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A PRESCRIPTION FOR WASTE: CONTROLLED SUBSTANCE ABUSE IN MEDICAID

HEARING

BEFORE THE

FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT INFORMATION, FEDERAL SERVICES, AND INTERNATIONAL SECURITY SUBCOMMITTEE

OF THE

COMMITTEE ON
HOMELAND SECURITY AND
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

OF THE

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

SEPTEMBER 30, 2009

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WEDNESDAY, SEPTEMBER 30, 2009

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

The Subcommittee met, pursuant to notice, at 3:13 p.m., in room SD–342, Dirksen Senate Office Building, Hon. Thomas R. Carper, Chairman of the Subcommittee, presiding.

Present: Senator Carper.

OPENING STATEMENT OF SENATOR CARPER

Senator CARPER. The hearing will come to order.

Thank you for your patience. It is one of those days that I wish, as I have talked about in years past, about cloning people, so I could be in two places at once.

Actually next door in the Hart Building, we are marking up health care reform legislation in the Finance Committee, and I would very much like to be there. I need to be here, but I also want to be there. The topics of what we are doing over there and actually what we are going to be talking about here kind of overlap, so there is a fair amount of synergy.

Sometimes I joke that until we get this cloning thing down pat, so I can be in two places at once, what we ought to do is use cardboard cutouts. I joke about getting the cardboard cutout, not the kind that stands up, but the kind that you could sit down.

Then I could cut out the mouth, my mouth in the cardboard cutout. I could sit here, and somebody on my staff could be right behind the cardboard cutout and speak the words: The Committee will come to order and next witness and stuff like that.

At the end, folks in the audience would probably say, "He seemed kind of stiff today."

We decided not to pursue that. So I will have to ask you to bear with me.

We are going to start voting on the floor around 4:30 p.m. So my goal is to have a chance to hear from all the witnesses and ask some questions and get some answers. Probably one or two of our colleagues will show up as well.

Over the past several months, the American people and those of us in Congress have engaged in an unprecedented conversation

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about our Nation's health care system. In fact, it may be, I think, the most important issue that I will work on during the time that I am privileged to serve here in the U.S. Senate.

While there are a few things that we disagree on, and the media is always very good to focus on those, I think almost everyone agrees that our system is broken, as it is. We spend more and more money on health care than any other country. We do not get better results. We could demonstrate in a lot of cases, we do not get better results. A lot of folks do not have health care coverage at all.

We can do better than that.

The focus for me has been, and continues to be, not just extending coverage to people who do not have it, not just improving the quality of health care, but making sure that as we improve the quality of health care, improve outcomes, we actually rein in the growth of costs.

When you have a country where we are spending almost 16, 17, 18 percent of our GDP for health care, then I think the next closest country is maybe 10 percent of GDP. That isn't good. And, when our health care costs are growing by two or three times the rate of inflation and most other countries are not, that isn't good either.

I have a chart over here that our staff member, John Collins, has prepared for us. As you can see, we look at health care expenditures per person. We go back to about 1960, and we run it up at least through 2007.

According to the information, I think they are using the Centers for Medicare and Medicaid Services (CMS) as the source, but we start in 1960, with about $148.[1]

Today, the idea that we are spending more than $7,400 or $6,400 or something in between, a huge amount of money—the idea that if we continue to go ever upward, we are doomed. We are not only doomed at the Federal level with Medicare costs and Medicaid costs. The States are in huge trouble, and our employers are in trouble, so are a lot of folks who do not have coverage today and, frankly, will not have coverage in the future if we do not do something about it.

While there are a number of reasons for the rise in health care over the past couple of decades, it is clear that prescription drugs are one of the main drivers of this increase.

We have another chart here,[2] and we look at the average cost of pharmaceuticals per person, starting again in 1960, about $14 for every one of us.

It is hard to believe, but as 2007 was coming to an end, we were between $700 and $800 in prescriptions per person, and that is obviously an unsustainable increase. I am told it is an increase of about 740 percent. That is just not sustainable.

The way medicine is practiced today has changed over time, as we know. Drugs are now offered to patients who just a few years ago may have been recommended for surgery or received no treatment at all. The whole new generation of painkillers has been developed to bring comfort to patients who, before, may have had to simply live with their pain.

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[1] The chart referred to appears in the Appendix on page 95.
[2] The chart referred to appears in the Appendix on page 94.

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Their benefits have been proven but so have some of their potential dangers, and that is the dangers of the painkillers. While these drugs bring relief, they also have the potential for patients to become dependent or even addicted to their powerful effects.

The next chart gives us a chance to look at the growth from 1994 to 2004.[1] During this period of time, the population grew by about 12 percent. Use of drugs grew by about 68 percent, and the abuse of drugs grew by about 80 percent.

More Americans abuse prescription drugs than the number who have used cocaine, heroin, hallucinogens, Ecstasy and inhalants, all combined.

The Drug Enforcement Administration classifies drugs that are most likely to be abused into a specific category they call controlled substances, a term we have all heard.

A few months ago, we asked the Government Accountability Office to see whether some Medicaid beneficiaries might be abusing the system to obtain these powerful drugs to fuel their own addictions or maybe to sell those drugs on the street.

GAO investigated controlled substance prescription claims. They looked at five States. They looked at North Carolina. I think they looked at California, Texas, New York, and Illinois. In total, those States, if you add up their populations, it is about 40 percent of our Nation's population. I think they also made up about 40 percent of the controlled substances claims that were paid for by Medicaid.

What GAO found were tens of thousands of Medicaid beneficiaries and providers involved in fraudulent or abusive purchases of controlled substances through the Medicaid program.

GAO found three major sources of fraud and abuse involving controlled substances.

The first included beneficiaries engaged in a practice commonly known as doctor-shopping. Over 65,000 Medicaid beneficiaries in the five states that GAO examined were going to six or more doctors for the same type of controlled substance. In one case, GAO found two beneficiaries working together to acquire Oxycodone, a powerful prescription painkiller, from over 25 prescribers and nine different pharmacies. In these types of cases, beneficiaries were either feeding their addiction or selling the extra pills on the street.

Drug dealers made the profit while guess who floated the bill—Medicaid. And, who is Medicaid? Well, it is us. The States pay basically about half of the cost and the Federal Government the rest.

Fraud and abuse of the Medicaid system also appears to be going on beyond the grave. Comparing Medicaid claims to Social Security data, GAO discovered thousands of controlled substance prescriptions were received by dead beneficiaries or they were written by dead doctors. In one case, a beneficiary submitted a Medicaid application using the Social Security number of a person who died in 1980. This beneficiary stayed on the Medicaid rolls for 3 years and during that time received thousands of controlled substance pills and over $200,000 in medical treatment.

GAO's report also found more than 65 doctors and pharmacies that the government knew were bad apples but were not taken out of the Medicaid system. Providers who were barred from Federal

[1] The chart referred to appears in the Appendix on page 93.

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health care programs for fraud and abuse convictions were still writing or filling prescriptions through Medicaid. In one specific case, a physician who had been banned after being convicted for writing fraudulent controlled substance prescriptions was still having his prescriptions paid for by Medicaid nearly 2 years after the incident.

The problems outlined in GAO's report have fairly simple solutions that, in many cases, already exist. Proper data-sharing agreements and basic fraud prevention controls would go a long way in stopping much of the abuse that we will be discussing here today.

Unfortunately, each State has developed its own individual approach without regard for the best practices and models available to them, and this has resulted in programs full of holes.

It is clear that the Centers for Medicare and Medicaid Services needs to do a better job of providing guidance and regulatory enforcement for the States. At the same time, States need to take greater responsibility for preventing and rooting out fraud, waste, and abuse from their own backyards.

As a recovering governor, that is how I describe myself, a recovering governor, I understand the unique challenges that come along with running a State Medicaid program.

And, as many of you know and have heard me say before, if it is not perfect, make it better. That is one of my core values. We all share a responsibility to do just that with Medicaid.

GAO's findings are troubling, and I look forward to an honest and frank discussion here today about what needs to be done to make sure that these abuses do not continue and to make sure that we recover some funds here for Federal taxpayers and for State taxpayers and reduce the likelihood that we will be tapped again.

As a member of the Finance Committee, we have had a lot of discussion about how to pay for health care reform. I share the President's belief that any plan we pass in Congress this year should not add a dime to our deficit going forward. It actually should reduce deficits. One of the ways that we can do that is through cutting the fraud, waste, and abuse in our current public health care systems.

We can go a long way in paying for health care by eliminating this sort of abuse we will be discussing today. This is just the tip of the iceberg. There is a whole lot more that goes on beyond this.

Before I close and turn to our witnesses, we have one more chart I want us to take a look at. I used to be the father of two teenage boys. One is now still 19; the other is 21. But we learned that one out of five teenagers has abused controlled substances—one out of five.[1] That is a number that troubles me, and my guess is it troubles everybody in this room, as it should.

The dangers of prescription drug abuse have become better known in the past few years as celebrities and other public figures succumb to their lethal effects. However, less widely publicized are the millions of American teenagers who abuse the same drugs. Unfortunately, they are doing so at a rate that causes alarm for me, and I suspect for many others.

[1] The chart referred to appears in the Appendix on page 96.

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I make this point so it is clear, while there is a financial cost to this fraud and abuse of controlled substances paid for by Medicaid, let's not forget there is a human cost as well. Prescription drug abuse is the fastest growing addiction in the United States today. The difference between a street drug like cocaine and a prescription pain pill is that in many cases the Federal Government is paying to feed this addiction with taxpayer money. Aside from our financial responsibilities, we have a social responsibility to ensure that our public health care system is not used to further intensify and subsidize a public health crisis.

With that in mind, I want to thank our witnesses for joining us today. I especially want to thank GAO for the work that you all have done to help put a big spotlight on this problem and this challenge that we can confront.

Our first witness today is from GAO, Greg Kutz. He has been before us on other occasions. He is the Managing Director of GAO's Office of Forensic Audits and Special Investigations unit. He has served GAO since 1991 and is responsible for overseeing high-level forensics audits and investigations on fraud, waste, and abuse in our National Government. He has plenty of work to do, and we are glad you do it. Thanks very much for joining us.

Our second witness is Penny Thompson, Deputy Director for the Center for Medicaid and State Operations within the Centers for Medicare and Medicaid Services (CMS). Ms. Thompson recently joined CMS after 8 years in the private sector and has over 20 years of direct Medicare and Medicaid program experience.

We thank you for your service and welcome you back to the government, at least for today.

I also want to acknowledge the presence of Ann Kohler, Executive Director of the National Association of State Medicaid Directors. Ms. Kohler has spent over 20 years in the health care administration field, including 4 years as a Medicaid Director for the State of New York, the largest Medicaid agency in the country.

One of your colleagues or former colleagues from New York was actually very helpful in helping us fashion an amendment that helped us, in the health care markup, helped us actually change the incentive system to better incentivize States to work with the Federal Government to do post-audit recoveries particularly in cases of fraud. So we can go out and get that money and share the money with the States and with the Federal Government in ways that made sense for both the State and the Federal Government.

New York, through Medicaid programs, past and present, is actually helping us again today.

The final witness is Joe Rannazzisi, Deputy Assistant Administrator for the Office of Diversion Control in the U.S. Drug Enforcement Administration (DEA). Mr. Rannazzisi began his career as a special agent with DEA in 1986. In his current position, he oversees major pharmaceutical investigations for the Agency.

And, we thank you for joining us. We thank all the witnesses for joining us.

I think we have indicated to you that we ask you to hold your statements to about 7 minutes. If you run a minute or so beyond that, we will let you slide. We will go start voting, a series of three or so votes, at 4:30. I want to make sure everybody has a chance

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to present their thoughts and give me a chance to ask some questions and give you a chance to answer them.

Again, Mr. Kutz, you are welcome to proceed. Your full statement will be made a part of the record. So, please summarize as you see fit. Thanks.

And, again, to all of you, thank you for being here. This is important. It is not important just for our kids, and it is important for them—not just important for health care concerns in this country, that is important.

But also in terms of in a day and age when you are running huge budget deficits, where we just finished the last 8 years running up more debt than we did in the previous 208 years of our Nation's history, and in a year when we are on track to run up the biggest budget deficit ever, and looking ahead for the next 10 years we are looking at the prospect, if we do nothing, of accumulating another $9 trillion worth of debt, it is important that we look under every rock and find ways that we are spending money inefficiently, inappropriately or, in some cases, fraudulently and stop that and recover the money as much as we can.

This is just a great place to do that kind of work. So we appreciate your help in enabling us to do that. Mr. Kutz.

TESTIMONY OF GREGORY KUTZ,[1] MANAGING DIRECTOR, FORENSIC AUDITS AND SPECIAL INVESTIGATIONS, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Mr. KUTZ. Mr. Chairman, thank you for the opportunity to discuss the Medicaid program.

Today's testimony highlights the results of our investigation into fraud and abuse related to controlled substances paid for by Medicaid. My testimony has two parts. First, I will discuss the results of our investigation, and, second, I will discuss our recommendations.

First, we identified Medicaid dollars fraudulently used by drug addicts and for the sale of addictive drugs on the street. Specifically, 65,000 individuals received prescriptions for the same controlled substance, as you mentioned, from six or more doctors. And, as you also said, this practice is referred to as doctor-shopping.

Our testimony today focuses on an investigation of five States and 10 frequently abused controlled substances. Medicaid paid $63 million for these prescriptions. We recognize that some of the 65,000 individuals may not have been doctor-shopping. However, we believe the $63 million estimate is understated. For example, this amount excludes the substantial cost of unnecessary office visits and trips to emergency rooms by addicts to get their drugs.

Examples of doctor-shopping that we found include an Illinois drug felon using her child to obtain ADHD medication from 25 doctors. She admitted her addiction to Ritalin and using her child in a doctor-shopping scheme to satisfy this addiction.

A New York woman using a scheme involving 10 doctors to satisfy her addiction to Ambien. The monitor on my left,[1] and for those in the audience, on my right, shows monthly prescriptions

[1] The prepared statement of Mr. Kutz appears in the Appendix on page 36.
[1] The chart referred to appears in the Appendix on page 00.

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from two of these doctors that, as you can see, were filled within 5 days.

And, an Illinois woman selling Vicodin and Duragesic patches on the street. One user of these drugs died of an overdose. The prescribing physician has been indicted for contributing to the fatal overdose of at least three individuals.

Again on my left shows the street values of Ambien, OxyContin and Adderall as reported by the National Drug Intelligence Center.[1] As you can see, the sale of just one prescription of OxyContin can result in a profit of over $2,700 for a drug dealer.

As an estimated $87 billion of the stimulus package represents increased Federal payments for Medicaid. These increased payments started retroactive to the beginning of fiscal year 2009. Unfortunately, it appears that fraud and abuse related to several of our cases continued into fiscal year 2009. As a result, millions of dollars of stimulus money is likely paying for the types of fraudulent doctor-shopping schemes that I just described.

We also identified 65 Medicaid providers and pharmacies barred from Federal health care programs that wrote or filled $2.3 million of controlled substance prescriptions.

Examples include a New York physician barred for submitting false Medicaid claims. This physician prescribed 350,000 controlled substance pills to 773 individuals, costing $764,000.

And, a California physician barred for incompetence, malpractice and negligence. This physician prescribed 142,000 controlled substance pills to 600 individuals, costing $109,000.

We also mentioned that Medicaid, as you said, paid for prescriptions written either for dead beneficiaries or submitted by pharmacies using the names of dead doctors.

For example, one California man was accepted into the program, using the identity of the individual that the monitor shows he died in 1980.[2] Medicaid paid for $200,000 of claims for this identity theft scheme, including prescriptions for Vicodin.

And, in New York, a man fraudulently received 1,000 Methadone, Xanax, and other pills that were prescribed for his deceased wife.

The problems we identified were caused by weaknesses in the Medicaid fraud prevention program. One of the key controls is to make sure that the known fraudsters and criminals are properly excluded from this program. However, we found that none of the States screen providers or pharmacies against the GSA Federal Debarment List.

The 65 providers and pharmacies that should have been excluded from Medicaid had felony convictions for controlled substances, welfare fraud, grand theft, grand larceny, and Medicaid fraud. We recommend that the States periodically scrub their data to make sure that these fraudsters are kept out of the Medicaid program.

We also found that Medicaid paid for controlled substances for 1,800 individuals after they had died. Medicaid also paid for prescriptions submitted using the names of 1,200 dead doctors. We recommend that beneficiary and provider data be periodically

[1] The chart referred to appears in the Appendix on page 00.
[2] The chart referred to appears in the Appendix on page 00.

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matched against death records and the results used to prevent fraud.

In conclusion, our work clearly shows fraud and abuse in the health care program designed to help our Nation's poorest and most vulnerable citizens. Perhaps more troubling is the use of taxpayer dollars to finance drug abuse in our Nation. I am hopeful that CMS and the States will use the results of this investigation to improve their fraud prevention programs.

Mr. Chairman, that ends my statement, and I look forward to your questions.

Senator CARPER. Good. Thanks for that statement, Mr. Kutz, and thank you very much, to you and your colleagues at GAO who have done this work and all five States to help point out the very troubling findings, but not just to point out the findings, but also to help point out a way that we can attack them.

Thanks so much.

Mr. KUTZ. Thank you.

Senator CARPER. Ms. Thompson, please proceed. Again, welcome.

TESTIMONY OF PENNY THOMPSON,[1] DEPUTY DIRECTOR, CENTER FOR MEDICAID AND STATE OPERATIONS, CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. THOMPSON. Thank you, Mr. Chairman. I am very pleased to be here and have an opportunity to sit with my colleagues and discuss this important topic, and I thank GAO for the work that it has done. We have agreed with all the GAO recommendations and look forward to working with the Agency as we implement those corrective actions.

I have submitted written testimony for the record, but in my oral remarks I would like to draw your attention to what are, I think, the most critical points I would like to make about protecting the Medicaid program from fraud and abuse, not only with respect to controlled substances but also with regard to the hundreds of billions of dollars we pay out every year for health care services of all kinds.

First, commitment is critical. This Administration has placed program integrity at the very center of its management agenda. The Secretary of Health and Human Services (HHS) has stressed to us that we literally cannot afford to allow scarce health care dollars to be diverted to unproductive purposes or for unlawful means. She has asked us to step up our game and work closely with our Federal and State colleagues to ensure that we do everything that we can to prevent, detect, and respond to fraud and abuse in the Medicaid program.

Second, like any other program expending hundreds of billions of dollars each year, virtually millions and millions of transactions, tens of millions of beneficiaries, the last data that I looked at showed that we had about 60 million unique eligible individuals served by Medicaid in fiscal year 2007. We are making payments to very large numbers of providers and entities, and we have the

[1] The prepared statement of Ms. Thompson appears in the Appendix on page 52.

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challenge of protecting that program from fraud and abuse, and it is substantial.

In order to be successful, it is critical for the Federal and State governments to work effectively together. States will always be the first line of defense, and they have obligations to meet in that regard. At the same time, the Federal Government can do a lot to help.

We have had some good success in using Federal dollars designated for Medicaid program integrity, to support seminars and training for both State and Federal staff, focused on Medicaid program integrity.

We have sent Federal employees onsite to work alongside State staff as they addressed specific vulnerabilities or problems within their State borders.

We spent time and effort reviewing State processes and procedures and providing feedback to States on their performance.

We have invested in data analysis and data-mining and algorithm development to identify areas in which we think we can work more effectively with States to address vulnerabilities.

We are also a few weeks away from releasing our 2008 Medicaid Payment Error Measurement. This is the annual measurement that we do, that shows us where we stand with regard to payment errors in Medicaid, and that is an important benchmark for us to use as we look at where we need to promote program improvement, particularly with regard to payment accuracy.

We look forward to accelerating our analysis and audit activities to help inform and expand State efforts and to testing some new ideas and tools with our State partners.

Third, a number of the issues that GAO raises in this very good piece that they are releasing today are really examples of systematic issues that we have in the larger Federal and State enterprise, in which critical data are housed inside various databases, sometimes different formats and different data models and sometimes different fields, codes, and definitions. While we can ensure that we are accessing this data and incorporating into our payment systems today, our ultimate challenge is to unlock that data from their silos and to enable the exchange of that information across the enterprise in an automated and real-time or near-time fashion.

Within Medicaid, CMS and the States have been working on systems modernizations to get our processing environments more modular, more standardized and more interoperable, so we can more easily set up interfaces to and from internal and external data sources and feed that data into the production flow, eliminating the need for manual downloads, data transformations, and rekeying.

Fourth, the specific issue of controlled substances illustrates an area in which we have to pay close attention nationally. To the extent that some of the health care products we pay for on behalf of beneficiaries can be abused or have street value, we must be especially vigilant. I have noted in my testimony that we plan some additional actions to ensure that we are all paying very strict attention to the possibilities of doctor-shopping and diversion, and we look forward to talking more with GAO, DEA, and NASMD about their ideas.

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I look forward to today's hearing and continuing our conversations in the future, and I would be happy to answer any questions you might have.

Senator CARPER. Great. Thanks so much for that testimony and, again, for joining us today. Ms. Kohler, you are recognized.

STATEMENT OF ANN KOHLER,[1] EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF STATE MEDICAID DIRECTORS

Ms. KOHLER. Good morning and thank you for having me here. I represent the 50 States, the District of Columbia, and the territories Medicaid programs.

When discussing fraud, waste, and abuse in Medicaid, it is really important to remember that it is a joint program. The State and the Federal Government pay for the program.

