz: That would be useful.

Representative Porter: Inside of the 3 bills is there a boiler plate used to create this. Are we at the minimum, middle, or maximum of what they would accepted for approval of such a unit?

M. Anderson: Dept. of Health was not involved in the drafting of the bill.
I sent this to CMS and asked them if they had any problem with the language and they said no, but I didn't ask them that. I have asked for that now, but I haven't received it yet.

Representative P. Anderson: I sat through a couple of hours of testimony regarding Medicare fraud with members of the Attorney General's office in Nebraska who was present to give us direction. We discussed a minimum cost of securing a fraud team. It was the smallest group we could have and it wasn't going to cost us anything. The federal government pays 90% of the cost to start with for the first three years to enhance operation and then it drops to 75% to 25%.

Michael Mahoney: Assistant Attorney General
Three bills should have been drafted as one. We used federal statutes from Montana to draft this bill. We asked them if our draft language will meet their demands for us to receive federal funding and they said there will be some amendments put forth for HB 1174.

Representative Porter: There were no other states were involved, provider groups and interested individuals that help draft this. It was just the Montana statute, the federal statute and the three bills.

M. Mahoney: Correct. There were other states but no group.

Representative Porter: Being a Medicaid provider, I always get anxious when the money to make it run the program, comes from the money collected. It's like putting the fox in charge of the henhouse thinking we are going to generate money from fraud and abuse by having this program. How are billing mistakes made inside of places a part of the problem? How do you differentiate between human error and intent to commit fraud?

M. Mahoney: "Knowingly" is the word that brings it to the criminal realm. We would be going after intentional criminals and not human errors.

Representative Porter: When you use the word "kickback". There are lots of interpretations of that word. If an ambulance service is owned by a government agency, like a city or municipality, and they choose not to balance bill the 20% co-pay, the office of Inspector General said it was okay, but those billing would be committing Medicare fraud. Sometimes the government says it is ok to do one thing to one person, but to the other they would say it is fraud. How do we make sure that word has a meaning?

M. Mahoney: You may want to amend the statue to define what "kickback" means. On page 2, line 7 you did include statutes that exclude some activity as in "kickback".

Representative Porter: We have need to make sure our language meaning is clearly defined. We need to make sure we are following in that category regarding these bills.

Chairman Weisz: Any further testimony? Seeing none, we will close the hearing on HB 1227.

2017 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1227
2/7/2017
27994

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Judy Kepple

Explanation or reason for introduction of bill/resolution:

Relating to Medicaid fraud; and to provide a penalty.

Minutes:

Chairman Weisz: Opened the discussion on HB 1227.
I will entertain a motion on HB 1227

Vice Chairman Rohr: I move a do not pass on HB 1227.

Representative B. Anderson: I second it.

Chairman Weisz: Is there any discussion? Seeing none, the clerk will call the roll for a do not pass on HB 1227

Roll call vote taken Yes 9 No 1 Absent 4
Motion carried for a do not pass on HB 1227.

Chairman Weisz: Do I have a volunteer to carry this.
Rep. B. Anderson, thank you.

Committee adjouned.

Date: 2/7/17
Roll Call Vote #: 1

2017 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1227

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☐ Do Pass ☑ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Rep. Rohr Seconded By Rep. B. Anderson

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz	✓		Rep. P. Anderson		✓
Vice Chairman Rohr	✓		Rep. Schneider	A	
Rep. B. Anderson	A				
Rep. D. Anderson	✓				
Rep. Damschen	✓				
Rep. Devlin	✓				
Rep. Kiefert	✓				
Rep. McWilliams	✓				
Rep. Porter	✓				
Rep. Seibel	A				
Rep. Skroch	A				
Rep. Westlind	✓				

Total (Yes) 9 No 1

Absent 4

Floor Assignment Rep. B. Anderson

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1227: Human Services Committee (Rep. Weisz, Chairman) recommends **DO NOT PASS** (9 YEAS, 1 NAYS, 4 ABSENT AND NOT VOTING). HB 1227 was placed on the Eleventh order on the calendar.

