



Preliminary Report

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COMBATING MEDICAID FRAUD IN NEW YORK STATE

THE SENATE REPUBLICAN TASK FORCE ON MEDICAID FRAUD

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EXECUTIVE SUMMARY

New York's Medicaid program is immense. In less than 10 years, enrollment in the program has jumped from 2.7 million in 2000 to 4.4 million in June 2009, second only to California (6.9 million). In just the past year the State's enrollment has swelled by nearly 300,000, and even with various proposed cuts and a proposed \$1.14 billion in additional taxes earmarked to support health care, the Governor projects that \$52.5 billion will be spent on Medicaid in New York in the 2010-11 fiscal year. That's one billion dollars per week being paid to over 70,000 providers of health care services, goods and drugs. For any given five-year period, one of the Task Force presenters estimated the number of providers, overall, to be 200,000.

One simple fact: Better than one in five New Yorkers are on the Medicaid rolls.

Contrasted with the education formulas with a finite 700 school districts, Medicaid is a study in complexity, intricacy and impenetrability. The sheer size of the State's Medicaid program makes it a system full of opportunities for fraud, waste, and abuse.

Further, once one comprehends the complexity and the size of New York's Medicaid program, the next realization is that the core purpose of the program is to pay bills, not to operate a health care program. Thus the intended use of the program (on the health care side) is to cover emergency and acute (sudden and severe) health care episodes. Major additional features of the State's Medicaid program include long term care (nursing home and home health care) as well as treatment for mental health and substance abuse.

The "bill payer" function of the Medicaid program, along with its roots in being a 1960s poverty program, has led to a growing and recurring resentment from individuals who pay for health care coverage, towards those that enjoy the benefits of the program but are not always perceived as deserving of the subsidy (e.g. Medicaid recipients do not have to pay the co-pay on a pharmacy prescription).

Testimony to the Task Force from the County District Attorneys and County Executives, along with voluminous direct communications, indicates a growing frustration in working between state and local government agencies as they work to limit fraud, waste and abuse of Medicaid – this is our preliminary report.

One of the important intentions of the statute enacted in 2006 creating the Office of Medicaid Inspector General (OMIG) (Chapter 442, Laws of 2006) was to ensure that the counties were active players in the effort to control fraudulent and wasteful Medicaid spending. It is obvious that the counties are willing to be engaged; they have tried to work with the State oversight agencies with limited success, and have enacted creative and successful initiatives on their own, such as setting up an anti-fraud unit in a local District Attorney's office, or purchasing technology at their own expense to track and uncover inconsistencies that point to fraud, waste or overutilization.

Testimony also confirms that we must look at ways to make sure our State's Medicaid dollars are spent in New York, not in other states. There are many cases of specific types of care only available in other states, and of individuals being shifted to other states due to a lack of beds in New York.

Going after improperly spent dollars is a significant component in the process of controlling Medicaid spending, but it is inherently obvious that the best approach is to mitigate the *opportunity* for misuse. Some of the critical tools to determine eligibility and to deter individuals from attempting to defraud the system were stripped from the system in the SFY 2009-10 Budget. In implementing those 2009 laws (Chapter 58, Laws of 2010, Sections 58 – 59(d)), the New York State Department of Health (DOH) recently directed the counties to “...minimize the scope of investigation into resources of the ...” recipients! The counties told us they want them back, and they are looking for new and better tools to assist them in their efforts.

In addition, there are a number of limitations that can be attributed to the often difficult to navigate bureaucratic waters of our State agencies. We need to refine and create new tools to better empower counties in their efforts to maximize fraud and waste recoveries, while at the same time ensuring that those in need of Medicaid are able to access the program in an efficient and effective manner. What follows are preliminary recommendations based primarily on the testimony of those who oversee Medicaid at the local level. If implemented Statewide they will save the State’s Medicaid program millions of dollars.

Obtaining billing data is a critical component in identifying potential fraud, waste and abuse. To assist county district attorneys, there should be an established a set of protocols so that they can gather data from state data banks within a set of parameters that does not exclude them from obtaining the information necessary to begin an investigation.

Research by one data mining company shows that if generic drugs were substituted for brands where physicians did not require brands, there could be as much as \$300 million annual savings Statewide. The company is operating a demonstration program in 12 New York State counties and has shown how their data mining technology can increase a county’s ability to locate and track improper Medicaid spending.

In New York City, another technology company is operating a voice activated time card system for personal care workers. Since its inception in 1995 the system has saved New York City approximately \$1 billion in time card abuse and reduced personal care hours by 4.6%. Statewide, the company believes personal care hours can be reduced anywhere from 5 – 10% with their system.

There are a myriad of technologies available that when incorporated at the State or local level, will allow New York State to realize strong savings and to maintain control over its expansive Medicaid funded health care system.

The next step is to refine our proposals and continue to listen to counties as they relate their experiences and provide us with their insight. As we move forward it is also critical that we examine how we can make our system more accessible and responsive to the needs of New Yorkers who fall under its umbrella of care.

UP TO HALF A BILLION DOLLARS IN SAVINGS TO THE MEDICAID PROGRAM

There are 11 proposals included in our preliminary report. Ensuring that generic drugs are properly dispensed when the physician does not specify a brand drug would save approximately \$300 million Statewide alone. Utilizing new technologies and increasing collaboration between State and local agencies will result in additional fraud, waste and abuse savings.

When all of the proposals are implemented, overall Medicaid savings could total between \$375 million and \$500 million on top of the current targeted savings through the OMIG.

How savings are derived:

- Clinical review of Medicaid expenditures (data mining, tracking how drugs are dispensed, tracking utilization);
- Utilizing new technology to track home and personal care services (voice time cards, etc. would create a 5 – 10% payroll savings Statewide, and lower transportation costs by up to 20%);
- Data sharing (allowing counties appropriate access to the Medicaid Data Warehouse to track provider billing);
- Allowing local district attorneys to prosecute fraud (increases efficiency and increases recoveries);
- Reinstate the asset/resource tests and include a credit check and real property search at application; and
- Change the definition of income to include in-kind income (when someone else is consistently paying the bills, such as a business).

TASK FORCE RECOMMENDATIONS

Empowering Localities to Initiate Local Medicaid Reform and to Combat Fraud, Waste and Abuse

Refer Cases of Fraud to the Local District Attorney Upon Their Request.

Currently, the OMIG is required by law, to refer all potential provider fraud cases to the State Attorney General. Thus, while recipient fraud is investigated by the local Department of Social Services (DSS) and prosecuted by the local district attorney (DA), provider fraud must be prosecuted by the State Attorney General.

Allowing the local district attorneys to handle prosecutions, will result in a more efficient and effective system. The benefits are many: the amount of time it takes to prosecute perpetrators should be reduced; the amount of State resources necessary to prosecute cases from Albany will be reduced, and recovery amounts will certainly increase. Their presence can directly result in not only a decrease in fraudulent activity, but in a decreased tax-burden at the local level. County DA's are essential partners in deterring fraud and should have a prominent role in those activities.

