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IS GOVERNMENT ADEQUATELY PROTECTING TAXPAYERS FROM MEDICAID FRAUD?

JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH CARE, DISTRICT OF COLUMBIA, CENSUS, AND THE NATIONAL ARCHIVES,

AND THE

SUBCOMMITTEE ON REGULATORY AFFAIRS, STIMULUS OVERSIGHT AND GOVERNMENT SPENDING

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

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IS GOVERNMENT ADEQUATELY PROTECTING TAXPAYERS FROM MEDICAID FRAUD?

Wednesday, April 25, 2012

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH CARE, DISTRICT OF COLUMBIA, CENSUS, AND THE NATIONAL ARCHIVES, JOINT WITH THE SUBCOMMITTEE ON REGULATORY AFFAIRS, STIMULUS OVERSIGHT AND GOVERNMENT SPENDING,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, D.C.

The subcommittees met, pursuant to call, at 9:37 a.m., in Room 2154, Rayburn House Office Building, Hon. Jim Jordan [chairman of the Subcommittee on Regulatory Affairs, Stimulus Oversight and Government Spending] presiding.

Present from Subcommittee on Health Care, District of Columbia, Census, and The National Archives: Representatives Gowdy, Gosar, DesJarlais, Davis, and Murphy.

Present from Subcommittee on Regulatory Affairs, Stimulus Oversight and Government Spending: Representatives Jordan, DesJarlais, Kucinich, and Speier.

Also Present: Representatives Issa, Burgess, Cummings, Ellison, Cravaack and McCollum.

Staff Present: Michael R. Bebeau, Majority Assistant Clerk; Brian Blase, Majority Professional Staff Member; Molly Boyl, Majority Parliamentarian; Drew Colliatie, Majority Staff Assistant; John Cuaderes, Majority Deputy Staff Director; Adam P. Fromm, Majority Director of Member Liaison and Floor Operations; Linda Good, Majority Chief Clerk; Tyler Grimm, Majority Professional Staff Member; Christopher Hixon, Majority Deputy Chief Counsel, Oversight; Sery E. Kim, Majority Counsel; Mark D. Marin, Majority Senior Professional Staff Member; Tegan Millspaw, Majority Research Analyst; Mary Pritchau, Majority Professional Staff Member; Laura L. Rush, Majority Deputy Chief Clerk; Jaron Bourke, Minority Director of Administration; Yvette Cravens, Minority Counsel; Ashley Etienne, Minority Director of Communications; Susanne Sachsman Grooms, Minority Chief Counsel; Devon Hill, Minority Staff Assistant; Jennifer Hoffman, Minority Press Secretary; Carla Hultberg, Minority Chief Clerk; Adam Koshkin, Minority Staff Assistant; Una Lee, Minority Counsel; Suzanne Owen, Minority Health Policy Advisor; Rory Sheehan, Minority New Media Press Secretary; and Safiya Simmons, Minority Press Secretary.

Mr. JORDAN. All right, the Committee will come to order. We are pleased today to have a hearing on, Is Government Adequately Pro-

tecting Taxpayers from Medicaid Fraud? We are excited about our first panel, two individuals who worked tirelessly on this issue and a host of issues. True great public servants. We are glad to have the Senator from Iowa, Mr. Grassley, with us today. We will start with him and then followed by Representative Bachmann from Minnesota's 6th District.

Senator, take all the time you want, and the floor is yours.

WITNESSES STATEMENTS

STATEMENT OF THE HONORABLE CHARLES E. GRASSLEY

Senator GRASSLEY. Well, I appreciate very much the opportunity to be here and to be with the famous congresswoman from Minnesota. And thank you for this very important work you are doing to help measure this along and get our money's worth out of Medicaid and other programs.

I appreciate the opportunity to be invited. I will have a very long statement, but I have a shorter statement, so I hope my entire statement will be put in the record.

Mr. Chairman, members of the Committee, for over 10 years the Federal and State government in the future will be spending roughly $7 trillion in combined dollars to run Medicaid programs. A very significant percentage of the Medicaid program will be run through what is called managed care.

Essentially, the States will take the Federal dollars that they receive, merged with their own dollars, and hand them over to a third party, a managed care company, to provide services for Medicaid beneficiaries. The Federal Government has encouraged States to do so, and certainly the current trend is for more and more managed care.

It is also Federal policy that States are supposed to conduct due diligence and oversight by knowing where Medicaid dollars are being spent. And CMS, likewise, is supposed to confirm that States are properly overseeing where the Medicaid dollars are being disbursed.

In August 2010, the Government Accountability Office issued a report that highlights the inconsistency of CMS's oversight of State rate setting. My ongoing investigation into Federal and State oversight of managed care contracting leaves me gravely concerned that accountability is severely lacking in a program that is spending $7 trillion of combined Federal and State taxpayer dollars

Today this hearing will focus largely on what has occurred in the State of Minnesota. There are allegations that the States systematically overpaid managed care companies to cover Medicaid beneficiaries while underpaying the same plans for coverage of individuals paid for with State-only dollars. This appears to be another example of the old game of States pushing the bounds to maximize Federal dollars received while minimizing State dollars spent.

If that isn't bad enough, when one of the plans tried to return the overpayment, documents show that the State schemed to keep the Federal Government from receiving its share of overpaying to one specific company, UCare. My investigation has turned up troubling questions that I am very pleased your committee will be able to explore further with relevant witnesses today.

Lucinda Jesson, of the State of Minnesota, has very difficult questions to answer, and some of these questions are:

So, was the State systematically overpaying managed care plans on Medicaid while underpaying the same plans to provide care for individuals covered by State-only dollars?

Documents show that at least once before a managed care company returned funds in 2003. So, how long has systematic overpayment been occurring in Minnesota?

Documents from the four plans in Minnesota prove that each one consistently showed excess revenues derived from Medicaid while showing losses to State-only plans. So, was the State aware of this disparity?

And while the State now trumpets the fact that they collect repayments for excess revenue over 1 percent, so does the State have any auditing mechanism in place to confirm that the amounts reported by the managed care companies are accurate?

Cindy Mann of CMS also has some very difficult questions to answer. In 2010, the Government Accountability Office raised significant questions about CMS's oversight of rate setting. So, what have you done, Ms. Mann, to assure beneficiaries and taxpayers that rates are being appropriately set?

In your March 21, 2011, letter to the State of Minnesota, you ask, "If the State included reserve fund requirements in calculating actuarially sound managed care rates"? So, isn't it the job of CMS to actually know that answer?

So, what assurance can you give us that what has gone on in Minnesota has not gone on all over the United States?

Mr. Chairman and Mr. Chairman, my investigation should not be interpreted as questioning the role of managed care in Medicaid. Quite to the contrary. I think having a risk-based outcome-driven role for managed care in Medicaid has tremendous potential to produce high-quality care to Medicaid beneficiaries. However, for this to happen, CMS and the States have to live up to their responsibilities in overseeing contracts with managed care.

So, in closing, Mr. Chairman, while my investigation is ongoing, one specific solution is fairly clear to me: States should be required to know the medical loss ratio of every managed care company they contract with specific to the Medicaid beneficiaries they serve. That medical loss ratio should be clearly defined by CMS and consistently implemented across every State that uses managed care. That medical loss ratio should be based on independently audited, verifiable encounter data and expense data.

That medical loss ratio should make clear what administrative expenses are related to the provision of Medicare benefits and what administrative expenses are not. That medical loss ratio should be transparent for CMS, the States, and the public to see.

So, let me be very clear. I do not support a federally-defined minimum threshold for medical loss ratio that requires all plans below a certain threshold to refund dollars. Instead, I believe the purchasers, in this case the States, using transparent information about how their dollars are being spent, are best suited to make decisions about the value provided for managed care companies.

We have legitimate disagreements about many issues in Congress, but on this issue it seems to me there can be no disagree-

ment. We must have a better understanding of where $7 trillion will be spent over the next period by Medicaid programs.

Thank you.

Mr. JORDAN. Thank you, Senator, for your good work and for your testimony. Your entire written statement will be made part of the record.

Before recognizing the gentlelady, I would ask unanimous consent that Mr. Burgess, Mr. Cravaack, Ms. McCollum, and Mr. Ellison be allowed to participate in today's hearing. Without objection, so ordered.

The gentlelady from Minnesota, where some of this activity took place, is now recognized for as long as she would like to.

Senator GRASSLEY. Mr. Chairman, I want to go because we have an oversight hearing with the Secretary of Homeland Security and I have a lot of questions I want to ask him.

Mr. JORDAN. We understand. Go ask your questions, Senator. Thanks for being with us.

The gentlelady from Minnesota is recognized.

STATEMENT OF THE HONORABLE MICHELE BACHMANN

Ms. BACHMANN. Good morning. Thank you, Chairman Jordan and Ranking Member Kucinich. Thank you, also, Chairman Gowdy and also Ranking Member Davis. It is a privilege to speak before the Committee today.

It was about a year ago when my office became aware that there was a problem going on in Minnesota. We actually had providers contacting our office and telling us they were not receiving the amounts of money under Medicaid, their reimbursements, they thought they were being due and, as a result, they were no longer taking Medicaid patients. So poor people in Minnesota who deserved and needed the Medicaid help weren't able to receive it anymore.

We began looking into the issue and we were shocked at what we found. What we found is that in the last 20 years there had been no verifiable, independent, third-party audit done of Medicaid money. This is unbelievable. There were audits conducted on Medicare money, but not under Medicaid money.

We started to look a little further. We investigated and we found this isn't just a Minnesota problem; this is a problem that appears to be happening all across the Country, that CMS, at the Federal level, which is tasked with auditing and supervising how the Medicaid monies are spent throughout all 50 States, has been remiss in doing their job on two counts: number one, we found there was no verifiable data, no standards of data, of meaningful data that CMS could look at to see if the charges that the Federal Government was being charged were even legitimate. So there wasn't any decent data, so to speak, to look at to see if the monies were spent right. But, number two, there weren't any independent third-party audits.

Now, let me just give you an example. And I should ask, first, that the Committee would receive my testimony in its written form that I presented for you today. I am just giving you my off-the-cuff remarks right now.

Probably an analogy would be if anyone would go to a grocery store and buy a grocery cart full of food, they would go up to the grocery store counter, they would run it all through the scanner, and then the grocery store clerk would say, "I would like to have $150 for your groceries." And you would write out the check, hand it to the person at the counter, and then you would say, "I would like my grocery tab, I would like to have my receipt so I can know if you charged me for three cans of peas or one can of peas"; and they would say, "Well, we are not going to give you the grocery tape." In other words, we are not going to itemize what it is that you owe.

So it appears that maybe a game has been played where managed care organizations can charge virtually anything they want for any expense they want because there is no one to make sure that the organizations are charging what they will.

And that brings us to the fact that Senator Grassley brought up, that over the next 10 years $7 trillion will be spent on this program. Now, if we don't have an accurate pulse on where this money is going today, under the new rules under ObamaCare, which is coming forward, in my State of Minnesota alone, Medicaid will expand 21 percent. If we have no accountability, no transparency of these monies, then what will we do when it is 21 percent more?

