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BOLSTERING THE SAFETY NET: ELIMINATING MEDICAID FRAUD

HEARING

BEFORE THE

FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT INFORMATION, AND INTERNATIONAL SECURITY SUBCOMMITTEE

OF THE

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

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MARCH 28, 2006

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BOLSTERING THE SAFETY NET: ELIMINATING MEDICAID FRAUD

TUESDAY, MARCH 28, 2006

U.S. SENATE,
SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT,
GOVERNMENT INFORMATION, AND INTERNATIONAL SECURITY
OF THE COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2:30 p.m., in room SD–342, Dirksen Senate Office Building, Hon. Tom Coburn, Chairman of the Subcommittee, presiding.

Present: Senators Coburn, Carper, and Akaka.

OPENING STATEMENT OF SENATOR COBURN

Senator COBURN. The Subcommittee on Federal Financial Management of the Homeland Security and Governmental Affairs Committee will come to order. I want to welcome each of our witnesses today, and to discuss briefly some of the problems that we face.

One in five Americans today is on Medicaid. That's somewhere between 57 to 60 million Americans. The program costs taxpayers $330 billion this year, and that figure is growing at more than twice the rate of inflation.

Between 2004 and 2005, the last years for which we have data, the program grew by 12 percent. Medicaid growth is outpacing even that of Medicare. What's more, the Federal investment in Medicaid is only growing—by 2016, it is estimated that Medicare and Medicaid alone will make up half of the Federal budget for mandatory spending.

That unchecked spending growth would be troublesome enough. However, that's not the end of the story. Unfortunately, fraud and improper payments is a huge problem in this program. We don't know how huge because nobody is measuring the problem in any sort of systematic way. As a result, the estimates of scope of Medicaid fraud are all over the map, but are likely to be no lower than 10 percent and could be, in some States such as New York, during some years, as high as 30 to 40 percent.

In just one year, New York was defrauded, some have estimated, by as much as $18 billion. If true, that would represent a fraud rate of about 42 percent for that year in New York alone. More than every third dollar that should help the poor was wasted to fraud and abuse. If we use CBO's current baseline estimates for the Federal share alone of Medicaid by 2016, and we assume what is probably a low estimate in terms of the rate of payment for fraud

or errors—10 percent—the total is $39 billion in taxpayers' dollars that are diverted from care for those that need it.

The reasons for the problem are mainly structural. We simply have not put into place the necessary systems to detect and control fraud and other improper payments. However, Congress did pass the Improper Payments Information Act of 2002, and to date, Medicaid is still out of compliance with that law, and CMS admits that the program will likely stay out of compliance until 2008 at the earliest.

We've had three hearings already on improper payments in this Subcommittee, and we will continue to have improper payment hearings until every agency is not only in compliance with but reporting their payment errors, but has also reduced those errors to more reasonable levels.

Apart from flagrant violations of the law, what we need to do is talk about some of the institutional reasons for the fraud problem. First, there's a responsibility problem, and this Subcommittee works under the idea of accountability. The Federal Government has chosen to abdicate on fraud control at the level where most fraud happens—individuals, providers, and facilities.

Instead, CMS focuses oversight efforts on how State governments behave, leaving the bulk of fraud control to States. However, this ceding of responsibility is not mandated by law and ignores the significant Federal interest in controlling fraud when 59 cents out of every dollar spent on Medicaid is Federal tax dollars.

Second, CMS monitors States' behavior primarily, but even this State monitoring by CMS is weak. Under the current CMS procedure, each State gets monitored for fraud control by CMS at best only once every 7 or 8 years. This means that at any given time, CMS has no accurate picture of fraud control efforts even in a majority of the States.

Third, States, who have by default become the primary fraud overseers, have typically diluted their fraud control's activities by housing them under the same roof as their program integrity operation. That is the unit responsible for ensuring that the State pays every claim and gets its full Federal match. The somewhat mutually exclusive missions between program integrity function and fraud control unit's function leads to fraud control getting the short end of the stick.

Fourth, our incentive structure is out of whack. States face the perverse incentive that for every additional dollar they spend on Medicaid, even if it's fraudulently paid, they receive more than that dollar back from the Federal Government in the Federal Medicaid match.

CMS is rightly tracking inappropriate and unlawful cost-shifting games that States play by artificially inflating their cost in order to maximize their Federal match, only to then place the surplus back into the supposed State contribution, which then pluses up their Federal match again.

Another scam along similar lines is the provider tax, whereby States charge providers taxes, which is reimbursed through increased payments. That increased charge the State uses to get a bigger Federal match, and then it reimburses the providers for the

tax and pockets the Federal cash. CMS has got to put an end to these schemes based on Medicaid's perverse incentive structures.

Finally, there is simply no strategic plan for getting the problem under control. There's no data collection to even measure the problem or track its progress over time.

With the Federal investment in Medicaid growing at exponential rates each year, CMS needs to take responsibility for fraud control by both increasing its efforts at the Federal level and providing some standardization, monitoring, and coordination at the State level.

I believe an effective strategic plan would have the following elements:

- Clearly delineate roles and responsibilities for fraud control and standardize those roles across States.
- Put CMS on record for measurable targets for fraud reduction and timelines for meeting those targets.
- Apply consequences with real teeth for failing to meet those targets on time.
- Provide support and assistance to States who create sound organizational structures for separating fraud control activities from programmatic financial management. Texas, who will be testifying today, is a model of how to provide both independence for its fraud control activities as well as integration of those activities with all the other players in government necessary to ensure that those activities are effective. For example, Texas' Inspector General has subpoena power, whereas New York's does not.
- Measure the problem in a systematic and reliable way, standardized across States. CMS officials themselves have estimated that appropriate information-sharing and data collection would not be expensive to support, perhaps as low as $100,000 annually.

Finally, I want to thank our witnesses for being here today, and I want to emphasize that their efforts to control fraud are not going unnoticed. Many individuals at both the State and Federal levels are working hard to combat fraud, and I commend them for their work. Some States have implemented creative solutions to prevent and control fraud. Texas just undertook a massive reorganization of its health and finance infrastructure in order to prevent and control fraud, and provides a good model for other States to follow.

I go home on weekends to Oklahoma and practice medicine. Many of my patients are Medicaid patients. Some of them actually are pregnant with the next generation of Americans. Every time I deliver a new baby into the world, I'm reminded why I spend the rest of my next week in Washington. I do not want us to become the first generation of Americans to leave our country in worse financial shape than we found it. I know each of you today share that goal, and I look forward to working with you.

Our first panelist is Daniel Levinson, Inspector General of the U.S. Department of Health and Human Services. As Inspector General, he serves as the chief audit and law enforcement executive for the largest civil department on the Federal Government, with a budget that accounts for nearly one of every four Federal dollars.

He manages an independent and objective oversight unit of 1,500 auditors, analysts, investigators, lawyers, and support staff dedicated to protecting the integrity of over 300 Department of Health and Human Services programs and the health and welfare program of beneficiaries.

Next is Dennis Smith, Director of the Center for Medicaid and State Operations. Mr. Smith has been Director of the Center for Medicaid and State Operations since July 19, 2001. As director, he provides leadership in the development and implementation of national policies governing Medicaid, the State Children's Health Insurance Program, survey and certification, and Clinical Laboratories Improvement Act, and he oversees CMS interactions with States and local governments.

Next is Leslie Aronovitz, Director, Health Care, U.S. General Accountability Office's health care team. She has held her position of Health Care Director at the GAO for most of the past 14 years. She is responsible for a variety of health care issues, including Medicare administration and management, the Centers for Medicare and Medicaid Services governance, Medicare and Medicaid program integrity, and health profession shortages.

I want to welcome each of you. Your statements will be submitted to the record without objection. And if you would limit your testimony to 5 minutes, or somewhere around that, then we'll get on to questions.

I welcome Senator Akaka. Would you care to make an opening statement, Senator Akaka?

Senator AKAKA. Yes, Mr. Chairman.

OPENING STATEMENT OF SENATOR AKAKA

Senator AKAKA. I thank you very much for having this hearing. Medicaid fraud needs to be examined so that we can see how we can improve the administration of this vital program. However, Mr. Chairman, we must ensure that individuals are not unfairly denied treatment in the name of a fraud crackdown, especially, since provider fraud is much more prevalent than beneficiary fraud.

The Deficit Reduction Act contained a provision that will require individuals applying or reapplying for Medicaid to verify their citizenship through additional documentation requirements. The requirements will—what I'm coming down to is that we must repeal this provision before it goes into effect July 1, 2006 because it will create barriers to health care. It is unnecessary and there will be an administrative nightmare to implement. For most native-born citizens, these new requirements will most likely mean that they will have to show a U.S. passport or birth certificate.

The Center on Budget and Policy Priorities estimates that more than 51 million individuals in this country will be burdened by having to produce additional documentation. In Hawaii, an estimated 200,000 people who are enrolled in Medicaid will be required to produce additional documentation. The estimate for Oklahoma is 654,000 people.

The requirements, as I said, will impact low-income, racial and ethnic minorities, indigenous people, and individuals born in rural areas within access to hospitals. One in 12 U.S. adults who earn

incomes of less than $25,000 report they do not have a U.S. passport or birth certificate in their possession.

An estimated 3.2 to 4.6 million U.S.-born citizens may have their Medicaid coverage threatened simply because they do not have a passport or birth certificate readily available. Many others will also have difficulty in securing these documents, such as Native Americans born in home settings, Hurricane Katrina survivors, and homeless individuals.

Mr. Chairman, you do understand the difficulty in gaining access to health care. Having to acquire a birth certificate or a passport before seeking treatment will create an additional barrier for care. Some beneficiaries may not be able to afford the financial costs or time investment associated with obtaining a birth certificate or passport. Hawaii Department of Health charges $10 for duplicate birth certificates. The costs vary by State and can be as much as $23 to get a birth certificate, or $97 for a passport.

Taking the time and obtaining the necessary transportation to acquire the birth certificate or passport, particularly in rural areas where public transportation may not exist, creates a hardship for Medicaid beneficiaries. Failure to produce the documents quickly may result in a loss of Medicaid eligibility. Further compounding the hardship is the failure to provide an exemption from the new requirements for individuals suffering from mental or physical disabilities.

Those suffering from diseases such as Alzheimers may lose their Medicaid coverage because they may not have or be able to easily obtain a passport or birth certificate. It is likely these documentation requirements will prevent beneficiaries who are otherwise eligible for Medicaid to enroll in the program. This will result in more uninsured Americans and increase the burden on our health care providers and the delay of treatment for needed health care.

Just last Friday, while visiting Kapiolani Medical Center for Women and Children in my home State of Hawaii, I met with a mother who said if it wasn't for Medicaid benefits, her special-needs child would not have the level of care he is getting now at Kapiolani. Parents who are dealing with hardships of having a sick child should not have to worry about their current Medicaid status due to these new requirements.

Citizenship status checks will impose unnecessary challenges that are not needed due to current protections already in place. The Hawaii Primary Care Association estimates that administrative costs for our Department of Human Services will increase by $640,000 as a result of these new requirements.

I know the authors of this provision in the House believe that illegal immigrants are costing their State significant amounts of money. They claim that more than $80 million of a State's total $7.6 billion Medicaid budget has gone to illegal immigrants. Other sources find the amount may exceed $300 million. If Medicaid fraud in Georgia is so rampant, perhaps it would be more responsible to first investigate the problems experienced by Georgia's Medicaid program. Mandating these requirements nationwide because of the difficulties confronting one State is a prescription for disaster.

The proponents of this misguided policy believe that applicants will be able to just show a driver's license or a State identification card under the REAL ID Act. However, it is not expected that the Department of Homeland Security will even issue regulations until this summer, and compliance is not expected until 2008.

The real purpose of the additional documentation requirements is to reduce the number of people on Medicaid in a short-sighted attempt to save money. All we have done is to make it more difficult for citizens to get Medicaid rather than undocumented immigrants. Denying access to Medicaid unfairly will cost more money than it will save.

Denying access to primary care will increase uncompensated care provided by our health care providers. Denying access to primary care will result in more pain and suffering of individuals. For example, people without Medicaid will have to seek treatment for renal failure instead of having access to the care needed to properly manage their diabetes.

I thank all of our witnesses today for being here, and look forward to your testimony. And again, I want to thank Mr. Chairman for having this hearing. Thank you very much, Mr. Chairman.

I would like to at this time ask unanimous consent that my full statement be included in the record.

Senator COBURN. Without objection.

PREPARED STATEMENT OF SENATOR AKAKA

Thank you Mr. Chairman. I appreciate your conducting this hearing today. Medicaid fraud needs to be examined so we can see how we can improve the administration of this vital program.

However, Mr. Chairman, we must ensure that individuals are not unfairly denied treatment in the name of a fraud crackdown especially since provider fraud is much more prevalent than beneficiary fraud. The Deficit Reduction Act contained a provision which will require individuals applying or reapplying for Medicaid to verify their citizenship through additional documentation requirements. I have introduced legislation, S. 2305, to repeal these burdensome documentation requirements for individuals applying or reapplying for Medicaid to verify their citizenship.

We must repeal this provision before it goes into effect July 1, 2006, because it will create barriers to health care, is unnecessary, and will be an administrative nightmare to implement. For most native-born citizens, these new requirements will most likely mean that they will have to show a U.S. passport or birth certificate.

The Center on Budget and Policy Priorities estimates that more than 51 million individuals in this country will be burdened by having to produce additional documentation. In 16 States, Arizona, California, Florida, Georgia, Illinois, Louisiana, Massachusetts, Michigan, Missouri, New York, North Carolina, Ohio, Pennsylvania, Tennessee, Texas, and Washington, more than a million Medicaid beneficiaries will be required to submit the additional documents to receive or stay on Medicaid. In Hawaii, an estimated 200,000 people who are enrolled in Medicaid will be required to produce the additional documentation. The estimate for Oklahoma is 654,000 people.

The requirements will disproportionately impact low-income, racial and ethnic minorities, indigenous people, and individuals born in rural areas without access to hospitals. Due to discriminatory hospital admission policies, a significant number of African-Americans were prevented from being born in hospitals. Data from a survey commissioned by the Center on Budget and Policy Priorities is helpful in trying to determine the impact of the legislation. One in 12 U.S. born adults, who earn incomes of less than $25,000, report they do not have a U.S. passport or birth certificate in their possession. Also, more than 10 percent of U.S.-born parents, with incomes below $25,000, do not have a birth certificate or passport for at least one of their children. An estimated 3.2 to 4.6 million U.S.-born citizens may have their Medicaid coverage threatened simply because they do not have a passport or birth certificate readily available. Many others will also have difficulty in securing these

documents, such as Native Americans born in home settings, Hurricane Katrina survivors, and homeless individuals.

Mr. Chairman, you understand the difficulty in gaining access to health care. Having to acquire a birth certificate or a passport before seeking treatment will create an additional barrier to care. Some beneficiaries may not be able to afford the financial cost or time investment associated with obtaining a birth certificate or passport. The Hawaii Department of Health charges $10 for duplicate birth certificates. The costs vary by state and can be as much as $23 to get a birth certificate or $97 for a passport. Taking the time and obtaining the necessary transportation to acquire the birth certificate or a passport, particularly in rural areas where public transportation may not exist, creates a hardship for Medicaid beneficiaries. Failure to produce the documents quickly may result in a loss of Medicaid eligibility.

Further compounding the hardship is the failure to provide an exemption from the new requirements for individuals suffering from mental or physical disabilities. Those suffering from diseases such as Alzheimer's may lose their Medicaid coverage because they may not have or be able to easily obtain a passport or birth certificate.

It is likely these documentation requirements will prevent beneficiaries who are otherwise eligible for Medicaid to enroll in the program. This will result in more uninsured Americans, an increased burden on our healthcare providers, and the delay of treatment for needed health care.

Just last Friday, while visiting Kapiolani Medical Center for Women and Children in my home state of Hawaii, I met with a mother who said if it wasn't for Medicaid benefits, her special-needs child would not have the level of care he is getting now at Kapiolani.

Parents who are dealing with the hardships of having a sick child should not have to worry about their current Medicaid status due to new requirements. Citizenship status checks will impose unnecessary challenges that are not needed due to current protections already in place.

The Hawaii Primary Care Association estimates the administrative costs for our Department of Human Services will increase by $640,000 as a result of the new requirements. Mr. John McComas, the Chief Executive Officer, AlohaCare, stated, "We anticipate that there will be significant administrative costs added to our already overburdened Medicaid programs. These provisions are absolutely unnecessary and place an undue burden on the Medicaid beneficiary, to our entire Medicaid program, and ultimately to our entire State."

I know that the authors of this provision in the House believe that illegal immigrants are costing their state significant amounts of money. They claim that "more than $88 million of the State's total $7.6 billion Medicaid budget has gone to illegal immigrants. Other sources find the amount may exceed $300 million . . ." If Medicaid fraud in Georgia is so rampant, perhaps it would be more responsible to first investigate the problems experienced by Georgia's Medicaid program. Mandating these requirements nationwide because of the difficulties confronting one state is a prescription for disaster. The proponents of this misguided policy believe that applicants will be able to just show a driver's license or state identification card under the REAL ID Act. However, it is not expected that the Department of Homeland Security will even issue regulations until this summer and compliance is not expected until 2008.

The real purpose of the additional documentation requirements is to reduce the number of people on Medicaid in a short-sighted attempt to save money. All we have done is make it more difficult for citizens to get Medicaid rather than undocumented immigrants.

Denying access to Medicaid unfairly will cost more money than it will save. Denying access to primary care will increase uncompensated care provided by our health care providers. Denying access to primary care will result in more pain and suffering of individuals. For example, people without Medicaid will have to seek treatment for renal failure instead of having access to the care needed to properly manage their diabetes.

I thank all of our witnesses today and look forward to their testimony. Thank you Mr. Chairman.

Senator COBURN. Well, Senator Akaka, let me first of all thank you. I know your heart and your compassion for people. This hearing really isn't about that. It's about fraud by providers and hospitals and services. And I do hope to have a hearing on that in the next 3 to 4 months, and look forward to you participating in that.

The fact is that with the current estimated fraud rate, that means many people aren't getting the care they should be getting

today. And what we want to try to focus on today is how do we address the lack of oversight and the noncompliance with improper payments in terms of the Medicaid program today?

So I know your heart and I know you care, and my hope is that we can solve that problem before July.

Senator AKAKA. Thank you very much, Mr. Chairman. And again, I commend you for having this hearing.

Senator COBURN. Thank you very much, Senator Carper, our Ranking Member.

OPENING STATEMENT OF SENATOR CARPER

Senator CARPER. Thank you, Mr. Chairman. To our witnesses, welcome. I look forward to your testimony today.

Senator Coburn and I and our Subcommittee have been focused on trying to figure out how to reduce our budget deficit. We all know that it's too large, and looking down the road it doesn't get, frankly, much smaller when we use realistic assumptions.

And just like I think all of us can do everything we do better, we can also find ways to bring down the deficit. And we have to look in every corner: On the revenue side, revenues that aren't being collected; on the payment side, the payments that are being made in some cases improperly.

This is an issue that's of interest to me as a former governor because the States, as you know, fund a significant portion of these costs. And to the extent that we can find ways where we're spending monies inappropriately at the Federal level, maybe we can help the States to save a few dollars, too. So whichever hat I wear, I'm interested in that, and I applaud what we're doing.

We have an opportunity that flows out of legislation adopted a year or so ago which attempts to provide an opportunity for CMS to set this up to the next level and to help us identify real savings. And I guess when you compare Medicare outlays to Medicaid, Medicare's appears to be a great deal larger.

But even so, the Federal portion of the Medicaid program is, in and of itself, larger than I think almost every Federal department except maybe the Department of Defense. And we know there's some waste in each of our departments, and there's clearly some here. And what we want to do is find it, and to the extent that we can eliminate it, good for us, good for the taxpayers, and, frankly, good for the States.

So thank you very much for joining us.

Senator COBURN. Inspector General Levinson.

TESTIMONY OF THE HON. DANIEL LEVINSON,[1] INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY MICHAEL LITTLE, DEPUTY INSPECTOR GENERAL FOR INVESTIGATIONS, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. LEVINSON. Thank you, Dr. Coburn and Senator Carper. Good afternoon. I am pleased to appear before you today on behalf of the Office of Inspector General at the U.S. Department of Health and Human Services. I would like to thank you for this opportunity to

[1] The prepared statement of Mr. Levinson with an attachment appears on page 31.

be a part of today's hearing on reducing fraud, waste, and abuse in Medicaid. With me, on my right, is Michael Little, the Deputy Inspector General for Investigations.

Protecting the integrity of HHS programs is at the core of our mission. While this charge extends to all of the Department's 300 programs, our office devotes most of its resources to Medicare and Medicaid. With the help of Federal prosecutors, the FBI, and State and local law enforcement agencies, our investigators focus chiefly on Medicare fraud.

While all of our authorities in the Medicare arena apply equally to Medicaid, it is the States that focus on Medicaid fraud, chiefly through their Medicaid fraud control units. These units have the lead responsibility for investigating and prosecuting provider fraud and patient abuse and neglect. They rely on criminal investigators, attorneys, and auditors to carry out their mission.

In fiscal year 2005, these units received $144 million under a Federal grant that is managed by our office. For the same fiscal year, these units recovered $710 million in receivables, and achieved over 1,100 convictions.

In the course of OIG and Medicaid fraud control unit investigations, we find it is often the case that providers who are involved in illegal activities in one program may be committing fraud in the other program, making coordination and cooperation between Federal and State enforcement officials very important.

In 2005, our office conducted joint investigations with the fraud control units on 331 criminal cases, 95 civil cases, achieving 54 convictions, and 28 settlements or judgments in civil cases. The increasing value of joint efforts, together with the growing exposure of Federal dollars to Medicaid fraud, has resulted in a need for our office to devote more resources to fighting health care fraud and abuse in Medicaid.

Let me note at the outset some of our most important work in this area. With the assistance of Civil False Claims Act case filings, our office has focused its Medicaid investigations on three types of cases: Nursing home quality of care, pharmaceutical manufacturer fraud, and drug diversion. These areas continue to be investigative priorities for our office.

OIG's nursing home quality of care investigations focus on patient abuse, neglect, and deaths, particularly where a pattern of abuse is involved. And these cases have led to sanctions imposed on staff, as well as administrators.

In our pharmaceutical manufacturer fraud investigations, one focus is on the price of the drugs as set and reported by the manufacturers. We have found that some companies report pricing data that result in inflated Medicaid payments, and that such reports also result in underpaying the Medicaid program for drug rebates. Some companies also engage in unlawful sales and marketing practices. In the past 2 years, these enforcement actions have been successful and have returned more than $523 million to the States.

Our office conducts drug diversion investigations involving prescription pain medications such as OxyContin which may involve kickbacks, physicians who buy back and either self-medicate or sell the diverted drugs, and pharmacists who are in collusion with doctors or with the beneficiaries. These matters are worked jointly

with the Drug Enforcement Administration, the fraud control units, local law enforcement, and the FBI, and are prosecuted at both the Federal and State levels.

Our office views the recently enacted Deficit Reduction Act as enhancing our law enforcement reach and adding fresh Medicaid integrity initiatives for our partners: CMS, the Medicaid program manager, State agencies, and Medicaid fraud control units. A key feature of the DRA is the creation of a new Medicaid Integrity Program, which is modeled after the Medicare Integrity Program that was established 10 years ago. The new Medicaid Integrity Program also provides funding to expand the roles of Federal contractors to carry out Medicaid program integrity activities.

Especially valuable for our crucial role in so many aspects of health care fraud prevention, detection, and investigation, the DRA includes an additional Medicaid-specific funding stream for our office. This will enhance our ability to identify vulnerabilities, question provider billings, and identify patterns of abuse and neglect which will then be formally investigated and prosecuted.

This includes the Medicare and Medicaid Data Match Pilot Program, referred to as the Medi-Medi program, to help identify suspect billing patterns. With our help, the targeted resources to this program will increase the number and quality of cases that are referred to law enforcement.

These new provisions will not only assist in tracking down financial crimes, but will also aid in the investigation of patient abuse and neglect in Medicaid-funded facilities and in boarding care facilities. In most instances, these cases do not generate monetary returns, but are critical to the provision of high quality and appropriate care, especially for our Nation's frail elderly. By working with these agencies to identify questionable provider billings, we maximize the impact of the resources available and focus on the providers that are causing the most harm to the program and to its beneficiaries.

Finally, the DRA also provides incentives for States to enact their own False Claims Acts, which are to include whistleblower provisions.

In conclusion, thanks to the targeted funding provided by DRA, our office will continue to devote substantial resources to auditing, evaluating, investigating, and prosecuting abuses in the Medicaid program.

I appreciate this opportunity to appear before the Subcommittee. Thank you.

Senator COBURN. Thank you, Inspector General Levinson.

Mr. Smith, thank you. And let me—since I'm pretty hard on witnesses not getting their paperwork in on time, I want to thank you. Your paperwork came in 5 days ahead of schedule. And I just think that you ought to be congratulated and rewarded for that, and I'll buy you a Coca-Cola some time for that.

TESTIMONY OF DENNIS SMITH,[1] DIRECTOR, CENTER FOR MEDICAID AND STATE OPERATIONS

Mr. SMITH. Thank you very much, Mr. Chairman and Senator Carper, for inviting me today. I appreciate the opportunity to appear before the Subcommittee to discuss the topic at hand because it is very timely with the passage of the Deficit Reduction Act.

And there are a lot of exciting things in there. For the first time, as Inspector General Levinson described, we have a dedicated stream of funding for program integrity in the Medicaid program, and we believe that it's very important.

I think that part of the message that I want to carry today is that we are on the right path. We're on the right road. In terms of combating fraud and abuse in the Medicaid program, more is better. And we are doing more reviews. The States are doing more reviews. And I'll be happy to provide some of the progress to date.

To be fully successful in the area of program integrity requires activities both on the front end and the back end, both in prepayment and post-payment. On the front end, our responsibilities, in terms of our guidance to the States: Reviews of State plan amendments; the investment—the substantial investment—that we've made in modernizing State computer systems, which we're now spending about a billion and a half dollars on. Each of the State computer systems—what is called the SURS systems, the Surveillance Utilization Review System, have to meet a certification so that those capabilities are already there to begin with to review patterns of provider payments so States can pick up those patterns and then intervene.

On the back end, there are revenue recoveries from overpayments to providers, and provider sanctions, which also include referrals to the Medicaid fraud control units that are supervised by the Inspector General.