Allow Counties to Keep a Portion of the Fraud Recoveries, Regardless of the Entity That Investigates and Recovers

Currently, the majority of fraud recoveries are returned to the State. Amending Social Services Law (Section 145-b) would allow counties to share in the recoveries; creating an incentive for the counties to invest critical resources (staff time and technology) to pursue fraud and abuse. These efforts will improve the integrity of the Medicaid program and result in offsetting some of the local costs of Medicaid.

Allow Counties to Access to the State Medicaid Data Warehouse (Billing Data)

Uncovering Medicaid fraud often requires a thorough review of a provider's billing records. For example, the only way to discover that a dentist is charging for more fillings than are possible to fill on one patient is to review their billing records. The same holds true for doctors that bill for services that were not rendered. Without this information it is difficult to perform the proper due diligence to detect fraud. The Department of Health (DOH) Medicaid Data Warehouse is the repository for the Medicaid billing information that could be accessed to uncover billing patterns that suggest there may be abuses in the system. Review of such data could result in fraud detection or alert officials to over-utilization of services in certain areas. In most cases, counties are denied access to the data warehouse by DOH, inhibiting any serious fraud and abuse activities they may want to pursue.

Strict parameters can be established to protect against unfettered access to the database. Restrictions on who has access to the data and clear standards for allowing access must be established. However, recognizing the need for counties to access this rich and important data warehouse is a critical component in fighting fraud and wasteful practices at the local level.

Enact a System to Notify Counties When Their Residents are Incarcerated in Other Counties

Medicaid recipients are no longer enrolled in the program when they become incarcerated. They are allowed to rejoin the system once they have been released. According to the counties, in many

instances, their residents are incarcerated in other counties and there is no automated system in place to make their county of residence aware of their status. Thus many times, they remain enrolled in the Medicaid program unnecessarily. This can lead to improper billing and payments as there is a lag in receiving this information. Improving real-time access to this information, in a collaborative effort among counties, state and local agencies will improve the ability to track the status of their incarcerated residents.

Require Recipients to Select One Primary Care Doctor and One Primary Pharmacist Similar to Managed Care Plan Requirements

“Doctor shopping” in some areas is a well documented form of Medicaid fraud. In this instance, recipients go from doctor to doctor getting prescriptions, such as pain medication, opening up the potential for misuse and abuse in the system. It can also lead to outright fraud, where these drugs are sold on the street. Requiring recipients to choose one physician and one pharmacist would serve to limit the opportunity for prescription fraud, and allow officials to more easily track suspicious activity. And, more importantly, this selection has the opportunity to improve the health outcomes of a Medicaid recipient, as one doctor can coordinate a recipient’s care more effectively.

Allow (at County Option) Elected Comptrollers, Treasurers, or Qualified Officials to Audit Medicaid Claims

Certain counties have elected positions such as comptrollers who have demonstrated expertise in monitoring fiscal expenditures of the county, including Medicaid. These offices have competent staff capable of closely overseeing Medicaid expenditures, if provided sufficient resources. A collaborative effort should include all entities with fiscal expertise and the resources to enhance the County’s efforts.

Repatriate Individuals Cared for in Other Counties or States for Long Term Care, Treatment for Traumatic Brain Injury (TBI), etc.

As the health care delivery system has downsized and retrenched, many county residents needing care, have been forced to go out-of-county or out-of-state to receive services. A very revealing example that highlights this issue is found in Albany County. Albany County has 107 individuals being cared for out-of-state (including those with TBI) at a gross Medicaid cost of more than \$5.5 million, while another 768 are cared for in other counties – all reimbursed by Albany County. According to the County Comptroller, payments made to these facilities are often higher than they would be had these individuals remained in Albany County. Complicating this problem is the emotional cost to families who must travel long distances to visit and care for their relatives. A closer analysis of this situation must be done to determine the basis for this phenomenon. Concerted efforts should be made to ensure there are enough services and beds within counties to allow their residents to remain close to home.

Examine Higher Payments to Out-of-State Hospitals

The OMIG in the 2008 Annual Report noted that often out-of-state hospitals are reimbursed at a higher rate than what would have been paid to a New York State provider for similar services. Regulations currently require that New York pay out-of-state providers the same rate that would be paid to a provider located “in the same medical marketing area of the community where the patient resides;” a determination that is difficult to make through the State’s automated claims system. A review of the

regulations and processes should be conducted to determine actions that can be taken to mitigate these discrepancies.

Reinstate the Asset and Resource Test for Medicaid Eligibility Determinations and Include the Local Department of Social Services (DSS) Fraud Unit as Part of the Application Process

In 2009, the Legislature and Governor enacted a measure (Chapter 58, Laws of 2009) that eliminated the resource review when determining eligibility for Medicaid. Testimony was provided to the Task Force from district attorneys that they have discovered instances in their districts whereby individuals had significant resources, in some cases millions of dollars in assets, and were able to qualify for Medicaid based on the fact that only “income” was considered for eligibility purposes.

In assisting in eligibility determinations, social services districts already have fraud units in place that can be deployed in this effort. This trained cadre of employees is already on-site and can provide invaluable assistance in being alert for inconsistencies in information prior to an application being approved for Medicaid assistance.

Require a Credit Report and a Real Property Tax Search at Application

Numerous media reports have exposed Medicaid recipients who were in fact wealthy individuals possessing a large amount of assets including real estate. Opportunities exist for people to hide income (particularly self-employed people) because of Medicaid’s more lenient screening process.

In cases where income is difficult to verify, conducting a credit check can assist in determining someone’s actual wealth. This report can provide information on liabilities such as mortgages and car payments. In certain circumstances this could trigger further inquiry, or provide sufficient information to investigate the county clerk real estate records. Performing checks at the application stage, even if only on a random basis to verify application information, will lower the probability of having to seek recoveries later.

Expand the Definition of Income for Medicaid Eligibility to Include In-Kind Income

Medicaid regulations currently only count an applicant’s cash income when determining eligibility. If an outside source covers expenses of an applicant, that expenditure is not treated as income. Testimony was provided that in some cases, self-employed persons have impoverished themselves by putting all their assets into a business name and then, allowing the company to pay all the living expenses, thereby avoiding declaring this as income for Medicaid eligibility purposes. All sources of an applicant’s income should be included in MA eligibility determinations.

Benchmarking the Utilization of New York State Databases

Going forward, the State should examine the current system of data collection and analysis to determine what opportunities exist to improve how data is collected, examined and utilized in the State’s efforts to mitigate fraud, waste and abuse. In the process, the State’s system should be compared to outside sources, such as other states and the federal government, to determine how New York can improve upon its current system of collection and analysis. Some areas to explore include fraud and abuse detection, fraud and abuse recoveries, data analytical services, subrogation services, enrollment integrity and others.

A BRIEF OVERVIEW OF MEDICAID

Medicaid is the United States health program for eligible individuals and families with low incomes and resources. It is one of the largest joint Federal-state programs and is intended to help lower income Americans obtain medical and health related care. It is a means tested program that is jointly funded by the states, counties and Federal government, and is managed by the states.

In 1965, Congress passed Title XIX of the Federal Social Security Act establishing a medical assistance program. States were required under the Act to provide Medicaid for certain low-income individuals and families; this includes those who receive public assistance and others determined to be medically needy because their resources or income, while ostensibly more than the required eligibility levels for public assistance, are inadequate to purchase essential health care.