We are a relatively small population in Minnesota; we are less than 5 million people. Imagine how that would translate in a highly populated State such as California or New York or Illinois or Florida. This is something that has to end, because we know the budget constrictions that we are up against. This isn't way off in the future; this is in the near term. And the people who will be most at risk in the future, I believe, will be poor people who are in need of Medicaid money. For them we need to have accountability.

And that is why, in the coming weeks, I will be introducing the Medicaid Integrity Act of 2012. This is not a partisan issue in any way; this is a complete bipartisan issue. Both Democrats and Republicans believe in accountability. We believe in transparency. We all want to make sure that the patients get the care they deserve and that providers get the reimbursements they deserve so that we can continue this program.

If we are to have any hope of having a viable program going forward, we have to have standards and we have to have accountability. This is something we can all agree, both chambers, Senate and House, both Republicans and Democrats, and I intend to reach out to my Democrat colleagues across the aisle because this is not partisan in any way; this is about making sure we all carefully watch over the taxpayers' money.

And I thank the Committee.

[Prepared statement of Ms. Bachmann follows:]

TESTIMONY
OF
CONGRESSWOMAN MICHELE BACHMANN
BEFORE THE
JOINT HEARING OF HOUSE OVERSIGHT AND GOVERNMENT REFORM
IN THE
THE SUBCOMMITTEE ON HEALTH CARE, DISTRICT OF COLUMBIA,
CENSUS AND NATIONAL ARCHIVES
AND
THE SUBCOMMITTEE ON REGULATORY AFFAIRS,
STIMULUS OVERSIGHT AND GOVERNMENT SPENDING

"IS GOVERNMENT ADEQUATELY PROTECTING TAXPAYERS FROM MEDICAID FRAUD?"

April 25, 2012

Chairman Jordan, Ranking Member Kucinich, Chairman Gowdy, Ranking Member Davis and Committee Members, thank you for your attention to this critical matter: Medicaid fraud.

In the previous months, my office has been made aware of the possibility of fraud within Minnesota's Medicaid program. This is alarming and warrants further investigation. Much of the information we received seems to point directly to the lack of any verifiable or meaningful data from the four managed care organizations (MCOs) who are contracted to administer Minnesota's Medicaid Program. Since this is the very data that Minnesota uses to bill the federal government for their 50 percent Medicaid contribution, we must ask an important question: without the MCOs providing verifiable and meaningful data, how is Minnesota able to determine what amount to bill the federal government? Furthermore, how does the federal government know that it is being legitimately billed?

Unfortunately, Minnesota isn't the only state that lacks accountability. In August 2010, the GAO published a report that was critical of the lack of oversight by the Centers for Medicaid and Medicare Service, or CMS. According to the GAO:

"When reviewing states' descriptions of the data used to set rates, CMS officials focused primarily on the appropriateness of the data rather than their reliability. With limited information on data quality, CMS cannot ensure that States' managed care rates are appropriate, which places billions of federal and state dollars at risk for misspending." *[GAO 10-810]*

"Billions of dollars at risk." This is unacceptable. Please note these are the government's words: "Billions of dollars at risk."

It appears that a lack of proper auditing has fostered a breeding ground for Medicaid fraud. In the history of Minnesota's Medicaid program, the MCOs have never once been required to demonstrate any success in improving costs or outcomes. There has not been a single, true third-party independent audit since its inception. If the MCOs have not undergone an independent third-party audit, then how do we know that other state, private, and personal interests are not being funded through the federal Medicaid program?

The answer is, "We don't know."

For this reason, in the coming weeks I will introduce, "The Medicaid Integrity Act of 2012." This is not a partisan issue. It is my hope that this bill will garner bipartisan support because it protects Medicaid dollars and their intended recipients by requiring independent, third-party audits of managed care financial statements and state contracts.

Title 42 of the Public Health Code states that "The Medicaid agency [CMS] must assure appropriate audit of records if payment is based on costs of services or on a fee plus cost of materials." My bill will hold CMS accountable to their task of seeing that those state audits are done or there will be consequences.

This is why accountability is more important than ever. With Medicaid expansion mandated under the President's health care overhaul, 21 percent in Minnesota alone, the United States government must know where the taxpayer dollars are going. It is not out of the realm of possibility that as time goes on; we will find many instances where federal Medicaid money has been fraudulently used. I believe my legislation will stop fraud in its track. Furthermore, it will provide a remedy that will allow us to be good stewards of Medicaid dollars and bring transparency back to the system.

The taxpayers are depending on us.

Again, thank you for holding this very important hearing.

Mr. JORDAN. I want to thank the gentlelady for her hard work on this issue and a host of others, and for being here and testifying. And, as I said, we will make your full statement part of the record.

Ms. BACHMANN. Thank you, Mr. Chairman.

Mr. JORDAN. Now we will get ready for our second panel. So if we can just take a short little break here while the Committee staff prepare the table for our next set of witnesses.

[Pause.]

Mr. JORDAN. We will be back in order here. I want to thank our witnesses. We will swear you in here just a second, but you know the typical routine is you have to listen to us talk for a few minutes. That is the way we do things. And today, because it is a joint hearing, you have to listen to four of us talk. But we will get to you as quickly as we can. So we will do our opening statements.

Today's hearing focuses on the serious problem of waste, fraud and abuse, and mismanagement in the Medicaid program. These problems are not new. In fact, in 1982, the House Select Committee on Aging issued a report concluding that "State enforcement of the Medicaid program has been an unmitigated disaster." Unfortunately, 30 years later, government's ability to safeguard taxpayer money in Medicaid is still an unmitigated disaster, but the actual dollar amount of waste, fraud, and abuse is much, much greater.

Over the past 20 years, Federal Medicaid spending has grown from $75 billion to $450 billion a year. And as our witnesses in the first panel indicated, it is slated to be $7 trillion over the next decade. No one knows how much this spending consists of waste, fraud, and abuse, but it may exceed $100 billion each year.

As Americans struggle to pay their bills and make ends meet, the Federal Government borrows 40 cents of each dollar it spends. Fraudsters are collecting tens of billions of dollars from Medicaid every year.

At the root of all the waste, fraud, and abuse is the open-ended Federal reimbursement of the Medicaid program. If the typical State identifies and recovers $1 of fraud or abuse in its program, it only keeps about 40 cents. Rather than protecting taxpayer dollars, the Federal reimbursement encourages each individual State to grow their programs unsustainably. When most States behave in this manner, there is waste, fraud, and abuse on a massive scale.

Most States employ a contingency fee to consultants to figure out how to maximize Federal Medicaid money. Rather than focusing on improving efficiency of the State programs, these consultants, who are highly compensated out of the funds that are supposed to go to the poor, as Representative Bachmann indicated, many poor were left untreated because of the situation in Minnesota, they spend their time figuring how to make Federal taxpayers pay for State spending.

For example, what we have learned about Minnesota's Medicaid program suggests that there is a new and creative way, a State scheme, to maximize Federal dollars. Information obtained through Senator Grassley's investigation shows that Minnesota's insurance companies were making large profits on Medicaid. One of the witnesses at today's hearing, David Feinwachs, has independently obtained information that shows the State was deliberately inflating Medicaid rates in order to leverage the Federal reimbursement.

In response to this controversy, Minnesota's governor has admitted that past contracts between the State and the insurance companies were "too generous with taxpayer money." The response to this is, of course, you have been too generous with taxpayers' money, but how long has this been going on and what are you going to do about it? And how many other States are in on the same game?

GAO and the IG have made numerous recommendations to improve program oversight. Regrettably, many of their recommendations have been ignored by CMS.

Today's hearing will shed light on some of the flagrant examples of waste, fraud, abuse, and mismanagement in the program. It is both shocking and disheartening that the Government failed to catch any of these cases. If it were not for the work of whistleblowers and investigative reporters, CMS may never have uncovered the problem.

At a more fundamental level, when a program becomes as big and complex as the Medicaid program, waste, fraud, and abuse are inevitable. The magnitude of taxpayer dollars wasted through Medicaid signifies the need for policymakers to immediately reform the program. Our Nation's limited tax resources must be targeted at individuals who genuinely need the public assistance, and cannot be used to provide huge windfall profits for large insurance companies and corporate dental practices, as took place in Texas.

Tragically, for both taxpayers and individuals who genuinely need public assistance, ObamaCare does not reform the Medicaid program; rather, it expands it by 20 million people and by nearly $1 trillion over the next 10 years, as Representative Bachmann pointed out. It also contains a feature that will undoubtedly make waste, fraud, and abuse in the program much worse. And as a sweetener to the States, ObamaCare makes the Federal Government reimburse at least 90 percent of State spending on newly eligible populations. It does not take an expert to realize that State manipulation of the Federal Medicaid reimbursement will become much worse.

While today's hearing will shed light on problems in the current program, I expect it will also provide some insights on a better way forward for the Medicaid program.

With that, I would yield to the gentleman from Ohio, the Ranking Member, Mr. Kucinich.

Mr. KUCINICH. Thank you very much, Chairman Jordan, Chairman Gowdy, for holding this hearing.

According to Harvard University scholar Malcolm Sparrow, the health care industry's complexity and volume of health care payments presents a business opportunity for a few bad actors suitably placed to steal hundreds of millions of dollars from Medicare and Medicaid.

The Government Accountability Office estimates that in 2010 Medicare and Medicaid made about $70 billion in improper payments. Improper payments include overpayments, underpayments, and fraudulent payments. Fortunately, the Center on Medicare and Medicaid Services, under Director Cindy Mann, and the U.S. Department of Justice are taking the threat of health care fraud very seriously.

CMS has moved quickly and aggressively to stand up its Office of Medicaid Program Integrity, utilize high speed computing and data analysis to identify patterns of fraudulent billing in real time, and adapt to Medicaid's successful anti-fraud initiatives developed to deal with Medicaid.

The Department of Justice has increased health care fraud prosecutions since fiscal year 2008 by nearly 75 percent. In fiscal year 2011, DOJ and the Department of Health and Human Services recovered a record $4.1 billion from health care fraud statements and settlements. Almost $600 million of that came from Medicaid anti-fraud efforts.

The Affordable Care Act made a significant contribution to Federal anti-fraud efforts both in terms of increased resources and authority to enhance oversight and screening measures, clarifying law enforcement access to claims and payment data, and expanding key anti-fraud programs to Medicaid, among other things.

But Federal anti-fraud efforts face a number of threats. At this very moment, the U.S. Supreme Court is considering striking down the Affordable Care Act. If they do, aggressive Federal anti-fraud activities authorized and financed by the Act will be compromised.

The House Republican budget also targeted the Affordable Care Act, calling for its repeal and banking on cuts of $106 billion in new Medicaid spending created by the law. The budget also would change the financing of Medicaid to block grants, which would lead the States to manage all aspects of Medicaid, including the bulk of anti-fraud efforts.

As one health care fraud expert testified to the Senate last year, health care fraud is an exceptionally complex crime. The perpetrators of this crime have proven themselves to be creative, nimble, and aggressive. Therefore, investing in and employing the most effective fraud prevention and detection techniques is critical to achieving success.

That level of investment can only come from the Federal Government. Today, Federal Medicaid, the Inspector General for the Department of Health and Human Services, and Justice Department prosecutors are mounting anti-fraud efforts with more success than ever before. Yet, unfortunately, my friends on the other side of the aisle have a budget and we have a U.S. Supreme Court which poses great threat to the continued existence and development of initiatives that would actually help to cut fraud.