Some of the results that we have seen to date, and we are seeing progress and would like to report some of that to you: Including third party liabilities, in which Medicaid is supposed to be the payor of last resort, so when there's another payor out there, to go and find that. In fiscal year 2002, the States reported third-party liability collections of $900 million; in 2005, up to $1.1 billion.

In terms of cost avoidance, putting edits in your system so you're not paying in the first place, so you're not doing pay and chase. That is up substantially. Now over $33 billion are reported as cost avoidance. That is up about $5 billion just between 2002 and 2004.

What we have been doing internally in the fiscal management reviews and our reviews teams, one of our initiatives 2 years ago, again one of those funding streams that is out there, is the so-called HCFAC money, the health care fraud money, that is shared between the Department of Justice, I believe OIG, and other parties as well.

We have used that HCFAC money to hire 100 FTEs to do some of that front-end review of State plan amendments advising the States on policies. And we believe that we can document over $400 million in savings to the Federal Government from that effort alone in linking up what we see at the Federal level in terms of State

[1] The prepared statement of Mr. Smith appears in the Appendix on page 44.

plan amendment reviews and to catch things like the provider taxes that the Chairman mentioned. So we believe we've already returned a substantial savings to that.

Financial management reviews: We have conducted almost 300 financial management reviews over the last 4 years that we have almost $4 billion in play at this time. Our partners at the OIG do audits for us, on our behalf. We asked them to do audits; right now, since between 2003 and 2006, I believe, over $400 million in audits that they have done.

In terms of deferrals, when we find ourselves in dispute with the State where we believe that there are improper claims against the Federal Government, we defer the money in terms of the cycle of grant awards. In 1999, the deferrals were $240 million in that particular year. In 2005, we've done almost a billion dollars in deferrals.

In disallowances, in most cases, when there's a dispute between the State and us at the Federal level, when we find something that we believe is wrong, we try to work that out with the State. In most cases, the States voluntarily make an adjustment to the Federal grant awards.

In some cases, they go to disallowances that then go to the departmental appeals board. In 2000, there were six disallowances against States. In 2004, there were 40 disallowances against the States. So because of all of this, I believe that we are being effective and aggressive on our end of managing the program.

Our partners are the States, and States have adopted a number of tools. In New York, they have now adopted a forgery-proof prescription drug program. There are over 200 million prescriptions filled in New York alone every year. And they have adopted this new tool to prevent forgeries of prescription drugs. Florida has been much more aggressive in dealing with providers. They terminated 224 providers in the recent year, compared to just 28 in 2 years previous to that.

The Medi-Medi program that the Inspector General mentioned, we are very excited about. And again, this is cooperation between Medicare, Medicaid, and the States. And we believe that has great potential, to restore trust in the programs. This is a rather unique approach in that there's really a steering committee that determines how to proceed once problems have been found. But it's a cooperative situation between CMS, the OIG, the State MFCU units, U.S. Attorney's office, the FBI, as well as the State Medicaid programs.

There have been more than 300 investigations, and I believe 42 referrals to law enforcement. We are about to expand that to States, nationally. I think we're in about 12 States now in Medi-Medi, and the DRA provided us dedicated fundings to expand that further.

The error rates, Mr. Chairman, you had mentioned. We are on the road. We have what is called the Payment Error Rate Measurement program (PERM), that started out as a pilot in nine States, and we are expanding that over time and working with the States to get that payment error rate calculation.

Not an easy thing to do, as you can imagine, as States—I mean, your error rate can come from so many different sources. It can be

a provider issue. It can be an eligibility issue. It can come from a variety of different angles. And that will be a challenge, quite frankly, to work through all of those issues to get to a reliable and verifiable payment error rate.

But as I said, we are very pleased with the dedicated funding that was provided in the DRA. We are already well into the planning stages for that internally, putting together hiring plans. That is an office that will have very high visibility in the organization, and we believe will make great returns on the investment that has been made into program integrity.

Senator COBURN. Thank you. Ms. Aronovitz.

TESTIMONY OF LESLIE ARONOVITZ,[1] HEALTH CARE DIRECTOR, PROGRAM ADMINISTRATION AND INTEGRITY ISSUES, GOVERNMENT ACCOUNTABILITY OFFICE

Ms. ARONOVITZ. Thank you, Dr. Coburn and Mr. Carper. I am pleased to be here today as you discuss control of fraud, waste, and abuse in the Medicaid program. We agree that the program, the size of Medicaid, and the importance of that program can ill afford to lose money through any means, so that Federal and State vigilance are critical.

With fiscal year 2004 benefit payments of $287 billion, including a Federal share of $168 billion, as you mentioned, Medicaid does in fact represent a significant portion of State and Federal budgets.

Last year we testified that while CMS had activities to help States combat fraud and abuse in their Medicaid programs, its oversight of States' activities and its commitment of Federal dollars and staff resources were not commensurate with the risks inherent in the program. We also noted that CMS lacked plans to guide State agencies working to prevent and deter Medicaid fraud and abuse.

However, the Deficit Reduction Act, enacted just last month, provided for the creation of the Medicaid Integrity Program, and included other provisions designed to increase CMS's level of support to States' activities to address fraud, waste, and abuse.

I would like my comments to focus on two issues. The first is the provisions in the DRA that can help CMS expand its efforts to address Medicaid fraud, waste, and abuse, and also the challenges CMS faces as it implements new Medicaid Integrity Program efforts.

The DRA's provisions have added substantially to CMS's authority, resources, and responsibilities. The law established the Medicaid Integrity Program and specified appropriations each year to conduct it, as you have heard. This gives CMS important flexibility in determining where the funds can most effectively be used in conducting its efforts.

Further, the DRA requires CMS to increase by 100 its full-time employees, whose duties are solely to protect the integrity of the Medicaid program by supporting and assisting the States. And these are an additional 100 people in addition to the ones that Mr. Smith mentioned that he's been very diligent about hiring to protect the financial integrity at the State and Federal interaction.

[1] The prepared statement of Ms. Aronovitz appears in the Appendix on page 53.

In addition, the new law requires CMS to develop a comprehensive plan every 5 fiscal years in consultation with Federal and State stakeholders, which will encourage dialogue on the overall direction of Federal and State efforts.

Finally, the DRA provides dedicated funding for continuing and expanding the Medi-Medi program, a fraud and abuse control activity that has shown promising results in many States. And we've talked about that just briefly already.

CMS faces several immediate challenges in implementing the DRA provisions related to the Medicaid Integrity Program, especially with regard to developing a comprehensive plan that provides strategic direction for CMS, the States, and law enforcement partners. In developing its plan, CMS will need to focus on how it intends to allocate resources among activities to minimize program risk and most effectively deploy program integrity staff in the central and regional offices.

CMS has experience in addressing fraud and abuse within the Medicare Integrity Program, which has historically been located within the Office of Financial Management (OFM). We believe that those responsible for establishing the Medicaid integrity program should leverage the expertise of OFM staff. Along these lines, we hope that Medicaid officials will partner with others across the agency and with the States to identify successful fraud, waste, and abuse control activities that could be replicated in the new Medicaid Integrity Program.

Developing a comprehensive and strategic approach for combating fraud in the Medicaid program is new for CMS staff, and they are just getting started. As a result, we could not obtain sufficient information from CMS on how it intends to develop its plan, allocate its resources, or look across the agency for help from those with longstanding expertise. However, we hope that in the months ahead, we will learn much more about the agency's plans and continue to have the opportunity to work on maximizing the effectiveness of its new resources.

Mr. Chairman, this concludes my prepared remarks, and I will be happy to answer any questions that you or Senator Carper may have.

Senator COBURN. Thank you all very much. As I raise questions, I want you to know that I don't doubt your sincere desire to fix the problems in Medicaid.

But if you look at the charts [1] and you look at CMS and you say, where is there transparency? Well, there's not any plan right now so there isn't any transparency because you don't have the plan. It's being developed? A comprehensive fraud and abuse plan is being developed per the Deficit Reduction Act?

Mr. SMITH. You're correct, Mr. Chairman, in that what is envisioned is a written document, shared with our partners and put in one comprehensive way. Organizationally, we have done a great deal, and to a large extent I think it's going to be documenting what we have already done and what we put into place.

Senator COBURN. I look at the unemployment insurance program through the Department of Labor, and they have eligibility screen-

[1] The charts referred to appear in the Appendix on page 83.

ing and then they have payment screening. And yet they've been able to accomplish what you all hope to accomplish, and they're reducing every year the amount of improper payments and the amount of improper overpayments and the amount of improper underpayments, most of the time overpayments.

I wonder if there's anything you all can learn from them on how they've taken a State-administered program with Federal dollars and have been able to reduce that to such an extent that they have. Is there something besides what CMS knows about Medicare? I'm not real excited about the Medicare fraud because I think there's still way too much fraud, abuse, and waste in Medicare. And so when you all compare it to that, I think that's a terribly low standard for where we want to be.

So is there anything we can learn from the Department of Labor in how they have accomplished this continuing decline in improper rates, knowing that they have both the same eligibility and payment problem and they're working through State agencies?

Mr. SMITH. Mr. Chairman, I think as we look across this in terms of State-administered programs, it would be a valuable lesson to look at them in terms of—I think to some extent it's slightly different in terms of eligibility rules for unemployment tending to be standard within the State, whereas in Medicaid literally you may have 50 different ways to determine eligibility.

The idea that you are cutting a check in the correct amount for unemployment insurance versus paying a variety of providers completely different rates, perhaps we want to learn from everyone that has experience in this area. But I think that the—and what we are testing in terms of the pilot leading up to PERM, working with the States in trying to come up with the error rate for that State because to some extent they will be unique, especially at the beginning as you get standardized ways of measuring things in the same way and making sure everyone is measuring in the same way.

But where you can pay just hospitals, for example, many different rates, you have your typical for-profit hospital that you are paying differently perhaps than your county hospital, that you're paying differently from your children's hospital, etc., on down the line.

Senator COBURN. Which is the problem with the whole health care industry and how we've got it set up today, which complicates your life?

Mr. SMITH. I think it is a big challenge out there, and it's going to take our effort to work with people of different expertise. Again, part of what we want to do in attracting new talent to the agency for our program integrity unit is to get people from different backgrounds and different areas of expertise to bring that all together for us.

Senator COBURN. Let me ask all three of you. Since we really don't know what the fraud levels are, and we really don't know what the inappropriateness of eligibility might be, what's your guess? Isn't most of it provider problems more than eligibility problems in terms of the dollars? Isn't the vast majority of it going to be either provider inappropriate billing or fraud or something like

that rather than people who are on the program who aren't eligible in terms of looking at the total? What's your thought about that?

Mr. LEVINSON. Well, Dr. Coburn, on eligibility, there is an effort underway to look at that kind of question in several large States now. In California——

Senator COBURN. Well, I understand. I know that. What I want to know is what's your thought now about what it is?

Mr. LEVINSON. Well, those numbers may reveal some important facets of the underlying problem based on what those numbers actually uncover. Fraud is really a subset, if you will, of improper payment.

Senator COBURN. Well, let me tie you down a little bit more. You read the article in the *New York Times* about the New York City Medicaid fraud. What percentage of that do you think was eligibility versus provider fraud? It was certainly more than 50 percent. There's a greater proportion of provider fraud than there is eligibility fraud. Wouldn't you agree with that, in terms of the dollar impact on inappropriate payments? You don't believe that to be true?

Mr. LEVINSON. Well, we certainly don't make any assumption about the numbers driving where we might go.

Senator COBURN. What about—well, we'll find out from Texas when they testify because I think they're going to—I think what they've done will pretty much show that's more of the case than not the case. Mr. Smith or Ms. Aronovitz?

Mr. SMITH. Mr. Chairman, I think in general you are looking at providers in terms of where the dollars are. But I don't want to dismiss that eligibility should it be done correctly as well.

Senator COBURN. Oh, I'm not. I'm just wondering, and I raise the question: Isn't it amazing that we've got a $330 billion program and we don't know?

Mr. SMITH. I think that the estimates over the years were a 5 to 8 percent error rate. I think this has been generally accepted in terms of what the number is. And clearly, I think that from our standpoint, the diffusion of responsibilities across the many different partners is both an advantage and a disadvantage to us.

And as I said, one of the most important things from the DRA was a dedicated stream of funding solely and specifically for Medicaid. Relatively speaking, that is still a pretty small number, looking overall to the entire Medicaid program.

We spend $16 billion just in administrative costs for the Medicaid program. That is everything from the salaries of eligibility workers to sophisticated computer systems. And I think that, as I said in my earlier remarks, part of it is we all need to do a better job documenting what we are doing.

In terms of program integrity, I mean, personally it's the job of all of us at CMS, whether at whatever level that we are doing, to ensure the public trust in the program. And I think we need to do a better job of explaining what we are doing, and to deliver on the results.

Senator COBURN. Ms. Aronovitz.

Ms. ARONOVITZ. Mr. Chairman, we actually don't know the answer to your question. But I do think that when the gentleman

from Texas does get to speak, he will be able to talk about his State.

And I'd like to take the liberty of underscoring another point that's related to your question that I think is critical for States and for CMS, and that is the idea that every State really needs to have the systems to identify where risk is in their program.

And it's possible that what is happening in Texas, in terms of their relationship between provider fraud and eligibility fraud, might not be the same as another State. Every State has to go through and figure out where its vulnerabilities are, and what best practices it can develop that could be replicated in other States.

That requires data. It requires vigilance in having communication and understanding what other States have done to be successful. And it needs a facilitator, and that's where CMS will now have the resources to be able to be a big player.

Senator COBURN. Is there any requirement that CMS—of the States now to identify their vulnerabilities? Is there an actual requirement that CMS says to the State of Delaware, part of your responsibility under Medicaid and getting this money is you have to develop a plan to identify your vulnerabilities?

Mr. SMITH. I don't think I've thought about it in that way. There certainly are a number of requirements of what they are to be doing. Again, their payment systems, the Medicaid management information systems, all have to be certified that they are paying correctly, etc. There are Federal dollars that are tied to the development of the MMISs and the ongoing relationships with them.

So to pay correctly, and that does—when States are changing their payment systems, for example, when I was in Virginia and we converted from a fee-for-service to a DRG payment system for hospitals, the regional office folks were there to back up to make certain they were being paid correctly. So again, I think that it's there in pieces, and——

Senator COBURN. Yes. But you would agree that CMS requiring States to have a program to identify where they're vulnerable should certainly be a part of any master plan that you develop.

Mr. SMITH. I think it is consistent, but I think there's also an underlying assumption that State dollars are at risk also. And so a State that is improperly paying is wasting their own State money. Also, there is a requirement in Medicaid as well, the Single State Auditor Act, again States not just in their Medicaid program but I believe every State has an independent State officer who is also responsible for doing an independent audit of the Medicaid program.

So again, I think that the pieces are there, and perhaps we just haven't described it correctly.

Senator COBURN. So under the Deficit Reduction Act, really it's going to require you and OIG to develop a comprehensive plan together. And you all are committed to doing that?

Mr. SMITH. That's correct, Mr. Chairman. That is one of the requirements, and we will be working with all of our partners in developing that.

Ms. ARONOVITZ. Can I add one thing? One thing that CMS has been very successful in doing, although we would encourage it to do it more, is establishing a technical assistance group. And that

is not a formal—I think Mr. Smith was talking about some of the structural requirements of States.

But one of the informal ways that CMS has been able to facilitate States' actions and really encourage them to do things has been with your TAG. And we think, with a little bit more funds devoted to letting States get together, talk about each others' successes, and work together, I think that States would really appreciate having that kind of conversation. So that's another area where that could be very successful.

Senator COBURN. Senator Carper.

Senator CARPER. Thank you. Just a couple of thoughts to go over some of the same terrain that our Chairman has gone over, just to follow up on what you were just saying, Ms. Aronovitz.

There's an association called the National Governors Association that's an association of governors, there also is, I believe, an association comprised of people from the 50 States and maybe the territories that are Medicaid directors. And they get together once or twice, three times a year, probably have subcommittees and so forth.

And among the things they're interested in doing are: How do we provide a better service to folks that are Medicaid-eligible? They're also interested in finding out how they're wasting money in their respective States, and how they can reduce that.

I don't know if it would have a committee or subcommittee that actually focuses on the issue of waste, fraud, and abuse within Medicaid. They might. But they probably have a committee, standing committee, whose responsibilities include that.

When I was active in the National Governors Association, we had or we established, largely through the encouragement of Governor Tommy Thompson, who thought that we should take National Governors Association Center for Best Practices, and really beef it up, and to find out what are the best models around the country, whether it's raising student achievement, holding down health care costs, improving outcomes, reducing recidivism in prison, you name it. We looked for best practice in all kinds of ways.

My guess is that within the Center for Best Practices, there's a lot of ideas that pertain to health care, probably some that provide to Medicaid. Our friends from CMS, as you go forward here, may want to try to figure out how to implement the Deficit Reduction Act of—I guess it's 2005, that we look there to some of the entities that already exist on the ground, the associations and relationships that exist on the ground that could be of some help.

I think it's sort of ironic to me that when you look at Medicaid, which is—no State gets less than 50 percent of the cost paid by the Federal Government. I think in some States—maybe it's Mississippi, but in some States where I think the Federal Government kicks in as much as 80 percent.

But yet historically, the effort to root out waste, fraud, and abuse has come not from the folks who have the largest dog in this fight, the most dollars at stake, but actually from the States, who have the smaller amount of money in place.

I think the Chairman said, in his statement earlier, he quantified the amount of money that might be improperly spent. I think

he put it maybe at $40 billion. I don't know if I heard him right or not.

Let me just ask Ms. Aronovitz: Do you have any idea what amount of money? I think we're looking at a program where we're spending—I want to say about $250, $260, or $270 billion in total?

Ms. ARONOVITZ. Right.

Senator CARPER. About $300 billion this year.

Ms. ARONOVITZ. About $300 billion.

Senator CARPER. And roughly two-thirds of that, almost two-thirds of that, is from the Federal Government, the rest from the States.

What do you think is being improperly spent out of that? Do you have a clue?

Ms. ARONOVITZ. I don't have a clue. And actually, Mr. Smith did bring up a number, which I'm surprised. I think that's great because——

Senator CARPER. What did he say?

Mr. SMITH. I think 5 to 8 percent is generally what we talk about in the Medicaid world.

Senator CARPER. Around $15 to $25 billion, somewhere in that range? Real money.

Mr. SMITH. Yes.

Senator CARPER. That's including roughly at two-thirds Federal, a third State? Is that the money that you're talking about?

Mr. SMITH. It would be 5 to 8 percent of total, State and Federal combined.

Senator CARPER. All right. Talk to us for a moment, if you will, and I don't care who responds to this question. But when you look at the waste and the abuse that exist, some of it comes from providers behaving fraudulently. Some of it comes from folks that are applying for the benefits that maybe are not eligible, and they're misrepresenting themselves.

Just talk about the different categories of waste, fraud, or abuse that may make up that $15 to $25 or $40 billion, what are they? And just give us some relative idea of where—which is the greatest and which is the least, if you can sort of arrange them for us in some sense of order. What's the worst part of the problem?

Mr. SMITH. Again, I think it's a combination of different things. I think providers who have an incentive to over-bill the program. Again, you see in these areas that providers have the incentive to provide you as many units of service as possible.

In some respects the over-utilization of the program is part of it, often encouraged by providers themselves. Certainly you see examples in the prescription drug program in particular to where that Medicaid card is money on the street in terms of being able to illegally obtain prescription drugs that are then put on the market.

In terms of eligibility, you can't—it's less fraud and it is more of a situation where many States have moved away—and it's been a good thing because you've expanded the number of people actually enrolled in the program.

So States have dropped asset tests. They have gone to relying more on self-attestation. When you do that, there is a certain amount of fraud in that. We saw that, unfortunately, in part of our September 11 waiver to New York, to where at the very end, that

we saw a great deal of utilization of services that weren't really related to the disaster at the time. And New York has just recently done a report on that—on the disaster relief waiver. Again, it did a great deal of good, but you also had that element of where people took advantage of the system.

So the extent to which you have a provider or an individual who is willing to take advantage of the good that everybody else is trying to do. It exists. You mentioned working with the Medicaid directors. We do that. We actually fund them getting together and helping us and talking with them. I believe we have 12 different technical assistance groups to help us in fraud and abuse. We've been reaching out to them in particular at this time to help us to implement the DRA provisions.

So it's a combination of many different things. Transportation has been an issue that, again, it's been an area of fraud to where you have a particular provider, one State kicked them out, and so they migrated somewhere else. They had a background that perhaps a State didn't check their prior experiences in another State.

You have areas again of where—providers who are willing to push the envelope, and that is again what the SURS systems is supposed to help us find in being able to find those patterns of doctors who are ordering more tests than other doctors who are providing 26 hours' worth of services in a single day, that sort of thing.

So we have sophisticated tools, lots of States who have updated their systems, but even more so, in being able to take advantage of those tools that are out there. So it comes in a variety of shapes, sizes, and that makes up that 5 to 8 percent. You have to look at it from a variety of different ways.

Senator CARPER. Mr. Levinson.

Mr. LEVINSON. I think we can provide perhaps some order to that, and I'm going to ask Mr. Little to do that.

Senator CARPER. Would you, please? And I'm going to ask you to do it quickly, and then I have one more thing I've got to say, and then I'm going to relinquish the microphone.

Mr. LITTLE. OK. Good afternoon.

Senator CARPER. Welcome.

Mr. LITTLE. Dr. Coburn and Senator Carper. Based on our experience of many years' investigations in both the Medicare and the Medicaid program, we have had a lot of impact and many investigations on the pharmaceutical industry with respect to the marketing of pharmaceuticals to both the Medicare and Medicaid program.

As a matter of fact, since January 1, 2001 to the present time, in the Medicare and Medicaid program just in pharmaceuticals, we have returned over $3.3 billion to the U.S. Government and to the States based on our investigations, civil settlements and criminal convictions.

We believe the durable medical equipment industry is also a vulnerable area for the Medicaid program based on our experience in the Medicare program. And clinical laboratories, we have had much success in investigating clinical laboratories as it relates to unbundling of services as well as provision of services not ordered by a physician or not rendered at all.

Senator CARPER. OK. Just one last thought, Mr. Chairman, and to our witnesses today. I mentioned the National Governors Association has a Center for Best Practices. Interestingly enough, two of the people who I think chaired the Center for Best Practices—in the NGA, you're vice chairman of the NGA, you're chairman of the NGA, and then I think you're chairman of the Center for Best Practices; it's sort of like going through three chairs. At least that's the way it used to be; maybe it still is.

But among the people who have been I think chairs of Center for Best Practices, in addition to being chair for the National Governors Association, were two fellows who ended up being Secretary of Health and Human Services, Secretary Thompson and Secretary Mike Leavitt today.

Whenever the NGA comes here to Washington every February, they usually ask somebody from the Senate and a couple people from the Administration to come and talk to them. And the governors also meet in the summer in different States. They all get together.

There's just a great opportunity for an old governor, whether it's Mr. Thompson or Mr. Leavitt or maybe somebody sitting up here, to go out, and when the governors are gathered, to talk to them about how we can help them save money, help reinforce what they're trying to do through their Center for Best Practices of sharing best ideas, best practices, in a way that helps them and that also helps the Federal taxpayers as well. There's a great opportunity here. And I just hope that they will take full advantage of that. Thank you.

Senator COBURN. I just have a couple more follow-up questions. I want to get a little bit specific about this plan. What are going to be the road marks? What's the timeline? Who's going to be in charge of it? When are we going to see something? Who's the point man on it? When are we going to hear back on something being developed? When do you hope to accomplish it, and when do you hope to implement it?

Mr. SMITH. Mr. Chairman, what we have been doing to date, and we brought in one of our senior people who had been in the regional office, and she has been on her SES development detail. Great background and experience in this area. So we have a combination of folks internally we've brought together to start drafting our plan to get our organizational plan in place, etc.

So what we have done to date is, taking it sort of sequentially, getting things in place at this—at one thing to do or another.

Senator COBURN. I want to know what time it is, not how you're building that watch. When are we going to see a plan? What are the markers for that plan?

Mr. SMITH. I think you'll see a plan within 6 weeks.

Senator COBURN. That's great news.

Inspector General Levinson, how often are program integrity reviews conducted on State audit initiatives?

Mr. LEVINSON. I think that's on an ongoing process. You want to know the actual number of——

Senator COBURN. Well, I know the number. The testimony gives us the number. When are we going to see it on a comprehensive and regular basis? That's really my question.

If you're sitting in Oklahoma, and you get reviewed once every 7 years, and you know you got reviewed and the probability is it's going to be another 6½ years till you look at them, there's no accountability. There's no transparency. There's not a demand for priority, and there's certainly not responsiveness. What is the plan, your component of this overall plan, for audits?

Mr. LEVINSON. Well, one of the very valuable aspects of the new funding stream, as a result of DRA, is that it in effect restores our ability to now increase our focus on Medicaid fraud, waste, and abuse, whereas for the last several years, because of a ceiling on the health care fraud control account, our resources were actually shrinking.

So whereas historically the office was only able to devote somewhere between a fifth and a quarter, probably, of its resources to Medicaid, we now anticipate that before the year is out, we'll be heading towards more like 29 or 30 percent of our office resources. That's going to significantly enhance, both from an audit as well as from an investigative standpoint, our ability to be a more active player at the Federal level.

Senator COBURN. Can you help me a little bit? What does "significantly enhance" mean in terms of number and frequency of audits and comprehensiveness of those audits?

Mr. LEVINSON. Well, with the $25 million, and the expectation that we'll be able to increase, perhaps by as many as 100 FTEs, and the need then to distribute those FTEs in accordance with the investigative and the audit responsibilities, at this point it would be difficult to give you a specific figure. But I certainly welcome the opportunity to keep you apprised of how those resources are devoted.

Mr. SMITH. Mr. Chairman, if I may, this might be helpful. Every State's Medicaid program is audited every year by the State itself.

Senator COBURN. Yes. I'm talking Federal audit.

Mr. SMITH. We do financial management reviews based on risk. We ask the IG to do some of that for us, and now, because we have more capabilities ourselves, we're doing more of them ourselves. So every year, we go through every State by 15 different types of risk areas and make a selection for what we want to audit this State on in this type of provider area and conduct that audit.

That is done between the regional office and central office, and I personally go through that. Katrina waivers, for example, we want to make sure all of those dollars are audited in particular. School-based waivers have been a particular area in some States that we believe need greater attention.

So the selection of those individual areas is something that we go through at the regional and central office, making those decisions about then. Do we ask the IG to do it for us, or do we put a team together to conduct the audit?

Senator COBURN. OK. When you have this comprehensive plan developed, who's going to be responsible for it?

Mr. SMITH. That would be me, Mr. Chairman.

