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Fact Sheet

Biometric Smart Cards in Medicaid: Barrier to Coverage and Ineffective at Reducing Fraud[1]

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This fact sheet discusses the use of "biometrics" for identity verification purposes in Medicaid. Biometric technology compares an individual's physical features (e.g., fingerprint, palm, iris) to information saved in a central database in order to verify that individual's identity. In 2011 there were several proposals in state legislatures involving the implementation of biometric smart cards to verify the identity of Medicaid beneficiaries. Proponents for the use of biometrics in Medicaid say this technology addresses both beneficiary fraud (by preventing card-sharing), and provider fraud (by reducing phantom-billing and other forms of fraud). Yet, past experience has shown that verification programs in government benefits do not effectively reduce fraud or save state resources, but rather serve as a barrier to enrollment into these programs. This fact sheet will: 1) discuss legislative activity in the states with respect to biometric legislation, 2) show how current biometric proposals create barriers to enrollment and care, 3) highlight how these proposals are a costly and misguided effort to address fraud, 4) explain CMS' position on finger-imaging and other similar procedures, 5) analyze the legality of smart card legislation, and 6) provide practical steps and recommendations for advocates to oppose similar legislation in their states.

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Legislative Activity in 2011

Georgia

A bill was introduced in February 2011 proposing to replace existing Medicaid cards with biometric smart cards.[3] The new cards were to include a photo of the beneficiary, which along with a fingerprint template would be stored in a central database. The bill required biometric fingerprint scanners and card readers to be installed in doctor's offices, hospitals, and pharmacies. Medicaid beneficiaries would be required to scan their fingerprint at the point of service, first in a limited pilot program and later statewide (based on the pilot's success.)

The bill passed in the Senate when the finger imaging component was removed. As amended, the bill required the use of "secure identification cards" which included a photo as well as other physical and electronic security features to prevent "duplication, counterfeiting, forging, or modification of the card."[4] The House did not act on the legislation, but the bill remains for consideration in the legislative session beginning January 2012.

New York

In the spring of 2011, a bill was introduced in both the Assembly and Senate to establish a "Medicaid identification and anti-fraud biometric technology program."[5] The program required the use of palm scanners by hospitals, clinics, and pharmacies. The bill was later amended, no longer mandating that palm scanners be used, but still required a biometric component capturing biological data such as DNA, fingerprints, eye retinas and irises, voice patterns, facial patterns, or hand measurements to verify the identity of Medicaid beneficiaries and providers.[6]

In the amended bill, Medicaid beneficiaries would be required to provide biometric proof of identity before receiving services and again at the completion of care or services. The bill required the development of a Request for Proposals to implement the program. After passing the Senate, the legislation was sent to the Assembly and referred to the health committee where it died in committee. In the new legislative session beginning January 2012, the Senate will have to once again pass the bill and send it to Assembly.

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[3] S.B. 63, 151st Gen. Assemb., Reg. Sess. (Ga. 2011)(as introduced Feb. 9, 2011), *available at* http://www1.legis.ga.gov/legis/2011_12/versions/sb63_As_introduced_LC_33_3950_2.htm.
[4] GA. CODE ANN.§ 49-4-1, *amended by* Ga. S.B. 63.
[5] A. 6555, 199th Reg. Sess. (N.Y. 2011) (as introduced Mar. 21, 2011), *available at* http://open.nysenate.gov/legislation/bill/A6555-2011; S. 4384, 199th Reg. Sess. (N.Y. 2011) (as introduced Apr. 4, 2011), *available at* http://open.nysenate.gov/legislation/bill/S4384-2011.
[6] N.Y. A. 6555 (as amended Jun. 6, 2011); N.Y. S. 4384 (as amended Jun. 3, 2011).