So, with that, respectfully, I yield back.

Mr. JORDAN. I thank the gentleman for this statement.

We will now yield to the Chairman of the Subcommittee, the gentleman from South Carolina, Mr. Gowdy.

Mr. GOWDY. Thank you, Mr. Chairman.

More than $450 billion will be spent on the Medicaid program this year and, for context, there are only two companies in the world that have larger worldwide revenue than Medicaid's budget.

Medicaid spending is actually 40 percent larger than the entire economy for a country we have heard a lot about lately, Greece.

So, Mr. Chairman, while it is hard to quantify with certainty, some experts believe waste, fraud, and abuse constitute more than $100 billion a year. And as we see time after time after time, we

are all too willing to overlook the waste of other people's money more so than we would if the money were our own.

I actually prefer a little different perspective. I think we should zealously protect the public treasury because the money was collected as part of a sacred trust. And as the money flees, Mr. Chairman, due to waste, fraud, mismanagement, or simply because we just don't seem to care, so too goes trust in the institutions of government.

Problems within Medicaid's Federal and State Medicaid partnership are the focus of today's hearing. We will hear from expert witnesses with firsthand knowledge of how the government is failing to prevent waste, fraud, and abuse in the program. Specifically, there will be witnesses who will share testimony regarding problems in New York's Medicaid home health program, Minnesota's Medicaid managed care program, and Texas's Medicaid dental program. We will examine how these problems occurred, why they remained undetected for so long, and whether States or local jurisdictions were complicit in the fraud and abuse.

But if all we do, Mr. Chairman, is have yet another hearing where we perform an autopsy on some program or initiative that failed, we are not doing our jobs. Something concrete must come from this. Accountability for fraud in the form of license revocations, debarment, indictments, restitution, seem to me to be an appropriate place to start.

When problems are identified, the people we are supposed to work for expect corrective measures to be taken immediately. When money is mismanaged, the people we work for expect us to seek a full recovery, not settling for cents on the dollar. When a fraud is suspected, the people we work for do not understand why it takes multiple prompts to see any real action taken and, frankly, Mr. Chairman, neither do I.

I lived in Texas for four years, Mr. Chairman, and I absolutely love that State. But it doesn't, or shouldn't, take an IG investigation to notice more money was being spent on orthodontia in Texas than the rest of the States combined. Either people are gaming the system or there is some genetic malady which leads to more crooked teeth in Texas than the rest of the Country put together. And I highly suspect it is the former and not the latter.

Which leads to this question, Mr. Chairman: Has the money been paid back? Do we know how this occurred? Or is it just another exhibit in the trial entitled this is what you get when give perverse incentives to spend more, you talismanically get more spending.

In New York City, the city failed to comply with State and Federal regulations and unlawfully enrolled thousands of people in a Medicaid personal care service's program without regard to their need for the program. The statistical expert hired for the lawsuit estimated the total damages caused by the City's conduct were between $1 billion and $3 billion. And this total included only the fraud in one relatively small program in New York City's enormous Medicaid budget.

Over the past 10 years, Mr. Chairman, the Inspector General for the Department of Health and Human Services has conducted 19 audits. Ten of the 19 audits and 5 of the 6 audits with the largest findings, each of which exceeded $170 million in improper State re-

ceipts of Federal Medicaid dollars, were the result of problems in just one State, New York.

So, Chairman Jordan, it strikes me that we can keep doing autopsies once the patient is dead to confirm what we already know, or we can practice preventive medicine. And the way to practice preventive medicine is to put everyone on notice, State officials, service providers, customers, and especially those who seek to take advantage of the generosity of our fellow citizens, that there will be consequences.

This is not a game to see how much money we can get from the Federal Government to run our State; this is a program designed to provide a safety net for the poor and the disabled. If you abuse this safety net and turn it into a trampoline, you will be prosecuted, barred from participating, and exposed as a fraud. Perhaps then we will have fewer hearings on what went wrong.

Mr. JORDAN. I thank the gentleman. Spoken like a prosecutor. We appreciate that opening statement.

The gentleman from Illinois, the Ranking Member of the Subcommittee, is recognized, Mr. Davis.

Mr. DAVIS. Thank you very much, Chairman Jordan, Chairman Gowdy, and Ranking Member Kucinich for holding this hearing.

Making sure that laws are carried out the way we intended for them to be carried out and making sure that money spent is spent the way we intended for it to be spent are great parts of our responsibilities as members of Congress.

Reducing health care fraud is a policy shared by both Democrats and Republicans. We must be vigilant in locating potential waste of precious Federal dollars. The amount of Federal dollars expended for managed care make oversight and limiting abuses of Federal dollars critically important.

Medicaid is a complex, high risk designated program, and I want to take this opportunity to encourage CMS to fully utilize all of the tools provided for in the Affordable Care Act. I am certain that these advancements will be invaluable to program integrity and have already begun to show great promise.

I am encouraged by the Federal efforts to stop fraud in the Medicare and Medicaid programs. Last year, the Government recouped more than $4 billion. Between 2009 and 2011, the Federal Government recovered more than $7 for every $1 spent on fraud prevention and recovery activities. The return on investment is about $2 higher than the historical average, and increased coordination between the State and Federal Governments will yield even greater results.

Yes, we want to ensure that every dime designated for beneficiaries, the elderly, the disabled, and the children, is spent exactly where it was intended to be spent, how it was intended to be spent, and for the purposes which it was intended to be spent.

So I want to thank our panel of witnesses that have come today to share issues related to their State programs. I appreciate your presence and I am certain that at the end of this hearing and other inquiries we will find a way to make sure that waste, fraud, and abuse is rooted out of these valuable programs and exist only to a minimum.

So I thank you, Mr. Chairman, and yield back.

Mr. JORDAN. I thank the gentleman for his statement.

We now yield time to the gentlelady from Minnesota, Ms. McCollum. We have a couple of Minnesota members with us and Ms. McCollum has asked to make an opening statement, so the gentlelady is recognized.

Ms. MCCOLLUM. Thank you very much, Mr. Chair. And I would like to thank you all for including me in this hearing today.

In this Congress, the safety net which protects millions of Americans, elderly, children, and the disabled, is under attack. While tax cuts for millionaires and billionaires are being protected, critical services for our most valuable citizens are being slashed. Medicaid provides a critical health service, keeping people in their homes, and contributes to a society that values human dignity. There should be no confusion about the current Republican plan, which was voted on in the chamber a week or two ago regarding Medicaid: they want to cut it and they want to block grant it.

Today's hearing, as far as it relates to Minnesota's Medicaid program, is about accusations of fraud under the administration of a former Republican, and the story of today is about the Democratic successor who made reforms to the program. Whether it is Medicaid or any other government program, I, along with the members of this Committee, want the dollars to be spent wisely and effectively. If waste, fraud, and abuse is taking place, it must be investigated and the responsible company, individual, or State needs to be held accountable. Mrs. Bachmann, Mr. Ellison, and I are here because of the focus today on Minnesota.

I think it is terrific. Our State is delivering high-quality, low-cost, better care than anywhere else in the Country. Last month, the Commonwealth Fund released a scorecard comparing all local health care regions in the United States. St. Paul, Minnesota, my home, ranked number one in the Nation for best overall health care system; Rochester ranked number three; Minneapolis number four; St. Cloud was number seven. Minnesota is a model for delivering quality health care and I applaud our doctors, nurses, hospitals, and health care professionals and policymakers for their partnership that works better than anywhere else.

Minnesota has long been committed to expanding health care coverage, containing costs, improving quality. We are unique in requiring HMOs to be nonprofit organizations. Quality health care for our State is to be a priority, not profit-taking. In 1992, we created Minnesota Care to provide access to services to more than 148,000 children and working parents who had no other insurance that they could turn to.

Clearly, I know Minnesota is not perfect and we have more work to do, but I ask this Committee to show a State that has a better performing record in providing quality health care. However, for eight years the Republican administration of Governor Tim Pawlenty negotiated Medicare contracts with health plans with little or no transparency, and the terms of these contracts were negotiated poorly. If they allowed fraud, waste, and abuse to take place, then this Committee has an obligation to investigate those claims. But, unfortunately, those members of the Pawlenty administration responsible for negotiating those very contracts on behalf of taxpayers, they are the ones who are not here to testify.

Starting January 11th, Democratic Governor Mark Dayton's administration took bold action to increase transparency and accountability for taxpayers. Here are some of the reforms that have been implemented by Governor Dayton and Commissioner Jesson: enacting competitive bidding for managed care contracts, saving the State and Federal taxpayers millions of dollars; committing the Office of Inspector General and Department of Human Services to rid out waste, fraud, and abuse; and launching a single website with managed care contracts and reports, financial data, and quality measurements available to the public, a truly unprecedented level of transparency that the Dayton administration engaged in.

In addition, Governor Dayton and Democrats and Republicans in the State House and Senate have worked bipartisan to require third-party financial audits of managed care plans going forward, and I am glad Ms. Bachmann has seen this as a way forward for the Federal Government to move on. Mr. Ellison and I couldn't agree more, and the State of Minnesota has already done it.

But I do say if this Committee is serious about investigating Medicare fraud, for-profit and nonprofit health plans must be required to open their books and let the public see if profit-taking at taxpayer expense is going on.

Other States and Congress must follow Minnesota's lead for transparency. I am proud of the health care system we have in Minnesota and we will continue to make it better for the people we serve and for the taxpayers we are responsible for. I believe that we can lead in being an example for the rest of the Country.

And again, Mr. Chair, thank you so much for the courtesy of allowing me and Mr. Ellison to be here today.

Mr. JORDAN. Great. I thank the gentlelady for her statement. I would just make one point about the Republican plan dealing with Medicaid. Our plan is to not cut Medicaid, but it is to block grant it back to the States. We actually think if you take away the incentive for States to try to leverage Federal dollars and say, no, here is the amount of money you are getting, now you manage it, that is what you get, and you serve your population; we think it takes away this perverse incentive that exists in the current program and would better help those individuals who may have not got treatment because of all the fraud that was going on.

With that, we would ask——

Ms. MCCOLLUM. Mr. Chairman, just a point of clarification. You know how all of us sometimes slip up and say Medicaid and Medicare?

Mr. JORDAN. Medicaid.

Ms. MCCOLLUM. I would like my statement to reflect Medicaid. Thank you.

Mr. JORDAN. Okay.

We have, first, with us Dr. Gabriel Feldman. He is the Local Medical Director for New York City's Personal Care Services Program. We also have with us Dr. Christine Ellis, an orthodontist and a member of the faculty of the University of Texas Southwestern. Mr. David Feinwachs is the former general counsel of the Minnesota Hospital Association; and Ms. Claire Sylvia is an attorney at Phillips & Cohen.

The practice of this Committee is we actually swear you in, so if you would stand and raise your right hand.

Do you solemnly swear or affirm that the testimony you are about to give will be the truth, the whole truth, and nothing but the truth?

[Witnesses respond in the affirmative.]

Mr. JORDAN. Let the record show that everyone answered in the affirmative.

Thank you.

We will start with Dr. Feldman and we will just go right down the line. Dr. Feldman, you are recognized for five minutes.