Senator COBURN. OK. So that responsibility is going to rest on you, and the implementation of that plan is going to rest on your shoulders. Is that correct?

Mr. SMITH. That is correct.

Senator COBURN. OK. The Medi-Medi plan right now, where you're comparing Medicaid and Medicare numbers, practice patterns, payments, and everything else, that's in 12 States now. Is there a plan to get it to 50 States?

Mr. SMITH. Yes, Mr. Chairman. And again, that's what the DRA funding will help us get.

Senator COBURN. When are we going to see that in 50 States?

Mr. SMITH. My off-the-cuff guess is we'll get to all 50 probably within 2 years.

Senator COBURN. OK. I'm not going to hold you to that because it's off the cuff. I understand. But when your plan comes out, it will have that in it. Is that true?

Mr. SMITH. Yes. Most definitely.

Senator COBURN. But your plans are for that?

Mr. SMITH. Medi-Medi is a central focus of our activities.

Senator COBURN. And the SURS program really just tracks patterns of provided data? It doesn't compare Medicare and Medicaid; it looks for patterns?

Mr. SMITH. Correct. Those are—those would be Medicaid claims only.

Senator COBURN. Right. Well, I want to tell you, half of everything I ever billed as a doctor went to Medicaid. And I want to tell you there's at least 10 percent fraud in Medicaid. At least 10 percent over billings. At least 10 percent deception. And the reason it's happening is because nobody knows—most people think they're not going to get caught. And so therefore it's easy dollars, and some of the systems that have been designed to correct it have actually enhanced making it worse.

And so my hope is if you take the 5 percent on the $300 billion we're going to spend this year, and take your bottom end of your number, that's $15 billion. That's enough to run all of CMS. And if 59 percent of that is Federal match, that's $9 billion. That makes a big difference in care to the people in this country who might not otherwise have care.

So the reason I'm hot after this is, that fraud is where the money is. The money is in the fraud. And it's not just Medicare and Medicaid and it's in the Defense Department. We know it. I'm not just picking on health care. I'm going after every bit of it. We've got to get better. And you all have to continue to help us get better.

My last comment is that I believe more physicians and providers need to go to jail. They are stealing from people who otherwise don't get care because they've taken money. And I would like to see the aggressive nature in terms of these prosecutions, get much heavier handed, not just banishment from the program but hard time in prison, so that they are made examples of so other people won't think so lightly about possibly cheating somebody out of their health care.

And when I read the articles in the *New York Times,* I was astounded that a dentist can do 500 procedures a day, and it took that long to catch him—500 procedures a day, that would be like me billing for 300 deliveries in a day. And the fact that can happen and it took us a while to catch it means what you're planning, the system's planning, the overall plan, but also the heavy hand of the law and justice being applied so that they're made an example of.

And I hope that is an aggressive party. I know you all don't get to prosecute these cases. But you can certainly make it difficult on those that do if they don't prosecute them aggressively. And my hope is that you send the message that when somebody is cheating the next two generations out of health care, that they're going to pay a big price for it.

And that's my profession as well as the rest of the providers. And if that happens, it's not going to take a whole lot of them where all of a sudden the benefits of maybe gaming Medicaid aren't seen as quite as valuable as they are today.

I want to thank each of you for the work that you do, your service to our country. It's hard, what you're doing. I know that. The system is hard. It's hard because health care is so messed up. But you're making a difference. Please don't quit. Please, exert an ever-increasing level of vigilance at what you're doing. Because it's $9 billion we don't have. Right now we don't have it.

And the last of my little exhortation is the real budget deficit last year was $620 billion. That's a real off budget. That's what we borrowed from our kids last year. And that is $9 billion that we could reduce. And so your work and your talent is appreciated. Just keep going after it. We're going to keep coming after you to see that you are. Thank you so much for your testimony.

I also would request if you have any staff here to hear the next testimony, it's very important that you hear this. You may already know what Texas is doing, but it's important that you hear their experience because I think it will be very helpful.

We had originally scheduled Kim O'Connor, Medicaid Inspector General for the State of New York. Because they're in the midst of their plan, she could not testify. I'm asking unanimous consent that her testimony be made a part of the record.[1]

And I want to submit my summary to the record of what her statement was. And I'm just going to spend a few minutes outlining that because I think it's very important. They learned a lot from you. And they are copying a lot of what you've done, and it's a great compliment.

The problems that New York identified were the following: The system had insufficient focus on specific auditing and fraud prevention goals, needed greater coordination and communication among State agencies engaging in fraud, waste, and control activities.

Their solution: The central component of New York's plan is the creation of the office of Medicaid inspector as the single State agency for the administration of Medicaid program in New York State with respect to prevention and detection of fraud, waste, and abuse. They are developing an independent fraud-fighting entity to prevent this waste, fraud, and abuse by prioritizing and focusing on fraud, waste, and abuse control activities.

The plan will be developed by creating a single point of leadership and of responsibility—both leadership and responsibility; that's called accountability—for those activities. By building an integrated system of communication among all involved agencies with fraud, waste, and abuse control responsibility. By maximizing the use of all available State resources for such activities.

[1] The prepared statement of Ms. O'Connor appears in the Appendix on page 78.

Their anti-fraud programs were concentrated primarily in the Department of Health, which also oversaw the Medicaid program. That created an obvious and inevitable conflict as the pressure to pay providers wars with efforts to ensure that monies are not misspent.

New York hopes that communication between agencies will guarantee that the mission of the Office of Medicaid Inspector General is free from conflict, and that its energies and resources will not get diverted.

Other projects: New York is focusing better on data mining, (shared data between systems and agencies); better utilization of existing technology; and efforts are underway for a peer review program with New York's extensive State university system. CMS has reported to me that New York has asked to be the next Medi-Medi State, which tells us about the value of that program.

Mr. Flood, I want to welcome you. In 2003, Texas Governor Rick Perry appointed Brian Flood as the Inspector General for the Health and Human Services Commission. Under Mr. Flood's leadership, 563 professional staff members work to control waste, fraud, and abuse in the State's health and human services program.

Mr. Flood, you are recognized. Thank you so much for coming and testifying for us. You are setting a great example, and we look forward to hearing your words.

TESTIMONY OF BRIAN FLOOD,[1] INSPECTOR GENERAL, HEALTH AND HUMAN SERVICES, STATE OF TEXAS

Mr. FLOOD. Thank you, sir, for the invitation. I'd like to submit the summary of my comments into the record because I'm known to deviate from them often.

Senator COBURN. Without objection, so ordered.

Mr. FLOOD. Thank you, sir. I do appreciate the invitation, and on behalf of my incredible staff, I thank you for the opportunity to come and talk to you today about the activities of the Inspector General within the State of Texas.

As you may know, I was asked to within 5 minutes succinctly explain what we did in 2½ years, which was: Why is an independent inspector general important with the waste, fraud, and abuse issue, why Texas created an inspector general, what it takes to do that, measuring the results of what that actually produces, and then the necessity of the continued activities of an inspector general or another accountability type of oversight function.

In this State of Texas, the reason that an independent inspector general was chosen was that you needed to eliminate conflicts of interest of philosophy within the various agencies. For example, the predominant focus of a State agency is the payment of claims and the inclusion of providers and the ongoing control of the system to efficiently deliver services.

It is not its natural focus to look for waste, fraud, and abuse caused by itself or the people that it brings into the system, whether they are a recipient or a contractor. And so the creation of an

[1] The prepared statement of Mr. Flood appears in the Appendix on page 69.

IG hopefully creates a function that's free from the influences of that system and able to properly account for its activities.

We do strive to minimize what waste, abuse, and fraud we can find. We incorporate more than simply fraud; we go into Federal definitions of 422.3 and 422.5 for abuse and fraud. And then we look for wasteful activities within the State system that simply waste State funds inappropriately.

Why did Texas create an inspector general? We created an inspector general because of the fiscal crisis 2 bienniums ago, or 4 years ago, where the State was facing a $10 billion deficit and had to come up with the funding streams necessary to operate.

It was felt that the embedded accountability of an Inspector General's office would make sure that funds that were appropriated by State or Federal law were actually received by the proper vendor, contractor, or beneficiary, and would make sure that the funds that were given to the program were not wasted, and therefore reduce the State's overall costs.

I would like to deviate for a moment. You did ask for what were the numbers. We have provided to the Chairman and the Subcommittee, if you are tired and need bedtime reading, volumes of information going back to 1999 of all of the functions within the State having anything to do with Medicaid, including recipient fraud. And the answer to your question is: Over 3,000 cases were created for providers, and 856 cases were prosecuted for Medicaid recipients, if that gives you a number to work with.

All the States are feeling the pinch from the increased budget loads and the increased financial pressures in today's budget environment. And so Texas looked to see what opportunities it could do to increase its resources. We are on the high end, according to the GAO, for performance, technology, and innovations in controlling spending and ensuring proper payments are made to beneficiaries and recipients.

When we did the consolidation, we included all of the functions. And by that definition, I mean all of recipient fraud is now within the Office of Inspector General, and all provider fraud is now in the same office. So you can easily see where all the trends are and how they criss-cross each other.

What did it take to get it done? First, people, very dedicated people, who worked thousands of hours of overtime while doing their regular job. When the legislature enacted S. 2292, it required that we increase reserves and returns at the same time that we did the reorganization. I have laid out in page 2 of my testimony all of the things we actually did for that function, and I will not read it to you.

But what we did is, in a nutshell, we went to the staff, the people who actually do the work, to find out where all the problems were in the system, and they told us. And what that gave us was, on page 3 of the testimony, a $100 million cash return in 1 year. That is, we increased cash recoveries to the State by almost $100 million by listening to the staff.

And in State fiscal year 2004, we returned $349 million in cash. We don't book payment plans, to any number that you see in our report is what we recovered and banked. And then in the next

year, we put $441 million in the bank. We increased referrals by 105 percent for providers.

And then, in closing, because I'm being rushed by this little timer——

Senator COBURN. Go ahead. Take your time.

Mr. FLOOD. OK. Five minutes for 2 years. Your preference, sir. What we found is that listening to the staff and taking into consideration the thousands of myriad little changes that they would make to the system, we had over the biennium a 30 percent increase in returns using the exact same amount of appropriations that we had in 2003. So therefore, in 2006, we had a 30 percent increase. The first year was 23 percent. The second year was 26 percent. I expect that number to begin leveling off as you optimize the system and there's no more money to be found.

But again, in our State, that equates to $132 million new dollars were developed through the program, which equated to 133,000 new Medicaid beneficiaries being given benefits for a year with no new expenditures upon the State. And so the governor considered that was a pretty fair return.

We do operate at a 10 to 1 cash ratio. That is, for every dollar I get, the legislature gets $10 back, and an overall ratio of 23 to 1. We have decreased all of our accounting methodologies for cost avoidance because it is, in my opinion, a fuzzy number. So we use the lowest denominator possible to measure cost avoidance and still book it as a value for the State because we believed that when the legislature was trying to allocate its resources in the next biennium, it would want the most accurate data possible to make decisions with.

On the final page, what do we do exactly now? I've listed the programs that we do. If it has anything to do with a social benefit, I do it. That's the easiest way to explain it. We incorporated every possible program—TANF, WIC, food stamps, financial aid assistance, grants, contracts—any appropriated dollar for social services comes through our program, which is $16.9 billion, which you placed up there.

We have partnered with the University of Texas of Dallas to learn new data mining methodologies. We believe that partnering with the premier academic institutions was a better way to solve the State's problem, using a State entity, the State colleges, for the State's computer systems versus trying to contract that out. And that's been pretty beneficial so far.

To give you an example, we took the Diabetes Council for Texas, their 2010 strategic plan and what they hope to accomplish through grants, studies, and research. We answered eight of their ten questions once we turned the system on. And that was within 1 year. So we considered that was a pretty good return.

We have tried everything we can pull out of the hat to make, as a partnership with any other agency, entity, nonprofit that we can find that would reap a benefit, whether it be training, technology, people, resources, or whatever we could do.

I will state for the record—because someone may tell you—I did file a letter to the *Federal Register* regarding the PERM project, and I hope to discuss with the agencies the implementation of PERM in the future to address our concerns with its implementa-

tion, to make sure it produces the most for the Federal Government that it possibly could. And that letter is in the *Federal Register* for your review.

Sir, this is all I've been doing for 2½ years, and I can speak much longer than you wish to listen. We have filed these. These are audited numbers. I'm audited by everyone. If you wish to study Medicaid, all the numbers for the State of Texas are available to you, and we'll supply you with whatever you need.

Senator COBURN. I have a couple of questions. Did anybody from CMS or OIG come talk to you about what you've accomplished in Texas?

Mr. FLOOD. No, sir.

Senator COBURN. So the implementation is they're developing a plan, and the most successful plan in terms of trimming waste, fraud, and abuse, which seems to be Texas, they haven't asked you for information about or sought your advice?

Mr. FLOOD. No, sir. But I don't think anybody knew we existed till recently.

Senator COBURN. OK. Well, I'm not sure I know how to answer that.

What have you seen from the aggressive stance you've taken in terms of trying to be out there—what have you seen in terms of behavior patterns now that the providers in Texas know you're there? What are you seeing?

Mr. FLOOD. We're seeing—at first there was the belief that the draconian implementation of this law would wipe out the medical industry as we know it. That was their initial reaction. After having a lot of meetings with the providers, convincing them that we were not out to shut down the industries, we've actually begun to partner with them as much as humanly possible. And we may not agree on the issue, but we'll at least discuss it.

We are seeing that they are beginning to focus on the Medicaid programs more than they have in the past. The focus up until this point has been on Medicare because of the obvious resources that were put into that. They responded to those resources.

The Medicaid programs, however, did not have those oversight resources, so the providers didn't provide resources to control their expenditures like they would for Medicare. And what we're seeing is that they are now turning their attention to Medicaid because we've made it abundantly clear to them that we will be coming. They've looked at our numbers and realized we have been coming to their neighbors, and therefore it's not long till I come to them. And it's better to have your house in order than to not.

Senator COBURN. So you've created the proper expectation for compliance?

Mr. FLOOD. I'm known to be very blunt and candid with the audience.

Senator COBURN. I kind of like that for some reason. I don't know why.

When you look at the numbers for Texas when you first started, what is your estimate of the waste, fraud, abuse, and including eligibility abuse, as a percentage of Texas's Medicaid program?

Mr. FLOOD. I would actually agree with Director Smith that 8 percent is actually what I would consider prosecutable abuse the

fraud. The PAM and PERM studies I personally participated in for the last 3 years and reviewed all of the results. They have averaged 13.7 percent over the 3-year period. Approximately 4 or 5 percent of that is simply documentation error, which we would not categorize as an abuse.

Senator COBURN. It's not intentional abuse?

Mr. FLOOD. It is not intentional and shouldn't be included.

Senator COBURN. So 8 to 9 percent is probably a good number?

Mr. FLOOD. Yes, sir. That is a solid number.

Senator COBURN. And you've seen that 3 years in a row?

Mr. FLOOD. Yes, sir.

Senator COBURN. OK. Do you still have 8 percent out there or is it getting down to 6 percent, 5 percent, 4 percent? What are the results?

Mr. FLOOD. We haven't seen what I would call deterrent effect yet. We are still in the process of picking up rocks to see what's underneath it because so many of them were not examined over time. I would not expect to see a deterrent effect for another couple of years because it takes—well, first——

Senator COBURN. Getting around the neighborhood?

Mr. FLOOD. Yes, sir. Well, first was just building the office, which was a feat in and of itself. Now a tour of the neighborhood is our next plan.

Senator COBURN. OK. If you were to give CMS and the OIG advice on their plan and how to work with States and how to implement to get to lessen this 8 percent number, what would you tell them? You can be blunt. It's just going to be on the record if you're blunt.

Mr. FLOOD. It's just on the record, and make sure my boss will sign my check this month.

Senator COBURN. Well, say it tactfully.

Mr. FLOOD. Having come to this industry, what I've noticed is that the industry is built around the payment system and the State agency system. In my personal opinion, the CMS agency is the Federal equivalent of the State's State agency. And to have them measuring themselves creates the same problem that we had in our own State, that we measured ourselves, which is how I came into existence.

So my concern is what filter is placed upon the PERM project. Is it more filtered to provider implementation and the delivery of services, and that is our primary focus, with the other being secondary? Or is it more Inspector General Levinson's focus of this is fraud and this is abuse and I see the red flags. I'll make sure that there's care, but I see the red flags.

Each one has their different focus, and that's my concern, is which direction you want to go. Because invariably, the agencies will set that tenor, in my personal opinion, not that of the Office of the Governor.

Senator COBURN. And this is opinion as well. Are you hopeful to see the kind of changes at CMS and OIG that will make it easier for us to eliminate fraud, waste, and abuse in Medicaid?

Mr. FLOOD. Oh, absolutely. I think the Budget Reduction Act gives sufficient resources to make a very robust system if it's knitted together well.

Senator COBURN. And so the question and the caveat is: How is it going to be knitted?

Mr. FLOOD. Yes, sir.

Senator COBURN. Well, we're going to find out in 6 weeks, according to the testimony we've had.

Mr. FLOOD. Yes, sir.

Senator COBURN. Well, I want to thank you for your testimony. I think this is a model that can happen in a lot of other States if they'll learn from you. My hope is that we start seeing deterrent effect because after 3 years we're still seeing 8 percent. That's an ever-enlarging number as we're growing at 10 to 12 percent per year. And that's care that can't be provided to somebody that needs it, or it's money that doesn't have to be spent, that can be spent somewhere else if we're taking care of everybody.

So thank you for the job that you've done for the State of Texas, and I appreciate you coming before our hearing.

Mr. FLOOD. Thank you.

Senator COBURN. Thank you so much. The hearing is adjourned.

[Whereupon, at 4:10 p.m., the Subcommittee was adjourned.]

APPENDIX

Testimony of
Daniel R. Levinson, Inspector General
U.S. Department of Health and Human Services

Good Morning Mr. Chairman and Members of the Committee. On behalf of the Office of Inspector General (OIG) at the U.S. Department of Health and Human Services (HHS), I would like to thank you for this opportunity to contribute to today's hearing on eliminating fraud in Medicaid. I am accompanied by Michael E. Little, Deputy Inspector General for Investigations.

My testimony highlights OIG's role under the Medicaid program integrity provisions of the recently enacted Deficit Reduction Act of 2005 (DRA); the program integrity responsibilities of the Centers for Medicare & Medicaid Services (CMS), the States, and OIG in overseeing Medicaid; and the increased use of Federal and State civil and administrative litigation cases to address Medicaid fraud and abuse. I will close with a discussion of OIG's investigative priorities.

The Federal Government pays a share, known as the Federal Medical Assistance Percentage (FMAP), of each State's Medicaid costs. Because Medicaid is a matching program, improper payments by States to providers virtually always result in corresponding improper Federal payments, whether payments for medical services or for administrative cost reimbursement. The Federal share of Medicaid outlays is expected to exceed $192 billion in FY 2006 and could approach $200 billion in FY 2007. Medicaid currently represents over 28 percent of the total budget of the U.S. Department of Health and Human Services.[1]

MEDICAID INTEGRITY PROVISIONS IN THE DEFICIT REDUCTION ACT OF 2005, PUBLIC LAW 109-171

The recently-enacted DRA includes several provisions that build on existing efforts to strengthen Medicaid program integrity. The DRA includes the creation of a new Medicaid Integrity Program, which is modeled after the Medicare Integrity Program that was established by law a decade ago. The DRA also provides incentives for States to enact and enforce false claims acts; prohibits providers from billing Medicaid multiple times for the same drug; enhances third party liability enforcement; improves enrollment documentation requirements; and creates Medicaid transformation grants for States to use to adopt innovative cost-saving methods.

The new Medicaid Integrity Program provides funding for the Secretary to enter into contracts with eligible entities to carry out Medicaid program integrity activities and also funds contracts to expand the Medicare-Medicaid Data Match Pilot Program (Medi-Medi program) that compares billings to both the Medicare and Medicaid programs by the same provider to identify aberrant patterns. OIG welcomes the addition of new contracting entities to bolster Medicaid program integrity activities and Medi-Medi. I will defer to CMS for a description of its plans for implementing and managing the program integrity contracts and for evaluating their contributions to the overall process.

The DRA provides an additional Medicaid-specific funding stream for OIG, which will allow us to increase participation and exert leadership in a number of Medicaid integrity efforts. In designing and implementing projects like Medi-Medi, CMS works with OIG, the Department of Justice

[1] The HHS Budget in Brief estimates $199.3 billion (rounded) in Medicaid program outlays in FY 2007.

(DOJ), and other oversight entities to ensure that such projects operate efficiently and effectively. As resources allow, OIG participates in various projects to identify areas of vulnerability, questionable provider billings, and patterns of abuse and neglect that are then formally investigated. These projects include the use of data-mining, community outreach, and other quality of care monitoring tools.

Under the DRA, we plan to dedicate more resources to the Medi-Medi project so that a full time OIG presence on the project might encourage further focusing of the data-mining and increase the number and quality of the cases that are referred by the project to law enforcement. The targeted Medicaid resources in the DRA will increase OIG's ability to become a more active full-time participant and leader in this and similar Medicaid program integrity projects.

The same is true of the quality of care initiative OIG jointly conducts with DOJ and others. While our efforts to address "failure of care" cases are extensive, the targeted DRA resources will allow us to work even more closely with CMS, the State Survey and Certification teams, Medicaid Fraud Control Units (MFCUs), and the State Long Term Care Ombudsmen to identify entities where there appears to be abuse and neglect of such a nature as to justify further investigation. OIG works with Federal prosecutors, the FBI, and State and local law enforcement agencies to conduct investigations into these matters and remedy the wrongdoing.

Further, DRA resources will allow OIG to continue its work with the National Association of Medicaid Fraud Control Units (NAMFCU), MFCUs, and State Medicaid Agencies (State Agencies) to conduct training to better enable program administrators and claims examiners to identify questionable billing practices earlier and more effectively. Such training is designed to assist agencies in gathering the information that is needed by investigators and prosecutors to successfully prosecute these cases.

FEDERAL AND STATE ROLES AND RESPONSIBILITIES

In 1977, Public Law 95-142 (the Medicare-Medicaid Antifraud and Abuse Amendments of 1977) was enacted to strengthen the capability of the Government to detect and prosecute fraudulent activities under the Medicare and Medicaid programs. CMS has a key role in Medicaid program integrity as the Federal program manager, and the State Agencies and MFCUs are responsible for protecting the integrity of the Medicaid program. State Agencies and MFCUs each perform unique roles in carrying out program integrity activities. OIG's authorities with regard to all of the Department's programs to prevent and detect waste, fraud, and abuse, and to promote economy, efficiency, and effectiveness apply fully to Medicaid.

CMS Responsibilities

CMS is responsible for overseeing each State's comprehensive State Medicaid Plan to ensure State compliance with Federal laws, regulations, and departmental policies, including the detection, development, and referral of suspected fraud cases. CMS is required to review State Agency performance through onsite reviews and examination of individual case records.[2] In 1996, CMS established a program integrity group to address fraud and abuse issues within the Medicare and Medicaid programs. This group conducts and oversees many projects that are intended to reduce program fraud.

[2] 42 CFR § 430.32(a).

State Agency Responsibilities
State Agencies are responsible for establishing policies, computer systems and edits to process Medicaid claims and for conducting analyses of providers' patterns of practice (data-mining). Federal regulations require State Agencies to conduct preliminary investigations when they identify questionable practices or receive complaints of suspected Medicaid fraud or abuse.[3] When the results of a preliminary investigation give a State Agency reason to believe that fraud has occurred, typically it must refer the matter to the State's MFCU for investigation.[4] Overpayments that are not the result of fraud generally remain in a State Agency's jurisdiction for collection.

To accomplish these tasks, State Agencies must have certain information processing systems, including a Medicaid Management Information System and a Surveillance and Utilization Review Subsystem (SURS).[5] Automated mechanized claims processing and information retrieval systems are used not only to process Medicaid claims for medical services, but also are used by the SURS staff to retrieve and produce service utilization and management information for program administration and audit purposes.

States establish various structures to carry out program integrity functions. Some State Agencies exclusively use staff within the SURS unit to conduct required analyses, while others have established comprehensive program integrity or Inspector General units to oversee these functions. In some States, the SURS units may operate the program integrity units, conducting preliminary analyses of potential Medicaid fraud or abuse and referring appropriate cases for full investigations.

In all States, the SURS units apply automated post-payment screens to Medicaid claims to identify aberrant billing patterns that may indicate fraud or abuse. When potential fraud cases are detected, the State Agency is required to refer the cases to the State's MFCU. Despite SURS being an important detection mechanism, OIG has found that the quality and quantity of referrals need improvement in many States. However, OIG has also observed that positive interagency and staff relationships between State Agencies and their respective MFCUs tend to contribute to successful referrals and resolution of fraud.

Medicaid Fraud Control Unit Responsibilities
MFCUs are responsible for investigating and prosecuting provider fraud and patient abuse and neglect.[6] They integrate the skills of criminal investigators, attorneys, and auditors to carry out their mission. Section 1903(q)(6) of the Social Security Act requires that MFCUs be composed of at least one investigator, one attorney, and one auditor.[7] MFCUs must be single identifiable entities of the State government and certified annually by OIG as meeting Federal requirements, including location within State government, staffing, roles, and responsibilities.[8] MFCUs receive at least 75 percent of their funding from a Federal grant managed by OIG. Forty-eight States and the District of Columbia have established MFCUs.[9] Most MFCUs are located within the State Attorney General's office.

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[3] 42 CFR § 455.14.
[4] 42 CFR § 455.15.
[5] 42 CFR § 456.3.
[6] Social Security Act, § 1903(q)(3).
[7] See also 42 CFR § 1007.13.
[8] 42 CFR § 1007.15.
[9] North Dakota and Idaho have not established MFCUs, and, in these two States, the State Agency is responsible for conducting investigations and referring cases to State or local prosecutors.

Under a 1999 amendment to the MFCU statute, the jurisdiction of the MFCUs was expanded to allow them to investigate and prosecute Medicare or other health care fraud, in addition to Medicaid, if the following conditions are met: (1) the OIG of the relevant Federal agency (such as HHS OIG for the Medicare program) approves the case, and (2) the "suspected fraud or violation of law primarily concerns Medicaid, i.e., the Medicare and other health care fraud allegation is a part of a case that is primarily a Medicaid fraud case. The same statutory amendment also authorized MFCUs to investigate patient abuse and neglect in non-Medicaid "board and care" facilities.

