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MEDICAID CLAIMS: WHO'S WATCHING THE MONEY?

HEARING

BEFORE THE

SUBCOMMITTEE ON GOVERNMENT EFFICIENCY, FINANCIAL MANAGEMENT AND INTERGOVERNMENTAL RELATIONS

OF THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

SECOND SESSION

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MEDICAID CLAIMS: WHO'S WATCHING THE MONEY?

THURSDAY, JUNE 13, 2002

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON GOVERNMENT EFFICIENCY, FINANCIAL MANAGEMENT AND INTERGOVERNMENTAL RELATIONS,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:02 a.m., in room 2154, Rayburn House Office Building, Hon. Stephen Horn (chairman of the subcommittee) presiding.

Present: Representatives Horn, Sullivan, and Schakowsky.

Staff present: J. Russell George, staff director and chief counsel; Bonnie Heald, deputy staff director; Rosa Harris, GAO detailee; Justin Paulhamus, clerk; Chris Barkley, staff assistant; Michael Sazonov, Sterling Bentley, and Freddie Ephraim, interns; David McMillen, minority professional staff member; and Jean Gosa, minority clerk.

Mr. HORN. A quorum being present, the Subcommittee on Government Efficiency, Financial Management and Intergovernmental Relations will come to order.

Each year, the Federal Government spends billions of dollars to provide health care for the Nation's most vulnerable people, the poor and the disabled. This assistance is provided through the Government's Medicaid program. Although it is a Federal program, Medicaid is administered by the States through 56 separate and distinct programs. The program's considerable cost is shared by the State and Federal Governments. Last year, the Federal Government spent an estimated $125 billion on the program. States contributed an additional $95 billion.

Overall, Medicaid is the Federal Government's third largest social program. Despite the size of this program, the Federal Government's lack of financial oversight has left it highly vulnerable to waste, fraud, and abuse. The Office of Management and Budget recently reported to Congress that the Government had made $20 billion in erroneous payments last year. That amount included $12.1 billion in the State and Medicare payments. As appalling as that figure is, no one can even calculate the amount of erroneous payments that have been made in the Medicaid program.

Today, we will examine the extent of these problems and what steps need to be taken to resolve them. The Federal Government

must do a better job of ensuring that the billions of dollars dedicated to the Medicaid program are being appropriately spent. We owe it to the American taxpayers who provide that hard-earned money, and we owe it to those who depend on this life saving program.

[The prepared statement of Hon. Stephen Horn follows:]

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Opening Statement
Representative Steve Horn, R-CA
Chairman, Government Efficiency, Financial Management and Governmental Relations
June 13, 2002

A quorum being present, the Subcommittee on Government Efficiency, Financial Management and Intergovernmental Relations will come to order.

Each year, the federal government spends billions of dollars to provide health care for the nation's most vulnerable people -- the poor and the disabled. This assistance is provided through the government's Medicaid program. Although it is a federal program, Medicaid is administered by the states through 56 separate and distinct programs. The program's considerable cost is shared by state and federal governments.

Last year, the federal government spent an estimated $124 billion on the program and states contributed an additional $95 billion. Overall, Medicaid is the federal government's third largest social program and one of the largest expenditures for all state governments. Despite the size of this vital program, the federal government's lack of financial oversight has left it highly vulnerable to waste, fraud and misuse.

The Office of Management and Budget recently reported to Congress that the government had made $20 billion in erroneous payments last year. That amount included $12.1 billion in mistaken Medicare payments. As appalling as that figure is, no one can even calculate the amount of erroneous payments that may have been in the Medicaid program.

Today, we will examine the extent of these problems and what steps need to be taken to resolve them. The Federal Government must do a better job of ensuring that the billions of dollars dedicated to the Medicaid program are being appropriately spent. We owe it to the American taxpayers who provide that hard-earned money, and we owe it to those who depend on this life-saving program.

I welcome each of our witnesses today and look forward to your testimony.

Mr. HORN. I welcome each of our witnesses today and look forward to their testimony. I will now swear in those that are both making a presentation to us as well as their assistants.

[Witnesses sworn.]

Mr. HORN. We have eight who took the oath, and the clerk will note who did. And that is just so we don't have a problem in questioning by the staff. It's so we don't have to take special oaths simply because we didn't do it to start with.

We will start with the General Accounting Office and the very fine document they have for us. And it is Linda Calbom, the Director, Financial Management and Assurance, U.S. General Accounting Office. Please present it.

STATEMENT OF LINDA M. CALBOM, DIRECTOR, FINANCIAL MANAGEMENT AND ASSURANCE, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY KIMBERLY BROOKS, ASSISTANT DIRECTOR, FINANCIAL MANAGEMENT AND ASSURANCE, U.S. GENERAL ACCOUNTING OFFICE

Ms. CALBOM. Thank you, Mr. Chairman. I am pleased to be here today to discuss the results of our review of CMS' oversight of Medicaid financial management. My testimony today summarizes our report that we issued in February for this committee, which discusses the need to improve Federal oversight of State Medicaid finances.

As you well know, the Federal Government and States share responsibility for financial management of the jointly funded Medicaid program. States are really the first line of defense in safeguarding Medicaid finances, since they are responsible for making proper payments to providers, recovering misspent funds, and making accurate reports of their cost for Federal reimbursement. CMS, at the Federal level, is responsible for overseeing State financial activities and ensuring the propriety of expenditures reported by States for Federal reimbursement.

You asked that we review how well CMS is carrying out its responsibilities for financial oversight of the Medicaid program. We found that the CMS financial oversight process has weaknesses that leave the program vulnerable to improper payments.

The root cause of improper payments is breakdowns in internal control. The Comptroller General's Standards for Internal Control in the Federal Government require that agency managers perform risk assessments, take actions to mitigate identified risks, and then monitor and communicate the effectiveness of those actions. In addition, the Standards provide that agencies should ensure their organizational structure is designed so that authority and responsibility for internal controls are clear.

The first chart on my right, and I think it is in your packet, Mr. Chairman, shows how all of these areas are key in effectively managing proper payments.

CMS oversight had weaknesses in each of these areas, which I will now just very briefly describe. First, our review found that CMS had only recently begun to assess areas of greatest risk for improper payments and, thus, did not know the full nature and extent of its risks, or the most efficient and effective controls to mitigate those risks.

CMS also was not effectively mitigating the controls it did have in place. For example, analysts across the 10 regions did not consistently conduct focused financial reviews that are beneficial in identifying unallowable costs in specific Medicaid service areas. Only eight of these reviews were conducted in fiscal year 2000 as compared to 90 reviews in fiscal year 1992. CMS attributed this decline to lack of resources.

The other chart we brought today demonstrates this. It shows that from 1992 to 2000, regional staff responsible for Medicaid financial oversight declined by 32 percent, while Federal Medicaid expenditures increased by 74 percent.

Recognizing its oversight deficiencies and resource constraints, CMS began efforts in April 2001 to develop a risk-based approach and revise its control activities. These efforts did not, however, integrate information available from State financial oversight program activities or consider other control techniques that could enable CMS to carry out its oversight responsibilities more efficiently and effectively.

Our review also found that CMS had few mechanisms in place to continuously monitor the effectiveness of its oversight. Managers had not established performance standards for financial oversight activities, and limited data were collected to assess regional financial analysts' performance in carrying out these activities. In addition, the CMS audit resolution procedures did not collect sufficient information on the status of audit findings or ensure that they were resolved in a timely manner.

We further found that the CMS organizational structure created roadblocks to effective oversight because of unclear lines of authority and responsibility between the regions and headquarters. As a result, CMS lacked consistency in its approach to establish and enforce standards, evaluate regional office oversight, and implement changes to improve financial oversight.

In closing, Mr. Chairman, I want to emphasize that while CMS is taking positive steps to improve its financial oversight of the Medicaid program, the increasing size and complexity of the program, coupled with diminished oversight resources, requires a new approach. Our report recommends ways CMS can revise its risk assessment efforts, restructure its financial control activities, improve monitoring, and address accountability and authority issues posed by its organizational structure.

CMS' ability to make the kind of changes we are recommending will require top level management commitment, a comprehensive financial oversight strategy that is clearly communicated, and clear expectations for implementation of the changes.

That concludes my statement, Mr. Chairman.

[The prepared statement of Ms. Calbom follows:]

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Government Efficiency, Financial Management and Intergovernmental Relations, Committee on Government Reform, House of Representatives

For Release on Delivery
Expected at 10 a.m. Thursday,
June 13, 2002

MEDICAID FINANCIAL MANAGEMENT

Better Oversight of State Claims for Federal Reimbursement Needed

Statement of Linda M. Calbom
Director, Financial Management and Assurance

GAO-02-706T

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the results of our review of Medicaid financial management by the Centers for Medicare and Medicaid Services (CMS). My testimony today summarizes our report to the Subcommittee, published in February of this year,[1] which discusses the need to improve federal oversight of state Medicaid financial activities.

As you know, the federal government and the states share responsibility for the fiscal integrity and financial management of the jointly funded Medicaid program. In fiscal year 2000, the Medicaid program served about 33.4 million low-income families as well as certain elderly, blind, and disabled persons at a cost of $119 billion to the federal government and $88 billion to the states for program payments and administrative expenses.

States are the first line of defense in safeguarding Medicaid funds through their responsibilities for making proper payments to providers, recovering misspent funds, and accurately reporting costs for federal reimbursement. At the federal level, CMS is responsible for overseeing state financial activities and ensuring the propriety of expenditures reported by the states for federal reimbursement.

Audits of state Medicaid finances conducted annually in accordance with the Single Audit Act, as amended, have identified millions of dollars of questionable or unallowable costs incurred by state Medicaid agencies. In addition, annual financial statement audits required under the Chief Financial Officers Act of 1990, as expanded by the Government Management Reform Act of 1994, have identified many internal control weaknesses in CMS oversight of state Medicaid operations.

In light of these findings, you asked that we review the adequacy of CMS's financial oversight process for Medicaid. We assessed whether (1) CMS has an adequate oversight process to help ensure proper Medicaid expenditures, (2) CMS adequately evaluates and monitors its oversight process, making adjustments as necessary, and (3) the current CMS

[1]U.S. General Accounting Office, *Medicaid Financial Management: Better Oversight of State Claims for Federal Reimbursement Needed*, GAO-02-300 (Washington D.C.: Feb. 28, 2002).

organizational structure for financial management is conducive to directing its oversight process and sustaining future improvements.

To evaluate financial oversight and monitoring at CMS, along with the control activities used to help ensure the propriety of Medicaid expenditures, we performed work at CMS headquarters and regional offices, surveyed regional financial management staff and reviewed CMS manuals and other documentation and audit reports. To determine whether CMS's organizational structure for financial management is conducive to effectively directing its oversight process and sustaining future improvements, we interviewed directors, managers responsible for financial management at headquarters, and managers in five regions. We compared information we gathered about organizational structure, communications, and improvement initiatives with the Comptroller General's *Standards for Internal Control in the Federal Government*[2]. We performed our work from October 2000 through September 2001 in accordance with generally accepted government auditing standards.

As discussed in our February 2002 report, we found that CMS has financial oversight weaknesses that leave the Medicaid program vulnerable to improper payments. The Comptroller General's *Standards for Internal Control in the Federal Government* requires that agency managers perform risk assessments, act to mitigate identified risks, and then monitor the effectiveness of those actions. In addition, the standards provide that agencies should ensure that the organizational structure is designed so that authority and responsibility for internal controls are clear. CMS oversight had weaknesses in each of these four areas, which I will discuss in turn.

CMS Had Not Implemented a Risk-Based Approach in Reviewing Expenditures

Our review found that CMS had only recently begun to assess areas at greatest risk for improper payments. As a result, controls were not in place that focused on the highest risk areas and resources had not yet been deployed to areas of greatest risk. The Comptroller General's *Standards for Internal Control in the Federal Government* requires that agency managers perform risk assessments and then act to mitigate identified risks that could impede achievement of agency objectives.

[2]U.S. General Accounting Office, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington D.C.: Nov. 1999).

Since 1998, financial auditors responsible for the annual financial statement audit of Medicaid expenditures have noted that CMS failed to institute an oversight process that effectively reduced the risk of inappropriate Medicaid claims and payments.[3] Financial auditors identified internal control weaknesses that increased the risk of improper payments, including a significant reduction in the level of detailed analysis performed by regional financial analysts in reviewing state Medicaid expenses; minimal review of state Medicaid financial information systems; and lack of a methodology for estimating the range of Medicaid improper payments on a national level. The auditors recommended that CMS implement a risk-based approach for overseeing state internal control processes and reviewing Medicaid expenditures.

Regarding the auditor's findings and recommendations, CMS officials attributed most of the weaknesses in its oversight to reductions in staff at the same time Medicaid expenditures and oversight responsibilities increased. CMS data show a 32 percent drop in regional financial management staff from 95 full-time equivalent positions in FY 1992 to approximately 65 in FY 2000. At the same time, federal Medicaid expenditures increased 74 percent from $69 billion to $120 billion.[4] On average, each of the 64 regional financial analysts is now responsible for reviewing almost $1.9 billion in federal Medicaid expenditures each fiscal year as compared to an average of about $0.7 billion a decade ago.

In light of these conditions, CMS managers acknowledged that they needed to revise their oversight approach and in April 2001, began to develop a risk-based approach for determining how best to deploy CMS resources in reviewing Medicaid expenditures.

This new assessment effort required each regional office to provide data on the states and territories in its jurisdiction based on regional analyst experience and knowledge. For each type of Medicaid service and administrative expense, the Medicaid risk analysis estimates the likelihood and significance of risk based on dollars expended annually and measures risk based on factors such as unclear payment policies; state payments involving county and local government; and federal audit results. The risk

[3]In some instances, these findings were included in the management letters that accompanied the audited financial statements for fiscal years 2000, 1999, and 1998.

[4]The $120 billion in expenditures in 2000 is equal to $97.8 billion in 1992 dollars when adjusted for inflation.

analysis provides a score for each state that is intended to specify the areas of greatest risk for improper payments.

Medicaid financial managers also tabulated a national risk score for each type of Medicaid service and administrative expense using the state risk scores. However, at the time of our review, CMS had not taken steps to use the risk analysis in deploying its regional financial oversight resources. Medicaid financial managers in headquarters and the regional offices plan to develop work plans that will allocate resources based on the risks identified from the analysis. CMS expects to implement these work plans in reviewing the state's quarterly expenditure reports for fiscal year 2003.

In evaluating the Medicaid risk analysis, we considered strategies that leading organizations used in successfully implementing risk management processes. Our executive guide, *Strategies to Manage Improper Payments*[6] included two risk assessment strategies that are particularly applicable to CMS. These are that management should

- use information developed from risk assessments to form the basis from which it determines the nature of any corrective actions, and to provide baseline data for measuring progress in reducing payment inaccuracies and other errors; and
- reassess risks regularly to evaluate the effect of changing conditions, both internal and external, on program operations.

While the Medicaid risk analysis is a good start, we identified several improvements that should be made to the assessment before it is used to deploy resources. First, the analysis does not sufficiently take into account state financial oversight activities in assessing the risks for improper payments in each state. Several states have implemented techniques such as (1) prepayment edits and reviews to help prevent improper payments, (2) screening procedures to prevent dishonest providers from entering the Medicaid program, (3) postpayment reviews to detect inappropriate payments after the fact, and (4) payment accuracy studies to measure the extent of improper payments. CMS did not ask the regional financial analysts to consider whether states use these techniques, which have identified millions of dollars in overpayments. While regional financial

[6]U.S. General Accounting Office, *Strategies to Manage Improper Payments: Learning From Public and Private Sector Organizations*, GAO-02-69G (Washington D.C.: Oct. 1, 2001).

analysts may know about many activities like these through their oversight responsibilities, without collecting and documenting this information, CMS does not have a complete picture of the risk for improper payments in each state; nor will it have comprehensive information to determine the appropriate level of federal oversight that should be applied.

A second deficiency we found in the Medicaid risk analysis is that it did not specifically integrate information about state anti-fraud and -abuse efforts in assessing risks for each state. Regional financial analysts were instructed to consider the last time the regional office or HHS/OIG conducted a review or audit as one of the factors in determining the likelihood and significance of risk in each state. However, the analysts were not specifically instructed to consider results from reviews of state anti-fraud and -abuse efforts recently conducted by the CMS Medicaid Alliance for Program Safeguards, which has performed structured reviews in 16 states and plans to continue the reviews until all states are covered. CMS could gain valuable information for more accurately assessing the level of risk for improper payments in these 16 states as well as the appropriate level of federal oversight required.

Third, we found that the Medicaid risk analysis did not include mechanisms to ensure that such analysis would be an ongoing part of financial oversight. As identified risks are addressed and control activities are changed, agency managers should have methods in place to revisit their analysis to determine where risks have decreased and new ones have emerged. Medicaid financial managers had not determined how they would accomplish this.

Finally, the Medicaid risk analysis would be strengthened if states were systematically estimating the level of improper payments in their programs. CMS management has recognized this and has begun efforts to develop an approach for estimating improper Medicaid payments. In September 2001, nine states responded to a CMS solicitation to participate in pilot studies to develop payment accuracy measurement methodologies. The objective is to assess whether it is feasible to develop a single methodology for the diverse state Medicaid programs and to explore whether the range of improper Medicaid payments can be estimated nationally. Each of the nine states involved is developing a different measurement methodology. CMS managers expect the states to complete the pilots during fiscal year 2003, after which time CMS will select several of the state methodologies as test cases for fiscal year 2004. It is important that CMS continues to emphasize development of these payment accuracy reviews on a state-by-state basis and ultimately on a national level, since

this is a key baseline measure for managing improper payments in the Medicaid program.

Control Activities Were Not Effectively Implemented

Our review also found that while CMS had certain control activities in place to oversee Medicaid programs, it was not effectively implementing them, and therefore not mitigating identified risks. Control activities are an integral part of an organization's efforts to address risks that lead to fraud and abuse. Given the current level of resources and the size and complexity of the Medicaid program, CMS needs a different approach that incorporates new oversight techniques and strategies as well as the results of the risk assessment discussed previously.

In 1994, CMS began changing its oversight approach in an attempt to address resource challenges and growth in Medicaid expenditures. At that time, regional offices shifted from emphasizing detailed review of Medicaid expenditure data to increasing the level of technical assistance provided to states. Auditors of CMS financial statements found that as a result of this shift, regional offices were not providing appropriate review and oversight of state Medicaid programs, thus increasing the risk that errors and misappropriation could occur and go undetected. In our review, we found that the weaknesses identified by the auditors were still present.