In most cases, the Federal government pays a share of the costs of Medicaid, requiring states and localities to cover the remainder. For New York, it is a 50 federal percent match under normal circumstances. However, currently the Federal share is closer to 62 percent because of the current enhanced Federal Medical Assistance Percentage (FMAP) applied under the American Recovery and Reinvestment Act (ARRA).

Medicaid provides three types of coverage: (1) health coverage for low-income families with children and people with disabilities; (2) long term care (LTC) for the elderly and for people with disabilities; and (3) supplemental coverage for low-income Medicare beneficiaries for services not covered by Medicare (such as outpatient, prescription drugs).ⁱ

While the benefits of the Medicaid program are evident and clearly supported by helping lower income families in need, it is an expensive program and costs have increased exponentially in recent years; in some cases Medicaid comprises about half of state and local budgets. Nationally, more than 59 million people are served by the program; more than 4 million are enrolled in New York State.

As the cost of health care has grown and enrollment in Medicaid has also increased, policymakers at all levels of government have grappled with how to provide what has become an essential service many low income individuals and families, while putting together balanced budgets. The results of the recent economic downturn (rising unemployment, sharp declines in revenues and higher demands for public programs, including Medicaid) continue to plague states.ⁱⁱ

Currently, a total of 44 states and the District of Columbia report that program enrollment and spending trends are well above levels projected at the beginning of their fiscal year. Twenty-nine states reported that additional mid-year cuts are likely; and many Medicaid programs have been forced to look at mid-fiscal year cuts in provider rates and program benefits. States are not allowed to reduce Medicaid eligibility this year because as a condition to receive the enhanced FMAP under ARRA they must maintain Medicaid eligibility at July 2008 levels.ⁱⁱⁱ

The states and Congress have gradually developed cost-containment strategies designed to ensure that medical services continue to be available to needy citizens, but at a more affordable cost. However, the size and scope of the program make it an easy target for fraud and provides ample opportunity for waste and abuse. In recent years, states have begun to focus on maintaining the integrity of the program.

MEDICAID IN NEW YORK STATE

Projected to cost more than \$52.5 billion in 2010, New York’s Medicaid program represents the largest single component of the State’s budget. Since its inception, Medicaid expenditures have increased at a tremendous rate, putting a strain on state and local budgets.

Statewide, from 2000 to 2008, Medicaid expenditures rose by 65%, while enrollment rose by more than 80%.

In many counties, Medicaid makes up more than half of the total county budget – in Chemung County, for example it is currently 73% of the total county budget.^{iv}

With regard to overall spending for Medicaid, New York ranks number one nationally, with the next closest states, California, spending \$8.5 Billion less and Texas spending \$29.5 Billion less than New York.

Total Medicaid Spending (billions of dollars)			
	SFY 2009-10 projected	SFY 2010-11 projected	SFY 2011-12 projected
Federal Funds	\$31.34	\$31.88	\$29.45
State Funds	\$13.79	\$13.86	\$19.28 (No enhance FMAP)
Local Fund	\$6.58	\$6.80	\$7.6
Total (Gross)	\$51.71	\$52.54	\$56.34

Source: New York State Division of Budget

In 2005, the Legislature acted to reduce the fiscal burden of Medicaid on counties by accelerating the State’s takeover of the cost of Family Health Plus. Also included were provisions for the State to take over county costs for total Medicaid expenditures that exceed an annual growth rate capped as follows: 3.5% in 2006; 3.25% in 2007; and 3% thereafter. The Legislature also gave the Department of Health the authority to institute a preferred drug program for the State’s Medicaid program.

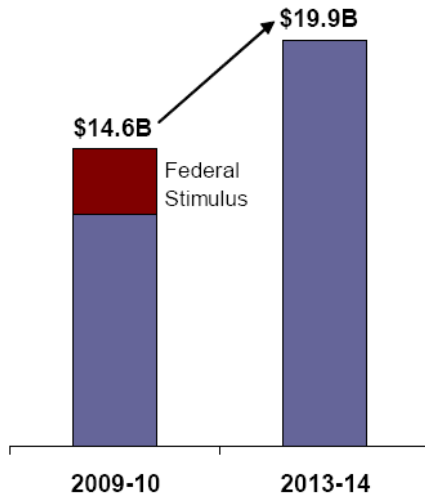
What is Driving the Increased Costs?

Over the last 18 years, Medicaid spending in New York has risen at an annual rate of more than 9%, compared to State spending growth of 3.3%.^v While the focus of this report is Medicaid fraud, it is worth briefly noting a few of the conditions that have driven up the cost of Medicaid.

In terms of per enrollee Medicaid payments, New York spends more than every state in the nation (refer to Appendix A for 2006 state by state details).^{vi}

Growth of 37%

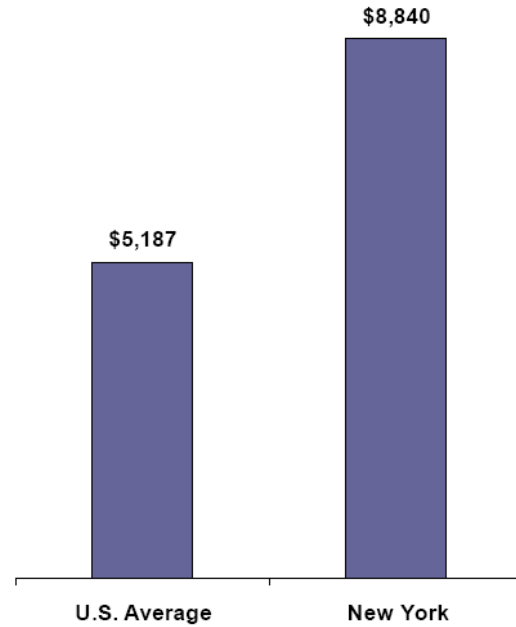
Planned Spending on Medicaid
Fiscal Year 2009-10 to 2013-14



Source: New York State Division of Budget, 2010-11
Executive Budget 21 Day Amendments, February 9, 2010

70% above U.S

Per Beneficiary Spending – NY vs. U.S.



Source: U.S. Department of Health, Center for Medicaid
and Medicare Services, State Data Files, Federal Fiscal
Year 2008

1. New York's Medicaid Eligibility Guidelines

People generally become eligible for Medicaid because they are poor. Eligibility is based on an applicant's income relative to the Federal Poverty Level (FPL) and there are three basic eligibility categories.