And, we also welcome GAO's work and because States are just as anxious to reduce these problems as the Federal Government is, as Ms. Thompson points out, we cannot afford to spend a single State dollar in error, or Federal dollar. So we are very anxious to work together on this.

Abuse of controlled substances clearly is not just a Medicaid issue. Some of the data you pointed out earlier shows that it is a real national issue. We want to work with our Federal partners and the other insurance companies to help reduce these problems.

Medicaid has spent over $200 million, the States, in their fraud activities, but they recovered over $1.3 billion.

Senator CARPER. For every dollar spent, how much did we recover?

Ms. KOHLER. Usually, it is like a one in 10 ratio overall.

I just want to share a few activities that States have done. Of course, I agree with you totally that it is not perfect. We are going to continue to work on it.

The first is tamper-resistant prescription pads. I was also Medicaid Director of New Jersey, and this was found to be an incredibly effective tool, and we thank Congress for putting it into the Deficit Reduction Act. Having a prescription pad that cannot be erased or whited out and copied has been very effective in New Jersey. I think we would certainly hope that Congress would consider, right now it is only a mandate for Medicaid, but in New Jersey we implemented it for all payers, and it really has been very helpful.

We are also doing a lot of work on E-prescribing, to have a computer system do a lot of the work, and we have drug utilization boards that will match against these to prevent the kinds of things that you saw where people were able to go to multiple doctors and get multiple prescriptions filled.

We have secret shoppers that go in and present, make believe they are a client and try and identify problem doctors.

We do lock-in programs where we limit the client to one doctor and one prescription if we have found that they appear to be doctor-shopping.

Data-mining is critical to our ability to identify fraud, waste and abuse, and we will expand our use of that. And, we want to work, as Ms. Thompson said, each data silo, we need to break them down

[1] The prepared statement of Ms. Kohler appears in the Appendix on page 67.

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and have them work together and find better ways to work across States and share our data.

But we still have issues and things we have to work on. We thank CMS for the Medicaid Integrity Program. The training that they have given to the States has been incredibly helpful to us.

We recognize that State budgets are very strained right now. As I am sure 48 States are in deficit, which makes it difficult to hire the auditors that we need to hire. Again, we thank the Medicaid Integrity Program for providing some Federal staff to do some of this work.

Senator CARPER. Let me interrupt again. You mentioned hiring State auditors. Is any of the collection work being done on a contingency basis?

Ms. KOHLER. No.

Senator CARPER. OK.

Ms. KOHLER. We have Federal rules on contingency.

Senator CARPER. We will come back to that. Thank you.

Ms. KOHLER. OK. One issue that gets raised frequently, and I spoke to your staff about, is what we affectionately call the 60-Day Rule which says that States need to give the Federal Government their share of any overpayment within 60 days of identifying it even if they can never collect it. That has had a bit of a damper on States because they are concerned.

Senator CARPER. I bet it has. Somebody should do something about that.

Ms. KOHLER. We hope so, and Senate Finance is talking about.

Senator CARPER. No, we are not just talking. We actually adopted the amendment.

Ms. KOHLER. Oh, wonderful.

Senator CARPER. We just did it earlier this week.

Ms. KOHLER. Well, thank you very much because that is a very big issue for States. So we are very glad.

Senator CARPER. It is hard to say to States, you ought to go out and follow up on fraudulent cases and where you think the money is being fraudulently misspent. By the way, even if you have not concluded the investigation, you have not recovered the State's share, you have to cough up the Federal share after 60 days. We should not be surprised we do not get a lot of money by doing that.

Ms. KOHLER. Right. Let me give you an example of one State. They have been very aggressive in suing manufacturers over the issue of best price when Medicaid is supposed to get the best price, and they have won some pretty significant judgments against them, but they are all on appeal. So probably the State will not be getting any money anytime soon, but, under the rule, they have to give the Federal Government half of these very large judgments.

So we thank you very much for that change in the 60-Day Rule.

So, in conclusion, let me just say that——

Senator CARPER. Did you say, in collusion?

Ms. KOHLER. No. In conclusion, fraud is not just a Medicaid issue. It is one that our health care system needs to deal with entirely, and we are committed to working with the States and the Federal Government and GAO to help identify ways to reduce fraud, waste, and abuse in the Medicaid program.

So, thank you very much.

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Senator CARPER. Thank you. Mr. Rannazzisi.

TESTIMONY OF JOSEPH T. RANNAZZISI,[1] DEPUTY ASSISTANT ADMINISTRATOR, OFFICE OF DIVERSION CONTROL, U.S. DRUG ENFORCEMENT ADMINISTRATION, U.S. DEPARTMENT OF JUSTICE

Mr. RANNAZZISI. Good afternoon, Mr. Chairman. On behalf of Acting Administrator Michelle Leonhart, I want to thank you for the opportunity to provide testimony today regarding the problem of prescription drug abuse, the illegal distribution of controlled substance pharmaceutical and associated Medicaid fraud.

The mission of the DEA Office of Diversion Control is to maintain the close system of distribution as envisioned by Congress when it enacted the Controlled Substances Act. To accomplish this task, DEA must balance the need to prevent, detect, or investigate the diversion of controlled substances and listed chemicals while ensuring there is an adequate supply to meet the legitimate medical, commercial and scientific needs of the country. All controlled substance diversion ultimately weakens the integrity of the closed system of distribution.

Though DEA does not have a direct role in investigating health care fraud, we do review paper copies of debarment orders from CMS on a monthly basis, and we use that information from those debarment orders to obtain voluntary surrenders of DEA registrants or seek orders to show cause against the registrations where appropriation.

DEA continues to review its methods of operations in an effort to enhance its ability to help identify or prevent fraud, waste, and abuse of resources. We work to ensure that all of our resources are being utilized in a most efficient and effective manner possible.

I would like to take this opportunity to discuss a few examples of how we have developed systems that are secure, efficient, and available for use by health care professionals and registrants.

We have implemented an E-commerce initiative, CSOS, which is the Control Substance Ordering System. It allows businesses to order controlled substances electronically. The system improves efficiency by reducing costs, errors, and paperwork while providing a secure platform to help prevent diversion. The system has been upgraded and now uses state-of-the-art technology and reduces operating costs by more than $6 million annually.

A registrant is required to report to DEA any significant loss or theft of a controlled substance. DEA recently improved this system to allow for a more efficient electronic reporting system where registrants will help identify breaches in the closed system of distribution.

We are finalizing a rule that will allow for electronic prescribing of controlled substances. The proposed system is anticipated to reduce errors, trim costs, and improve health care delivery while increasing security.

And, our Office of Diversion Control is working internally on integrating various electronic database systems that traditionally

[1] The prepared statement of Mr. Rannazzisi appears in the Appendix on page 72.

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have been stovepiped. Once completed, the total integration of these systems will allow DEA to better identify areas of diversion.

DEA recognizes that State also play a significant role in curbing waste, fraud, and abuse of Medicaid reimbursements. To assist in this endeavor, DEA makes its registrant database available in a variety of ways:

First, registrants can perform an online check of the current status of another registrant's DEA registration via the DEA web site.

DEA also provides on a weekly basis a download of the registrant database to 28 specific States that have requested it for use in their health care fraud investigations.

Additionally, DEA provides the registrant database to the National Technical Information Service (NTIS), under the U.S. Department of Commerce. NTIS, in turn, sells this information to the general public.

As pointed out by a recent GAO study, there are several independent systems currently in use that, if paired with other systems' agencies, may be able to better identify potential avenues of fraud, waste, and abuse. To this end, DEA is already working with the Social Security Administration to obtain data that would identify deceased practitioners and reconcile that information with DEA's registrant database.

DEA has reached out to the Centers for Medicare and Medicaid Services for electronic access to databases that identify individuals who have been debarred from participation in the Medicaid program. DEA is reviewing its ability to modify the registration process and inquire whether or not an applicant has ever been convicted of Medicaid or Medicare fraud and whether they have ever been currently debarred from receiving reimbursements from Medicaid and Medicare.

Finally, representatives of DEA and HHS Office of Inspector General have met within the last several weeks to discuss the sharing of information as well as forging a strong investigative partnership that involves controlled substance diversion and health care fraud.

Although health care fraud is not specifically within the statutory authority of DEA, these crimes are often linked to other crimes that do fall under DEA's investigative authority. To become more efficient and to have a greater investigative reach, DEA is establishing a total of 62 Tactical Diversion Squads across the United States which will be deployed in two phases. These groups will utilize investigative talents of diversion investigators, special agents and task force officers from Federal, State, and local law enforcement, and State regulatory agencies.

The primary mission of the Tactical Diversion Squads will be to conduct criminal investigations involving the diversion of controlled substances, pharmaceuticals, or listed chemicals. These investigations frequently identify criminal acts that can be the root cause of debarment actions under Title 42. These investigations often result in criminal, civil, and administrative action against DEA registrants.

One method that currently helps States identify the causes of waste, fraud and abuse is the use of the Prescription Drug Monitoring Program (PDMP). Currently, there are 33 States that use

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some type of PDMP. DEA is a strong and long-supporting advocate of the PDMP. Timely reporting prescriptions to PDMPs and the greater use by participants within those States will only improve the usefulness and success of such systems.

In conclusion, DEA will continue to detect, prevent, and investigate the diversion of controlled substance pharmaceuticals. We will continue to refine our methods and processes to identify and address controlled substance diversion.

I want to thank you for holding this hearing and the opportunity to testify, and I look forward to addressing any questions you may have, sir.

Senator CARPER. Mr. Rannazzisi, thank you very much.

The first question I want to start off with is each of you, I do not know if you have had a chance to read the testimony of your colleagues. Some of you have, maybe some of you have not.

But let me start with Mr. Kutz. As you listened to the comments of our other witnesses, did anything kind of pop out to you that says, you know that makes a lot of sense and why do we not do that or maybe that does not make a lot of sense?

From each of our three witnesses, what kind of raises its head for you as something that maybe we should work on?

Mr. KUTZ. The use of electronic records and data-sharing to prevent the doctor-shopping. I think we saw these drug utilization review programs in place in theory. In practice, they did not all work as effectively as each other. In some cases, you had information available for the pharmacist, for example, that could have actually been used to deter people from doctor-shopping, but they had soft edits in place, and it was easily overridden.

Senator CARPER. You said they had soft edits in place?

Mr. KUTZ. In other words, it was not mandatory that you rejected what was clear doctor-shopping, so you could override, whereas other States had more of a hard edit where the prescription was denied. So that issue of giving the pharmacist a point of sale, electronic information that can determine doctor-shopping has promise to address this issue, in my judgment.

Senator CARPER. All right. Ms. Thompson, the same question, what did you hear from your colleagues at the witness table that said, that is a good one?

Ms. THOMPSON. Well, if I can follow up on the point that Mr. Kutz just made, data inside of silos is killing us—the fact that people do not have access to important information because it does not happen to reside in their own production systems.

Senator CARPER. When you say people do not have access in their own production systems, what kind of people?

Ms. THOMPSON. Whether it is the pharmacist looking at the data inside of a pharmacist's environment, whether it is a State individual who is looking at a drug utilization review but does not have access to the law enforcement data, whether it is the sanctioned data that has to be gotten and pulled down rather than simply moving automatically in the background into the processing environment, it is one of the reasons why we are making such significant investments in things like systems modernization and modularity and exposing business processes so that data can be

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better shared across those organizational divisions and systems divisions.

The other thing that I would build on from Ms. Kohler is this notion that the problems that we face in Medicaid are not much different than the problems that we face in Medicare and not much different than the problems that we face in private insurance. I think that the need to collaborate organizationally and to attack some of these problems as a health care enterprise is also a point that I would build on as well.

Senator CARPER. All right, thank you. Ms. Kohler, same question.

Ms. KOHLER. OK. Well, I could not agree more with what has been said already.

Senator CARPER. You can say it again, if you want.

Ms. KOHLER. OK. We need to build technology that can provide real-time information to the providers, to the patients, so that we know Ann Kohler has been to five doctors over the past month and gotten prescriptions for these five drugs.

We need to be able to link that data. We need to be able to send it across State lines. And, we need to be able to find a way to better automate matches so that we could, for example, match Medicaid against vital statistics every month and identify.

Senator CARPER. Now do you think some States are doing a better job of that than others?

Ms. KOHLER. Some States have been able to put more resources in it than others. I know New York has a very active Medicaid Inspector General. New Jersey has just appointed one, so they are a little bit further behind. But it is an area that is very important to States. The State of Washington is very active, and all States really want to find ways to reduce fraud.

Electronic health records are very important to the Medicaid directors, and a number of States have been working diligently to implement records. I always bring up the State of Alabama who has 98 percent of their people in their database. Ninety-eight percent of all Alabamians are in the electronic health record system maintained by Medicaid, so that they are able to share information back and forth.

Senator CARPER. That is pretty amazing—98 percent of all Alabamians.

Ms. KOHLER. That is very amazing.

Senator CARPER. We are proud of the work we are doing in Delaware, but I do not think we are 98 percent. That is pretty amazing for Alabama.

Ms. KOHLER. Yes. For the electronic health records.

Senator CARPER. All right, Mr. Rannazzisi.

Mr. RANNAZZISI. I believe that the information-sharing piece is important, and I agree with my colleagues about the drug utilization review.

I would like to concentrate more on the use of Prescription Drug Monitoring Programs, though. Prescription Drug Monitoring Programs, in the States that they are operating in, work very well. It is the ability of a doctor to get into a system and see if his patient is actually seeing multiple doctors within a certain time period or visiting multiple pharmacies.

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The key with the Prescription Drug Monitoring Programs is all the prescriptions have to be placed in that program, but all the doctors are not accessing the program. If you are a Medicare or Medicaid doctor, maybe the time is to mandate that because the fact of the matter is you have great systems, but if only 5 or 10 or 15 percent of the doctors are using those systems, it is being underutilized.

A system like the system in Kentucky, the KASPER system, is a perfect example, or the Ohio system, where the doctors, the pharmacies and the regulatory boards are using the systems to the best of their ability, and they are finding things.

Senator CARPER. Who is?

Mr. RANNAZZISI. Kentucky, under the KASPER system and Ohio, I do not remember the name of their system, but those two. The Kentucky system is basically the gold standard system within the Prescription Drug Monitoring Programs, and Ohio has a very good system as well.

Senator CARPER. OK.

Mr. KUTZ. If I could comment on that too because we saw the doctors were not using that database, and so really if you want to step back in the process, I said the drug utilization reviews (DURs) because it was the last line of defense. But, here, you could prevent the doctor from writing the prescription in the first place which means they never get to the pharmacy and do not have a chance to do the doctor-shopping.

If that could ever work, which we did not see it working by the way—if it could work, and it did not work because people were not using it. I mean that is what we saw. It could be better.

Senator CARPER. It did not work because?

Mr. KUTZ. The doctors were not looking. I mean they were prescribing. All the doctors we interviewed said I did not know that this person has gone to 50 other doctors, but they could have had, in some States, the data available to see in fact that person had gone to 50 other doctors for Ambien or OxyContin or whatever the case may be.

So that would mean to me earlier in the process, if you could get it done there, the prescription would not be written in the first place.

Senator CARPER. Let me go back to I do not know who it was. Maybe it was you, Ms. Kohler. Somebody was talking about tamper-resistant prescription pads.

Ms. KOHLER. Yes.

Senator CARPER. I think you were, and I think you also mentioned the E-prescribing. There is a big piece of funding in the stimulus package, about $20 billion.

Ms. KOHLER. Yes, and we thank you for that.

Senator CARPER. It is designed to help move us toward electronic health records for a lot more folks.

To the extent that at some point in time we have a majority of people in this country having electronic health records for them, and we move toward closer to 100 percent, to what extent does that help fix this problem?

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Ms. KOHLER. Well, I think it is going to be very helpful. As a matter of fact, before we started, Ms. Thompson and I were talking about that and our work together.

We thank Congress for that money that is going to be critical to States to get them off the ground. Some States have gotten transformation grants earlier from CMS, and they have been working on their electronic health records, which is how Alabama came to have such a high percent in their database.

It will give providers an opportunity, like the drug diversion, drug monitoring program. Before you prescribe, you will be able to see what the person has received.

So I think the first wave of them will be driven off the claims processing systems that are in place, like Alabama's is right now, but eventually States will get more sophisticated and be able to add enhancements to their programs. I think it will be very important.

Senator CARPER. I was in Cleveland, Ohio, about 3 weeks ago to visit the Cleveland Clinic, not as a patient but as a student. My staff and I went to better understand how Cleveland Clinic, like Mayo Clinic, like Geisinger in Pennsylvania, like Intermountain Health and Kaiser Permanente and the big health co-op, Group Health in Washington State, how they provide better health care, better outcomes, for less money.

One of the things that we spent a fair amount of time talking about was their IT, information technology, and how they have harnessed that into the delivery of health care. They talked about the inability of doctors.

We will say you have a patient who is seeing several doctors in their system. Each of the doctors may be prescribing more and more medicines, and a doctor decides to prescribe yet another medicine. Before the prescription can be filled, their system, the technology is such that it can actually say this is a new drug that is being prescribed, these are the five that this patient is already taking, and if this drug does not work in concert with the other five, that prescription will not be written or filled.

It would seem to me that kind of technology might really help us in a situation where we have somebody trying to get the same prescription filled by a bunch of doctors, dead or alive. That could go a long ways toward fixing the problem.

Let me follow up with Mr. Rannazzisi. I want to go back to something you were saying just a minute ago, but according to your testimony 33 States have operational Prescription Drug Monitoring Programs, eight more States have passed legislation to put such programs in place. I might be wrong, but I think that Delaware is not on either list.

In States like Delaware that apparently do not yet have these programs, who is responsible for monitoring controlled substances, and, in your view, what can be done to get these monitoring programs active in every State, including the First State. That would be Delaware.

Mr. RANNAZZISI. Yes, sir. Well, I do not know. Whenever we go out to talk to the States, the regulatory bodies, the State associations, we always tout how wonderful the Prescription Drug Monitoring Programs are, and there is money available. Between the

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Harold Rogers Grant program and then the NASPER, there is more than enough money available.

I think certain States just do not want to jump into the program because one thing we hear over and over again is privacy issues. People feel that data are somehow going to get out to non-authorized personnel. I believe that is what Florida's biggest problem was before they passed it, was privacy issues.

Law enforcement in most cases does not have direct access. I know the Drug Enforcement Administration definitely does not have access unless we request access on a case-specific basis. So I do not really understand why a State would not jump into the program. It just seems like the next step to prevent diversion, nationwide.

Senator CARPER. I was just talking with our staff member, John Collins, about finding out which States have not gotten on board and just sending a friendly letter, maybe one that Senator McCain would join me in signing, to the governors of the States where they are not doing it and just encourage them to do so. Maybe that would be helpful.

Mr. RANNAZZISI. Thank you.

Senator CARPER. I want to go back to financial incentives. States are, as more and more of our witnesses said, finding it very difficult to balance their budgets. They are running huge deficits in a lot of cases.

We are fighting a tough battle in Delaware, and I think I heard on the radio the other day Pennsylvania, 3 months into the new fiscal year, still had not adopted a budget, and a lot of States are struggling.

How do we, given the plight of States, the rising cost of Medicaid, the inability to fund education programs and a variety of other programs that flow from runaway health care costs, runaway Medicaid costs, how do we better incentivize the States to do what they need. One, to reduce the abuses that are going on but, two, to reduce the outflow of funds that represent their share, the 50 percent share of Medicaid costs?

How do we do this better? How do we get them to do what is in their own best financial interest?

Obviously, one of them is the 60-Day Rule, which we have taken steps to address and fix in the health care markup, where now States can go up to a year to identify fraud in Medicaid, not have to cough up the Federal share after 60 days, even when the States do not have the money. I think that goes a long ways, I hope, in incentivizing the States.

But, hopefully, that will be in the final bill that the President signs into law this year. Beyond that, what do we need to incentivize the States?

I went to Ohio State as an undergraduate. I studied economics, not nearly enough, but one of the things that has always intrigued me, not only as an undergrad but a graduate student, and now to this day I have always been intrigued by how do we use economic incentives, how do we use financial incentives to shape good public policy behavior. As we do our health care legislation, we are trying to find all kinds of ways to do that.

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But how do we use financial incentives, economic incentives, to shape the kind of behavior from States or from providers or doctors or whomever? How do we do that better?

Ms. KOHLER. Well, a number of States are doing pay for performance right now, that they are actually paying you more money if you have a good outcome.

Senator CARPER. They are paying money to whom? I am sorry.

Ms. KOHLER. To the providers.

Senator CARPER. And, in this case, the providers being the doctors, the pharmacies?

Ms. KOHLER. The physicians, mainly.

In the case of fraud, waste, and abuse, right now, the Federal Government funds the Medicaid program 50–50 for their activities. They fund the attorney general's office 75–25. So, certainly a change of that and allowing States to have a 75–25 match would help them.

Senator CARPER. I am sorry. Say that again.

Ms. KOHLER. The Medicaid fraud staff in the attorney general's office of every State, the Medicaid Fraud Control Units are matched at 75 percent Federal dollars, 25 percent State dollars. The same staff doing the same kind of work but in the State Medicaid agency is matched at 50–50.

Senator CARPER. OK. Now in terms of when the investigations recover money that has been fraudulently spent or misspent and it is recovered, is it returned to the States and is the distribution of the recovery?