In August 2001, we surveyed regional financial analysts to obtain their perspectives on the design and implementation of the Medicaid financial oversight process, covering the period from October 1, 1999, through the date of the survey. In comments to the survey, some regional analysts indicated that they were inundated with responsibility for multiple control activities and unable to perform them effectively. We asked the analysts to rate each of the control activities that they perform. The activity rated most important by 89 percent of those surveyed was quarterly expenditure reviews performed on-site at state Medicaid agencies. However, when asked about the adequacy with which they performed on-site expenditure reviews, almost 36 percent rated their performance "inadequate" or "marginal." In discussions, many financial analysts attributed deficiencies in expenditure reviews to inadequate staff resources, the low priority placed on financial management oversight, lack of training, and conflicting priorities.

Survey respondents also rated two other activities as important in overseeing the propriety of Medicaid activities—these were activities to (1) defer and disallow[6] Medicaid expenditures and (2) perform focused financial management reviews. While more than 75 percent of analysts rated these activities as highly important, data provided by CMS indicate, however, that the amount of Medicaid expenditures disallowed by regional analysts has declined. For example, from 1990 to 1993, analysts disallowed on average $239[7] million in expenditures annually. However, for fiscal years 1997 through 2000, analysts disallowed on average $43 million annually, which represents an 82 percent decline. During the same period, Medicaid expenditures went from an average of $58 billion annually to $106 billion annually—an increase of 83 percent.[8]

Similarly, focused financial management reviews declined. These reviews generally involve selecting a sample of paid claims related to certain types of Medicaid services provided. The reviews have been useful in identifying unallowable costs outside of those detected by reviewing quarterly expenditure reports. According to CMS managers, in fiscal year 1992, analysts performed about 90 in-depth reviews of specific Medicaid issues that identified approximately $216 million in unallowable Medicaid costs. In fiscal year 2000, analysts only performed 8 focused financial management reviews but these 8 reviews resulted in almost $45 million in disallowed costs—an average of about $5.6 million per review. As demonstrated, this control activity is effective in detecting unallowable Medicaid costs; however, it must be consistently performed for cost savings to be realized.

CMS is taking actions to improve oversight by beginning a comprehensive assessment of its Medicaid oversight activities. However, agency managers are concerned that their ability to address identified risks effectively may be hindered without additional oversight resources. In the interim, CMS plans to use the current oversight process (i.e., quarterly expenditure

[6]A deferral is an action taken to withhold funds from the states until additional clarification or documentation is received from the states regarding Medicaid costs claimed. A disallowance is a determination by CMS that a claim or portion of a claim by a state for federal funds is unallowable.

[7]The calculation of this amount does not include $1.15 billion in disallowances of Medicaid amounts for Disproportionate Share Hospital (DSH) claims in FY '92 that resulted from a change in the legislation related to DSH. Including this amount would increase the average disallowance to $527 million for FY '90 – '93.

[8]Expenditure and disallowance data provided by CMS.

reviews and technical assistance) for targeting those Medicaid issues that the new risk analysis identifies.

In assessing what steps CMS could take to more efficiently and effectively carry out its responsibilities to help ensure the propriety of Medicaid finances, we considered strategies that other organizations have used in successfully addressing risks that lead to fraud, error, or improper payments. As discussed in our executive guide on *Strategies to Manage Improper Payments*, key strategies include

- selecting appropriate control activities based on an analysis of the specific risks facing the organization, taking into consideration the nature of the organization and the environment in which it operates.
- performing a cost-benefit analysis of potential control activities before implementation to ensure the cost of the activities is not greater than the benefit.
- contracting activities out to firms that specialize in specific areas like neural networking, where in-house expertise is not available.

Our executive guide points out that many organizations have implemented control techniques including data mining, data sharing, and neural networking to address identified risk areas and help ensure that program objectives are met.

- Data mining is a technique in which relationships among data are analyzed to discover new patterns, associations, or sequences. Using data mining software, the Illinois Department of Public Aid, in partnership with the Office of Inspector General at the Department of Health and Human Services, identified 232 hospital transfers that may have been miscoded as discharges, creating a potential overpayment of $1.7 million.
- Data sharing allows entities to compare information from different sources to help ensure that Medicaid expenditures are appropriate. Last year we reported on a data sharing project called the Public Assistance Reporting Information System (PARIS) that has identified millions of dollars in costs savings for states.[9] PARIS helps states share information on public assistance programs, in order to identify individuals who may be receiving benefits in more than one state simultaneously. Using the PARIS data match for the first time in 1997, Maryland identified numerous

[9]U.S. General Accounting Office, *Public Assistance: PARIS Project Can Help States Reduce Improper Benefit Payments*, GAO-01-935 (Washington, D.C.: Sept. 6, 2001)

individuals who no longer lived in the state but for whom the state was continuing to pay a Medicaid managed care organization. The match identified $7.3 million in savings for the Medicaid program.
Neural networking is a technique used to extract and analyze data. A neural network is intended to simulate the way a brain processes information, learns, and remembers. This technique can help identify fraud schemes by analyzing utilization trends, patterns, and complex interrelationships in the data. In 1997, the Texas legislature mandated the use of neural networks in the Medicaid program. In fiscal year 2000, using neural networking, the Texas' Medicaid Fraud and Abuse Detection System recovered $3.4 million.

These techniques, which have been shown to achieve significant savings by identifying and detecting improper payments, could help CMS better utilize its limited resources in applying effective oversight of Medicaid finances at the federal level.

Some state Medicaid agencies have already implemented data mining, data sharing, and neural networking techniques to help ensure Medicaid program integrity. State auditors and HHS/OIG staff have also had success using these techniques in overseeing state Medicaid programs. However, resources devoted to protecting Medicaid program integrity and the use of these techniques varies significantly state by state. When designing its Medicaid financial oversight control activities, CMS should take into consideration the use of data mining, data sharing, and neural networking as well as other control activities performed at the state level. In states where these techniques are not being used, CMS should consider using these tools in its oversight process.

Monitoring Activities Were Limited in Scope and Effectiveness

The Comptroller General's Standards for Internal Control in the Federal Government requires that agency managers implement monitoring activities to continuously assess the effectiveness of control activities put in place to address identified risks. Our review found that CMS had few mechanisms in place to continuously monitor the effectiveness of its oversight. Managers had not established performance standards for financial oversight activities, particularly their expenditure review activity. Limited data were collected to assess regional financial analyst performance in overseeing state Medicaid programs. Without effective monitoring, CMS did not have the information needed to help assure the propriety of Medicaid expenditures.

A CMS official told us that steps would be taken within the next year to begin monitoring the effectiveness of the Medicaid financial oversight process. Medicaid financial managers plan to reinstitute a performance reporting process that was in place prior to 1993. While this is a good step, the previous process lacked several elements necessary for effective internal control monitoring. For example, the performance reporting process did not establish agency-specific goals and measures for evaluating regional performance in reducing payment errors and inaccuracies. In addition, there were no formal criteria or standard estimation methodologies for regions to use in measuring the amount of unallowable costs that the states avoided because of technical assistance provided before payment. As discussed in our executive guide, *Strategies to Manage Improper Payments*, establishing such goals and measures is key to tracking the success of improvement initiatives.

In addition, the CMS audit resolution procedures did not collect sufficient information on the status of audit findings or ensure their timely resolution, as required by federal internal control standards. We found that audit resolution and monitoring activities performed by CMS and its regional offices were limited. Audit resolution activities were also inconsistently performed across the regions.

Within CMS, three units share responsibility for audit resolution activities related to the Medicaid program. In accordance with the HHS *Grants Administration Manual*,[10] regional financial analysts are responsible for working with auditors to resolve findings, ensure questioned costs are recovered, verify that corrective actions have been taken, and document the status of audit resolution in quarterly reports. The Division of Audit Liaison (DAL) is responsible for maintaining a tracking system for each audit report and related findings, monitoring the timeliness and adequacy of audit resolution activities, distributing all audit clearance documents, and preparing monthly reports on the status of audit resolution and collection activities. The Division of Financial Management (DFM), the headquarters unit responsible for Medicaid financial management, has one headquarters staff person responsible for coordinating and interacting with DAL and regional analysts to ensure that Medicaid related findings

[10]The *Grants Administration Manual*, issued by HHS, provides guidance on implementing HHS policies on the administration of HHS grants. Chapter 1-105 of the manual addresses the resolution of audit findings.

are resolved. We found that many of these responsibilities were not being effectively carried out or were carried out inconsistently.

For instance, in discussions with regional financial analysts, we found that they spend very little time resolving state single audit findings due to competing oversight responsibilities. As a result, these findings are not always resolved, and related questioned costs are not promptly recovered. We found unrecovered questioned costs totaling $24 million that were identified in audit reports that had been issued for years prior to fiscal year 1999. In addition, we found that as of September 30, 2001, regional analysts had not determined whether actions had been taken to resolve 85 Medicaid findings included in state single audit reports for fiscal year 1999. Lack of timely follow-up on financial management and internal control issues increases the risk that corrective actions may not have been taken, and that erroneous or improper payments are continuing to be made.

We also found that the regional financial analysts inconsistently followed procedures for monitoring, tracking, and reporting on the resolution of single audit and HHS/OIG audit findings. For example, 3 of the 10 regions had not prepared quarterly status reports that are intended to provide information on corrective actions that states have taken to resolve audit findings.

Further, pertinent information was not identified, documented, and distributed among those responsible for audit resolution. The internal control standard related to information and communication provides that pertinent information be identified, recorded, and distributed to the appropriate areas in sufficient detail, and at the appropriate time to enable the entity to carry out its duties and responsibilities efficiently and effectively. In our review, we found that the monthly DAL report intended to provide a complete list of all audits with unresolved Medicaid findings did not meet this standard. We analyzed a list provided by the HHS/OIG that included 23 Medicaid related reports issued by the HHS/OIG and state auditors in fiscal year 2001. We found four reports from the HHS/OIG list that were not included in DAL monthly reports related to the second, third, and fourth quarters of that year. This information is critical and must be distributed to the regions to ensure that they are acting to resolve all Medicaid related findings.

We also found that the regions did not document information critical to tracking unresolved audits in their regional quarterly status reports. The regions reported which audits had been resolved but not the status of those still under review. This makes it difficult to track audit status.

Organizational Structure Impedes Effective Oversight

The current organizational structure of CMS compounds the weaknesses I have highlighted today. This organizational structure has created challenges to effective oversight because of unclear lines of authority and responsibility between the regions and headquarters. Although the 10 regional offices are the CMS front line in overseeing state financial management and Medicaid expenditures, there are no reporting relationships to DFM, the headquarters unit responsible for Medicaid financial management.

For example, a working group headed by the director of DFM updated guidance for expenditure reviews in September 2000 in response to concerns raised by auditors about the inconsistency in expenditure reviews across regions. While the guide strongly encouraged regional analysts to perform all procedures, it did not mandate that they do so. Headquarters financial managers do not have direct authority to enforce such a directive and regional managers have discretion in how resources are utilized. Similarly, the guide allowed regional branch managers the discretion to review regional analyst's expenditure review workpapers for compliance with the guide or simply to obtain written or verbal assurance from the analyst that the procedures were performed. By allowing supervisors to satisfy their review responsibilities merely with verbal assurance, CMS minimized the effectiveness of this basic control. During our site reviews, we found evidence that supervisory reviews were not conducted.

The CMS organizational structure also hindered efforts to evaluate and monitor regional office performance. At the time of our review, there were few formal requirements for regions to report to headquarters and CMS did not collect, analyze, or evaluate consistent information on the quality of regional financial oversight for Medicaid across the country. Previous efforts to monitor performance were discontinued because regional staff resources were not available to collect and submit the data to headquarters managers. Headquarters managers, in turn, did not have the authority to require regions to collect such data. As a result, Medicaid financial managers in headquarters were not in a position to provide formal feedback to region financial management staff to improve their performance and therefore have not been in a position to assess the effectiveness of Medicaid oversight activities.

The current organizational structure also poses challenges to implementing corrective actions aimed at addressing oversight weaknesses and improving accountability. Over the past 2 years, headquarters financial managers have taken steps to develop and

implement improvements to the financial oversight process. Medicaid staff are currently

- developing risk analysis to identify expenditures of greatest risk;
- working with states to develop methodologies for estimating Medicaid improper payments;
- developing work plans that guide efforts to allocate financial oversight staff and travel resources based on the risk analysis; and
- developing performance-reporting mechanisms.

Medicaid staff have also recently

- formed a financial management strategy workgroup of headquarters and regional financial management staff to review the entire Medicaid financial oversight process and determine the proper structure for an adequate oversight process;
- updated its expenditure and budget review guides; and
- gathered information on how regional financial analyst staff time is allocated between oversight responsibilities.

Headquarters DFM managers recognize that regional office commitment is critical to successfully implementing and sustaining its improvement initiatives. The current structural relationship could diminish the chances of such success. Headquarters managers expressed concern that despite recent efforts to develop risk analysis and implement work plans that allocate resources based on identified risks, regional managers will still have the authority to decide how oversight resources are utilized. Given the multiple oversight activities that regional financial analysts are responsible for, headquarters managers have no assurance that review areas included in the work plans will be given priority in each region. Headquarters managers may experience similar difficulties in reestablishing performance reporting. According to one senior Medicaid manager, some regions have already petitioned headquarters managers not to use data on the amount of expenditures deferred and disallowed in gauging performance.

During our review, we asked regional financial analysts about several recent improvement initiatives to gauge their knowledge and participation in the initiatives. Several analysts we spoke with did not think the risk assessment effort was useful because they felt that they already knew the risks within the states that they were responsible for and did not need a formal assessment to tell them that. In our survey, we asked regional financial analysts to rate the importance of the risk assessment, staff time

allocation effort, and review guide updates to overall financial oversight. Approximately half of the survey respondents thought the initiatives were of marginal or little importance. During pretests of our survey, several analysts said they did not understand the purpose of the initiatives because no one had communicated to them how the information was going to be used.

In discussions with headquarters managers, they acknowledged that a written plan or strategy that describes the initiatives and the responsibility for implementing them was still being drafted. Such a plan or strategy could be very useful in soliciting regional analyst support. More importantly, headquarters managers acknowledged that performance accountability mechanisms for the regions are needed to implement improvements successfully. CMS is currently planning some changes that may improve mechanisms to hold CMS financial managers, including regional managers and administrators, accountable for critical tasks. CMS has developed a restructuring and management plan that seeks to add specific responsibilities tied to agency goals into senior managers' performance agreements. CMS has not determined how Medicaid financial management oversight responsibilities that can be evaluated will be included in the plan. This information is key to establishing a sound internal control environment for Medicaid finances throughout CMS.

As you can see, this structural relationship has created challenges in (1) establishing and enforcing minimum standards for performing financial oversight activities, (2) routinely evaluating the regional office oversight, and (3) implementing efforts to improve financial oversight. As a result, CMS lacks a consistent approach to monitor and improve performance among the units that share responsibility for financial management and ingrain a sound internal control environment for Medicaid finances throughout CMS.

In closing, Mr. Chairman, I want to emphasize that while CMS is acting to improve its financial oversight of the Medicaid program, the increasing size and complexity of the program, coupled with diminishing oversight resources, requires a new approach to address these challenges. Developing baseline information on Medicaid issues at greatest risk for improper payments and measuring improvements in program management against that baseline is key to achieving effective financial oversight. Determining the level of state activities in place to monitor and control Medicaid finances is also critical to determining the extent and type of control techniques as well as the amount of resources CMS must apply at

the federal level to oversee the program adequately. Establishing clear lines of authority and performance standards for CMS oversight would also provide for a more efficient, effective, and accountable Medicaid program. Our report includes recommendations in each of these areas. CMS's ability to make the kind of changes that we are recommending will require top-level management commitment, a comprehensive financial oversight strategy that is clearly communicated to all those responsible for program oversight, and clear expectations for implementation of the changes.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or other members of the subcommittee may have.

Contact and Acknowledgments

For information about this statement, please contact Linda Calbom, Director, Financial Management and Assurance, at (202) 512-9508 or at *calboml@gao.gov*. Individuals making key contributions to this statement include Kimberly Brooks, W. Ed Brown, Lisa Crye, Chanetta Reed, Vera Seekins, Taya Tasse and Cynthia Teddleton.

GAO
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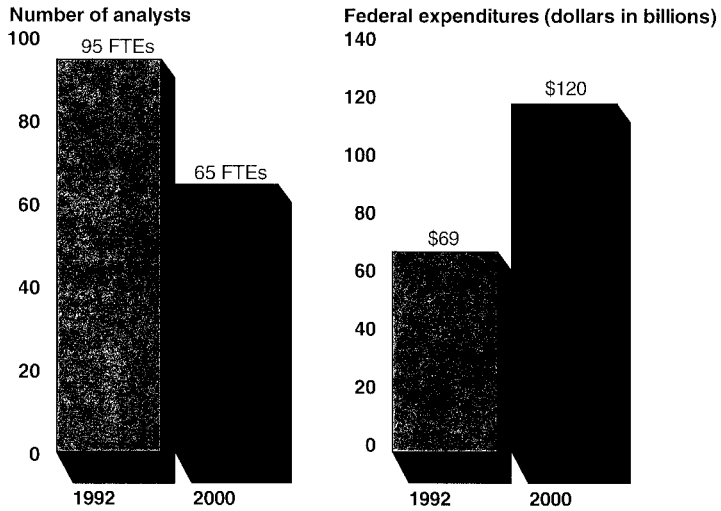
Change in Financial Analysts (FTEs) vs. Change in Federal Medicaid Expenditures 1992 and 2000



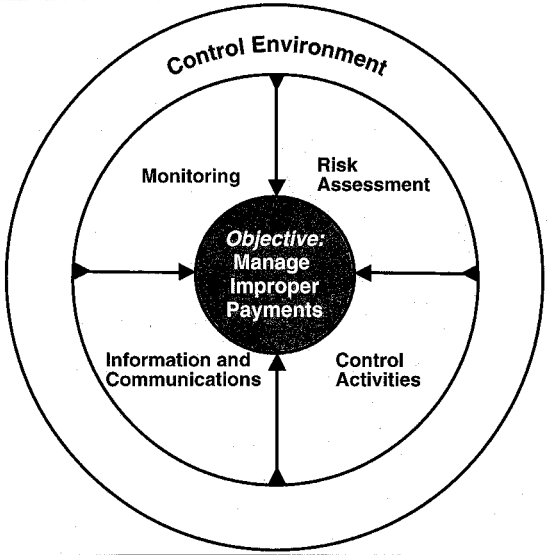
Source: CMS

Note: The $120 billion in expenditures in 2000 is equal to $87.8 billion in 1992 dollars when adjusted for inflation.