In addition to receiving referrals of allegations from the State Agencies, MFCUs receive leads from other sources, including other State and Federal law enforcement agencies, whistleblowers, beneficiaries, concerned citizens, the press, and legislative bodies. If a matter referred to a MFCU is determined to involve an improper payment that does not warrant a fraud investigation, the matter is referred to the State Medicaid agency to pursue recovery of the improperly paid amount. Otherwise, the MFCU fully investigates and ensures appropriate resolution, including prosecution. Outcomes may include convictions, restitution, fines, penalties, or corporate integrity agreements, as well as incarceration.

The following chart shows MFCUs' funding and statistical accomplishments for the past 10 years. Federal/State investigative receivables include settlements or court-ordered restitution, fines, and penalties.

Medicaid Fraud Control Units
Federal Expenditures and Related Federal/State Statistical Accomplishments

Year	Federal Grants*	Federal/State Receivables	Convictions
2005	$144,330,097	$709,619,411	1,123
2004	131,086,294	572,585,322	1,160
2003	119,831,000	268,481,661	1,096
2002	116,979,079	288,315,524	1,147
2001	106,699,505	252,585,423	1,002
2000	95,979,000	180,941,872	970
1999	89,703,745	88,738,327	886
1998	85,793,887	83,625,633	937
1997	80,557,146	147,642,299	871
1996	77,453,688	57,347,248	753

* Amount awarded to MFCUs.

This chart provides a rough measurement of MFCU accomplishments and does not reflect the responsibilities MFCUs have for investigating patient abuse and neglect in Medicaid-funded facilities and in board and care facilities. In most instances, these cases do not generate monetary returns, but are critical to the provision of high quality and appropriate care, especially for our Nation's frail elderly. Later in my testimony, I will describe nursing home quality of care, which includes patient abuse, as a priority concern of OIG as well.

OIG Responsibilities
Protecting the integrity of all HHS programs is at the core of OIG's mission. Accordingly, OIG initiates audits, evaluations, and investigations of the expenditure of Medicaid dollars and the operation of the Medicaid program as appropriate. We have developed good working relationships with the agencies responsible for identifying, preventing, and curbing fraud in Medicaid. In addition to CMS, the State Agencies, and MFCUs, OIG partners with the NAMFCU, State and local law enforcement, the HHS Administration on Aging, State Long Term Care Ombudsmen, the FBI, and DOJ.

Currently, approximately 23 percent of OIG's resources under the Health Care Fraud and Abuse Control account are focused on Medicaid matters. With regard to our investigative work, many of these matters are investigated jointly with MFCUs and/or the FBI. By working with these agencies to identify questionable provider billings, we maximize the impact of the resources available and focus on the providers that are causing the most harm to the program and to its beneficiaries. The structure of these relationships is different in each State because the Medicaid program structure is unique to each State.

OIG's Role in State Medicaid Audit Partnerships
One of OIG's major outreach initiatives has been to work more closely with State auditors in reviewing the Medicaid program. To this end, a partnership plan was developed to foster joint reviews and provide broader coverage of the Medicaid program. The partnership approach has proven an overwhelming success in ensuring more effective use of scarce audit resources by both the Federal and the State audit sectors. To date, partnerships on such issues as prescription drugs, clinical laboratory services, the drug rebate program, school-based services, durable medical equipment, hospital transfers and transportation have been developed in 25 States. Reports have resulted in identification of more than $262 million in Federal and State savings and have led to joint recommendations for savings at the Federal and State levels, as well as improvements in internal controls and computer system operations.

OIG's Role in Identifying Improper Payments
Improper or fraudulent payments result in a substantial drain on State and Federal funds. Therefore, OIG directly conducts a large number of Medicaid audits and evaluations on our own initiative or at the request of CMS, the Department, or Congress. Intended to identify improper payments, these audits and evaluations not only reveal questionable billings, but sometimes also expose fraud, program management deficiencies, weaknesses, and loopholes in program rules. When we question Medicaid payments, we notify CMS of our findings, and, if CMS agrees that the questioned payments were improper, it seeks to recover the Federal share from the States. If possible fraud is found, our investigators review the matter and determine whether to open an investigation. Our auditors may also assist in the ongoing investigations being conducted by our office or other law enforcement agencies.

OIG's Oversight of MFCUs
In addition to OIG's general Medicaid oversight work, as mentioned previously, the Secretary delegated to OIG the responsibility for administering grants to fund MFCUs' ongoing operations. The States are reimbursed for the operation of MFCUs at a rate of 90 percent of costs for the first 3 years after the Unit's initial certification by OIG and 75 percent thereafter. Thus far in FY 2006, OIG has awarded approximately $159.1 million in grant funds to MFCUs.

OIG's responsibilities for oversight of the funding and operation standards of MFCUs include monitoring their overall performance and productivity and ensuring that they devote their full-time efforts to Medicaid-covered health care fraud and patient abuse. Our oversight also includes responsibility for the initial certification and yearly recertification of MFCUs. Regulations require MFCUs to submit an application to our office with an annual report and a budget request. The MFCUs' applications, annual reports, and budget requests are reviewed to determine if they are in conformance with performance standards that were developed jointly by OIG and MFCUs. OIG also relies on feedback from the State Agency and OIG's Office of Investigations field offices to assess MFCUs' performance. OIG staff are now conducting between 8 and 14 on-site reviews annually. We maintain ongoing communication related to the interpretation of program regulations and other policy issues with individual State MFCUs and NAMFCU.

For example, OIG works with NAMFCU to train MFCUs on the importance and effectiveness of using the exclusion process to ban problem providers from participating in Federal and State health care programs. In addition to providing speakers at NAMFCU's annual conferences, OIG staff routinely conduct outreach and training with individual State Agencies and MFCUs, as well as licensing boards and State and local prosecutors, to establish case referral processes and to develop the working relationships that will allow potential exclusion matters to reach OIG.

Our office, MFCUs, and other law enforcement agencies work closely together on fraud cases and other activities, and these partnerships have greatly enhanced OIG's ability to carry out our mission. Generally, the MFCUs focus on Medicaid fraud, and OIG's investigators focus on Medicare fraud. However, many providers who are involved in illegal activities are found to be defrauding both programs at the same time. Therefore, an investigation of either program may reveal fraud in the other program as well. In FY 2005, OIG conducted joint investigations with MFCUs on 331 criminal cases and 95 civil cases and achieved 54 convictions and 28 settlements or judgments in civil cases.

FEDERAL AND STATE CIVIL LITIGATION INVOLVING MEDICAID

OIG, along with DOJ and other Federal law enforcement agencies, has achieved major successes in using the civil False Claims Act, and in particular its *qui tam*[10] provisions, in pursuing fraud in both the Medicare and Medicaid programs. Many major cases have been brought against pharmaceutical manufacturers in particular.

States are increasing their own efforts in civil litigation. The amount of civil recoveries by MFCUs has been increasing in recent years. Under a 1999 policy interpretation by OIG, MFCUs are expected to investigate any potential criminal violations and must then consider if there is a civil fraud case. Civil fraud cases may be pursued under State laws, including false claims acts in those States that have such laws, or under the Federal civil False Claims Act, which has been a longstanding and powerful tool in the fight against health care fraud and abuse. Under the False Claims Act, DOJ may seek penalties and damages. Under our own administrative sanction

[10] The *qui tam* provisions allow whistleblowers to bring suit under the civil False Claims Act seeking recoveries against defrauders of government programs. DOJ, with input from OIG, determines whether or not to intervene in the case; the case may proceed without DOJ. In either case, the whistleblower, or relator, may share in any later recoveries, whether ordered by a court or as the result of a settlement.

authorities, OIG may impose civil monetary penalties and exclude providers for violations of Federal health care laws.

The DRA specifies that OIG, in consultation with the Attorney General, will review State laws relating to false and fraudulent claims to determine that the laws (1) establish liability to the State for false or fraudulent claims described in the Federal False Claims Act with respect to Medicaid expenditures; (2) contain provisions that are at least as effective in rewarding and facilitating *qui tam* actions as those in the Federal False Claims Act; (3) contain a requirement for filing an action under seal for 60 days with review by the State Attorney General; and (4) contain a civil penalty that is not less than the amount authorized by the Federal False Claims Act. If a State has in effect a law relating to false or fraudulent claims that meets Federal requirements, the State is entitled to a greater share of the recoveries in any action brought under such a law. This provision is effective January 1, 2007.

The DRA requires certain Medicaid providers to educate their employees about false claims recoveries. Entities meeting certain criteria are required, as a condition of receiving Medicaid payments, to establish written policies, procedures, and protocols for training all employees, contractors, or agents of the entity. This training must include a detailed discussion of the Federal False Claims Act, Federal administrative remedies for false claims and statements, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws. We anticipate that this employee education will result in better awareness of fraud in the work place and may help prevent fraud and abuse of the Federal health care programs.

OIG'S INVESTIGATIVE PRIORITIES

OIG's criminal investigations and related activities supplement MFCUs' efforts to curb Medicaid fraud. In the current and coming fiscal year, OIG's antifraud priorities in Medicaid will include:

- working more closely with MFCUs and CMS in the States that participate in Medi-Medi projects;
- focusing on areas of the Medicaid program that are known to be vulnerable in the Medicare arena;
- working with MFCUs and State Agencies to identify patterns of potential fraud;
- initiating projects that cross State and program lines–such as reviewing billing data from providers that bill more than one State or that bill both Medicare and Medicaid (outside the Medi-Medi project States) to determine if the volume of claims reveals the potential for false billing;
- continuing to expand our work on quality of care;
- partnering with MFCUs, the State Survey and Certification teams, DOJ, and State prosecutors to bring to justice those providers who abuse this vulnerable population;
- supporting outreach and education efforts to MFCUs, Attorneys General Offices and licensing boards to refer matters to OIG for exclusion action.

OIG has historically focused on three Medicaid program vulnerabilities: nursing home quality of care, pharmaceutical manufacturer fraud, and drug diversion. These areas continue to be investigative priorities for our office.

Nursing home quality of care. Matters for which OIG initiates quality of care investigations include patient abuse, neglect, and deaths. While such cases are usually pursued by MFCUs under State laws, OIG typically becomes involved when there is either a pattern of abuse and neglect or egregious single instances. At the Federal level, remedies under the False Claims Act are available if the investigation demonstrates that a nursing home (its staff and/or its administrator) provided to Medicaid residents services that were so poor as to constitute billing for services not rendered. Claims or cost reports may also be considered false if the nursing home does not provide the level of care or the number of staff as reported on the cost report. Abuse may also be considered a criminal case on the Federal level if the investigation reveals the submission of false adverse event reports, for example, if a patient was reported to have fallen but was, in fact, abused.

In one example, OIG investigated and participated in the prosecution of a matter that led to Federal indictments of a nursing facility and its administrators on local and Federal charges involving the death of a resident. The resident, a person with Alzheimer's Disease who needed supervision, wandered out of the nursing home and froze to death. Prior to reporting the death, employees of the nursing home brought her body back into the home, dressed her, put her into a bed, and reported to the family that the woman had died of natural causes while asleep. The defendants were convicted of the Federal charges of health care fraud and making false statements; they are awaiting sentencing. The State trial is set to convene in late April, with one of the subjects facing involuntary manslaughter charges.

Pharmaceutical manufacturer fraud. These investigations often involve the price of the drugs as set and reported by the manufacturers. Medicaid reimbursement of drugs is often based on the Average Wholesale Price (AWP) of the drug as reported by the manufacturers. OIG has found that companies report AWPs that often far exceed actual acquisition costs, resulting in inflated payments made by the Medicaid programs. There are also fraudulent practices relating to misreporting and underpaying of the Medicaid rebates for drugs and the promotion of drugs for non-FDA approved uses. OIG also investigates kickbacks paid to prescribing physicians and others for drugs covered by the Medicaid program. Often the damages associated with this conduct are substantial. For example, in 2001 a pharmaceutical manufacturer entered into a global settlement to resolve its criminal, civil, and administrative liability for sales, marketing, and pricing practices. The total settlement amount in that case was $875 million in payment to the Federal and State governments. More recently, in 2004 and 2005, other pharmaceutical manufacturers settled large fraud cases involving Federal health care and other programs, including Medicaid. Through these settlements, pharmaceutical manufacturers agreed to pay more than $523 million to the States for Medicaid-related issues.

Drug diversion. OIG conducts many investigations involving Medicaid prescription drug fraud issues in addition to pricing. These cases—many of which involve prescription pain medications such as oxycontin—focus on the following providers: physicians who unnecessarily prescribe these drugs in exchange for cash or in-kind kickbacks; physicians who buy back and either self medicate or sell the diverted drugs; and pharmacists who are in collusion with the doctors or with the beneficiaries. In such fraudulent schemes, the pharmacists buy back and resell the drugs, agree to fill prescriptions in exchange for kickbacks from physicians, short the amount of the drug provided and then sell the "excess" pills, or pay kickbacks to doctors for referring the patients to them. The Medicaid program, which pays for the drugs, and Medicaid beneficiaries are both victims of these schemes. These matters are worked jointly with the Drug Enforcement

Administration, MFCUs, local law enforcement, and FBI and are prosecuted at both the Federal and State levels.

CONCLUSION

In conclusion, Mr. Chairman, thanks to the targeted funding provided by DRA, OIG will continue to devote substantial resources to auditing, evaluating, investigating, and prosecuting abuses in the Medicaid program. OIG identifies payment issues and errors, uncovers program vulnerabilities, recommends improvements to the program, and, when necessary, pursues appropriate law enforcement actions to recover funds paid to fraudulent providers. OIG will also continue to collaborate with CMS, State auditors, MFCUs, DOJ, and other government enforcement agencies to identify, prevent, and deter fraud and abuse. The management and fiscal integrity of Medicaid is a top priority for OIG. I appreciate this opportunity to testify, and I welcome your questions.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

APR - 5 2006

The Honorable Tom Coburn, M.D.
Chairman
Subcommittee on Federal Financial Management,
Government Information, and International Security
Washington, DC 20510

Dear Mr. Chairman:

I am writing to supplement the official record of the hearing on eliminating fraud in the Medicaid program that your subcommittee conducted on March 28, 2006. The enclosed is a letter to Mr. Brian Flood, Inspector General of the Texas Health and Human Services Commission, who also testified at that hearing. The letter follows up on an issue raised in Mr. Flood's testimony regarding ongoing collaboration between our two offices.

We appreciate and share your interest in preventing and detecting Medicaid fraud. If you would like to discuss this matter further, please contact me or have your staff contact Judy Holtz, Acting Director of External Affairs at (202) 619-0260.

Sincerely,

Daniel R. Levinson

Daniel R. Levinson
Inspector General

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

APR - 5 2006

Mr. Brian Flood
Texas Health and Human Services Commission
Office of Inspector General
P.O. Box 85200
Austin, Texas 78708-5200

Dear Mr. Flood:

I appreciated the opportunity to meet you last week at the March 28, 2006, hearing held by the U.S. Senate Committee on Homeland Security and Governmental Affairs, Subcommittee on Federal Financial Management, Government Information, and International Security. I have reviewed your office's semiannual reports, which you provided to me at the hearing, describing the work that your office has accomplished in the past 2 years. As would be expected from the similar missions of our respective agencies, the nature of the work of the Texas Inspector General's office reflects part of a much broader oversight role that our office has played for many years with respect to the programs and operations of the U.S. Department of Health and Human Services.

I understand that in your testimony you were asked about prior contact between our two agencies. I thought I would take the opportunity to elaborate on the many interactions our two offices have had over the past few years, including collaboration with respect to both investigations and audits, since you were appointed as Inspector General.

First, we are currently working jointly with your staff on three active cases. These include:

(1) A case that has both criminal and civil components involving a Dallas area physician indicted for prescribing narcotics without a valid medical purpose, manslaughter, and fraud. The fraud charges, which we are pursuing in conjunction with your office and the FBI, are primarily Medicaid-based, but there is also significant Medicare involvement, totaling an estimated loss to both programs of about $500,000.

(2) Another joint civil case against a nursing and rehabilitation center, alleging that the provider falsified documents in order to entitle unqualified residents to physical therapy services, and that documentation in residents' files did not support the Minimum Data Set forms submitted to Medicaid and Medicare. The overpayment in this case is estimated to be over $6 million.

(3) A qui tam case involving allegations that Medicaid was billed over $8 million for noncovered services provided to undocumented aliens.

Second, as part of our general efforts to work closely with all of our Federal, State, and local law enforcement partners, we have collaborated with representatives of your office, beginning in 2004. This collaboration has included joint attendance at meetings focusing on the Medicare-Medicaid Data Match Pilot Program, referred to as the Medi-Medi program (which compares billings to both the Medicare and Medicaid programs by the same provider to identify aberrant patterns), and meetings in Dallas at the National Crime Information Bureau and at the Healthcare Fraud Task Force, the latter sponsored by the FBI.

At the 2005 SCAM JAM Conference in Dallas, where you were the keynote speaker, the Special Agent in Charge of our Dallas Regional Office of Investigations appeared on the stage with you, along with representatives of the United States Attorney's Office and the FBI.

Also, at your office's invitation, at a 2005 conference in Austin, our Dallas Regional Office of Investigations Assistant Special Agent in Charge presented to your staff a session outlining our investigative efforts and the types of cases our Office of Investigations is working in Texas.

Third, we have engaged in continued correspondence with the Texas Inspector General's Office of Chief Counsel regarding the imposition of exclusions upon health care providers from participation in Federal health care programs, including Medicaid, based on a variety of circumstances, including fraud or adverse actions taken against them by State professional licensing boards.

Fourth, during the last 10 to 15 years, we have had extensive contacts with staff of the Texas State Auditor's Office, with whom we have conducted joint projects, including the sharing of staff, information, and computer data. These efforts have resulted in the issuance of several significant audit reports.

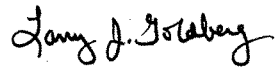
More recently, we participated in training provided by your contract audit unit manager at the AGA Professional Development conference held in Dallas this past January. After that presentation, your contract audit unit manager and our Dallas Regional Inspector General for Audit Services shared information and discussed pursuing possible further joint work regarding the Texas Medicaid drug vendor program. The manager raised the possibility that we might address Texas OIG staff at a May meeting to further discuss previous work our office has done with respect to the Medicaid drug rebate program.

All of this joint work is consistent with our longstanding practice of working closely with all of our law enforcement partners at the Federal, State, and local levels. We have appreciated our many interactions with you and representatives of your office and believe they foster exactly the type of cooperation and exchange of information and expertise that was deemed as critical in the recent hearing before Senator Coburn's Committee.

We plan on supplementing the record of the March 28 hearing with a copy of this letter, so that Senator Coburn and the other Subcommittee Members can be fully informed of the extensive interaction and joint work that has occurred between our two offices.

We look forward to continued interaction and collaboration with your office in the coming years as you further develop your program of investigations, audits, and interagency cooperation to control waste, abuse, and fraud in health and human services programs in Texas.

Sincerely,



Larry J. Goldberg
Principal Deputy Inspector General

Testimony of
Dennis Smith
Director
Center for Medicaid Services
Before the
Senate Subcommittee on Federal Financial Management,
Government Information and International Security
of the
Committee on Homeland Security and Governmental Affairs

March 28, 2006

Chairman Coburn, Senator Carper, distinguished Committee members, thank you for inviting me to discuss our initiatives to eliminate fraud in the Medicaid program. Medicaid is a partnership between the Federal government and the states. While the Federal government provides financial matching payments to the states, each state essentially designs and runs its own program within the Federal structure and each state is responsible for overseeing its Medicaid program.

Efforts to safeguard the Medicaid system can be divided into the areas of fraud or abuse and financial management. The former includes incidents of intentional illegal activity, while the latter consists of proper oversight of expenditures and financing systems to avoid inefficient operations or inadvertent errors.

Fraud and Abuse Activities

When considering fraud and abuse reduction efforts in the Medicaid program it is critical to remember that this is a joint Federal-state effort and that both levels of government have people and systems devoted to preventing and addressing fraud.

With the passage of the Deficit Reduction Act, CMS is now planning the implementation of the Medicaid Integrity Program. We are required to enter into contracts with eligible entities to carry out certain specified activities including reviews, audits, and identification and recovery of overpayments and education. For purposes of carrying out this Medicaid Integrity Program, an additional $5 million is appropriated for FY 2006, $50 million for FY 2007 and 2008 and $75 million for each year thereafter. From these amounts, the Secretary must add an additional 100 full-time equivalent employees whose duties consist solely of protecting the integrity of the Medicaid program. Besides providing oversight of Medicaid providers, CMS will increase its oversight of State program integrity efforts as well as provide training and best practices guidance to State program integrity units.

Federal regulations also require that each state Medicaid agency maintain a Medicaid Management Information System (MMIS). The MMIS is a claims processing and information retrieval system. A vital part of each state's MMIS is the Surveillance and Utilization Review Subsystem (SURS). SURS is a mandatory component of MMIS. The principal purpose of the SURS unit is to safeguard against inappropriate payments for Medicaid services. This is done by analyzing and evaluating provider service utilization to identify patterns of fraudulent, abusive, unnecessary and/or inappropriate utilization.

Each MMIS must be federally certified before funding is granted. The Centers for Medicare & Medicaid Services (CMS) utilizes multidisciplinary teams to conduct comprehensive, onsite reviews before such certification is granted. CMS funds 90 percent of the administrative costs associated with the start up of each state's MMIS and then continues to fund each state at a 75

percent Federal match for the ongoing operations of these systems. Projected expenditures for MMIS in FY '06 are slightly over $2 billion, with almost $1.6 billion coming from the Federal government.

Medicare-Medicaid Data Matching Project

In an effort to better coordinate Medicare and Medicaid program integrity, CMS, in partnership with the State of California, initiated a project, designed to share and analyze both Medicare and Medicaid data beginning in 2001. Now known as Medi-Medi, this work involves comparing data from both programs to reveal fraudulent patterns previously invisible to either program, independent of the other. Our Administrator, Dr. Mark McClellan, has publicly expressed his strong support for this program.

Another nine states have since either established Medi-Medi projects or are developing them. These states include: Florida, Illinois, Ohio, North Carolina, Washington, New Jersey, Texas, Pennsylvania and New York. In all of the projects, our federal and state law enforcement and program integrity partners work hand in hand with CMS to identify fraudulent behaviors. Since its inception, the Medi-Medi project has been allocated approximately $22.8 million in funds from the Health Care Fraud and Abuse Control Program (HCFAC) and $7.8 million in FBI funds, for a total of $30.6 million. During that same time, it has generated 335 investigations. Through FY 2005, it has also identified $253.94 million in potential overpayments, including payments at risk associated with those investigations, programmatic vulnerabilities, identified overpayments and denied claims.

With the enactment of the DRA, Medi-Medi will now be expanded nationally and will be provided a stable funding stream which peaks at $60 million annually by FY 2010 and each year thereafter.

These projects have uncovered a number of fraudulent schemes. In one of the most recent examples, the Pennsylvania Medi-Medi project has identified a significant vulnerability that may well exist in many, if not most, states. Data analysis of Medicaid and Medicare billings revealed that several pharmacies in the state had either inappropriately billed Medicaid first for Medicare-covered drugs or had double-billed both programs. Until the Medi-Medi review there had been no crosswalk between the Medicare and Medicaid codes. Further analysis and investigation identified overpayments to over 48 pharmacies on a small number of pharmaceutical codes. The State and the contractor estimate Medicaid overpayments alone at about $20 million; a conservative estimate given the large number of pharmaceutical codes yet to be analyzed.

The Medi-Medi projects in New Jersey, Ohio and California have found similar patterns. For example, the State of New Jersey has identified approximately $332,000 at risk as a result of problematic billings to both programs for just 28 dual eligible beneficiaries receiving just one drug, Neulasta, over the course of one year. Data analysis and follow-up work suggest that similar overpayments exist in Ohio and California, but further analysis and field work will be necessary to quantify the problem in those states. It should be noted that these are the types of patterns that a project like Medi-Medi, which shares and compares billings from both programs, is uniquely designed to discover. All Medi-Medi projects have been directed to conduct analyses to determine if, and to what extent, this vulnerability exists.

Other Provisions of the Deficit Reduction Act

- States are provided an incentive to enact State False Claims Acts (FCA) that meets certain Federal requirements. States whose FCA law meets those requirements will receive additional federal matching funds for any amounts recovered as a result of enforcing their state False Claims Acts.
- Any entity which receives or makes annual Medicaid payments under the state plan of at least $5 million must provide Federal False Claims Act education to their employees.
- Medicaid payment is prohibited for the ingredient cost of a drug for which the pharmacy has already received payment under Medicaid (other than a reasonable restocking fee).
- The Office of Inspector General within the Department of Health and Human Services is appropriated an additional $25 million for each of FYs 2006 through 2010 for Medicaid fraud and abuse control activities.
- Before making payment for health care services, state Medicaid programs are required to seek payment from other third parties that may be responsible for those costs. Maintaining Medicaid's status as the payer of last resort reduces overall expenditures. The DRA clarified that the list of third parties from which state or local agencies must seek payment includes self-insured plans, pharmacy benefit managers, and other parties that are by statute, contract, or agreement legally responsible for payment of a claim. States are required to enact laws that mandate that all such parties provide information to the state needed to facilitate determination of liability, cooperate with the state in determining liability, and except the state from administrative timing and other procedural requirements for claims if the claims are submitted within 3 years and pursued within 6 years.

- Beginning on July 1, 2006, individuals who declare themselves to be US citizens or nationals are now required to provide satisfactory documentary evidence of citizenship or national status.

CMS is working to implement these various provisions in accordance with their specific statutory effective dates and will release more information to the states and the public about these efforts when as they are completed.

Strengthening Financial Management Activities

In addition to our efforts to control fraud, CMS works to ensure that Medicaid payments to states are based on legitimate and legal expenditures. These efforts have resulted in greatly reduced improper payment to states.

In 2002, we created a new team within CMS to specifically review state plan amendments (SPAs) that involved reimbursement to institutional providers such as nursing homes and hospitals. We subsequently created another group to review plans affecting non-institutional providers such as physicians and clinics. Over time, these teams evolved into the Division of Reimbursement and State Financing (DRSF), consolidating in one CMS component responsibility for all payment policy and state Medicaid funding issues. A central responsibility of this Division is to ensure consistency in the nationwide application of Medicaid payment and funding policy. The Division now comprises three teams, which are responsible for institutional reimbursement, non-institutional reimbursement, and state funding policy and oversight.

As part of this integrated approach, DRSF holds monthlly conference calls with the CMS Regional Offices, in which we discuss pending Medicaid reimbursement State Plan Amendments (SPAs) and Medicaid financial management issues in the respective Regional Offices. Through these monthly calls, we develop a cross-representational team that is equipped to address the full range of Medicaid reimbursement and financial issues in each state within each region. These calls began on February 7, 2005.