If the State and the Federal Government are 50–50 on Medicaid, I presume half would go to each. In some States' cases, the States are putting up 40 percent, the Federal Government, 60 percent. I think in some cases it is as much as 70–30, Federal-State.

Ms. KOHLER. That is how it is returned to them, according to what your match rate is.

Senator CARPER. Thank you.

Others talk to me about, again, using financial incentives to shape good public policy behavior. We know what we have in place. We know how we are trying to improve on that. What else can we do, should we do, anyone?

Mr. KUTZ. Well, I would just say that the doctor-shopping and other things here we talked about, there is the other savings you get if you eliminate some of this, of the trips to the emergency rooms and the unnecessary office visits, which we did not calculate how much those are, but they may very well be more than the cost of the drugs.

Senator CARPER. Oh, yes. Did you not mention that in your study? I thought you did.

Mr. KUTZ. Yes, I did, and I think that is important. That is not an additional financial incentive, but if you fix some of the doctor-shopping, you will have the added benefit of savings with less office visits and possibly trips to emergency rooms.

Senator CARPER. That is a good point. Any other ideas, please?

Ms. THOMPSON. I would also just add, following up on the point that Ms. Kohler made.

Typically, the way that the Federal Government supports States and their activities is through the Federal match, and we do have

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various levels of matching for different kinds of activities. We have had good success when we provided 90 percent funding for development of IT systems. We provide 75 percent funding for skilled medical professionals as well as the 50 percent funding for general administrative activities.

And, it is true that we have a 75 percent match—again, these are statutory match amounts—for the Medicaid Fraud Control Units.

I also think that it is true that by providing some of the technical assistance and training, sometimes these are matters of I do not know what to do or I do not know if I have the problem. And so, the idea of sharing information is very important—the idea of providing measurement, so people have quantifiable information to understand where they stand, either in terms of error rates or in terms of things like performance measures, as we go through and look at program integrity operations.

I think then being able to follow back up on corrective actions and assess whether or not those corrective actions have been taken. That is an important element of this as well in order to achieve the success that we want to achieve.

Senator CARPER. OK. I have several questions I want to get to before we adjourn around 4:30, but this would be a question probably for Ms. Thompson and for Ms. Kohler.

I bet a lot of people are going to read the report that GAO has graciously provided for us. They are going to wonder why some fairly common-sense things were not done, have not been done. It sounds like some are being done, but give us a better idea.

Why would States not require a Social Security number or other basic information on a claim before it was paid?

Second, why is basic data-sharing between Federal or State agencies not happening or not happening enough to stop this sort of fraud?

Ms. THOMPSON. I will go first and then jump in with any other thoughts.

Ms. KOHLER. OK.

Ms. THOMPSON. With regard to Social Security numbers, we do allow States to enroll individuals without a Social Security number as long as the individual can demonstrate that they have applied for a Social Security number.

It is also true that there are some beneficiaries who have religious objections to providing Social Security numbers, and we allow them to use a Medicaid identification number.

And, there are a couple of waiver programs in which we allow States to, for very narrow program purposes, not collect Social Security numbers, but in those cases we actually make some adjustments to the Federal match to account for the fact that they are not doing that part of the process.

So, generally speaking, we would expect very much to see Social Security numbers as part of the determination process and as part of the beneficiary file.

Is there anything else that you wanted to mention about Social Security numbers?

Ms. KOHLER. Yes. I think the main thing is that you cannot deny Medicaid eligibility if the person has not given you a Social Secu-

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rity number. So States try to get them as much as they can, but they cannot deny eligibility if the person does not give you one.

And, remember, a lot of Medicaid clients are children. We are adding babies every day. We are adding them before they get their Social Security number and then hoping that the parents will come back and give us one.

Senator CARPER. Good luck.

Ms. KOHLER. It is a challenge. It is an enormous challenge, and we recognize that.

Senator CARPER. That is called the triumph of man's hope over experience or woman's hope over experience.

Ms. THOMPSON. With regard to going and getting the exclusion data and going and getting the death data, we were having conversations about this. I think we have provided guidance around how to do this and when to do it.

Actually, not long ago in 2008, we provided some information around Arizona's process for looking at vital statistics. The IG's office in HHS actually had done a report looking at death data and had identified Arizona as one of those States that seemed to have a handle on this. They seemed to be doing it right. They actually had looked at a number of different States, and Arizona was the one State that had zero errors with regard to some of that death data. So we circulated that information and made States aware of what Arizona was doing.

In that particular case, Arizona had made the investment. They had found the resources and made the investment to combine a lot of that vital record data in one place and make it available to a number of their State program offices, and that was working quite well.

I think what we need to do is follow up more forcefully, and we will plan to do that in the coming months, to really ask for information from each State about what their controls are and how they access these data, whether they know that they are available, whether they access them, who accesses them, how do they come into their systems, how often do they access those data.

Then I think once we have that kind of a report card across the States, to really sit down with others and talk about what is it that we need to do to improve this, so we have more consistency and avoid these gaps and problems.

Ms. KOHLER. I agree 100 percent.

Senator CARPER. The National Governors Association has a Center for Best Practices. It is really a clearinghouse for good ideas, and some you probably have heard, maybe used. In the 8 years I was governor, we really sought in the NGA to strengthen it and to make it a more effective tool for all the States.

I used to say most of the problems we face in Delaware, some other State had grappled with, and we figured out how to solve those problems. What we needed to do was to learn from the other States.

Some of you talked about silos. States can be silos too. But a lot of the best ideas are out there. We just need to identify them, be able to find contacts in other States who have been working on a problem, and get their help. We find a lot of States are proud of

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what they have done and more than willing to provide that assistance.

Not only do we have the National Governors Association, which includes all the governors of all 50 States and the territories, but we also have a National Association of State Budget Directors. These are men and women who go to wake up every morning, worrying about budget deficits, and go to bed at night, maybe sleepless nights, and worry about what to do about their budget deficits.

To what extent are we using entities like the National Governors Association, like their Center for Best Practices, that clearinghouse?

To what extent might we be using the National Budget Directors organization, to take these ideas and to infuse these ideas that in some cases are being incorporated or working, to better inform the other States and to, frankly, get people excited about addressing social problems but also addressing their budgetary shortfalls?

Just think out loud on that, if you will.

Ms. THOMPSON. We do work very closely with them and share information back and forth, to share with our respective members, both the NGA and NASBO.

Senator CARPER. NASBO stands for?

Ms. THOMPSON. National Association of State Budget Officers.

Senator CARPER. Thank you.

Ms. THOMPSON. I worked in OMB for a while, in New Jersey. So I worked with all the organizations. I worked with NGA, NASBO and NASMD at points in my career.

It is getting the State people to talk too, among themselves. Sometimes there are silos, and hopefully they are working on that too.

We do also spend a lot of time with NGA as well as NASMD.

Senator CARPER. What is NASMD?

Ms. THOMPSON. National Association of State Medicaid Directors.

Senator CARPER. Thank you.

Ms. KOHLER. In fact, we were down speaking with the budget officers just a few weeks ago. So we try to maintain those connections and ensure that we are talking with all the constituencies in the States that can help us solve these problems.

Senator CARPER. All right. Any other thoughts on this before we move on?

OK, we have about 10 minutes to go, and I would like to ask a couple more questions. This one is for Mr. Rannazzisi.

Mr. Rannazzisi, prescription drug abuse is the fastest growing addition. As I said earlier, prescription drug abuse may be the fastest growing addiction in this country of ours. In my own State, there has been a rash of pharmacy and home break-ins with thieves looking specifically for controlled substances. I doubt that Delaware is the only State where that is taking place.

How widespread is the use of public health programs like Medicare and Medicaid in acquiring these sources of drugs by addicts or by dealers and do you have any hard numbers on how many pills on the street might actually be paid for by the government?

You do not have to say this is the number but like some idea of a percentage. Less than 10 percent, I presume, but just some idea of how widespread this problem is. Any idea at all?

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Mr. RANNAZZISI. How widespread is the use of Medicaid and Medicare?

Senator CARPER. Yes, Medicaid and Medicare dollars being used to fraudulently acquire drugs. I know that we use Medicare and Medicaid legally to acquire a lot of drugs, but without using dead doctors, dead patients, and that sort of thing. But how widespread is the problem?

Mr. RANNAZZISI. Sir, I do not think we have statistics that I could go to, to determine that. That is something we could look into.

As you have said before and as the testimony has revealed, the prescription drug abuse problem is out of control. I think in 2007 we had 6.9 million non-medical users of prescription medication, psychotherapeutic. I cannot pare that down to how many of those people were using medications obtained illegally through Medicaid and Medicare, but it is something I could look at.

Senator CARPER. OK, fair enough.

This is a question for Mr. Thompson, and I do not know if Mr. Thompson is in the audience.

Ms. THOMPSON. I did not bring him along today.

Senator CARPER. But, since he is not here, I am going to ask Ms. Thompson, his wife, to respond for him.

Ms. Thompson, what are the consequences for those beneficiaries who are caught defrauding the Medicaid program and can their actions ever cause them to be removed from the program?

Ms. THOMPSON. This is a thorny question. If a beneficiary is convicted and incarcerated, then they are disenrolled from the program because they are no longer covered by Medicaid, and that really is the trigger for that kind of an action. There is actually today no specific exclusion authority for a beneficiary, per se.

There are enforcement actions that can be taken to control beneficiaries in terms of how they get their services and from whom—the lock-in provisions that Ms. Kohler mentioned, where we direct beneficiaries to particular providers, and we will only allow for services to be delivered and paid through those particular providers. So that is a way that we address beneficiaries that we believe are abusing the program.

Senator CARPER. OK. If you were able to design a system from the get-go, right from the start, redesign it, any thoughts on how you might do that, on this front?

Ms. THOMPSON. With regard to beneficiaries?

Senator CARPER. It sounds like we do not remove somebody from the program until they have been maybe arrested, charged, convicted, put in jail. Then we take them off. I do not know if that is the right approach or not. If you think it is not, any ideas what might be a better approach?

And, if you want to answer that for the record, you are welcome to do so.

Ms. THOMPSON. I will take that opportunity to give you an answer for the record.

[The information supplied by Ms. Thompson follows:]

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INFORMATION SUBMITTED FOR THE RECORD

Fighing fraud is one of the Obama Administration's top priorities. However, at this time, the Administration is still analyzing the advisability of Medicaid exclusion authority for a beneficiary who participates in Medicaid fraud activities. From a program perspective, the Administration would need to consider numerous factors prior to supporting an exclusion policy, including:

- The existing legal system and due process and whether exclusion of a beneficiary should be contingent upon a conviction and/or civil court judgment and service time for such a conviction and/or judgment.
- The clear definitions needed to determine that a beneficiary knowingly participated in an activity that warrants such an exclusion and how such exclusion may or may not apply to beneficiaries who are unknowingly caught up in a fraudulent scheme.
- The population Medicaid serves, in that the Medicaid population has particularly high mental health needs. Exclusing a beneficiary with such a need may put the beneficiary at risk for a mental health or substance use relapse.
- The scope of a beneficiary exclusion and whether certain hardship factors, including permanent loss of public or private insurance, should be included in determining whether to apply the exclusion and tow hat degree.
- The Administration's goal to ensure coverage for all Americans to lower health care costs and consideration of whether Medicaid exclusion authority may deny Medicaid coverage to some of the most vulnerable and medically needy individuals in our country.

Aside from Medicaid beneficiary suspension or exclusion uthority, States can address beneficiary fraud through Surveillance and Utilization Review Sysems, pre-authorization of services, and a restricted recipient or "lock-in" program.

Mr. KUTZ. Can I just say something on that?

Senator CARPER. OK.

Mr. KUTZ. I mean I think the perception of the risk of getting caught and prosecuted is very low, and that does encourage people to do this. I mean, first of all, the drugs are free, and so you are getting controlled substances for free. So whether you are an addict or a dealer, your cost of goods sold is one or two dollars possibly for a co-pay.

But I think that issue is we saw a lot more activity on the provider and the pharmacy side than the beneficiary with respect to people that were committing fraud. There is not a lot done to those committing fraud on the beneficiary side.

Ms. THOMPSON. I will, if I could, just add a point, though.

Senator CARPER. Sure.

Ms. THOMPSON. I will, in drawing back to some of the initial remarks that you made about the human cost here. To the extent that beneficiaries are suffering from addiction problems and that is causing their drug-seeking behavior, I think part of what we want to do is find those beneficiaries not just because of the financial cost that they are imposing on the program but because they in fact have a health issue that we need to intervene and address.

And so, I would say that with respect to that kind of behavior, that does represent a health program that the Medicaid program is there to try to help address.

Senator CARPER. Back to Mr. Kutz, Mr. Kutz, earlier this year, a representative from Health and Human Services reported to us that for Medicaid the improper payment rate estimate for 2008 was 10.5 percent. Are today's findings relating to doctor-shopping, deceased beneficiaries, deceased doctors, likely to be part of the 10.5 percent estimate of fraud in the Medicaid program?

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Mr. KUTZ. I expect many would not be because the improper payment rate has errors, and it has fraud in it, but it also has things in it that are not necessarily fraud, and there is a lot of fraud that is not in the improper payment rates.

So, if you are talking about doctor-shopping, unless you actually did data-mining around the case picked, that is probably a statistical sample that projects that, you would not know because there was a legitimate beneficiary, a legitimate provider, a legitimate prescription and everything else looked good on paper. So it may be a lot of these would be outside of the actual calculation of an improper payment rate because fraud is very hard to detect even when you pull a transaction.

We had to go out and interview the pharmacist, the doctor, the prescriber to determine these cases. Plus, we had to have all the data available to look at how many pharmacies and doctors that they had gone to for these drugs. So, unless you did that for each case that was projecting out the 10.5 percent rate you described, it would be hard to get them all.

Senator CARPER. OK. Last question, Ms. Thompson, in your testimony, you say CMS conducts reviews of State Medicaid Integrity Programs every 3 years. I think that is what you testified. Why is there such a long time between these reviews? Could more frequent exams help create better programs in the States?

Ms. THOMPSON. Well, I think in part that is the initial program that we established after we received the authority under the Medicaid Integrity Program, that gave us dedicated resources including the ability to hire Federal staff to provide that kind of oversight and technical assistance.

I think one of the things that we need to do in addition to looking at the periodicity of those reviews is really focus them on performance. We have really focused on structure and process, I would say, more so than outcomes and performance.

I think I see us moving towards an approach in which we are testing some of the propositions that we are talking about here today—what are your controls for different kinds of issues—and really ensuring that the actual operational environment is sound from a program integrity perspective.

Senator CARPER. I am going to just ask us to recess for a moment. I am going to check and see if I need to run to my Finance Committee markup. I will be right back.

So we are going to recess for about 3 minutes. I will be right back.

[Recess.]

Senator CARPER. I think we have time maybe for one more before we start voting in the Senate.

Mr. Rannazzisi, according to GAO, one long-term care pharmacy dispensed controlled substances to over 50 beneficiaries after they died because the nursing homes did not notify the pharmacy that they died before the drugs were delivered.

How does DEA ensure that there is no diversion of drugs at a nursing home for such situations and why cannot the nursing homes return the drugs back to the long-term care pharmacy?

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Mr. RANNAZZISI. Let's start off, a lot of nursing homes are not DEA registrants. So we have no inspection authority, so we cannot actually enter the premises with a notice of inspection.

Senator CARPER. When you say a lot, would that be most?

Mr. RANNAZZISI. Many. A lot of States do not, States do not generally license them for controlled substances, and therefore we do not license them for controlled substances.

As far as the destruction, since a nursing home is considered basically a caretaker, they coordinate or they maintain the medicine for the patient. When that patient expires and the medication is there, the problem is since they are not registrants, the Controlled Substances Act has given them no vehicle to return those medications to a registrant which would be a reverse distributor.

There is no mechanism within the Controlled Substances Act. Anytime a non-registrant turns around and distributes to a registrant, that is an illegal distribution under the law. It is going to require some type of statutory change for us to change that.

But, in the meantime, we have offered through regulation the ability for nursing homes to do different things in order to prevent an accumulation of those drugs. For instance, automatic dispensing machines within the nursing homes, that way, they do not have to maintain a large amount of controlled substances. They could just go to the automatic dispensing machine, take what they need, and that is a secure machine.

For Schedule II medications, we are allowing for Schedule II medications pharmacies to partial fill. That way, they do not have to have 100 tablets. They could fill every day, every 2 days, every 3 days without expending that prescription. A normal Schedule II prescription, once it is filled, it is done, and you cannot partial fill. In this case, we are giving them the opportunity to do partial fills.

We are allowing doctors to fax Schedule II prescriptions into the pharmacy for small amounts. Schedule II prescriptions normally not allowed to be faxed, but for a patient in a long-term care facility we are giving the doctor the opportunity, instead of prescribing a large amount, prescribing smaller amounts via fax. That way, it can maintain a very small amount onsite, on-premise, rather than maintain a large amount.

It is a difficult situation with the nursing homes, and I understand what they are going through right now. We are attempting to work with Congress to figure a way for a statutory change.

Senator CARPER. This has been a good hearing. We would not have as good a hearing as we have had without the good work done by GAO. Again, we want to express our thanks to everyone from GAO who has participated in the work that has been done on this. Thanks very much.

Plenty of work still to do, and what you have done at GAO helps inform us and gives us a better path forward, actually several paths forward.

In terms of takeaways, I always ask for takeaways from hearings like this, and I probably should ask that before we leave.

But, in terms of what we ought to be doing, the people who sit on this side of the dais, in the Senate and the House and our staffs, what should we be doing to help address the problems of the abuse, the idea that Federal taxpayers through Medicaid are literally

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coughing up a lot of money that none of us have at the State or Federal level, to help facilitate the purchase of controlled substances, illegal substances, in some cases to make money for drug dealers, in other cases just to feed habits.

We talked a little bit about what we are doing at the Federal level. A lot of money we have provided through the stimulus package, $20 billion for IT programs, to extend those in States across the country. Obviously, from what I have heard here today, that is a very good idea.

The notion that we ought to give States more than 60 days in cases of fraud before they have to pay over to the Federal Government our share of whatever might have been defrauded would give States the opportunity to actually investigate, recover the money and to incentivize them to do what they ought to be doing.

Those are some ideas that are my takeaways.

But, in terms of what else we should be doing and our staffs and people that serve on this Subcommittee, what should be our takeaways, really to add to our to-do lists? Mr. Kutz.

Mr. KUTZ. Well, I think hearings like this are good, and certainly the things that we do, my unique unit that does the forensic audits and investigations, coming with these real-life case studies of fraud is useful to you and the other witnesses at the panel here today, just to help with concrete solutions. You are not talking at a real high level. Now you are talking down at a real fraud level and how did they actually get into the system and what can be done to prevent this in the future.

So I think that is a healthy discussion, and it is good for you to understand what is going on, Members of Congress, and I think it helps the people sitting at the table just to see what we have actually found on the cases in particular.

Senator CARPER. The idea of States doing more and us trying to work through the National Governors Association, the Center for Best Practices there, also the idea of working with the State Budget Officers and maybe Medicaid managers—I had not thought until just now that every State has an attorney general, and they have some interest in these issues as well. If we are smart, we will reach out to them, too.

Ms. THOMPSON. The only other item that I would add is that I think that we should take a look at how available and costly are some of the data feeds that we are asking States to access and if we can make that easier. If we can facilitate some of that access through free data and even create some hubs of that data to make it easier for a single point, for them to come in and get all of that information, I think that would be something we should take a look at.

Senator CARPER. All right, thank you.

Ms. Kohler, again, takeaways for what my colleagues and I and our staffs ought to be doing?

Ms. KOHLER. I think everything that was said here. Some, perhaps, changing the Federal match to make it consistent with what the attorney generals get would help States also.

Senator CARPER. OK, thank you. Mr. Rannazzisi.

Mr. RANNAZZISI. As far as the Prescription Drug Monitoring Programs, anything that you could do to promote those because it real-

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ly helps us, helps the States identify diversion and ferret out diversion.

I just want to bring your attention back to the nursing home program. There is S. 1292 and a companion bill, H.R. 1359 in the House, that addresses that issue on disposal.

Senator CARPER. S. 1292.

Mr. RANNAZZISI. S. 1292 is a Senate bill.

Senator CARPER. Do you know whose bill that is?

Mr. RANNAZZISI. Ms. Klobuchar and Mr. Grassley, and Mr. Stupak in the House.

Senator CARPER. All right, good.

I understand that we have about a 15-day comment period that is open if some of my colleagues have additional questions to share with you. If you get those questions, please respond to them promptly and fully.

I appreciate the efforts that all of you have made in your various roles to address the challenge we have discussed today and others that I am probably not even mindful of.

There is something for all of us to do here and to do better. As I said earlier, everything I do I know I can do better, and I think the same is true for all of us, and we need to do better here. We are doing better in some results, in some respects, but we need to do better still.

I will close with this. I shared this with my colleagues as we were marking up in the Finance Committee, on the issue of the 60 days for States to begin turning over money to the Federal Government for frauds, fraudulent funds that the States have not even recovered and trying to explain why that was a good idea.

When I led off introducing my amendment, I said that a number of years ago, earlier in this decade though, the Congress adopted and President George W. Bush signed into law, legislation creating the Improper Payments Act. We said in the Improper Payments Act, we want States to start identifying improper payments, overpayments, or underpayments and not only to identify improper payments but to report them, and not only to report them but to try to reduce them, and then not only to reduce them but to try to recover monies that have been improperly paid, especially when monies were overpaid.