1. Those receiving public assistance in most cases are automatically enrolled in Medicaid because the asset and income standards for both programs are similar;
2. Those with incomes below the guidelines (refer to Table 2 below);
3. Those deemed medically-needy.^{vii}

The last category is exceptionally large in New York representing more than a quarter of the national total. New York uses the medically-needy category as a primary route to delivering services to the elderly and disabled including those with modest incomes who lack health insurance as well as those with higher incomes who have high expenses.^{viii} Table 2 below provides income and resource levels for Medicaid eligibility.^{ix}

Table 2**2010 Income & Resource Levels**

Number of Family Members	Medicaid Standard for Singles People, Couples without Children & Low Income Families		Net Income for Families; and Individuals who are Blind, Disabled or Age 65+		Resource Level (Individuals who are Blind, Disabled or Age 65+ ONLY)
	Annual	Monthly	Annual	Monthly	
1	\$8,479	\$707	\$9,200	\$767	\$13,800
2	\$10,584	\$883	\$13,400	\$1,117	\$20,100
3	\$12,593	\$1,050	\$15,410	\$1,285	\$23,115
4	\$14,622	\$1,219	\$17,420	\$1,452	\$26,130
5	\$16,719	\$1,394	\$19,430	\$1,620	\$29,145
6	\$18,253	\$1,522	\$21,440	\$1,787	\$32,160
7	\$19,869	\$1,656	\$23,450	\$1,955	\$35,175
8	\$21,943	\$1,829	\$25,460	\$2,122	\$38,190
9	\$23,131	\$1,928	\$27,470	\$2,289	\$41,205
10	\$24,321	\$2,027	\$29,480	\$2,457	\$44,220
For each additional person, add:		\$99	\$2,010	\$168	\$3,015

Care for disabled and elderly beneficiaries has a significant impact on Medicaid expenditure growth, both because those recipients are considerably more expensive to serve on average and because the number of disabled recipients is growing faster than the number of other types of recipients. New York spends \$20,819 per elderly Medicaid enrollee and \$26,535 per disabled enrollee. The national averages are \$10,691 and \$12,874 (refer to Appendix A for more details).

2. Medicaid Enrollment

In 2007, New York ranked as the fourth highest in the nation in terms of having the highest percentage (21.2%) of people in the State enrolled in Medicaid—only Vermont, Arkansas and Louisiana had higher percentages (refer to Appendix B).

A number of factors including expanding eligibility guidelines; increasing services covered under Medicaid; and economic trends impact Medicaid enrollment. While worth noting, these issues are not the focus of this report.

3. Less than 100% enrollment in Medicaid Managed Care

One of the most fundamental forms of managed care is the use of a network of health care providers to provide care to enrollees. Provider networks can be used to reduce costs by negotiating favorable fees from providers, selecting cost effective providers, and creating financial incentives for providers to practice more efficiently. This type of an integrated delivery system generally includes:

- A set of selected providers that furnish a comprehensive array of health care services to enrollees;
- Explicit standards for selecting providers;
- Formal utilization review and quality improvement programs;
- An emphasis on preventive care; and
- Financial incentives to encourage enrollees to use care efficiently.^x

In recent years, New York has increased the percentage of Medicaid recipients that are enrolled in a managed care system. According to DOH, 37 counties and New York City have mandatory managed care enrollment; 16 are under a voluntary system; and four only require managed care for Family Health Plus enrollees. Thus, the ability for Medicaid enrollees to be part of a managed care program varies across the State from county to county.

A benefit of managed care to both the state and to the recipient is that enrollees have a medical home and see one physician. Two of the counties presenting testimony indicated they had dealt with cases of doctor shopping; both counties have a voluntary managed care program.

According to DOH, enrollment in a Medicaid managed care program through a Health Maintenance Organization (HMO), clinic, hospital, or physician group is available at any local department of social services. Managed care covers most of the benefits recipients will use, including all preventive and primary care, inpatient care, and eye care. People in managed care plans use their Medicaid benefit card to get those services that the plan does not cover.

4. Medicaid Optional Services

In addition to the federally mandates services states are required to provide, states may also receive Federal funding if they elect to provide other optional services allowed by federal law. The categories of services do not describe specific medical treatments or procedures; rather, they identify broad types of services. Optional services are estimated to cost New York State approximately \$15.5 Billion in 2010-2011, nearly 30% of the Medicaid budget. Table 3 below illustrates how many more services New York's Medicaid program offers in addition to the Federally mandates services.

The most commonly covered optional services under the Medicaid program include: clinic services; nursing facility services for the under age 21; intermediate care facility/mentally retarded services; optometrist services and eyeglasses; prescribed drugs; TB-related services for TB infected persons; prosthetic devices; and dental services.

TABLE 3**New York State Medicaid – Mandated And Optional Services**

New York State Medicaid Required (Federally Mandated) Services	New York State Medicaid Optional Services
Home Health Care Services including:	Prescription/Non-prescription Drugs
Medical Home Health Services	Personal Care Services
Personal Care Services	Clinic Services
Inpatient/Outpatient Hospital Care	Prosthetic and Orthotic Devices including Hearing Aids and Prescription Shoes
Laboratory Tests and X-Ray Services	Eyeglasses
Nursing Facility Services for Persons Over Age 21	Physical Therapy and Rehabilitation
Nurse Midwife Services	Dental Care Services
Physician's Services	Dentures
Family Planning Services	Emergency Hospital Services
Nurse Midwife Services	Psychologist Services
Pediatric and Family Nurse Practitioner Services	Optometrist Services
Early and Periodic Screening Diagnosis and Treatment (EPSDT) for Persons Under Age 21	Private Duty Nursing
Medical Transportation	Inpatient Psychiatric Services for Persons Under Age 21
	Transportation
	Case Management Services
	Respiratory Care Services
	Intermediate Care Facilities for the Mentally Retarded
	Nursing facility Services for Persons Under Age 21
	Diagnostic Services
	Screening Services
	Preventive Services
	Rehabilitative Services
	Speech, Hearing and Language Therapy

MEDICAID FRAUD, WASTE AND ABUSE

Medicaid Fraud can be defined as a false representation of fact or a failure to disclose a fact that is material to a healthcare transactions, along with some damage to another party that reasonably relies on the misrepresentation or failure to disclose.^{xi}

As Medicaid costs continue to skyrocket during difficult economic times, the issue of Medicaid Fraud has become increasingly important. Any amount of fraud diverts needed resources away from people that rely on them and into the hands of dishonest providers, recipients, or healthcare workers while imposing a greater financial burden on taxpayers.

While it is very difficult to determine an exact amount of Medicaid dollars lost to fraud, the estimates range from three to 10%. Based on this estimate, New York taxpayers are losing between \$1.5 and \$5 billion each year.

In the 1970s, in response to Medicaid fraud and abuse, Congress enacted the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (Public law 95-142), requiring states to establish Medicaid Fraud Units with the assistance of Federal funding. These units investigate fraud and abuse on the part of providers, while recipient fraud cases are left in the hands of local authorities.

One of the largest challenges New York State faces in its fight against Medicaid fraud is the sheer size the Medicaid program. With a budget projected to exceed \$52.5 billion in SFY 2010-11 and more than one fifth of the State's population enrolled in the program, there are many opportunities for deception and dishonesty.