North Carolina

On June 13, 2011, Governor Perdue signed a bill into law creating a Smart Card Biometrics Pilot Program, set to last six-to-twelve months.[7] The pilot will involve the use of smart cards by designated Medicaid beneficiaries to verify their identity at the onset and completion of each service. Authentication of the provider will also occur at the time of service. The original bill required finger-imaging and for a photo of the beneficiary to be stored both on the smart card and a central database.[8] However, the final bill signed into law did not include these requirements.[9] The bill still says the purpose of the pilot program will be to "authenticate" Medicaid beneficiaries and providers at the time of services in order to prevent card-sharing, phantom billing, and other forms of fraud.[10] But the state Department of Health and Human Services was simply provided a list of optional requirements and given a lot of flexibility in determining how to implement the pilot program.

Virginia

In 2010, the state enacted a law that directed the Department of Medical Assistance Services (DMAS) to develop a Medicaid biometric pilot program that would use data, "such as fingerprints to immediately verify a recipient's identity and eligibility for services."[11] Participation in the program would be mandatory for all Medicaid beneficiaries residing in three localities: an urban, suburban, and rural locality.[12] The program was to be funded entirely using federal funds.[13]

The pilot program has not been implemented for two reasons. First, the pilot was contingent upon the federal government specifically allocating funding for the pilot, which has not occurred.[14] Second, since the pilot program required mandatory participation of Medicaid beneficiaries, DMAS needed to submit the proposal to the Centers for Medicare and Medicaid Services (CMS) for review. CMS determined that the biometric requirement was a condition of Medicaid eligibility that would violate the Maintenance of Effort (MOE) requirements of the American Recovery and Reinvestment Act of 2009 (ARRA) and the Affordable Care Act (ACA).[15] As such, the state stood to

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[7] Act to Establish the North Carolina Smart Card Pilot Program to Combat Fraud, Ch. 117, 2011 N.C. Sess. Laws, *available at* http://www.ncleg.net/Sessions/2011/Bills/Senate/PDF/S307v5.pdf.

[8] S.B. 307, 2011-12 Gen. Assemb., Reg. Sess. (N.C. 2011) (as introduced Mar. 9, 2011), *available at* http://www.ncleg.net/Sessions/2011/Bills/Senate/PDF/S307v0.pdf.

[9] *Compare* 2011 N.C. Sess. Laws, Ch. 117, *with* N.C. S.B. 307.

[10] 2011 N.C. Sess. Laws, Ch. 117.

[11] Act Establishing Pilot Program for Use of Biometric Data, Ch. 870, 2010 Va. Acts, *available at* http://leg1.state.va.us/cgi-bin/legp504.exe?101+ful+CHAP0870+pdf (enacting H.B. 1378).

[12] 2010 Va. Acts, Ch. 870.

[13] DEP'T OF MEDICAL ASSISTANCE SERV., VIRGINIA MEDICAID BIOMETRIC PILOT IMPLEMENTATION REPORT, H. Doc. 2010-10, Reg. Sess., at 1 (2010), *available at* http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/HD102010/$file/HD10.pdf.

[14] *Id.* at 4.

[15] *Id.* at 5.

lose all federal Medicaid funding if recipients were required to participate.[16] As a result, DMAS decided to make the pilot a voluntary program, but has not implemented it because federal funding has not been made available.[17] Also, a voluntary program would produce minimal cost-savings.[18] Therefore, it is unclear whether this program will move forward.

Barriers to Enrollment and Care

The stated aim of biometric programs is to reduce costs by reducing fraud. However, the evidence to date shows that identity verification programs reduce costs by discouraging eligible beneficiaries from obtaining benefits rather than by preventing fraud.

Biometric smart cards require the collection of biometric data (fingerprint, palm scan, etc.) which is stored in a central database. If the collection of this data is made part of the Medicaid application process, this means that in addition to submitting an application, Medicaid applicants will have to go into a county social service office or other location to have this data collected. If the requirement applies to current beneficiaries as well, they would have to do the same. For some people, this additional hurdle will make it difficult to apply for Medicaid and keep those benefits. This will particularly be true for seniors and people with disabilities.