GAO

Accountability * Integrity * Reliability

Managing Improper Payments Through Internal Controls



Mr. HORN. Thank you very much. Our next presenter is Dennis Smith, the director of the Centers for Medicaid and State Operations.

STATEMENT OF DENNIS SMITH, DIRECTOR, CENTERS FOR MEDICAID AND STATE OPERATIONS

Mr. SMITH. Thank you, Mr. Chairman. Our deputy administrator and chief operating officer, Ruben King-Shaw, was not available today because of a personal medical emergency. I will do my best to fill his shoes.

Thank you very much for the opportunity to discuss some of the things that we are doing at CMS. I appreciate the opportunity to have the benefit of the experts on both sides of me, the GAO and the OIG, and some of our partners out there.

Again, as GAO explained, the first line of defense really is the States themselves that administer the program and are responsible for setting reimbursement rates, for monitoring those, etc.

I think a large part of the stepped-up efforts that you have seen really came out of, in large part, the Y2K efforts as well. As States were updating their computer systems, they were also taking the opportunity to update their MMIS systems and their service systems, which is the utilization review. It really is the first line of defense in making sure those payments are accurate from the very beginning, having systems in place where you can identify the outliers, and then followup to make sure that where there have been overpayments those are investigated for the reasons why.

As you know, there can be a number of different ways that inappropriate payments can be made: An individual is not eligible, services are billed for that were not really provided in the first place, etc. Those things really have to be identified at the State level, and we have seen improvement over the past couple of years where States have improved their systems, upgraded their computer systems. As you know, the Federal Government pays an enhanced match for States as they upgrade their systems, and those Federal funds, clearly, are very important to updating those systems themselves.

The States also operate the Medicaid fraud control units out of, I believe, almost all States are operating their systems out of their Attorney General's offices. Having those strong enforcements at that State level, obviously, is also very critical to it to know that where there has been fraud found that those cases will be prosecuted.

In terms of the strengthening of the management systems, we appreciate GAO's guidance. We also appreciate what I think are some very positive findings in terms of getting our feet on the ground, and I don't think that you will find any daylight between the administration and the GAO in terms of commitment to updating the financial integrity of this system. The administration has, maybe a little too quietly, put some new controls into place, doing a number of things that are just good sound management tools to make sure that we are monitoring.

When you have the hearing next year, I think that you will hear about and see a great deal of improvement as we have put these systems into place. We have structured work plans and we have

done risk-assessments. The regional offices have done risk-assessments: where is the greatest risk out there? What should we be targeting? Etc. The work plans themselves are now in effect, and, again, the monitoring, I can assure you that we take this very seriously.

I think also a year from now, when we look back in terms of what the GAO has referred to in the previous report in terms of the decline in disallowances that were taken previously, those deferrals and disallowances are now up considerably. And, again, the will is there and the commitment is there to make certain financial integrity is well-grounded out there in terms of the managers and staff understanding the commitment to financial integrity.

So I am pleased to hear some of the positive comments that we are making progress, and, as I said, a year from now I think you will see a great deal more progress.

There are a number of commitments that are summarized. I won't go through them all in terms of your having a large panel here, but our written statement for the record describes a number of the initiatives that we have.

In particular, in your own State, Mr. Chairman, we are doing data matches between the Medicaid and the Medicare systems themselves. If you find a provider who is ripping off one program, chances are pretty good they are ripping off the other program as well. So getting the two different programs to talk to each other is, we believe, a great potential for success. So we have a pilot program going on.

We also have pilot programs with nine States that are going on, and we think that will grow in terms of payment accuracy. We are very pleased to have our State partners join us in that and believe that also will yield a great deal of benefits.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Smith follows:]

TESTIMONY OF
RUBEN KING-SHAW, JR.
DEPUTY ADMINISTRATOR AND CHIEF OPERATING OFFICER
CENTERS FOR MEDICARE & MEDICAID SERVICES
ON
MEDICAID FINANCIAL MANAGEMENT
BEFORE THE
HOUSE GOVERNMENT REFORM
SUBCOMMITTEE ON GOVERNMENT EFFICIENCY, FINANCIAL MANAGEMENT AND INTERGOVERNMENTAL RELATIONS

JUNE 13, 2002

Chairman Horn, Congresswoman Schakowsky, distinguished Subcommittee members, thank you for the opportunity to discuss CMS's efforts to improve financial oversight and management of the Medicaid program. We share your concern for protecting taxpayer dollars and ensuring Medicaid's financial integrity. As Federal and State Medicaid spending continues to grow rapidly, it is increasingly important for us to make sure that taxpayer dollars are serving their intended statutory purposes of improving health care quality and access for Medicaid beneficiaries. As you know, improving financial performance is one of five government-wide initiatives that comprise the President's Management Agenda and reducing improper payments is a key component of the initiative. We believe that there are many opportunities for improving the fiscal integrity and management of the Medicaid program. This is a critical priority of mine as Chief Operating Officer for the Centers for Medicare & Medicaid Services (CMS). We appreciate the recommendations provided by the Office of Inspector General, the General Accounting Office (GAO) and others as to how we might strengthen and improve our oversight processes in the Medicaid program. We take these recommendations seriously and they provide a valuable roadmap for the future.

We, along with the States, have a strong interest in strengthening financial oversight and ensuring payment accuracy. The States provide a crucial first line of defense in safeguarding Medicaid program dollars. At the Federal level, our primary roles are to exercise proper oversight and review of State financial practices and to provide guidance and support for States' program integrity efforts. While we have made substantial progress in helping States identify

and reduce improper payments, we are now turning our attention to strengthening Medicaid Federal financial management activities. We have taken some initial steps to improve our financial management processes, but we know that more work can and must be done. As part of the President's FY 2003 Budget, we have dedicated $10 million from the Health Care Fraud and Abuse Control (HCFAC) account to develop a comprehensive Medicaid program integrity plan. Once developed, this plan will provide for a coordinated strategy of Federal financial management based on sophisticated risk management techniques. Among other things, this strategy will allocate resources based on a risk assessment methodology, more fully align Central Office and Regional Office efforts, capitalize on regional best practices, promote independence of the program integrity function, and continuously measure performance and monitor results. This plan will address the concerns raised by the GAO and others, and I am pleased to share with you today the progress we have made.

BACKGROUND

Medicaid is a partnership between the federal government and the States. Each year the federal government and the States together spend $225 billion providing services to 40 million eligible Medicaid beneficiaries. While the federal government provides financial support to the States and is responsible for overseeing the Medicaid program, each State essentially designs and runs its own program. Beyond a core set of mandatory covered services, Medicaid programs vary widely among States. The States are responsible for establishing their own financial management internal control structures and plans to ensure that program dollars are spent appropriately. We are responsible for approving these plans and ensuring that they safeguard the fiscal integrity of the Medicaid program and meet other Federal requirements.

CMS's Central Office in Baltimore, in collaboration with our 10 Regional Offices across the country, has responsibility for administering the Medicaid program and overseeing States' related financial activities. Under direction from the Central Office, our Regional Office staff work in close partnership with the States in performing a variety of financial oversight activities, such as reviewing State budget and expenditure reports for accuracy, identifying allowable and unallowable program costs, as well as providing advice and guidance to the States on Medicaid financial management matters. They also work collaboratively with Medicaid Agency Program

Integrity Units to ensure Medicaid program integrity and minimize the potential for waste, fraud, and abuse within the Medicaid program. Furthermore, the Agency is responsible for reviewing the results of State Medicaid audits conducted in accordance with the Single Audit Act to ensure that States take corrective actions to address any identified weaknesses.

STRENGTHENING MEDICAID FINANCIAL MANAGEMENT

We recognize the need to strengthen our Medicaid financial management efforts and, as part of the proposal in the FY 2003 President's Budget, are taking a number of proactive steps to address areas of concern and build strong protections for the future. We are increasing attention to, and emphasizing the importance of Medicaid financial management at all levels of our Agency and across all of our regions. This effort involves improving Federal oversight capabilities of State Medicaid financial practices, and focusing attention on program areas of greatest risk, so that our resources are targeted appropriately. We are redoubling our efforts to reach out to our partners at the State level to get their insight and expertise on how to best focus our financial management activities and improve information sharing between the HHS Inspector General, State agencies, and our Agency. Finally, we are building on our fraud, waste, and abuse efforts with the States and developing new and innovative approaches to identifying and measuring payment errors. The following are examples of improvements and progress we have made as part of our Medicaid financial management and program integrity redesign:

Managing for Results. In 2002, we put a structured financial management work planning process in place for each of our Regional Offices, which are directly responsible for Medicaid oversight activities. These new work plans detail the specific financial management activities that each region is responsible for, and will provide the Agency with tangible results that we will use to measure our own performance in achieving our objectives on an ongoing basis. Moreover, these work plans will give our Regional Offices a clear picture of performance expectations, allow senior management to track performance results, and provide improved communication pathways for ensuring consistency in the guidance provided to our Regional Offices. In addition, these concrete work plans will allow us to align management priorities between our Central Office and the regions, which will, in turn, strengthen accountability at all levels. We also are working on several internal pilot projects to improve coordination between

our Central Office and the Regional Offices in the areas of financial management resource allocation and goal setting, as well as to establish consistency in the application of Medicaid reimbursement policies across the nation.

Working with our State Partners. We are taking steps to strengthen our partnership with the States and ensure that the financial management process is mutually beneficial for the States and our Agency. We know there is a great deal we can learn from one another. Therefore, we recently established a joint State-Federal technical advisory group in cooperation with the National Association of State Medicaid Directors (NASMD). This group will be responsible for a number of important information-sharing activities. They will help ensure that the recommendations made by the Inspector General in their annual audit of the Medicaid program, and that the advice provided by the GAO, are put into place as appropriate. This group also will serve as a sounding board for the States and allow them to provide feedback to us on how we can improve our management review activities. We want the States to advise us on issues such as expanding and improving the use of the Medicaid Management Information System or changing State reporting forms so that they highlight key activities and are clear and understandable. We also hope that the group will help us to identify significant financial trends in Medicaid and make changes to our reviews to address these areas. Finally, the group will help facilitate communication and information sharing between our other technical advisory groups that work on related activities like fraud and abuse and issues surrounding third-party liability.

Focusing on Areas of Greatest Risk. A key element of our overall Medicaid financial management strategy is to focus our Regional Offices' financial reviews on high-risk areas of the Medicaid program. To identify these areas, we performed a nationwide risk assessment of improper claiming of Federal Medicaid funds last spring on a State-specific and service-by-service basis. The results provided us with a useful baseline by which we can measure future performance and improvements on the part of our Regional Offices, as well as the States. This effort also helped confirm and document in a systematic way what we already knew to be areas of risk.

We are using the information we gathered to improve our own financial management oversight strategy, and methods, and to help States comply with the law. For example, we are refining our processes to focus our available resources on State reviews on those program areas that we know are of greatest risk. In addition, we have begun on-site reviews of States' quarterly expenditure reports where the magnitude of State spending or past history of Medicaid claiming issues warrant them. Also, we are working more closely with State and federal audit agencies to ensure that problems are remedied. Based on what we learned through the risk assessment process, we are re-examining our financial management guidance to the States. And we are making changes, where necessary, to ensure that our guidance and policies are articulated clearly and understood by the States, recognizing that the States are ultimately responsible for ensuring that their claims for federal reimbursement are appropriate.

We also plan to explore the use of new data analysis techniques and look for new opportunities to incorporate data from different sources to better inform and focus our oversight processes. We currently are examining the use of information from the Medicaid Statistical Information System, a database containing Medicaid enrollment and paid claims data, to see if it may provide new sources of information to strengthen our review. This will help us to better understand the financial management environment as well as improve the techniques used by our Regional Office staff in performing their oversight activities.

Improving Payment Accuracy Measurement. We are taking concrete steps to ensure that taxpayer dollars invested in the Medicaid program are managed and spent appropriately by developing tools to measure payment accuracy in Medicaid, similar to that of the Medicare program. We are committed to developing a solution to this. In fact, one of our Government Performance and Reporting Act goals is to assist States in developing this type of measurement tool, as well as conducting pilot tests of various approaches, and exploring the feasibility of measuring payment accuracy at the national level.

We recognize, however, that given the diversity among State Medicaid programs, developing this tool will be challenging for our Agency and the States. Over the past several years, several States have pioneered projects on their own to measure payment accuracy within their Medicaid

programs. We want to build on their experience and to share what these States have learned on a broader scale. We have already made substantial progress. This year, working collaboratively with nine States and an outside technical consultant, we developed a model for estimating payment accuracy in Medicaid fee-for-service and managed care programs at the State level. Next year, we plan to expand the accuracy project to up to fifteen States, most of which will test our model measurement methodology. It is a demanding, but important challenge, and we will work closely with the States to meet it.

Strengthening State Program Integrity Efforts. We are making a strong and concerted effort, in cooperation with our State partners, to significantly strengthen State program integrity. And we are working closely with State and Federal law enforcement to improve their coordination and effectiveness. Our Agency's Southern Consortium, which consists of the Atlanta and Dallas Regional Offices, leads our National Medicaid Fraud and Abuse oversight efforts, what we call the Medicaid Alliance for Program Safeguards. Established in 1997, the Alliance has been successful in tackling some of the most daunting program integrity issues and has developed a strong and sustaining partnership with the States. By basing our efforts at the regional level, we are able to get closer to the "front lines" of State activity in tackling program integrity issues. Last October, the Alliance sponsored a focus group with a number of our State partners to develop new program integrity strategies for fighting waste and abuse and to examine how we might better coordinate our Medicaid program integrity efforts with those of Medicare. Many ideas have been generated from focus groups like this one, including our recently announced partnership with the California State Department of Health. Now, computers in the State of California will share Medicare and Medicaid program data and help us to detect fraudulent patterns in either program that might not be evident when viewed in isolation. We know when problems crop up in Medicare; they are likely to also be found in Medicaid. Through this data-sharing partnership, analysts and investigators will be able to see the "whole picture" instead of focusing on one program.

The move in Medicaid from a predominantly fee-for-service mode to a managed care or capitated model presented a challenge for States to curb fraud and abuse in their Medicaid programs. Many States are still learning how to address the unique program integrity challenges

posed by managed care, and some are fighting the misconception that managed care somehow does away with program integrity issues. In response to these concerns, the Alliance organized and sponsored a series of *Fraud in Medicaid Managed Care* Workshops, focusing on how fraud manifests differently within the managed care setting and how programs to address it should be structured. The workshops brought State program and Fraud and Abuse staff together with Federal law enforcement to better coordinate anti-fraud efforts. Forty-nine States participated. In addition, the Alliance released a document entitled, "Guidelines for Addressing Fraud and Abuse in Managed Care" to provide ideas and guidelines to assist States and other stakeholders in preventing, identifying, investigating, reporting, and prosecuting fraud and abuse in capitated managed care programs. The guidelines focused on:

- Key components of an effective managed care fraud control program;
- Data necessary to detect and prosecute managed care fraud;
- How to report managed care fraud;
- Suggested language for managed care contracts and waivers to help fight and prevent program integrity problems; and
- Our role, along with the roles of State Medicaid agencies, State fraud control units, managed care organizations, and the HHS Inspector General.

Also, the Alliance has instituted a multi-year program of State Medicaid Program Integrity Reviews. Our Regional Offices conduct these reviews in order to assess State fraud and abuse efforts in both fee-for-service and managed care, as well as to provide technical assistance and identify "Best Practices." These program integrity reviews, lauded by GAO, focus on State compliance with applicable program integrity statutes and regulations and may also include a detailed assessment of the States' strengths and vulnerabilities in this area. The information that we obtain from these reviews is very relevant to the financial management work planning process that I described earlier, particularly with respect to risk assessment and analysis, which ensures that the findings are considered as annual Regional Office and national financial management work plans are developed. Additionally, the Alliance developed a new section of the Program Integrity Review Guide for use in monitoring States' managed care plans.

Creating A National Institutional Reimbursement Team. In an effort to improve national consistency in the issuance and application of Medicaid reimbursement policy, we have put together a team of Central and Regional Office staff, the National Institutional Reimbursement Team, who are responsible for reviewing all institutional reimbursement State plan amendments, providing technical assistance to the States, and developing Medicaid institutional reimbursement regulations and policy. For example, the team is currently creating a standard set of questions that must be answered by States before a State plan amendment can be approved and will help ensure that the payment methodology is clear. As a result of this effort, we will better know what we are paying for and how we are paying for it. The team's work will help ensure consistency in the application and review of our Medicaid policies.

Making Federal Matching Payments Only When State Plan Amendments Are Approved. In the past, States have been allowed to draw down federal matching payments for State plan amendments that were submitted, but not yet approved. This allowed States to assume a financial risk if their plan amendment was subsequently disapproved. Since federal matching payments were readily available while their State plan amendments were being considered, States had little incentive to ensure their plan amendments were approved. In fact, some State plan amendments were pending for years while the States continued to draw down federal matching payments. In January 2001, we issued a State Medicaid Director letter informing the States that we would no longer make federal matching payments until State plan amendments were approved, thus removing the previous incentive for States to keep plan amendments pending. For our part, we have changed our policy so that we will either approve or disapprove plan amendments within 90 days.

Prohibiting Federal Matching Payments for Contingency Fee Contracts. In addition, we have a longstanding policy that federal matching payments can only be made for professional services contracts related to the filing and collection of Medicaid claims that provide payment on a fixed-price basis and not on contingency. Additionally, our policy provides that contracts must be competitively awarded, except under very limited circumstances. Our Regional Offices recently surveyed all States to ensure that this policy was being followed. In a few limited cases, we found that States were incorrectly claiming federal matching payments under contingency fee

arrangements. As a result, we issued a memorandum this past month to the States, reiterating our policy that federal matching payments cannot be made on contingency fee contracts.

Partnership with State and Federal Oversight Agencies. Another key element of our new financial management strategy is to strengthen our working relationships and our exchanges of information with several State entities. Every State has one or more audit entities responsible for ensuring that State expenditures, including those in the Medicaid and State Children's Health Insurance Programs, are properly made and documented. Furthermore, every Medicaid Agency has a surveillance and utilization review staff to pinpoint and pursue questionable provider claims and Agency payments. Finally, as you know, virtually all States operate a Medicaid Fraud Control Unit, typically housed in the Attorney General's office, to pursue instances of suspected Medicaid fraud. By better cultivating our relationships with State agencies that perform these types of functions, we believe we can continue to enhance our oversight of the Medicaid program nationwide. In addition, over the last several years, at the Federal level, we have developed a close collaboration with the Department of Health and Human Services Office of the Inspector General. We intend to continue this relationship. Finally, in cooperation with the American Public Human Services Association, we plan to survey State Medicaid agencies this year in order to identify specific ways to improve the usefulness of the annual Single Audits performed by every State pursuant to the Single Audit Act Amendments of 1996.