From August of 2003 through mid-March of this year, CMS has reviewed and approved nearly 1,100 SPAs. Our review of these SPAs has reduced inappropriate payment of Federal matching funds in the past and will continue to do so into the future.

To improve the internal controls related to the Medicaid program to ensure a strong oversight function, beginning in late 2004 and into 2005, CMS hired 100 new financial management staff to monitor state activities, enforce compliance with CMS financial management procedures and improve Medicaid financial management oversight. The funding specialists enforce compliance with Medicaid financing requirements by proactively monitoring the State Medicaid budget process and reviewing claimed expenditures in order to identify, resolve, and avert State Medicaid financing proposals/practices that are inconsistent with the Social Security Act. Almost all of these individuals were assigned to specific states and 10 were based in our Central Office. Extensive training for these new hires was conducted beginning in late 2004 and running through 2005.

The additional staff have made the necessary contacts with their respective Medicaid agencies to gain a thorough understanding of the overall organizational structure of the state's Medicaid program; the programmatic structure of the state's Medicaid program; and the state budget, expenditure, and financial management processes. They have been working closely with Regional Office and state financial management staff on these activities.

These new employees have met with numerous health officials in their respective states, attended public hearings regarding state budgets, have performed significant research of public records, and participated in financial management reviews with current Regional Office staff. They have assisted with the review of Medicaid reimbursement state plan issues, performed reviews of state funding issues, assisted in the resolution of OIG and GAO audit findings, and performed other financial oversight activities. Through their work, and through coordination with the Regional Offices, we expect to prevent new versions of inappropriate financing arrangements before they are put in place and replicated.

Florida's Efforts

States can take significant actions on their own to reduce Medicaid fraud within their jurisdiction. Florida has experienced some significant successes in this area within the past few years. The following offers anecdotal examples of what can happen when states focus on bolstering the integrity of their Medicaid program.

In 2005, Florida identified 627 pharmacies, including national chain outlets, which were inappropriately submitting claims for in-house preparation of unit dose packaging when in fact the manufacturer had prepared

the unit dose packaged product. Thanks to their diligence, a National Medicaid Fraud Alert was issued. Several other states indicated this could be a significant problem for them as well.

Florida's FY 2003-2004 Medicaid Program Integrity report identified savings of $16.5 million over 18 months as the result of a special review of high billing providers for Intravenous Immune Globulin (IVIG) claims in South Florida. The state had previously addressed the issue by requiring that physician claims for this service be restricted to specific diagnosis claims, causing expenditures to fall by approximately half. Over time, however, the billings crept back up at which time Florida cracked down with its special reviews of 80 high billing providers. The overall effect of those reviews was a sharp and sustained drop in billings.

Florida's FY 2004-2005 MPI report also documented the results of its year long project, again in South Florida, involving DME site visits. The state examined medical documentation, licensure and ownership documents and thoroughly inspected the facilities to determine compliance. State officials believe those reviews caused an approximate $2.1 million reduction in DME expenditures in FY 2005.

That same report also reported a remarkable 140% increase in the number of potential fraud referrals by the Medicaid program to the Medicaid Fraud Control Unit. In FY 2004-2005, the MPI staff provided the MFCU with 230 referrals compared to 96 in FY 2003-2004.

Conclusion

CMS has made significant progress in protecting the integrity of the financing of the Medicaid program. We know our work is not over and we must remain vigilant and proactive. Thank you again for the opportunity to speak with you today. I look forward to answering any questions you might have.

United States Government Accountability Office

GAO

Testimony

Before the Subcommittee on Federal Financial Management, Government Information, and International Security, Committee on Homeland Security and Governmental Affairs, U.S. Senate

For Release on Delivery
Expected at 2:30 p.m. EDT
Tuesday, March 28, 2006

MEDICAID INTEGRITY

Implementation of New Program Provides Opportunities for Federal Leadership to Combat Fraud, Waste, and Abuse

Statement of Leslie G. Aronovitz
Director, Health Care

GAO-06-578T

Highlights

Highlights of GAO-06-578T, a testimony before the Subcommittee on Federal Financial Management, Government Information, and International Security, Committee on Homeland Security and Governmental Affairs, U.S. Senate

Why GAO Did This Study

Today's hearing concerns fraud, waste, and abuse control in Medicaid, a program that provides health care coverage for over 56 million eligible low-income people and is jointly financed by the federal government and the states. In fiscal year 2004, Medicaid had benefit payments of $287 billion, with a federal share of about $168 billion.

The states are primarily responsible for ensuring appropriate Medicaid payments through provider enrollment screening, claims review, overpayment recovery, and case referral to law enforcement. At the federal level, the Centers for Medicare & Medicaid Services (CMS) is responsible for supporting and overseeing state fraud, waste, and abuse control activities.

The Subcommittee requested information on how CMS and the states can better serve taxpayers and beneficiaries by reducing Medicaid fraud. This statement will focus on existing concerns about CMS's efforts to help states prevent and detect fraud, waste, and abuse; how provisions in recent legislation providing for a Medicaid Integrity Program will help CMS expand its current efforts; and challenges CMS needs to address as it implements new Medicaid Integrity Program efforts.

www.gao.gov/cgi-bin/getrpt?GAO-06-578T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Leslie G. Aronovitz at (312) 220-7600 or aronovitzl@gao.gov.

March 28, 2006

MEDICAID INTEGRITY

Implementation of New Program Provides Opportunities for Federal Leadership to Combat Fraud, Waste, and Abuse

What GAO Found

As GAO testified in 2005, there has been a wide disparity between the level of staff and financial resources that CMS has expended to support and oversee state activities to control fraud and abuse and the amount of federal dollars at risk in Medicaid benefit payments. In fiscal year 2005, CMS dedicated an estimated 8.1 full-time equivalent employees to support states in their anti-fraud-and-abuse operations. In contrast, the federal government spent over $168 billion for Medicaid benefits in fiscal year 2004. Further, resource shortages severely limited two efforts that had shown potential to help states prevent and detect fraud, waste, and abuse. In addition to devoting limited staff and financial resources, CMS lacked a strategic plan to direct its anti-fraud-and-abuse efforts.

Enacted in February 2006, the Deficit Reduction Act of 2005 (DRA) provided for creation of the Medicaid Integrity Program and includes specific appropriations that CMS can use to fund activities to support anti-fraud-and-abuse efforts. It also included provisions that will address the agency's staffing and planning limitations related to Medicaid program integrity. For example, the law requires CMS to add 100 employees to work with states in support and oversight of their Medicaid program integrity efforts and to develop a comprehensive plan to explain how the agency will address Medicaid fraud, waste, and abuse. In addition, the DRA provided funds to expand a program that is designed to identify program vulnerabilities in Medicaid and Medicare—the federal health insurance program for the elderly and some disabled people—by examining billing and payment abnormalities in both programs.

In implementing the DRA provisions related to the Medicaid Integrity Program, CMS has a unique opportunity to strengthen its leadership of state and federal efforts to control fraud, waste, and abuse in the Medicaid program. The most immediate challenge will be to develop its comprehensive plan that will provide strategic direction for CMS, the states, and law enforcement partners.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you discuss the control of fraud, waste, and abuse in Medicaid, the program that provided health care coverage for over 56 million low-income individuals in fiscal year 2004, including children and the aged, blind, and disabled. Medicaid is jointly financed by the federal government and the states. In fiscal year 2004, Medicaid's benefit payments totaled $287 billion, of which the federal share was about $168 billion. Medicaid is administered directly by the states and consists of 56 distinct state-level programs.[1]

In 2003, GAO added Medicaid to its list of high-risk programs, owing to the program's size, growth, diversity, and fiscal management weaknesses.[2] We noted that insufficient federal and state oversight put the Medicaid program at significant risk for improper payments. Improper payments may be due to mistakes, abuse, or fraud.[3] Because, by their nature, fraud and abuse are not apparent until detected, the amount of Medicaid funds lost through health care providers' inappropriate billings cannot be precisely quantified. A nationwide rate of improper payments for Medicaid has not been estimated, but even a rate as low as 3 percent would have resulted in a loss of about $5 billion in federal funds in fiscal year 2004. To put this hypothetical figure in perspective, it is more than the amount that the federal government spent in fiscal year 2004 on the State Children's Health Insurance Program (SCHIP).[4] Further, Medicaid can be subject to waste, or extravagant and unnecessary expenditures. Because Medicaid represents a large and growing share of state budgets—more than 20

[1]The 56 Medicaid programs include one for each of the 50 states, the District of Columbia, Puerto Rico, and the U.S. territories of American Samoa, Guam, Northern Mariana Islands, and the Virgin Islands. Hereafter, all 56 entities are referred to as states.

[2]GAO, *Major Management Challenges and Program Risks: Department of Health and Human Services*, GAO-03-101 (Washington, D.C.: January 2003).

[3]Improper payments can result from inadvertent errors as well as intended fraud and abuse. Unlike inadvertent errors, which are often due to clerical errors or a misunderstanding of program rules, fraud involves an intentional act or representation to deceive with knowledge that the action or representation could result in gain, while abuse typically involves actions that are inconsistent with acceptable business and medical practices that result in unnecessary cost. See, e.g., 42 CFR § 455.2 (2005).

[4]SCHIP is a jointly funded federal-state program that provides health insurance to children in low-income families who do not qualify for Medicaid and are not covered by other insurance.

percent of state expenditures—funds lost to improper payments and waste can impact states' abilities to serve beneficiaries in need.

Fraud, waste, and abuse drain vital program dollars in ways that hurt both taxpayers and beneficiaries. Seeking and receiving reimbursement for services not provided squanders public funds that could have been used for beneficiaries' health care. For example, in 2005, a North Carolina pharmacist was sentenced to 33 months in prison and ordered to pay more than $2 million in restitution for defrauding the Medicaid program by submitting claims for long-term care patients' prescriptions that had not been refilled, delivered, or even requested by their caregivers. Similarly, a New York hospital agreed to pay $76.5 million to resolve allegations that it overbilled the Medicaid program for services provided in its clinics. In addition, when providers receive payment for unnecessary services, it can have a negative impact on health care quality. For example, consider the case in 2004 against 20 dentists in California who were charged with conspiracy to defraud the state's Medicaid program of $4.5 million. The dentists are alleged to have billed Medicaid for unnecessary or inappropriate services that placed patients at risk of pain, infection, loss of teeth, and bodily injury—including reusing dental instruments without sterilizing them, performing dental surgeries without adequate anesthesia, and developing treatment plans that called for unnecessary root canals and fillings.

States are the first line of defense against Medicaid fraud, waste, and abuse. Specifically, they must comply with federal requirements to ensure the qualifications of the providers who bill the program, detect improper payments, recover overpayments, and refer suspected cases of fraud and abuse to law enforcement authorities. At the federal level, the Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS), is responsible for supporting and overseeing state fraud, waste, and abuse control activities. Last year, we testified that CMS had initiatives to assist states in combating fraud and abuse in their Medicaid programs but that its oversight of states' activities and commitment of federal dollar and staff resources were limited.[5] Since then, the Deficit Reduction Act of 2005 (DRA)[6] provided for creation of a Medicaid Integrity Program and included other provisions designed to

[5]GAO, *Medicaid Fraud and Abuse: CMS's Commitment to Helping States Safeguard Program Dollars Is Limited*, GAO-05-855T (Washington, D.C.: June 28, 2005).

[6]See Pub. L. No. 109-171, § 6034, 120 Stat. 3, 74-78 (2006).

increase CMS's level of effort to support state activities to address fraud, waste, and abuse in Medicaid.

The Subcommittee requested information on ways that CMS and the states can better serve taxpayers and Medicaid recipients by reducing or eliminating fraud in the program. My remarks today will focus on (1) existing concerns regarding CMS's efforts to help states prevent and detect fraud and abuse in the Medicaid program, (2) how provisions in the DRA will help CMS expand current efforts to address Medicaid fraud, waste, and abuse, and (3) challenges CMS faces as it implements new Medicaid Integrity Program efforts. To address these issues, we reviewed agency documents on Medicaid program integrity and oversight activities, relevant provisions of the DRA, and our issued reports on CMS's and states' efforts to address Medicaid fraud, waste, and abuse. (Related GAO products are listed at the end of this statement.) We also interviewed CMS officials. We conducted our work in March 2006 in accordance with generally accepted government auditing standards.

In summary, we testified last year that while CMS has activities to oversee and support state efforts to address fraud and abuse in the Medicaid program, the agency has not devoted the staff and financial resources to its efforts that are commensurate with the risks involved. In addition, CMS has lacked plans to guide federal and state agencies that were working to prevent or deter Medicaid fraud and abuse. Enacted in February 2006, the DRA provided for the creation of a new Medicaid Integrity Program, with specified appropriations to fund it. DRA also requires CMS to devote an additional 100 full-time-equivalent staff to combating Medicaid provider fraud and abuse; develop a comprehensive plan for the Medicaid Integrity Program every 5 fiscal years; and report annually on its use, and the effectiveness of its use, of the appropriated funds. In implementing the DRA provisions related to the Medicaid Integrity Program, CMS faces a major challenge—to develop a comprehensive plan that provides strategic direction for CMS, the states, and law enforcement partners. In developing its plan, CMS will need to focus on how it intends to allocate resources among activities to reduce program risk to the greatest extent possible and how to effectively deploy program integrity staff within the agency. Planning for, and implementing, the DRA provisions provide CMS with a unique opportunity to strengthen its leadership of state and federal efforts to control fraud, waste, and abuse in the Medicaid program.

Background

Within broad federal guidelines, each state's Medicaid program establishes its own eligibility standards; determines the type, amount, duration, and scope of covered services; and sets payment rates. In general, the federal government matches state Medicaid spending for medical assistance according to a formula based on each state's per capita income. In fiscal year 2006, the federal contribution ranges from 50 to 76 cents of every state dollar spent on medical assistance. For most state Medicaid administrative costs, the federal match rate is 50 percent.[7]

As program administrators, states have primary responsibility for conducting program integrity activities that address provider enrollment, claims review, and case referrals. Specifically, federal statute or CMS regulations require states to

- collect and verify basic information on potential providers, including whether the providers meet state licensure requirements and are not prohibited from participating in federal health care programs;
- have an automated claims payment and information retrieval system—intended to verify the accuracy of claims, the correct use of payment codes, and patients' Medicaid eligibility—and a claims review system—intended to develop statistical profiles on services, providers, and beneficiaries to identify potential improper payments;[8] and
- refer suspected overpayments or overutilization cases to other units in the Medicaid agency for corrective action, and potential fraud cases to law enforcement—generally to the state's Medicaid Fraud Control Unit for investigation and prosecution.[9]

[7]For skilled professional medical personnel engaged in program integrity activities, such as those who review medical records, 75 percent federal matching is available.

[8]CMS requires that states have certain information processing capabilities, including a Medicaid Management Information System and a Surveillance and Utilization Review Subsystem.

[9]Medicaid Fraud Control Units can, in turn, refer some cases to the HHS Office of Inspector General, the Federal Bureau of Investigation, and the Department of Justice for further investigation and prosecution.

As noted in our 2004 report,[10] states use a variety of controls and safeguards to stem improper provider payments. For example, states reported using information technology to integrate databases containing provider, beneficiary, and claims information and to increase the effectiveness of their utilization reviews. Various states individually attributed cost savings or recoupments to these efforts, valued in the millions of dollars.

In contrast, CMS's role in curbing fraud, waste, and abuse in the Medicaid program is largely one of support to the states. As we reported in 2004,[11] CMS administers two pilot projects, one focused on measuring the accuracy of a state's Medicaid claims payments—Payment Accuracy Measurement (PAM)—and the other focused on improper billing detection and utilization patterns by linking Medicare[12] and Medicaid claims information (Medi-Medi). CMS also sponsors general technical assistance and information-sharing through its Medicaid fraud and abuse technical assistance group (TAG). In addition, CMS performs oversight of states' Medicaid fraud and abuse control activities through its compliance reviews. (See table 1.)

[10]GAO, *Medicaid Program Integrity: State and Federal Efforts to Prevent and Detect Improper Payments*, GAO-04-707 (Washington, D.C.: July 16, 2004).

[11]GAO-04-707.

[12]Medicare is the federal program that helps pay for a variety of health care services and items on behalf of about 42 million elderly and disabled beneficiaries.

Table 1: CMS Activities to Support and Oversee States' Fraud and Abuse Control Efforts, Fiscal Year 2004

CMS initiatives	Description
PAM/ Payment Error Rate Measurement (PERM)	CMS conducted a 3-year pilot called PAM to develop estimates of states' accuracy in paying Medicaid claims. During fiscal year 2006, PAM will become a permanent program—to be known as the PERM initiative—in order to measure improper payments in Medicaid, to fulfill a requirement of the Improper Payments Information Act of 2002.[a] Under PERM, states will be expected to ultimately reduce their payment error rates over time by better targeting program integrity activities in their Medicaid and SCHIP programs.
Medi-Medi	Under this pilot program, CMS facilitates the sharing of health benefit and claims information between the Medicaid and Medicare programs. Medi-Medi is a data match pilot designed to identify improper billing and utilization patterns by matching Medicare and Medicaid claims information on providers and beneficiaries to reduce fraudulent schemes that cross program boundaries.
TAG	Through telephone conferencing, CMS provides a forum for states to discuss issues, solutions, resources, and experiences on fraud and abuse issues. Any state may participate; roughly one-third do so regularly. States have also used the TAG to propose policy changes to CMS.
Compliance reviews	CMS conducts on-site reviews to assess whether state Medicaid fraud and abuse control efforts comply with federal requirements, such as those governing provider enrollment, claims review, utilization control, and coordination with each state's Medicaid Fraud Control Unit. If reviewers find a state that is significantly out of compliance, they may encourage it to develop a corrective action plan and revisit the state to verify actions taken.

Source: GAO-04-707.

[a]Pub. L. No. 107-300, 116 Stat. 2350.

CMS also has a significant role in curbing fraud, waste, and abuse in Medicare. Through its Medicare Integrity Program, CMS contracts with companies to conduct program integrity activities, such as reviewing claims and ensuring that Medicare pays the appropriate amount when beneficiaries have other health insurance.

CMS Committed Few Resources and Had No Strategic Plan to Address Medicaid Fraud and Abuse

As we testified last year, a wide disparity exists between the level of staff and financial resources that CMS has expended to support and oversee states' fraud and abuse control activities and the amount of federal dollars at stake in Medicaid benefit payments.[13] In fiscal year 2005, CMS dedicated an estimated 8.1 full-time-equivalent employees to support and oversee states' anti-fraud-and-abuse operations. In contrast, the federal government spent over $168 billion for Medicaid benefits in fiscal year 2004. Further, some of the promising efforts to support and oversee states were at risk of being cut back or terminated, and CMS lacked a strategic plan to direct its anti-fraud-and-abuse efforts.

Funding for some of CMS's most promising anti-fraud-and-abuse activities declined in recent years, which threatened the continuity of these efforts. The amount of funding for the project to estimate state improper payment rates, PAM/PERM, and the project to match Medicare and Medicaid claims, Medi-Medi, declined from $7.8 million in fiscal year 2004 to $3.6 million in fiscal year 2005. Both of these projects are important. Measuring improper payments in Medicaid and other programs is required by statute, while Medi-Medi is uncovering significant billing problems. As of March 31, 2005, seven states with fully operational Medi-Medi projects reported a total of $133.1 million in returns to the Medicaid and Medicare programs, $59.7 million in program vulnerabilities identified, and $2 million in overpayments to be recovered. However, because of anticipated unmet funding needs, we testified that existing Medi-Medi projects were at risk of being scaled back considerably or eliminated entirely. Last year, agency officials noted that several other states were interested in participating in the program but that CMS would not expand the program without a new allocation or realigment of funds.

Further, we testified that the HHS budget appropriations for CMS's Medicaid compliance reviews had decreased each year from fiscal year 2002 through fiscal year 2004. Since 2000, CMS staff from the regional offices and headquarters had conducted compliance reviews of seven to eight states a year. These reviews proved to be effective. However, at that pace, CMS would review states' programs once every 7 years, preventing the agency from having up-to-date knowledge on more than a handful of states at any given time.

[13]GAO-05-855T. We did not address issues regarding waste in this testimony.

Resource shortages also have severely limited CMS's activities to provide technical assistance and disseminate information on states' best practices. These activities had demonstrated positive results. However, CMS has not sponsored a national conference with state program integrity officials since 2003 and has not sponsored any fraud and abuse workshops or training since 2000.

In addition to devoting limited staff and financial resources, CMS lacked a strategic plan to direct its anti-fraud-and-abuse efforts.[14] Neither HHS nor CMS had produced a public document that included long-term goals in the area of supporting states' efforts to address fraud and abuse in the Medicaid program and specific plans for achieving these goals.

CMS Has New Authority, Resources, and Responsibilities to Address Fraud, Waste, and Abuse

The DRA has added substantially to CMS's authority, resources, and responsibilities to address Medicaid fraud, waste, and abuse.[15] It established a new program that is solely focused on promoting the integrity of Medicaid and provides specified appropriations that CMS can use to fund activities to support state efforts to combat fraud, waste, and abuse. To conduct the new Medicaid Integrity Program, the law specified an appropriation of $5 million in fiscal year 2006, $50 million in each of fiscal years 2007 and 2008, and $75 million in each of the subsequent fiscal years. As part of the Medicaid Integrity Program, CMS is given authority to contract with eligible entities to conduct activities to address fraud, waste, and abuse in the state programs through activities such as audits of consulting contracts and reported costs of nursing home services.[16] In addition, CMS is required to increase by 100 its full-time-equivalent employees whose duties consist solely of protecting the integrity of the Medicaid program by providing effective support and assistance to the

[14]GAO-05-855T.

[15]While the DRA vests the Secretary of Health and Human Services with authority to implement the Medicaid Integrity Program, in general, administration of the Medicaid program is delegated to CMS.

[16]The activities for which CMS can contract with entities under the Medicaid Integrity Program are (1) review of Medicaid providers or others—such as managed care plans—to determine whether their actions have led, or could lead, to waste, fraud, or abuse; (2) audit of claims for payment for items, services, or administrative services rendered, including audits of reported costs and consulting and other contracts; (3) identification of overpayments to individuals or entities receiving Medicaid payments; and (4) education of providers of services, managed care entities, beneficiaries, and other individuals on payment integrity and quality of care.

states.[17] The authorization of funds for the Medicaid Integrity Program is similar to that of the Medicare Integrity Program, which was also established with specified appropriations and the authority for CMS to contract with companies to conduct integrity activities. CMS credits the Medicare Integrity Program with helping the agency measure and reduce payment errors in the Medicare fee-for-service program.

The DRA also provides for a national expansion of the Medi-Medi program. The statute appropriates funds for CMS to contract with third parties to identify program vulnerabilities in Medicare and Medicaid through examining billing and payment abnormalities. The funds also can be used in connection with the Medi-Medi program for two other purposes. First, the funds can be used to coordinate actions by CMS, the states, the Attorney General, and the HHS Office of Inspector General to protect Medicaid and Medicare expenditures. Second, the funds can be used to increase the effectiveness and efficiency of both Medicare and Medicaid through cost avoidance, savings, and recouping fraudulent, wasteful, or abusive expenditures. For Medi-Medi, the statute appropriates $12 million for fiscal year 2006, $24 million for fiscal year 2007, $36 million for fiscal year 2008, $48 million for fiscal year 2009, and $60 million for fiscal year 2010 and each subsequent fiscal year.

Beginning in fiscal year 2006 and every 5 fiscal years thereafter, the DRA requires CMS to establish a comprehensive plan for ensuring the integrity of the Medicaid program by combating fraud, waste, and abuse. CMS is required to develop the plan in consultation with the Attorney General, the Director of the Federal Bureau of Investigation, the Comptroller General, the HHS Office of Inspector General, and state officials responsible for controlling Medicaid provider fraud and abuse. Developing a plan in consultation with other agencies with responsibilities to address fraud, waste, and abuse issues will encourage additional dialogue on the overall direction of federal and state efforts. In addition, CMS is required to submit an annual report to Congress no later than 180 days after the end of each fiscal year, which identifies the agency's use, and the effectiveness of the use, of the Medicaid Integrity Program funds it has expended. This reporting mechanism can help CMS focus on making the wisest investment of its new resources.

[17]The DRA did not establish a date for CMS to complete its hiring of full-time-equivalent staff.

Developing CMS's Plan Is a Critical First Step

CMS faces a key implementation challenge early on—to develop a comprehensive plan for Medicaid program integrity. A properly developed plan will provide strategic direction for CMS, its contractors, the states, and law enforcement partners. Key areas that the plan should address include the allocation of financial resources among activities to reduce program risk to the greatest extent possible and the effective deployment of program integrity staff within the agency. CMS's plan—if well thought out and formulated—could provide a blueprint for ensuring that new DRA funding is appropriately invested and that CMS staff devoted to Medicaid program integrity efforts are most effectively deployed. CMS is still in the beginning stages of formulating its plan and has not received final departmental approval for some of its initial implementation steps. As a result, agency officials were not at liberty to discuss their planning efforts with us in much detail.

A comprehensive plan for program integrity is not a new concept for CMS. In February 1999, CMS issued such a plan for the Medicare and Medicaid programs.[18] Most of the material in this plan focused on Medicare, and the plan has not been updated since 1999. However, it could serve as a possible template for communicating updated information on Medicaid efforts. In addition to communicating information about the goals that CMS hoped to achieve and proposed strategies for achieving them, the plan described an iterative program integrity process that focused on identifying and assessing risk, developing and implementing approaches to addressing risk, and monitoring and measuring progress. Further, the process described in the 1999 program integrity plan is similar to strategies that we have highlighted in the past as being used by public and private sector organizations to manage improper payments.[19]

Structured analysis of risk and meaningful measures of performance are an integral part of any plan, but will prove challenging to develop in the Medicaid program. The difficulty stems from CMS's having limited

[18]Health Care Financing Administration, *Comprehensive Plan for Program Integrity*, HCFA-02142 (Baltimore, Md.: February 1999). Until July 1, 2001, CMS was called the Health Care Financing Administration.

[19]GAO, *Strategies to Manage Improper Payments: Learning from Public and Private Sector Organizations*, GAO-02-69G (Washington, D.C.: October 2001). Strategies include creating a culture of accountability by establishing a positive and supportive attitude toward improving program integrity; assessing the nature and extent of risks; taking action to address identified risk areas; using and sharing information to manage improper payments; and monitoring activities to address improper payments over time.

information on the extent of improper payments in the state programs. In addition, because state programs vary in their design, the intensity of their risks of fraud, waste, and abuse may differ. While a comprehensive plan cannot deal with the issues of each state, it can articulate a strategy for states to address the vulnerabilities in their programs. Further, developing meaningful measures of the impact of the Medicaid Integrity Program will require a long-term investment of resources, and these measures will not be available for CMS's first comprehensive plan. Medicare has taken years to develop and refine its error-rate testing program, under which CMS conducts an annual study to estimate Medicare improper payments.