2017 TESTIMONY

HB 1227

Att. 1
HB 1227
1-18-17

TESTIMONY
HB 1227
House Human Services Committee
January 18, 2017
Representative Kathy Hogan

Chairman Weisz and member so the House Human Service Committee, for the record, my name is Kathy Hogan and I represent District 21, the heart of Fargo.

During the 2015 legislative session, the House Appropriations committee had serious discussions regarding the need for and structure of a Medicaid fraud unit. These hearings and discussion were in the Government Operations Division of Appropriations. In the end we agreed that there were a number of related issues that needed to be considered before beginning and so it was not funded at that point in time.

During the interim, several of us have worked to address this issue and we have prepared three bills related to Medicaid Fraud. The first bill 1174 was heard in Judiciary on January 16 regards civil liability in false claims. HB 1227 is the second bill heard this week that identifying what Medicaid fraud is. The third bill (HB 1226) is a bill to establish a Medicaid Fraud Unit in the Attorney General's Office was re-referred yesterday to this committee.

Two significant events have happened in the last 6 weeks. During the organizational session, a major meeting was held with providers, DHS and other key partners to review this issue and idea of Medicaid Fraud. Secondly, unknown to me, the ND Department had requested an exemption to the federal Medicaid Fraud requirements which we have had in place since about 1994. On January 6, the Governor was notified that the continuation of that exemption was denied and the state had 60 days to develop a plan to implement a Medicaid Fraud unit. Attached is the letter.

These bills have been drafted in collaboration with the Attorney General's office. This bill defines what Medicaid fraud is and defines the penalties for fraudulent activities. Staff from the Attorney General's office are available to answer specific question.

Thank you for your consideration and I would be more than willing to answer any questions.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

JAN - 6 2017

The Honorable Jack Dalrymple
Governor of North Dakota
600 East Boulevard Avenue
Bismarck, ND 58505

Dear Governor Dalrymple:

Thank you for your letter dated September 12, 2016, in which you requested that the State of North Dakota be granted a new waiver from the requirement that it operate a Medicaid Fraud Control Unit (MFCU). Along with your letter, you enclosed several documents in support of the state's waiver request, including those that address fraud and abuse efforts in its managed care program; expenditure summaries; corrective actions taken related to various state and federal program integrity reviews; and state abuse and neglect processes.

As you are aware, section 1902(a)(61) of the Social Security Act outlines two criteria, which must co-exist, under which a state may be granted a waiver from the requirement to operate a MFCU. To qualify for a waiver, a state must demonstrate to the satisfaction of the Department of Health and Human Services' (HHS) Secretary: (1) that the effective operation of a MFCU would not be cost-effective because minimal fraud exists in connection with the provision of covered services to eligible individuals under the state plan, and (2) that beneficiaries under the plan are protected from abuse and neglect in connection with the provision of services under the plan without the existence of a MFCU. The Centers for Medicare & Medicaid Services (CMS) has carefully reviewed the information you provided and determined that the state's waiver request does not meet these criteria.

We appreciate the analysis outlined in your letter of MFCUs in similar sized states that had years in which operational costs exceeded their recoveries. However, we do not believe that this observation is indicative of a MFCU's cost-effectiveness. Monetary recoveries are only one factor in measuring the success and impact of an effective MFCU. MFCUs primarily conduct criminal prosecutions that result in criminal indictments and convictions, in addition to the recovery of criminal restitution. MFCUs' deterrent value, and the sentinel effect of their successful criminal and civil cases, cannot be measured in dollars. This is especially so for prosecutions of patient abuse or neglect that occur in North Dakota health facilities, which typically do not involve a Medicaid overpayment and result in criminal outcomes with no monetary recovery.

Moreover, in reviewing the recovery information in similar states, while in a single year MFCU operational costs may exceed recoveries when analyzing MFCUs over a longer period of time, such as a 3-year period (2013-2015), recoveries in similar sized states often exceeded the operational costs of operating a MFCU. Wyoming, for example, recovered roughly $3.1 million and expended $1.4 million, and South Dakota recovered roughly $7 million and expended $1.2 million. While Montana had a negative return on investment for this time period, during the prior 3-year period (2010-2012), Montana had recoveries of $3.2 million and expenditures of

$697,345. Overall, the data suggest that MFCUs are cost-effective in the similar sized states, and there is insufficient reason to believe that a MFCU operating in North Dakota will be an exception.