STATEMENT OF GABRIEL E. FELDMAN

Dr. FELDMAN. Good morning. My name is Dr. Gabriel Ethan Feldman and I am a whistleblower.

I would certainly like to start by thanking Senator Grassley, Congresswoman Bachmann, Congressman Issa, Gowdy, and Congressman Jordan, of course, and the other Committee members for convening this important hearing and for inviting me to discuss my role in helping the Federal Government recover $70 million that was improperly billed for New York City's Personal Care Services Program. I would also like to make very clear that all my comments here today are my own and do not reflect my employer, my colleagues, or any other entity.

I was born in Brooklyn, New York, and have lived on Manhattan's Upper West Side in a small studio apartment for most of the last 20 years. I am a registered Democrat. I received my medical degree from the Sackler School of Medicine in Tel Aviv, Israel. I have a BA from Brandeis University, a Master's degree in Public Health from New York Medical College, an MBA and a Master's in Health Administration from Georgia State University in Atlanta. I am board certified in both preventive medicine and public health, and I hold an active medical license in New York.

I began working as a New York City PCSP, or Personal Care Services Program local medical director in 1990, worked through 1993, and returned to work there in 2006, and hopefully I will be still working there tomorrow.

As an LMD, I am responsible for impartially evaluating a client's home health care needs and appropriateness for the PCS program. Not every State has a PCS program. The Federal Medicaid Act was amended in 1990 to permit States to offer PCS as an optional home health care benefit. States that choose to implement the PCS program are required to set forth "reasonable standards" for determining individual eligibility and benefits.

New York State has always offered the most generous and comprehensive safety net, including the most comprehensive Personal Care Services Program in the world. New York State regulations mandate that personal care services should only be provided if they are medically necessary and only if the patients have physical and medical conditions that are "stable."

The PCS program has two levels: one is limited to basic housekeeping and chores; the other includes assistance with daily functions such as bathing, dressing, feeding, grooming, walking, and

toileting. The PCS program aides do not provide any sort of skilled nursing care or monitoring.

While the State is ultimately responsible for overseeing the PCSP and for providing a fair hearing appeals process, the program is run day-to-day at the county level. Thus, PCS is run quite differently in New York City than it is in upstate or rural counties.

My false claims case involved Medicaid clients who received PCS around the clock, either on a sleep-in or split shift basis. Sleep-in refers to an assistant that sleeps in the home; split shift refers to two separate, always awake assistants who provide care to the client in separate shifts. Sleep-in costs about $75,000 a year; split shift costs twice that.

In 2009, the year my qui tam complaint was filed, New York spent about $50 billion on Medicaid. About $20 billion of this was on long-term care, of which about $10 billion was home health and personal care services. These figures are by far the highest in the Country and partly reflect the fact that, nationwide, Medicaid now spends most of its funds on long-term care and not on primary, acute, or preventive care.

For the last 20 years, Medicaid clients in New York City have received far more PCS service hours than any other group in the Country, and I believe that this was likely due in part to poor oversight at both the State and local levels.

New York State does have a dense set of regulations that dictate criteria for admission to and reauthorization of its PCS benefits, yet I frequently found myself at odds with city level staff and my own supervisors regarding the determination of level of service.

In New York State, those of us who work in the PCS program are under tremendous pressure from advocacy groups, politicians, administrative law judges, and family members of clients to rubber-stamp service requests.

I have found my independent and very well supported recommendations regarding home care needs routinely overridden by the City's powers that be, or by administrative law judges, who are not required to even have any formal medical, nursing, or disability training. When I would suggest that a client was no longer appropriate for the PCS program or appeared to be unstable, I was taken to task as being one of those unfeeling bureaucrats.

Until recently, a pervasive culture of non-accountability and noncompliance to PCS State regulations made it simply far too easy for local social service offices in New York City to spend billions in taxpayer money without regard to common sense oversight, regulations of the State, or patient safety concerns.

Despite my complaints to appropriate internal parties, little seemed to change. I grew tired of seeing so much waste in the Medicaid system while hundreds of thousands of poor children in my State had no health insurance at all. As Justice Brandeis said, sunshine is the best disinfectant. So I contacted Levy Phillips & Konigsberg and decided to become a whistleblower.

My complaint was filed under seal and I hoped the issue would be resolved quickly and quietly. After the case was unsealed, however, New York City still defiantly proclaimed that they would win their fight and the case in the end. The case was heavily litigated before Judge Rakoff in the Southern District. I continued to show

up for work each day and was grateful that family, friends, and co-workers supported me. The case was finally settled just a few months ago.

In sum, New York City's Medicaid program is still in dire need of reform. Many providers simply refuse to accept Medicaid. The cost growth is unsustainable and a million people in New York City have no health insurance at all. Higher spending simply had not led to better outcomes, higher patient satisfaction, or to better access to care. In New York City, Medicaid simply does not excel with regard to quality, access, cost, or oversight. This simply must change.

I would also like to suggest much stronger oversight and independent auditing of ALJ, administrative law judges, who hear appeals.

Mr. JORDAN. Doctor, can you close up?

Dr. FELDMAN. Yes.

While Governor Cuomo has taken bold steps to redesign Medicaid in New York State, the Medicaid industrial complex is thriving, especially in New York City. I hope today to make some sort of impact on this situation.

Thank you very much.

[Prepared statement of Dr. Feldman follows:]

TESTIMONY BEFORE CONGRESS
BY GABRIEL FELDMAN

I. Introduction

Hello, my name is Dr. Gabriel Ethan Feldman. I would like to thank Congressman Issa, Congressman Gowdy, Congressman Jordan and the other committee members for convening this hearing on Medicaid accountability and reform. My statement will focus on my whistleblower experience, assisting the federal government in recovering $70 million dollars that was improperly billed for New York City's Personal Care Services Program (PCSP).

II. Qualifications/Background/Experience

I was born in Brooklyn, and have lived on Manhattan's Upper West Side in studio apartments for most of the last 20 years. I am a registered Democrat.

I received my medical degree from the Sackler School of Medicine in Tel Aviv, Israel. I have a Masters Degree in Public Health from New York Medical College, and an M.B.A. and a Masters in Health Administration (M.H.A.) from Georgia State University. I am board certified in preventive medicine and public health, and I hold an active medical license in New York State.

I am proud to say that I am still employed as a Local Medical Director (LMD) for New York City's Personal Care Services Program (PCSP), which is the same position I held in 2009 when I first filed my *qui tam* complaint. The PCSP is locally operated by New York City's Human Resource Administration (HRA) agency.

I worked as a PCSP Local Medical Director from 1990 through 1993, and returned to work there in 2006 until today. As a Local Medical Director, or LMD, I am responsible for impartially evaluating a client's home health care needs and appropriateness for the PCS Program.

III. The PCS Program

Not every state even has a Personal Care Services (PCS) Program. The federal Medicaid Act was amended in 1990 to permit states to offer PCS as an optional home health care benefit. States that choose to implement a PCS Program are required to set forth "reasonable standards" for determining individual eligibility, and for the extent of medical assistance that could be provided. New York State opted to have a Medicaid PCSP, and continues to offer the most generous and comprehensive Personal Care Services program in the world.

In New York State, the regulations governing the PCSP say that the program is intended to provide *"some or total assistance with personal hygiene, dressing and feeding and nutritional*

and environmental support functions" which are "essential to the maintenance of the patient's health and safety in his or her own home..." [18 N.Y.C.R.R. § 505.14 (a)(1)]. New York State regulations also say that personal care services are only provided if they are "medically necessary" for patients with physical and mental conditions that are "stable."

The PCSP has two levels - Level I services are confined to basic housekeeping, while Level II services also include assist with daily personal functions such as bathing, dressing, ambulation and toileting. PCS aides do not provide any skilled nursing care or monitoring.

While the State is ultimately responsible for overseeing the PCS Program and for providing a fair hearing appeals process, the program is run day-to-day at the county level. Thus, the PCS program is run quite differently in New York City than it is in upstate or rural counties, such as Onondaga, Dutchess, or Orange.

My false claims case involved Medicaid clients receiving PCS services either on a sleep-in (where the assistant sleeps in the home of the beneficiary), or split-shift (where two or more always awake assistants are provided in two separate shifts) basis. Sleep-in (or live In) service costs approximately $75,000 per year per patient, while split shift care costs approximately $150,000 per year per patient.

In 2009, the year my *qui tam* Complaint was filed, New York State spent $49.3 billion on Medicaid. About 43% of that, or $21.2 billion, was on long-term care, while $9.7 billion was

spent on home health and personal care services. These figures are by far, the highest in the country. Nationwide, Medicaid now spends most of its funds on long term care, not on primary or preventive care. And for the last 20 years, Medicaid clients in New York City have received far more PCS service hours than any group in the country. This was likely due, in part, to poor oversight, and a prior culture of "padding" hours out of sympathy or guilt, or simple inertia, at both the state and local levels.

IV. Governing State Regulations

While New York State has a dense set of regulations that dictate the criteria for admission to and reauthorization of PCS Program benefits, I frequently found myself at odds with city-level staff and my own supervisors regarding the determination of level of service.

In New York State, those of us who work in the PCS system are all under tremendous pressure from advocacy groups, politicians, administrative law judges, and family members of clients to rubberstamp service requests for individuals who do not meet the state regulatory requirements for medical necessity for the services requested. Not surprisingly, my colleagues and I find our independent medical recommendations regarding home care needs routinely overridden by the city 'powers that be', or by Administrative Law Judges (ALJs) who are not required to have any formal medical, nursing or disability training.

Throughout my employ, my decisions were overridden and PCS care was commonly, and inappropriately, awarded to individuals with severely deteriorating, likely unstable conditions. Some clients could have posed a risk to themselves or the workers around them, as these clients often had serious mental health, dementia or behavioral issues that were not fully controlled. However, it's important to state clearly - virtually all clients can be cared for at home, very few need long term institutionalization, but some might have benefited from short term inpatient or rehab care.

When an LMD suggested that a client was no longer appropriate for the PCS program or that a service level was not medically necessary or appropriate, we were labeled as "unfeeling bureaucrats" by advocacy groups and angry family members. Thus, until recently, a culture of non-accountability and non-compliance to PCS state regulations made it far too easy for local social service offices to spend billions in taxpayer money without regard to common sense oversight, or the state's rules.

V. Decision to be a Whistleblower

Despite complaints to appropriate internal parties, the culture of indifference to state regulations, and the taxpayer, persisted in New York City. Even though I feared for my job, I was tired of seeing more and more waste in the Medicaid PCS system, while hundreds of thousands of poor children in my state had no health insurance at all. I contacted Levy Phillips & Konigsberg, and decided to become a whistleblower.

My complaint was filed under seal, and I hoped the issue would be resolved quietly. After the case was unsealed, however, New York City defiantly proclaimed that they would win in the end. My case was heavily litigated before Judge Jed Rakoff in the Southern District of New York City. I continued to show up for work each day. Family, friends and co-workers that understood my efforts comforted me and supported me throughout the two-year long case process.

With the assistance of my attorneys at Levy, Phillips and Konigsberg, I feel strongly that my actions will eventually help expand and strengthen the safety net in New York State, so that more people will ultimately benefit from more equitably allocated resources. My case will also help ensure that the taxpayer has more confidence in how their money is spent.