CONCLUSION

We are strongly committed to protecting taxpayer dollars and ensuring the sound financial management of the Medicaid program. As evidenced by our testimony today, we are taking a number of proactive steps to reach out to our State partners to get their insight and expertise on how to best focus our financial management activities and improve information sharing. Going forward, we are developing a comprehensive strategy that will also strengthen Federal oversight of State financial practices. We have made a great deal of progress and we look forward to continuing to work cooperatively with you, Chairman Horn, Congresswoman Schakowsky, this Subcommittee, and the Congress as we work to strengthen and protect the Medicaid program for the future. I thank you for the opportunity to discuss this important topic today, and I am happy to answer your questions.

Mr. HORN. Thank you, that is a thorough presentation.

Let me move now to Mr. Mangano, the Principal Deputy Inspector General, Office of the Inspector General for the Department of Health and Human Services.

STATEMENT OF MICHAEL F. MANGANO, PRINCIPAL DEPUTY INSPECTOR GENERAL, OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY JOHN HAGG, AUDIT MANAGER, OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. MANGANO. Thank you, Mr. Chairman, I am pleased to be with you here this morning to describe how our office is working with the States and the Centers for Medicare and Medicaid Services to protect taxpayer dollars against Medicaid fraud, waste, and abuse. My written testimony focuses on how we are joining forces with the State Medicaid Fraud Control Units to fight fraud, with the State auditors to identify suspected cases of abuse, and three recent reviews we have completed on State abuses with Medicaid payment systems, and Medicaid prescription drug pricing.

Each State is required to have a program integrity unit dedicated to detecting and investigating suspected cases of Medicaid fraud. Most States fulfill this requirement by establishing a Medicaid Fraud Control Unit, which I will call MFCU for short. Our office has the responsibility to oversee the grants to and the operations of these units.

As the chart in my testimony demonstrates, in the last fiscal year those units accounted for over 1,000 convictions and a total of $253 million that was recovered back to the Medicaid program. Our office also conducts joint investigations with MCFUs. Last year, we worked together on 179 criminal and 41 civil cases, and achieved 47 convictions.

Over time, we have learned the same abuses perpetrated against Medicare are often committed against Medicaid, so we have launched another important cooperative program to partner with State auditors. This program allows us to provide broader coverage than our resources would allow us to do by sharing our methodologies and experiences in investigating the Medicare program with State auditors who are looking at the same kind of issues in the Medicaid program. Our role ranges anywhere from sharing methodologies with the States that they can use themselves in their Medicaid fraud investigations, up to joining those teams ourselves and becoming a full-fledged partner in doing a particular audit.

To date, we have ongoing partnerships with 25 States, and we have identified over $246 million of misspent funds. Some of the reviews focused on issues like unbundling clinical laboratory services, outpatient physician services, hospital transfers, durable medical equipment, and managed care.

Our office also conducts a number of audits and evaluations in areas of suspected abuse. One recent series of reviews examined the use of States' manipulating schemes that exploited a loophole in Medicaid's upper payment limit regulations. This manipulation used intergovernmental transfers to artificially generate excessive

Federal matching funds for enhanced payments to certain providers.

Very briefly, the States were able to pay nursing homes, hospitals, and certain other health care providers up to the amount that Medicare pays for the same service. But in six of the States that we examined, they required the city and county nursing homes to transfer back to the State most, if not all, of that enhanced payment. When it was returned, some went back to the general fund for the State; some of it was used for Medicaid. And when it was, it also generated additional Federal matching funds. And some of it was used for other purposes. But practically none was kept by the nursing homes to increase the quality of care for the beneficiaries it was intended to serve.

A related abuse we are now examining involves Medicaid disproportionate share payments to hospitals that provide care to a large number of Medicaid beneficiaries and uninsured people. We found that some of the hospitals that did get to keep some of their enhanced payments did not receive or were required to return their disproportionate share payments back to the State. We are currently reviewing this problem in 10 States.

Finally, our recent work on the Medicaid prescription drug pricing clearly shows that Medicaid is paying far too much compared with other payers. Most States pay pharmacies an average of 10 percent below the average wholesale price, which we call AWP, plus an additional fee for the cost of dispensing the drugs. We found, however, that those pharmacies actually paid an average of 22 percent below AWP for the brand name drugs and 66 percent below AWP for the generic drugs. Had the State Medicaid agencies actually paid at these lower rates, they would have saved the program $1.5 billion a year.

Mr. Chairman, fraud and abuse practices are harming the Medicaid program. We pledge our commitment to work with our partners at the State and Federal levels to root out these problems and ensure that taxpayer dollars are spent on high quality services for the benefits they are intended to serve.

This concludes my testimony, and I will be happy to answer any questions at the appropriate time.

[The prepared statement of Mr. Mangano follows:]

Medicaid Oversight

Testimony of Michael F. Mangano
Principal Deputy Inspector General
U.S. Department of Health and Human Services

Hearing Before:
House Committee on Government Reform
Subcommittee on Government Efficiency, Financial Management
and Intergovernmental Relations
June 13, 2002

Office of Inspector General
Department of Health and Human Services

Testimony of
Michael F. Mangano
Principal Deputy Inspector General

Good Morning, I am Michael F. Mangano, Principal Deputy Inspector General at the U.S. Department of Health and Human Services (HHS). You asked our office to testify on how the Federal Government and the States protect the Medicaid program and its beneficiaries against fraud, waste, and abuse. My testimony describes how we are working with the States, the Centers for Medicare & Medicaid Services (CMS), and other Federal and State law enforcement offices to address these problems. In addition, I want to describe some of the area s we have observed that provide opportunities for continued improvement in the financial health of the Medicaid program itself. Specifically, I will discuss our work on State abuses of Medicaid payment systems and Medicaid prescription drug pricing.

The Office of Inspector General

The Office of Inspector General (OIG) was created in 1976 and is statutorily charged with protecting the integrity of Departmental programs, as well as promoting their economy, efficiency and effectiveness. The OIG meets this statutory mandate through a comprehensive program of audits, program evaluations, and investigations designed to improve the management of the Department and to protect its programs and beneficiaries from fraud, waste and abuse.

The Medicaid Program

The Social Security Act authorizes Federal grants to States for Medicaid programs that provide medical assistance to needy persons. Each State Medicaid program is administered by the State in accordance with an approved State plan. While the States have considerable flexibility in designing their State plans and operating their Medicaid programs, they must comply with broad Federal requirements. Medicaid programs are jointly financed by the Federal and State governments. States incur expenditures for medical assistance payments to medical providers who furnish care and services to Medicaid-eligible individuals. The Federal Government pays its share of medical assistance expenditures to the States according to a defined formula which yields the Federal medical assistance percentage. This percentage ranges from 50 percent to 83 percent, depending on each State's relative per capita income.

Medicaid Fraud Investigations

The responsibility for detecting, investigating and prosecuting fraud and abuse in the Medicaid program is shared between the Federal and State Governments. Each State is required to have a program integrity unit dedicated to detecting and investigating suspected cases of Medicaid fraud. Most States fulfill this requirement by establishing a Medicaid Fraud Control Unit (MFCU). Each of the Medicaid State agencies also has a Medicaid Management Information System. A subpart of this data system is the Surveillance and Utilization Review Subsystems Units (SURS). The SURS units are charged with ferreting out fraud by conducting preliminary reviews of providers and beneficiaries

with aberrant claims or billing patterns that possibly indicate criminal fraud. When potential fraud cases are detected, the SURS units refer the cases to the MFCUs. Regulations require the Medicaid State agencies and the MFCUs to enter into a Memorandum of Understanding in which the agencies agree to refer all cases of suspected provider fraud to the MFCUs.

State MFCUs are part of the State Attorney General's office or other State agency that is separate and distinct from the Medicaid State agency. The purpose of the MFCUs is to investigate and prosecute Medicaid provider fraud, patient abuse and fraud in the administration of the program. Although originally managed within CMS, the oversight responsibilities for the MFCUs were transferred to the Office of Inspector General in 1979 since the MFCUs' activities were determined to be more closely related to the OIG investigative function. Federal funds for the Medicaid fraud control program are included in the CMS appropriation. The program reimburses the States for the cost of operating a MFCU at a rate of 90 percent for the first 3 years and 75 percent thereafter. Currently, all MFCUs are receiving the 75 percent rate.

Since the inception of the Medicaid fraud control program, the MFCUs have recovered hundreds of millions of program dollars. The following chart shows their recoveries to the Medicaid program as well as the number of convictions achieved and their funding for the past several years:

Year	Federal Funding Allocated by CMS	Federal Expenditure*	Federal/State Recoveries	Convictions
2001	$106,699,505	$106,699,505	$252,585,423	1002
2000	97,700,000	95,979,000	180,941,872	970
1999	92,200,000	89,703,745	88,738,327	886
1998	87,000,000	85,793,887	83,625,633	937
1997	82,000,000	80,557,146	147,642,299	871
1996	79,000,000	77,453,688	57,347,248	753
1995	76,000,000	73,258,421	88,560,361	684
1994	65,600,000	64,573,926	42,780,015	671

* Amount of Federal grant award that was received by the MFCUs

It should be noted that there are areas of MFCU activity, such as patient abuse cases, that do not generate a monetary return, but are part of the overall effort to provide quality care and to hold the health care community accountable for the Federal and State dollars spent. The following are examples of investigations led by State MFCUs:

> In FY 2001, a bookkeeper for a nursing home in Ohio used her position to steal over $14,000 from patient accounts. In January 2001, the bookkeeper pled guilty to one count of theft, a felony of the fourth degree. In March 2001, she was sentenced to 18 months in prison,

suspended; 30 days in the county jail; placed on 3 years community control; ordered to perform 100 hours of community service; and ordered to pay $14,855 in restitution plus court costs.

- In FY 2000 in New York, a home health aide who pushed an elderly male resident of an adult home to the floor, fracturing his pelvis and ribs, entered a guilty plea to the crime of endangering the welfare of a vulnerable elderly person in the second degree. The aide was sentenced in July 2000 to 6 months in jail and 5 years probation. The aide's conviction was the first obtained by the MFCU under a recently enacted State statute known as "Kathy's Law" which makes the crime a felony. Before "Kathy's Law," the aide could only have been convicted of a misdemeanor for the crimes she committed. Kathy's Law was enacted in November 1998 after an aide in a Rochester nursing home raped a comatose patient.

The OIG has responsibility for oversight of the funding and operating standards of the MFCUs, including coordinating part of their investigative training. During FY 2001, we provided oversight and administered approximately $106.7 million in funds granted by CMS to the MFCUs to facilitate their mission. The OIG's oversight duties include the initial certification and yearly recertification of the MFCUs. Regulations require the MFCUs to submit an application to the OIG with an annual report and a budget request. The MFCU application, annual report, budget and quarterly statistical reports are reviewed by the OIG to determine if the MFCUs are in conformance with standards issued by the OIG. The OIG also reviews questionnaire responses from the Medicaid Agency and OIG Field Offices. On-site inspections and reviews of the MFCUs are conducted by the OIG on an as needed basis. The OIG maintains ongoing communication with individual State MFCUs and the National Association of Medicaid Fraud Control Units related to the interpretation of program regulations and other policy issues.

A major component of the Health Insurance Portability and Accountability Act of 1996 was the establishment of a program to coordinate health care anti-fraud efforts. The OIG, MFCUs, and other law enforcement agencies work together to coordinate anti-fraud efforts. These partnerships have greatly enhanced our ability to carry out our mission. In FY 2001, we conducted joint investigations with the MFCUs on 179 criminal cases and 41 civil cases and achieved 47 convictions.

State Medicaid Audit Partnerships

Another important cooperative effort includes State Medicaid Audit Partnerships. Several years ago, we began an initiative to work more closely with State auditors in reviewing the Medicaid program. The Partnership Plan was created as a way to provide broader coverage of the Medicaid program by partnering with State auditors, State Medicaid agencies, and State internal audit groups. The level of involvement of each partner is flexible and can vary depending upon specific situations and available resources. In one instance, the OIG role may entail the sharing of our methodology and experience in examining similar Medicare issues. In other cases, we may join together with State teams to audit suspected problems.

For example, an audit conducted with the Delaware State Auditor indicated that a state agency had overpaid Medicaid managed care organizations and other health care providers $364,000 for services rendered on behalf of deceased recipients. The overpayments resulted because of major weaknesses in internal controls. The state agreed with recommendation to recover the overpayments and has begun to strengthen internal controls. Other issues examined in this partnership program include Medicaid outpatient prescription drugs, unbundling of clinical laboratory services, outpatient non-physician services already included as an inpatient charge, excessive costs related to hospital transfers, excessive payments for durable medical equipment, acquisition costs for Medicaid drugs, and program issues related to managed care.

The goal of our Federal and State partnerships is not just to identify and recommend recovery of unallowable costs from State agencies but is designed to focus on issues that will result in program improvements and reduce the cost of providing necessary services to Medicaid recipients. This approach provides broader coverage of the Medicaid program and a more effective and efficient use of scarce audit resources by both the Federal and State audit sectors. To date, these joint efforts have been developed in 25 States. Completed reports have identified $246 million in Federal and State savings and included recommendations for improvement in internal controls and computer systems operations.

OIG Audits of Medicaid Issues

In addition to our partnerships with the States, the OIG also directly conducts a number of audits and program evaluations as part of our general work planning process or at the request of CMS, the Department, or the Congress. The OIG has focused considerable resources in two areas in particular: abuses of Medicaid payment systems by the States themselves and Medicaid prescription drug pricing.

State Abuses of Medicaid Payment Systems

The OIG found that some States required public providers to return Medicaid payments to the State governments through intergovernmental transfers. Once the payments were returned, the States were able to use the funds for other purposes, some of which were unrelated to Medicaid. Although this practice could, potentially, occur with any type of Medicaid payment to public facilities, we identified this practice in two types of payments: Medicaid enhanced payments available under upper payment limits and Medicaid disproportionate share hospital (DSH) payments.

Enhanced Payments Available Under Upper Payment Limits. The CMS allowed State Medicaid agencies to pay different rates to the same class of providers as long as the payments, in aggregate, do not exceed the upper payment limits (what Medicare would have paid for the services). Federal regulations in effect before March 13, 2001, established two separate aggregate limits applicable to each group of health care facilities (i.e., nursing facilities, hospitals, and intermediate care facilities for the mentally retarded). For each group, the first limit applied to all providers in the State (private, State operated, and city or county operated). The second limit applied to only State-operated facilities. Because there was no separate aggregate limit that applied to non-State-owned providers, such as city- and county-owned facilities, State Medicaid agencies were able to calculate the total

enhanced payment amount on the basis of all private, State operated, and city or county operated facilities but distribute the entire amount to only city and county owned facilities without violating the upper payment limit regulations.

Based on audit results in six States, we concluded the following:

- In general, enhanced payments to city- and county-owned providers were not based on the actual cost of providing services to Medicaid beneficiaries or directly related to increasing the quality of care provided by the public facilities that received the enhanced payments.

- Enhanced payments to nursing home facilities were not retained by the facilities to provide services to Medicaid beneficiaries. Instead, billions of Federal Medicaid dollars were returned by the providers to the States through intergovernmental transfers.

- Some of the money sent back to the State governments were deposited in the general fund or earmarked for use in health related service areas, but not necessarily for the medicaid services approved in the State plan. Those funds that were used for Medicaid purposes were used as the States' share to match more Federal funds.

- Unlike nursing facilities, public hospital providers retained the majority of the Medicaid enhanced payments but still returned millions of dollars in disproportionate share payments to the States for other uses through intergovernmental transfers.

In short, the States' use of intergovernmental transfers as part of the enhanced payment program was a financing mechanism designed to maximize Federal Medicaid reimbursements by effectively avoiding the Federal/State matching requirements. In an effort to curb these abuses and ensure that State Medicaid payment systems promote economy and efficiency, CMS issued a final rule, effective March 13, 2001, which modified upper payment limit regulations in accordance with the Benefits Improvement and Protection Act of 2000. The regulatory action created three aggregate upper payment limits -- one each for private, State, and non-State government-operated facilities. The new regulations will be gradually phased in and become fully effective on October 1, 2008. We commend CMS for changing the upper payment limit regulations. The CMS projected that these revisions would save $55 billion in Federal Medicaid funds over the next 10 years. The CMS changed the enhanced payments that States may pay public hospitals from 100 percent to 150 percent of the amount that would be paid under Medicare payment principles. We recommended that the payments continue to be limited to 100 percent, and CMS took that action at an additional savings of $24.3 billion over 10 years.

When fully implemented, these changes will dramatically limit, though not entirely eliminate, the amount of State financial manipulation of the Medicaid program because the regulation does not require that the enhanced funds be retained by the targeted facilities to provide medical services to Medicaid beneficiaries.

An example of how an upper payment limit mechanism operates is provided in the Appendix to this statement.

Disproportionate Share Hospital (DSH) Payments. Medicaid DSH payments are designed to financially assist hospitals that provide care to a large number of Medicaid beneficiaries and uninsured patients. We believe that these payments are important because public "safety net" hospitals face special circumstances and play a critical role in providing care to vulnerable populations. However, during audit work involving enhanced payments available under the upper payment limit regulations, we found that hospitals that retained the enhanced payments noted above did not receive or did not retain DSH funds. Audit results in several States show that public hospitals that received these payments returned large portions (80 to 90 percent) of the payments back to the State Medicaid agencies through intergovernmental transfers. We have expanded our audit work to additional States to further review the DSH payments being made to hospitals.

We believe that public hospitals would receive adequate reimbursement to provide services to Medicaid beneficiaries and uninsured patients by (1) retaining the State and Federal shares of the enhanced Medicaid payments up to the 100 percent aggregate limit payable under Medicare payment principles, and (2) receiving and retaining 100 percent of the State and Federal shares of allowable DSH payments.

Medicaid Prescription Drug Pricing

Based on a number of reports over the past decade, we have recommended that CMS and the States make adjustments to avoid paying too much for prescriptions drugs under Medicaid. Two OIG audits completed in the past year found that the pharmacy actual acquisition cost of brand and generic drugs is substantially less than States pay under under current reimbursement methodologies. For example, most States use average wholesale price (AWP) minus a percentage discount as a basis for reimbursing pharmacies for both brand name and generic drug prescriptions. The average discount for both brand and generic drugs combined was about 10.3 percent nationally in 1999. We believe this is not a sufficient discount to ensure that reasonable prices are paid for drugs.