Moreover, past experience has shown that identity verification programs save money by keeping eligible beneficiaries away. This happened in New York, in 1995, when it became mandatory for all public assistance beneficiaries to have their fingerprints, signature, and photograph taken at a local social service facility before any benefits were issued. In the first two years of the program, more than 38,000 beneficiaries were removed from public assistance programs for not submitting biometric samples, saving the state $297 million.[19] Yet most of the individuals had not submitted samples because they were either "unaware of the requirement, did not understand it, or were unable to meet the compliance deadline." The state later reinstated benefits for most of these beneficiaries.[20]

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[16] Under the ACA's MOE provisions, states are barred from making their Medicaid eligibility "standards, methodologies, or procedures" more restrictive than those in place on March 23, 2010. Patient Protection and Affordable Care Act (ACA) § 2001(b), 42 U.S.C.A. 1396(gg) (West 2011). The Center for Medicaid and Medicare Services (CMS) issued a Dear State Medicaid Director letter issued in August, 2011, further reminding states that "there is extensive evidence that eligibility methods and procedures are strong determinants of whether eligible individuals can actually gain and retain coverage." CMS, *Dear State Medicaid Director* (Aug. 5, 2011) (SMDL #11-009, ACA # 19), *available at* https://www.cms.gov/smdl/downloads/SMD11-009.pdf. The MOE provisions are time limited (in effect until 2014 for adults and 2019 for children). While any current biometric proposals would be measured against the MOE requirements, this limitation will not always apply.

[17] DEP'T OF MEDICAL ASSISTANCE SERV., *supra* note 13, at 6.

[18] *Id.* at 9.

[19] *Id.* at A-4.

[20] *Id.* at A-5.

Five years later (in 2000), New York required adults qualifying for Medicaid to enroll in its public assistance biometric system due to concerns of identity fraud.[21] However, the state terminated this requirement in 2008 because it was becoming increasingly difficult to obtain biometric data from Medicaid beneficiaries (since in-person applications were no longer required), and there was lack of evidence that the program reduced Medicaid fraud.[22] At a time when online applications are more prevalent, and the ACA specifically encourages states to streamline their application processes and simplify eligibility requirements to make it easier for people to get benefits, biometric smart card proposals are counter-productive and create barriers to enrollment and care.[23]

Costly and Misguided Effort to Address Fraud

Biometric smart card proposals will be expensive to implement. In Georgia, a statewide rollout would cost approximately $23 million for the first year.[24] Similarly, in New York it would cost $20 million.[25] Yet, the savings under these programs are unclear, and their effectiveness questionable. Texas was one of the first states to use biometric finger-imaging in Medicaid.[26] In 2004, the state implemented the Medicaid Integrity Pilot (MIP).[27] At the conclusion of the pilot, Texas was unable to determine the extent to which the MIP reduced beneficiary fraud, in part, because it had not determined the extent to which this type of fraud was occurring prior to the pilot.[28] Nevertheless, in 2006, Texas implemented the Medicaid Access Card (MAC) program, which was a mandatory smart card/biometric identification program for Medicaid beneficiaries and providers in three counties.[29] While the program was scheduled for statewide implementation in 2008, the fingerprint component was dropped after federal officials questioned its cost-effectiveness.[30]

Moreover, it is estimated that only ten percent of health care fraud is attributable to consumers, while eighty percent is committed by medical providers and ten percent, by others, such as insurers and their employees.[31] In addition, "card-sharing" has never been proven to be a widespread problem in the Medicaid program. For example, in March 2011, during legislative hearings, the Inspector General for Georgia's

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[21] *Id.*
[22] *Id.*
[23] ACA § 1413, 42 U.S.C.A. 18083 (West 2011).
[24] Letter from Russell W. Hinton, Georgia State Auditor, Dep't of Audits and Accounts, to Honorable John Albers, Georgia State Senator (Feb. 25, 2010) (on file with author).
[25] S. 4384, 199th Reg. Sess. (N.Y. 2011) (as introduced Apr. 4, 2011), *available at* http://open.nysenate.gov/legislation/bill/S4384-2011.
[26] Carrie Teegardin & Christopher Quinn, *Medicaid smart card idea raises questions*, ATLANTA JOURNAL-CONSTITUTION, Mar. 25, 2011, *available at* http://www.ajc.com/news/georgia-politics-elections/medicaid-smart-card-idea-885664.html.
[27] DEP'T OF MEDICAL ASSISTANCE SERV., *supra* note 13, at A-5.
[28] *Id.* at A-6.
[29] *Id.*
[30] Teegardin & Quinn, *supra* note 26.
[31] Sara Rosenbaum et al., George Washington University Department of Health Policy, Health Care Fraud 14 (2009), *available at* http://www.rwjf.org/files/research/50654.pdf.