Common Forms of Medicaid Fraud

Individuals intent on defrauding the Medicaid system have developed numerous, inventive ways to steal taxpayers' money. As the system has grown in terms of size and complexity, preserving the integrity of the program has become more of challenge. Some of the most common forms of Medicaid fraud are highlighted below.^{xii}

1. False Claim Schemes – Can be perpetrated by recipients and providers and include the following;

- Billing for services not provided
- Misrepresentation of what was provided
- Providing unnecessary services
- Charging Medicaid patients more than uninsured patients
- Unbundling of claims
- Double billing
- Fraudulent claim coding (upcoding, miscoding)
- Kickbacks
- False patient review instruments (PRIs)

2. Excessive or Inappropriate Testing – Some physicians order unnecessary tests in order to draw additional Medicaid dollars;

3. Accepting Payment from Other Insurers – This type of fraud involves billing two or more insurance companies simultaneously for the same service or equipment;
4. Personal Injury Mills – Corrupt attorneys and health-care providers sometimes work together to bill Medicaid for non-existent or minor injuries for many unrelated people whom they provide with similar unnecessary services;
5. Sharing Medicaid Identification Cards – Sharing a Medicaid card with someone not authorized to use it could be diminished by using biometric identification technology;
6. Medicaid Prescription Fraud – In some cases providers sell their prescription books to recipients; provide addicts with access to prescriptions that are not medically indicated ; and write prescriptions to be used by people other than the people listed on the prescription;
7. Reselling Items Provided by Medicaid – Reselling items obtained through Medicaid may include prescription drugs as well as expensive and specialized equipment for ill persons and people with disabilities;
8. Recipient Eligibility Fraud – This type of fraud is often reported in the media, highlighting cases of wealthy individuals underreporting their income in order to obtain Medicaid; and
9. Cost-Based Fraud – Providers such as nursing homes are reimbursed by Medicaid based on the provider’s costs of doing business. Cost-based fraud over-represents the costs of doing business.

Some Egregious Examples of Medicaid Fraud and Abuse

- A recent news story reported of several Medicaid recipients who were cheating the system. One incident involved a woman who claimed more than \$60,000 in Medicaid benefits for medical care. The woman being investigated had a bank account balance of \$400,000 and owned several luxury cars along with a home worth more than a million dollars. In addition, she owned two rental properties in Brooklyn, two vacant lots in Florida, along with a commercial glass business.^{xiii}
- A couple accepted more than \$43,000 in Medicaid benefits over a three-year period. The husband worked as an office worker for a construction company making \$1,000 a week, while the wife was a New York City public school teacher who earned \$60,000 a year. On their application the husband stated he worked at a yogurt shop in Manhattan which didn’t exist, and the wife claimed she was unemployed.^{xiv}
- A New York Times investigation of Medicaid fraud revealed in New York City that Medicaid was billed 153 times by an ambulette company that transported a single passenger two or three times a week to doctors’ offices and back for an entire year in 2003. Another Medicaid beneficiary took an ambulette 152 times. In some cases rides that the State paid for, never took place.^{xv}

- Investigations by the New York Times have shown that many of the shuttled patients have had no trouble walking. Medicaid usually covers up to \$31 dollars each way for ambulette rides. They are only supposed to pay for the ambulette service when the patient is severely disabled and unable to walk. While at the same time the public transportation system in the city offers a variety of cheaper transportation methods. Out of all 50 states, New York State Medicaid topped the list paying the most to get patients to hospital and doctors appointments. The cost was \$316 million.^{xvi}
- The New York Times discovered that Executives who head nursing homes and clinics profit from the Medicaid program. Investigators obtained records from the State Health Department showing that 70 executives made more than \$500,000 in 2002 and 25 earned more than \$1 million annually. For example in the Bronx, Laconia Nursing Home’s operator earned \$3 million in salary and profit, 90% derived from Medicaid. Also the Grand Manor Nursing Home earned \$2.4 million in profit and salaries, 90% was financed by Medicaid.^{xvii}
- A New York City-based operation between home health agencies, home health aides and home health training school collaborated in producing bogus certificates for health aides who lacked the proper training mandated by law. This resulted in millions of dollars in illegal Medicaid billing.^{xviii}

Addressing Medicaid Fraud, Waste and Abuse in New York State

New York’s increasing enrollment, expanded services and growing number of providers has created a system that is ripe for fraud and abuse. The State has attempted to get a handle on the Medicaid fraud problem with mixed success.

There are currently six different entities responsible for combating Medicaid Fraud in New York State: the Office of the Medicaid Inspector General, the New York Attorney General’s Medicaid Fraud Control Unit, the Office of the Welfare Inspector General, the 62 New York District Attorneys, local social service districts, and the Office of the New York State Comptroller (see table 2 below).

One of the most significant and recent attempts to combat Medicaid fraud in New York was enactment of Chapter 442 of the Laws of 2006 creating the Office of Medicaid Inspector General (OMIG) within the State Department of Health. The OMIG was created by consolidating responsibilities and staff from six agencies into the new Office and empowering the Medical Inspector General with the ability to detect, investigate, and recover improper payments. The intent of the law states:

“This title establishes an independent office of Medicaid inspector general within the department to consolidate staff and other Medicaid fraud detection, prevention and recovery functions from the relevant governmental entities into a single office, and grants such office new powers and responsibilities. As such, this title is intended to create a more efficient and accountable structure, dramatically reorganize and streamline the state's process of detecting and combating Medicaid fraud and abuse and maximize the recoupment of improper Medicaid payments.”

One tactic employed by OMIG to uncover fraud, is the use of their Undercover Investigations Unit. The process usually begins with a telephone hotline call, an internet complaint, an anonymous report, and/or a report sent out to recipients explaining their medical benefits. Once the Investigations Unit

has identified an alleged fraud abuser, they will then seek services from the targeted Medicaid providers. The unit carried out 2,192 investigations during 2008.^{xix}

The OMIG coordinates Medicaid fraud, waste, and abuse control activities of all State Executive Branch agencies. Through audit, investigative, fraud detection and enforcement efforts, the OMIG recovers State funds that have been inappropriately claimed by individuals and providers. The work of the OMIG is funded in significant part (more than 50%) by the Center for Medicare and Medicaid Services (CMS) of the federal Department of Health and Human Services. In 2006, New York entered into an agreement with CMS requiring the State to identify fraud and abuse recoveries of \$215 million in Federal Fiscal Year 2008. This requirement has led to a significant expansion of OMIG's initiatives and resources.

The SFY 2007 - 08 Budget included numerous initiatives to address fraud, waste, and abuse in Medicaid. To provide for increased auditing of providers, the Budget increased staff of the Office of Medicaid Inspector General by 30% including 100 new auditors to identify, prevent, and combat Medicaid fraud.

Recently, a New York State False Claims Act for Health Care was enacted, modeled after the Federal False Claims Act. The Act authorizes an individual with evidence of fraud to file a case in court and sue on behalf of the state or local government and obtain a share of the recovery.^{xx} Under the "Labor Law section 740 and Civil Service Law section 75-b", the whistleblower receives many of the same protections as afforded in other states. These protections include that public and private employers cannot take retaliatory action towards whistle blowers. In addition aggrieved employees can sue for reinstatement, back-pay and benefits and may be entitled to court costs and attorney fees. (S. 2108-C, Chapter 58, Laws of 2007).

The 2008-09 State Budget also provided support for the operations of the OMIG including resources for additional staff; for investments in technology to strengthen the prepayment identification and verification process to maximize third party recoveries; to enhance the State's ability to investigate fraud and ensure compliance with provider Medicaid standards; to implement new technologies to maximize the capabilities of the eMedNY system for assisting in the detection of fraud, waste, and abuse; and to increase the coordination of anti-fraud activities with other State agencies in order to improve the procedures and protocols for the detection and prevention of Medicaid fraud.