The paragraphs below outline the results of our brand name and generic prescription drug reviews. Our reviews were limited to ingredient acquisition costs and did not address other areas such as the cost of dispensing the drugs. Generally, States pay retail pharmacies for the ingredient cost of the drug plus a dispensing fee.

In both reports we recommended that CMS require the States to bring pharmacy drug reimbursement more in line with the actual acquisition costs of both brand and generic drugs. The CMS concurred that an accurate acquisition cost should be used to determine drug reimbursement and will encourage States to review their estimates of acquisition costs in light of our findings.

Medicaid Pharmacy - Actual Acquisition Cost of Brand Name Prescription Drug Products. In a final report issued in September 2001, we pointed out that significant savings could be realized on brand name prescription drugs reimbursed by States under the Medicaid program. Our review of

pricing information from 216 pharmacies in 8 States estimated that pharmacy actual acquisition cost nationwide averaged 21.84 percent below AWP in 1999. For the 200 brand name drugs with the greatest amount of Medicaid reimbursement in 1999 we calculated that as much as $1.08 billion could have been saved if reimbursement had been based on a 21.84 percent average discount from AWP.

Medicaid Pharmacy - Actual Acquisition Cost of Generic Prescription Drug Products. In a report issued in March 2002, we concluded that significant savings could be realized on generic prescription drugs reimbursed by States under the Medicaid program. Our review of pricing information from 217 pharmacies in 8 States estimated that pharmacy actual acquisition cost nationwide for generic drugs averaged 65.93 percent below AWP rather than the 10.3 percent discount most States averaged. For the 200 generic drugs with the greatest amount of Medicaid reimbursement in 1999 we calculated that as much as $470 million could have been saved if reimbursement had been based on a 65.93 percent average discount from AWP.

Because of interest shown by the States and some industry groups, we will provide a more comprehensive breakdown of the above noted discount percentages as part of a new report planned for later this summer.

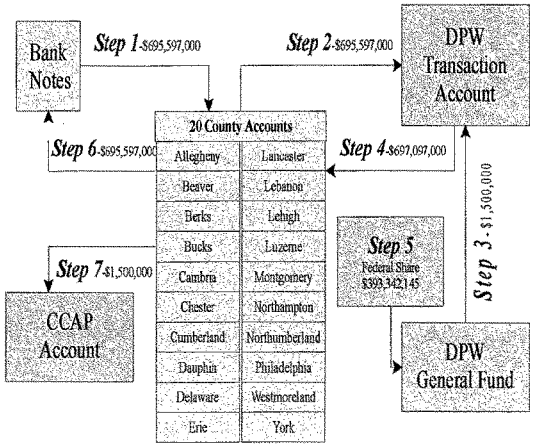
Conclusion

The OIG has had more than 20 years' experience monitoring the Medicaid program. It has been a challenge given the amount of Federal dollars represented in the outlays and the fact that, apart from certain basic threads of policy and procedure, the States tailor Medicaid to the needs of their own populations. We believe that, in terms of Federal tax dollars, accounting loopholes and failure to set reasonable reimbursement levels are resulting in great losses. There is also, without a doubt, fraud in Medicaid. We pledge our continuing efforts to help ensure that dollars intended for Medicaid are actually used for its beneficiaries and that the program pays a fair price for goods and services. This concludes my testimony, and I welcome your questions.

APPENDIX

The following chart illustrates the flow of funds for Pennsylvania's intergovernmental transfer transaction of June 14, 2000.

INTERGOVERNMENTAL TRANSFER
JUNE 14, 2000



As shown in the illustration, the counties borrowed $695,597,000 (Step 1) and transferred it to the Department of Public Welfare (DPW) transaction account (Step 2). The DPW added a $1,500,000 transaction implementation fee to the DPW transaction account (Step 3), transferred $697,097,000 as Medicaid enhanced payments to the county bank accounts (Step 4), and claimed from CMS $393,342,145 in Federal Financial Participation (FFP) (Step 5). The counties used the enhanced payments to satisfy the bank loans (Step 6) and transferred the unused portion of the transaction implementation fee to the County Commissioners Association of Pennsylvania (CCAP) (Step 7).

None of the enhanced payments reached the participating nursing facilities, and the Medicaid residents received no additional services. Pennsylvania retained the entire $393,342,145 in Federal financial participation to use as it pleased. This was the second of two intergovernmental transfer transactions processed in State Fiscal Year (SFY) 1999. The first transfer provided for enhanced payments of $823,907,000, generating $464,793,744 in Federal financial participation.

Our review also revealed that, during the period SFY 1992 to SFY 1999, DPW reported $5.5 billion in enhanced payments, none of which was ever paid directly to participating county owned nursing facilities. These reported enhanced payments generated $3.1 billion in Federal matching funds without any corresponding increase in services to the Medicaid residents of the participating county nursing facilities. Further, in the last 3 years (SFYs 1997-1999) about 21 percent of the Federal match generated by the intergovernmental transfer transactions was not even budgeted for Medicaid purposes, and another 29 percent remained unbudgeted and available to Pennsylvania for non-Medicaid related use.

The net effect of DPW's intergovernmental transfer financing mechanism was that the Federal Government paid significantly more for the same level of Medicaid services, while the DPW paid significantly less. We determined that for Federal Fiscal Year 2000, the effective Medicaid FFP matching rate was about 65 percent of total Medicaid expenditures, or 11 percent higher than the 54 percent average FFP rate under the statutory formula.

Mr. HORN. Thank you. We will wait until two more presenters have finished, and then we will open it up to the ranking member and the questioning.

So let us start with the next presenter. I believe we also have a new Member also wish us, Mr. Sullivan, who we are delighted to have with us. He is a new Member from Oklahoma here, and I am sure that in Oklahoma and other places that your constituency will have some of these problems. So we are glad to have you here.

Mr. SULLIVAN. Thank you.

Mr. HORN. We will now go then to Mr. Maddox, who is the Inspector General of the District of Columbia, and he is accompanied by Sidney Rocke, Director of the District of Columbia Medicaid Fraud Control Unit.

So Inspector General.

STATEMENT OF CHARLES C. MADDOX, INSPECTOR GENERAL, DISTRICT OF COLUMBIA, ACCOMPANIED BY SIDNEY ROCKE, DIRECTOR, DISTRICT OF COLUMBIA MEDICAID FRAUD CONTROL UNIT

Mr. MADDOX. Thank you, Mr. Chairman, Mr. Sullivan. It is a pleasure to testify before the subcommittee today regarding the oversight role of the D.C. Office of the Inspector General in deterring waste, fraud, and abuse in the Medicaid program.

Because we conduct our oversight through a combination of investigations, audits, and inspections, the OIG has a unique perspective about the challenges that States must overcome in order to ensure that the Medicaid program does not lose funds needlessly. In addition, our experience also has taught us important lessons about ways that oversight entities can be most helpful to administrators and to the legislation. I am pleased to say the D.C. OIG has enjoyed an extremely constructive partnership with local executive and legislative branches of the D.C. government to achieve a measure of progress that I believe establishes the Nation's Capital as a leader in finding new ways to address waste, fraud, and abuse in this most important program.

Consistent with several key findings published in the General Accounting Office's recent report on Medicaid financial management and the need for better oversight of State Medicaid claims, we have used our audits, inspections, and investigations divisions to accomplish four objectives: Developing a comprehensive oversight strategy, identifying problems and performing risk assessments, taking action to mitigate risk, and monitoring the effectiveness of those actions.

We have developed a comprehensive oversight strategy by deploying the resources of three distinct divisions: For instance, in 1999, our audit division found that the D.C. Public School System was not in compliance with Federal or District regulations with respect to the way Medicaid records were maintained. Because this problem continues to interrupt the flow of reimbursement of Medicaid payments to the District, we will conduct another audit in fiscal year 2002 focusing on chronic problem areas, such as transportation of special education students.

Another example of our team approach is our 3-month inspection of our District's surveillance and utilization review unit, which is part of the Department of Health, that is responsible for monitoring the Medicaid claims processing system for indications of fraud and abuse. We have made several recommendations for improvement of this critical link between governmental units that process bills and those that prosecute false claims.

Although our auditors and inspectors review issues that are related to effectiveness and efficiency of Medicaid program management, our Medicaid Fraud Control Unit [MFCU], carries the primary responsibility of working with the District's agency, the Medical Assistance Administration [MAA], which is responsible for administering the program. The MFCU's mission is to investigate and prosecute financial fraud committed against the Medicaid program by large health care providers as well as solo practitioners.

I am proud to say that after a 17-year hiatus in the District of Columbia Mayor Anthony Williams and former U.S. attorney Wilma Lewis joined me to create the MFCU. With strong legislative support from the City Council, we have been able to seek enforcement using criminal, civil, and administrative remedies.

The MFCU receives a variety of leads, tips, and intelligence regarding possible fraud in the Medicaid program. We build on this information through extensive use of data mining techniques. The MFCU can manipulate extensive claims data to look for aberrational patterns that may indicate fraud. For example, a small pharmacy that is responsible for filing a highly disproportionate amount of prescriptions may warrant a greater scrutiny. Of course, this capability requires an investment in manpower, training, and technology, but we believe the effort is worthwhile in the long run.

In working individual cases, our MFCU remains sensitive to the need for systemic reform. In fact, the two are often intertwined. For example, the MFCU recently investigated allegations of fraud in the Medicaid taxi voucher program. We discovered that the program rules were incomplete and out of date and lacked internal controls. This can greatly undermine any attempt to prosecute for intentional fraud, since money is paid in a seemingly improper way, but a prosecutor may have difficulty showing a deceptive act that violates a particular government expectation.

However, difficult terrain for a prosecution can often be fertile ground for an audit. With this in mind, the MFCU referred the matter to the OIG's audits division for a comprehensive audit of the program.

In all our reports, we require that affected agencies comment on our recommendations and begin implementation of corrective action within a designated timeframe. Within the last year, we have begun a process for tracking compliance on priority recommendations, and we will direct our findings to the Mayor's office for continued monitoring.

Moreover, we are providing these services based, in part, on feedback we solicit from District leaders. As a result of this communication, we are better able to use our limited resources to address priority issues.

Both locally and nationally, experience has shown that fraud cases are lengthy and give the target ample opportunity to hide or

spend all of the stolen funds. Although the government may eventually obtain a restitution order or judgment, this is of little practical value if no assets can be located. Payment suspensions can be a vital safeguard in preventing this outcome.

Our MFCU strives to keep the Medicaid program informed of the progress of the cases. Whenever appropriate, we provide information about overpayments we have calculated and evidence of fraud against the program. As a result, an appropriate MAA can suspend payments to the provider for the duration of the case. In this way, we mitigate damages by preventing further losses during the pendency of the case. Naturally, we are careful to avoid undermining the fraud investigation in any way.

Experience has taught us that agencies make optimal progress when top-level managers are committed to preventing waste, fraud, and abuse of the Medicaid program. We have taken several steps to ensure "buy-in" at every stage of our investigations, audit and inspections. Our most successful effort has been to secure a Mayor's order requiring agency heads to respond within a certain timeframe to our report recommendations and to any OIG referrals sent to them regarding noncriminal allegations. As a result, many agencies are much more responsive in terms of timelines and substance. In addition, our auditors and inspectors engage top-level management from the beginning to the end of each of our reviews.

Furthermore, the MFCU has provided training to the MAA on the basics of health fraud prosecutions and audit techniques. We share our expertise, and, in so doing, cultivate improved working relations among agencies.

Although the GAO report did not recommend specific actions regarding provider relations, I would like to comment on the importance of conducting regular outreach to the provider community. In the MFCU, our outreach is premised on the belief that the vast majority of providers are honest and want to see a Medicaid program free of fraud and abuse. We meet with provider groups and trade associations to explain the government's concerns and to provide some basic advice on avoiding problems.

We also encourage buy-in by underscoring common interests in the fight against fraud. For example, many Medicaid programs nationwide are being hard hit by false claims for OxyContin. This issue encapsulates many of the problems facing government health care. Patients will often pretend to be in pain to obtain a prescription for this powerful narcotic. They may alter or forge any prescription they get and then sell the narcotics on the street. Sometimes they steal prescription pads off of doctors' desks. Sometimes they conspire with doctors to dispense the drugs illegally. In the latter case the physicians may receive payment from Medicaid for medical exams that never occur or are very unnecessary.

The vast majority of physicians are outraged at this abuse, but are also determined to preserve their ability to prescribe OxyContin when necessary. We wrote a letter to the Medical Society of D.C. stressing our common ground on this issue. Our letter was reprinted in the Society's newsletter and distributed to doctors throughout the District. In this way, we believe we have addressed a problem in a proactive fashion before it becomes an epidemic.

In conclusion, taken together, our strategic allocation of resources to assess risk, monitor corrective actions, and engage top-level management has brought much-needed focus to our oversight efforts. In fact, most of these efforts were initiated only since my tenure as Inspector General in 1999. With the continued cooperation of the City's leaders and the diligent work of the OIG, I am extremely optimistic we will realize even more cost savings, restitution payments, and prosecutions that will improve the fiscal integrity and financial management of the District's Medicaid program.

This concludes my statement, sir.

[The prepared statement of Mr. Maddox follows:]

TESTIMONY OF DC INSPECTOR GENERAL CHARLES C. MADDOX, ESQ.
BEFORE THE SUBCOMMITTEE ON GOVERNMENT EFFICIENCY,
FINANCIAL MANAGEMENT AND INTERGOVERNMENTAL RELATIONS,
THE HOUSE COMMITTEE ON GOVERNMENT REFORM
"Medicaid Claims: Who's Watching the Money?"
June 13, 2002

It is a pleasure to testify before this Committee today regarding the oversight role of the D.C. Office of the Inspector General (OIG) in deterring waste, fraud, and abuse of the Medicaid program. Joining me today is Sidney Rocke, Director of our Medicaid Fraud Control Unit (MFCU).

Because we conduct our oversight through a combination of investigations, audits, and inspections, the OIG has a unique perspective about the challenges that states must overcome in order to ensure that the Medicaid program does not lose funds needlessly. In addition, our experience also has taught us important lessons about ways that oversight entities can be most helpful to administrators and to the legislature. I am pleased to say that the DC OIG has enjoyed an extremely constructive partnership with the local executive and legislative branches of the D.C. government to achieve a measure of progress that I believe establishes the nation's capital as a leader in finding new ways to address waste, fraud, and abuse in this most important program.

Consistent with several key findings published in the General Accounting Office's recent report on Medicaid financial management and the need for better oversight of state Medicaid claims, we have used our audits, inspections and investigations divisions to accomplish four objectives: 1) developing a comprehensive oversight strategy; 2) identifying problems and performing risk

assessments; 3) taking action to mitigate risks; and 4) monitoring the effectiveness of those actions.

1. A Comprehensive Strategy

We have developed a comprehensive oversight strategy by deploying the resources of three distinct divisions. For instance, in 1999 our audit division found that the DC Public School System was not in compliance with federal or District regulations with respect to the way Medicaid records are maintained. Because this problem continues to interrupt the flow of reimbursement of Medicaid payments to the District, we will conduct another audit in FY 2002, focusing on chronic problem areas, such as the transportation of special education students. Another example of our team approach is our three-month inspection of the District's Surveillance and Utilization Review Unit, which is the part of the Department of Health that is responsible for monitoring the Medicaid claims processing system for indications of fraud and abuse. We made several recommendations for improvement of this critical link between governmental units that process bills and those that prosecute false claims

Although our auditors and inspectors review issues that relate to the effectiveness and efficiency of Medicaid program management, our Medicaid Fraud Control Unit (MFCU) carries the primary responsibility of working with the District's agency, the Medical Assistance Administration (MAA), which is responsible for administering the program. The MFCU's mission is to investigate and prosecute financial fraud committed against the Medicaid Program by large healthcare providers as well as solo practitioners. I am proud to say that, after a 17- year hiatus in the District of Columbia, D.C. Mayor Anthony Williams and former U.S. Attorney Wilma Lewis joined me to create the MFCU. With strong legislative support from the City Council, we have been able to seek enforcement using criminal, civil and administrative remedies.

The MFCU receives a variety of leads, tips, and intelligence regarding possible fraud in the Medicaid program. We build on this information through extensive use of data mining techniques. The MFCU can manipulate extensive claims data to look for aberrational patterns that may indicate fraud. For example, a small pharmacy that is responsible for filling a highly disproportionate amount of narcotics prescriptions may warrant greater scrutiny. Of course this capability requires an investment in manpower, training and technology – but we believe the effort is worthwhile in the long run.

2. Identifying Problems and Assessing Risks

In working individual cases, our MFCU remains sensitive to the need for systemic reform. In fact, the two are often intertwined. For example, the MFCU recently investigated allegations of fraud in the Medicaid taxi voucher program. We discovered that that the program rules were incomplete, inadequate, and lacked internal controls. This can greatly undermine any attempt to prosecute for intentional fraud, since money is paid in a seemingly improper way, but a prosecutor may have difficulty showing a deceptive act that violates a particular government expectation. However, difficult terrain for a prosecution can often be fertile ground for an audit. With this in mind, the MFCU referred this matter to OIG's audit division for a comprehensive audit of the program.

3. Taking Action to Mitigate Risks

In all of our reports, we require that affected agencies comment on our recommendations and begin implementation of corrective action within a designated timeframe. Within the last year, we have begun a process for tracking compliance on priority recommendations, and we will direct our findings to the Mayor's Office for continued monitoring. Moreover, we are providing these services based, in part, on feedback we solicit from District

leaders. As a result of this communication, we are better able to use our limited resources to address priority issues.

Both locally and nationally, experience has shown that fraud cases are lengthy and give the target ample opportunity to hide or spend all of the stolen funds. Although the government may eventually obtain a restitution order or judgment, this is of little practical value if no assets can be located. Payment suspensions can be a vital safeguard in preventing this outcome. Our MFCU strives to keep the Medicaid program informed of the progress of cases. Whenever appropriate, we provide information about overpayments we have calculated and evidence of fraud against the program. As a result, when appropriate, MAA can suspend payments to the provider for the duration of the case. In this way, we mitigate damages by preventing further losses during the pendency of the case. Naturally, we are careful to avoid undermining the fraud investigation in any way.