Department of Community Health indicated that in the past two and a half years, there were only five reports of someone trying to use another person's Medicaid card and only three of those reports were substantiated.[32]

Those in favor of biometric technology claim it can also help stop provider fraud. Yet, these biometric programs place the burden on Medicaid beneficiaries in order to catch dishonest providers. Less costly and more effective methods of uncovering provider fraud exist. In North Carolina, the state has contracted with IBM for a computer software program that can crunch raw electronic billing records to identify suspicious trends among Medicaid providers.[33]

By investing more money in Medicaid Fraud Control Units (MFCUs) rather than in biometric technology, states can obtain greater financial resources to combat fraud and can achieve greater cost savings by addressing provider fraud (the most prevalent type of fraud) .[34] The MFCU budget for an individual state is generally funded with federal grants on a 75 percent matching basis.[35] MFCUs conduct a statewide program for the investigation and prosecution of health care providers that defraud Medicaid. The states with recent legislative proposals involving biometrics: Georgia, New York, North Carolina, and Virginia, all spend only a small percentage of their Medicaid budget on their MFCUs.[36] Yet, for every dollar spent on MFCUs, the return can be significant.[37]

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[32] Teegardin & Quinn, *supra* note 26; *see also* GEORGIA COUNTY WELFARE ASSOC., REPORT ON THE 2012 SESSION OF THE GEORGIA GENERAL ASSEMB., 10 (2011) *available at* http://www.gcwa.us/documents/Reporton2011Legislation.pdf.

[33] Gary Robertson, *NC Medicaid fraud, waste prevention effort begun*, Bloomberg Businessweek, Mar. 24, 2010, http://www.businessweek.com/ap/financialnews/D9EL8IV80.htm; *see also* Liv Osby, *Software roots out Medicaid fraud*, Greenville News, Mar. 7, 2011, http://www.thesunnews.com/2011/03/07/2022884/software-roots-out-medicaid-fraud.html. IBM will receive an amount equal to 10 percent of the fraudulent payments it identifies, capped at $5.4 million annually. *Id.* At the time of this paper, the results of this project were not made public by the state, so it is difficult to assess its validity for other states.

[34] While increasing MFCU resources and workforce may produce substantial cost-savings, it is important to make sure MFCUs are not following cost-saving practices which involve denying or aggressively contesting Medicaid reimbursements for providers who perform legitimately rendered services.

[35] NATIONAL ASSOCIATION OF MEDICAID FRAUD CONTROL UNITS, MEDICAID FRAUD CONTROL UNITS, http://www.namfcu.net/about-us/about-mfcu (last visited Dec. 1, 2011).

[36] OFFICE OF INSPECTOR GENERAL, U.S. DEP'T OF HEALTH & HUMAN SERVICES, MFCU STATISTICAL DATA FOR FISCAL YEAR 2010, (2010), http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2010-statistical-chart.xlsx (last visited Dec. 1, 2011).

[37] *Id.* For example, in 2010, North Carolina spent about $10.9 *billion* in total Medicaid expenditures, but only about $3.1 *million* was spent in its MFCU grant expenditures. *Id.* Yet for every $1 spent on fraud prevention, the state received $17.53 in return. *Id.*

CMS' position on finger-imaging and other similar procedures

In 2001, CMS (then called the Health Care Financing Administration or HCFA) clarified federal policy on the use of finger-imaging or similar procedures as part of Medicaid programs.[38] According to CMS, for a state to use finger-imaging procedures, it must demonstrate that these procedures will be:

- Cost effective and efficient in addressing a particular identified problem,
- Administered in a way that will minimize deterrents to enrollment and ongoing access to benefits for eligible individuals, and
- More effective than other procedures.[39]