VI. Problems still exist

New York City's Medicaid program is still in dire need of reform. Many providers refuse to accept Medicaid, outcomes are mediocre, and a million people in New York City still have no health insurance at all. Higher spending has not led to better outcomes, higher patient satisfaction, or to better access to care. Medicaid simply does not excel with regard to quality, access, cost, or oversight in New York City. This must change.

If we are to expand access, ensure quality, and promote accountability and sustainable cost growth, we simply must have better oversight of our public benefit programs. With regard to the PCS Program, I would like to see more oversight of Administrative Law Judges (ALJ's) who hear appeals of Medicaid clients who are denied service requests. ALJ's routinely overturn clearly supported medical decisions, and may be vulnerable to the same pressures that we all face when we have to follow regulations meant to protect both Medicaid beneficiaries and the taxpayer.

The Medicaid Industrial Complex is thriving in this country, and especially in New York City. I hope that my whistleblower experience will raise awareness on both sides of the aisle that if we are to expand health care access to needy citizens, we must better ensure that scarce taxpayer dollars are spent in the most cost effective and equitable manner possible. Opening dialogues, like the one we are having here today, is another great step. Thank you and I am happy to answer any questions.

Mr. JORDAN. Thank you, doctor, for your testimony and for your courage in stepping forward and bringing this to our attention.

Dr. Ellis, you are recognized.

STATEMENT OF CHRISTINE ELLIS

Ms. ELLIS. Thank you very much for inviting me to speak today.

In Texas, Medicaid has provided funding for the orthodontic treatment of severe handicapping malocclusions, which are defined as an HLD index score of 26 points. In plain English, a severe handicapping malocclusion is found in the mouth of a child whose teeth are so far out of position that they cannot do normal things like eat and talk without difficulty.

Everyone who knows them knows that these kids desperately need braces. Children born with a cleft lip and palate are an example. So are kids born with craniofacial syndromes and certain special needs. The handicapping malocclusion exists because of their medical diagnosis. They are in need of orthodontic treatment if they are to have any hope of having teeth in a position remotely approaching normal.

In many cases these kids depend on Medicaid for the funding of their orthodontic treatment.

On screen 1 is an example of a child with a cleft lip and palate.

While I certainly appreciate the value of an attractive smile, it is important to recognize the difference between the crooked teeth of an otherwise healthy child and a handicapping malocclusion. Unlike a healthy child with crooked teeth, children with handicapping malocclusion must be treated as they are growing up. Postponing orthodontic care until adulthood risks devastating consequences like speech that is difficult to understand, premature loss of teeth, and greater surgical risk. Braces for these kids are not optional and they are definitely not just for aesthetics. But in Texas these kids are at risk of losing the orthodontic providers who are most capable of providing care.

As they say, everything is bigger in Texas, and thanks to the investigative reporting of WFAA's Byron Harris, we now know that orthodontic Medicaid fraud is no exception. Since September of 2011, Texas OIG has been investigating high volume providers suspected of Medicaid orthodontic fraud. I have consulted with them by auditing the patient records of these offices.

The flagrancy of the fraud that I found is truly unbelievable. It was not accidental; providers submitted falsified HLD index forms to obtain preapproval for their care. These scores weren't off by just a point or two; they were inflated by all 26 points in some cases. If scored accurately, at best, only 10 percent of the cases would have qualified. These providers didn't want to put braces on the kids that Medicaid was designed to help, they were only interested in treating children without any real problems. Once they had them in braces, they delivered inefficient care and a whole lot of additional unnecessary appliances to increase their payment from Medicaid.

Amazingly, Texas is making a bad problem worse. In March, the administration of Medicaid-funded orthodontics was outsourced to three dental managed care companies. The complexity of the approval process increased and provider reimbursement was cut. This

is the wrong response and will only attract unqualified orthodontic providers, if anybody at all, to help these kids.

The corrective measures needed are: one, ensure that only children who qualify for orthodontic care are approved and, two, ensure that they are adequately funded.

In supporting increased Medicaid reimbursement of orthodontics, I am in no way advocating for greater amounts of public money to be spent on braces. Elective orthodontic treatment should not be funded by Medicaid. The eligibility for orthodontics should be limited to children with a medical diagnosis and an accompanying dental deformity. It is not just my opinion, but also that of the American Association of Orthodontists. These recommendations will help ensure that children truly needing orthodontic treatment will have access to high quality care.

As you are aware, there is significant disagreement between dental policymakers on how best to ensure access to care. Policy groups like the Pew Dental Campaign and Kellogg Foundation advocate for greater public spending for pediatric dental care. To these groups, numbers define success; they advocate for greater numbers of dental procedures performed, patients treated, and dollars spent. I do not question their good intent. But as a boots on the ground provider, I am here to warn of the side effects that accompany some of their recommendations. Texas has learned a painful and expensive lesson in the folly of simply increasing public funds in hopes of increasing access to care.

Several years ago, Texas settled the long-running Frew class action lawsuit. It claimed, among other things, that children covered by Medicaid did not have access to care mandated under EPSDT. Part of the settlement mandated the increased spending of $1.2 billion to increase their access to care. While Medicaid dental spending took off, Texas looked at the increasing numbers and they thought that they had achieved success.

Things did not work out as they had planned. Five years and over half a billion dollars later, Texas has spent a lot of money straightening basically already straight teeth and has gained a lot of fraudulent orthodontic providers, including many private equity-owned dental clinics that are engaged in the illegal practice of dentistry.

The sad conclusion to this entitlement-driven transfer of money is that, in Texas, we have used the mouths of children to enrich unethical providers and private equity investors. While access to care has increased, access to quality care remains a problem. In fact, it is possible that these children are more at risk of receiving unneeded poor quality care than they were before the changes mandated by Frew took effect.

In conclusion, we all realize that public dollars must be carefully allocated to the areas of greatest need. Even though I am an orthodontist, I know that crooked teeth do not prevent one from enjoying life, liberty, and the pursuit of happiness.

However, for a child with a true handicapping malocclusion, it is good and proper to craft public policy that addresses their deformity through Medicaid-funded orthodontic treatment. You can ensure their public safety net by clearly defining these children as the only patients who are eligible for well funded Medicaid orthodontic

treatment. You can help ensure the public that their dollars are well spent by clearly defining dentists as the only people qualified to own and operate a dental business.

Thank you for your time.

[Prepared statement of Ms. Ellis follows:]

Is Government Adequately Protecting Taxpayers from Medicaid Fraud
Written Congressional Testimony of Christine Ellis DDS, MSD
April 25, 2012

Good morning and thank you for inviting me to testify to the committee about the Medicaid funding of orthodontic treatment in Texas. I will do my best to clarify my perspective of the events that have taken place and to answer any questions that you have for me. I have a unique understanding of Medicaid funded orthodontics, thanks to my rather unconventional orthodontic career. In 1995, I graduated from St. Louis University with my masters in Orthodontics and began working with my father in his private orthodontic office in Altamonte Springs, Florida. After marrying a Texan, I continued to work part time with my father but moved to Texas, where I joined the cleft team at Children's Medical Center of Dallas. In 2003, I joined the faculty of the division of Oral and Maxillofacial Surgery at UT Southwestern. I currently see patients funded by Medicaid in both the faculty practice in Texas and the private practice in Florida.

In Texas, Medicaid has provided funding for the orthodontic treatment of severe handicapping malocclusions which are defined by an HLD index score of 26 points. In plain English, a severe handicapping malocclusion is found in the mouth of a child with teeth so far out of position that they cannot do normal things like eat and talk without difficulty. Everyone who knows them knows that these kids desperately need braces. Children born with cleft lip and palate as well as children born with other craniofacial anomalies such as Crouzon's or Apert's Syndrome develop a handicapping malocclusion as a result of their medical diagnosis and are in need of orthodontic treatment as they mature. Similarly, children born with other medical conditions such as Down Syndrome, Muscular Dystrophy, connective tissue disorders and developmental delay also frequently develop a handicapping malocclusion that results from their medical diagnosis.

In many cases, these children depend on Medicaid for funding of their orthodontic treatment. It has been my great pleasure to have worked with this patient population over the past 12 years. I have had the opportunity to participate in the life changing results that dedicated physicians and dentists are able to provide, and find no higher professional calling than caring for these children. At the same time, I have also provided routine orthodontic care for children, adolescents and adults, and recognize the value of an attractive healthy smile.

It is important to recognize the differences between these patient populations. Orthodontic treatment of children with a handicapping malocclusion is quite different from that of a straightforward case of crooked teeth. Unlike crooked teeth, children with a handicapping malocclusion must be treated as they are developing. Frequently their orthodontic care is provided in concert with surgeons who are intervening at specific developmental landmarks. Postponing orthodontic care until adulthood does not meet the standard of care. It risks devastating consequences, including compromised speech, pre-mature loss of teeth and increased surgical risk. The importance of maintaining

adequately reimbursed Medicaid funding for orthodontic treatment for handicapping malocclusions cannot be understated. Due to a series of problems, Medicaid funding in Texas for the orthodontic treatment of these children has been put at risk. It is my intention to explain the problems that have developed in Texas and to suggest corrective actions that can be taken to safeguard both taxpayer's money from fraudulent Medicaid activity and qualifying children's access to high quality orthodontic care.

In May 2011, Byron Harris of WFAA ran a story that exposed the likelihood that Texas was experiencing massive fraudulent billing of Medicaid for routine orthodontic care. In 2010, Texas Medicaid paid out over $184 million in orthodontic care. For comparison, during the same year California paid $19.4 million. In fact in 2010, Texas paid more than the top 10 most populous states combined. Texas has been leading the nation for several years in orthodontic payments under Medicaid. In 2008, Texas Medicaid paid over $102 million in orthodontic treatment and in 2009, over $133 million was paid.

Until recently, orthodontic treatment funded by Medicaid has been administered by TMHP and guided by the policies published annually in provider handbooks. Orthodontic treatment has always only been available for children demonstrating a severe, handicapping malocclusion which is defined as a score of 26 points on the Handicapping Labio-lingual Deviation (HLD) index. Orthodontic treatment for children with unaesthetic, crooked teeth has never been a benefit covered by Medicaid, which specifically excludes orthodontic treatment for cosmetic or self esteem purposes. Orthodontic fees have been paid on a per visit / per orthodontic appliance basis instead of the set global fee typical found in most fee for service orthodontic contracts. The Medicaid orthodontic policies were written to give the provider wide discretion in the management of difficult cases as well as to avoid limiting providers to any particular orthodontic treatment philosophy.

Since joining the faculty at UT Southwestern, I have been asked to consult with our surgeons on many cases undergoing Medicaid funded orthodontic treatment by a variety of orthodontists in the Dallas area. Specifically, I was asked to provide orthodontic advice on how to properly prepare these cases for surgery, as there were many complications that would have occurred had the surgeons taken these cases to surgery in their presenting condition. After seeing case after case of poorly handled orthodontic treatment, I became concerned that these children were frequently receiving orthodontic care that was of such poor quality that it was detrimental to the child's dental health. My concern led me to offer my assistance to WFAA's Byron Harris after his first story aired. Several months later, I was contacted by Texas OIG and asked to participate in audits of high volume Medicaid orthodontic offices, which I immediately agreed to undertake.