In 2009, the Legislature and Governor enacted a measure (Chapter 58, Laws of 2009) that eliminated the resource review when determining eligibility for Medicaid. The move has proven to be very controversial. Testimony provided to the Task Force from district attorneys enumerated instances in their districts whereby individuals had significant resources, in some cases millions of dollars in assets, and were able to qualify for Medicaid based on the fact that only cash "income" was considered for eligibility purposes.

Table 2
Entities Currently Responsible for Combating Medicaid Fraud

Entity		Authority
New York State Office of Medicaid Inspector General (OMIG)	<p>Est. in 2005, within the Dept of Health</p> <p>Coordinates fraud prevention, detection and investigation activities of all state entities responsible for administering the Medicaid system.</p>	<p>Investigation of fraud committed by providers and recipients;</p> <p>Does not have authority to prosecute criminal violations;</p> <p>Can pursue civil and administrative enforcement actions against individuals committing fraud or abuse</p>
Attorney General’s Medicaid Fraud Control Unit (MFCU)	<p>Est. to comply with Federal laws; (75% of expenditures reimbursed by the feds)</p> <p>Has criminal jurisdiction and civil enforcement tools</p> <p>Focus is on provider fraud</p>	<p>Investigates and prosecutes fraud;</p> <p>Investigates and prosecutes patient abuse and neglect in health care facilities and nursing homes;</p> <p>Seeks the recovery of Medicaid overpayments</p> <p>Federal regulations preclude MFCU from examining Medicaid claims data to develop new fraud cases and from investigating and prosecuting recipient fraud not involving conspiracy with a provider.</p>
New York State Office of Welfare Inspector General	<p>Est. 1992, autonomous office within MFCU.</p> <p>Focus is on recipient fraud</p>	Has jurisdiction to investigate and prosecute recipients and providers
District Attorneys	Primary focus is on recipient fraud	General jurisdiction
Social Service Districts	Report fraud to OMIG	Empowered to investigate fraud
State Comptroller	May audit DOH with respect to fraud	Does not have direct authority over the investigation and prosecution of fraud

THE BENEFITS OF NEW TECHNOLOGY IN REFORMING MEDICAID AND COMBATING MEDICAID FRAUD, WASTE AND ABUSE

Fraud is a moving target, shifting to new and more sophisticated schemes as opportunities arise, yet leaving trails that can be followed with the proper tools, training and a willingness on the part of those charged with protecting taxpayers' money. The focus must be on prevention because once an improper payment is made, only a small portion is ever recovered.

Due to fiscal constraints in budgets at all levels of government; no amount of fraud can be overlooked or tolerated. New York's ever-growing Medicaid Budget echoes calls for our government to do more to combat fraud and incorporate greater technological approaches to keep up with sophisticated scams run by personal injury mills, providers, and recipients who take advantage of loose verification during the application process.

Today, drug abusers and dealers are finding ways to fraud the system to obtain drugs for which there is great demand on the streets. Prescriptions for controlled drugs increased 154% between 1992 and 2002. Hydrocodone is the number one generic drug in the country in volume (102 million prescriptions). By "doctor shopping" and using different pharmacies these individuals can amass a supply of controlled drugs including Hydrocodone and Oxycodone.

The Task Force heard very compelling testimony from county officials and individuals from the technology sector about exactly how systems they have recently put in place have successfully detected fraud and recouped tens of thousands of dollars in lost revenue.

Earlier this year, Salient Management headquartered in Horseheads, and operating a demonstration program in 12 New York State counties, partnered with OMIG to assist in the elimination of Medicaid fraud. The company uses data-mining technology to enable staff to easily visualize the behaviors of providers, recipients, pharmacies and others involved in Medicaid drug and services utilization.

Sandata Technologies, Inc. operates a voice activated time card system in New York City for personal care workers. Since its inception in 1995 the system has saved New York City approximately \$1 billion in time card abuse and reduced personal care hours by 4.6%.

LexisNexis is currently developing solutions that will allow pre-payment analytics to build predictive models. Verification, background checking, monitoring changes, and providing links between individuals and entities are tasks the company claims its software can accomplish.

Other States are also working fervently to put technological safeguards in place to protect Medicaid funds from ending up in the hands of scammers and drug dealers. South Carolina is utilizing sophisticated anti-fraud software. The software develops an algorithm to identify Medicaid beneficiaries who show a pattern of doctor shopping in order to obtain narcotic prescriptions and other controlled substances.

Following testimony in Albany on March 8th and dialogue with officials in our municipalities across the State, it is clear there is great determination to combat Medicaid fraud. The recurring theme was, "give us the flexibility to do our jobs." Those working on the ground are often in a better position to investigate fraud than State bureaucrats based in Albany.

A SUMMARY OF TESTIMONY PRESENTED TO THE TASK FORCE

March 8, 2010, Albany, NY

Kathleen Rice, Nassau County District Attorney

In April 2007, the District Attorney created a Medicaid Fraud Unit, which has uncovered more than \$3.5 million in fraud. She testified that while the County has had success in combating fraud, there are obstacles that impede investigations and prosecutions. The Office of Medicaid Inspector General (OMIG) has claimed that they are forbidden to work with district attorneys because Public Health Law requires OMIG to refer all fraud allegations to the Attorney General for prosecution.

District Attorney Rice stated that bureaucratic compartmentalization has compounded the problem of conducting fraud investigations. A Demonstration Project in Nassau County allowing the County Department of Social Services to investigate provider fraud under the supervision of OMIG has created more bureaucratic hurdles. A bill introduced into the Legislature (S.4774/A.10047, Fuschillo, Weisenberg) would authorize any prosecutor of competent jurisdiction to receive referrals from certain agencies and break down the walls that constrain local investigations.

Another limitation to counties conducting Medicaid fraud investigations is the lack of access to the State Department of Health Data Warehouse. Allowing county investigators access to billing data would make it easier to uncover provider fraud. The District Attorney believes that Federal law would allow access to such information but that the Department of Health interprets such laws more restrictively, only allowing access to data for an “on-going” investigation.

District Attorney Rice emphasized that prosecutorial steps are only part of the equation when developing a plan to combat Medicaid fraud and that preventive measures must be built into the system including credit report and real property searches as part of the application process; including in-kind income as income for determining eligibility; and including the DSS fraud unit as part of the application process.

Kathleen B. Hogan, Warren County District Attorney, President, District Attorneys Association of New York State

District Attorney Hogan spoke of some of the difficulties that exist when conducting a complete Medicaid fraud investigation. Under recent Department of Social Services rules as required by Chapter 58, Laws of 2009, the Department can no longer look at bank accounts, 401K accounts, homes, properties or assets when determining eligibility for Medicaid. This new procedure does not allow a locality to accurately verify an individual’s reported information.

The wide latitude Medicaid enrollees have with regard to doctors and pharmacies allows those who wish to abuse or sell drugs to do so under the radar. They can shop around for doctors willing to provide them with narcotics and then have the prescriptions filled by numerous pharmacies. The Office of Inspector General for Medicaid tracks doctor visits but does not track where drugs are dispersed.