4. Monitoring Effectiveness of those Actions/Encouraging Top-Level Management Commitment.

Experience has taught us that agencies make optimal progress when top-level managers are committed to preventing waste, fraud and abuse of the Medicaid program. We have taken several steps to ensure "buy-in" at every stage of our investigations, audits and inspections. Our most successful effort has been to secure a Mayor's Order requiring agency heads to respond within a certain timeframe to our report recommendations and to any OIG referrals sent to them regarding non-criminal allegations. As a result, many agencies are much more responsive in terms of timeliness and substance. In addition, our auditors and inspectors engage top-level management from the beginning to the end of each of our reviews. Furthermore, the MFCU has provided training to MAA on the

basics of health fraud prosecution and audit techniques. We share our expertise and, in so doing, cultivate improved working relationships among agencies.

Provider Relations

Although the GAO report did not recommend specific actions regarding provider relations, I would like to comment on the importance of conducting regular outreach to the provider community. In the MFCU, our outreach is premised on the belief that the vast majority of providers are honest and want to see a Medicaid program free of fraud and abuse. We meet with provider groups and trade associations to explain the government's concerns and to provide some basic advice on avoiding the problems.

We also encourage buy-in by underscoring common interests in the fight against fraud. For example, many Medicaid programs nationwide are being hard hit by false claims for OxyContin. This issue encapsulates many of the problems facing government health care. Patients will often pretend to be in pain to obtain a prescription for this powerful narcotic. They may alter or forge any prescription they get and then sell the narcotics on the street. Sometimes they steal prescription pads off of doctors' desks. Sometimes, they conspire with doctors who dispense the drugs illegally. In the latter case, the physicians may receive payment from Medicaid for medical exams that never occurred or were unnecessary.

The vast majority of physicians are outraged at this abuse, but are also determined to preserve their ability to prescribe OxyContin when medically necessary. We wrote a letter to the Medical Society of DC, stressing our common ground on this issue. Our letter was reprinted in the Society's newsletter and distributed to doctors throughout the District. In this way, we believe we have addressed a problem in a proactive fashion before it becomes an epidemic.

Conclusion

Taken together, our strategic allocation of resources to assess risks, monitor corrective actions, and engage top-level management has brought much needed focus to our oversight efforts. In fact, most of these efforts were initiated only since my tenure as Inspector General in 1999. With the continued cooperation of the city's leaders and the diligent work of the OIG, I am extremely optimistic that we will realize even more cost-savings, restitution payments, and prosecutions that will improve the fiscal integrity and financial management of the District's Medicaid program. We would be pleased to respond to your questions at this time.

Mr. HORN. Thank you. Mr. Rocke, do you have anything to add to that, or are you going to be doing so in the question period?

Mr. ROCKE. Precisely. I would be happy to address any questions you may have, but I have no additional comments at this point.

Mr. HORN. OK, I now yield to the ranking member, Ms. Schakowsky.

We have a vote on the floor. Both of us will have to be over there and then recess. So you will have your opening statement right now, and then, if you would like, you might want to just start with some of the questions and I will try to get over, vote, and get back, so we don't keep you all morning.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman, and thank you panelists. I appreciate your testimony and the work that went into it.

I share everyone's concern about the financial management of the Medicaid program, and the reason is that every single dollar of improper payment to a health care provider is a dollar that is not spent on those who most desperately need our help and need health care.

Medicaid is a critical piece of our public safety net. However, it is a safety net with a lot of holes for people to fall through. The public thinks of Medicaid as a low-income health insurance program, but it is really not. If you are not poor and disabled, poor and old, or poor and pregnant, you don't qualify. Only 40 percent of those in poverty qualify for Medicaid. Nonetheless, Medicaid is critical to those who do receive it.

Twenty-five percent of children under 5 rely on Medicaid for health care coverage. I think that is a really stunning number in the United States, meaning that many children live in poverty and can't afford other kinds of health insurance. Eighteen percent of children between 5 and 18 rely on Medicaid for health insurance. Over 15 million children in total rely on Medicaid. Without those services, those children would go without health care.

These are the same children who are often forced to skip meals, because there is no food in the house, and who sleep in apartments with inadequate heat and no air-conditioning. These are the children who are the most likely to need health care.

On the other side of this equation are a few doctors and hospitals who are either too inefficient or careless to avoid billing twice for services or providers who scam the system by billing for services never performed. Choosing between the two is an easy call. The problem is, what do we do about it?

The decentralized nature of the Medicaid system means efforts to address the problem will always be uneven. Half of the States spend no more than one-tenth of 1 percent of program expenditures on anti-fraud activities. There is more Federal money available, but that would require the State to spend more of its funds as well. If the Federal Government is paying 50 cents of every Medicaid dollar, as it is in Illinois, there is little incentive to spend money on fraud.

I hope our witnesses—well, this statement was to be given prior to your testimony—tell us what can be done to reduce the level of improper payments and what you are doing.

Medicaid fraud threatens the welfare of the patient and strains the capacity of the doctors and hospitals providing services by taking dollars away that would otherwise be available for patient treatment. States struggle with the increasing costs of medical services, severe constraints on reimbursable costs, and ever-declining allocations for administrative expenses.

Just last month, the House passed a welfare reform bill that cut the administrative funds for Medicaid. That means less money for eliminating improper payments and less money for benefits. That just does not make sense.

I would like to thank you all for taking the time to be here today.

[The prepared statement of Hon. Janice D. Schakowsky follows:]

**STATEMENT OF THE HONORABLE JAN SCHAKOWSKY
AT THE HEARING ON
MEDICAID FINANCIAL MANAGEMENT**

JUNE 13, 2002

Thank you Mr. Chairman for holding this hearing today. I am as concerned about the financial management of the Medicaid program as anyone. Every dollar of improper payment to a health care provider is a dollar that is not spent on those who most desperately need health care.

Medicaid is a critical piece of our public safety net. However, it is a safety net with a lot of holes for people to fall through. The public thinks of Medicaid as low-income heath insurance, but that is not the case. If you are not poor and disabled, poor and old, or poor and pregnant you don't qualify. Only 40% of those in poverty qualify for Medicaid.

Nonetheless, Medicaid is critical to those who do receive it. Twenty-five percent of children under five rely on Medicaid for health care coverage. Eighteen percent of children between five and eighteen rely on Medicaid for health insurance. Over 15 million children rely on Medicaid. Without those services those children would go without health care.

These are the same children who are often forced to skip meals because there is no food in the house, and who sleep in apartments with inadequate heat and no air conditioning. These are the children who are the most likely to need health care.

On the other side of this equation are a few doctors and hospitals who are either too inefficient or careless to avoid billing twice for services. Or providers who scam the system by billing for services never performed.

Choosing between the two is an easy call.

The problem is what do we do about it? The decentralized nature of the Medicaid system means that efforts to address the problem will always be uneven. Half of the states spend no more that one-tenth of one percent of program expenditures on anti-fraud activities. There is more federal money available, but that would require the state to spend more of its funds as well. If the federal government is paying 50 cents of every Medicaid dollar, as it is in Illinois, there is

little incentive to spend money on fraud.

I hope our witnesses today will tell us what can be done to reduce the level of improper payments. Medicaid fraud threatens the welfare of the patients, and strains the capacity of the doctors and hospitals providing services by taking dollars away that would otherwise be available for patient treatment.

States struggle with the increasing cost of medical services, severe constraints on reimbursable costs, and ever declining allocations for administrative expenses. Just last month the House passed a welfare reform bill that cut the administrative funds for Medicaid. That means less money for eliminating improper payments, and less money for benefits. That just doesn't make sense.

I would like to thank the witnesses for taking the time to be here today, and I look forward to you comments.

Ms. SCHAKOWSKY [presiding]. I will ask one question. I am sorry, is it Calbom?

Ms. CALBOM. Yes, Calbom.

Ms. SCHAKOWSKY. Maybe you said this, I heard the rest of the testimony, but what is the estimate not of what we have recovered, but what is the potential for cost recovery in the Medicaid program; in other words, an assessment of the level of fraud that is out there?

It appears to me, and Mr. Mangano mentioned a dollar figure, that is a tiny percent of the Medicaid cost, and it seems like an underestimation or an understatement of what is really out there.

Ms. CALBOM. I think that is one of the big issues, that there has not yet been an estimate of what the amount of improper payments is in the Medicaid program. Of course, there has been an estimate in Medicare but not yet on Medicaid.

I know that CMS is working on some pilot programs, Mr. Smith was mentioning that, and trying to come up with a way to do this. Because the programs are all different, it can be difficult, they tell us, to come up with an assessment that can be used across the States. Right now, there isn't an assessment.

You cannot figure out how to tackle the problem if you don't know how big it is, and you don't exactly know where all your pockets are, where the biggest problems are. So we think that is the first thing that needs to be done.

Ms. SCHAKOWSKY. There is no effort under way currently, or dollars allocated or assignments given, to making that assessment yet?

Ms. CALBOM. There are some efforts under way, and Mr. Smith might want to expound upon that.

Ms. SCHAKOWSKY. I would appreciate it.

Mr. SMITH. Thank you very much. Medicaid now is spending about $240 billion. So even if it is only 1 percent, that is $2.4 billion. If it is the error rate that Medicare is, and Medicare is about 6 percent, so assuming a 5 percent error rate is talking about real money.

Ms. SCHAKOWSKY. But are there efforts to not just come up with an aggregate figure but understand where most of the fraud occurs, etc?

Mr. SMITH. I want to reiterate one of the other points as well. The fraud in the system you are going to find by a handful of people. The vast majority of the providers, the doctors, the hospitals, the nurses, the therapists who participate in the Medicaid program are good, honest people who are——

Ms. SCHAKOWSKY. Let us take that for granted, OK.

Mr. SMITH. Again, I don't know that we have a nationwide estimate on the percentage of providers that have had claims disallowed, under appeal, etc. There is also a great deal of difference between fraud and errors.

Ms. SCHAKOWSKY. And that is why I am asking the question. What are you doing to distinguish between the last two points that you made and to determine just exactly what is going on?

Mr. MANGANO. If I might add, I think I can get to your point. Over the last 2 years, the CMS has been putting together a demonstration project. Right now, I believe in this year, it is up to nine

States, where they are trying to come up with a methodology to identify what the improper payment rate is for that particular State. Next year, I believe the plan is to go to 15 States.

The difficulty here is that every State is a little different in the Medicaid program. So coming up with a nationwide figure on what the abuse level is, is very difficult. They are trying to work on some methodologies that will come up with some models for all States to use. So over time, I believe they will coming up with the answer you are looking for, and that is what is the error rate or the improper payment rate across the country. But right now, it is in the early stages of that.

Mr. SMITH. And to followup and to be clear, there is no national Medicaid error rate at this point. But in our nine- State pilot we hope to come up with a payment accuracy measurement that would give you what you are looking for. Right now, we have nine and we intend to expand it to 15 States next year.

Ms. SCHAKOWSKY. I am going to have to go vote, but I would say that I am interested in that figure only to the extent that it is helpful, then, for us to develop a plan on how to address it. I really am much more concerned about the plan and how to stop it. But it does seem, as Ms. Calbom said, as a first step we have to know how big is this problem.

I thank you, and I am going to have to go vote, so this committee stands in recess.

[Recess.]

Mr. HORN [presiding]. The subcommittee will come to order, and the two votes we just finished probably will not occur again, and so I thank you for your patience.

Let me just ask you a few questions and then others, I'm sure, will have other questions. In terms of the GAO report, which is very fine, what can the Centers for Medicare and Medicaid Services do to improve its oversight of Medicaid expenditures?

Ms. CALBOM. Mr. Chairman, again, if you look at this little chart you have in front of you, I can speak to it along those lines because this is really the model for what you need to do to manage improper payments, and there is something in each of these areas that we have found that needs to be done.

I will start with the risk assessment area. As I was mentioning when you were voting, the biggest thing that needs to be done is find out how big the problem is. They need to measure their improper payments in the program. I know you have introduced some legislation that has been supportive along these lines. If you don't know how big the problem is, you don't know what kind of resources you should devote to trying to fix it.

Also, in the risk assessment area, there are a lot of things that the States have been doing to measure their risks, too, and we would like to see CMS take a look at what the States have been doing and factor that into their own risk assessments.

Control activities are what you need to do to try to manage the risks. And you have to know where the pockets of the problems are so that you can put more of your resources there. You need to know what kind of programs have the highest risk so that then you can put the controls in place that specifically focus on those programs. And there are some really good new techniques out that I know the

IG has used, and Mr. Maddox was talking about as well, where you can use computerized techniques to look at huge data bases of information. You can match it against other data bases to look for improper payments, or even erroneous payments. Those kinds of tools would help CMS, in light of the fact that they have such limited resources in particular.

Information and communications. One of the things we found is that this whole risk assessment activity that CMS has been trying to carry out at headquarters has not been communicated to the field. Now Mr. Smith is saying that is starting to happen, and we are happy to see that, because you have to get everybody on board with it.

The next area is monitoring, which is absolutely critical. If you don't take a look at whether or not your activities are helping, then it doesn't make any sense to put the money into it. And that gets back to measuring. How large are improper payments, are the activities we are carrying out helping, are they lowering improper payments? If they are not, we can do something different. But it is a whole cycle that is continuous.

And then what encircles the whole thing is the control environment. What you need there is the tone at the top. Everybody has to know this is a big priority. Everybody has to be held accountable for it. And it should be, frankly, part of their performance assessment. So we would like to see some performance measures put in place. We would like to see the lines of accountability between headquarters and the field. Not that there should be a direct line, but people have to know they are accountable for doing these activities to help manage these improper payments.

Mr. HORN. And you are touching on this, but can you elaborate on why it is important to estimate the level of improper payments in the Medicaid program; and can you tell me the difference between improper and erroneous?

Ms. CALBOM. I'll take the second question first.

I think those two terms are fairly synonymous. I think OMB uses "erroneous payments," we use "improper payments." Improper is meant to mean both fraudulent-type activities as well as inadvertent-type errors.

But as far as why we need to measure it, you know——

Mr. HORN. Well, why would the U.S. attorney want to do anything? I'm looking for language and wondering—because some of the U.S. attorneys don't do much of anything.

Ms. CALBOM. Well, where there is fraud, that gets turned over to the U.S. attorneys ultimately. We have seen cases where the U.S. attorney has declined to prosecute because the dollar amount is too small. We hate to see that——

Mr. HORN. What is their idea of small?

Ms. CALBOM. I believe it differs depending on what jurisdiction you're in.

Mr. HORN. What's the worst case that you know of that GAO sent over to the U.S. attorneys?

Ms. CALBOM. I don't have an example of that because, typically, what happens is we find some fraud, we turn it over to the IG investigative group, and then they would typically be the ones that

followup. So I haven't seen a particular case how it came to its outcome. I don't have a good example.

Mr. HORN. Well, let's ask the IG, Mr. Mangano.

Mr. MANGANO. First of all, these cases can be prosecuted either in Federal court, which the U.S. attorney would have responsibility for, but many of the cases that are investigated by Medicaid State fund control units are tried in local courts as well, State courts and local courts. So there is the two venues. When we do get the allegations from either the General Accounting Office, or from other sources, we will conduct the investigation and work with the proper legal authority—for us, it is always the U.S. attorney—and bring those cases to trial.

If the U.S. attorney believes that the case is too small or they have other priorities at the time and can't get to it, we have other authorities that we can use to administratively adjudicate the case. If the U.S. attorney believes that they do not want to continue with it, they would decline that case and give it to us. We would pursue it administratively, and we have done that a number of times.

Mr. HORN. Well, what is the worst decision in your—you don't have to tell us which U.S. attorneys, but did you feel this was wrong? Because, obviously, deterrence is helpful here.

Mr. MANGANO. I would say that the way I would answer it is not a threshold of money, because money differs depending on the judicial district that's involved. What might be a small case in California might be a huge case in Utah because the dollars are different. But I think where we have been disappointed, and only a very few instances of it, is where a U.S. attorney decided to not continue with a case. Either they felt the evidence wasn't strong enough or were not in a position at that time to pursue the case. That gets under our craw a little bit, particularly if the case isn't declined so that we can take it up.

If the U.S. attorney holds on to a case too long, the statute of limitations runs out; and, therefore, there is nothing that we can do.

Mr. HORN. What is the statute of limitations on those?

Mr. MANGANO. Most of them are 5, 6 years. So from the time the incident occurred. But I have to hasten to say, though, there are very few instances that are like that.

Mr. HORN. Mr. Maddox.

Mr. MADDOX. Yes, Mr. Chairman. One of the unique situations we have in the District—I mentioned in my testimony when we started in the District is that I worked very closely with the mayor and the council and, in particular, the former U.S. attorney Wilma Lewis. To speak to the issue which we were just talking about, whether or not the U.S. attorney would find interest in a particular case, whether it was a large dollar amount or de minimis amount, that we agreed that, to avoid that, the U.S. attorney allowed us to incorporate our MFCU authorities to prosecute our own cases; and the majority of our employees in MFCU are attorneys and have been deputized as special assistant U.S. attorneys.

So, regardless of the dollar amount, if we think that the issue is egregious enough and if we want to send a message, we don't have a problem of whether or not the U.S. attorney finds the case effective to prosecute.

Mr. HORN. Thank you.

Based on your knowledge of other Federal programs, how costly is it to estimate improper payments? What else comes under your jurisdiction there?

Mr. MADDOX. With respect to——

Mr. HORN. Different programs.

Mr. MADDOX. Different programs.

Mr. HORN. The way it is done another way. Social Security might be one way, so forth.

Mr. MADDOX. I'm not sure I understand where you are going with the question, Mr. Chairman. How costly it would cost to prosecute it or——

Mr. HORN. Well, I'll go down to GAO and the knowledge of other Federal programs. You have a broad gaze across the executive branch, and some are done in other ways. So I'd just be curious whether that ought to be put into the Medicaid operations.

Ms. CALBOM. You're asking about estimating the level of the problem in the program?

Mr. HORN. Well, that's OK, too. But is there other ways in the executive branch where they can either disbar someone from having the—whatever you want to call it. You can call it permitting, if the doctor is the problem, and often it is, and if the person is just a group——

I remember when this committee went up to New York in 1994, and it was just one big mess all over New York. And that was—the U.S. attorney did take that one. Because it was so blatant they couldn't do anything, and they did do it, and a few people are in jail.

But I'm thinking of just other ways, Federal benefit payments go out and are misused. Are there any agencies where there might just be an administrative action rather than going into the judicial arena and the U.S. attorney?

Ms. CALBOM. I guess the types of actions that I can think of that agencies take—of course, it is a little different with Medicaid because you have the providers, but if it is something that is an internal thing you ought to get rid of the people. That's the bottom line there.

As far as when you're dealing with third parties, you know, I'm not sure. I'd have to think about that.

Mr. SMITH. Mr. Chairman.

Mr. HORN. We will be glad to have a little space in the record for your thoughts. So take your time.