CMS is in the early stages of developing a similar measure for Medicaid. The agency recently completed its 3-year PAM pilot, so the results of payment error studies are available from the 27 participating states. CMS is transitioning from PAM to PERM. Under PERM, states will be expected to ultimately reduce their payment error rates over time by better targeting program integrity activities in their Medicaid and SCHIP programs. When fully implemented, PERM should allow CMS to compile data about Medicaid improper payments on the state and national levels, which could allow CMS to track progress, as well as identify states that may require special assistance, in reducing improper payment error rates. CMS expects to have its first PERM results in 2008. In addition to assessing progress toward reducing improper payments, CMS will also need to develop other methods of measuring the effectiveness of program integrity activities. One such measure, used in the Medicare program, is calculating a return on investment, which measures the dollars saved for each dollar spent.

In developing its plan, CMS must decide how to most appropriately invest new resources. In the past, CMS has invested a substantial amount of its resources in the oversight of states' financial management activities, such as state claims for federal matching. For more than a decade, states have used various financing schemes to inappropriately cause the federal government to pay an excessive share of reported Medicaid costs.[20] While financial oversight of these schemes was needed, states also needed

[20]GAO, *Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight*, GAO-05-748 (Washington, D.C.: June 28, 2005); *Medicaid: States' Efforts to Maximize Federal Reimbursements Highlight Need for Improved Federal Oversight*, GAO-05-836T (Washington, D.C.: June 28, 2005); and *Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed*, GAO-04-228 (Washington, D.C.: Feb. 13, 2004).

encouragement and support to address fraud committed by providers against the state Medicaid program.

Now, in light of new funds provided through the Medicaid Integrity Program, CMS will be faced with the goal of prudently investing millions of dollars each year to address fraud by providers and others—such as managed care plans—in Medicaid. In order to spend its new funds appropriately, CMS must weigh its options and consider both the costs and benefits of various activities, such as educating providers as compared with conducting reviews to help identify potential fraud. Nevertheless, CMS does have some flexibility in investing its new Medicaid Integrity Program resources. If CMS does not spend all the funds appropriated for the Medicaid Integrity Program in one year, the agency will be allowed to spend them in succeeding years.[21] However, the requirement to annually report on its use of funds will provide information on whether CMS is generally using the funding, as opposed to continually rolling funding forward.

CMS may also be able to use some of its DRA funds to help facilitate communication and coordination with states through conferences and the TAG. According to a CMS official, such information-sharing and technical assistance activities would not be expensive to support and could result in returns that would exceed the relatively low investment. Similarly, the TAG has served as a forum to share expertise and best practices; advise CMS on policies, procedures, and program development; and make recommendations on federal policy and legislative changes. CMS might be able to further facilitate state participation through additional support for this forum.

Another key planning area for CMS involves deciding how best to deploy Medicaid program integrity staff within the agency. This is a particularly critical issue as CMS ramps up its Medicaid Integrity Program with the hiring of new employees. A CMS official told us that the agency is already developing position descriptions as a precursor to hiring new employees to help address the DRA requirement to increase by 100 the number of full-time-equivalent employees devoted to assisting states in efforts to combat Medicaid provider fraud and abuse. In addition, the agency has made some preliminary decisions about placement of staff within the central office and its regional offices. It will take considerable time and effort for CMS to

[21]See Social Security Act § 1936(e), as added by Pub. L. No. 109-171, § 6034, 120 Stat. at 76.

hire qualified staff and train them to perform the various activities that ensure good stewardship of the program. CMS could not provide us with a definitive schedule for when the bulk of its hiring will be completed. Also consistent with a new focus on fraud, waste, and abuse prevention, the agency is considering the steps it will need to take to competitively select contractors to conduct reviews to help identify fraudulent and abusive billing behavior by providers. CMS is currently exploring how it will use these contractors, either to support state efforts or to identify problems across states.

CMS has also decided to establish a new group to house the Medicaid Integrity Program. This group will be composed of both central and regional office staff and report directly to the director of the Center for Medicaid and State Operations (CMSO). CMSO, which is responsible for most other Medicaid activities, currently staffs the state compliance reviews and TAG activities. However, the Medi-Medi and PAM/PERM projects are the responsibility of CMS's Office of Financial Management, which also staffs the Medicare Integrity Program. In the past, we have raised concerns that Medicaid anti-fraud-and-abuse staff at headquarters have not been a part of the agency's office responsible for conducting other key anti-fraud-and-abuse activities, including those for the Medicare program. The staff at CMSO have the most experience working with Medicaid issues, although the staff at CMS with experience in Medicare program integrity contracting are located in the Office of Financial Management. As CMS establishes the Medicaid Integrity Program and new employees come on board, it will be important to ensure that the agency is in an optimal position to leverage the expertise and experience of its existing staff. For example, CMS will need to ensure that staff with expertise in developing strategies for combating Medicare fraud, waste, and abuse work in a closely coordinated fashion with staff that are familiar with states' Medicaid plans and fraud control officials and activities.

Concluding Observations

Implementing the Medicaid Integrity Program and developing a comprehensive plan gives CMS a unique opportunity to provide leadership to states and law enforcement in their fraud, waste, and abuse control efforts. Having dedicated resources also presents challenges to ensure that CMS spends wisely as it starts new initiatives and ensures the continuity of current beneficial activities. Using this opportunity to develop an iterative process of working with states to identify risks, develop strategies to address them, and measure the results through assessing improper payment rates and potential recoveries can help ensure that the Medicaid

Integrity Program funding is targeted to an optimal effect. CMS has expertise in addressing fraud, waste, and abuse within the Medicare program and in the state programs that can be leveraged to benefit the Medicaid Integrity Program. Properly leveraging this expertise will require effective coordination and communication within CMS, with states, and with their law enforcement partners.

We discussed the facts in this statement with a CMS Medicaid official, who stated that the agency is pleased to have new resources to address fraud, waste, and abuse in the Medicaid program. He indicated that CMS had developed proposals for implementing the Medicaid Integrity Program, but he was not in a position to discuss them in detail because they are undergoing review within HHS. CMS is presently deciding on the skills needed by the 100 additional full-time-equivalent employees required by the DRA; exploring options for contracting; and developing its comprehensive plan.

Mr. Chairman, this concludes my prepared remarks. I would be happy to answer any questions that you or other Members of the Subcommittee may have.

Contact

For further information regarding this statement, please contact Leslie G. Aronovitz at (312) 220-7600.

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Testimony

Of

Brian G. Flood

Inspector General
Texas Health and Human Services Commission

Before the

United States Senate

Committee on Homeland Security and Government Affairs
Subcommittee on Federal Financial Management, Government Information, and International Security

Hearing
"Bolstering the Safety Net: Eliminating Medicaid Fraud"

March 28, 2006

Mr. Chairman and Members of the Subcommittee: Good Afternoon. Thank you for the invitation to come before this committee. I am Brian Flood. I was appointed Inspector General by Texas Governor Rick Perry in 2003 to create and operate the Office of Inspector General for the Texas Health and Human Services Commission (HHSC). Today I will try to succinctly explain:

- Why an independent Inspector General is important in the control of waste, abuse and fraud.
- Why Texas created an Inspector General.
- What it takes to form an Office of Inspector General.
- Measuring the results or success of the new office.
- The necessity for the office to maintain constant vigilance.

Why is an independent Inspector General important to control waste, abuse, and fraud?

Appearance, credibility, and eliminating conflict of interest are key to a successful OIG operation. The State of Texas has taken a large step in establishing an independent OIG to oversee waste, abuse, and fraud activities for all health and human services (HHS) agencies.

An inspector general should be free from undue influences that may make attempts at controlling or interfering with its investigative, quality review, audit findings, imposition of appropriate sanctions, recommendations for improvement or change in state agency operations, policies or procedures, or the substance of investigative or audit reports or findings.

The function performed by an independent Inspector General is complementary to, but distinctly different from, the service performed by a state auditor. A state auditor's office is largely composed of audit staff that review accounting practices, policies and procedures, and performs audits on a rotating schedule. State audits are an important function. At the same time, we need to do more to ensure ultimate accountability with taxpayer funds.

An inspector general will not only look to see if agency policies and procedures are followed, but whether those policies and procedures ensure an efficient delivery of services. The Inspector General strives to minimize waste, abuse, and fraud while authorized to initiate recovery of funds lost to those activities and making recommendations to avoid future losses or risks.

The inspector general leads staff that includes auditors, program specialists, criminal investigators, lawyers, professional nurses, and subject matter experts authorized to inquire into all aspects of the subject agency's operations.

OIG should have clear authority to subpoena documents in civil and criminal investigations and coordinate with law enforcement to make sure that scam artists and crooks are brought to justice.

To accomplish its mission, the office requires broad authority to launch thorough investigations, and make sweeping recommendations for changes to the structure and culture of an agency.

Why did Texas create one?

The creation of the Office of Inspector General (OIG) occurred mostly in response to a state fiscal crisis, the same crisis many states are currently facing in their social services programs. It was created to instill, in Texas state government's largest reorganization in history, an independent voice and new accountability, so that shrinking state budgets could be better utilized for their intended purposes. This was done for better fiscal management not to create more government.

In response to this fiscal crisis, the 78th Texas Legislature in 2003 passed House Bill 2292, which, in part, reorganized the Texas HHS system, improving and streamlining operational and administrative effectiveness. Twelve HHS agencies were consolidated into five and a Governor appointed inspector general position was specifically created to combat waste, abuse, and fraud by providers, recipients, contractors, and employees in all HHS programs (including the state Medicaid program).

The independent OIG concept combining the investigative, audit, medical, legal, technical, and other related functions of the agencies ensures consistency, creates synergy, and eliminates differential treatment of HHS providers and clients across all programs and agencies. Prior to consolidation, the OIG functions were placed at various organizational levels of authority. The new OIG consolidated these fragmented units under one authority. Having a Governor appointed inspector general eliminates the perception of a conflict of interest and enhances credibility and objectivity when the OIG audits or investigates agency programs or staff.

Texas Governor Rick Perry has clearly stated his vision for inspector general programs:

> One initiative that I believe is essential to government accountability is the creation of Inspector General positions at large state agencies.
>
> I believe we need an independent voice at large state agencies that is accountable not to the bureaucracy but to independent boards or individual commissioners and ultimately, to the people.
>
> The function performed by an independent inspector general is complimentary to but distinctly different from the service performed by the state auditor. [1]

All of the states, at the local, county, state and federal levels are feeling the pinch from the increased budget loads that the various benefits programs place on them. Since 1999, the General Accounting Office and Centers for Medicare and Medicaid Services have made several reviews of the states. They found a wide variance in program sophistication and ability to address waste, abuse, and fraud. Texas is on the high end for performance, technology, and innovations to control spending and ensure proper payments.

I have testified in the New York and Missouri state senates regarding what changes we made in Texas. Texas, was cited in a February 3, 2006, edition of the *New York Times* in an article titled, "Texas' Medicaid Watchdog Shares Tips for Success," by Richard Perez-Pena, as a positive comparison model for Medicaid fraud control. Since January 2005, we have supplied similar

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[1] Governor Perry's vision on waste, abuse, and fraud, can be found at http://www.governor.state.tx.us/priorities/other/fraud.. Speech - Remarks To the Texas Association of Broadcasters

information at the request of Georgia, Florida, Pennsylvania, Maryland, and New Jersey, and to the United States Congress and Senate.

What did it take to get it done?

A. People

The newly created OIG not only faced the demands inherent in any inspector general day-to-day operation, but also a massive effort to concurrently consolidate and transform legacy agency organizational structures and business units into a focused and interactive operation. Staff from diverse organizational cultures worked thousands of overtime hours to complete the transformation while not only sustaining daily business activities, but also to provide the greater rate of return expected by State leadership and the public. The transformation effort[2] contained four distinct phases:

- Consolidation – Merging of legacy agency personnel, budgets, and other resources to form the new OIG;
- Integration – Enabling working relations between legacy agency staff to perform the mandates of the new office;
- Optimization - Ensuring efficient, productive, and cooperative working relations and operations; and
- Transformation - Operating under the new structure.

Although each phase was critical in achieving the legislature's transformation goals, the optimization phase yielded the most significant structural changes to operations. OIG established clear optimization goals to:

- utilize the knowledge of legacy agency staff to identify appropriate and necessary OIG activity;
- employ organizational design tools to identify and review OIG roles, processes, and mandates;
- identify areas of improvement within OIG, including improvements to the organization, business processes, and existing technology support systems; and
- implement change based upon the findings from organizational tools and other analytics.

In 2004, OIG was organized to include distinct functions related to enforcement, compliance, sanctions, third party recovery, audit, utilization review, and technology and automated systems. These units operate collaboratively with clear objectives, priorities, and performance standards to:

- coordinate investigative efforts to aggressively recover Medicaid overpayments;
- allocate resources to cases that have the strongest supportive evidence and the greatest potential for recovery of money; and
- maximize the opportunities for referral of cases to the Office of Attorney General for prosecution.

[2] The transformation effort is detailed at http://www.hhs.state.tx.us/OIG/Reports/FY04_Semi_Annual_Report.shtml#TransformationProject

B. Technology

Governor Perry reinforced his desire for this project to proceed in his Executive Order RP36 issued on July 12, 2004, Relating to Preventing, Detecting, and Eliminating Fraud, Waste and Abuse,[3] through which the OIG was directed to continually initiate proactive measures and deployment of advanced information technology systems to aggressively reduce, pursue, and recover expenditures not medically necessary or justified. In response, OIG enriched its technical infrastructure by implementing external systems allowing easier public access for complaints by phone and online. In addition to consolidating multiple fraud telephone hotlines and deploying several web-based applications and information technology tools, OIG is soundly committed to making it easier, faster, and more useful for recipients, providers, HHS employees, and the public to report potential cases of waste, abuse, and fraud.

As background, beginning in 1998, Texas was the first state in the nation to utilize learning and neural network technology to pinpoint potential waste, abuse, and fraud in the Medicaid program. This technology in Texas is called the Medicaid Fraud and Abuse Detection System. It is an automated system designed to detect potential fraud and abuse using predictive neural network models and targeted detection queries. It is designed to identify known and unknown patterns of conduct and changes in provider activities and trends.

Since 2004, we have improved our automated systems that enhance our capability for identifying inappropriate patterns of behavior and allow investigative resources to target cases with the strongest supporting evidence and greatest potential for monetary recovery.

What measurable results came out of creating the new office?

The consolidation of OIG functions has resulted in substantial cost benefit to the State and taxpayers. A few of our recent performance statistics amply demonstrate the results.

A. SFY 2004

In the first state fiscal year (SFY) of consolidated operation (SFY 2004), OIG recovered $349,500,000 (cash) and achieved cost avoidance of $389,500,000. Total recovery and cost avoidance for SFY 2004 was $739,000,000. Excluding third party recovery and audit, OIG achieved a 23 percent increase in recoveries in SFY 2004 over SFY 2003.

Also in SFY 2004, OIG referred a record 257 provider cases to the Texas Office of the Attorney General - which received the nation's top Medicaid fraud-fighting award for opening a total of 348 cases - and referred in excess of 3,500 felonies and misdemeanor cases to district and county attorneys for prosecution and over 6,500 cases were completed and referred for administrative disqualification hearings.

B. SFY 2005

In the second year of consolidated operation (SFY 2005), OIG recovered $441,551,341 (cash) and cost avoided $362,489,120. As these funds are directed back into health and human

[3] Executive Order RP36 is located at http://www.governor.state.tx.us/divisions/press/exorders/rp36.

services programs, we know that the $804,040,461 is providing needed healthcare and other assistance to many Texans. Total recoveries in SFY 2005 increased by 26 percent over SFY 2004.

Therefore, in the first biennium of consolidated operation, OIG's efforts resulted in over $1.5 billion in recoveries and cost avoidance for the State of Texas. For SFY 2004-2005 biennium, total recoveries exceeded $791 million (cash) and total cost avoidance exceeded $752 million.[4]

C. SFY 2006

For the first two quarters of SFY 2006, OIG has recovered (cash) $220,100,295 and cost avoided $177,312,439. For the same period, the number of provider complaints more than doubled from the same time frame in SFY 2005, from 213 to 438 cases – a 105% increase.

In addition, Texas requires all Managed Care Organizations (MCO's) contracting with the State of Texas to adopt a plan to prevent and reduce waste, abuse and fraud and file their plan annually with OIG's approval. For the first two quarters of FY 2006, OIG saw a 108% increase in complaint referrals from MCO's based on their mandated Special Investigative Units (SIUs).

The following tables provide additional activities for the first two quarters of the current state fiscal year.

WASTE, ABUSE, AND FRAUD REFERRALS RECEIVED SFY2006 (1ST & 2ND QUARTERS)

Referral Source	Received
Office of the Attorney General's Medicaid Fraud Control Unit (MFCU)	3
United States Department of Treasury	1
Medicare Matching Project	2
Assistant US Attorney's Office	1
Texas Department of Aging & Disability Services (DADS)	22
Texas Health Steps	31
Texas Department of State Health Services (DSHS)	9
Texas Medicaid Healthcare Partnership (TMHP)	5
Texas Department of Family and Protective Services (DFPS)	1
Law Enforcement Agency	1
Managed Care Organizations /SIUs	19
2005 PAM III Study (Comptroller's Office)	1
2005 Year Four Perm Study (Comptroller's Office)	4
TX Health Care Claims Study 2005 (Comptroller's Ofc)	4
Parent/Guardian	19
Provider	20
Public	66
Recipient	147
Anonymous	44
HHSC – Internal Affairs	3
HHSC – Medicaid/Chip Division	2
HHSC – MPI-OIG Self-initiated (MPI)	16
HHSC – Utilization Review	14
Vendor Drug	3
Total Cases Received:	**438**

[4] OIG published report may be found at: http://www.hhs.state.tx.us/OIG/OIE_Reports.asp

WASTE, ABUSE, AND FRAUD REFERRALS SENT SFY2006 (1ST & 2ND QUARTERS)

Referral Source	Referred
Office of the Attorney General's Medicaid Fraud Control Unit (MFCU)	89
Medicare Part A& B	7
Palmetto GBA	1
Department of Family and Protective Services (DPRS)	2
Texas Department of Aging & Disability Services (DADS)	5
Texas Department of State Health Services	1
Texas Department of Transportation (TXDOT)	2
Board of Dental Examiners	5
Board of Medical Examiners	4
Board of Nurse Examiners	2
Board of Pharmacy	1
Claims Administrator – Educational Contract	30
Claims Administrator – Claims/Record Review	1
HHSC – Audit	1
Vendor Drug	1
Total Cases Sent:	**152**

MEDICAID WASTE, ABUSE, AND FRAUD WORKLOAD STATISTICS AND RECOUPMENTS

Action	1st Quarter SFY2006	2nd Quarter SFY2006	Total SFY2006
Medicaid Provider Integrity			
• Cases Opened	235	203	**438**
• Cases Closed	74	71	**145**
• Criminal History Checks Conducted	0[5]	3,923	**3,923**
Medicaid Fraud & Abuse Detection System (MFADS) [6]			
• Cases Opened	367	1,259	**1,626**
• Cases Closed	621	1,079	**1,700**
Office of Inspector General Recoupments	**1st Quarter SFY2006**	**2nd Quarter SFY2006**	**Total SFY2006**
Sanctions[7]	$ 3,430,511	6,042,488	**$ 9,472,999**
Providers Excluded	55	77	**132**

What exactly do you do now?

The Office of Inspector General now has over 550 employees providing oversight for a wide variety of programs and activities, including Medicaid, Food Stamps, Temporary Assistance for Needy Families, the Children's Health Insurance Program, the Women, Infants and Children program, and the Bureau of Vital Statistics, among others.

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[5] Criminal history process not initiated during the 1st quarter.
[6] MFADS is a detection source and as such the numbers are duplicated within sections that work or take action on MFADS generated cases.
[7] May include OAG identified amounts and Medicaid global settlements. Amounts listed in OAG's statistics may also include potential overpayments identified by OIG.

A constant game of one-upmanship takes place between the OIG, the system's guardian, and the increasingly sophisticated parties who seek to misuse or abuse it. We face challenges that investigators and compliance personnel could not have imagined ten years ago. New technologies and fiscal pressures have changed the rules of the game. We have had to build a better system to better utilize limited resources so we can produce the maximum results and keep the quality that we expect for the state and the taxpayer.

OIG is focused on enriching its business organization and processes, expanding stakeholder partnerships and recommending policies to strengthen fraud prevention. To ensure quality, OIG operates in accordance to the National Association of Inspectors General principles and standards, and all audit activity is performed in accordance to United States General Accounting Office Government Auditing Standards.

To advance the operational process of identifying and eliminating waste, abuse, and fraud, OIG has increased training, technology, and staff awareness of its role in supporting the overall HHS purpose and mission. Specialized training was acquired from organizations such as the National White Collar Crime Center (NW3C) and Association of Certified Fraud Examiners. We host ongoing training to the provider community. Last year, we trained over 1700 provider staff on Medicaid policy and billing. In the last two years, we have also appeared at many provider and legal forums to explain how we operate. We believe that an informed relationship better serves the program, the providers, and the beneficiaries.

OIG continues to assess and improve the quality of its audits, investigations, reviews, advanced automated analysis tools, and monitoring through standardization of practices, policies, and ethics, encouragement of professional development by providing educational opportunities, and the establishment of a quality assurance function.

We continually initiate proactive measures and deploy advanced information technology systems to aggressively reduce, pursue, and recover expenditures not medically necessary or justified. For example, our Texas Health Analytics System Information Technology (TxHASIT) project is a joint effort between OIG and the University of Texas at Dallas (UTD) to solve vital HHS issues. Since September 2004, OIG and UTD School of Social Sciences and Erik Jonsson School of Engineering and Computer Science have been working in partnership to create a groundbreaking data resource that will facilitate scientific measurements and studies of numerous social services phenomena. This data resource will enable social scientists to apply advanced research methodologies and theories to understand behaviors, procedures, and policies that result in excessive waste, abuse, and fraud of HHS funds. TxHASIT incorporates a multifaceted team of inspector general staff and Medicaid healthcare experts from HHSC and computer engineers, data analysts and social scientists. It has already answered significant questions, including diabetes and renal failure, that were previously unattainable.

We continually monitor our case processing to ensure timely investigation of potentially fraudulent providers. Roles and expectations of each agency are documented and regularly updated. Additionally, OIG regularly enhances educational training for providers and claims administrator contractors and utilizes medical consultants to increase cost avoidance activities, improve quality of care, and decrease claim-processing errors.

Most recently, in December 2005, OIG initiated a process to conduct criminal history background checks for all potential Medicaid, Medicaid Managed Care, and Children with Special

Health Care Needs (CSHCN) Services Program providers submitting an enrollment application through Texas's claims processing and case management administrator, the Texas Medicaid and Healthcare Partnership. To date during the 2nd Quarter of the current SFY 2006 (December 2005 – February 2006), OIG conducted nearly 4,000 criminal history checks on Medicaid providers. Of those, 155 were denied or are pending based on return information. Additionally, criminal background checks are performed for any person or business entity that meets the definition of "indirect ownership interest" as defined in the Texas Administrative Code, Title 1, §371.1601 who are applying to become a Medicaid provider, or who are applying to obtain a new provider number or a performing provider number.

To put all of this in perspective, our efforts over the past 2 years resulted in the equivalent of over 130,000 new Texas Medicaid recipients receiving benefits for a year and a return to the state and the taxpayer, in cash, $10 dollars for every one dollar spent on its operational budget.

Although we have been praised in some circles as a leader in waste, abuse, and fraud prevention, we realize that much more needs to be done as Medicaid and other service programs consume more and more of our tax dollars. We know we must continue to strive to ensure that each dollar is spent effectively. That is what we, in OIG, do. On behalf of my incredible staff, I thank you for the opportunity to speak to you today.

Testimony of Kimberly A. O'Connor, New York State Medicaid Inspector General
March 28, 2006
Subcommittee on Federal Financial Management, Government Information and International Security
Senate Homeland Security and Governmental Affairs Committee

Mr. Chairman, Committee members, thank you for the opportunity to present this written testimony concerning the recent changes made by Governor Pataki to New York's Medicaid program. My name is Kimberly A. O'Connor and I am the New York State Medicaid Inspector General.

Last July, Governor Pataki appointed an outside expert to conduct a comprehensive review of New York State's Medicaid system and recommend fundamental, long-term structural changes and reforms to improve efforts to control fraud, waste and abuse. In August, Governor Pataki, by Executive Order, appointed me to the newly created position of New York State Medicaid Inspector General. My charge was to coordinate Medicaid fraud, waste and abuse control activities of all State executive branch agencies and to recommend legislative, policy and structural changes needed to strengthen the integrity of the Medicaid program. Accordingly, I worked in conjunction with the outside expert and we conducted an extensive review of New York's Medicaid system and examined the systems of other states. We also had the input of the Rockefeller Institute, private sector insurers and consultants, provider groups, medical professionals and information technology analysts.

Together we concluded that at that time, New York's Medicaid fraud, waste and abuse control activities conducted by the Department of Health's Office of Medicaid Management and various state regulatory agencies, while having been successful at recouping, withholding or avoiding $9.3 billion of overpayments since 1999, suffered from fragmentation among the various state agencies and offices charged with Medicaid fraud-fighting responsibilities. Additionally, we found that the system had an insufficient focus on specific auditing and fraud prevention goals and needed greater coordination and communication among the State agencies engaging in fraud, waste and control activities.

We made several key recommendations to Governor Pataki, the central component of which was the expansion of the Office of the Medicaid Inspector General from an advisory role to actually undertake and be responsible for the New York State Department of Health's duties as the single state agency for the administration of the Medicaid program in New York State with respect to the prevention and detection of fraud, waste and abuse.

In so doing, we sought to establish an independent fraud-fighting entity within the Department of Health that would build on our State's accomplishments in preventing Medicaid fraud, waste and abuse by prioritizing and focusing fraud, waste and abuse control activities; creating a single point of leadership of and responsibility for such activities; building and maintaining an

integrated system of communication among all involved agencies with fraud, waste and abuse control responsibilities; and maximizing the use of all available state resources for such activities.