Your letter offers an analysis conducted by Optum related to Professional Provider Specialty Peer Outliers suggesting that minimal fraud exists in North Dakota's Medicaid program and that beneficiaries are protected from abuse and neglect without the existence of a MFCU. This Optum analysis was only for Sanford Health Plan, and therefore, covers only North Dakota's Medicaid expansion population and represents only about 25 percent of the state's Medicaid budget. CMS does not believe this information persuasively argues that the operation of a MFCU would not be cost-effective because minimal fraud exists in North Dakota and that beneficiaries under the plan would be protected from abuse and neglect without the existence of a MFCU.

Finally, the enclosures to your letter include a description of the affirmative steps taken by HHS in response to program integrity-related deficiencies identified by CMS and other agencies. CMS appreciates these actions, but none of them are germane to our determination that the state has not demonstrated in its request that minimal fraud exists or that, absent a MFCU, all beneficiaries under the plan are fully protected from abuse and neglect. In sum, upon carefully reviewing the information provided, CMS has determined that North Dakota has not demonstrated that operating a MFCU would not be cost-effective because minimal fraud exists and that all beneficiaries under the plan are fully protected from abuse and neglect without the existence of a MFCU.

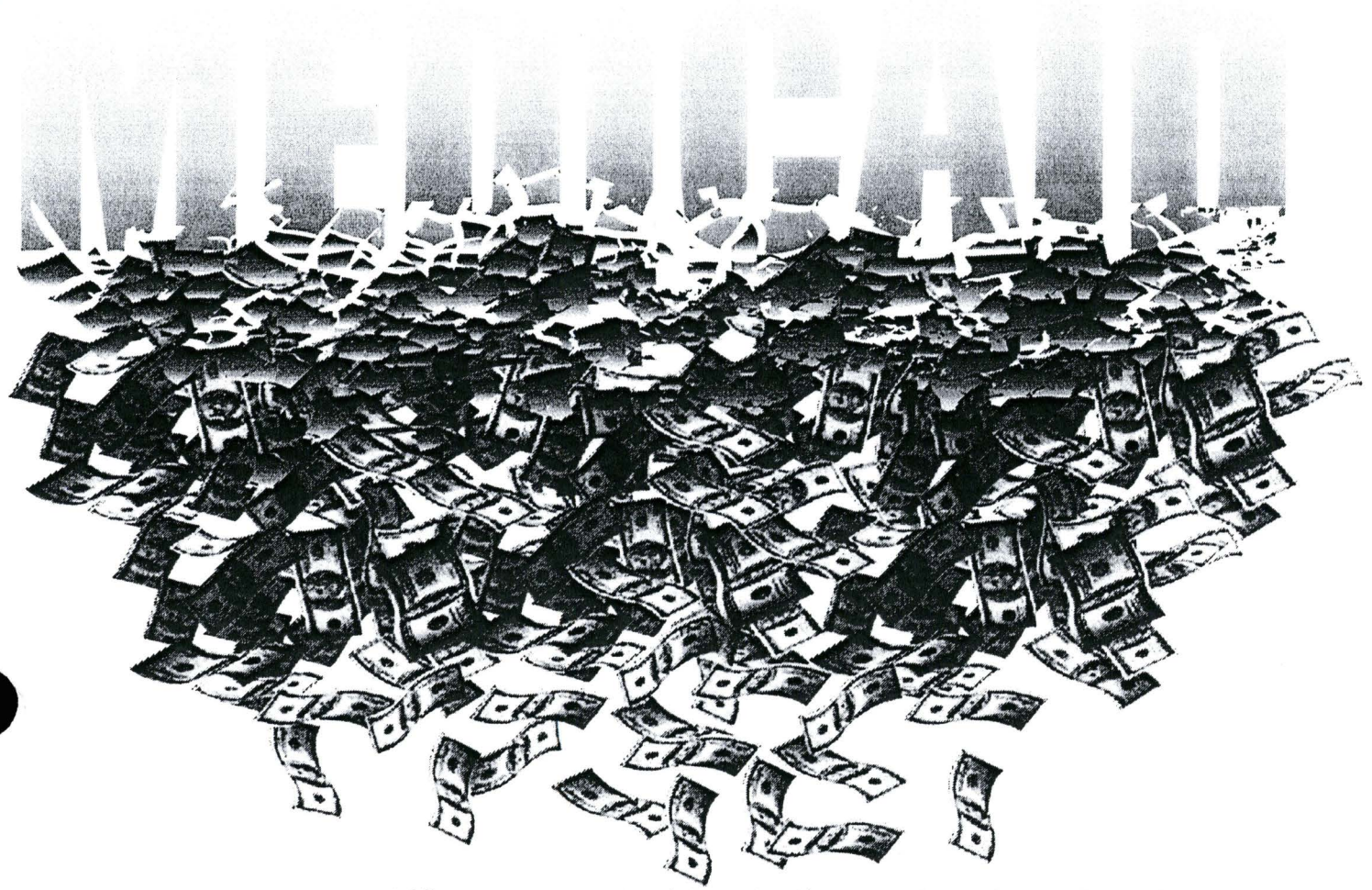
As such, CMS is requesting that North Dakota submit an implementation plan within 60 days of receipt of this letter. The implementation plan should include a timetable for establishing a MFCU, including the earliest feasible date by which North Dakota will submit an application for certification of a MFCU to the Office of Inspector General (OIG). Please submit the implementation plan to the CMS Administrator and provide a copy of your reply to Daniel R. Levinson, Inspector General, 330 Independence Ave., SW, Washington DC 20201.