[The information referred to follows:]

The government has adopted several sanctions other than criminal prosecution that are imposed against parties that engage in fraud or abuse of the Medicare and Medicaid Programs and/or their beneficiaries. The HHS OIG plays a key role in sanctioning such entities. In addition, several states have adopted certain administrative actions to put a stop to improper Medicaid payments. Following are some examples of these sanctions and state actions:

- Title XI of the Social Security Act provides a wide range of authorities to exclude individuals and parties from participation in the Medicare and Medicaid programs. Exclusion is mandatory for those convicted of crimes against the programs and or beneficiaries. As reported by the HHS OIG in its semiannual reports, thousands of individuals and entities are excluded from participation each year.

- Under the Civil Monetary Penalty (CMP) authorities enacted by Congress, the OIG may impose penalties and assessments against healthcare providers who submit false or improper claims to the Medicare and State health care programs. The CMP law allows recoupment of monies lost through illegitimate claims as well as the imposition of additional penalties.

- The OIG frequently imposes corporate integrity programs on entities that have filed false or improper claims as a condition for being allowed to remain as a provider in the Medicare program. These integrity programs are designed to prevent a recurrence of the fraudulent activities that gave rise to the case at issue.

- California bars providers with previously questionable billing patterns from submitting claims electronically and performs a manual review before making payment.

- Connecticut, Florida, Georgia, and Texas revised Medicaid provider agreements so they can terminate providers from the program without cause, allowing for more expeditious removal of providers who are billing inappropriately.

Mr. SMITH. Mr. Chairman, in terms of the Medicaid program itself, the States certainly can take action—the State and Medicaid program can take administrative action against the provider. All providers have to sign the provider agreement, and if you find that—so the State itself can terminate that provider agreement.

In the case of different types of provider, there are different levels of sanctions that you can take against a provider without going into the court system themselves.

Generally, there are appeals that a provider can have an appeal, etc. But the Medicaid program you can take administrative action.

Mr. HORN. Do you see any difference in the States on the percent that they put up to match to Medicaid? Is it any higher in fraud or anything or misuse or however you want to call it?

Mr. SMITH. Mr. Chairman, I really could not—we would have to take a look at that State by State at this point. I don't have the comparisons that I could offer to you.

Mr. HORN. Well, let's just go back and take a look at it. I'm not looking for some huge thing.

Mr. SMITH. Be happy to, Mr. Chairman.

Mr. HORN. Is there a feeling there that the more money they put in, the more the fraud is?

Mr. SMITH. Again, certainly that would be the suspicion so you would look at the cases—you would look at the States with the highest Medicaid expenditures—New York, California, Texas, Illinois. Nine States spend more than half the Medicaid money. Also, as I suggested, cross-matching with the Medicare program where, if the provider is taking advantage of one program, the likelihood is pretty good that they are taking advantage of that other program as well. So having matching between the programs would be—we think has great potential.

Mr. HORN. Information provided the General Accounting Office in this recent study indicated that staff resources devoted to Medicaid financial oversight has declined significantly over the past decade, even though the program continues to grow. How are you addressing that problem?

Mr. SMITH. Mr. Chairman, that is an area that we are looking at and have already taken some steps. A couple of different things, and one I also believe in, looking at where all the people are, rather than just automatically assuming you need more.

First, let me point out that my partner is the Inspector General's Office, because in fact they do a lot of work for us that does not show up in our FTE levels. So looking at the whole picture, I would like to include what the IG is doing.

Second, we have taken a couple of steps internally too—we have formed what we call the National Institutional Reimbursement Team. This team of eight people, four from central office, four from regional office, that this group now is looking at all of our institutional State plan amendments, whereas that had been scattered through the regional office. But that team has a number of advantages to it.

First, consistency in making our decisions about State plan amendments. So we are being more consistent. No doubt you have heard concerns from States that there have been regional variations, that sort of thing. So having formed the National Reim-

bursement Team also then frees up personnel in the regional offices and central office as well.

So we want to make sure we are using all the resources that we have at our disposal first. But I certainly can assure you that the Administrator and Secretary will make certain that we have the resources that we need to address the effort.

Again, I think we've already seen a lot of progress in just the Office of the Director itself. But a couple of—Bill Osowski, who is background and financial management, is now directly in my office. We have done a lot to strengthen the financial management team itself. A lot of it is simply to assure people in central office and in the regional office and the States that financial management is important and a priority, and I think we have very strongly signalled that by the personnel that we have to oversee and hold people accountable. So we are getting that message out there and will continue to press that message.

Mr. HORN. In your testimony, you noted the nine States that were involved in the pilot programs to develop a method of estimating improper Medicaid payments. Are any States now using that developed methodology?

Mr. SMITH. No, sir. There are two efforts going on at the same time. One—we are developing one for the fee for service and managed care. The Lewin Group has a contract with us to develop that. The other nine States, they are looking at their own methodologies so, at this point in time, we don't feel we can assume that there is one way to do it. So we are looking at different options and trying to sort of prime the pump in terms of encouraging States to come up with different methodologies that then we can test out. But we are still at the beginning of that.

Mr. HORN. Which State Medicaid agencies are doing a good job of ensuring that claims are paid properly and which are not?

Mr. SMITH. Well, as a former Medicaid director of Virginia, I would like to say that Virginia does a very good job.

Mr. HORN. We will consider that, and I think it would. So go ahead.

Mr. SMITH. I really couldn't give a rundown State by State. I think, for my own personal experience, Medicaid directors themselves are deeply committed to combating fraud and abuse in the system. They understand how it hurts the program when you do have abuse in the system.

Again, there are other partners to bring into it, also. Looking at the fraud control units at the State levels, States have single State auditors as well, so—again, oftentimes independent of the administration at the time. So we have another level of accountability there.

I would—again, there are pockets—and that's part of what our risk assessment has been about, to identify areas. So I think that you look at particular areas that have kind of had outliers or specific problems and then you look at those particular problems. So I think that the States themselves across the board, when you—they have also joined our efforts in that reform of financial management technical assistance group with the States, so the States have been very willing partners looking for new, improved ways.

Again, commitment of resources is often at the heart of it. In today's technology, the commitment to update your surveillance utilization programs, etc., those are resources that you have to ask your State legislatures for. So it's hard to measure why—so the commitment isn't just the Medicaid director or the Medicaid program. You have to bring the other partners into it as well.

Just to be fair to the States, often these are not their decisions alone on how to target resources or not.

But we've been very pleased with the reception that we have gotten from the State Medicaid directors in terms of participation with our financial management tag. We have a fraud and abuse tag, the alliance for program integrity. We have enthusiastic support from the States, in my opinion.

Mr. HORN. Let's just pick on one State where the claims are paid appropriately or inappropriately, and that's the State of California, of which I am a citizen. I won't get bent if there is something wrong there, so you will make brownie points.

Mr. SMITH. Well, in California, I'm very pleased that California is joining us in the pilot to match claims with the Medicare program. So, again, I've—you know, I think all States are looking for ways to improve their systems. There are many upon different decisionmakers in how to target resources. And I think every State would say, yes, we know that we can do better. That's the best I can do for you.

Mr. HORN. What does the General Accounting Office think of California?

Ms. CALBOM. We haven't really done any specific work looking at the particular States, Mr. Chairman, on this.

Mr. ROCKE. Mr. Chairman, I don't know if you are interested in hearing any more on the original alternative remedies, alternatives to prosecution, but there are a few points we could make if you are interested.

As Mr. Maddox pointed out, one of the unique things about our unit is that we're trying to break the mold and do some things that are different from Medicaid fraud units across the country. When we receive a case from a tip or referral from another agency, we don't view it as a criminal case or a civil case or administrative case. It is simply a case, and we see where the case takes us. We are very comfortable with bringing cases criminally in court when that's appropriate or civilly for civil damages, or using the administrative remedies that are available both in the District and federally.

Sometimes that's the quickest and easiest way to stop the flow of blood. Even if you don't necessarily get the money back, at least you stop the damages from being aggravated.

One of the other unique things is we're comfortable with doing all of these things at once, simultaneously, as a parallel case.

Earlier this year I made a presentation to the Medicaid fraud control units around the country pitching the idea of parallel cases. The reception was a generally positive one, although there was some hesitancy. There are some folks who say, "I do criminal cases and nothing but that." There are folks who see things only through the prism of the administrative process. What we like to think is that the best approach is that you have a number of arrows in your

quiver and you reach back and pull whichever one is appropriate for that case—sometimes two or three of them at the same time. It is a unique approach and, frankly, has been successful so far.

Mr. HORN. Well, that's very good.

How much did the District of Columbia's Medicaid Fraud Control Unit collect in the fiscal year 2001?

Mr. ROCKE. 2001, I believe about $250,000, off the cuff.

The important thing to keep in mind, I have to say out of fairness, is that we were just created in fiscal year 2000, so we spent the previous 6 months getting carpets and other materials.

We were very successful that year. We gained even more in restitution and recoveries in the following 6 months. And, quite frankly, we are confident that we were going to do quite well. I wish I could tell you about the cases that are in the pipeline right now. It is a long pipeline in terms of fraud cases. Typically they take 3 years.

Mr. HORN. Were there any convictions after the $250,000?

Mr. ROCKE. We've had a number of convictions, and I have to be clear on that. We've had five convictions. Four of them have been patient abuse convictions.

One of the things I was very——

Mr. HORN. I'm sorry, what's that?

Mr. ROCKE. Patient abuse.

Mr. HORN. What do you mean by that?

Mr. ROCKE. We prosecute cases in which the residents of the nursing home have been physically attacked or financially abused by the employees of that nursing home. Frankly, I was very pleased with Mr. Mangano's testimony that he pointed out that a lot of the work that we do doesn't bring back a dime to the system but it protects some of our most vulnerable citizens. There is a financial aspect to it because, if an elderly resident is being beaten up, that is not good care and not a good use of taxpayer money to pay for that caregiver.

In today's Post, one of our cases is featured. We got a conviction yesterday—to bring you up to speed—yesterday we had a conviction of a caregiver in a group home who took a 69-year-old retarded woman, threw her to the floor, bashed her face in essentially; and she had to go to the hospital and get stitches. It was a horrible incident, regardless of who the victim is, made even worse by the fact that Medicaid dollars are funding these sorts of situations.

So we have had four of those kinds of convictions because we have also had a fraud conviction. The pipeline is usually 3 years. I found that unacceptable when we established our unit because we knew that nobody would hear from us basically for 3 years. So what we did was look for some smaller cases, cases that traditionally would fall under the threshold that we have been talking about before.

We found an instance of an optometrist in the District of Columbia that had been ripping the system off for years. Unfortunately, most of the claims had been lost due to the statute of limitations. We were still able to rescue about $1,000 worth of theft, and we prosecuted him for that.

Mr. HORN. Well, could you pull the plug of the benefits going out to some of these people that misuse the whole system?

Mr. ROCKE. Sure. That was one of the reasons why we prosecuted him, was the criminal sanction. Because we wanted the word out that even if you steal $1,000 in Medicaid you are putting your license in jeopardy.

But automatically, by law, once you are convicted of stealing from the Medicaid program, even a nickel you are excluded from the program for 5 years. So not only do we not have to face claims from this provider, but he can't go across the river to Virginia or to Prince George's County, Maryland. He was excluded from the program nationwide.

So these are the approaches that Mr. Maddox and I have tried to implement that we think are a little different. And the cooperation of the U.S. attorney's office, they understood that sometimes it is not just the numbers that are important, it is the deterrent effect. It is making the statement. And I believe every optometrist in the District of Columbia has heard about this case. We'd like to think they take it to heart.

Mr. HORN. Well, just a few more examples and maybe they will.

Mr. ROCKE. We are trying; and, as I said, we have a number of cases in the pipeline. I'd like to talk about them, but I'd be in trouble if I did.

Mr. HORN. Yeah, well, you are on the right track, no question about it.

When you look at those typical kind of cases, does it really—you said it yourself, and I see it all the time with the IRS, that you have got somebody that gets away with murder, in fiscal matters or whatever, and just goes somewhere else, as you said, but you have apparently closed that plug up. Was that a matter of law or—when you said they can't get away with going into Virginia or Maryland once they've been taken care of in the District of Columbia?

Mr. ROCKE. It is. It is a part of the Social Security Act. By operation of law, when you are convicted of stealing from Medicaid or Medicare program, the minimum exclusion is 5 years. In fact, we work very closely with HHS IG's office because they help maintain the actual physical files printed in the Federal Register when you're excluded, when you're known as an excluded provider.

The good thing about that is every program is aware of it theoretically across the country, and employers should be checking that list. That is one of the things that I do. I do a lot of outreach to the industry and make sure they check these lists look to see what the background is of the employees they are hiring, see if they are excluded.

Obviously, you shouldn't hire anyone who is on that list. Most providers don't want to. Sometimes they don't do their homework, and that is one of the things that we accomplish through outreach.

Mr. HORN. Do some try to change their name or get a relative or uncle or cousin or something and they do the dirty work and they are told "how I did it in the District of Columbia?"

Mr. ROCKE. Are you sure you haven't prosecuted fraud before? That is exactly what they do. They will use a straw man. They will use a front.

As a matter of fact, I had a conversation with our single State agency just last night about an individual whose provider number

was shut down because of suspected fraud. Now his brother is billing for similar services from the exact same location. It doesn't take Sherlock Holmes to realize what is probably going on there, and we are trying to urge them to take this into account and shut down that particular provider number.

One of the frustrating things as a prosecutor is you can lead a horse to water but you can't always make it drink. We provide information when we can to the various State agencies to take action. We can't require people to do the right thing. We urge them to; and, frankly, we think that some progress is being made. But, as Mr. Maddox pointed out in his testimony, buy-in is critical. People have to take fraud seriously and have to take steps to address the issue in a very serious way.

Mr. HORN. In Mr. Maddox's testimony, he mentioned that the Medicaid program is inundated with false claims for a pain medication called OxyContin. Is that about what it is?

Mr. ROCKE. Yes.

Mr. HORN. What is the Medicaid Fraud Control Unit doing to address this problem?

Mr. ROCKE. OK. Well, what we are trying to do is, frankly, get ahead of the curve. OxyContin is a problem nationwide. It is a part of the drug diversion problem. Percocet, Dilaudid, other narcotics that are diverted from legitimate uses into drug abuses, into illegal narcotics sales. OxyContin is just the latest twist on this. There is nothing new about it except it is much stronger than Percocet, much more prone to addiction and much more prone to abuse.

What we have tried to do is make sure it did not reach an epidemic here in the District of Columbia. Unfortunately, in parts of our neighbors—Virginia, West Virginia, rural areas of Pennsylvania—it is a very, very serious problem.

We addressed the District of Columbia Medical Society and talked about the fact that we're doing our statistical analysis to look for anomalies, warn them about the fact that a lot of patients are out there malingering, pretending to have this particular pain or some sort of an ailment that would require the prescription. They get the prescription, and then they sell it, and they go to four, five, other particular doctors and do the same thing.

Another variation is the scheme that they work with doctors sometimes—and that's a very unfortunate situation that rarely happens, but when it happens it does a lot of damage. If a corrupt doctor who is known throughout the county to simply write scripts—what we thought we would do is work with the Medical Society of D.C. and explain this problem. They are mortified by it. Let them know that these fraud schemes are out there, not to be taken advantage of, and to give implicitly the message to the few bad doctors that are out there that we're looking at this issue.

We are aware of the fact that there are patients out there who strike a deal with the doctor and say you can pretend to examine me if you write a script. That is the worst of all worlds. The illegal drugs are getting on the street, and the Medicaid program is paying for a bogus exam.

We wanted that word out there. I was pleased with the reception we got from the Medical Society. They printed our letter in their

newsletter. They invited me to discuss the issue with their executive board.

We think that is the important thing that we're doing that is different. We try to get ahead of the curve instead of simply reacting to these fraud cases.

Mr. HORN. Mr. Mangano, anything to add as Inspector General?

Mr. MANGANO. In terms of the OxyContin case, we have a number of cases in primarily the Northeast as far down as the District of Columbia. I think we have had an arrest or conviction of 27 people for this. Our investigations are focusing not just on the people, the Medicaid recipients who get these scripts and sell them, but also the physicians that are actually writing the script and the pharmacists involved in it who are actually filling the orders of the persons that they know are improper. So the OxyContin one is fairly significant.

With respect to the operation of the exclusion list, every year we compile this list. We have a total list of all those persons who have been convicted of fraud against the Medicare Medicaid program, and they are included in our exclusion list. Last year, we added 3,700 new names to that list of persons who were excluded. That list is made available to all the Medicare insurance carriers.

Mr. HORN. 3,700 you said?

Mr. MANGANO. 3,700 new ones, 3,770. Those are distributed to the Medicare contractors who have it available to them.

We also distribute the list to every State. The Medicaid agencies have it, etc. It is a ready list of persons who shouldn't be doing business with the Medicare and Medicaid programs.

I think one of the good pieces of news is that about a year ago we conducted a program evaluation, and we took all the persons that had been convicted of crimes in the Medicare program and Medicaid on that exclusion list and matched them against persons who were submitting bills to the Medicare and Medicaid program and only found a handful of individuals who were on both lists, which told us that, unless some other nefarious means were being used, that the Medicare-Medicaid programs were doing a pretty good job of keeping those persons out of the program.

Mr. HORN. Can you explain the "upper payment limit" and the intergovernmental transfer mechanism being used by the States?

Mr. MANGANO. Sure. What had happened was the Medicaid upper payment was a device that was given to the States to enable them to pay more than they would ordinarily pay into the Medicaid program for services. The upper payment limit is the amount that Medicare pays for that service. In every State in the country that I can think of, Medicare pays more than Medicaid does for the same service. That service is available for nursing homes, hospitals and certain other providers in the State.

If you like, I would be happy to go through the State of Pennsylvania and explain how it works.

Mr. HORN. Don't whisper it in my ear. Just put it on the record.

Mr. MANGANO. The State says we need to increase the quality of care in nursing homes or hospitals, so what we're doing to do is increase the payment to the amount that Medicare pays. Sounds good. Here is how the pool of money then works.

The State of Pennsylvania took every nursing home in the State—private, State operated, and nonstate operated, which were generally county nursing homes—and they said, OK, in our State we are paying an average of $146 a day for a Medicaid patient. We are going to raise that up to the Medicare level. So we will add up every Medicaid beneficiary in our State and figure out what is the incremental amount needed for everyone. We will put them in the pool of money that says this is how much money we need to raise that enhanced payment for the hospital or the nursing home.