CMS also requires that a state show it has explored alternatives to address the identified problem that might have less of a deterrent effect and has determined that imaging procedures are superior to those other procedures.[40]

Also, in any demonstration of cost-effectiveness and efficiency, anticipated savings must be based on reasonable projections of savings to be achieved due to fraud detection, "not savings likely to be achieved because eligible families and individuals are deterred from applying for or retaining Medicaid coverage as a result of the procedures."[41] Finally, CMS says that states will have to demonstrate that other, less intrusive, procedures would not adequately address the problem and that this technology will be implemented in a manner that is not likely to deter eligible individuals from applying for or continuing to receive benefits.[42]

Yet current biometric proposals stigmatize Medicaid beneficiaries. Having Medicaid beneficiaries scan their fingerprint or palm every time they go in and out of a doctor's office, hospital or pharmacy targets Medicaid beneficiaries by making them stand out in public settings. Only Medicaid beneficiaries will be required to do this each time they receive a medical service, adding to any stigma that may already exist about receiving government benefits. As indicated in a report by Virginia's Department of Medical Assistance Services, there is a negative public perception around fingerprints because they are used by law enforcement agencies, and using fingerprints to verify the identity

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[38] Memorandum from Cindy Mann, Director, Family and Children's Health Program to Health Care Financing Administration Associate Regional Administrators (April 4, 2001) (on file with author).
[39] *Id.*; *see also* GERALD FRALICK, NORTH CAROLINA CHIEF INFO. OFFICER, SMART CARD INITIATIVE: QUARTERLY REPORT TO THE JOINT LEGISLATIVE OVERSIGHT COMMISSION ON INFORMATION TECHNOLOGY, at 5 (Jan. 2011), *available at* https://www.scio.nc.gov/library/pdf/Smart_Cards_report_%28January_2011%29_FINAL.pdf.
[40] Mann, *supra* note 38.
[41] *Id.*
[42] *Id.*

of Medicaid beneficiaries will intimidate people and keep them away from the Medicaid program and the health care services they need.[43]

Legality of Smart Card Legislation

To date, there are no published cases where a court has ruled directly on the legality of biometric smart cards in Medicaid. However, courts have assessed state laws that impose substance abuse testing requirements for public assistance applicants and recipients. These cases provide helpful analogies to assess the validity of biometric legislation.

In *Marchwinski v. Howard*, the Sixth Circuit Court of Appeals affirmed a District Court decision holding that the suspicionless testing for substance abuse of public assistance applicants/recipients is an unconstitutional search and seizure under the Fourth Amendment of the U.S. Constitution.[44] The district court stated that "some quantum of individualized suspicion" is generally required for a search or seizure to be constitutional except in "certain limited circumstances" when "special needs" are shown.[45] The court further noted that the state had not demonstrated a special need that justified a departure from the requirement of "individualized suspicion" and failed to show that public safety was genuinely placed in jeopardy in the absence of substance abuse testing of all public assistance applicants and of random testing of public assistance recipients.[46]

Similarly, biometric data collection and verification based on a belief that applicants/recipients of the Medicaid program are committing fraud may also be considered an unconstitutional search and seizure. The collection of an individual's physical features (e.g., fingerprint, palm, iris) compared to a central database each time the Medicaid beneficiary receives services, is not much different from the collection and testing of a urine sample, which is considered a "search" within the meaning of the Fourth Amendment.[47] The states proposing to collect biometric data are doing so without an individualized suspicion of fraud. Rather the states simply believe "some" people in the Medicaid program are committing fraud. As in *Marchwinski*, there are no special needs showing a public safety concern that would justify a suspicionless search. Standards and methods for determining Medicaid eligibility must be consistent with rights of individuals under the U.S. Constitution and civil rights laws.[48] Therefore, if

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[43] DEP'T OF MEDICAL ASSISTANCE SERV., *supra* note 13, at 2-3. Other biometric options have other types of disadvantages, for example, iris imaging requires lengthy staff training, hand geometry requires a large amount of storage space to maintain data electronically, and palm vein imagining requires a certain amount of physical contact with biometric sensors, which may spread disease. *Id.*
[44] 60 Fed. App'x. 601, (6th Cir. 2003), ***aff'ing*** 113 F. Supp. 2d 1134 (E.D. Mich. 2000).
[45] *Id*. at 1138.
[46] *Id*. at 1139-1140.
[47] *Marchwinski, supra* note 44.
[48] 42 C.F.R. § 435.901.

biometric data collection is a violation of the Fourth Amendment, it would be unconstitutional and could not be used as a standard for determining Medicaid eligibility.