So it had three things: Identify the improper payments, stop making them, and eventually recover the improper payments.

Last year, using contract auditors in three States, some $700 million worth of improper payments in the Medicare program were recovered—$700 million, and that is a lot of money.

What we are doing now through the work of CMS and others, contract auditors that they have retained, is we are going after not just improper payments or overpayments in those three States. We are going to turn to all 50 States. If we can collect $700 million in three States, what do you think we can do in 50 States?

I think, as I understand it, we were not doing all of Medicare A, B, C, D. It was not the full nine yards, but it was part of Medicare. But now I think we are going to go back, and it is even in the legislation we were just working on, that says let's do the cost recovery in all parts of Medicare, including the Medicare Prescription Drug Program.

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And, using what we have learned in Medicare, let's see if we cannot do a better job in Medicaid.

At the end of the day, we are going to recover a lot of money. In a day when States are going broke practically and Medicaid is the big cost driver there, we are going to help, I believe. In the Medicare program which is supposed to go bust in about 7 years, 8 years, we are going to make a difference there too.

So this is real important work, and we just want to continue to build on the good work that is being done and do it even better.

We are going to be sending letters to all of the governors. I think we said about 10 or so governors that were not participating in one of the programs, including my State, to make sure they are aware of it and the opportunities lost.

I think we might want to mail letters to the attorney generals and share with them maybe some best practices and draw to their attention what is being done.

I want to share in the letter to the governors, the best practices in Alabama. It is still almost too good to be true, but I will shame the other States. If Alabama can be doing this, why are you not? We have some outreach to do.

I do not know that I am going to ask that we reconvene this group, maybe with somebody from CBO, but we might want to do that within less than month, where our staff has the opportunity to talk with you again, maybe even with me, or with the Republican staff too, to come back and revisit what we discussed here and after we have some follow-up questions.

I do not want this just to be a one-time only discussion. I want to make sure this is not just an ongoing discussion but really that we have built an action plan and get more good work. I think CBO should be a part of that, going forward.

All right, well, I am out of time and you probably are as well. My thanks to everybody for being with us, again, for the great work by GAO, and I will look forward to continue work with you in the months to come. Thanks so much.

This hearing is adjourned.

[Whereupon, at 4:42 p.m., the Subcommittee was adjourned.]

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APPENDIX

FOR IMMEDIATE RELEASE

TOM CARPER

UNITED STATES SENATOR · DELAWARE

FOR RELEASE: Sept. 30, 2009
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SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT INFORMATION, FEDERAL SERVICES, AND INTERNATIONAL SECURITY

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

HEARING: "A Prescription for Waste: Controlled Substance Abuse in Medicaid"

Opening Statement of Senator Thomas R. Carper, Chairman

Over the past several months, the American people and those of us in Congress have been engaged in an unprecedented conversation about our nation's health care system. In fact, it may be the most important issue many of us will ever work on. There are a few things we disagree on, but almost everyone agrees that the system is broken. We have seen a dramatic rise in health care costs that is simply unsustainable for American families, for businesses and for our nation as a whole.

In 2007, we as a nation spent over $2.2 trillion on health care. That's nearly 16% of the nation's Gross Domestic Product. As you can see on the chart behind me, in 2007, the average American spent over $7000 on healthcare. Compare that with 1985, where the average was just under $2000. There's been a lot of talk around here about trying to "bend the cost curve" of health care and this is the curve we are talking about. The slope is simply too steep for many of us to climb anymore.

While there are a number of reasons for the rise in health care costs over the past few decades, it is clear that prescription drugs are one of the main drivers of this increase. As you can see in my next chart, in 1985, the average American spent about $90 a year for prescription medicines. Today, they spend over $700 - an increase of nearly 740 percent.

The way medicine is practiced has changed over time. Drugs are now offered to patients who just a few years ago may have been recommended surgery, or received no treatment at all. A new generation of painkillers has been developed to bring comfort to patients who before may have had to simply live with their pain. Their benefits have been proven, but so have some of their potential dangers. While these drugs bring relief, they also have the potential for patients to become dependent or addicted to their powerful effects.

The next chart behind me shows this impact.

Between 1994 and 2004, the population of the United States grew 12 percent, while at the same time the number of prescription drugs dispensed grew 68 percent. The only thing that

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has outpaced this figure is the rate of abuse of those drugs, growing over 80 percent. In fact, more Americans abuse prescription drugs than the number who abuse cocaine, heroin, hallucinogens, Ecstasy, and inhalants – combined.

The Drug Enforcement Administration classifies drugs that are most likely to be abused into a specific category called "controlled substances." A few months ago, we asked the Government Accountability Office to see whether some Medicaid beneficiaries might be abusing the system to obtain these powerful drugs to fuel their own addictions or to sell on the street.

The Government Accountability Office investigated controlled substance prescription claims in five states – New York, North Carolina, California, Illinois and Texas. In total, they make up over 40 percent of all the controlled substances claims paid for by Medicaid.

What GAO found were tens of thousands of Medicaid beneficiaries and providers involved in fraudulent or abusive purchases of controlled substances through the Medicaid program.

GAO found three major sources of fraud and abuse involving controlled substances. The first included beneficiaries engaged in a practice commonly known as "doctor shopping." Over 65,000 Medicaid beneficiaries in the states GAO examined were going to six or more doctors for the same type of controlled substance.

In one case, GAO found two beneficiaries working together to acquire oxycodone, a powerful prescription painkiller, from over 25 prescribers and 9 different pharmacies. In these types of cases, beneficiaries were either feeding their addiction or selling the extra pills on the street. Drug dealers made the profit, while Medicaid footed the bill.

Fraud and abuse of the Medicaid system also appears to be going on beyond the grave. Comparing Medicaid claims to social security data, GAO discovered thousands of controlled substance prescriptions were "received" by dead beneficiaries or "written" by dead doctors.

In one case, a beneficiary submitted a Medicaid application using the social security number of a person who had died in 1980. This beneficiary stayed on the Medicaid rolls for three years and during that time received thousands of controlled substance pills and over $200,000 in medical treatments.

GAO's report also found that more than 65 doctors and pharmacies the government knew were bad apples, but weren't taken out of the Medicaid system. Providers who were barred from federal health care programs for fraud and abuse convictions were still writing or filling prescriptions through Medicaid.

In one specific case, a physician who had been banned after being convicted for writing fraudulent controlled substance prescriptions was still having his prescriptions paid for by Medicaid nearly two years after the incident.

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The problems outlined in GAO's report have fairly simple solutions that in many cases already exist. Proper data sharing agreements and basic fraud prevention controls would go a long way in stopping much of the abuse we will be discussing today. Unfortunately, each state has developed its own individual approach, without regard for the best practices and models available to them. This has resulted in programs full of holes.

It is clear that the Centers for Medicare and Medicaid Services need to do a better job of providing guidance and regulatory enforcement for the states. At the same time, states need to take greater responsibility for preventing and rooting out fraud, waste and abuse from their own backyards.

As a recovering governor, I understand the unique challenges that come along with running a state Medicaid program. As many of you have heard me say before, "If it's not perfect, make it better," and we all share a responsibility to do just that with Medicaid.

GAO's findings are troubling and I look forward to an honest and frank discussion today about what needs to be done to make sure these abuses don't continue. As a member of the Finance Committee, we've had a lot of discussion about how to pay for health care reform. I share the President's belief that any plan we pass in Congress this year should not add a dime to our deficit going forward. One of the ways we can do that is through cutting the fraud, waste and abuse in our current public health care system. We can go a long way in paying for health care reform by eliminating the sort of abuse we will be discussing today.

Finally, before I close, I have one last chart I would like to share.

The dangers of prescription drug abuse have become better known in the past few years as celebrities and other public figures have succumbed to their lethal effects. However, less widely publicized are the millions of American teenagers who abuse the same drugs. And, unfortunately, they're doing so at a rate which should cause alarm. One out of five teenagers in America has abused, or is abusing, prescription drugs. This is a drug problem that could impact any American home with a medicine cabinet. As a father, I certainly find this an alarming statistic.

I make this point so that it's clear that, while there is a financial cost to the fraud and abuse of controlled substances paid for by Medicaid, let's not forget there is a human cost as well. Prescription drug abuse is the fastest-growing addiction in the United States. The difference between a "street drug" like cocaine and a prescription pain pill is that in many cases the federal government is paying to feed this addiction with taxpayer money.
Aside from our financial responsibility, we have a social responsibility to ensure that our public health care system isn't used to further intensify and subsidize a public health crisis.

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STATEMENT OF SENATOR JOHN MCCAIN, RANKING MEMBER

SUBOCMMITTEE ON FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT INFORMATION, FEDERAL SERVICES AND INTERNATIONAL SECURITY

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

"A Prescription for Waste: Controlled Substance Abuse in Medicaid"

September 30, 2009

Senator Carper, thank you for holding this timely hearing on Medicaid today. As Congress continues the debate on health care reform and considers an expansion of Medicaid, we must conduct a vigorous examination of the existing program to root out fraud, waste, and abuse and ensure that it provides quality health care.

Unfortunately, the Medicaid program is fraught with problems. Earlier this year, the Office of Management and Budget reported that approximately $19 billion in improper payments was made by Medicaid last year. The GAO cited continued weaknesses in internal controls for effectively identifying and detecting improper payments by Medicaid, whose expenditures topped $352 billion in fiscal year 2008.

Today, GAO will testify about rampant fraud and abuse of controlled substances obtained through the Medicaid program. We will hear about Medicaid beneficiaries engaging in "doctor shopping"; Medicaid paying for controlled substances for deceased beneficiaries or prescriptions written by dead doctors; and, controlled substances being prescribed or filled by providers banned from the Medicaid program.

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The proposed expansion of the Medicaid program not only exacerbates these problems, but also lessens the quality of health care to its beneficiaries. Medicaid reimbursement rates are so far below those of Medicare and private insurance that an estimated 40% of physicians do not participate in the program. On average, children's hospitals' Medicaid payments are only about 80% of what Medicare would pay for similar services. For physicians, Medicaid pays only 72% of what Medicare pays.

Medicaid is flawed. Physicians don't want to participate in the program. It is prone to waste, and it is prone to fraud and abuse. Yet, my Democratic colleagues want to expand the program. They also want to create a broader, public option health plan for all Americans. The federal government can't run the health care plan it has now. It is unfair to place more low-income Americans into a defective program, and is it irresponsible to offer a broader health plan rife with problems to all Americans.

In closing, I want to thank the witnesses for their participation, and I look forward to hearing their testimony on how we can make Medicaid a more effective program.

Thank you again, Mr. Chairman.

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United States Government Accountability Office

GAO

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

For Release on Delivery
Expected at 3:00 p.m. EDT
Wednesday, September 30, 2009

MEDICAID

Fraud and Abuse Related to Controlled Substances Identified in Selected States

Statement of Gregory D. Kutz, Managing Director
Forensic Audits and Special Investigations

GAO
Accountability * Integrity * Reliability

GAO-09-1004T

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Mr. Chairman and Members of the Subcommittee:

Prescription drug abuse is a serious and growing public health problem. According to the Centers for Disease Control and Prevention (CDC), drug overdoses, including those from prescription drugs, are the second leading cause of deaths from unintentional injuries in the United States, exceeded only by motor vehicle fatalities. There are reports and allegations that criminals and drug abusers are able to illegitimately acquire controlled substances by filing fraudulent Medicaid claims, seeking treatment from medical practitioners for feigned injuries and illnesses, and perpetrating other fraudulent activities.[1] The cost associated with controlled substance fraud and abuse is more than the cost of prescription drug purchases since there are related medical services, such as doctor and emergency room visits, which precede the dispensing of these medications. Several closed criminal cases highlight Medicaid fraud and abuse related to controlled substances.

- An Ohio physician was convicted in 2006 for filing $60 million in fraudulent Medicaid, Medicare, and other insurance claims. The physician, a pain management specialist, prescribed multiple injections of controlled substances for his patients. He then billed Medicaid and other insurance plans for those treatments. The physician was found to have fostered an addiction to controlled substances in his patients so that he could profit from their habit and increase the income he received from their medical claims. Two patients who regularly saw him died under his care; one from a multiple-drug overdose in the physician's office and one from an overdose of OxyContin taken on the same day that the prescription was written. The physician was sentenced to life imprisonment.

- In 2006, a Florida physician was sentenced to life in prison following his conviction on multiple charges, including wire fraud, illegal distribution of controlled substances, and Medicaid fraud. The physician, a general practitioner, wrote excessive prescriptions to patients for controlled substances without giving them physical examinations or additional follow-up treatments. The physician directed patients to have their prescriptions filled at specific pharmacies and warned them against filling their prescriptions at pharmacies that would ask too many questions about the quantity and

[1] For purposes of this report, "controlled substance abuse" refers only to abuse related to drugs or substances that are regulated by the Drug Enforcement Administration (DEA).

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combination of controlled substances prescribed. In fact, the physician was found to have known some of his patients were addicts feeding their drug habits. Five of his patients died from taking drugs he prescribed.

- During 2004 to 2005, a pharmacist created false telephone prescriptions for Vicodin, an addictive narcotic pain reliever that combines hydrocodone and acetaminophen, and provided thousands of the pills to at least two purported customers. The pharmacist also submitted false claims for the drugs to Medicaid and other insurance companies stating that they were prescribed for legitimate patients. The customers were actually friends of the pharmacist who sold the drugs and split the profits with him. In 2009, the pharmacist was convicted of health care fraud, Medicaid fraud, and distribution of dangerous controlled substances.

My statement summarizes our report issued today to your subcommittee.[2] This testimony discusses (1) continuing indications of fraud and abuse related to controlled substances paid for by Medicaid; (2) specific case study examples of fraudulent, improper, or abusive controlled substance activity; and (3) the effectiveness of internal controls that the federal government and selected states have in place to prevent and detect fraud and abuse related to controlled substances.

To identify whether there are continuing indications of fraud and abuse related to controlled substances paid for by Medicaid, we obtained and analyzed Medicaid claims paid in fiscal years 2006 and 2007 from five states: California, Illinois, New York, North Carolina, and Texas. To identify indications of fraud and abuse related to controlled substances paid for by Medicaid, we obtained and analyzed Medicaid prescription claims data for these five states from the Centers for Medicare & Medicaid Services (CMS). To identify other potential fraud and improper payments, we compared the beneficiary and prescriber shown on the Medicaid claims to the Death Master Files (DMF) from the Social Security Administration (SSA) to identify deceased beneficiaries and prescribers.[3]

[2] GAO, Medicaid: Fraud and Abuse Related to Controlled Substances Identified in Selected States, GAO-09-957 (Washington, D.C.: Sept. 9, 2009).

[3] Certain Medicaid claims did not capture the date of the prescription. If the prescribing date was unknown, we based our calculations on the 6 month period prior to the order being filled. This proxy was used as a reasonable estimate to be consistent with the 6 month period allowed for valid refills and partial filling of prescriptions for certain controlled substances.

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To identify claims that were improperly processed and paid by the Medicaid program because the federal government banned these prescribers and pharmacies from prescribing or dispensing to Medicaid beneficiaries, we compared the Medicaid prescription claims to the exclusion and debarment files from the Department of Health and Human Services Office of Inspector General (HHS OIG) and the General Services Administration (GSA). To develop specific case study examples in selected states, we identified 25 cases that illustrate the types of fraudulent, improper, or abusive controlled substance activity we found in the Medicaid program. To develop these cases, we interviewed pharmacies, prescribers, law enforcement officials, and beneficiaries, as appropriate, and also obtained and reviewed registration and enforcement action reports from the Drug Enforcement Administration (DEA) and HHS. To identify the effectiveness of internal controls that the federal government and selected states have in place to prevent and detect fraud and abuse related to controlled substances, we interviewed Medicaid officials from the selected state offices and CMS. More details on our scope and methodology can be found in our report that we issued today.[4]

We conducted this forensic audit from July 2008 to September 2009, in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. We conducted our related investigative work in accordance with standards prescribed by the Council of the Inspectors General on Integrity and Efficiency (CIGIE).

[4] GAO-09-957.

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Tens of Thousands of Medicaid Beneficiaries Visit Multiple Medical Practitioners to Obtain Controlled Substances

Approximately 65,000 Medicaid beneficiaries in the five states investigated visited six or more doctors to acquire prescriptions for the same type of controlled substances in the selected states during fiscal years 2006 and 2007.[5] These individuals incurred approximately $63 million in Medicaid costs for these drugs, which act as painkillers, sedatives, and stimulants.[6] In some cases, beneficiaries may have a justifiable reason for receiving prescriptions from multiple medical practitioners, such as visiting specialists or several doctors in the same medical group. However, our analysis of Medicaid claims found at least 400 of them visited 21 to 112 medical practitioners and up to 46 different pharmacies for the same controlled substance. In these situations, Medicaid beneficiaries were likely seeing several medical practitioners to support and disguise their addiction or fraudulently selling their drugs.

Our analysis understates the number of instances and dollar amounts involved in the potential abuse related to multiple medical practitioners. First, the total we found does not include related costs associated with obtaining prescriptions, such as visits to the doctor's office and emergency room. Second, the selected states did not identify the prescriber for many Medicaid claims submitted to CMS. Without such identification, we could not always identify and thus include the number of unique doctors for each beneficiary that received a prescription. Third, our analysis did not focus on all controlled substances, but instead targeted 10 types of the most frequently abused controlled substances. Table 1 shows how many beneficiaries received controlled substances and the number of medical practitioners that prescribed them the same type of drug.

[5] The approximately 65,000 Medicaid beneficiaries comprise less than 1 percent of the total number of Medicaid beneficiaries in these five states.

[6] The $63 million makes up about 6 percent of the 10 controlled substances that we analyzed in these five states.

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Table 1. Number of Beneficiaries That Received 1 of 10 Controlled Substances from 6 or More Prescribers in Fiscal Year 2006 and Fiscal Year 2007

	Number of prescribers in selected states						
Controlled substance	**6-10**	**11-15**	**16-20**	**21-50**	**51+**	**Total**	**Medicaid amount paid**
Amphetamine derivatives (e.g., Adderall)	2,877	55				**2,932**	$6,616,000
Benzodiazepine (e.g., Valium and Xanax)	14,006	669	85	22		**14,782**	7,266,000
Fentanyl (e.g., Duragesic)	777	41	6	1		**825**	7,810,000
Hydrocodone (e.g., Vicodin and Lortab)	31,364	3,518	723	340	9	**35,954**	9,172,000
Hydromorphone (e.g., Dilaudid)	590	67	14	11		**682**	983,000
Methadone (e.g., Dolophine and Methadose)	824	76	9	2		**911**	546,000
Methylphenidate (e.g., Ritalin and Concerta)	4,821	106	3	1		**4,931**	10,866,000
Morphine (e.g., MS Contin and AVINZA)	810	50	8	1		**869**	4,119,000
Non-Benzodiazepine sleep aids (e.g., Ambien and Lunesta)	2,821	49	5			**2,875**	5,739,000
Oxycodone (e.g., OxyContin and Percocet)	5,349	435	73	18		**5,875**	10,163,000
Total	**54,239**	**5,066**	**926**	**396**	**9**	**70,636**	**$63,280,000**

Source: GAO.

Note: The numbers in the total columns do not necessarily represent unique beneficiaries. A single beneficiary could have been prescribed more than one type of controlled substance by more than one doctor. The number of unique beneficiaries represented in this table is 64,920. The maximum number of doctors from which a beneficiary received 1 of the 10 types of controlled substance prescriptions was 112.

Controlled Substances Prescribed or Filled by Banned Providers

We found 65 medical practitioners and pharmacies in the selected states had been barred or excluded from federal health care programs, including Medicaid, when they wrote or filled Medicaid prescriptions for controlled substances during fiscal years 2006 and 2007. Nevertheless, Medicaid approved the claims at a cost of approximately $2.3 million. The offenses that led to their exclusion from federal health programs included Medicaid fraud and illegal diversion of controlled substances. Our analysis understates the total number of excluded providers because the selected states either did not identify the prescribing medical practitioner for many Medicaid claims (i.e., the field was blank) or did not provide the taxpayer

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identification number for the practitioner, which was necessary to determine if a provider was banned.

Medicaid Paid for Controlled Substance Prescriptions Filled for Dead Beneficiaries or "Written" by Dead Doctors

Our analysis of matching Medicaid claims in the selected states with SSA's DMF found that controlled substance prescription claims to over 1,800 beneficiaries were filled after they died. Even though the selected state programs stated that beneficiaries were promptly removed from Medicaid following their deaths based on either SSA DMF matches or third party information, these same state programs paid over $200,000 for controlled substances during fiscal years 2006 and 2007 for postdeath controlled substance prescription claims. In addition, our analysis also found that Medicaid paid about $500,000 in Medicaid claims based on controlled substance prescriptions "written" by over 1,200 doctors after they died.[7]

The extent to which these claims were paid due to fraud is not known. For example, in the course of our work, we found that certain nursing homes use long-term care pharmacies to fill prescriptions for drugs. One long-term care pharmacy dispensed controlled substances to over 50 beneficiaries after the date of their death because the nursing homes did not notify the pharmacy of their deaths prior to delivery of the drugs. The nursing homes that received the controlled substances, which included morphine, Demerol, and Fentanyl, were not allowed to return them because, according to DEA officials, the Controlled Substances Act of 1970 (CSA) does not permit the return of these drugs. Officials at two selected states said that unused controlled substances at nursing homes represent a waste of Medicaid funds and also pose risk of diversion by nursing home staff. In fact, officials from one state said that the certain nursing homes dispose of these controlled substances by flushing them "down the toilet," which also poses environmental risks to our water supply.