Should you or your staff have questions about this letter, please contact Jonathan Morse, Deputy Director, Center for Program Integrity, Centers for Medicare & Medicaid Services, at 410-786-1892, Jonathan.Morse@cms.hhs.gov, while questions about requirements of the MFCU program may be directed to Richard Stern, Director, OIG Medicaid Fraud Policy and Oversight Division, at 202-205-0572, Richard.Stern@oig.hhs.gov. Mr. Stern's OIG division would be pleased to provide North Dakota with technical assistance regarding establishing a MFCU, and CMS looks forward to continuing to work with you to protect North Dakota's Medicaid program against fraud and abuse, and its beneficiaries against abuse and neglect.

Sincerely,

Andrew M. Slavitt
Acting Administrator

FIGHTING FRAUD



States are sniffing out Medicaid swindlers and saving a lot of money.

BY MEGAN COMLOSSY

Combating Medicaid fraud and abuse is no easy task. And while some states do it better than others, all face enormous challenges. Limited resources, mountains of transactions and sophisticated scams make for a very tough, but extremely important, job. Just ask Texas.

Dr. Michael David Goodwin, an orthodontist, devised a scheme to defraud the Lone Star State's Medicaid program out of more than $2.6 million. From 2008 to 2011, he billed for services that weren't medically necessary and during times when he wasn't even in town. His bonanza ended when he was caught by state and federal anti-fraud agencies.

Goodwin was by no means a lone ranger. Texas has been hit hard by similar attempts to defraud Medicaid in the past few years. After dental and orthodontic reimbursement rates increased for children's Medicaid in 2007, spending on those services in Texas shot through the roof, much more than in other states. It's not that children in Texas were in greater need of orthodontic services or receiving more expensive care than kids in other states. Rather, it was a handful of orthodontists putting braces on children who didn't need them that was behind the spike in reimbursable care. Some dental clinics were even going so far as to entice Medicaid patients with gift cards and other incentives.

These cases of crooked orthodontists, physicians, home health care providers, pharmacists or other providers are not unique to Texas. Nor are fraud, waste and abuse new to Medicaid programs across the country.

The sheer size and complexity of the joint state-federal Medicaid program—60 million Americans covered at a cost of more

Megan Comlossy is a policy associate in the Health Program at NCSL.

4

than $450 billion annually—put it at considerable risk for violations. Exactly how much is unknown, although estimates by the Centers for Medicare and Medicaid Services suggest tens of billions of dollars each year.