In *Lebron v. Wilkins*, a district court granted a preliminary injunction finding that a Florida law requiring all Temporary Assistance for Needy Families (TANF) applicants to submit to suspicionless drug testing is highly likely to violate the Fourth and Fourteenth Amendments.[49] The plaintiff in this case contended that the state's drug testing program violated his right to be free from unreasonable searches.[50]

In 2001, Florida had developed and implemented a "Demonstration Project" to study and evaluate the impact of drug-screening and testing on employability, job placement, job retention and salary levels of program participants, and make recommendations based, in part, on a cost-benefit analysis.[51] The recommendation at the end of the project was that it not be expanded because of the high costs of drug testing compared with the benefits derived, and the "minimal differences in employment and earnings between those who showed evidence of current substance abuse and those who did not."[52]

Yet, ten years later, in 2011, the Florida legislature "resurrected" the concept of drug testing TANF applicants.[53] No new studies were conducted, and no new data was offered, nevertheless, on July 1, 2011, drug testing of TANF applicants became effective in the state.[54] In the program's first month, preliminary results from drug testing showed that only 2% of applicants tested positive.[55] Applicants that did not take the drug test were denied benefits.[56] The district court mentions that some of these denials may be due to the statute's deterrent effects, for example: inability to pay for the drug test, lack of "approved" laboratories near the applicant's residence, inability to secure transportation to a laboratory, or refusal to accede to what an applicant considers an unreasonable condition to receive benefits.[57] Ultimately, the court held the state had not shown evidence that any TANF funds would be saved by instituting the program, or that there would be any financial benefit or net savings due to the passage of the statute.[58]

In a very similar way, biometric smart card policies produce questionable cost-savings and cause the same deterrent effects. As explained more fully in the sections above, the evidence to date shows that identity verification programs reduce costs by discouraging eligible beneficiaries from obtaining benefits rather than by preventing

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[49] No. 6:11-cv-01473-Orl-35, 2011 WL 5040993 (M.D. Fla. Oct. 24, 2011).
[50] *Id.* at *1.
[51] *Id.* at *2.
[52] *Id.* at *4.
[53] *Id.*
[54] *Id.* at *4,6.
[55] *Id.* at *6.
[56] *Id.*
[57] *Id.*
[58] *Id.* at *15.

fraud. This was the case in New York where thousands of beneficiaries were removed from public assistance for not submitting biometric samples, and eventually this requirement was removed, in part, because of lack of evidence that the program reduced Medicaid fraud.[59]

Conclusion and Recommendations

Biometric smart card programs claim to reduce fraud and save state resources, yet they place an undue burden on Medicaid applicants and beneficiaries. Past biometric technology programs have not proven to be cost-effective and have deterred eligible beneficiaries from enrolling in the program and receiving services. The vast majority of Medicaid fraud is committed by providers, not beneficiaries, and there are other less costly ways to address provider fraud. Finally, the legality of biometrics legislation is questionable, and it appears the collection of biometric data in Medicaid would be considered unconstitutional.

Recommendations:

1) Monitor policy developments in your state so you will know when biometrics policies are under consideration.

2) Develop a quick response to proposed biometric legislation.

3) Make policy makers aware of the legal impediments and policy concerns with the use of biometrics in Medicaid.

4) Use the information in this fact sheet to prepare one-page alerts and/or information pages for distribution to stakeholders and policy makers.

5) If smart card legislation is enacted in your state and you are considering a legal challenge, the National Health Law Program is available to support you. Please do not hesitate to contact us.

[59] DEP'T OF MEDICAL ASSISTANCE SERV., *supra* note 13, at A-4, 5.