[7] If the prescribing date was unknown, we based our calculations on the 6 month period prior to the order being filled. This proxy was used as a reasonable estimate to be consistent with the 6 month period allowed for valid refills and partial filling of prescriptions for certain controlled substances.

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Examples of Fraud, Waste, and Abuse of Controlled Substances in Medicaid

In addition to performing the aggregate-level analysis discussed above, we also performed in-depth investigations for 25 cases of fraudulent or abusive actions related to the prescribing and dispensing of controlled substances through the Medicaid program in the selected states. We have referred certain cases to DEA and the selected states for further investigation. The following provides illustrative detailed information on four cases we investigated:

- **Case 1:** The beneficiary used the identity of an individual who was killed in 1980 to receive Medicaid benefits. According to a state Medicaid official, he originally applied for Medicaid assistance in a California county in January 2004. During the application process, the man provided a Social Security card to a county official.[8] When the county verified the Social Security Number (SSN) with SSA, SSA responded that the SSN was not valid. The county enrolled the beneficiary into Medicaid provisionally for 90 days under the condition that the beneficiary resolve the SSN discrepancy with SSA within that time frame. Although the beneficiary never resolved the issue, he remained in the Medicaid program until April 2007. Between 2004 and 2007, the Medicaid program paid over $200,000 in medical services for this beneficiary, including at least $2,870 for controlled substances that he received from the pharmacies.[9] We attempted to locate the beneficiary but could not find him.

- **Case 2:** The physician prescribed controlled substances to the beneficiary after she died in February 2006. The physician stated that the beneficiary had been dying of a terminal disease and became unable to come into the office to be examined. The physician stated that in instances where a patient is compliant and needs pain medication, physicians will sometimes prescribe it without requiring an examination. A pharmacy eventually informed the physician that the patient had died and the patient's spouse had continued to pick up her prescriptions for Methadone, Klonopin, and Xanax after her death. According to the pharmacy staff, the only reason they became aware of the situation was because an acquaintance of the spouse noticed him picking up prescriptions for a wife who had died months ago. The acquaintance informed the pharmacy staff of the situation. They subsequently contacted the prescribing physician. Since this incident,

[8] In California, Medicaid applications are submitted to the county, which are then forwarded to the state following a review.

[9] The controlled substance amount is for fiscal years 2006 and 2007.

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the pharmacy informed us that it has not filled another prescription for the deceased beneficiary.

- **Case 3:** A mother with a criminal history and Ritalin addiction used her child as a means to doctor shop for Ritalin and other similar controlled stimulants used to treat attention-deficit/hyperactivity disorder (ADHD). Although the child received overlapping prescriptions of methylphenidate and amphetamine medications during a 2-year period and was banned (along with his mother) from at least three medical practices, the Illinois Medicaid program never placed the beneficiary on a restricted recipient program. Such a move would have restricted the child to a single primary care physician or pharmacy, thus preventing him (and his mother) from doctor shopping. Over the course of 21 months, the Illinois Medicaid program paid for 83 prescriptions of ADHD controlled stimulants for the beneficiary, which totaled approximately 90,000 mg and cost $6,600.

- **Case 4:** Claims indicated that a deceased physician "wrote" controlled substance prescriptions for several patients in the Houston area. Upon further analysis, we discovered that the actual prescriptions were signed by a physician assistant who once worked under the supervision of the deceased physician. The pharmacy neglected to update its records and continued filling prescriptions under the name of the deceased prescriber. The physician assistant has never been a DEA registrant. The physician assistant told us that the supervising physicians always signed prescriptions for controlled substances. After informing her that we had copies of several Medicaid prescriptions that the physician assistant had signed for Vicodin and lorazepam, the physician assistant ended the interview.

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Improved Fraud Controls Could Better Prevent Abuse and Unnecessary Medicaid Program Expenditures

CMS Conducts Limited Oversight over Controlled Substances in the Medicaid Program

Although states are primarily responsible for the fight against Medicaid fraud and abuse, CMS is responsible for overseeing state fraud and abuse control activities. CMS has provided limited guidance to the states on how to improve the state's control measures to prevent fraud and abuse of controlled substances in the Medicaid program. Thus, for the five state programs we reviewed, we found different levels of fraud prevention controls. For example, the Omnibus Budget Reconciliation Act (OBRA) of 1990 encourages states to establish a drug utilization review (DUR) program.[10] The main emphasis of the program is to promote patient safety through an increased review and awareness of prescribed drugs. States receive increased federal funding if they design and install a point-of-sale electronic prescription claims management system to interact with their Medicaid Management Information Systems (MMIS), each state's Medicaid computer system. Each state was given considerable flexibility on how to identify prescription problems, such as therapeutic duplication and overprescribing by providers,[11] and how to use the MMIS system to prevent such problems. The level of screening, if any, states perform varies because CMS does not set minimum requirements for the types of reviews or edits that are to be conducted on controlled substances. Thus, one state required prior approval when ADHD treatments like Ritalin and Adderall are prescribed outside age limitations, while another state had no such controlled substance requirement at the time of our review.

[10] Omnibus Budget Reconciliation Act of 1990, Pub L. No. 101-508, 104 Stat. 1388(1990).

[11] Therapeutic duplication is the prescribing and dispensing of the same drug or two or more drugs from the same therapeutic class when overlapping time periods of drug administration are involved and when the prescribing or dispensing is not medically indicated.

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Under the Deficit Reduction Act (DRA) of 2005,[12] CMS is required to initiate a Medicaid Integrity Program (MIP) to combat Medicaid fraud, waste, and abuse.[13] DRA requires CMS to enter into contracts with Medicaid Integrity Contractors (MIC) to review provider actions, audit provider claims and identify overpayments, and conduct provider education.[14] To date, CMS has awarded umbrella contracts to several contractors to perform the functions outlined above. According to CMS, these contractors cover 40 states, 5 territories, and the District of Columbia. CMS officials stated that CMS will award task orders to cover the rest of the country by the end of fiscal year 2009. CMS officials stated that MIC audits are currently under way in 19 states. CMS officials stated that most of the MIP reviews will focus on Medicaid providers and that the state Medicaid programs handle beneficiary fraud. Because the Medicaid program covers a full range of health care services and the prescription costs associated with controlled substances are relatively small, the extent to which MICs will focus on controlled substances is likely to be relatively minimal.

Selected States Lack Comprehensive Fraud Prevention Framework for Controlled Substances

The selected states did not have a comprehensive fraud prevention framework to prevent fraud and abuse of controlled substances paid for by Medicaid. The establishment of effective fraud prevention controls by the selected states is critical because the very nature of a beneficiary's medical need—to quickly obtain controlled substances to alleviate pain or treat a serious medical condition—makes the Medicaid program vulnerable to those attempting to obtain money or drugs they are not entitled to receive. Instead of these drugs being used for legitimate purposes, these drugs may be used to support controlled substance addictions and sale of the drugs on the street. As shown in figure 1 below, a well-designed fraud prevention system (which can also be used to prevent waste and abuse) should consist of three crucial elements: (1) preventive controls, (2) detection and monitoring, and (3) investigations and prosecutions. In addition, as shown in figure 1, the organization should also use "lessons learned" from its detection and monitoring

[12] Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4(2005).

[13] Although individual states are responsible for the integrity of their respective Medicaid programs, MIP represents CMS's first national strategy to detect and prevent Medicaid fraud and abuse.

[14] In addition, CMS is required to provide effective support and assistance to states in their efforts to combat Medicaid provider fraud and abuse.

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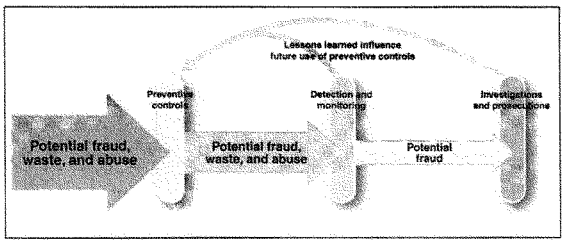
controls and investigations and prosecutions to design more effective preventive controls.

Figure 1: Fraud Prevention Model



Source: GAO.

Preventive Controls: Fraud prevention is the most efficient and effective means to minimize fraud, waste, and abuse. Thus, controls that prevent fraudulent health care providers and individuals from entering the Medicaid program or submitting claims are the most important element in an effective fraud prevention program. Effective fraud prevention controls require that where appropriate, organizations enter into data-sharing arrangements with organizations to perform validation. System edit checks (i.e., built-in electronic controls) are also crucial in identifying and rejecting fraudulent enrollment applications or claims before payments are disbursed. Some of the preventive controls and their limitations that we observed at the selected states include the following.

- **Federal Debarment and Exclusion:** Federal regulation requires states to ensure that no payments are made for any items or services furnished, ordered, or prescribed by an individual or entity that has been debarred from federal contracts or excluded from Medicare and Medicaid programs. Officials from all five selected states said that they do not screen prescribing providers or pharmacies against the federal debarment list, also known as the Excluded Parties List System (EPLS). Further, officials from four states said when a pharmacy claim is received, they do not check to see if the prescribing provider was excluded by HHS OIG from participating in the Medicaid program.

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- **Drug Utilization Review:** As mentioned earlier, states perform drug utilization reviews (DUR) and other controls during the prescription claims process to promote patient safety, reduce costs, and prevent fraud and abuse. The drug utilization reviews include prospective screening and edits for potentially inappropriate drug therapies, such as over-utilization, drug-drug interaction, or therapeutic duplication.[15] In addition, selected states also require health care providers to submit prior authorization forms for certain drug prescriptions because those medications have public health concerns or are considered high risk for fraud and abuse. Each state has developed its DUR differently and some of the differences that we saw from the selected states include the following.
    - Officials from certain states stated that they use the prospective screening (e.g., over-utilization or overlapping controlled substance prescriptions) as an automatic denial of the prescription, while other states generally use the prospective screening as more of an advisory tool for pharmacies.
    - The types of drugs that require prior authorization vary greatly between the selected states. In states where it is used, health care providers may be required to obtain prior authorization if a specific brand name is prescribed (e.g., OxyContin) or if a dosage exceeds a predetermined amount for a therapeutic class of controlled substances (e.g., hypnotics, narcotics).

Detection and Monitoring: Even with effective preventive controls, there is risk that fraud and abuse will occur in Medicaid regarding controlled substances. States must continue their efforts to monitor the execution of the prescription program, including periodically matching their beneficiary files to third-party databases to determine continued eligibility, monitor controlled substance prescriptions to identify abuse, and make necessary corrective actions, including the following:

- **Checking Death Files:** After enrolling beneficiaries, Medicaid offices in the selected states generally did not periodically compare their information against death records.

[15] In addition, state Medicaid offices also perform retrospective analysis to identify patterns of potential waste and abuse of drugs so that pharmacies and Medicaid providers are notified of this potential problem.

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- **Increasing the Use of the Restricted Recipient Program:** In the course of drug utilization reviews or audits, the State Medicaid offices may identify beneficiaries who have abused or defrauded the Medicaid prescription drug program and restrict them to one health care provider or one pharmacy to receive the prescriptions. This program only applies to those beneficiaries in a fee-for-service arrangement. Thus, a significant portion of the Medicaid recipients (those in managed care programs) for some of the selected states are not subject to this program.

- **Fully Utilizing the Prescription Drug Monitoring Program:** Beginning in fiscal year 2002, Congress appropriated funding to the U.S. Department of Justice to support Prescription Drug Monitoring Programs (PDMP). These programs help prevent and detect the diversion and abuse of pharmaceutical controlled substances, particularly at the retail level where no other automated information collection system exists. If used properly, PDMPs are an effective way to identify and prevent diversion of the drugs by health care providers, pharmacies, and patients. Some of the limitations of PDMPs at the selected states include the following:

    - Officials from the five selected states said that physician participation in PDMP is not widespread and not required. In fact, one state did not have a Web-based PDMP; the health care provider has to put in a manual request to the agency to have a controlled substance report generated.

    - No nationwide PDMP exists, and only 33 states had operational prescription drug monitoring programs as of June 2009. According to a selected state official, people would sometimes cross state borders to obtain prescription drugs in a state without a program.

Investigations and prosecutions: Another element of a fraud prevention program is the aggressive investigation and prosecution of individuals who defraud the federal government. Prosecuting perpetrators sends the message that the government will not tolerate individuals stealing money and serves as a preventive measure. Schemes identified through investigations and prosecution also can be used to improve the fraud prevention program. The Medicaid Fraud Control Unit (MFCU) serves as the single identifiable entity within state government that investigates and prosecutes health care providers that defraud the Medicaid program. In the course of our investigation however, we found several factors that may limit its effectiveness.

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- Federal regulations generally limit MFCUs from pursuing beneficiary fraud. According to MFCU officials at one selected state, this limitation impedes investigations because agents cannot use the threat of prosecution as leverage to persuade beneficiaries to cooperate in criminal probes of Medicaid providers. In addition, the MFCU officials at this selected state said that this limitation restricts the agency's ability to investigate organized crime related to controlled substances when the fraud is perpetrated by the beneficiaries.

- Federal regulations do not permit federal funding for MFCUs to engage in routine computer screening activities that are the usual monitoring function of the Medicaid agency. According to MFCU officials at one selected state, this issue has caused a strained working relationship with the state's Medicaid OIG, on whom they rely to get claims information. The MFCU official stated that on the basis of fraud trends in other states, they wanted the Medicaid OIG to provide claims information on providers that had similar trends in their state. The Medicaid OIG cited this prohibition on routine computer screening activities when refusing to provide these data. In addition, this MFCU official also stated that its state Medicaid office and its OIG did not promptly incorporate improvements that it suggested pertaining to the abuse of controlled substances.

Monitoring of Pharmacy and Physician Prescription Practices by DEA Related to Controlled Substances

DEA officials stated that although purchases of certain schedules II and III controlled substances by pharmacies are reported to and monitored by DEA, they do not routinely receive information on written or dispensed controlled substance prescriptions. In states with a PDMP, data on dispensed controlled substance prescriptions are collected and maintained by a state agency. In the course of an investigation on the diversion or abuse of controlled substances, information may be requested by DEA from a PDMP. In those states without a PDMP, DEA may obtain controlled substance prescription information during the course of an inspection or investigation from an individual pharmacy's records.

GAO Recommendations and Agency Response

To address the concerns that I have just summarized, we made four recommendations to the Administrator of CMS in establishing an effective fraud prevention system for the Medicaid program. Specifically, we recommended that the Administrator evaluate our findings and consider issuing guidance to the state programs to provide assurance on the following: (1) effective claims processing systems prevent the processing of claims of all prescribing providers and dispensing pharmacies debarred from federal contracts (i.e., EPLS) or excluded from the Medicare and

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Medicaid programs (LEIE); (2) DUR and restricted recipient program requirements adequately identify and prevent doctor shopping and other abuses of controlled substances; (3) effective claims processing system are in place to periodically identify both duplicate enrollments and deaths of Medicaid beneficiaries and prevent the approval of claims when appropriate; and (4) effective claims processing systems are in place to periodically identify deaths of Medicaid providers and prevent the approval of claims when appropriate. CMS stated that they generally agree with the four recommendations and that it will continue to evaluate its programs and will work to develop methods to address the identified issues found in the accompanying report.

Mr. Chairman, this concludes my prepared statement. Thank you for the opportunity to testify before the Subcommittee on some of the issues addressed in our report on continuing indications of fraud and abuse related to controlled substances paid for by Medicaid. I would be happy to answer any questions from you or other members of the Subcommittee.

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STATEMENT OF

PENNY THOMPSON
DEPUTY DIRECTOR,
CENTER FOR MEDICAID AND STATE OPERATIONS
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

CONTROLLED SUBSTANCE ABUSE IN MEDICAID

BEFORE THE

SENATE HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS COMMITTEE
SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT INFORMATION, FEDERAL SERVICES, AND INTERNATIONAL SECURITY

SEPTEMBER 30, 2009

CMS

CENTERS for MEDICARE & MEDICAID SERVICES

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TESTIMONY OF
PENNY THOMPSON
DEPUTY DIRECTOR,
CENTER FOR MEDICAID AND STATE OPERATIONS
IN THE
CENTERS FOR MEDICARE & MEDICAID SERVICES
ON
"A PRESCRIPTION FOR WASTE: CONTROLLED SUBSTANCE ABUSE IN MEDICAID"
BEFORE THE
SENATE HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS COMMITTEE
SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT INFORMATION, FEDERAL SERVICES, AND INTERNATIONAL SECURITY

SEPTEMBER 30, 2009

Chairman Carper, Senator McCain, and distinguished Subcommittee members, thank you for inviting me here to discuss the Government Accountability Office (GAO)'s report on Medicaid Fraud and Abuse Related to Controlled Substances. Let me begin by stating that the President, Secretary Sebelius and the Department of Health and Human Services (HHS), and the Centers for Medicare & Medicaid Services (CMS) are committed to protecting our health care programs from fraud, waste, and abuse. While CMS realizes that we have to be constantly vigilant against new and emerging threats and schemes, the Agency believes it should insist on near perfect performance to assure that inappropriate payments are not made to ineligible providers or on behalf of ineligible beneficiaries. In addition, CMS expects States to utilize the wide variety of tools currently available to them to ensure Medicaid does not subsidize addiction to or diversion of controlled substances.

For our part, the Federal government must do a better job of measuring States' performance and results, drawing national attention to program vulnerabilities, deploying tools, and building capability to prevent and attack fraud. To this end, CMS agrees with each of the four

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recommendations made by the GAO. However, CMS would like to point out that implementing the changes recommended by the GAO requires cooperation by other Federal agencies to facilitate data sharing and other technical assistance. CMS continues to evaluate its programs and will work to develop methods to address the identified issues found in the GAO study.

Federal-State Relationship in the Medicaid Program

Medicaid is a partnership between the Federal government and the States. State governments have a great deal of programmatic flexibility within which to tailor their Medicaid programs to their unique political, budgetary, and economic environments. As a result, there is considerable variation among the States in eligibility, services, and reimbursement rates to providers and health plans. The Federal government reimburses the States a portion of their costs through a statutorily determined matching rate called the Federal Medical Assistance Percentage, or FMAP, that normally ranges between 50 and 76 percent. The American Recovery and Reinvestment Act (ARRA, P.L. 111-5) temporarily increased FMAP rates by a minimum of 6.2 percent through December 31, 2010. In CY 2010, total Medicaid expenditures – those that include both Federal and State contributions – are estimated to be approximately $419 billion.[1]

While the Federal government sets broad guidelines and provides matching payments to the States, each State is responsible for administering and designing its own program within Federal parameters. The States enroll providers, set reimbursement rates, and negotiate managed care contracts. Each State, therefore, is primarily responsible for oversight of its Medicaid program.

[1] 2009 National Health Expenditures Data (Table 3)

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Let me take this opportunity to talk about several steps CMS has taken to strengthen Medicaid program integrity with respect to all types of claims and services, including prescription drugs. Congress gave CMS new authority in the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) to establish and operate the Medicaid Integrity Program (MIP). This program parallels similar authority granted to the Medicare program roughly a decade ago. However, the Medicaid program differs in several important aspects, including authority to use some of the funding for hiring federal employees, not just contractors, and a requirement to provide support and assistance to States to combat provider fraud and abuse.

Medicaid Integrity Program

Section 6034 of DRA implemented the Medicaid Integrity Program within Section 1936 of the Social Security Act. The Act directs the Secretary to establish a 5-year comprehensive plan to combat fraud, waste, and abuse in the Medicaid program, beginning in FY 2006. The first comprehensive Medicaid Integrity Plan covering FY 2006-10 was released in July 2006; the second, covering FY 2007-11, was released in October 2007; the third, covering FY 2008-12, was released in June 2008; and the fourth, covering FY 2009-13, was released in July 2009.

Through MIP, CMS is committed to working with States to identify and eliminate fraud in the Medicaid program. The MIP offers a unique opportunity to prevent, identify, and recover inappropriate Medicaid payments. It also supports the efforts of State Medicaid agencies through a combination of oversight and technical assistance. Although each State works to ensure the integrity of its respective Medicaid program, the MIP provides CMS with the ability

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to more directly ensure the accuracy of Medicaid payments and to deter individuals who would exploit the program.

The DRA states that CMS must enter into contracts to perform four key oversight activities: 1) review provider actions; 2) audit claims; 3) identify overpayments; and 4) educate providers, managed care entities, beneficiaries, and others on payment integrity and healthcare quality. CMS has completed the process of awarding MIP review and audit contracts, which now cover the entire country. Audits completed between 2007 and 2009 have identified $8.5 million in final overpayments as of August 26, 2009. These overpayments were identified through both direct provider audits as well as automated reviews of State claims. CMS has identified an estimated $68 million in potential overpayments, mostly through similar automated reviews. These payments will be further evaluated by MIP contractors. It is important to note, however, that these overpayment amounts do not directly correlate to fraudulent payment amounts. Rather, many of these errors are the result of documentation and processing mistakes.