Let's just take nursing homes in Pennsylvania. That's the scheme they used. What they did then was said now we have this money. We do not have to, under law, distribute it to every nursing home. We can pick and choose who we're going to send it to. So they decided to send it just to the nursing homes that were operated by the counties. There were only 23 of them in the State. The State had 670 nursing homes; 23 were county operated. So you might say, why would they do that? Why would they only give it to the county nursing homes? They had a deal worked out with the county administrators that they would get the money back to the State.

In my testimony, I have the appendix of how this Ponsi scheme worked. What would happen is that these 20 counties that ran these nursing homes would figure out—they would ask the State for X amount of dollars, which would use up the entire State-enhanced payment amount on these 20 homes. They went to a bank, the same bank in the State, they got a bank note to cover it. In this case, it was just under $700,000,000. They took that amount and gave it to the State. They gave it to the Department of Public Welfare.

The Department of Public Welfare then transferred back to the county within 24 hours the same amount of money, plus $1.5 million more to cover their interest payments and the payments they needed to make to the county commissioners association. They submitted a bill to the Medicaid program federally and the Medicaid program had to pony up their 54 percent share for $393 million. The county, which had gotten their full payment back from the State, went back and paid off their bank notes.

Now the State has all this money that they got from the Federal Government. So one might think, did they distribute that to the nursing homes? No, what they did was put it into several pockets. Half went to Medicaid purposes in the State. Once they put it into the Medicaid program, they can match additional Federal money. Twenty-one percent was spent for nonMedicaid services, and about 29 percent was spent for we don't know what. It went into the general fund. We don't know how they used that money.

By doing this, the State effectively changed their State Federal match from 54 percent to 65 percent. This was free money from the Federal Government to do this. From 1992 to 1999, the State came up with $5.5 billion of enhanced payments of which $3.1 billion was Federal money.

Now there is a happy ending to this, and that is that I have to compliment CMS because they did take a good, quick action on that. There has been a series of regulations produced over the last year in which, by closing off most of this scheme, it will save the

Federal taxpayers about $79 billion over the next 10 years. So the happy ending is that most of it is cutoff.

The only thing that is not cutoff is that the States still don't have to use the money for the intended purpose that it was put together for.

Mr. HORN. Fascinating. If you put it in fiction, nobody would believe it. It's amazing.

Is anybody else trying to be like Pennsylvania? Or have you taken that little turn?

Mr. MANGANO. When the scheme came to light in 1993, there were 12 States that were doing this. As soon as word got out, by the year 2000, 28 States were involved with it. As it became public what the scheme was about and that we and CMS were working hard to resolve it, States became aware of it. They all started submitting amendments to their State plan to do exactly the same thing. So that, in the year 2000, the States had submitted bills for $10 billion on which the State was only on the hook for $5.8 billion of it.

Mr. HORN. Well, did the disease get cured? Nobody is doing that now?

Mr. MANGANO. Mostly. It is because the CMS in their regulations came up with a plan to phase this out over time. There are three—actually, now four—different pay pools that have been put together.

CMS said that we realize that by allowing people have a pool that included all of the private providers, all of the county and city operators and State and we had that big pool of money, it is too much money. What it said was they were going to narrow the pools down so that the only pool would be either all privates, all counties or all States. And then there was a phasing process.

Actually, the Congress acted to give these States who were in this scheme the longest period of time to get out of it. They gave them an 8-year transition period.

CMS came up with two different phases. Those who were in it before October 1999 would have 5 years, and those that were in it after that would have 2 years, and there was one additional one that allowed the people that came in right on the borderline, to have actually only 1 year to participate in the scheme. So most of this problem has been solved.

The only thing we would like to have seen gone further was the requirement that the money be actually used for the beneficiaries for the purpose it was actually intended to. So if the money was to be derived from nursing home patients, the money would actually have to be used on the nursing home patients. But the States have a great deal of flexibility in this program, and they can determine its use.

Mr. HORN. In your testimony, you stated the revised regulations involving the upper payment would save about $55 billion in Federal Medicaid funds over the next 10 years. What's being done to ensure that those savings are realized? Are there additional further reforms needed?

Mr. MANGANO. That was based on the projection of those people who were in the system as well as those who would have come into the system over time. As I recall, it was the CBO that came up

with those projections for the next 10 years—I'm sorry, it was the CMS actuary that came up with that projection.

The way that it will be enforced, I believe, and Mr. Smith can correct me if I am wrong, is that the State plans have to be approved by CMS and they will be casting a watchful eye over anything that looks like this in the future.

Mr. SMITH. That's correct, Mr. Chairman.

Again, I mentioned our National Institutional Reimbursement Team. So all State plan amendments dealing with institutional payments, of which a UPL amendment would fall into that category, would be reviewed by the team. And any State plan, the regulation—the final regulation is now in effect. So any plan amendment has to be in compliance with the new regulation. If it's not in compliance, it would be disapproved.

I think another one of the reforms that I think has been very important is that States are now not able to draw down Federal funds until their State plan amendment is actually approved. They can only go back to the first day of the quarter.

One of the problems historically has been States would send in State plan amendments and action was not really taken on it. That put everybody in a very difficult situation. The State thinks that it's OK and goes ahead and changes its program accordingly, and at some point in time CMS at the time might have come back later and questioned the State plan amendment.

We have instituted processes in the system now to assure that doesn't happen again, to where they are handled within a certain period of time and specific action is taken.

On UPL, California is one of those States, Mr. Chairman, that had been using UPL through a waiver and is on one of the longer transition periods. So California will continue to draw Federal funds under UPL that will be phased out over an 8-year period of time.

Mr. HORN. Well, take me through this a little more, California, UPL. Get it in the record.

Mr. SMITH. I'm sorry. The upper payment limits that allowed the States to draw funds—not only what Medicare would pay but in fact above what Medicare would pay—in many respects, as Mr. Mangano was describing to you, California had been using that through a waiver that had been granted. I can't tell you the precise date, back to the early 1990's.

But, again, now all States have to come into compliance with the final regulation. California will have the benefit of the 8-year transition, though, because they had gotten into the system so early. The rationale there was that State budgets had been already based the assumption that those funds would be available to them. So the States that had relied on them for some time had longer transition periods.

But when California received it—I believe California is unique in the respect that it was through a waiver that—what they called in California the "selective provider contracting program." It is a specific waiver that allows them to contract with hospitals in California. But, as I mentioned, that program will be phasing out as the State comes into compliance.

Mr. HORN. Now, most Governors are having financial problems now just because of various and sundry things, not Medicaid necessarily. But I suspect they will start moving around, doing creative ways of moving the dollars from one place to the other place to try and get a balanced budget, which most of them have to have under their constitutions. So are we looking for that and seeing anything here that would—where they would want to move Medicare funds, Medicaid funds and balance things out?

Mr. SMITH. We are looking, Mr. Chairman. Again, I think that the strength of our reimbursement team will help us to identify those early on.

Again, in the past, part of this would start to occur, but because it might have been disbursed—the plans were disbursed among the regional office, you might not have picked up the pattern until it was established. So the review team will help us identify early on whether or not it is simply moved to another area. But we are—we have some ideas about where that might move to, and we are certainly looking for them.

Mr. HORN. Mr. Maddox, in your Inspector General level with the District of Columbia, let me get a few things on the record here. In your testimony you stated that lengthy fraud cases give guilty defendants time to hide or spend all of the stolen funds. To combat this problem, provider payments can be suspended until the case is resolved. How often is this mechanism used?

Mr. MADDOX. I will let Mr. Rocke address that question, Mr. Chairman.

Mr. ROCKE. Right now, we have about four cases where that issue is coming into place. It is a case-by-case decisionmaking process.

One aspect that's very, very important to us is, as I said before, is to stop the flow of bad money. But there are some countervailing points. We may have an undercover investigation ongoing. We may have other police or legal aspects of the case that a suspension would interfere with. So it is always a case-by-case decision as to whether we can effectively cutoff the flow of money without alerting the target of the investigation or undermining our case.

But what I try to do is always keep that option in the forefront as a possibility, keep the single State agency informed of the progress of the case so that, if they choose to go forward with a suspension, they are given all the evidence, all the ammunition to support that suspension. At the same time, they're very careful to talk with us and work with us to make sure that they don't take any steps that would undermine our case.

Mr. HORN. Well, I don't want to uncover your thing. God bless you for cleaning house.

Mr. ROCKE. We are trying.

Mr. HORN. Are there any legislative actions that Congress should consider that would restore Medicaid's financial integrity? All of you down the line, anything you see or have heard this morning that maybe there is a weakness here somewhere in Congress and should we do anything more about restoring Medicaid's financial integrity? How about the General Accounting Office?

Ms. CALBOM. I think, Mr. Chairman, the action that you have taken already introducing legislation to require improper payments

to be reported is a huge first step, because that really is what you need to do, as I said earlier, to know how big your problem is and what kind of resource you need to throw at that problem to take care of it.

Mr. HORN. Yes, that's H.R. 4878; and we haven't got it on the books yet. It's going through the process. And you think that will help on improper payments by Federal agencies?

Ms. CALBOM. I think that would be a tremendous help.

Mr. HORN. OK. Well, we will take your word for it and see if we cannot use you as a bat on the head to some of our colleagues. So thank you.

Mr. Smith? What's your opinion?

Mr. SMITH. Mr. Chairman, I don't have any recommendations for you today. We do have tools out there. We do have Medicaid as a matching program. It does require the States to put their dollars up so the money doesn't flow unless the State is willing to put its resources into it. But we do have a lot of tools out there. We are trying to improve coordination and communication so that all the parties who are involved in these discussions are talking to each other and taking advantage of it.

A part again of our approach has been to be out there in the States and be visible to the States to know that we are watching and, certainly, if we come back to you at a later time with other recommendations for legislation.

Mr. HORN. Mr. Mangano, Inspector General, do you see any more legislative actions Congress should consider?

Mr. MANGANO. I don't think so at this time.

The fundamental issue here is the difference between Medicare and Medicaid programs. Medicare is a national program with national rules and regulations, and the CMS can have people tow the line in terms of reforms that are needed. Medicaid, being a jointly funded Federal-State program but managed by the States, in many of the cases CMS can only provide an encouragement factor.

As an example, in the testimony I talked about Medicaid drug pricing. Clearly, the States and the Federal Government are getting fleeced on the amount money that we are paying for drugs, but every State can decide how much they are going to pay for those drugs. So we are in a position and CMS is in a position to encourage them to make those changes and reduce those price, etc.

Given that kind of scenario, I think the kinds of reforms that Mr. Smith and Ms. Calbom have talked about in terms of you actually manage the program and getting better information, getting that information analyzed at a national level, as well as at the State level, and acting on that information, is probably the best way to go at this point.

Mr. HORN. I want to put in the record to back you up, this is entitled Outrageously High Drug Prices. The source is the Life Extension Network 2002, and let me just give you an example: U.S. price, Cipro, $87.99; European price, $40.75. Paxil, $83 U.S. price; $49 in Europe. And Prozac, $91 U.S. price; and $18 European price. And on and on and on. We'll put this in the record just because it's enough to make us all mad.

Of course, a lot of pharmaceutical people will come in and cry and whine and say, oh, everything costs $300 million to get our re-

search and so forth. They've got to wake up on this, and we have to get that law moved this next few months in terms of the Federal Government subsidizing those things.

Of course, a lot of it is just overuse; and I don't know how you stop that. When a professional says, gee, we have to have this, or the patient is sitting in the office and sees the big, huge ads in medical journals, health journals, you name it, or they go to the doctor and say, why can't you do it for me, that's supposed to be the best thing since sliced bread, and that kind of thing.

I just have one more question; and that is, you are doing the match between Medicaid and Medicare. Who provided the software for that? Did the agencies here, or how do you—and is it comparable?

Mr. SMITH. Mr. Chairman, I believe that we had developed the software through a contract; and that was funded with Medicare funds.

Mr. HORN. So there is comparability across the States.

Mr. SMITH. Yes.

Mr. HORN. I'm all for it.

I remember 20 years ago I made that suggestion on another Federal program and said, for Heaven's sake, just get them the new software and see if they can work with it and not just have it hung out there.

So I thank you all for what you have done and keep up the good work. With that——

Mr. MADDOX. Mr. Chairman?

Mr. HORN. Yes.

Mr. MADDOX. Mr. Chairman, I have one question you asked about Federal legislation. As you know, many of the Federal laws that apply to Federal agencies also apply to the District of Columbia. There are two such laws that I think would be very beneficial to us, one being obstruction of an audit, which is a felony.

Mr. HORN. I'm sorry. I missed the first part.

Mr. MADDOX. Obstruction of an audit. It's not a felony in the District, and I think that would go a long way in helping us complete our audits. The other is false statements. Title 18, USC 1001, applies to the Federal side but not to the District. Those are two investigative tools that are badly needed.

Mr. HORN. So we need to expand that to——

Mr. MADDOX. The District of Columbia.

Mr. HORN. We did not treat it like a State in terms of Medicaid?

Mr. MADDOX. Not in those two instances. The false statement act with regard to the District is a misdemeanor. It is only written a statement where there is a warning. Otherwise——

Mr. HORN. Get us a letter from you on that situation so we can talk to people around here.

Mr. MADDOX. I certainly will. Thank you, sir.

Mr. HORN. OK. That is a good suggestion.

Let me thank the individuals who have been responsible for this hearing. The staff director and chief counsel is doing other things right now, J. Russell George.

Bonnie Heald is the deputy staff director. Put your hand up, Bonnie.

Then the individual that has really struggled with this and done a great job as usual, and that is Rosa Harris who is a GAO detailee. It's great having her here.

Then Justin Paulhamus is the majority clerk. He is right back there with all the equipment.

Chris Barkley is part of our new subcommittee staff.

Michael Sazonov, subcommittee intern; Sterling Bentley, subcommittee intern; Freddie Ephraim, subcommittee intern.

The minority staff here is out 100 percent: David McMillen, professional staff, and Jean Gosa, the minority clerk; and we thank you both for all you have done.

The court reporters, Pam Garland and Joe Strickland, we thank you for all your fine catching the language, which is very difficult for us to hear, so we can read it from you.

I want to thank you all again; and, with that, we are adjourned.

[Whereupon, at 12:05 p.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL

Inspector General

July 10, 2002

The Honorable Stephen Horn
Chairman
House Committee on Government Reform
Subcommittee on Government Efficiency, Financial Management and Intergovernmental Relations
2157 Rayburn House Office Building
Washington, DC 20515-6143

Via facsimile and first class mail

Dear Chairman Horn:

We were pleased to participate in your hearing on Medicaid claims, which was held on June 13, 2002. Since seventy percent of the funding for the DC Medicaid Fraud Control Unit comes from the federal government, we understand and appreciate your interest in hearing about our experience with protecting the Medicaid program from waste, fraud, and abuse. In response to your request, we are submitting my suggestions for two legislative proposals that would enhance our ability to improve the integrity of the Medicaid program. The amendments would pertain to 18 USC § 1001 and 18 USC § 1516.

As I testified, the District's Medicaid program is audited both by personnel from the DC Office of the Inspector General and from the Medical Assistance Administration, the single state agency that administers the program. However, unlike their federal counterparts, none of these auditors have the protection of a statute criminalizing obstructive behavior. As a consequence, District personnel, who audit health-care providers and other entities suspected of fraud or abuse, have been subject to obstruction and delaying tactics by parties not wishing to have their records thoroughly reviewed.

We concur with your observation that District employees auditing this program should have no less protection then federal auditors. Accordingly, we suggest amending 18 USC § 1516, *Obstruction of Federal Audit,* so that it would prohibit attempts to influence, obstruct or impede Federal or District of Columbia audits of this joint Federal/District program.

Similarly, at present 18 USC § 1001, *Statements or entries generally,* applies only to false statements given to the federal government. It does not cover false statements provided to the District Medicaid program, the joint nature of its funding notwithstanding. In this regard, you

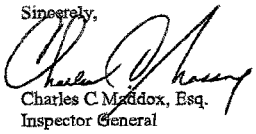
brought out at the hearing some hypothetical examples in which providers excluded from the program for criminal activity attempt to circumvent the federal program exclusion by using a relative as a "straw man" or front to obtain a new provider number. Unfortunately, these criminals currently can file false applications with the District Medicaid program for a new provider number and remain beyond the reach of section 1001. Accordingly, we suggest the situation be remedied by amending the language of 18 USC § 1001 to include the District of Columbia.

Enclosed in Attachments 1 and 2 is suggested language for amendments to 18 USC § 1001 and 18 USC § 1516, respectively. As I mentioned to you at the hearing, I also submitted these legislative proposals to the City Council several months ago for their review.

In addition, we also are enclosing our grammatical and typographical edits to your copy of the testimony I provided at the hearing, as requested. *See* Attachment 3.

If you have questions, please contact me directly, or have your staff contact my General Counsel, Karen E. Branson, at (202) 727-2540.

Sincerely,



Charles C. Maddox, Esq.
Inspector General

CCM/gj

Enclosures

cc: The Honorable Anthony A. Williams, Mayor, District of Columbia
The Honorable Linda W. Cropp, Chairman, Council of the District of Columbia
The Honorable Vincent B. Orange, Chairman, Committee on Government Operations, Council of the District of Columbia

ATTACHMENT 1

Proposed Amendment

We recommend amending 18 USC § 1001, to include the District of Columbia government in the following manner:

> (a) Except as otherwise provided in this section, whoever, in any matter within the executive, legislative, or judicial branch of the Government of the United States **or the District of Columbia**, knowingly and willfully-
>
> (1) falsifies, conceals, or covers up by any trick, scheme, or device a material fact;
> (2) makes any materially false, fictitious, or fraudulent statement or representation; or
> (3) makes or uses any false writing or or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry;
>
> shall be fined under this title or imprisoned not more than 5 years, or both.

ATTACHMENT 2

Proposed Amendment

We recommend amending 18 USC § 1516, to include the District of Columbia government in the following manner:

(a) Whoever, with intent to deceive or defraud the United States **or the District of Columbia**, endeavors to influence, obstruct, or impede a Federal **or District of Columbia** auditor in the performance of official duties relating to a person receiving in excess of $100,000, directly or indirectly, from the United States, **or the District of Columbia**, in any 1 year period under a contract or subcontract, or relating to any property that is security for a mortgage note that is insured, guaranteed, acquired, or held by the Secretary of Housing and Urban Development pursuant to any Act administered by the Secretary, shall be fined under this title, or imprisoned not more than 5 years, or both.

(b) For purposes of this section —

(1) the term "~~Federal~~ auditor" means any person employed on a full- or part-time or contractual basis to perform an audit or a quality assurance inspection for or on behalf of the United States **or the District of Columbia**; and

(2) the term "in any 1 year period" has the meaning given to the term "in any one-year period" in section 666.