Senator Kemp Hannon (R) New York

"There are too many instances of providers engaging in waste, fraud and abuse," says New York Senator Kemp Hannon (R). And many agree with him. Although this is not a new issue, states and the federal government have renewed their efforts to protect the integrity of the Medicaid program as one way to contain rising costs.

Fraud Fighters

Even in an age of bitterly divided politics and polarization, legislators—from both sides of the aisle and at the state and federal levels—agree that detecting, deterring and combating Medicaid fraud is a way to hold down costs. So what can lawmakers do?

Senate President Wayne Niederhauser (R) Utah

"Our role is to create an environment where auditors, investigators and other fraud-fighters have the statutory authority and budgetary resources to do their jobs," says Utah Senate President Wayne Niederhauser (R).

How states do that looks somewhat different from one state to another. Federal funding, support, technical assistance and, in some cases, collaboration from federal agencies, aid states' efforts to combat fraud. But day-to-day responsibility for fighting fraud rests with state entities. Depending on the state, these may include Medicaid agencies, Medicaid fraud control units, Medicaid inspectors general, attorneys general, auditors or others.

To address the reports of costly dental and orthodontic fraud in Texas, for example, the state formed a task force with officials from the Health and Human Services Commission, that agency's Office of Inspector General, the Office of Attorney General and the OAG Medicaid Fraud Control Unit. These fraud-fighting agencies are common in many states.

The Texas Office of Inspector General, a division of the state's Health and Human Services Commission, is charged with preventing, detecting and pursuing fraud, waste and abuse in all the state's health and human services programs—including Medicaid. Independent of the state Medicaid agency, the office conducts audits and investigations to ensure fraudulent beneficiaries and providers—such as Goodwin—are held accountable. Depending on the situation, the inspector general may try to recover taxpayer money from fraudsters, or refer cases of suspected fraud to the Medicaid Fraud Control Unit for prosecution.

At least eight states have established independent offices of Medicaid inspector general, similar to the one in Texas. Utah is the most recent state to set up an independent Medicaid watchdog. A 2009 report by the Utah Legislative Auditor General estimated the state could save millions of dollars by curbing fraud and abuse in the Medicaid program. Senator

The Defining Differences

Abuse: Conducting unnecessary medical services, procedures or treatments or engaging in questionable and costly business, fiscal or medical practices.

Fraud: Deceiving Medicaid intentionally for unauthorized financial gain. This includes getting kickbacks for promoting certain tests, treatments or medications; billing for services not provided; and billing more complex and costly procedures than were actually performed.

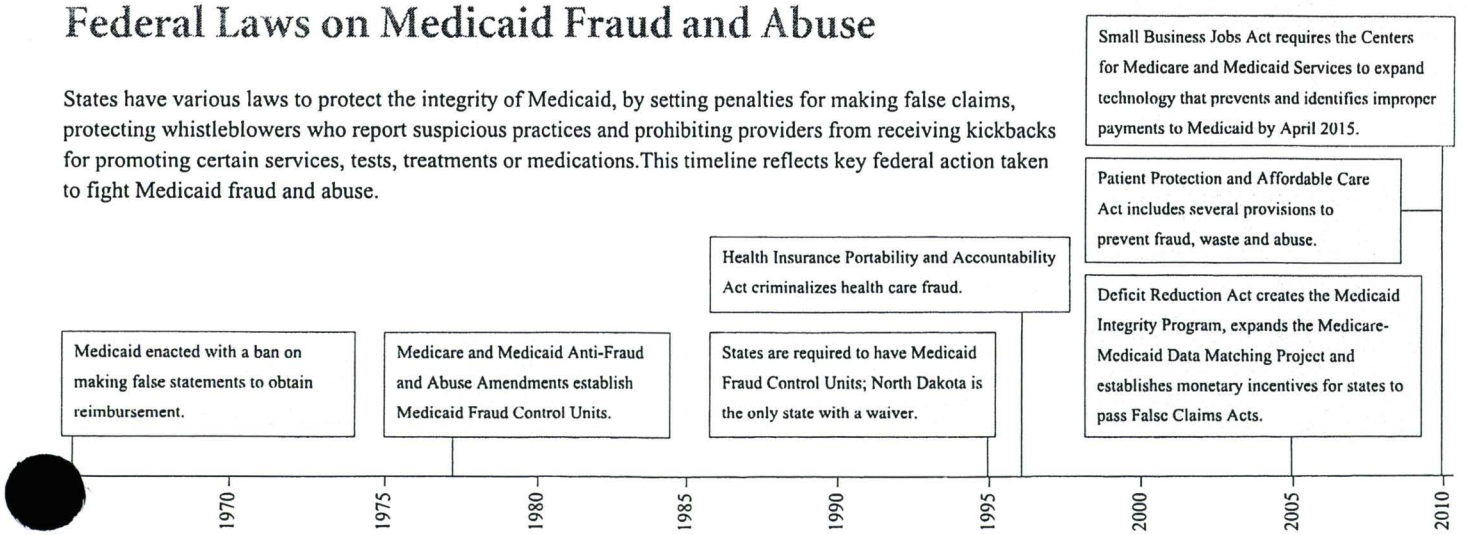
Waste: Misusing resources or billing incorrectly, usually unintentionally, and overusing services, either by beneficiaries or providers.