Also within Section 6034 of the DRA, CMS received enhanced funding for Medicaid fraud efforts, specifically the national expansion of the Medicare-Medicaid (Medi-Medi) Data Match Pilot Program. Matching Medicare and Medicaid claims data to find patterns of fraud, previously undetectable to the programs individually, has provided State and Federal law enforcement and program integrity units with dramatic insights into the overall practices of providers who are exploiting both programs. In FY 2008, 30 Medi-Medi cases were referred to law enforcement, over $27 million in overpayments were referred for collection, and $7 million in improper payments were caught before erroneous payments were made.

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In addition to implementing key program integrity functions such as reviewing Medicaid providers and identifying inappropriate payments, the DRA requires CMS to provide effective support and assistance to States to combat fraud and abuse. CMS provides this support in the form of State program integrity reviews, training opportunities, resource support for special projects, and ongoing technical assistance. I would like to talk about a few specific support mechanisms that CMS has developed.

Training of State Program Integrity Staff – The Medicaid Integrity Institute

The Medicaid Integrity Institute (MII) was established in September 2006 to provide quality education on program integrity to State Medicaid employees free of cost. Through an interagency agreement with the National Advocacy Center of the U.S. Department of Justice (DOJ)'s Office of Legal Education, CMS supports training in all aspects of program integrity. Since February of 2007, more than 1,300 State employees have been trained at the MII. CMS and the MII have hosted 26 different classes during that time. In FY 2008 and 2009, CMS expended $2.05 million on the MII. The MII will sponsor at least 12 classes in FY 2010 which will provide program integrity education to an estimated 700 additional State employees.

State Program Integrity Reviews

In addition to the MII, CMS conducts comprehensive management reviews of each State's Medicaid program integrity procedures and processes on a triennial basis. Through these reviews, CMS assesses the effectiveness of State program integrity efforts and determines whether a State's policies and procedures comply with Federal regulations. CMS also uses the reviews to identify and disseminate effective practices.

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The most common regulatory violations cited in these reviews include: the failure to collect required ownership, control, and criminal conviction disclosures; the failure to require disclosure of business transaction information; and the failure to report adverse actions on providers to the HHS' Office of Inspector General (OIG). The most common vulnerabilities, which can place State program integrity at greater risk than regulatory violations, include: inadequate protections in the provider enrollment process; lack of exclusion checking after initial enrollment; undocumented program integrity procedures; failure to disenroll inactive providers; inadequate oversight of Medicaid managed care organizations; and ineffective relationships with State Medicaid Fraud Control Units (MFCU).

The States have responded positively to the reviews, indicating that they will implement corrective actions in response to the regulatory findings identified in the reviews. CMS has posted an annual summary of effective practices, findings, and vulnerabilities on its website.[2] CMS has also identified States with effective practices by name so State Medicaid agencies may consult each other and collaborate on what may work in their State.

State Program Integrity Assessment

Following the groundwork laid by the State Medicaid program integrity reviews, the State Program Integrity Assessment (SPIA) is CMS's first national data collection on State Medicaid program integrity activities. The SPIA provides standardized data that can be used for program evaluation and technical assistance and support to States, and allows both the States and CMS to

[2] http://www.cms.hhs.gov/FraudAbuseforProfs/Downloads/2008pireviewannualsummaryreport.pdf

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identify areas of opportunity to build on current practices, and areas where improvement is needed. The States and CMS will be able to use the SPIA to gauge our collective progress in improving the overall integrity of the Medicaid program. Thus far, CMS has taken information collected from the SPIA to develop individual reports for each State and the District of Columbia's FY 2007 data using 25 key questions from the SPIA data collection instrument.

States reported in FY 2007 that they employed 3,799 program integrity staff and expended $181 million on program integrity activities. States conducted 54,829 audits that resulted in the recovery of $568 million. While individual State performances are as varied as their operations, overall the States have reported robust recoveries and return on investment in program integrity. The States reported they recovered $1.3 billion from all program integrity-related activities, or a cumulative return on investment of $7 for every dollar spent on the programs.[3] The FY 2007 SPIA reports, along with a complete data set and high-level executive summary, are available on the CMS website.[4] CMS has recently begun FY 2008 data collection, and the Agency looks forward to continuing this valuable partnership with the States that will only improve State Medicaid program integrity.

Dissemination of Best Practices and Review of Program Data

In response to an OIG audit report (A-05-05-00030), CMS provided guidance to the States to periodically identify deaths of Medicaid beneficiaries and prevent the approval of claims when appropriate. In a memo dated May 2008, guidance was given for State Medicaid agencies to work with other relevant agencies in their State to eliminate payments for services claimed to

[3] http://www.cms.hhs.gov/FraudAbuseforProfs/11_SPIA.asp
[4] Ibid.

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have been provided to deceased beneficiaries. States were also provided information on the Arizona Medicaid agency's implementation of the Arizona Health Care Cost Containment System, which was identified by CMS for utilizing a noteworthy approach to addressing this problem.

Beginning in 2009, CMS has been working to make timelier the Medicaid Statistical Information System (MSIS), the primary source of national Medicaid program data. Working with the CMS Office of Information Systems (OIS) and the States, CMS has converted the quarterly tape submissions for the eligibility and claims data to Electronic File Transfers (EFT) systems. As of September 15, 2009, 47 States and the District of Columbia are now submitting their files electronically, reducing the delays associated with the mailing and processing of tape files. The 3 remaining States will submit their files electronically no later than the end of 2009.[5]

CMS has also worked to identify additional data collection needs beyond the data currently collected in MSIS to improve national Medicaid fraud and abuse reviews. CMS initiated a review to identify and request more detailed data to conduct national Medicaid fraud and abuse reviews. A cross-agency Data Element Workgroup was then established. The workgroup consists of representatives from CMS as well as the HHS OIG. The workgroup also consulted with State Medicaid agency representatives. The fundamental goal of the workgroup was to develop a list of Medicaid data elements that could be captured in a single submission of data from the states to fulfill the requirements of the MSIS, MSIS Plus, Medi-Medi and PERM programs. These data elements were identified for enhanced fraud detection and prevention,

[5] The three remaining States are: Colorado (CMS is in contact with State to begin testing); Nebraska (actively testing), and Utah (actively testing).

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reduced costs and increased quality in information systems and increased efficiency and accuracy in data analysis. In fulfilling this goal, the burden on the States to provide data to CMS should be reduced and the ability of the Agency to work with Medicaid data should be improved.

Other CMS Program Integrity Efforts

While CMS has implemented a number of successful Medicaid program integrity initiatives, the Agency is committed to further strengthening these activities going forward. This commitment specifically includes comprehensive strategies to address on a national basis the vulnerabilities in Medicaid program integrity. Our efforts to combat problems identified in State provider enrollment processes offer examples of this approach.

States face significant challenges in their attempts to successfully monitor Medicaid claims and keep unscrupulous providers out of their Medicaid programs. There is a recognized advantage in a common provider enrollment system that would create efficiencies of scale and improve program integrity. CMS is laying some ground work for such a system now and will work with States to explore this concept further. Such a system may include automated file checks of Federal exclusions, Social Security numbers, date of death, and State licensing board records.

One of the most common problems we learned from our discussions with States was the need for manual entry of data. For example, Medicaid eligibility files include the beneficiary date of death when such information is received. A State Medicaid agency may obtain that information from data collected by another State agency, or it may possibly receive the Social Security Agency (SSA)'s death master file. In either case, however, the data on date of death often cannot be automatically integrated into the State's Medicaid payment system. Instead, because

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of systematic issues, the date of death must be manually keyed-in, inevitably resulting in errors in data entry, such a data entry clerk inadvertently entering a date of death as 9-1-2009 instead of 1-9-2009. Errors like these would mistakenly allow payments to be made for several months after a beneficiary's true date of death.

To assist States in correcting these issues, CMS has: notified States of the need to review and correct claim payments that were made for services provided after the date of death; advised States to review system functions to determine if these payments were a result of system problems; and begun to set up a process to conduct periodic reviews of all State eligibility files against the SSA death master file to ensure continued compliance.

Concurrently, CMS has taken a variety of other actions to assist States with provider enrollment issues. In June 2008, CMS issued a letter to State Medicaid Directors (SMD) clarifying Federal policy prohibiting payment to providers excluded from participation in Medicaid. CMS advised the States that providers may become ineligible for participation in their Medicaid programs after enrollment, and strongly recommended States conduct monthly checks for exclusions from program participation. CMS issued another SMD letter in January 2009 that advised States to require providers to check the OIG exclusion list monthly for names of employees and contractors that were also subject to exclusion.

Our recent accomplishments illustrate CMS' program integrity strategy: CMS will continuously review and test States' program integrity capabilities through triennial program integrity reviews, our ongoing data analysis, and our use of the SPIA collection tool, all with the aim of identifying vulnerabilities as well as effective program integrity practices. When problems are identified,

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CMS addresses them using a wide variety of available tools, including audits to collect overpayments; issuance of performance standards; other guidance documents; providing technical assistance to help States correct the problem; and program integrity reviews to ensure that the issue has in fact been addressed. And through the MII, CMS offers ongoing training to States' program integrity employees to provide them with the knowledge and tools they need to further improve their State program integrity efforts, and thus, protect Medicaid dollars.

Drug Utilization Review Program

CMS also believes that drug monitoring and drug utilization reviews should be effective in promoting program integrity, just as they are in promoting safety, quality care and preventing prescription errors. The enactment of the Omnibus Reconciliation Act (OBRA) of 1990 created the Medicaid Drug Utilization Review (DUR) Program to implement these types of reviews within the Medicaid program and its use is required for providers to receive Medicaid reimbursement for covered outpatient drugs. States were also encouraged by enhanced Federal funding to set up DUR programs and design and install point-of-sale electronic claims management systems that interface with their MMIS operations. Federal regulations also require States to submit an annual DUR report. These reports provide an excellent measurement tool to assess how well efforts to address issues of patient safety and provider prescribing habits are working. In addition, the DUR reports identify dollars saved by avoidance of problems, such as drug-drug interactions, drug-disease interactions, therapeutic duplication, and over-prescribing by providers, and outline statements of purpose that specify working relationships with other State units, such as the MFCUs.

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Prescriptions undergo DUR both before they are dispensed (prospective DUR) and after they are dispensed (retrospective DUR). Prospective DUR takes place by automatically prescreening the prescription prior to its being dispensed. Retrospective DUR is a broader analysis of prescribing patterns and may focus on a specific provider or specific drug use in individual patients. The State Medicaid plan must provide for a retrospective DUR program for ongoing examinations, at least quarterly, of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and Medicaid recipients. The DUR program also looks for suspicious patterns associated with specific drugs or groups of drugs. This examination must involve pattern analysis, using predetermined standards of physician prescribing practices, drug use by individual patients and, where appropriate, dispensing practices of pharmacies.

That said, the GAO report has identified some cases where DUR procedures did not appear to work. CMS is already in the process of updating the DUR annual report instructions used to measure State performance. We are adding new sections to address fraud and abuse detection practices, and will provide States with a list of best practices so that all States may learn from fraud and abuse deterrence and detection practices that other States have initiated.

Health Care Fraud and Abuse Control (HCFAC) Funding

Program integrity and fiscal oversight is an integral part of CMS' financial management strategy and a high priority is placed on detecting and preventing improper or fraudulent payments. To that end, CMS has made significant changes to our program integrity activities in recent years.

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These changes include the creation of new divisions within CMS to focus on identifying problem areas through trend analysis of claims data.

Title II of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) established the Health Care Fraud and Abuse Control Program (HCFAC) program to detect, prevent, and combat health care fraud and abuse. HCFAC is comprised of three separate funding streams, and HCFAC funding supports four key CMS program integrity strategies: prevention, early detection, coordination, and enforcement. Each of these strategies is designed to ensure that CMS can address payment issues as quickly and efficiently as possible, and allows the Agency to coordinate with our colleagues at OIG, DOJ, and the Federal Bureau of Investigation (FBI) in identifying, fighting, and prosecuting fraud and abuse.

The President has made increased HCFAC funding a strong priority by requesting $311 million in additional discretionary resources in his FY 2010 Budget Request. This fund will enable CMS to expand our existing efforts against fraud and abuse in the Medicaid and CHIP programs. This appropriation will supplement existing HCFAC programs, such as our regional HCFAC satellite offices, and strengthen combined HHS/DOJ investigatory efforts into Medicaid (through the MIP), and CHIP. CMS appreciates the $198 million in new discretionary funding Congress provided for HCFAC in the Omnibus Appropriations Act of 2009 (P.L. 111-8) and again asks that Congress fully fund our request for FY 2010.

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Conclusion

Finally, I would like to point to larger reforms such as electronic health records and medical homes which, if successful, not only may hold promise for reducing overall health care costs, improving care coordination, and improving health care outcomes, but may also strengthen program integrity and address identified vulnerabilities such as doctor shopping and drug diversion.

CMS is strongly committed to protecting taxpayer dollars and ensuring the sound financial management of the Medicaid program. As evidenced by my testimony today, the Agency recognizes the need for stronger guidance for State Medicaid agencies to address the issues raised by the GAO. CMS has made progress, but there remains more work to be done to root out waste, fraud and abuse in the Medicaid program. We appreciate the discretionary HCFAC funding appropriated by Congress in FY 2009, and ask that Congress fully fund the President's FY 2010 HCFAC Budget request. CMS will use any funds appropriated by Congress to build upon our work and rapidly respond to emerging program integrity vulnerabilities. CMS looks forward to continuing to work cooperatively with the Congress and this Subcommittee in protecting taxpayer dollars and improving the fiscal integrity of the Medicaid program.

I look forward to answering any questions you might have.

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NASMD

National Association of State Medicaid Directors

an affiliate of the American Public Human Services Association

STATEMENT OF
ANN CLEMENCY KOHLER
DIRECTOR, NATIONAL ASSOCIATION OF STATE MEDICAID DIRECTORS
AMERICAN PUBLIC HUMAN SERVICES ASSOCIATION

BEFORE THE
SENATE HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS COMMITTEE
SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT INFORMATION, FEDERAL SERVICES, AND INTERNATIONAL SECURITY

A PRESCRIPTION FOR WASTE: CONTROLLED SUBSTANCE ABUSE IN MEDICAID
SEPTEMBER 30, 2009

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Introduction

Chairman Carper, Ranking Member McCain, and Distinguished Members of the Panel: Thank you for the opportunity to discuss current State Medicaid Agency activities to reduce fraud, waste and abuse of controlled substances, and to suggest ways to improve the ability of states to effectively identify, monitor and combat these issues. My name is Ann Clemency Kohler and I am the Director of The National Association of State Medicaid Directors (NASMD). NASMD is a professional, non-profit organization of representatives of state Medicaid agencies, including the District of Columbia, the Commonwealth of Puerto Rico, and the territories. The primary purposes of NASMD are to serve as a focal point of communication between the states and the federal government, and to provide an information network among the states on issues pertinent to the Medicaid program. Prior to NASMD, I was State Medicaid Director in New York and New Jersey, as well as in a management position in New Jersey's Office of Management and Budget.

When discussing fraud, waste, and abuse in Medicaid, it is important to remember that Medicaid is a jointly operated and jointly funded program. While the Federal government finances approximately 57% of Medicaid outlays, on average, the remaining funds come from State General Funds. In Many States, Medicaid represents the largest program in the State budget. States have as much of a vested interest in the integrity of the Medicaid Program as the Federal government. For that reason it is important to collaborate on productive ways to prevent fraud and abuse and to quickly identify and address problems when they occur.

It is also important to remember that abuse of controlled substances is not solely a Medicaid issue. According to a 2007 report by the Coalition Against Insurance Fraud, abuse and fraud related to drug-diversion scams costs private insurers nearly $25 billion annually. This represents over 1/3 of all costs related to drug-diversion scams[1]. The Medicare prescription drug benefit is not immune to provider and beneficiary fraud either, as several GAO recent reports suggest[2 3]. Fraud, waste and abuse are significant issues that all insurance providers must address. Medicaid agencies, like other health insurers, are attempting to mitigate these issues through a variety of activities intended to identify and prevent fraudulent activities and to strengthen existing protections. Additionally, fraudulent behavior occurs in very small segments of the population. It is easy to become reactive to high-profile, worst-case examples, but Medicaid agencies must balance activities to identify fraudulent behavior with the need to ensure that the vast majority of honest providers and beneficiaries receive necessary services.

Current State Efforts

States are currently involved in a number of efforts to reduce the incidence of fraud and abuse related to controlled substances. All State Medicaid agencies engage in fraud and abuse prevention, detection and correction activities. According to self-reported data, States estimate that they expended $181 Million on program integrity activities during

[1] http://www.insurancefraud.org/downloads/drugDiversion.pdf
[2] http://www.gao.gov/new.items/d08760.pdf
[3] http://oig.hhs.gov/oei/reports/oei-03-07-00380.pdf

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Federal Fiscal Year 2007, which resulted in approximately $1.3 Billion in Medicaid recoveries due to improper payments, fraud and abuse. Some of these activities include:

- *The implementation of tamper-resistant prescription pads*
  In 2007, Congress passed a requirement that all Medicaid prescriptions be written on "tamper-resistant" pads. These pads are intended to prevent copying of blank prescriptions, prevent individuals from erasing or modifying information on the prescription, and prevent counterfeit prescriptions. On October 1, 2008, States were required to be in full compliance with these requirements.
- *Electronic prescriptions*
  Many states have been using Health Information Technology, funded through Medicaid Transformation Grants and other mechanisms, to develop E-prescribing technology. This technology not only reduces accidental provider error, but can also help identify patterns of abuse by providers and by beneficiaries.
- *Secret shoppers*
  Many States have also been involved in the development and implementation of "secret shopper" initiatives. In these programs, Medicaid investigators pose as beneficiaries to probe providers suspected of fraud and abuse. States have been able to identify and correct a number of instances of providers not complying with Medicaid policies through these projects.
- *Treatment Control Mechanisms*
  Medicaid agencies have established a number of mechanisms to monitor and control drug utilization within the program. Some of these mechanisms include requiring prior-authorization for certain classes of prescription drugs, performing utilization reviews on services provided, limiting the number of prescription drugs available in certain classes, and implementing Preferred Drug Lists for beneficiaries. These policies limit beneficiary access to drugs with high potential for abuse, and allow agencies to flag cases where exceptional treatments have been prescribed or acquired.
- *Establishing Lock-in Programs*
  One of the most common mechanisms for individual fraud and abuse is "Doctor-shopping," where individuals go to a number of doctors and pharmacies in order to receive multiple prescriptions of the same drug. Many states are establishing or enhancing lock-in programs, which restrict provider and pharmacy access for individuals suspected of fraudulent behavior.
- *Surveillance and Utilization Review Systems*
  States regularly utilize SURS systems to identify cases of inappropriate prescriptions, over-prescribing, provider malpractice and other potential instances of fraud and abuse. According to the CMS State Program Integrity Assessment, all 50 states engage in some type of SURS data mining to identify potential cases of fraud[4]. While not every single case is resolved, States are able to identify and mitigate a significant amount of abusive activity.
- *Program Data Matching*
  A variety of mechanisms exist to increase data integrity by matching information from other public programs. States are currently in the process of developing electronic data sharing systems with the Social Security Administration to process

[4] http://www.cms.hhs.gov/FraudAbuseforProfs/Downloads/spiaffy2007executivesummary.pdf

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Medicare Part-D Low-income Subsidy Applications. Many LIS clients are also dual-eligible for Medicaid and this information can be used to ensure that client data is consistent across programs. States also have the ability, through the State Data Exchange, to receive timely information from the Social Security Administration regarding individuals receiving SSA Benefits. These programs are crucial for verifying Medicaid eligibility, including identifying individuals who have died since entering the program.

Challenges and Recommendations

As I discussed, States are engaged in a number of activities to prevent fraud, waste, and abuse; however, there are still significant issues that must be addressed to improve the effectiveness and efficiency of integrity activities. While States are committed to further reducing incidence of fraud, waste and abuse, several structural issues create significant challenges when states attempt to establish these projects. These include:

- *The 60-Day Repayment Rule*
  When a State or Federal audit reveals an improper payment, and overpayment, or an instance of provider/beneficiary fraud, States are required to repay the Federal share of the money within 60 days. This requirement exists regardless of whether the State is able to recoup the claim from the provider within the 60 day period, or at all. In effect, strong program integrity activities can actually be detrimental to State budgets. Not only do States have to expend money investigating, identifying, and attempting to recoup the payments, they are also required to pay additional funds as a repayment to the Federal government. While this does not prevent States from engaging in integrity activities, it is a serious detriment to Medicaid programs at a time when funding is already severely limited. Congress should modify the rule to require States to repay the Federal share within 60 days of recovery, not identification. On September 23rd, The Senate Finance Committee approved an amendment to the Chairman's Mark of the America's Healthy Future Act of 2009 that would resolve this disconnect in overpayment collections. NASMD supports the ultimate passage of this policy fix.
- *Coordination of Federal Integrity Activities*
  The Centers for Medicare and Medicaid Services currently have a broad range of integrity activities that are intended to identify cases of fraud and abuse. However, these initiatives often overlap with each other and are not appropriately coordinated. The lack of coordination in these programs creates administrative inefficiency and increases the burden on State staff, who often have to respond to multiple similar requests from different parts of CMS. Improving the coordination of these activities can improve the overall efficiency and outcomes of Federal-State integrity projects.
- *Improve Data Sharing Between Medicare and Medicaid*
  Many individuals enrolled in Medicare are also dually eligible for Medicaid. Although prescription drug coverage for this population has shifted from Medicaid to Medicare with the enactment of Part-D, many Medicaid agencies still provide wrap-around pharmaceutical benefits for dual eligibles. State agencies do this because the Part-D approved formularies and prescription limits do not always meet the needs of beneficiaries. However, without adequate knowledge of

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the benefits provided from Part-D, Medicaid agencies can be susceptible to individuals who attempt to receive the same prescriptions from both programs simultaneously. Improving data sharing regarding beneficiary encounters in Part A Hospital Benefits, Part B Physician Benefits and Part D Drug Benefits would greatly increase Medicaid's ability to identify potential cases of fraud and abuse. Congress should pass legislation to allow more comprehensive data-sharing for Medicare and Medicaid within CMS and the States.