New York's anti-fraud programs were concentrated principally in the Department of Health, which also oversees the Medicaid program itself. That creates an obvious inevitable conflict, as the pressure to pay providers wars with efforts to ensure that monies are not misspent. Increasingly, other states are also separating the funding of Medicaid services and recipient eligibility determinations from the policing of service providers. Such a separation will guarantee that the mission of the Office of the Medicaid Inspector General is free from conflict and that its energies (and resources) do not get diverted.

We concluded that New York should devote additional resources to Medicaid fraud, waste and abuse prevention and detection. In recent years, there had been a commendable investment of funds in the development of computer technology, which is essential to an effective anti-fraud program. We have the capacity to "data mine" and thereby to identify "outliers" -- practitioners whose billings seem out of the ordinary. Data mining, however, is only the first stage of an effective program as auditors, investigators, and medical professionals are needed to determine whether an outlier is committing fraud or whether legitimate factors explain the billings. We believed that some resources could be used more efficiently (e.g., that sample sizes for initial provider audits could be reduced), but firmly believe that additional auditing staff would far more than pay for itself in additional recoveries of misspent Medicaid funds. Due to the "aging out" of New York's state workforce, a large number of retirements have occurred. New York is now filling existing vacancies within its Medicaid integrity program and will also aggressively recruit for 81 new state positions as well that have been proposed in the Governor's Executive Budget.

Also, in response to our recommendations, New York is currently in the process of increasing the number of medical professionals that are available to assist auditors and investigators to determine if Medicaid billings are proper. As noted above, sophisticated data mining is only the first step in curtailing fraud, waste and abuse. An auditor often cannot determine whether a doctor is improperly billing unless she can review the case with an experienced medical practitioner in the same field. Efforts are underway to develop a peer review program with New York's extensive state university system. At the same time, the civil service pay scale for state nurses and other medical professionals involved in anti-fraud efforts should be reevaluated. The expertise of a good medical professional is invaluable to an anti-fraud program, and the State is losing good staff because of lower pay.

The State is planning on devoting resources to a State-Federal task force to be located in New York City that will be dedicated to investigating and prosecuting criminal groups that engage in extensive health fraud. Although Medicaid fraud knows no geographic limits, there is no doubt that large-dollar frauds are heavily concentrated in New York City and often perpetrated by organized groups. We have spoken at length with federal law enforcement authorities in New York City -- to the FBI and senior federal prosecutors -- and they are eager to join forces with the State in creating a task force that would focus on health care fraud. Adding their resources and targeting large-scale schemes can only strengthen our anti-fraud efforts.

Another state-federal initiative recently commenced by New York and CMS is the Medi-Medi program. When fully operational, New York will be able to look at Medicaid and Medicare claims simultaneously and identify inappropriate billing patterns that are not clearly evident when claims from either program are viewed independently.

It is imperative that those engaged in anti-fraud efforts share information more effectively. Throughout our review, we have been surprised by how poorly information is shared by those involved in preventing health care fraud, waste and abuse. In New York, a significant portion of our Medicaid program is now administered by managed care organizations, and each is obliged to have an investigative unit to ferret out fraud. Private insurance companies have similar units. Everyone in "the business" knows that a provider who is defrauding one program is likely to be defrauding others, yet there is little communication among programs. I have made it a high priority to remedy this deficiency.

While most Medicaid providers (and recipients) are entirely honest, the program has grown so large that even a small percentage of fraud, waste and abuse represents a large diversion of taxpayers' monies. New York can and will do better.

As a result of our review and recommendations, Governor Pataki expanded the functions of the Office of the Medicaid Inspector General by issuing a superseding Executive Order on February 2, 2006. We are now seeking legislative adoption of the Office of the Medicaid Inspector General in statute as a part of the Governor's Executive Budget proposal and are hopeful that this proposal will become law on or before April 1 of this year.

The proposed statute provides that the head of the Office of the Medicaid Inspector General is the Medicaid Inspector General of the State of New York who shall be appointed by the Governor and confirmed by the Senate, and shall report directly to the Governor's Office. To maximize the independence of the office, the Governor has proposed a five year term for the Medicaid Inspector General.

Existing state personnel from various state executive branch agencies, including the Department of Health, the Office of Mental Retardation and Developmental Disabilities, the Office of Mental Health, and the Office of Alcohol and Substance Abuse Services, that engage in the detection and prevention of Medicaid fraud, waste and abuse, will be transferred to the OMIG. Pursuant to the February 2, 2006 Executive Order, this process was already started by transferring the appropriate personnel from the Department of Health, Office of Medicaid Management to the Office of the Medicaid Inspector General.

The functions of the OMIG include:

- conducting and supervising activities to prevent, detect and investigate Medicaid fraud, waste and abuse and, to the greatest extent possible, coordinating such activities amongst the Offices of Mental Health, Mental Retardation and Developmental Disabilities, Alcoholism and Substance Abuse Services, Temporary Disability Assistance, and Children and Family Services; the Department of

Education; the fiscal agent employed to operate the Medicaid management information system; the State Attorney General for Medicaid Fraud Control; and the State Comptroller;

- pursuing civil and administrative enforcement actions against those who engage in fraud, waste, abuse or other illegal or inappropriate acts perpetrated within the Medicaid program, including providers, contractors, agents, recipients, individuals or other entities involved directly or indirectly with the provision of Medicaid care, services and supplies;

- keeping the Governor and the heads of agencies with responsibility for the administration of the Medicaid program apprised of efforts to prevent, detect, investigate, and prosecute fraud, waste and abuse within the Medicaid system;

- making information and evidence relating to potential criminal acts which he or she may obtain in carrying out his or her duties available to appropriate law enforcement officials and consulting with the New York State Deputy Attorney General for Medicaid Fraud Control, federal prosecutors, and local district attorneys to coordinate criminal investigations and prosecutions;

- recommending and implementing policies relating to the prevention and detection of fraud, waste and abuse;

- monitoring the implementation of any recommendations made by the Office of the Medicaid Inspector General to agencies or other entities with responsibility for administration of the Medicaid program;

- receiving and investigating complaints of alleged failures of state and local officials to prevent, detect and prosecute fraud, waste, and abuse; and

- performing any other functions that are necessary or appropriate to fulfill the duties and responsibilities of the office.

The OMIG also has broad subpoena powers, both duces tecum and ad testificandum, and has the authority to:

- subpoena and enforce the attendance of witnesses;
- administer oaths or affirmations and examine witnesses under oath;
- require the production of any books and records deemed relevant or material to any investigation, examination or review;
- examine and copy or remove documents or records of any kind prepared, maintained or held by any agency the patients or clients of which are served by the Medicaid program, or which is otherwise responsible for the control of Medicaid fraud, waste and abuse; and
- perform any other functions that are necessary or appropriate to fulfill the duties and responsibilities of office.

The Executive Order also requires the cooperation of all relevant state and local agency officials and employees.

Projected figures for state fiscal year 2005-2006 for fraud waste and abuse initiative include: 300 provider exclusions and terminations, 90 referrals to the Attorney General's Medicaid Fraud Control Unit, 1200 undercover shops/onsite inspections, and at least $89 million in audit recoveries.

Statistics for the fourth quarter of 2005 include audit recoveries of approximately $25 million and there were 20 referrals to the Attorney General's Medicaid Fraud Control Unit.

Based upon the reform initiatives that have already been put into place, the Governor's Executive Budget proposal has doubled our audit target for state fiscal year 2006-2007 from the previous year.

I hope that the preceding information has been helpful to the Committee and I appreciate being given the opportunity to submit this written testimony.

I look forward to providing this Committee with information regarding the progress and accomplishments that New York has made with respect to the OMIG and the fight against Medicaid fraud, waste and abuse as we move this critical mission forward.

Thank you.

Big Spenders

Medicaid Expenditures for Top States Ranked by Population Size FY2004 (in millions)

	Federal Share	State Share	Total
California	$17,740	$15,786	$33,527
Texas	$10,421	$6,352	$16,773
New York	$22,103	$20,181	$42,284
Florida	$8,136	$5,233	$13,369
Illinois	$5,540	$5,022	$10,562
Pennsylvania	$8,405	$6,420	$14,826
Ohio	$7,292	$4,641	$11,933

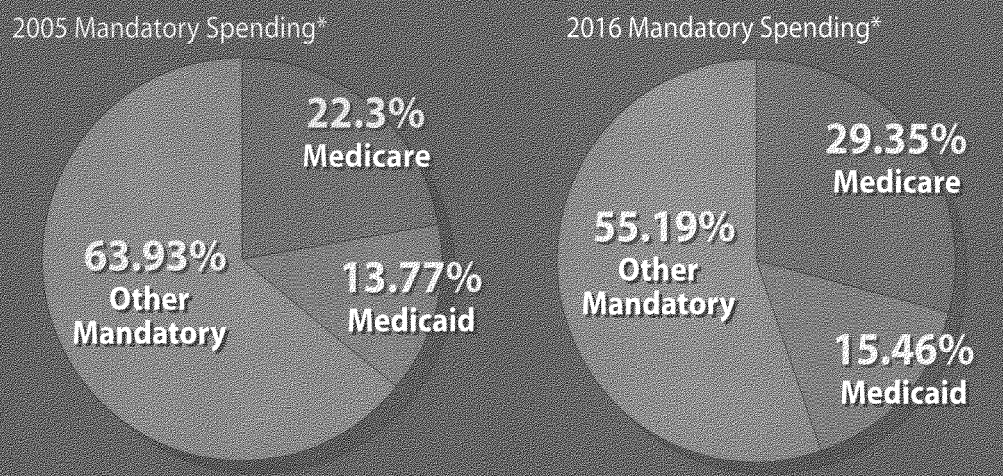
Source: Table prepared by Congressional Research Service (CRS) based on analysis from Centers for Medicare and Medicaid Services (CMS), Form 64. This data may include adjustments from prior periods.

Medicaid - The "Provider of Last Resort" for 57 Million of America's Most Needy

One Out of Every Five of America's Poor, Disabled, or Elderly Relies On Medicaid As Their Health Care Safety Net.

Vision of the Future:

Medicare & Medicaid Make Up A Huge Federal Investment



***CBO baseline analysis estimates project that Medicare/Medicaid could make up almost half of mandatory spending by 2016.**

Source: CRS memo based on CBO Report "Current Budget Projections, March 3, 2006"

Questions by
Chairman Tom Coburn for
Daniel R. Levinson, Inspector General
U.S. Department of Health and Human Services

1. What do you think are the most important areas that OIG can identify that should be strengthened to improve overall Medicaid integrity efforts? What efforts has OIG made to identify past vulnerabilities in the Medicaid integrity program?

Answer. Areas that would improve the integrity of the Medicaid program include encouraging States to develop better methods for preventing and identifying payment and eligibility errors and encouraging CMS to continue its efforts to curb State financing mechanisms that inflate the Federal share of Medicaid in ways that were not intended by Congress. We believe continued investigation of pharmaceutical manufacturer fraud and anti-kickback and quality of care violations also contribute to overall Medicaid program integrity.

In the past five years, OIG has expended significant resources to successfully focus on State financing mechanisms. We have audited issues such as upper payment limits, intergovernmental transfers, and disproportionate share hospital payments, resulting in hundreds of millions of dollars in questioned costs and billions in funds put to better use. As a related matter, we are studying States' use of consultants on a contingency fee basis with the intent of inappropriately inflating Federal reimbursements.

In other areas, OIG is currently conducting audits of Medicaid eligibility errors in three States; we are looking at the inappropriate payments of specific benefits including dental and transportation services; and we plan to continue to monitor CMS's process for measuring Medicaid payment errors.

2. What is the role of OIG in identifying improper payments in Medicare and Medicaid?

Answer. The identification of improper payments in Medicare and Medicaid has always been a primary focus of OIG. As our semiannual reports to Congress highlight, we continuously review health care issues to identify program overpayments to be recovered and to identify the vulnerabilities that lead to improper payments. OIG findings have identified improper payments in areas such as Medicaid hospital disproportionate share payments, State calculations of upper payment limit funding pools, Medicaid school based services claims, improper use of consultants in Medicaid claims submissions, hospital compliance with Medicare's postacute care transfer policy, chiropractic services in the Medicare program, and payments for durable medical equipment rentals and purchases by Medicare beneficiaries. For the 6-month period ending September 30, 2005 (the latest semiannual report), we issued reports recommending collection of over $710 million in improper payments, and CMS agreed with the recovery of over $762 million that had been identified in prior reports.

In addition, in collaboration with CMS, OIG developed the first comprehensive Medicare improper payment rate as part of the annual financial statement audit of Medicare operations. We have either calculated or monitored this annual improper payment rate in

each year since 1996. We are presently assisting CMS in its planning for a similar payment error rate for Medicaid. CMS plans to include these Medicaid improper payment determinations as part of the fiscal year 2007 financial statement report.

3. What efforts has OIG made to collect data on improper payments in Medicaid? Fraudulent payments?

Answer. For the last several years, OIG has worked closely with CMS and the Office of Management and Budget in helping to identify an approach to determine an annual Medicaid improper payment rate. CMS is finalizing a core set of requirements that a sample of States will use each year to calculate a national Medicaid error rate. We will continue to monitor these CMS and State activities to help ensure that accurate rates are calculated.

Public Law 107-300, known as the Improper Payments Information Act of 2002, requires the head of each agency to estimate the annual amount of improper payments, and report on what actions the agency is taking to reduce improper payments. OIG does not identify improper payment rates in Medicaid or Medicare but monitors and oversees the methodology CMS uses in all its programs to estimate improper payment rates. CMS is currently working towards implementing the Payment Error Rate Measurement Program (PERM), detailing the methodology to estimate improper payments in the Medicaid, managed care, and State Children's Health Insurance Programs. We are working with CMS through this process and will begin our oversight responsibilities when the PERM is fully operational.

The objective of many of our audits and evaluations is to identify improper payments or to highlight areas vulnerable to abuse by providers. However, improper payments identified through these reviews are not necessarily indicative of fraud. Although audits and evaluations will occasionally identify fraud, they are not typically designed for that purpose. Extensive investigative steps are needed to bring a criminal or civil fraud case against a provider.

Fraud is an undetermined subset of improper payments. Non-fraudulent causes of improper payments include errors, lack of knowledge about existing rules, or misunderstanding of policies. Estimating a fraud rate is almost impossible to calculate because fraud reflects a legal definition involves establishing intent and weighing the merits of a case against standards. A billing instance or pattern may be improper but not necessarily fraudulent. Conversely, false documentation related to claims for payment may appear on the surface to be correct. Further, many allegations of fraud are settled without admissions of guilt or formal determinations of wrongdoing, and, therefore, would not be categorized as fraudulent.

OIG works closely with the State Medicaid Fraud Control Units (MFCUs) to identify and bring to justice those providers who have attempted to defraud the Medicaid Program. We periodically publish reports of the MFCUs' operations that provide statistical summaries by unit and information on individual fraud actions completed during the reporting period.

4. What is the biggest program integrity problem - provider fraud or questionable State practices to increase matching funds? What is OIG's strategy for dealing with both of these problems?

Answer. Both are equally significant problems. In recent years, we have expended a significant amount of resources auditing questionable State practices to increase matching funds. The areas we audited included upper payment limits, intergovernmental transfers, disproportionate share hospital payments, and contingency fee payment arrangements. Our presence in these areas will continue and we also plan to expand our work to new financing areas, such as provider taxes and certified public expenditures.

From an investigative perspective, OIG's role in identifying fraud is similar in both Medicare and Medicaid; however, our primary partners differ between the two programs. In Medicare, OIG works primarily with the CMS Program Integrity Group and the Program Safeguard Contractors to identify areas of vulnerability and problem providers. On the Medicaid side, our role is similar; however, we work with the State Agency's Surveillance and Utilization Review Subsystem (SURS) units, the MFCUs, and sometimes State Inspectors General to identify instances and patterns of potential fraud. For both programs, our goals include detecting and addressing fraudulent activity, as well as identifying vulnerabilities to fraud and recommending actions to remedy the vulnerabilities and prevent future fraud.

With the Medicaid-specific funding provided by the Deficit Reduction Act (DRA), OIG plans to increase its identification and review of providers with aberrant billing patterns. The increased use of software applications will help OIG identify leads to Medicaid fraud, as well as improper payments. In coming months, our work priorities will include reimbursements for pharmaceuticals, dental services, home health care services, durable medical equipment supplies, and psychiatric services.

5. What are the lessons learned from efforts to combat fraud and abuse in the Medicare program that OIG could apply to new Medicaid program integrity initiatives?

Answer. The addition of the new Medicaid program integrity initiative will offer OIG many opportunities to apply what we have learned from our Medicare experience and build upon our successes in that program. For example, our Medicare experience has taught us that vulnerabilities lie in areas where provider enrollment is easy and where licensure is not required, such as with durable medical equipment suppliers and home health agencies. OIG's agents have gained wide-ranging experience in the investigation of Medicare fraud and are able to apply the successes of the past to their increasing presence in the Medicaid environment. The Medicaid program covers many of the goods and services that are also covered by the Medicare program. Therefore, agents can transition from one focus to another.

Medicaid does offer some unique benefits that do not directly correspond to Medicare coverage. For example, the Medicare and Medicaid programs cover different transportation services. Under Medicare, transportation reimbursement is primarily limited to ambulance transport. Under Medicaid, reimbursable transports also include other forms of travel such as taxis and community buses.

6. Do you have any issues or concerns with how CMS may organize Medicaid anti-fraud and abuse activities within the agency following the implementation of the recently passed DRA?

Answer. We understand that CMS is currently preparing a detailed plan for organizing its Medicaid anti-fraud and abuse activities. We have had some preliminary discussions with CMS regarding its plan, but because the plan has not yet been finalized we do not have any issues or concerns to discuss at this time.

7. How does OIG rate the effectiveness of State audit initiatives? How often are program integrity reviews of State Medicaid agencies conducted? When can we expect to see similar activities on a much more comprehensive and regular basis?

Answer. OIG interacts with State auditors in two ways. First, we work with them in implementing the requirements of the Single Audit Act and OMB Circular A-133, which establishes audit requirements for State and local governments, colleges and universities, and nonprofit organizations receiving Federal awards. Under this circular, covered entities are required to have annual organization-wide audits. OIG reviews the quality of these audits and assesses the adequacy of the entity's management of Federal funds. Overall, we have found these audits to be in compliance with Federal requirements. Second, we have an ongoing initiative to work more closely with State auditors in reviewing program issues in Medicaid. To this end, a partnership plan was developed to foster joint reviews between OIG and State auditors to provide broader coverage of the Medicaid program. To date, partnerships have been developed in 25 States, the results of which have identified over $263 million in Federal and State possible savings.

8. Do Medicaid Fraud Control Units report that Medicaid agency referrals are inadequate in many States? What efforts are being made to encourage States to increase referrals and coordination between agencies in this area?

Answer. MFCUs report to us on a quarterly basis the number of referrals by their State's Medicaid agency, as well as by other sources both within and outside the State. State agency referrals generally appear to be lower than would be expected. In all States, the SURS units apply automated postpayment screens to Medicaid claims to identify aberrant billing patterns that may indicate fraud or abuse. When potential fraud cases are detected, the State Agency is required to refer the cases to the State's MFCU. We currently have work in progress to review performance indicators for Medicaid fraud referrals. As part of this study, we are examining data on referrals by State Medicaid agencies and acceptance of those referrals by MFCUs.

There are a number of methods MFCUs use to increase the number of referrals and other leads, including such things as caller "hotlines" to report complaints of alleged Medicaid fraud and patient abuse and neglect; outreach to the State's medical board, nursing board, licensing authorities, and other agencies; maintaining a web-page for public use; and outreach activities to groups such as the medical community, elder advocacy groups, and other law enforcement agencies. The extent of these activities varies among the 49 MFCUs.

9. Under the DRA, what efforts are being made to encourage the critical role of whistleblowers, concerned citizens, etc.?

Answer. OIG will draft standards for reviewing State false claims acts and will begin reviewing existing State laws before January 1, 2007. The DRA requires OIG to determine, in consultation with the Department of Justice, whether a State has in effect a law that meets certain requirements that parallel those contained in the Federal False Claims Act. If the State law meets those requirements, the Federal percentage of amounts recovered under such laws shall be decreased by 10 percent. OIG has already received a number of inquiries from State legislatures and State Attorneys General offices regarding particular State laws. OIG intends to draft standards of review, to be published as a notice (without comment) in the Federal Register, and then begin its review of existing State laws.

10. With the recent passage of the DRA, do you expect that OIG will shift focus somewhat from Medicare program integrity to a greater emphasis on monitoring State Medicaid fraud control efforts? Why is it that Medicare program integrity efforts are so much more developed than Medicaid?

Answer. With the passage of the DRA, OIG has been provided additional funds to review the Medicaid program, and we will be expanding our efforts to monitor Medicaid fraud control efforts. While OIG is in the process of planning for this expanded effort in Medicaid, Medicare remains the primary focus of our resources. Medicare program integrity efforts may appear to be more developed because there are national policies followed in operating the Medicare program, and Medicare utilizes a long established network of contractors (fiscal intermediaries and carriers) to process all Medicare claims transactions and accounting operations.

While Medicaid is operated within Federal rules that require each State to submit a plan for approval, there are differences in how States operate their programs, including program integrity and safeguard systems and activities. Moreover, States can apply to waive certain Federal requirements. In the past, States have used these waivers to expand programs. More recently, States have used waivers to change eligibility rules in order to limit those covered. A State can also request to modify the Federal rules through issuance of State plan amendments. The nature of these waivers and plan amendments, coupled with the different methods that States use to pay claims and operate their computer systems, makes it more difficult to review Medicaid on a national basis.

In addition to OIG's general Medicaid oversight work, we have responsibility for administering grants to fund MFCUs' ongoing operations. The States are reimbursed for MFCUs' operations at a rate of 90 percent of costs for the first 3 years after the Unit's initial certification by OIG and 75 percent thereafter. Thus far in FY 2006, OIG has awarded approximately $159.1 million in grant funds to MFCUs. In FY 2005, about $144.3 million was awarded to MFCUs.

OIG's responsibilities for oversight of the funding and operation standards of MFCUs include monitoring their overall performance and productivity and ensuring that they devote their full-time efforts to Medicaid-covered health care fraud and patient abuse. In

FY 2005, OIG conducted joint investigations with MFCUs on 331 criminal cases and 95 civil cases and achieved 54 convictions and 28 settlements or judgments in civil cases.

11. Does OIG support a strong emphasis on data mining between critical agencies, e.g., Medicare and Medicaid? Are all States being encouraged to support a strong emphasis on data mining?

Answer. OIG strongly supports data mining efforts both within a program and between multiple programs. We have utilized data mining software techniques in many of our activities. OIG supports the present effort by CMS to compare data between the Medicare and Medicaid programs (called Medi-Medi), and we continue to work closely with CMS, through its contractors and the MFCUs, to pursue the identified aberrant providers. While we believe that CMS has encouraged States to incorporate data mining techniques in reviewing their Medicaid claims process, CMS would have to provide details on which States have instituted data mining activities in their operations.

12. Because Medicaid is a needs-based program, a robust eligibility component should be factored into the improper payment rate calculation. Does such a component currently exist?

Answer. CMS is working on developing a Medicaid eligibility component to be factored into the improper payment rate calculation. The first Medicaid eligibility component error rate to be factored into the improper payment rate calculation will be reported as part of the annual financial statement report in 2008. CMS is currently drafting the interim final PERM regulation to be published in August 2006. The PERM regulation includes the process to measure a Medicaid and State Children's Health Insurance Program fee-for- service, managed care and eligibility error rates. The first national Medicaid error rate that includes an eligibility component error rate will be published in the Department of Health and Human Services' Performance and Accountability Report in November 2008.

13. Does OIG have suggestions for improving Medicaid program integrity that have not yet been implemented (limitations for Upper Payment Rules; facility-specific limits to cap the amount of enhanced payments sent to any one facility, etc.)? If so, please detail.

Answer. We have previously recommended that Medicaid payments returned to States by public providers should be declared refunds, facility-specific limits should be based on actual cost data rather than aggregate limits, and CMS should establish regulations regarding disproportionate share hospital payments. These prior recommendations and others are described in detail in OIG's 2005 Red Book. Similarly, OIG's Orange Book is a compendium of significant unimplemented, nonmonetary recommendations for improving departmental operations. These publications are available on OIG's Web site at the following addresses:

http://www.oig.hhs.gov/publications/redbook.html
http://www.oig.hhs.gov/publications/orangebook.html

14. What comprehensive procedures or programs to verify provider eligibility (e.g., valid license; no criminal record; has not been excluded from other Federal health programs; practices from a legitimate business location) could OIG identify to strengthen pre-screening of providers with the goal of reducing Medicaid fraud?

Answer. Placing new providers on a 6-month prepayment review is one possibility. Another is requiring surety bonds. These steps would be especially helpful for DME providers where experience has shown that where large scale fraud exists, it generally occurs in the first few months of a company's existence. Often once the problem is detected, the providers typically close their doors or begin billing under different provider numbers. Another possibility would be to establish thresholds programmed into the Medicaid payment systems to detect "above the average" claims for the initial enrollment period. This would lessen the provider burden of waiting for its funds and allow the Government to focus efforts upon providers that appear to be exhibiting potentially fraudulent behavior. These thresholds could be established on a State-by-State basis.

15. Do current safeguards exist to assure that Federal dollars are expended only for a State's actual expenditures - not including any amount paid to a provider, which has then been returned to the State from the provider?

Answer. CMS has been taking steps through its State Plan Amendment review process to help ensure that Federal Medicaid funds are only available for States' actual expenditures. In recent years, CMS has been working with States to halt financial mechanisms involving Medicaid payments returned to the State from the provider. CMS identified 33 States that were using this type of financing mechanism. CMS believes that 26 of the 33 States have halted the practice because of CMS's strong corrective actions in reviewing the State plans. CMS continues to work with additional States to eliminate this financing mechanism.

The Administration has proposed amending the Medicaid statute to ensure that all future Federal matching funds are available only for a State's actual expenditures. The amendment would preclude Federal matching funds for payments to State or local governmental providers that (1) are not retained under control of the provider for the purpose of furnishing Medicaid care and services, or (2) are either returned to the State or local government, or (3) are used to supplant other State or local funding obligations. We support this proposed amendment.

QUESTIONS FOR THE RECORD SUBMITTED TO
DENNIS SMITH FROM SENATOR COBURN

Hearing: *"Bolstering the Safety Net: Eliminating Medicaid Fraud"*
Senator Tom Coburn, M.D.
Senate Subcommittee on Federal Financial Management,
Government Information and International Security

1. What measures will be taken to ensure that CMS' strategic plan for fraud control has specific goals and accountability standards for reporting improper payments and prosecuting fraud? Will such a plan take into account past vulnerabilities, clearly delineate roles and responsibilities for fraud control, and standardize those roles across the states? What are the measurable goals CMS will use, and a date or goal for implementation of the strategic plan?