"Our role is to create an environment where auditors, investigators and other fraud-fighters have the statutory authority and budgetary resources to do their jobs."

—UTAH SENATE PRESIDENT WAYNE NIEDERHAUSER (R)

Federal Laws on Medicaid Fraud and Abuse

States have various laws to protect the integrity of Medicaid, by setting penalties for making false claims, protecting whistleblowers who report suspicious practices and prohibiting providers from receiving kickbacks for promoting certain services, tests, treatments or medications.This timeline reflects key federal action taken to fight Medicaid fraud and abuse.



Fighting Fraud

The Patient Protection and Affordable Care Act contains several provisions to help states fight fraud. A few follow.

1. Information Sharing

The federal law requires states to share information about providers whose billing privileges have been revoked, so they aren't allowed into other state Medicaid or Medicare programs. Previously, a shady Medicaid provider could simply hop state lines to continue swindling taxpayers.

2. Heightened Scrutiny

The law also creates new screening and enrollment requirements for some Medicaid providers—such as home health care attendants and durable medical equipment providers—who historically have higher levels of fraud and abuse. These high-risk providers will be subject to a higher level of scrutiny, including licensure checks, fingerprinting, criminal background checks, and medical site visits to confirm legitimacy and location.

3. Payment Freezes

States now can freeze payments to Medicaid providers if there is a "credible allegation of fraud." The potential savings to Medicaid are obvious: fewer improper payments and less time lost trying to recover funds. Many providers, however, are concerned that Medicaid reimbursements may be halted without just cause, potentially restricting resources for legitimate services.

Niederhauser says the report prompted lawmakers to establish a more "accountable system," with an Office of Inspector General of Medicaid Services.

It's been worth the investment, he says. "We're spending pennies but saving dollars. Having an independent office of inspector general has been money well spent and good policy for Utah so far."

While inspectors general and Medicaid officials are responsible for preventing and investigating fraud and abuse, they also refer certain cases to the state Medicaid Fraud Control Unit. Typically located within the Office of Attorney General, Medicaid Fraud Control Units are responsible for conducting criminal investigations and prosecuting providers suspected of fraud, fraud in the administration of the Medicaid program, and physical abuse in Medicaid-funded facilities. With the exception of North Dakota, every state has one.

Coordination is Key

Despite the fact that these state entities share the common goal of detecting and prosecuting Medicaid fraud, they have not always—and, in some states, still do not—work together. So lawmakers in a few states have mandated interagency collaboration through legislative action. A recent law in Oklahoma, for example, requires the attorney general and the Health Care Authority to share data and allows the attorney general to pursue cases without a referral from the Health Care Authority.

Interagency collaboration has resulted in successful investigations of fraudulent providers, which can send a powerful message that Medicaid fraud won't be tolerated. For example, in Florida, the Medicaid Fraud Control Unit opened an investigation on Nasim Hashmi, based on information provided by the Agency for Health Care Administration. The investigators discovered Hashmi, the owner of L'Image Physical Therapy and Rehabilitation in Miami-Dade County, had billed Medicaid for therapy provided by unlicensed therapists and overbilled for work done by assistant therapists. Hashmi was sentenced to five years' probation and ordered to repay nearly $500,000.