- *Information Technology/Data Collection*
  Many States have been working to improve their data systems in order to collect more comprehensive information regarding individuals in health and human services programs. This can be used to verify eligibility across programs, to ensure that personal information is accurate, and to increase coordination of benefits and decrease administrative complexity. Superior information technology can also be used to improve data analysis to identify potential cases of fraud, waste and abuse. While system upgrades are desirable, State Medicaid IT systems are currently under a tremendous amount of stress due to several major revisions, including the move to the ICD-10 disease classification system, adoption of the 5010 transaction standards, and upgrade to the Nursing Home Minimum Data Set v3.0. Combined, these IT upgrades will consume millions of dollars and thousands of hours of labor – leaving little time for other upgrades.
- *State Finances*
  At a time when States are experiencing record budget shortfalls, funds are not readily available to finance system upgrades. We thank Congress for passing the American Recovery and Reinvestment Act (ARRA), which provided significant funding to avoid drastic Medicaid cuts and to implement Health Information Technology. However, State budgets are still strained, and fraud detection activities require substantial investments. States are committed to ensuring the integrity of the programs, but current economic conditions require difficult funding decisions. Due to the Maintenance of Effort Requirements in ARRA, which prevent states from restricting Medicaid eligibility, States don't have their usual Budget flexibility – creating significant strains on programs, services and activities that are not directly related to eligibility and acute care.

Conclusion

Although cases of fraud, waste and abuse exist in Medicaid, they are also a significant problem for all health insurance providers. It is also important to note that instances of fraud or abuse generally occur in very small portions of the Medicaid population. However, the State and Federal Governments continue to share responsibility for the administration of Medicaid, and need to work collaboratively to increase the integrity of the program.

I would like to thank the panel for the opportunity to speak today, and am enthusiastic that Congress, the Centers for Medicare and Medicaid Services and the States can effectively collaborate to reduce instances of fraud, waste and abuse in Medicaid – especially abuse of controlled substances. We look forward to working with you in the future. At this time, I would be happy to answer any questions you have.

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Department of Justice

STATEMENT OF

JOSEPH T. RANNAZZISI
DEPUTY ASSISTANT ADMINISTRATOR
OFFICE OF DIVERSION CONTROL
DRUG ENFORCEMENT ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT,
GOVERNMENT INFORMATION, FEDERAL SERVICES, AND
INTERNATIONAL SECURITY
COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

UNITED STATES SENATE

ENTITLED

"A PRESCRIPTION FOR WASTE: CONTROLLED SUBSTANCE ABUSE IN MEDICAID"

PRESENTED

SEPTEMBER 30, 2009

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Written Statement of
Joseph T. Rannazzisi
Deputy Assistant Administrator
Office of Diversion Control
U.S. Drug Enforcement Administration

"A Prescription for Waste: Controlled Substance Abuse in Medicaid"

September 30, 2009

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

Introduction

Chairman Carper, Ranking Member McCain, and distinguished Members of the Subcommittee on Federal Financial Management, Government Information, Federal Services and International Security, on behalf of the Acting Administrator and the more than 9,300 men and women of the Drug Enforcement Administration, I want to thank you for the opportunity to discuss the problem of prescription drug abuse and the illegal distribution of controlled substance pharmaceuticals and associated health care fraud.

Abuse of Controlled Substance Pharmaceuticals

The level of control mandated by Congress for pharmaceutical controlled substances far exceeds that for other prescription drugs. This level of control is commensurate with the potential for physical and psychological dependence and abuse properties that have historically been associated with controlled substances. Several studies of drug abuse patterns indicate that nonmedical use of pharmaceutical controlled substances is an increasing problem.

According to the 2008 National Survey on Drug Use and Health, 6.2 million Americans indicated that during the past month they had used psychotherapeutic drugs non-medically (4.7 million reporting abusing pain relievers). Nationally, the misuse of prescription drugs is second only to marijuana. Part of this increase in abuse is fueled by the fact that there is relatively little stigma associated with prescription drug use compared to other commonly abused drugs such as cocaine, heroin, and methamphetamine. Because they are manufactured for a legitimate medical purpose, many teenagers and young adults have the mistaken belief that they are safer than traditional illicit drugs such as cocaine or heroin.

Results of a separate study of seventh through twelfth grade students were released May 15, 2006, by the Partnership for a Drug-Free America. The Partnership Attitude Tracking Study tracks consumers' exposure to and attitudes about drugs. The study found that teenagers are more likely to have abused a prescription pain medication to get high than they are to have experimented with a variety of illicit drugs including Ecstasy, cocaine, crack and LSD. The study reported that nearly one in five (19 percent, or 4.5 million) teens has tried pharmaceutical

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controlled substances (pain relievers such as the schedule II substance OxyContin® and the schedule III substance Vicodin®, or stimulants such as the schedule II substances Adderall® or Ritalin®) to get high. Abuse of these medications is equivalent to or higher than abuse of illegal drugs such as Ecstasy (8 percent), cocaine/crack (10 percent), and methamphetamine (8 percent). The 2005 survey indicated that 50 percent of the teenagers surveyed indicated that pharmaceutical controlled substances are widely available; a third indicated that they were easy to purchase over the Internet.

The Partnership Attitude Tracking Study also focused on perceived risk and social attitudes. Some of their Key Findings are most alarming:

- Two in five teens (40 percent or 9.4 million) agree that prescription medicines, even if they are not prescribed by a doctor, are much safer to use than illegal drugs;
- Nearly one third of teens (31 percent or 7.3 million) believe there's "nothing wrong" with using prescription medicines without a prescription "once in a while;"
- Nearly three out of 10 teens (29 percent or 6.8 million) believe prescription pain relievers – even if not prescribed by a doctor – are not addictive.

Means by Which Controlled Substances Are Diverted

According to the Kaiser Family Foundation, there were more than 3,450,000,000 total prescriptions dispensed in calendar year 2007. Of these, approximately 11 percent are for pharmaceutical controlled substances. With approximately 380,000,000 prescriptions being written for pharmaceutical controlled substances, and 6.2 million Americans abusing pharmaceutical controlled substances, the potential for diversion and health care fraud is considerable.

Understanding the means by which controlled substances are diverted is critical in determining appropriate regulatory controls. One of the factors that contribute to the abuse of pharmaceutical controlled substances is the perception by some members of the public that it is safer to abuse prescription substances than to abuse illicit substances. This could not be farther from the truth. Additionally, black-market sales for prescription controlled substances are typically five to ten times their retail value. Profits generated from these street sales provide a strong incentive for continued diversion.

Diversion of pharmaceutical controlled substances can occur in a number of ways, including, but not limited to, the following:

- Prescription pads are stolen from practitioners' offices by patients, staff, or others and illegitimate prescriptions are written and forged.
- Legitimate prescriptions are altered to obtain additional amounts of legitimately prescribed controlled substances.

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- Drug-seeking patients may falsify symptoms and/or obtain multiple prescriptions from different practitioners for their own use or for resale. In some cases, organized groups visit practitioners with fake symptoms to obtain prescriptions, which are filled and resold. Some patients resell their legitimately obtained drugs to earn extra money.
- Prescription pads containing legitimate practitioner information (e.g., name, address, DEA registration number) are printed with a different call-back number that is answered by an accomplice to verify the prescription.
- Computers and scanning or copying equipment are used to create prescriptions for nonexistent practitioners or to copy legitimate practitioners' prescriptions.
- Pharmacies and other locations where pharmaceutical controlled substances are stored are robbed or burglarized.

Diversion from within the practitioner's practice or pharmacy may also occur, such as in the following situations:

- Prescriptions are written for other than a legitimate medical purpose. Some practitioners knowingly write prescriptions for nonmedical purposes. Criminal organizations commonly referred to as "rogue Internet pharmacies" often employ practitioners to issue prescriptions based on on-line questionnaires from patients with whom the practitioner has no legitimate medical relationship.
- Pharmaceutical controlled substances are stolen from pharmacies by pharmacy personnel. Legitimately dispensed prescriptions may be altered to make the thefts less detectable.

Registration

As part of the closed-system of distribution and to ensure proper oversight and accountability, the following individuals and entities are required to apply for registration with DEA: any business that imports or exports a controlled substance, or that manufactures or distributes a controlled substance; pharmacies that dispense controlled substances; practitioners that prescribe, administer, or dispense controlled substances; or any person that conducts research or chemical analysis with a controlled substance. Currently, there are more than 1.3 million registrants registered with the DEA with the vast majority of them being practitioners. Once registered, each individual or business location is issued a unique DEA registration number. DEA maintains these numbers in a database that includes historical or current action(s) taken against a registrant.

DEA provides an electronic means by which registrants can check the validity of another registrant's DEA registration number. DEA also provides access to state agencies that have a responsibility to investigate health care fraud. DEA provides access to the registrant database to 28 states that have requested the data. DEA provides this data to agencies such as the New York State Medicaid Inspector General's Office; the Illinois Office of Inspector General Health and Family Services; the Illinois Department of Human Services Bureau of Pharmacy and Clinical Support Services; the North Carolina Medical Board; and the Texas Department of Public Safety,

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Controlled Substances Registration section. Additionally, DEA provides a listing of current DEA registration numbers to the National Technical Information Service (NTIS), an agency of the U.S. Department of Commerce, on a weekly basis. NTIS collects and disseminates technical information produced by and for Federal agencies. It operates on a self-sustaining basis and makes this information widely available to those who need it on a subscription basis at no cost to the Treasury.

DEA is working to acquire Social Security death records electronically from NTIS. DEA will then cross check that information against DEA registration records to better reconcile these two databases and thereby curb potential avenues of healthcare fraud.

The CSA and DEA Regulations Pertaining to Prescriptions for Controlled Substances

In enacting the CSA, Congress sought to control the diversion of pharmaceutical controlled substances into illicit markets by establishing a "closed system" of drug distribution governing the legitimate handlers of controlled substances. The CSA and implementing regulations build in checks and balances to help maintain the integrity of this closed-system. When used correctly, these checks and balances help reduce waste, fraud, and abuse.

The CSA requires that a prescription for a controlled substance may be issued only by an individual practitioner who is authorized to prescribe by the state in which he or she is licensed to practice and is registered, or exempted from registration, with DEA. Additionally, to be valid, a prescription must be written for a legitimate medical purpose by an individual practitioner acting in the usual course of professional practice; a corresponding responsibility also rests with the pharmacist who fills the prescription. An order purporting to be a prescription issued not in the usual course of professional treatment is not a prescription within the meaning and intent of the CSA, and the person knowingly filling such a purported prescription, as well as the person issuing it, is subject to the penalties provided for violations of the provisions of law relating to controlled substances.

A prescription may be filled only by a pharmacist acting in the usual course of professional practice who is employed in a registered pharmacy. Except under limited circumstances, a pharmacist may dispense a schedule II controlled substance only upon receipt of the original written prescription manually signed by the practitioner. A pharmacist may dispense a schedule III or IV controlled substance only pursuant to a written and manually signed prescription from an individual practitioner, which is presented directly or transmitted via facsimile to the pharmacist, or an oral prescription, which the pharmacist promptly reduces to writing containing all of the information required to be in a prescription, except the signature of the practitioner.

Every prescription must be initialed and dated by the pharmacist filling the prescription. Under many circumstances, pharmacists are required to note certain specific information regarding dispensing on the prescription or recorded in a separate document referencing the prescription before the prescription is placed in the pharmacy's prescription records.

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DEA requires the registered pharmacy to maintain records of each dispensing for two years from the date of dispensing of the controlled substance. However, some states require that these records be maintained for longer periods of time. These records must be made available for inspection and copying by authorized employees of DEA. This system of records is unique in that the prescribing practitioner creates the prescription, but the dispensing pharmacy retains the record.

The elements of the prescription that identify the practitioner (the practitioner's name, address, DEA registration number, and signature) also serve to enable the pharmacy to authenticate the prescription. If a pharmacy is unfamiliar with the practitioner, it can use the registration number to verify the identity of the practitioner through publicly-available records. Those same records would indicate to the pharmacy whether the practitioner has the authority to prescribe the schedule of the controlled substance in question.

Prescription Drug Monitoring Programs

Prescription drug monitoring programs (PDMPs) are typically electronic database systems used by practitioners, pharmacists, medical and pharmacy boards, and law enforcement. These programs are established through state legislation and are tailored to the specific needs of a particular state. DEA strongly supports PDMP programs and encourages the use of these programs by medical professionals in detecting and preventing doctor shopping and other forms of diversion. Currently, 40 states have enacted some type of legislation to establish a PDMP and of those 33 are operational. Additionally, DEA makes its registrant database available to any state, free of charge, for use in their PDMP or other state agency whose mission is to prevent health care fraud or diversion. These programs, however, are only as good as the data that is in each system and the willingness of practitioners and pharmacists to use such systems on a consistent basis.

Medicare – Medicaid Fraud

Medicare and Medicaid are administered by the Department of Health and Human Services (HHS). Federal investigations of health care fraud and misuse are investigated by investigators from HHS and the FBI, under Title 18 U.S.C. §§ 287 and 1001, and Title 42 U.S.C. § 1320a-7b. State agencies also have a responsibility to investigate Medicaid health care fraud within their jurisdiction. When conducting investigations into violations of the Controlled Substances Act, DEA agents and investigators may also uncover violations involving health care fraud. This information is typically turned over to investigators from HHS, the FBI, or state authorities within their area of responsibility. DEA does not have any databases that have information regarding the dispensation by a pharmacy to individual patients. Records at this granular level are acquired through investigations of a pharmacy on a case-by-case basis.

DEA's Regulatory and Enforcement Strategy

As previously stated, DEA maintains a registrant population of more than 1.3 million registrants under a variety of business activities. DEA is currently restructuring its Diversion

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Control Program to establish approximately 57 new Tactical Diversion Squads (TDS). These TDS groups will include Diversion Investigators, Special Agents, and state and local Task Force Officers and will focus efforts on criminal investigations related to the diversion of controlled substances. Where a TDS group uncovers evidence of health care fraud, the TDS group will partner with additional investigative agencies to fully utilize all investigative tools and expertise. Currently, DEA is working with HHS to integrate investigators from HHS into these TDS groups to help combat health care fraud. The restructuring plan will also include strengthening DEA's efforts to provide the necessary regulatory oversight of the registrants by ensuring that registrants are adhering to their responsibilities under the Controlled Substances Act and its implementing regulations.

The vast majority of the more than 800,000 medical doctors and doctors of osteopathy medicine are law-abiding professionals. During any given year, DEA arrests only approximately 75 medical doctors or doctors of osteopathy for violations of the Controlled Substances Act. Additionally, DEA has taken the following actions against registrants:

- FY-2007 DEA issued 31 Orders to Show Cause/Immediate Suspensions
- FY-2008 DEA issued 40 Orders to Show Cause/Immediate Suspensions
- FY-2009 (as of August) DEA issued 48 Orders to Show Cause/Immediate Suspensions

Conclusion

Individuals and organized groups, regardless of their professional status, continue to circumvent both state and federal laws and regulations which threaten the health and safety of Americans. Nevertheless, the DEA continues to refine its methods of identifying, pursuing, and ultimately dismantling these criminal entrepreneurs. DEA remains committed to bringing to bear all of the resources at its disposal to fight this growing problem while simultaneously ensuring an uninterrupted supply of pharmaceutical controlled substances for legitimate demands. DEA's core mission is to disrupt and dismantle drug trafficking organizations, including those who seek to illegally distribute or divert pharmaceutical controlled substances.

Chairman Carper, Ranking Member McCain, and members of the Subcommittee, I thank you for the opportunity to discuss this vital issue and welcome any questions you may have.

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Questions and Answers for the Record
Submitted by Gregory D. Kutz

1. **In the report, you state that Medicaid programs are required to perform Drug Utilization Reviews (DURs). How does the DUR process help prevent fraud and abuse of controlled substances paid for by Medicaid?**

Answer:

State Medicaid offices perform DURs and other controls during the prescription claims process to promote patient safety, reduce costs, and prevent fraud and abuse. The DURs include prospective screening and edits for potential inappropriate drug therapies, such as over utilization, drug-drug interaction, or therapeutic duplication. In addition, selected states also require health care providers to submit prior authorization forms for certain prescriptions of drugs because those medications have public health concerns, are considered high risk for fraud and abuse, or both. Both prospective screening and prior authorizations can be required on certain controlled substances to minimize the risk of fraud and abuse of those drugs. For example, officials from certain states said that they use the results of prospective screening, such as overlapping controlled substance prescriptions, as an automatic denial of the prescription. Such controls can be used to help prevent "doctor shopping" and other forms of fraud and abuse in the Medicaid program.

2. **As a follow-up to today's hearing, this Subcommittee has requested that GAO conduct an investigation of controlled substances fraud and abuse in Medicare Part D. Mr. Kutz, I understand that in the past you have had some challenges in obtaining Medicare data from CMS, is that correct?**

Answer:

Yes, in August 2005, the Permanent Subcommittee on Investigations, Committee on Homeland Security and Governmental Affairs requested GAO to conduct a review of Medicare providers that owed federal taxes. GAO obtained Fiscal Year 2005 Medicare

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payment claims data. GAO discovered some claims records were corrupted and were consequently returned to CMS. GAO spent considerable time processing and reviewing the remaining data due to the data format and the complexity and size of the data. GAO subsequently asked CMS to provide additional claims data in a format that was easily processed, sorted, and analyzed. CMS initially concluded that this request for data presented significant resource challenges for its staff; however, CMS ultimately provided the requested data.

3. **I also understand that in the past you have had some challenges in obtaining DEA registration data from DEA, is this correct? Did you ask for the DEA registration database? Did they give you what you initially asked for? How did this affect or impede your analysis?**

Answer:

It is correct that we faced challenges in obtaining DEA registration data. For our review of controlled substance abuse in Medicaid, we requested the DEA registrant database from DEA. DEA provided us the data, but they truncated the Social Security Number. We agreed to the truncated data to expedite the acquisition of the data. However, because the data was not complete, we were not able to determine the number of Medicaid providers who were not registered with DEA to prescribe controlled substances. In addition, we were not able to determine the number of Medicaid providers that were registered with DEA but did not have authorization to prescribe the controlled substance schedule (e.g., DEA schedule II drugs) that they prescribed. For the Medicare Part D review, in October 2009, we requested the entire DEA registrant database including the full social security numbers and DEA registration numbers for all DEA registrants.

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4. **In the report, you identified several examples of physicians prescribing controlled substances that they did not have proper DEA registration to prescribe. Why did the states or the pharmacies not prevent this from occurring?**

Answer:

Although DEA's registrant database is available, none of the five state Medicaid offices obtained the database at the time of our study to determine if physicians are authorized to prescribe particular controlled substances. Thus, the selected state Medicaid programs do not screen prescription claims for controlled substances to ensure that a health care provider is authorized to prescribe the particular drug(s). Further, DEA officials stated that pharmacies have corresponding responsibility to determine if a prescription is legitimate, which includes determining whether a health care provider is authorized to prescribe the particular schedule of controlled substance before filling a prescription. However, none of the pharmacy boards of the selected states said that this is a requirement they monitor. In fact, four pharmacy boards stated that the states only require that their pharmacists check to see if the DEA number on the prescription appears to be a valid DEA number, without verifying it with the DEA registration database.

5. **In the report, you identified about 65,000 beneficiaries that may have been doctor shopping in the five selected states. How did you develop this estimate? Could this number be underestimated and, if so, how? What can CMS and the states do to better prevent doctor shopping?**

Answer:

To develop an estimate of doctor shopping, we selected 10 types of controlled substances that are commonly abused and set the criteria for "doctor shopping" to be obtaining prescriptions from at least six different medical practitioners over a two year period. We developed this approach based on our review of drug diversion literature and discussions with a criminal investigator whose recognized expertise is drug diversion. To determine the total number of different prescribers a beneficiary visited, we identified and totaled the number of different prescribers shown on each beneficiary's claims data. Because the

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Medicaid prescription claims databases did not track doctors who practiced in groups, we could not determine the amount of duplication caused by this factor.

Our analysis of 65,000 beneficiaries that may have been doctor shopping is understated. The selected states did not identify the prescriber for many Medicaid claims submitted to CMS. Without such identification, we could not always identify and thus include the number of unique doctors for each beneficiary who received a prescription. Our analysis also did not focus on all controlled substances, but instead targeted 10 types of the most frequently abused controlled substances. Further, our analysis did not identify individuals that received prescriptions who may have been "doctor shopping" and received prescriptions for different types of controlled substances.