The flagrancy of the fraud that I have found in the course of auditing for OIG is truly unbelievable. It is highly likely that it was intentional. Quite simply, providers submitted falsified HLD index forms in order to obtain pre-approval for orthodontic care. Providers did not appear to screen prospective orthodontic patients to find the children that Medicaid was designed to help. Not one patient with a craniofacial anomaly or medical compromise was found during the audit. Submitted HLD scores weren't off by

just a point or two. They were inflated by all 26 points in some cases. If scored accurately, at best only 10% of the cases would have qualified.

Examination of individual billing incidence revealed troubling trends as well. Providers found creative ways to bill for services that were either not provided or not medically necessary. Offices tracked orthodontic visits to ensure that braces were not removed until all 26 visits had been billed. Patients with documented poor oral hygiene remained in orthodontic treatment despite multiple warnings that braces would be removed. My general conclusion was that providers delivered inefficient orthodontic care and a whole lot of additional unnecessary appliances with the main goal of increasing their payment from Medicaid, not providing competent patient care.

One of the largest billers for Medicaid funded orthodontic treatment is All-Smiles, based in Dallas and majority owned since 2009 by Valor Equity, a private equity firm. All Smiles received over $10 million for Medicaid orthodontic services in 2010. In addition to Medicaid orthodontics, All-Smiles provides both office based and mobile pediatric dental services to a target base of Medicaid patients. Dr. Richard Malouf, who remains a 30% owner of All-Smiles, recently settled allegations of orthodontic Medicaid fraud from 2004-2007 for $1.2 million with the Texas Attorney General. The Texas Dental Practice Act (TDPA) clearly states that only dentists can own dental practices. In September 2011, I filed a complaint against Dr. Richard Malouf with the Texas State Board of Dental Examiners (TSBDE) for facilitating the illegal practice of dentistry by a corporation. My complaint was dismissed by the TSBDE without action. The TSBDE claimed that they did not have jurisdiction over corporations practicing dentistry, only individual dentists possessing a Texas dental license. Recent Texas State House and Senate committee hearings investigating the corporate practice of dentistry reveal continued resistance from the TSBDE to enforce the TDPA by sanctioning corporations owning and operating dental clinics within the state. It begs the question that if the TSBDE will not defend the TDPA against the illegal corporate practice of dentistry, who will?

The fifth circuit Court of Appeals in Texas has maintained that business service agreements or Management Agreements entered into with corporations by orthodontist are illegal under Texas law (see OCA vs. Jordan No. 07-30430). This precedent directly applies to the non-dentist owned corporations currently conducting business in Texas and other states. Much has been written about the inherent conflict of interest that arises when a for-profit enterprise owns a medical provider business. Correctly in their Dental Practice Acts, states have prohibited the corporate (non-dentist) ownership of dental offices to avoid conflict of interest problems.

As demonstrated by All-Smiles in Texas, corporations are not only illegally practicing dentistry, but are using fraudulently authorized orthodontic Medicaid claims to boost profits. The evidence found in the recent bankruptcy of private equity owned Small Smiles (FORBA) indicates that similar fraudulent Medicaid activity exists in pediatric dental claims as well. It is imperative that Texas as well as other states Attorneys General actively prosecute corporations found to be in violation of the law. A white

paper summarizing the laws in every state and the District of Columbia has been provided by well respected lawyer, Martin Siegel and has been made available to this committee. The dental board of North Carolina has been particularly proactive in this area and should serve as a model for other state boards to follow.

Amazingly, in their attempt to reduce orthodontic Medicaid fraud, Texas is making a bad problem worse. In March, the administration of dental Medicaid was outsourced to three dental managed care companies. The Department of Health has increased the complexity of the approval process for orthodontic treatment and has cut reimbursement. This is the wrong response. The corrective measures needed are 1) ensure that only the children who qualify for orthodontic care are approved and 2) ensure that they are adequately funded. Adding complexity and reducing funding will not attract the highly skilled orthodontic providers necessary to best care for the most challenging orthodontic patients.

While I encourage increased reimbursement for the orthodontic care of eligible children, I am in no way advocating for greater amounts of public money to be spent on braces. Elective orthodontic treatment should not be funded by Medicaid. Eligibility for orthodontics should be limited to children with a medical diagnosis and accompanying dental deformity. This is not just my opinion, but also that of the American Association of Orthodontists. By doing so, children truly needing treatment will be ensured that access to high quality orthodontic care will be available.

As you are aware, there is significant disagreement between dental policy makers on how best to ensure access to care. Policy groups like the Pew Dental Campaign and the Kellogg Foundation advocate for greater public spending for pediatric dental care. To these groups, numbers define success; they advocate for greater numbers of dental procedures performed, greater number of patients treated and greater number of dollars spent. I do not question their good intent. But as a boots on the ground provider, I am here to warn of the side effects that accompany some of their recommendations. Texas has learned a painful and expensive lesson in the folly of simply increasing public funding in hopes of improving access to care.

Several years ago, Texas finally settled the long running Frew class action lawsuit. It claimed among other things, that Medicaid children in Texas did not have the access to dental care mandated under EPSDT. Part of the Frew settlement required the increased spending of 1.2 billion dollars with the stated goal of improving access to care. When dental Medicaid spending took off, Texas looked at Medicaid's increasing dental numbers and believed that they had achieved success.

Things did not work out as planned. Five years and over half a billion dollars later, Texas has spent a lot of money straightening basically already straight teeth and has gained a lot of fraudulent orthodontic providers, including many private equity owned dental clinics engaged in the illegal practice of dentistry. The sad conclusion to this entitlement driven transfer of money is that in Texas we have used the mouths of children to enrich unethical providers and private equity investors. Access to quality care for

these children remains a problem. In fact, it is possible that these children are more at risk of receiving unneeded poor quality care now than they were before the changes mandated by Frew took effect.

In conclusion, we all realize that public dollars must be carefully allocated to the areas of greatest need. Even though I am an orthodontist, I know that crooked teeth do not prevent one from enjoying life, liberty and the pursuit of happiness. However, for a child with a true handicapping malocclusion, it is good and proper to craft public policy that addresses their deformity through Medicaid funded orthodontic treatment. You can ensure their public safety net by clearly defining these children as the only patients who are eligible for well funded Medicaid orthodontic treatment. You can ensure the public that their dollars are well spent by clearly defining dentists as the only people qualified to own a dental business.

I appreciate your time and attention to the details concerning Medicaid orthodontic fraud in Texas. Public awareness of Medicaid fraud results in the honest, necessary debate as to the best use of scare funds. Thank you for your service to the public by allowing me the opportunity to share the good, the bad and the ugly of my experience with Medicaid. I truly hope that my testimony has been helpful, and that it will assist you all as you work together to serve your constituents.

Respectfully submitted,

Christine P. Ellis, DDS, MSD

CHRISTINE PORTER ELLIS, DDS, MSD
CURRICULUM VITAE

OFFICE ADDRESS	5939 Harry Hines Blvd. POB #2, Suite 210 Dallas, TX 75390-9193
OFFICE TELEPHONE	214-645-3999
OFFICE FAX	214-645-3995
E-MAIL ADDRESS	christine.ellis@utsouthwestern.edu

EDUCATION	Southern Methodist University – Bachelor of Arts, Biology 1989 Baylor College of Dentistry – Doctor of Dental Surgery 1993
RESIDENCY	St. Louis University – Master of Science in Dentistry 1995 Certificate in Orthodontics
ACTIVE LICENSURE	Texas, Florida
BOARD CERTIFICATION	Diplomate - American Board of Orthodontics - Lifetime

ACADEMIC APPOINTMENTS
Assistant Clinical Professor – UT Southwestern; 2003-present

HOSPITAL APPOINTMENTS
Children's Medical Center of Dallas; 1999-2011

ASSOCIATION MEMBERSHIPS
American Association of Orthodontists
Southwestern Association of Orthodontists
American Board of Orthodontics
Orthodontic Education and Research Foundation

PROFESSIONAL EXPERIENCE
2003-present
Assistant Clinical Professor
Dentofacial Deformity Resident conference Co-Founder
UT Southwestern Department of Surgery
Division of Oral Surgery
Dallas, Texas

1995-present
Associate orthodontist
Dr. Bradford Porter DDS, MS, PA
Private Practice
Altamonte Springs, Florida

1999-2006
Associate orthodontist
Orthodontics for Infants and Children
Hospital based private practice at Children's Medical Center of Dallas
Dallas, Texas

PERSONAL AND PROFESSIONAL RECOGNITION AND AWARDS

Outstanding Senior Dental Student (1993) – American Association of Orthodontists

PUBLICATIONS

Buschang PH, Porter CL, Genecov E, Salyer KE. Face mask therapy of surgically corrected unilateral cleft lip and palate patients. Angle Orthod Dentofac Orthop 1993; Volume 64, Pages 145-150

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INVITED PUBLICATIONS

Invisalign and Changing Relationships – AJODO July 2004

Self Ligating Brackets – AJODO Volume 133, Issue 1, January 2008, Pages 4-5

Lack of evidence forces practitioners to make clinically based decisions – AJODO, January 2-11, Page 3.

LECTURES AND PRESENTATIONS

Dentofacial Deformity Conference at UT Southwestern
"Orthodontic Principles", November 2004

Dentofacial Deformity Conference at UT Southwestern
"The Etiology of Anterior Open Bites", August 2005

St. Louis University Graduate Orthodontic Residents
"Multidisciplinary Treatment", August 2006

Dentofacial Deformity Conference at UT Southwestern
"Multidisciplinary Treatment", November 2007

St. Louis University Graduate Orthodontic Residents
"Open Bite Malocclusion", February 2009

Dentofacial Deformity Conference at UT Southwestern
"Alveolar bone and orthodontic tooth movement", January 2010

Dentofacial Deformity Conference at UT Southwestern
"Cephalometrics", February 2012

POSTER SESSIONS

American Association of Dental Research – 1992, 1993

Committee on Oversight and Government Reform
Witness Disclosure Requirement – "Truth in Testimony"
Required by House Rule XI, Clause 2(g)(5)

Name: Christine Porter Ellis DDS, MSD

1. Please list any federal grants or contracts (including subgrants or subcontracts) you have received since October 1, 2009. Include the source and amount of each grant or contract.

None.

2. Please list any entity you are testifying on behalf of and briefly describe your relationship with these entities.

Self.

3. Please list any federal grants or contracts (including subgrants or subcontracts) received since October 1, 2008, by the entity(ies) you listed above. Include the source and amount of each grant or contract.

None.

I certify that the above information is true and correct.
Signature: Christine P Ellis Date: 4/23/12

Mr. JORDAN. Thank you, Doctor.

Dr. Feinwachs, you are recognized for five minutes.

STATEMENT OF DAVID FEINWACHS

Mr. FEINWACHS. Thank you. Mr. Chairman, distinguished members, thank you for the privilege of being allowed to participate in the process today and for asking me to be here.

My name is David Feinwachs. I was, for 30 years, the general counsel of the Minnesota Hospital Association. In 2010, I was fired from that position. The reason I was fired is because I asked the wrong question. The question I asked was: Was the State of Minnesota using Federal Medicaid dollars for purposes other than Medicaid, or are we using it to cross-subsidize non-qualified programs, maybe even prop up commercial insurance products, or other things which were clearly impermissible? That was the wrong question.