And in New York, the attorney general, armed with information from the Office of the Medicaid Inspector General, caught Brooklyn pharmacist Rao Veeramachaneni buying prescription medications on the black market, dispensing them to unknowing patients, and then submitting claims to Medicaid. Between 2006 and 2008, Veeramachaneni bilked the state out of $1.2 million, the amount he was charged to repay. He was also banned from ever working in the pharmaceutical or health care industry again.

Looking for Savings

"Preventing fraud and abuse is always a priority," says Washington Representative Eileen Cody (D), "but when facing tough economic times, as we have over the last few years, we are looking for coins in the couch cushions."

Representative Eileen Cody (D) Washington

For many state lawmakers, those coins are the savings that come from the difficult re-examination of how limited resources are currently used.

When Douglas Wilson took the reins as Texas inspector general, for example, most investigations were aimed at Medicaid beneficiaries. Based on historical trends, however, Wilson knew that efforts to recover fraud, waste and abuse from Medicaid providers—rather than beneficiaries—reaped a much higher rate of return for the state. So he switched gears and focused the majority of efforts instead on catching fraudulent providers. Although it's hard to prove that a single policy reduced fraud by a specific amount, officials believe that this change, and others designed to improve efficiency and increase monetary returns, are yielding positive results.

North Carolina beefed up its fraud prevention resources—doubling the Medicaid Fraud Control Unit's Medicaid Investigation Division—believing the money it saves will more than pay for their added costs.

Wisconsin appropriated an additional $2 million and 19 positions to the Department of Health Services' Office of Inspector General to support fraud prevention and program integrity efforts, beginning in FY 2013.

With the nation's most expensive Medicaid program, New York has taken various steps to combat fraud in the past few

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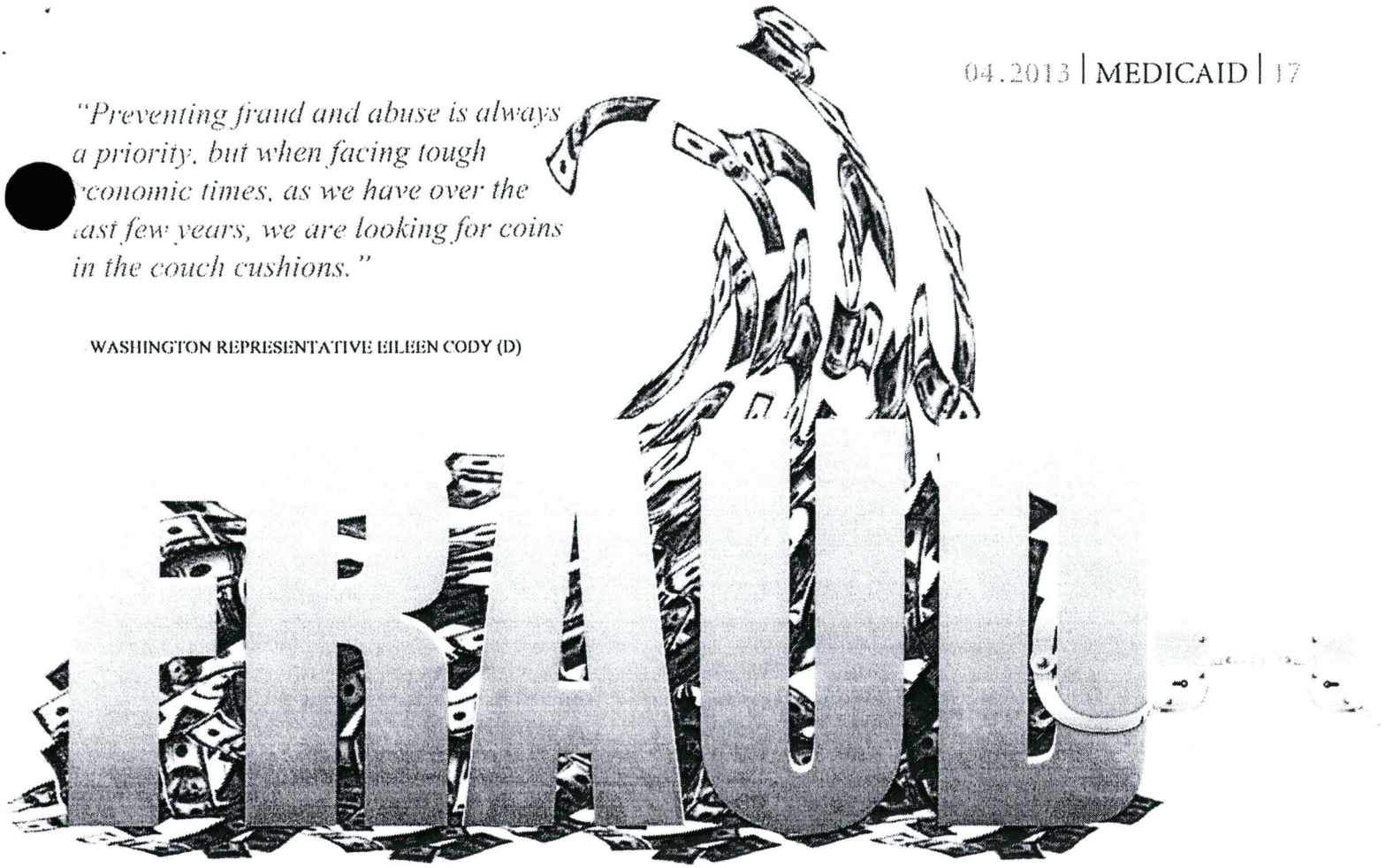
WASHINGTON REPRESENTATIVE EILEEN CODY (D)