To prevent doctor shopping, CMS can encourage the states to perform DURs and other controls during the prescription claims process to detect and prevent doctor shopping. As mentioned before, DURs include prospective screening and edits for potential inappropriate activities, such as overutilization, and also could require health care providers to submit prior authorization forms for certain prescriptions of drugs that are considered high risk for fraud and abuse. The states can also encourage their health care providers to use their prescription drug monitoring program (PDMP) prior to prescribing or dispensing controlled substances. For PDMPs to be useful, health care providers and pharmacies must use the data. Officials from the five selected states said that physician participation in the PDMP is not widespread and not required. In fact, one state did not have a Web-based PDMP; a health care provider has to put in a manual request to the agency to have a controlled substance report generated.

6. **Did you find any instances where Medicaid beneficiaries were doctor shopping in order to sell drugs on the street? Why does the Medicaid Fraud Control Unit (MFCU) not investigate these types of cases?**

Answer:

In our investigation of doctor shopping cases, we did find a case (i.e., case 6 in the report) where a Medicaid beneficiary was doctor shopping to sell drugs. There are likely other cases where the beneficiary did not admit to selling the drugs. We also found another instance

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where a Medicaid beneficiary was over-prescribed controlled substances and later sold those drugs on the street (i.e., case 1 in the report).

Federal regulations generally limit MFCUs from pursuing beneficiary fraud. According to MFCU officials at one selected state, this limitation impedes investigations because agents cannot use the threat of prosecution as leverage to persuade beneficiaries to cooperate in criminal probes of Medicaid providers. In addition, the MFCU officials in this selected state said that this limitation restricts the agency's ability to investigate organized crime related to controlled substances when the fraud is perpetrated by the beneficiaries.

7. **The report states that you found many instances where Medicaid claims submitted to CMS had the prescribing provider field blank. If the states do not identify the prescriber, how does CMS know who is prescribing the controlled substances? What impact did this have on your estimate of doctor shopping?**

Answer:

In our investigation, we found that the selected states did not identify the prescriber for many Medicaid claims submitted to CMS. Without such identification, we could not, nor could CMS, identify the unique doctor for each beneficiary who received a prescription. As a result, we believe that our doctor shopping estimate of 65,000 beneficiaries is understated.

8. **In the report, you found 65 medical practitioners and pharmacies had been barred from federal health care programs, excluded from these programs, or both, when they wrote or filled Medicaid prescriptions. Why did the states not prevent these prescriptions from being processed? Why is this an important fraud prevention control?**

Answer:

To protect the government's interest, federal regulation requires states to ensure that no payments are made for any items or services furnished, ordered, or prescribed by an

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individual or entity that has been debarred from federal contracts, excluded from Medicare and Medicaid programs, or both. Officials from all five selected states said that they do not screen prescribing providers or pharmacies against the federal debarment list, also known as the EPLS. Further, officials from four states said that when a pharmacy claim is received, they do not check to see if the prescribing provider was excluded by HHS OIG from participating in the Medicaid program. Screening of individuals and businesses with known criminal histories or other problems that resulted in debarment is an effective control to minimize fraud, waste and abuse.

9. **You identified a number of troubling problems at the hearing related to "doctor shopping," suspended and debarred physicians and pharmacies receiving federal dollars, deceased beneficiaries, deceased doctors, and doctors prescribing drugs that they are not authorized by DEA to prescribe. Will you be sharing or referring the information necessary to CMS, the states and DEA for them to further investigate and where appropriate take action on these cases of fraud and abuse?**

Answer:

We referred "doctor shopping" cases and the physician that over-prescribed a controlled substance to the states for further investigation. In addition, we referred to DEA for further investigation those doctors prescribing drugs that they are not authorized by DEA to prescribe.

10. **My staff spoke with the Delaware State Police about the prescription drug problem in my state. Police officials say they take the problem so seriously that they've established a special office staffed with veteran officers dedicated to prescription drug abuse related crime. In one specific case that just occurred in August, a Medicaid beneficiary fraudulently acquired 100 tablets of 30 milligram Oxycodone pills. He paid a $6 co-pay on a prescription that cost Medicaid $105. Delaware State Police told us that the street value was roughly $3,000, or $30 per pill. To what extent do you believe the cases you investigated involved**

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doctor shoppers who are running illicit drug businesses using taxpayer dollars?

Answer:

We believe that there are "doctor shoppers" who are running illicit drug businesses using taxpayer dollars. We do not know the extent to which that this is occurring. In our investigation of doctor shopping cases, we did confirm an example (i.e., case 6 in the report) where a Medicaid beneficiary was doctor shopping to sell drugs but there are likely other cases that the beneficiary did not admit to selling the drugs.

11. **Were you able to update your cases to tell if any stimulus money was contributing to the controlled substances fraud and abuse you found? Is it safe to assume that perhaps tens of millions of stimulus dollars are going towards fraudulent doctor shopping activity in Medicaid?**

Answer:

Funding from the American Recovery and Reinvestment Act was available for certain Medicaid claims in fiscal year 2009 and thereafter. Several of our fraudulent doctor shopping cases were still in Medicaid and appeared to be doctor shopping at the time of this funding.

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Post-Hearing Questions for the Record
Submitted to Penny Thompson
From Senator Tom Carper

"A Prescription for Waste: Controlled Substance Abuse in Medicaid"
September 30, 2009

1. It is clear that there are certain controls states can use to stop the sorts of abuse GAO found in its report. The restricted recipient program and requiring prior authorization for certain prescriptions comes to the top of my mind. My question is, why doesn't CMS set minimum requirements for the review and screening of these types of prescriptions?

CMS is supportive of certain controls that states can use to deter fraudulent behavior and contribute to patient safety. Prior authorization is one means that Medicaid programs use to control abuse and misuse of controlled substances at the point of sale. Program edits in their automated claims processing systems are designed to identify possible misuse such as duplicate therapy, exceeding normal quantity limits, and exceeding normal daily dosage limits. These edits can require the pharmacist/prescriber to obtain prior approval before filling the prescription. When a recipient shows a pattern of substance misuse, their access to services can be restricted. States have adopted the restricted recipient program or "lock-in" program as a tool to limit "doctor shopping" by assigning the recipients to one primary care prescriber and one pharmacy. This has been a proven mechanism to minimize program misuse. Any services outside the assigned providers require program approval.

CMS is supportive of sharing the best practices states have cultivated to address the issue of controlled substance misuse in Medicaid. The Agency sees the Medicaid drug utilization review (DUR) program, a state requirement, as a model for spreading such best practices. The DUR program was created through Congressional authority in the Omnibus Budget Reconciliation Act (OBRA) of 1990. The emphasis of the program is to promote patient safety by generating an increased review and awareness of outpatient prescribed drugs. States were encouraged by enhanced federal funding to design and install point-of-sale electronic claims management systems that interface with their Medicaid Management Information Systems (MMIS) operations. Each state uses recognized professional standards of practice edits in their automated claims processing systems to send alerts or deny payment of claims that do not meet those standards. Additionally, states are continually reassessing those standards based on new medical data as well as current trends in misuse of drugs.

The annual DUR report requirement provides an excellent measurement tool to assess how well patient safety is being monitored. Provider prescribing habits are meeting standards and dollars are saved by avoidance of problems such as drug-drug interactions, drug-disease interactions, therapeutic duplication, and over-prescribing by providers. Currently, CMS is in the process of updating the survey instrument that States use as a tool to prepare their annual DUR reports. We have developed new questions relating to fraud and abuse and whether or not states use prescription drug monitoring programs (PDMPs). In addition, we

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will update the survey instrument to glean information about innovative and best practices with respect to the utilization of PDMP data.

2. What can be done to better promote best practices among states?

Promoting best practices among States is an integral part of CMS's provision of technical assistance to States. We are committed to deploying evidence-based tools that States can use to combat waste, fraud and abuse in Medicaid. The first phase in this continuum of technical assistance to States is assessing what States are doing now in the area of program integrity and how successful those activities have been.

We have made great headway in this area by conducting routine State Program Integrity Reviews and, more recently, with the collection and release of the State Program Integrity Assessment (SPIA). SPIA is the first national data collection of State Medicaid Program Integrity (PI) activities. One of our next steps will be to use the data from SPIA to develop descriptive reports on each State's program integrity activities, and identify target areas needing technical assistance as well as 'best practices.' Not only can the data be used to establish a baseline assessment of each State that can be analyzed yearly to evaluate States' performance over time, but for the first time, States have access to information on other States' PI activities. We announced the publication of the SPIA in late August and the response from States has been extremely positive.

We currently publish on the CMS website a report highlighting the best practices found in the conduct of Program Integrity Reviews (http://www.cms.hhs.gov/FraudAbuseforProfs/Downloads/2008pireviewannualsummaryreport.pdf). The SPIA Fact sheet and reports for each State and the District of Columbia are available on the CMS website at the following address: http://www.cms.hhs.gov/FraudAbuseforProfs/11_SPIA.asp#TopOfPage.

3. My staff visited with Delaware Medicaid officials to try and obtain a ground-level view of some of these problems. They expressed a lot of excitement about the potential for E-prescribing to stop the sort of abuses GAO revealed at the hearing. Why is E-prescribing so useful in combating controlled substance abuse? What are some of the barriers states encounter in trying to implement such a system?

The Obama Administration is highly supportive of information technology (IT) efforts and the use of IT to improve quality of care and clinical outcomes. The CMS strongly supports State Program Integrity measures and wants States to be aware that e-prescribing may reduce instances of unauthorized, improperly altered, and counterfeit prescriptions. There are many ways that e-prescribing can be used as an effective tool to detect and prevent fraud and abuse. For example, in Medicaid an e-prescribing system can show the clinician the medication history of the patient, in real-time, across all Medicaid providers. The e-prescribing tool indicates if a prescription was filled, what the dosage was, who prescribed it

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and when. This data can indicate if the patient is "doctor-shopping" for pain medications or other often misused drugs. Hospital emergency department doctors have indicated strong appreciation for e-prescribing for this reason, as they often struggle to identify what is an attempt to get medications fraudulently, versus what is a true medical complaint. Medicaid agencies can also analyze data from beneficiaries' medication histories to look for trends in improper treatments by provider type, by drug, or by facility, etc.

Several State Medicaid agencies have sponsored e-prescribing for their Medicaid providers, such as Delaware, Alabama, New Mexico, Florida, Mississippi and Arizona. These States and others have determined what kinds of incentives help overcome barriers to adoption and best promote e-prescribing adoption, such as provision of hardware (e.g. personal handheld devices), free e-prescribing software, and implementation training. A different approach is to offer e-prescribing as a function of a comprehensive EHR. An EHR with e-prescribing functionality that is accessible wherever and whenever a beneficiary seeks care can provide a more complete picture because it offers the service utilization history, diagnoses, lab results and other data that can help clinicians determine the best course of treatment and if there is potential fraud involved.

E-prescribing of controlled substances is under the purview of the Drug Enforcement Administration (DEA). DEA has submitted a final rule on e-prescribing of controlled substances to OMB for review under Executive Order 12866.

CMS has assisted working with the DEA on their proposed rule-making and adjudicating the public comments; by offering technical assistance to State agencies on how to engage pharmacies and key stakeholders in public/private partnerships that can leverage training, resources and technology; and offering technical assistance to States on how to reconsider privacy laws in light of the benefits of e-prescribing for care coordination, reducing adverse drug events, and controlling costs.

4. While many of the individuals we referenced at the hearing committed some pretty serious crimes, many of them are also sick and addicted to these prescription drugs. How do prescription drug monitoring programs help people who may have a substance abuse problem get the services they need? For example, is there any data to show whether those that are doctor shopping are eventually referred to facilities at which they can receive treatment? Is there any information about processes that connect the prescription drug monitoring program with state substance abuse prevention or treatment agencies?

Our agency does not have responsibility for the prescription drug monitoring program (PDMP); all PDMP programs are established by State legislation and operate by the provisions of that legislation. The CMS agrees that the issue of controlled substance misuse and the prevalence of mental health and substance use illness in the Medicaid population should be taken into consideration as senior policy officials in the Agency and the Administration deliberate on this issue.

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Post-Hearing Questions for the Record
Submitted to Ann Kohler
From Senator Tom Carper

"A Prescription for Waste: Controlled Substance Abuse in Medicaid"
September 30, 2009

1. It is clear that there are certain controls states can use to stop the sort of abuses GAO found in its report. The restricted recipient program and requiring prior authorization for certain prescriptions comes to the top of my mind. My question is, why doesn't every state use these proven controls? *Most states do use such programs. They do, however make sure they thoroughly investigate any clients before they are placed in a restrictive program.*

2. What can be done to better promote best practices across states? *NASMD works closely with states to share best practices. This is an area that perhaps CMS could work with NASMD to sponsor a conference or meeting with states to discuss best practices*

3. My staff visited with Delaware Medicaid officials to try and obtain a ground-level view of some of these problems. They expressed a lot of excitement about the potential for E-prescribing to stop the sort of abuses GAO revealed at the hearing. Why is E-prescribing so useful in combating controlled substance abuse? What are some of the barriers states encounter in trying to implement such a system? *States are very excited about E-prescribing and some, such as Florida are in the process of implementing such a program for their Medicaid program. E-prescribing eliminates the ability for the patient to multiple drug stores since the prescription is sent directly from the physician. Also E-prescriptions cannot be altered in any way.*

4. While many of the individuals we referenced at the hearing committed some pretty serious crimes, many of them are also sick and addicted to these prescription drugs. How do prescription drug monitoring programs help people who may have a substance abuse problem get the services they need? For example, is there any data to show whether those that are doctor shopping are eventually referred to facilities at which they can receive treatment? Is there any information about processes that connect the prescription drug monitoring program with state substance abuse prevention or treatment agencies? *I do not know of any programs that automatically refer such clients to treatment. However many Medicaid directors work closely with the Substance Abuse director in their state*

5. Why do all state Medicaid programs not automatically remove deceased doctors and beneficiaries from the Medicaid system? Why is this an important fraud prevention control? *Unfortunately too often the Medicaid program does not know the doctor is deceased. Many states are working to develop ways to match their records against vital statistics in their states to remove deceased providers and clients.*

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6. In your testimony, you say that there is a lack of coordination when it comes to federal integrity activities. In your experiences, what have you seen to bring you to this conclusion? What could CMS do to better serve the states? *As I mentioned the higher match that the Medicaid Fraud Units in the state's Attorney General's office should be extended to the Medicaid agency. In addition, CMS could bring together the Medicare fraud staff, the Medicaid Program Integrity staff and the state staff for some joint projects.*

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Post-Hearing Questions for the Record
Submitted to Joseph Rannazzisi
From Senator Tom Carper

"A Prescription for Waste: Controlled Substance Abuse in Medicaid"
September 30, 2009

1. At the hearing, you said you were not aware of how widespread the use of public health programs like Medicare and Medicaid were in acquiring controlled substances by addicts and dealers, but that you might be able to look into it. Does DEA have any sense of what percentage of the controlled substance pills on the street might have been paid for by the government?

   Answer:

   Under 21 U.S.C. §827(d), DEA has statutory authority to collect limited data on controlled substances distributed by manufactures and distributors. However, DEA does not collect data regarding the method of payment for dispensed prescriptions nor does it maintain a database that collects prescription data. Therefore, DEA cannot provide any information related to the percent of controlled substances on the street paid by the government.

2. As a follow-up to our hearing, this Subcommittee has requested that GAO conduct an investigation of controlled substances fraud and abuse in Medicare Part D. Will you pledge to provide GAO the complete database of DEA registrants, including all key identifiers necessary to perform aggregate-level analysis such as the complete DEA registration number, complete SSN, Name and Registered schedules?

   Answer:

   As always, DEA will work with the GAO to make reasonable accommodations to provide them the necessary data to effectively complete their investigations. As an example, during the GAO's 2008 investigation into Medicaid abuse and fraud, DEA provided GAO investigators with information from the registrant database for GAO to conduct their investigation. The DEA registrant database contains more than one million records each containing sensitive Personal Identifiable Information (PII). DEA works very hard to protect the privacy and security of this information. DEA stands ready to assist the GAO in conducting comprehensive investigations into fraud and abuse in Medicare Part D while protecting the registrant's PII to the fullest extent possible.

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3. Is the DEA working with Medicaid to go after drug abusers? Can you give some examples?

   Answer:

   Historically, DEA has used its limited resources to conduct investigations that are directed at organizations and individuals responsible for large-scale diversion or illegal distribution of controlled substances. DEA has not focused its resources on targeting individual drug abusers. DEA does, however, work with the Federal Bureau of Investigation (FBI) , the Food and Drug Administration (FDA), and state agencies responsible for investigating Medicaid fraud, including Medicaid Fraud Control Units (MFCUs). As an example, DEA has recently established over 30 Tactical Diversion Squads across the United States. These squads incorporate DEA Special Agents, DEA Diversion Investigators, and state and local law enforcement and regulatory agencies. In the case of the Washington, D.C. Field Division Office of the DEA, the Tactical Diversion Squad has two FBI agents and an FDA agent assigned to the investigative unit. These combined teams will conduct investigations into the diversion of controlled substance pharmaceuticals and, when appropriate, also investigate any allegations related to Medicaid fraud.

   While conducting investigations involving violations of the Controlled Substances Act, DEA may become aware of possible Medicaid fraud violations. In such cases, DEA will work with MFCUs and other agencies that investigate and prosecute Medicaid fraud..

4. At the hearing, you said that there is more than enough money available for states to implement a Prescription Drug Monitoring Program (PDMP). Could you explain where and how states can acquire funds to establish such programs? For states such as Delaware that do not yet have a PDMP, is DEA willing to help provide guidance and assistance for those who wish to start one?

   Answer:

   DEA supports the use of PDMPs; however, DEA does not have the ability to fund any state PDMP. Presently there are two federal sources for funding in support of PDMPs. The first, and most common source, is the Harold Rogers grant program that is administered through the Federal Bureau of Justice Assistance Program. Funding via this program can be used to establish a new system or to maintain an existing system through enhancement to established IT systems. The second grant program is the National All Schedules Prescription Electronic Reporting Act (NASPER) that is administered through the Department of Health and Human Services. In Fiscal Year 2009, Congress appropriated $2 million for NASPER. That money was issued out in grant funding to approximately 13 states. DEA does and will continue to support states that use PDMPs and encourage those states without PDMPs to consider legislation in support of such programs.

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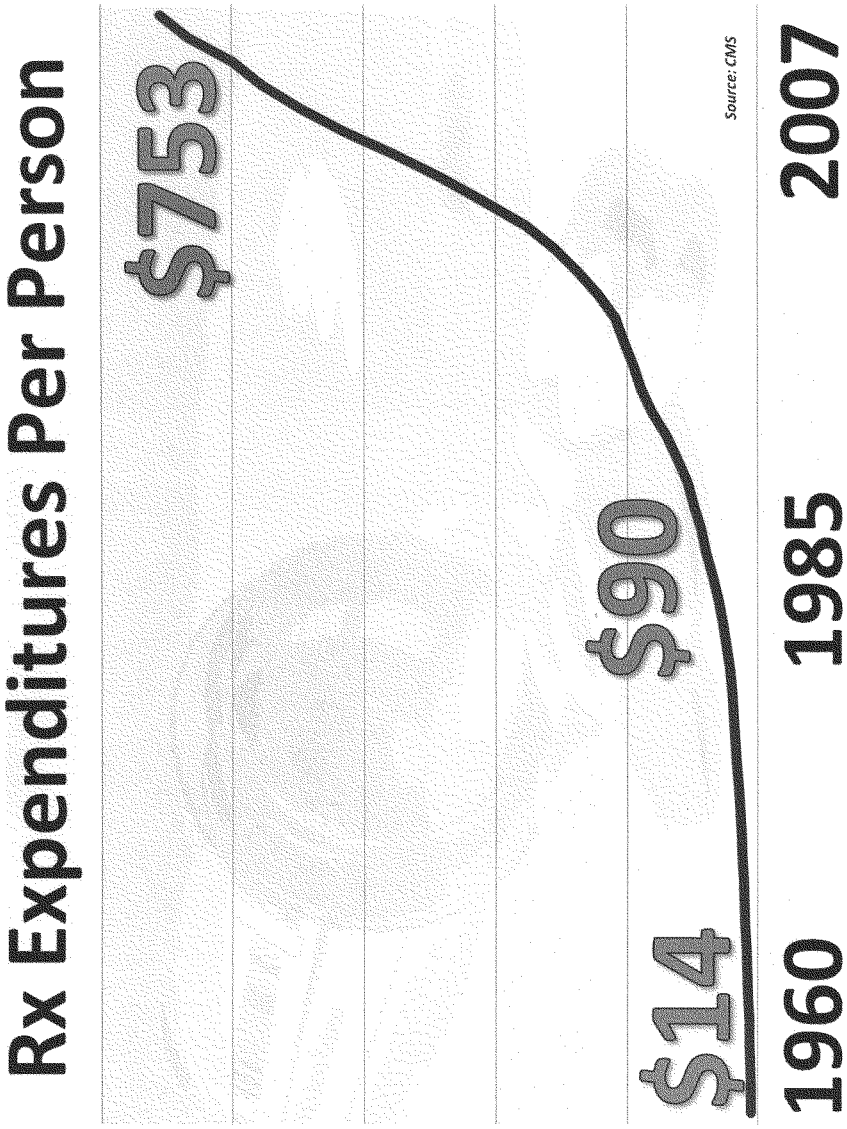

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1 out of 5 teenagers

has abused controlled substances

Source: Drug Enforcement Administration

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