Answer:

The Medicaid Integrity Program (MIP) planning and implementation group is developing the Comprehensive Medicaid Integrity Plan (CMIP) along with planning the overall implementation of the MIP. The specific goals and standards have not been developed at this time. The CMIP will take into account past vulnerabilities of the Medicaid and Medicare programs. The Deficit Reduction Act (DRA) clearly defines CMS' role and expands the resources it has to meet those goals. State program integrity efforts will likely continue to be as varied as the State Medicaid programs themselves. Over the next year or more, the MIP does, however, expect to develop consistent and fair program integrity measurements for all States. The first CMIP was released in July 2006 and will be periodically updated.

2. What are the specific mechanisms and plans for coordination between CMS's Medicaid and Medicare program integrity staff, as well as the HHS OIG program integrity staff?

Answer:

Recognizing that unscrupulous providers rarely make distinctions between the two programs, the Medicaid Integrity Program (MIP) planning and implementation group has made it a priority to build into both the MIP implementation plan and the CMIP strong coordination with the Medicare program. The fact that the Medicare Program Integrity Group is the business owner of two Medicaid- related functions and projects (PERM and the Medi-Medi project) has served to facilitate that coordination. The MIP planning group has consulted extensively not only with the Medicare Program Integrity Group, but a number of other internal and external components as well. The statute requires that CMS consult with a number of law enforcement components in the development of the CMIP, among them HHS/OIG; that has already been done. However, the MIP intends to use contractors to assist it in the development of its Audit and State Oversight Programs. To date, there has been considerable consultation with the HHS/OIG Office of Audit in the process of procuring these contractors. This coordination and interaction will continue as we implement the CMIP and begin to bring on contractors to do the ongoing audit work mandated by the statute.

3. What are the most important issues that CMS should address in its plan for Medicaid program integrity efforts?

Answer:

CMSO has identified several specific issues that may be appropriate to address at the outset of the Medicaid Integrity Program. In drawing from its own experience and that of the OIG and the GAO, CMSO plans to initially focus on a number of areas. They include: a) nursing and personal care such as fraud related to long term care facilities and home health agencies; b) the provision of prescription drugs to beneficiaries and the underlying costs of those drugs as reported to the States; c) durable medical equipment and other medical suppliers; and, d) improper claims for payment from hospitals and individual practitioners. Over the next several months, the Medicaid Integrity Program will develop a more detailed work plan to address these and other vulnerabilities.

4. What are the lessons learned from efforts to combat fraud and abuse in the Medicare program that CMS could apply to the new Medicaid Integrity Program?

Answer:

CMS and its staff have learned a great deal in their collective efforts to combat Medicaid fraud and abuse over the years. That experience has led the Medicaid Integrity Program to base its operational philosophy on four equally important points:

- CMS enthusiastically accepts its national **leadership** role in Federal and State Medicaid program integrity efforts. That responsibility will be accomplished through training and other technical support and assistance to the States. It will also include increased oversight of State program integrity units with an eye to the establishment of program integrity benchmark practices and standards. Through its oversight of and assistance to the States, MIP will play a vital role in promoting the integrity of the Medicaid program.

- CMS will oversee and report on not only its own activities but those of its contractors, but also the States' program integrity efforts. The success of the Medicaid Integrity Program depends on ensuring **accountability** for all. The annual report to Congress on the use and effectiveness of its appropriation wil describe MIP's return on investment (ROI) for its audit, oversight and technical assistance activities.

- The MIP will be in continual communication and coordination with its internal and external program integrity partners, particularly CMS' Office of Financial Management's Program Integrity Group which implements Medicare program integrity activities and Health and Human Services' (HHS) Office of Inspector General. CMSO will rely upon developing strategic partnerships with those entities, Federal and State law enforcement agencies and State Medicaid Agencies. In addition, MIP will work closely with organizations such as the National Association of Surveillance Officials and the National

Association of Medicaid Fraud Control Units. Through **collaboration**, the MIP will leverage its resources for the benefit of all.

- Those who defraud Medicaid are unhindered by bureaucracy and organizational constraints. To the greatest degree possible, CMSO expects its leadership and staff to be **flexible** in their efforts to combat fraud and abuse. The evolving nature of fraud demands that MIP be nimble, mapping its tactics to an ever changing fraud landscape. The Comprehensive Medicaid Integrity Plan (CMIP) reflects an overall strategy that keys on the most important vulnerabilities without committing disproportionate resources to any single area. The organizational structure of the Medicaid Integrity Group, particularly the Divisions of Fraud Research and Detection and Field Operations, must remain similarly flexible to address the most critical issues.

Going forward, MIP will take the lessons it learns through its own experiences, and those of the States and others, and turn them into guidance and directives aimed at preventing future improper payments. Audit issues will take into account not only the potential value of individual provider overpayments but also the potential for prevention oriented guidance to the States.

The anecdotal experiences of the Medicaid Integrity Contractors and the field operations functions of the Medicaid Integrity Program will offer invaluable insights into future fraud prevention and cost savings strategies. We expect to identify significant overpayments through a carefully crafted provider audit program. However, those overpayments will likely be dwarfed by the potential savings from more global strategies developed from those audit experiences. Similarly, by identifying the States' best practices and vulnerabilities, CMS will make recommendations and directives to the States to prevent future improper payments to providers.

5. What is the biggest program integrity problem – provider fraud or questionable state practices to increase matching funds? What is CMS's strategy for dealing with both of these problems?

Answer:

These types of program integrity problems are of equal importance. Section 6034 of the Deficit Reduction Act (DRA) creates the Medicaid Integrity Program (MIP) which clearly focuses on provider fraud. However, CMS has devoted considerable time, effort and resources to the issue of questionable state practices and will continue to do so.

In terms of provider fraud, the DRA provides not just funding for this new program, but 100 new FTEs, "whose duties consist solely of protecting the integrity of the Medicaid program," and to provide support and assistance to states to combat provider fraud and abuse. In addition, the statute requires CMS to engage contractors to conduct provider oversight by performing the following specific duties: review provider claims to determine if fraud, waste and abuse has occurred or has the potential to occur; conduct provider audits based on these reviews and other trend analysis; identify overpayments; and, conduct provider education.

CMS is also developing a structure to address the following critical functions:

- Procuring and providing oversight of the Medicaid Integrity Contractors;
- Through a field operations component, providing strengthened state program integrity oversight, as well as support through technical assistance and training; and,
- Creating a fraud research and detection component to provide statistical and data support, identifying emerging fraud trends and conduct special studies as appropriate.

In addition, CMS has developed and released a five-year Comprehensive Medicaid Integrity Plan (CMIP), which is also mandated by the statute. There was considerable informal internal and external consultation in the development of the CMIP. Formal consultation sessions were conducted with law enforcement entities, state officials with responsibility for controlling provider fraud and abuse in their states and with the Government Accountability Office (GAO).

Regarding questionable state practices, since August 2003, CMS has been requesting information from states regarding detail on how they are financing their share of Medicaid program costs under the Medicaid reimbursement State Plan Amendment (SPA) review process. The questions related to state financing are applied consistently and equally to all states under the SPA review process. CMS will not approve new SPA proposals until states have fully explained how they finance their Medicaid programs and until such time that states have agreed to terminate any financing practices that contradict the spirit of the Federal-state partnership. In addition, follow-up audits are conducted for any questionable financing practice that is discovered as part of the Medicaid reimbursement SPA review.

Other resource commitments include increased integration of fiscal activities with our Regional Offices and the hiring of the 100 new Medicaid financial management specialists/accountants to ensure that states are appropriately financing their Medicaid programs in accordance with Federal and regulation and to improve Medicaid financial management oversight

Through our ongoing financial management review process, as outlined in our FY 2006 work plan, CMS will continue to monitor outstanding state financing areas. In particular, for those areas where we have notified the state that there is a concern with their financing of the non-federal share of their Medicaid program, we have instructed our Regional Offices to conduct a financial management review to document issues and develop a course of action.

However, CMS recognizes the danger inherent in dealing with these problems in a vacuum. Both of these problems impact the overall fiscal integrity of the Medicaid program. Therefore, CMS has built into its CMIP ongoing interaction between these two functional components to assure the synergy necessary to share information and address these two program integrity problems.

6. As CMS begins to contract for specific program integrity activities, what are the three most important tasks that CMS will expect contractors to perform?

Answer:

The Medicaid Integrity Program (MIP) intends to use contractors to assist it in the development of its Audit and State Oversight Programs. The Audit Program Development contractor will be

primarily responsible for helping CMS design a strategic audit targeting system that focuses on potential high dollar recoveries which will also result in knowledge that can be transformed into regional/national guidance to states to prevent future similar overpayments.

A separate contracting function, the State Program Integrity Assessment contractor, will assist CMS in identifying the baseline demographics that need to be captured to accurately depict the critical issues related to assessing State program integrity activities. Ultimately, the most important tasks MIP contractors will perform are the review of Medicaid claims, the auditing of Medicaid providers and the identification of Medicaid overpayments.

7. Given that CMS is required to annually report on the effectiveness of the use of Medicaid Integrity Program funds, what measurements of effectiveness does CMS propose to use?

Answer:

The Medicaid Integrity Program (MIP) workgroup has developed the Comprehensive Medicaid Integrity Plan (CMIP) and is proceeding with the overall implementation of the MIP. The specific goals and standards have not been developed at this time.

8. What is the annual amount budgeted by CMS for Medicaid program integrity efforts (improper or erroneous payments, and including fraud)? In addition, what is the amount budgeted annually by CMS for states' program integrity efforts? Please provide a table detailing budgets from FY04 – FY07, detailing changes resulting from the recently passed DRA.

Answer:

Outlined in Attachment 1 are HHS funding levels related to Medicaid program integrity efforts, some of which include anti-fraud efforts. However, CMS does not have figures for the percentages or amounts of federal funding States allocate to their respective program integrity efforts. States are not required to specifically report on their expenditures for program integrity. The MIP planning and implementation work group is currently working on the implementation of the Medicaid Integrity Program. The MIP will be the focus of CMS' efforts to protect the integrity of the Medicaid program from this point forward. This will be in addition to and supportive of States' program integrity efforts.

9. Knowing that states' Medicaid programs differ in some ways, how does CMS plan to assess the vulnerabilities and risks associated with different states' programs?

Answer:
CMS is in the process of procuring a national developmental contractor – the State Program Integrity Assessment (SPIA) contractor – to assist us with the task of strategically gathering information about State program integrity activities. The "baseline" developed from this information gathering will assist CMS in identifying States' commitments to program integrity efforts and will serve as the basis for guidance and technical assistance provided to States. Further, CMS will continue to conduct State Program Integrity Oversight Reviews to ensure

States meet federal requirements relative to program integrity and are encouraged to adopt best practices.

10. What are the current standards CMS is using to phase out provider tax and donation programs used by some states to increase Federal matching funds?

Answer:

Until 1991, when Federal law restricted the use of health care provider related taxes, states were able to tax health care providers as a way to raise their share of the Medicaid matching payment. These funds, used to draw down Federal Medicaid dollars were then returned to the provider, in effect, holding them harmless for the tax they originally paid. This loophole in Federal law permitted states to shift the cost of their Medicaid programs directly to the Federal government.

After 1991, state taxes must be imposed on a permissible class of health care services; be broad based or apply to all providers within a class; be uniform, such that all providers within a class must be taxed at the same rate; and avoid hold harmless arrangements in which collected taxes are returned to the taxpayers directly or indirectly. The Secretary shall approve broad based (and uniformity) waiver applications if the net impact of the tax is generally redistributive and that the amount of the tax is not directly correlated to Medicaid payments. The hold harmless requirements cannot be waived.
States can tax classes of health care services and providers, including inpatient hospital and outpatient hospital services, and nursing facility services, up to 6% of their net revenues without violating prohibitions on the indirect "hold-harmless" arrangement, a percentage of which is defined in current Federal regulations.

The President's FY 2007 Budget proposes to revise the definition of an indirect hold harmless so that it would be considered to exist if the health care-related tax revenue collected by a state or unit of local government exceeds 3% (rather than the current 6%) of the taxpayers' net operating revenue applicable to the health care service assessed by the state or unit of local government.

Section 1903(w)(4) of the Social Security Act establishes the direct and indirect hold harmless violations, which were implemented in Federal regulation at 42 CFR 433.68(f). Section 42 CFR 433.68(f)(1)(i) implemented the statutory "indirect" hold harmless provision through a percentage limit on the collection of health care-related taxes.

CMS will use its administrative authority through the regulatory process to revise the indirect hold harmless provisions contained in regulation to reduce the regulatory defined percentage from 6 percent to 3 percent.

11. How does CMS rate the effectiveness of efforts such as the Medicaid Alliance for Program Safeguards and state audit initiatives?

Answer:

The Medicaid Alliance for Program Safeguards, a CMS initiative, was considered effective given the resources available. Forty-four (44) state program integrity reviews were conducted over six years. A number of "best practices" and other types of technical assistance were also provided to States. Moreover, State program integrity directors have repeatedly praised CMS' work over the last 10 years to do more to assist them in their efforts.

There is no requirement that States publish the results of the provider audit efforts. A few States (e.g. Florida, Texas, Illinois) periodically report on their program integrity activities. It would appear those States have had successful audit programs. One of the goals of the new Medicaid Integrity Program (MIP) will be to first identify a baseline for each State's program integrity activities, including provider audits. MIP will then continue to monitor State activities and identify areas of possible improvement.

12. What comprehensive procedures or programs to verify provider eligibility (e.g.: valid license; no criminal record; has not been excluded from other Federal health programs; practices from a legitimate business location) could CMS either implement or strengthen to pre-screen providers with the goal of reducing Medicaid fraud?

Answer:

States have the sole responsibility for provider enrollment in the Medicaid program. Enrollment efforts vary from state to state. When a provider is federally excluded from participation by the Office of Inspector General, the provider is excluded from participation in both the Medicare and Medicaid programs. States are prohibited from making Medicaid payments to excluded providers.

Some states already conduct criminal background checks, onsite verifications and other pre-enrollment screening practices. However, criminal background checks and onsite verifications are discretionary and not required by federal law. Developing more effective provider screening tools and procedures will be critical to the success of the new Medicaid Integrity Program (MIP).

13. What are CMS's recommendations to strengthen Federal guidelines regarding reporting and recovery of third party payments, and the elimination of a pay-and-chase methodology in some states (allowing a state to pay a provider's claim and then seek recovery from a liable third party)?

    a) Are states required to use cost avoidance for most services unless a state obtains a waiver from CMS allowing it to pay and chase? How often do states obtain waivers?

Answer:

States are generally required to cost avoid Medicaid claims. Cost avoidance entails states' rejecting the claim, returning it to the provider, who in turn bills for liable third party coverage. The governing regulations are found at 42 CFR 433.139(e).

There are four exceptions to this general rule. The first three, found in statute at section 1902(a)(25)(E-F) of the Social Security Act (Act) and in regulations at 42 CFR 433.139(b), require states to pay and chase claims for (1) prenatal services (2) preventive pediatric services and (3) in situations in which a child has coverage resulting from a non-custodial parent's obligation to provide medical coverage. The fourth involves situations in which a state can demonstrate that it is more cost-effective to pay and chase, than to cost avoid, a particular service or claim type. In such cases, the state may seek permission to pay and chase such claims by requesting a waiver from CMS of the requirement to cost avoid. Before granting such a waiver, CMS requires documentation from the state that paying and chasing for the particular service or claim type is more cost effective than cost avoidance. In recent history, CMS has approved only a few such waivers.

Several recommendations for strengthening Federal cost avoidance guidelines are reflected in the President's proposed Fiscal Year 2007 Budget. First, there is an administrative proposal requiring states to cost avoid all pharmacy claims by eliminating cost avoidance waivers for this service. Implementation of this proposal will result in the elimination of paying-and-chasing all pharmacy claims, with the exception of those claims that fall into one of the three statutorily-mandated pay-and-chase scenarios, discussed above.

The proposed FY 2007 Budget also contains several legislative proposals for strengthening the reporting and recovery of third party payments. First, the President's Budget recommends that Congress amend title XIX of the Act to require states initially to cost avoid claims for prenatal and preventive pediatric services and in situations in which a non-custodial parent is liable for medical coverage (i.e., initially to cost avoid claims for which the statute currently mandates that the state pay and chase). If the provider does not receive third party payment within 90 days from the date the provider bills the third party, the state then would be required to pay and chase the claim.

Finally, the President's budget recommends amendments to title XIX to expressly permit states to place liens against liability settlements to recover Medicaid funds. States have been challenged in their right to use a lien to recover from a Medicaid beneficiary's liability settlement or award based on the current anti-lien language in the Social Security Act. The President's legislative proposal would strengthen these statutory provisions.

14. What is the role of CMS in identifying improper payments in the Medicare and Medicaid program? By whom, and how many audits have been requested in this area by CMS or another body? Is requesting audits to identify improper payments a consistent practice?

Answer:

CMS is the federal agency responsible for all payments made under the Medicare, Medicaid and SCHIP programs. Under the Improper Payments Information Act of 2002 (P.L. 107-300), CMS is required to measure and reduce improper payments in these program areas. For Medicare, CMS has contractors selecting claims, requesting medical documentation and conducting audits. Approximately 120,000 Medicare claims are audited each year by these contractors to produce the Agency's Medicare fee-for-service improper payments report. In the Medicaid arena, to date, the states have conducted their own internal audits and reviews. The number of audits and/or reviews conducted has varied by state. Requesting audits or looking behind the claim submitted for payment is the best method to detect improper payments that are not otherwise evident on the claim itself. This method is consistently used among the Medicare, Medicaid and State Children's Health Insurance programs.

In 1996, the Department of Health and Human Services' (DHHS) Office of Inspector General (OIG) began estimating improper payments in the Medicare fee-for-service program as part of the Chief Financial Officer's Audit. The OIG produced fee-for-service error rates from fiscal year (FY) 1996 to FY 2002. Beginning in FY 2003, CMS, working with the OIG, implemented a much more robust process – the Comprehensive Error Rate Testing program – to assess and measure improper payments in the Medicare fee-for-service program. We believe our efforts in Medicare have been a success. In November 2005, CMS reported a Medicare fee-for-service paid claims error rate of 5.2 percent which is significantly lower than the 10.1 percent rate reported in FY 2004.

In FY 2000, CMS adopted a Government Performance and Results Act goal to explore the feasibility of developing a method to estimate improper payments in the Medicaid program. CMS initiated the payment accuracy measurement (PAM) demonstration project. This commitment evolved into a five-year project that tested various methods and strategies for measuring improper payments at the state level. Based on the pilot results, requirements in the Improper Payments Information Act of 2002 and subsequent guidance from the Office of Management and Budget, CMS developed a national contracting strategy to calculate Medicaid and SCHIP improper payments and implemented the strategy in Medicaid fee-for-service in FY 2006 through the Payment Error Rate Measurement (PERM) program.

States will be measured once, and only once, every 3 years for each program, Medicaid and SCHIP. There are 17 States participating in PERM for the FY 2006 measurement and 17 new States will participate in the FY 2007 measurement. The final 17 States will be measured in FY 2008. After FY 2008, States will begin the rotation cycle again so that the States that were measured in FY 2006 will be measured again in FY 2009. This predictable cycle allows States to plan for the reviews.

In FY 2006, CMS is measuring Medicaid fee-for-service (FFS) in the initial 17 States. In FY 2007, CMS plans to fully implement the PERM program by measuring FFS, managed care and eligibility in both Medicaid and SCHIP in the next set of 17 States.

15. Payment Error Rate Measurement Project (PAM/PERM): Please provide a table detailing the most recent list of participating states, as well as the programs being tested in those states (Medicaid, Medicare, SCHIP).

    a) If all participating states are not required to test the PERM pilot in their Medicaid programs, why not?

Answer:

CMS has concluded its PAM/PERM pilots. State participation in the PERM pilot, which was conducted for FY 2005, was voluntary. The chart below shows the PERM pilot findings as well as the programs tested in those states. The PERM pilot did not measure improper payments in Medicare since CMS has been measuring improper payments in that program since FY 2003.

State Participation in PERM Pilot – FY 2005

State	Medicaid		SCHIP	
	Fee-for-Service	Managed Care	Fee-for-Service	Managed Care
Alabama			•	
Alaska	•		•	
Arizona	•	•	•	•
Arkansas	•		•	
Colorado	•	•	•	•
DC	•	•		•
Delaware	•	•	•	•
Florida	•	•	•	•
Georgia	•		•	
Idaho	•		•	
Indiana	•		•	•
Iowa	•		•	•
Kansas	•			•
Kentucky	•	•	•	•
Maryland	•	•	•	•
Minnesota	•	•		
Missouri	•	•	•	•
Nevada	•	•	•	•
New Mexico	•	•	•	•
New York				•
Oklahoma	•		•	
Pennsylvania	•	•		
South Carolina	•		•	
South Dakota	•		•	
Texas	•	•	•	

State	Medicaid		SCHIP	
	Fee-for-Service	Managed Care	Fee-for-Service	Managed Care
Alabama			•	
Alaska	•		•	
Arizona	•	•	•	•
Arkansas	•		•	
Colorado	•	•	•	•
DC	•	•		•
Delaware	•	•	•	•
Florida	•	•	•	•
Georgia	•		•	
Idaho	•		•	
Indiana	•		•	•
Iowa	•		•	•
Kansas	•			•
Kentucky	•	•	•	•
Maryland	•	•	•	•
Minnesota	•	•		
Missouri	•	•	•	•
Nevada	•	•	•	•
New Mexico	•	•	•	•
New York				•
Oklahoma	•		•	
Pennsylvania	•	•		
South Carolina	•		•	
Virginia	•	•	•	•
West Virginia			•	
Wisconsin	•	•	•	•
Wyoming	•			
TOTAL	26	15	23	16

CMS has implemented a national contracting strategy to measure Medicaid improper payments in all states. The following chart shows the states selected in which CMS will measure Medicaid improper payments over the next three years. The states being measured in FY 2006 are being measured for improper payments in Medicaid fee-for-service (see chart below). In FY 2007 and FY 2008, we expect to measure improper payments in Medicaid fee-for-service and managed care arrangements as well as improper payments made to ineligible recipients or for ineligible services in the states selected for those years (see chart below). CMS' state selection process allows states to plan for the reviews as each state will be selected once and only once every three years for Medicaid.

States Selected for Medicaid Improper Payment Measurements

FY 2006	Pennsylvania, Ohio, Illinois, Michigan, Missouri, Minnesota, Arkansas, Connecticut, New Mexico, Virginia, Wisconsin, Oklahoma, North Dakota, Wyoming, Kansas, Idaho, Delaware
FY 2007	North Carolina, Georgia, California, Massachusetts, Tennessee, New Jersey, Kentucky, West Virginia, Maryland, Alabama, South Carolina, Colorado, Utah, Vermont, Nebraska, New Hampshire, Rhode Island
FY 2008	New York, Florida, Texas, Louisiana, Indiana, Mississippi, Iowa, Maine, Oregon, Arizona, Washington, District of Columbia, Alaska, Hawaii, Montana, South Dakota, Nevada

By FY 2009, all 50 States and the District of Columbia will have been measured under for improper payments in Medicaid FFS, managed care, and eligibility under PERM.

16. What are the most recent expectations for a date for implementation of a national adoption of a Medicaid and SCHIP Payment Error Rate Measurement (PERM) project?

Answer:

In FY 2006, CMS implemented PERM to measure improper payments in Medicaid fee-for-service for the first set of 17 states. Therefore, based on these reviews, the error rate that CMS will report in the FY 2007 Performance and Accountability Report (PAR) will only reflect the Medicaid fee-for-service error rate. However, in FY 2007, CMS expects to measure improper payments in the fee-for-service, managed care and eligibility components of both Medicaid and SCHIP. Each year, these reviews will occur on a rotational basis for a defined set of 17 states. Based on these reviews, CMS expects to report baseline error rates for Medicaid and SCHIP in the FY 2010 PAR.

17. Because Medicaid is a needs-based program, a robust eligibility component should be factored into improper payment rate calculation. Does such a component currently exist?

Answer:

Currently, for FY 2006, the Payment Error Rate Measurement (PERM) program is measuring improper payments only in Medicaid fee-for-service. In FY 2007, we expect to measure improper payments based on eligibility errors in both Medicaid and SCHIP. The eligibility improper payment rate will be factored into the overall program error rate which also includes the error rates from the fee-for-service and managed care reviews.

18. Do current safeguards exist to assure that Federal dollars are expended only for a state's actual expenditures – not including any amount paid to a provider which has then been returned to the state from the provider?

Answer:

Yes. Through our ongoing financial management review process CMS will continue to monitor outstanding state financing areas. In particular, for those areas where we have notified the state that there is a concern with their financing of the non-federal share of their Medicaid program, we have instructed our Regional Offices to conduct a financial management review to document issues and develop a course of action.

Since August 2003, CMS has been requesting information from states regarding detail on how they are financing their share of Medicaid program costs under the Medicaid reimbursement State Plan Amendment (SPA) review process. The questions related to state financing are applied consistently and equally to all states under the SPA review process. CMS will not approve new SPA proposals until states have fully explained how they finance their Medicaid programs and until such time that states have agreed to terminate any financing practices that contradict the spirit of the Federal-state partnership. In addition, follow-up audits are conducted for any questionable financing practice that is discovered as part of the Medicaid reimbursement SPA review.

We now have reviewed more than 1100 state requests for changes in payment methodologies through SPAs. As of August 3, 2006, 28 states have revised their financing arrangements related to over 60 different provider payments. We continue to work cooperatively with 5 states to resolve outstanding financing arrangements.

Other safeguards include increased integration of fiscal activities with our Regional Offices and the hiring of the 100 new Medicaid financial management specialists/accountants to ensure that states are appropriately financing their Medicaid programs in accordance with Federal law and regulation and to improve Medicaid financial management oversight. Ninety of the staff are allocated to specific states and 10 of these staff are based in the CMS Central Office.

In addition, for each SPA that has terminated an impermissible financing arrangement, through our Regional Offices, we are performing financial management reviews of impermissible financing arrangements to ensure uniform application and confirm compliance with termination provisions. Further, we are also verifying through detailed reviews of the CMS-64 submissions beginning with the quarter ending September 30, 2005, to verify compliance with termination of impermissible financing arrangements as they relate to supplemental payment methodologies.

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