ears. In 2006, legislation increased fraud penalties; 2010 saw the creation of a Republican Task Force on Medicaid Fraud; and, in 2011, the governor formed a statewide team to develop recommendations to reform the Medicaid system and reduce costs.

Nevertheless, the state has come under increased scrutiny, after a recent report from the U.S. House Committee on Oversight and Government Reform identified waste, fraud and mismanagement in New York Medicaid. In response, Senate Republicans called for an immediate independent audit of the program and announced a joint roundtable meeting of the Senate Health and Investigations Committees to investigate allegations of inaction by the Office of the Medicaid Inspector General.

"Medicaid is New York state's largest spending program, and we must conduct a thorough and sweeping audit of the entire system to make certain that it is operating as efficiently as possible," says Senator Hannon. "We need to constantly monitor and review Medicaid because taxpayers have a right to expect that their tax dollars are being spent wisely to care for people who truly need health care."

Moving Away From "Pay and Chase"

Fraud fighters are getting assistance from new technology that helps catch fraud before it occurs, rather than chasing after it later on. The technology aims to detect illicit behavior and suspicious billing practices before reimbursement checks are written. It uses real-time data and advanced analytics to identify suspect patterns, flag dubious claims and, potentially, deny payments.

Texas, for example, secured matching federal funds to develop "pattern recognition analysis" technology, a system that will provide near real-time analysis, capable of sifting through immense amounts of data to identify suspicious activity. Illinois' Office of Inspector General developed its own highly advanced predictive analytics technology using a 2007 federal Medicaid Transformation Grant that does similar analyses.

Other technical innovations also offer hope in thwarting Medicaid abuse and fraud. New York, for example, enacted legislation that requires certain groups of providers with a history of Medicaid fraud—such as large home health agencies, long-term home health care programs and personal care providers—to electronically verify services performed. The technology quickly verifies that the services billed to Medicaid are what beneficiaries actually receive.

"History has shown that there are always individuals who try to take advantage of the program—either by outright fraud or not carrying out program requirements properly," says New York's Senator Hannon. "What we need to do is keep a careful eye on providers—and on government—to ensure that entitlements are allotted, apportioned, paid and accounted for in a very fair way."

As Medicaid continues to evolve and expand, those intent on cheating the system will invariably develop new, sophisticated schemes. The challenge for states is to develop equally intelligent, timely strategies to keep one step ahead of the fraudsters.