Minnesota, in 2010, did in fact seek legislation to provide for a medical loss ratio for these public programs. During the course of that time, one of the fascinating things was that our Department of Human Services produced a fiscal note that discussed why that proposal would never yield any savings for either the State or the Federal Government. They said that any assessment on one of our HMOs in Minnesota, any payment of a penalty, a fine, a clawback, a give-back would never benefit the government because it would simply be built into the rate calculation for the subsequent years and be returned to the HMOs.

This is a strange assertion because, number one, it flies in the face of the notion that these companies are assuming insurance risk in their administration of these programs and, number two, it raises the question of why do these companies reserve, in massive amounts, against what appears to be non-existent risk. So the fiscal note raised a number of questions.

In July of that same year I reported to the management of the Hospital Association that I believed that we had uncovered a substantial and massive fraud against the Federal Government. In August, on August 13 of 2010, I was asked to participate in a conference call involving our State Department of Human Services, an employee named Karen Peed. Ms. Peed was the Director of Medicare Managed Contracting.

During the course of that conference call, Ms. Peed made the following statement: If you can't keep a secret, you have to leave the room, but we have been adjusting the reserve amount for State-only funded programs by making it essentially zero, and increasing the amount for PMAP Federal programs, blending the rate, and returning it to the insurers.

Upon hearing this statement, I believed that all the pieces of the puzzle had now been assembled. We suspected that there was a massive fraud; Ms. Peed's statement explained the mechanism by which the fraud was being accomplished.

I again went to the management of the Hospital Association and told them what had been discussed and urged them to do something. They did something: within 60 days I was terminated.

Following my termination, I continued my advocacy on this issue; I returned to our State capital and continued to lobby. In 2011, a

number of bills were introduced, but the most interesting thing that happened in 2011 is one of our HMOs, UCare, said that they were going to give a donation to the State of Minnesota of $30 million, a give-back. This, coincidentally, was exactly the amount that the year before we had claimed would be owing as a clawback or return because of the elimination of one of the programs in Minnesota that was not a federally qualified program.

When UCare announced the donation, as it was called and attributed, they distributed to a select group of legislators a letter explaining the reason for the donation, and the letter said that the money was being returned because Medicaid rates had been inflated to subsidize the program, which was now being eliminated, and, therefore, since the Medicaid rates had not been lowered, they were returning what they characterized in their own words as an overpayment.

Now, clearly that is not a donation.

If we fast-forward another year, to 2012, our media in the State of Minnesota got hold of this letter, as well as documents related to Ms. Peed's statement and some other things, and began to take a close look and to scrutinize the statements which were made by UCare and, in fact, the statements which were made by the State of Minnesota saying that this was in fact a donation and that the Federal share was not required to be returned.

During the course of these investigations, the media went to Commissioner Jesson and presented to her the Karen Peed statement, as well as other documents and, of course, the letter that UCare had written, and they asked her if this would be defrauding the Federal Government. Commissioner Jesson responded as follows: Let me say two things. Let me be very clear. We are not doing it that way anymore and Karen Peed is no longer in charge of contracting with the health plans.

Now, this is an interesting and simultaneously troublesome statement because currently we are, in part, celebrating the return of $15 million to the Federal coffers. But the celebration is a little premature, and let me explain why.

Mr. JORDAN. Dr. Feinwachs, can you close up here in just a few seconds?

Mr. FEINWACHS. In the last year, this return has been called a donation, a refund, and now an administrative expense, and it is the last that is most important. As an administrative expense, it is going to be billed into the rate certification and you are going to return half to the State and the HMOs next year. The $15 million they are giving you, you are going to give them back next year because there are no audits, there are no accountability, and there is no verification.

Thank you.

[Prepared statement of Mr. Feinwachs follows:]

Testimony of David Feinwachs, M.H.A., M.A., J.D., Ph.D.

Before the
U.S. House of Representatives Committee on Oversight and Government Reform
Subcommittee on Health Care, District of Columbia, Census, and the National Archives and the
Subcommittee on Regulatory Affairs, Stimulus Oversight and Government Spending
Wednesday, April 25, 2012

Thank You, Mr. Chairman and distinguished members of the subcommittee for inviting me today. I am David Feinwachs. I was, for nearly 30 years, the general counsel of the Minnesota Hospital Association. This is the trade association for all the hospitals in Minnesota. In addition to serving as their general counsel, I also directed their legislative advocacy.

In 2010, the Board of the Minnesota Hospital Association established as one of its priorities achieving transparency and accountability in Minnesota's publically funded health care programs. These programs included Medical Assistance (aka, Medicaid), Minnesota Care and the now defunct General Assistance Medical Care Program (GAMC). It's important to note that Medical Assistance is jointly funded in Minnesota, as in other states, by millions of federal and state dollars, in contrast to the Minnesota Care program and GMAC, which are supposed to be strictly state funded.

I was assigned as the lead staff person in this area. I began my work by analyzing what data I could obtain regarding these programs. I noticed that our managed care organizations (HMOs) made considerably more profit in the publically funded programs than they did in their commercial insurance products. I quickly came to realize that the question of whom or what regulated these managed care entities is difficult to answer. These HMO contractors have had these management contracts for over 15 years.

In Minnesota, all HMOs are statutorily required to be non-profit organizations. Their licensure is granted by the Minnesota Department of Health. The regulation of their financial transactions is the responsibility of the Minnesota Department of Commerce. And their involvement in the management of public programs, such as Medicaid, is regulated by the Minnesota Department of Human Services. This fragmented, uncoordinated regulatory scheme made it difficult, if not impossible, to gain a clear understanding as to how our public programs operated. This fact is confirmed by the Minnesota Department of Health's February 15, 2012 Report.[1]

During the 2010 legislative session, I worked for the introduction and enactment of legislation which would have required three things: (1) the establishment of a specific medical loss ratio for public programs; (2) the use of outside third party audits; and (3) a requirement that the state's healthcare programs use the Generally Accepted Accounting Principles to determine how public funds are allocated among administrative expenses, reserves and medical payment. This legislation was consistent with the position of the board of the Minnesota Hospital Association.

[1] Advisory Group on Administrative Expenses Report to the Minnesota Legislature 2012 Minnesota Department of Health, February 15, 2012.

This proposal had its first legislative discussion in a committee hearing in February of 2010. I provided testimony in support of these concepts. After the hearing, the executive director of the Minnesota Council of Health Plans, which is the trade association for the HMOs in Minnesota, scheduled a meeting with my boss, the president of the Minnesota Hospital Association. My boss told me of the meeting and informed me that the Minnesota Council of Health Plans (for the HMOs) had asked that I be prohibited from providing further public testimony on these issues. He explained to me that the Council believed so long as I was not the public face on these issues they could defeat these proposals.

The president of the Minnesota Hospital Association did instruct me not to testify on these issues again. I was concerned as to why the hospital association would agree to do this, but I followed the directive and I inquired if there were other limitations on pursuing the hospital association's goal of transparency and accountability. I was told the only prohibition was on testifying before the legislature and in all other respects I was to continue to pursue legislation requiring transparency and accountability in our public programs.

Throughout the remainder of the 2010 legislative session I prepared testimony, which was delivered by others, briefed legislators, lobbied the issue and did background research all directed at achieving the Minnesota Hospital Association's goal. In May of 2010, near the end of our legislative session, it became clear that Minnesota was going to repeal its state-only funded General Assistance Medical Care program. During the repeal debate I suggested to legislators that this repeal would create a windfall for our HMOs since we had pre-paid them for a program that would no longer exist and therefore we should consider clawing back some of this money.

At the time this was suggested, the Director of Managed Care Contracting for the Minnesota Department of Human Services, Ms. Karen Peed, testified that any such attempt to recover money would be illegal and would in fact violate federal principles of actuarial soundness. Prior to Ms. Peed's testimony our Department of Human Services had prepared a fiscal note[2] indicating that any fines, penalties or assessments of any nature against the HMOs would not yield savings because such sums would be incorporated into the health plans experience rating for subsequent years and returned to them in later years as increased payments. I found this assertion and the fiscal note to be very troubling. I began to ask questions about how the statements made in the fiscal note could be reconciled with the commonly held belief that our HMOs entered into risk bearing contracts with our Department of Human Services.

After the close of the legislative session, I made a video that summarized the issues that had been raised during the course of the legislative process. In this video, I raised questions about how either government or taxpayers might ever be able to detect cross subsidization between non-federally qualified state programs and/or commercial insurance products and especially the Medicaid program. When I use the term cross subsidization, I refer to the inappropriate allocation of administrative expenses, insurance reserves, which are massive, and other costs to the Medicaid program which taxpayers should not have to cover.

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[2] Fiscal Note: SF 2986-1E Narrative "If a health plan does not meet the 93.5% loss ratio and pays a penalty, the cost of paying the penalty will be included in the health plan's experience in subsequent years and may result in higher DHS capitation rates. Dated 4/12/10.

In July of 2010, I began to make inquiry of certain current and former Minnesota Department of Human Services employees. These employees were asked what the level of administrative expense was before we outsourced these programs to HMOs and whether or not they thought the outsourcing was a good idea.

One of the retired Minnesota Department of Human Services employees who was interviewed reported the inquiry to the Department. Following this report, Ms. Karen Peed, the State's Medicaid Contracting Director, informed the Minnesota Council of Health Plans that these questions were being asked. The response from the Council and its member HMOs was grossly disproportionate to the issue. The Minnesota Medicaid Director then contacted the president of the Minnesota Hospital Association. Following this contact I was summoned to a meeting with the president and Vice President of Regulatory Affairs for the hospital association. At this meeting I was asked if I had made these inquiries and told them that I had. I explained that these inquiries were essential to achieving an understanding of the operation of our state programs.

During the course of that meeting and immediately after, I explained to the other gentlemen involved that I believed that I had uncovered a massive financial fraud against the government of the United States, and that the member hospitals of the Minnesota Hospital Association were among the victims of this fraud.[3]

On August 13, 2010, I was asked by the hospital association's Vice President of Regulatory Affairs to be an undisclosed participant in a conference call with Minnesota's Managed Care Contracting Director, Karen Peed. The purpose of the call was to explore the department's reluctance to try to obtain additional federal money through such strategies as intergovernmental transfer and certified public expenditures, both of which are suspect but legitimate mechanisms. I had been instructed not to speak during the course of the call because it was feared that Ms. Peed might not be candid and forthcoming if she knew I was listening.

During the course of this conference call, I heard Ms. Peed make the following statement: "If you can't keep a secret you have to leave the room, but we have been adjusting the reserve amount for state-only funded programs by making it essentially zero, and increasing the amount for PMAP federal programs, blending the rate and returning it to the insurers." Mr. Anderson confirmed this statement in a subsequent deposition.[4]

Immediately after the phone call I met with the president of the Minnesota Hospital Association and told him what had been said. I explained to him the significance of the Peed statement. I told him it appeared that the State of Minnesota and HMOs were engaged in the manipulation of the Medicaid rate certification process. This manipulation was apparently designed to obtain unwarranted federal funding in violation of federal cost allocation principals and regulations.