Kathleen M. Jimino, Rensselaer County Executive

County Executive Jimino voiced similar concerns others presented to the Task Force - localities are have a limited role in addressing Medicaid fraud. However, the County does have two contracts for Medicaid fraud detection: one with Island Peer Review Organization (IPRO) and the other with Salient.

While the County has recouped some money as a result of its contract with IPRO, the other advantage to using such technology is that general awareness is raised in the provider community. Those entities who deal with the County are aware that they are under scrutiny and therefore more careful with paperwork.

The County's work with Salient has resulted in recoupment and savings by way of the company's data-mining abilities that demonstrate various relationships. They have identified individuals whose premiums have been paid after their death; those whose service access should be restricted; how often emergency rooms have been used; and whether name brand drugs are being over-prescribed when generic drugs are available.

Thomas J. Santulli, Chemung County Executive, President, NYS Association of Counties (NYSAC)

Mr. Santulli described the "strangling" effect the Medicaid program has on other local spending priorities. The Medicaid program consumes 73% of the Chemung County real property tax levy, and has devastating effects on the budgets of every county in New York. The State draws Federal money by taking advantage of Medicaid maximization, adding \$9 billion to the State's revenue stream. However, the state/local cost sharing agreement adds to the local financial burden, creating a disproportionate local share of Medicaid costs compared to every other state in the nation.

Mr. Santulli recommended counties change their role in the Medicaid relationship to one of an "incentivized" care management partner assisting in reducing wasteful spending. To do this, he recommended utilizing "clinical review" of Medicaid claims and cited the implementation of a county operated medical home as steps Chemung County has taken to manage the outcomes and cost of Medicaid funded healthcare. The medical home – Priority Community Healthcare – was very recently opened and the county believes that because it will provide a single point of entry for health care services, the result will be improved medical outcomes and reduced costs. With regard to clinical review of claims, Mr. Santulli cited successes utilizing a system developed by Salient Management Company which provides easily managed detailed data mining to the county (see Guy Amisano testimony below).

Guy Amisano, CEO, Salient Management

Salient assists high transaction volume businesses and government entities see precisely where spending goes and the outcomes obtained in return, to maximize efficiency and reduce wasteful spending. Twelve New York counties and the OMIG have contracted with Salient for services involving Medicaid oversight and/or Social Services case management. The complexity of the Medicaid program and the abundance of important data fields contribute to profusion of fraud schemes. Increased visibility will increase the capacity for oversight and will decrease fraud. To increase visibility, Salient's "Visual Data Mining" software provides benefits in two distinct areas. Salient first enables individuals to move more quickly through large scale data summaries to outliers that reveal details of fraudulent schemes or over-utilization. Second, because the software is relatively easy to use, it will increase the number of currently employed staff who can explore data and use intuition to discover fraudulent trends and patterns.

Bert E. Brodsky, Chairman, Sandata Technologies

Sandata created Santrax, an electronic time and attendance system, which has been used by Human Resources Administration (HRA) of New York City since 1995. Among other things, the system eliminated the ability of homecare workers to round off times they enter and leave a patients home, and has saved the city over \$1 billion since its implementation. Savings were greater than anticipated because additional unknown fraudulent time card activity was discovered when the paper system was eliminated. New York City along with Monroe, Nassau, Onondaga, Rockland and Westchester counties mandate that home care agencies utilize the system.

Mr. Brodsky explained that the system includes a voice verified phone-in time card system. In other words, the system confirms the identity of home care workers who are required to make a phone call from a patient's home for time and attendance purposes. The system also automatically identifies the location of the caller. The system also has the capability to require caregivers to enter the tasks they performed during the visit to ensure compliance with the Plan of Care. The company has a database of over 300,000 registered home care workers and can keep track of over 50 different fields of compliance criteria (e.g. employee drug screens and certification status). This information is a critical component in ascertaining that providers are certified, credentialed and qualified to provide home care.

Michael F. Conners, III, Albany County Comptroller

The Comptroller reasoned that the massive Medicaid program is a claims paying program with little accountability and oversight. The Legislature could help control waste by allowing elected comptrollers and treasurers to audit Medicaid claims. The Comptroller provided specific examples in which his office discovered discrepancies in expenditures and was able to get access to important information from the Department of Health and Department of Social Services utilizing file FOIL requests.

The Comptroller also contended that the process of "trans shipping" to other states or counties those who need skilled nursing facility treatment or other medical care is inefficient and wasteful in terms of resources, and ultimately unfair to the families involved.

Maggie Brooks, Monroe County Executive (Written Testimony Provided)

Monroe County initiated the County Medicaid Demonstration Project, partnering with the OMIG, a local data tracking company, and private auditing firms. The program allowed Monroe County to recover \$4 million of wrongly claimed funds from 2004 to 2009. Another initiative implemented by the County is the Front End Detection System (FEDS). FEDS requires social service districts to identify and investigate potential cases of fraud, misrepresentation, or questionable documentation before an applicant is made eligible. Of the cases referred for investigation, 35% are denied benefits due to application discrepancies. FEDS also allows for information sharing between eligibility staff and the county Special Investigations Unit.

Traditional audits are performed by Monroe County and a partnering CPA firm, to ensure self-employed applicants and recipients of Medicaid benefits are properly reporting income. In addition, the county has formed a collaborative partnership between the Monroe County Department of Human Services, Sheriff's Office, and District Attorney's Office (a Disqualification Consent Agreement) to ensure prosecution and timely termination of benefits to those who commit fraud. A live fraud hotline

and complaint form on the Monroe County website have also attributed to savings of \$2 million in Medicaid fraud detection. Monroe County is advocating for increased local control to address specific community needs in the fight against social service fraud.

C. Scott Vanderhoef, Rockland County Executive (Written Testimony Provided)

Mr. Vanderhoef submitted a letter detailing bureaucratic and ineffective practices of the OMIG regarding the Medicaid Provider Fraud Demonstration Project. In his letter he explained that the OMIG has not provided sufficient resources including staff and time, and has consistently changed protocols and personnel contacts to make it difficult for the counties to work with them. The OMIG has also narrowed demo project audits exclusively to Pharmacy, Durable Medical Equipment and Medical Transportation, which does not make the best use of the program. Specifically, dental audits are not performed by the OMIG and if the counties were allowed to complete these audits, the project would more efficiently locate fraud. Finally, information from any case that had been initially identified by the county and submitted to the OMIG or the State Attorney General's Medicaid Fraud Control Unit (MFCU) is not shared with the county. Mr. Vanderhoef's letter suggests that a higher level of cooperation and collaboration between the state and the counties is necessary to effectively combat Medicaid fraud, waste and abuse.

LexisNexis (Written Testimony Provided)

Present recoveries of Medicaid fraud make up just over 1% of the budget, while 3-10% of the budget is actually lost to fraud. The two main issues regarding deficiencies in claims systems are their reliance on manpower, and their inability to detect improper payments before they are made. Once an improper payment is made, only a small portion of those funds can ever be recovered.

LexisNexis is currently developing solutions that will allow pre-payment analytics to build predictive models, to analyze a claim for compliance and detection of critical issues (including exclusions and licensure issues, criminal records, dates of death, or relationships with known fraudsters). These alerts will allow for nearly real time review of claims, and those claims exceeding criteria for fraud can be held for review before payment is made. Claims reaching a lower level of fraud criteria can be marked earlier for post payment review, cutting down on the time required to start the process.

True identity management throughout the government enterprise is something LexisNexis can achieve through public records and proprietary data, and linkage of that data to the correct entities. This process provides visibility into the Medicaid system and can block fraudsters from entering the program before Medicaid funds are expended. Verification, background checking, monitoring changes, and providing links between individuals and entities are tasks this software can accomplish without leading to information overload.

Appendix A
Medicaid Payments per Enrollee by State, 2006

Rank	1=low 51=high	Children	Adults	Elderly	Disabled	Total
United States		\$1,708	\$2,142	\$10,691	\$12,874	\$4,757
1. Arizona		\$1,983	\$1,533	\$2,512	\$5,575	\$2,206
2. California		\$1,228	\$847	\$8,369	\$11,890	\$2,740
3. Georgia		\$1,435	\$2,806	\$7,295	\$8,408	\$3,296
4. Texas		\$1,607	\$2,510	\$6,371	\$10,615	\$3,367
5. Louisiana		\$1,003	\$2,751	\$7,007	\$9,267	\$3,563
6. Arkansas		\$1,747	\$1,108	\$10,643	\$10,031	\$3,676
7. Tennessee		\$1,681	\$2,914	\$7,214	\$8,453	\$3,975
8. Alabama		\$1,799	\$1,094	\$7,404	\$5,992	\$4,015
9. Oklahoma		\$1,879	\$2,370	\$8,872	\$11,793	\$4,063
10. Illinois		\$1,400	\$1,981	\$5,037	\$13,933	\$4,129
11. Mississippi		\$1,427	\$2,111	\$8,472	\$7,540	\$4,144
12. South Carolina		\$1,691	\$1,746	\$4,844	\$9,219	\$4,164
13. Michigan		\$1,134	\$2,190	\$10,423	\$8,439	\$4,199
14. Florida		\$1,321	\$2,275	\$7,603	\$10,233	\$4,204
15. Oregon		\$1,840	\$3,381	\$10,102	\$10,218	\$4,272
16. Missouri		\$1,992	\$2,057	\$10,931	\$10,775	\$4,387
17. Washington		\$1,490	\$2,088	\$11,180	\$10,732	\$4,388
18. Wisconsin		\$1,234	\$2,066	\$8,804	\$13,345	\$4,440
19. Hawaii		\$1,859	\$2,832	\$11,002	\$12,956	\$4,484
20. Nevada		\$1,795	\$2,274	\$9,793	\$13,409	\$4,490
21. New Mexico		\$2,091	\$2,522	\$11,271	\$15,358	\$4,521
22. Colorado		\$1,762	\$2,577	\$12,730	\$13,561	\$4,759
23. Idaho		\$1,598	\$3,363	\$12,115	\$14,655	\$4,799
24. Pennsylvania		\$1,767	\$2,576	\$13,247	\$8,585	\$4,832
25. Virginia		\$1,954	\$2,990	\$9,277	\$12,154	\$4,840
26. Kentucky		\$2,074	\$3,479	\$8,841	\$8,661	\$4,870
27. Indiana		\$1,866	\$2,895	\$14,628	\$13,669	\$4,907
28. North Carolina		\$1,882	\$3,133	\$9,738	\$12,673	\$4,943
29. Utah		\$1,508	\$1,957	\$9,742	\$13,908	\$5,005
30. Wyoming		\$2,064	\$3,424	\$14,115	\$18,120	\$5,056
31. South Dakota		\$2,145	\$3,209	\$12,066	\$14,296	\$5,072
32. Vermont		\$2,523	\$2,617	\$9,089	\$14,876	\$5,096
33. Delaware		\$2,255	\$3,688	\$12,760	\$15,244	\$5,152
34. Kansas		\$2,071	\$2,874	\$13,350	\$15,176	\$5,578
35. Iowa		\$1,769	\$2,150	\$13,863	\$17,082	\$5,600
36. Montana		\$2,370	\$3,376	\$15,365	\$12,067	\$5,617
37. West Virginia		\$2,014	\$2,233	\$11,430	\$8,847	\$5,682
38. Ohio		\$1,696	\$2,930	\$18,034	\$15,516	\$5,768
39. Nebraska		\$2,548	\$2,587	\$14,680	\$16,940	\$5,915
40. New Hampshire		\$2,609	\$2,784	\$16,708	\$15,100	\$6,047
41. Maryland		\$2,578	\$3,003	\$14,214	\$18,434	\$6,600
42. North Dakota		\$1,931	\$2,582	\$18,652	\$19,535	\$6,925
43. Massachusetts		\$3,565	\$2,856	\$14,878	\$14,331	\$6,961
44. Minnesota		\$2,475	\$2,927	\$14,887	\$23,131	\$7,129
45. Connecticut		\$2,363	\$2,591	\$23,124	\$23,034	\$7,598
46. Alaska		\$4,078	\$4,851	\$19,809	\$23,865	\$7,644
47. Maine		\$4,237	\$4,389	\$12,637	\$19,928	\$7,775
48. New Jersey		\$2,086	\$2,928	\$16,668	\$21,271	\$7,869
49. New York		\$2,140	\$3,554	\$20,819	\$26,535	\$7,927
50. Rhode Island		\$3,199	\$3,324	\$16,750	\$18,477	\$8,082
51. District of Columbia		\$2,908	\$4,261	\$16,919	\$19,439	\$8,484

Source: The Kaiser Family Foundation

TABLE B**Percent Of Population Enrolled In Medicaid In 2007 – By State**

Rank	State	Percent
1	Vermont	23.5
2	Arkansas	22.1
3	Louisiana	21.4
4	New York	21.2
5	New Mexico	21.1
6	Maine	19.3
7	Tennessee	19.2
8	Mississippi	18.8
9	California	17.8
10	Rhode Island	17.2
11	Kentucky	16.9
12	West Virginia	16.8
13	Delaware	16.7
14	Massachusetts	16.7
15	Oklahoma	16.4
16	Georgia	15.8
17	Hawaii	15.8
18	Alabama	15.6
19	Arizona	15.6
20	Illinois	15.6
21	Washington	15.4
22	Wisconsin	15.2
23	Michigan	15.1
24	Ohio	15.0
25	South Carolina	14.9
26	North Carolina	14.6
27	Pennsylvania	14.3
28	Alaska	14.1
29	Missouri	14.0
30	Indiana	13.0
31	South Dakota	12.7
32	Texas	12.6
33	Iowa	12.3
34	Maryland	12.3
35	Florida	12.1
36	Idaho	12.0
37	Nebraska	11.9
38	Wyoming	11.7
39	Connecticut	11.6
40	Minnesota	11.5
41	Oregon	10.6
42	New Jersey	10.1
43	Kansas	9.8
44	Virginia	9.0
45	Montana	8.4
46	New Hampshire	8.3
47	North Dakota	8.2
48	Colorado	7.9
49	Utah	7.5
50	Nevada	6.7

Source: Morgan Quinto Press, State Rankings 2009

ENDNOTES

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