I subsequently showed the Hospital Association President and Vice President for Regulatory Affairs a copy of the Report of the Government Accountability Office (GAO), dated August 4, 2010 (GAO-10-810). This report was consistent with my assertions in so far as the report expressed concerns that such manipulations would not be detected by the Center for Medicare

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[3] Deposition of Matthew Anderson, April 27, 2011, pages 107-109.
[4] Deposition of Matthew Anderson, April 27, 2011, pages 60-62.

and Medicaid Services (CMS) and further the report stated in unequivocal terms that there was no standard of actuarial practice that applied to work performed by actuaries working in the Medicaid rate certification process.

On August 18, 2010, the president of the Minnesota Hospital Association related to me a chance encounter that he had with the executive director of the Minnesota Council of Health Plans. He told me that she was very angry about the work that I was doing and that he had told her that: "Dave has gotten it in his head that DHS and/or the plans are manipulating the rate certification process to get unwarranted federal funding."

I asked what the Council's response was to his comment. I was told that the executive director of the Minnesota Council of Health Plans had said, "So what if we are, it is no different than hospital cost shifting." Upon hearing this, I informed the president of the Minnesota Hospital Association that I vehemently disagreed with this characterization and told him in my view this would be like comparing pan handling to bank robbery. "One is annoying, the other is a crime."

Several days later, I was informed there had been a meeting scheduled. The meeting participants would be the executive director of the Minnesota Council of Health Plans, the President of the Minnesota Hospital Association and me. The stated purpose of the meeting was to "clear the air."

At this meeting, which was held on September 8, 2010, the executive director of the Minnesota Council of Health Plans stated, "we are inextricably tied together in this Medicaid program and if we go down you go with us!"

I continued to work on behalf of the Minnesota Hospital Association on the issues of transparency and accountability until October 20, 2010 when I was placed on administrative leave. On November 9, 2010, my employment with association was terminated. Although I was offered two severance agreements from the hospital association I refused them because I did not want to be limited in what I could do or say regarding this or other issues.

Following the termination of my employment with the hospital association, I continued my advocacy at the Minnesota legislature. This advocacy continues to this day. In January of 2011, I brought a lawsuit against the Minnesota Council of Health Plans and subsequently against several of their member health plans alleging tortious interference with my employment. As a byproduct of this litigation, I obtained access to documents and testimony depositions, which significantly furthered the understanding of what was occurring in the HMO administration of Minnesota's public programs.

During the course of the 2011 Legislative Session I was able to get various legislators to introduce a dozen pieces of legislation directed at the issues of transparency and accountability in the management of Minnesota's public health care programs. There was considerable legislative interest regarding these topics in no small part due to a multi-billion dollar budget deficit. Despite the looming deficit and the fact that these proposals would have saved the state money, not one of these bills received a hearing.

Another notable event occurred during the course of the 2011 legislative session. This event was the unprecedented give-back of thirty million dollars by UCare, the smallest of Minnesota's four principal HMOs. The $30 million dollar amount was exactly the rough estimate that my colleagues and I had been repeatedly telling Minnesota legislators was the minimum overpayment that the HMOs' likely received during just the fiscal year at issue.

This give-back was heralded as a donation to ease the state's budget crisis. Although announced as a donation, select legislators received correspondence from UCare dated March 16, 2011, which explained the give back as a refund of overpayment resulting from an inflated Medicaid rate related to the subsidization of the now defunct General Assistance Medical Care Program. The statement contained in this document was completely consistent with the assertions I had advanced.

In January of 2012 I began to utilize the now publicly available documents and transcripts from my lawsuit as well as the UCare letter of March 16, 2011, to brief legislators, the media and the general public regarding my concerns relative to the integrity of Minnesota's Medicaid program. Despite the fact that the subject matter was somewhat arcane and tedious, to their great credit, both print and television media explored the issue in depth. As a result of the media attention, grassroots advocacy and the efforts of many medically related groups (such as the Minnesota Dental Association, the Minnesota Chiropractic Association, the Minnesota Podiatric Medical Association, the Minnesota Nurses Association and virtually every other health care association with the notable exception of the Minnesota Hospital Association), legislation has now been introduced in 2012 which would require independent third party audits, establish a prohibition against the state's consulting actuary from also consulting with the state's HMO vendors and would require the real time use of encounter-claims and payment data. This legislation is moving through the process but has been significantly altered by opponents, including the Minnesota Department of Human Services.

On February 13, 2012, the Minnesota Department of Human Services Commissioner Lucinda Jesson was interviewed by Jay Kolls, an investigative reporter from KSTP television. The reporter showed Commission Jesson documents and transcripts obtained from my lawsuit and asked, "Would that be defrauding the federal government?" Commissioner Jesson responded by saying, "Let me just say two things. Let me be very clear. We are not doing it that way anymore… and Karen Peed is no longer in charge of contracting with the plans."

The next day, February 14, 2012, I testified before a joint hearing in the Minnesota House of Representatives of the Committees on Health Finance and Reform. During my testimony I asserted that this so called "donation" by UCare was actually the refund of an overpayment caused by an improperly inflated Medicaid rate. In making this argument, I presented legislators with the letter written by UCare's CEO, Nancy Feldman, dated March 16, 2011. I also presented to legislators a sampling of the documents and transcripts I had obtained in the course of my litigation. During the course of the hearing I asked two critical questions. First, I asked given the fact that everyone seems to agree that non-federally qualified programs are being subsidized by the Medicaid program, do we all agree that the federal government is aware of this? Second, I asked if the health plans involved in the management of these public programs were actually assuming any insurance risk? Despite the fact that both the chief actuary for the Minnesota Department of Commerce and the Commissioner of the Department of Human Services provided

testimony at the hearing, both inquiries went unanswered. Following the February 14, 2012 hearing the UCare issue has received heightened media attention.

In the aftermath of the February 14, 2012 hearing, it has come to light that the Minnesota Department of Human Services has been less than candid in their handling of these issues. The Minnesota Legislative Auditor has recently discovered that documents that he had requested on more than one occasion from the Minnesota Department of Human Services have been withheld. Minnesota Law is clear in its requirement that the legislative auditor is entitled to the receipt of such documents. The principal document in question is correspondence from CMS to the Minnesota Department of Human Services dated July 1, 2011. This correspondence seeks recovery of the federal share of the thirty million dollar UCare give-back. This document conflicts with the Minnesota Department of Human Service's assertion that the UCare giveback had been properly characterized as a donation and that this characterization had been accepted by the Center for Medicare and Medicaid Services.

On February 15, 2012, the Minnesota Department of Health released a report that was prepared with the assistance of Deloitte Consulting LLP. This report concluded that: "To the extent health plans participate in the commercial market as well as the state public programs, it was not possible to determine if administrative expenses and investment income was being properly and fairly allocated among all of an HMO's lines of business." The title of this report is Advisory Group on Administrative Expenses, Report to the Minnesota Legislature 2012 Minnesota Department of Health, February 15, 2012.

It is clear that something is very wrong in Minnesota. It is not possible to obtain a straight answer to the following simple question: who certifies the Minnesota Medicaid rates to the federal government? Minnesota's health plans say the Minnesota Department of Human Services does this. The Minnesota Department of Human Services say it is done by the state's consulting actuary. The state's consulting actuary says that the health plans and the Minnesota Department of Human Services do it. Someone must do it, and more importantly, someone must be accountable for having done it.

Bear in mind the conclusion reached in the report of the General Accountability Office dated August 24, 2010: "With limited information on data quality, CMS cannot ensure that states' managed care rates are appropriate, which places billions of federal and state dollars at risk for misspending."

The Center for Medicare and Medicaid Services (CMS) is highly vulnerable to fraud because it focuses solely on the receipt of information and disregards the veracity and authenticity of information that is submitted to them. The federal government has exhibited a trust in this area that borders on recklessness. It is assumed that auditing and verification of information that is submitted to obtain federal funds has occurred when in fact it has not.

Minnesota's experience demonstrates the nature of this problem. According to the 2008 report of the Minnesota Legislative Auditor, Minnesota's managed care capitation rates for public

programs are relatively high compared to other states.[5] Minnesota's managed care spending per enrollee grew faster than the national rate in recent years.[6] Minnesota's managed care organizations have not reported aggregate losses from public programs in recent years[7]. However, health plans have consistently reported losses for the General Assistance Medical Care program.[8] Despite these facts, Minnesota's health care providers have experienced flat or decreasing reimbursement levels for more than a decade. Hospitals have seen some increases but certainly not enough to make them whole in the aggregate. All health care providers report losses on public programs both in the aggregate and individually. Also of concern is the fact that the State of Minnesota has used the same consulting actuary for as long as anyone can remember. I am not aware of any evidence to suggest that this actuarial work has ever been put out for bid. Until quite recently the state's consulting actuary has been permitted to consult with at least some of the state's HMO vendors.[9] It appears that the most recent attempt to address this conflict of interest is simply to require different employees from the same actuarial firm to represent both the state and its vendors. These facts, combined with the apparent manipulation of the Medicaid rate certification process requires immediate and thorough auditing of Minnesota's Medicaid Program.

Equally important is the question of how long we have employed the mechanism which our Department of Human Services Commissioner now disclaims with the statement, "We are not doing it that way anymore..." How much money is owed to the federal government for the period of time that we did in fact "...do it that way"? We must confront the fact that in the absence of thorough and truly independent audits how do we know if we are not still "doing it that way"?

The federal government must take steps to require independent and rigorous auditing of the information which is and has been received by the Center for Medicare and Medicaid Services. The government has an obligation to taxpayers to recover funding, which was improperly obtained through a manipulation of the rate certification process.

The federal government must also view, with a jaundiced eye, any request for block granting made by states, such as Minnesota, who now seek to avoid prospective accountability requirements for federal funding. This strategy of sweeping past practices under the rug and directing the federal government's attention elsewhere must be rejected.

It would, in my opinion, be ill advised to weaken requirements for transparency and accountability on those who have avoided both by manipulating and exploiting the existing system to defraud the federal government.

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[5] Office of the Legislative Auditor, State of Minnesota, Evaluation Report, Financial Management of Health Care Programs, February, 2008, page 38.
[6] Ibid page 40.
[7] Ibid page 42
[8] Ibid page 43
[9] DHS response regarding competitive bidding and managed care. December 1, 2011. DHS has a contract with Milliman for actuarial services related to Minnesota Health Care Programs. The current contract prohibits the actuary from entering into consulting contracts with health plans that deliver PMAP services. Past administrations have permitted actuaries that contract with the state to enter into consulting contracts with health plans that have PMAP contracts.

Minnesota, which is considered a heath care leader nationally, appears to have been lured into highly questionable conduct, perhaps for as long as 15 years. It is possible this conduct is occurring in other states as well. In our current system it would be difficult for the federal government to detect this because as the GAO pointed out in its August, 2010 report, "the federal government focuses on the appropriateness of data rather than their reliability.[10]

With the recent failure of the Minnesota legislature to order truly independent audits, past and future, I can think of no more appropriate place than this committee for me to make these comments. What is required here is significant government oversight and regulatory reform. The lack of oversight by CMS as documented in the GAO report and as experienced in Minnesota is of great concern. It is to a degree understandable because of misplaced blind trust on the part of the federal government in institutions such as managed care organizations and state agencies.

My advice to federal regulators is contained in the maxim, "Fool me once, shame on you. Fool me twice, shame on me." The amount of potentially misappropriated federal funding for the time in question in Minnesota alone is very large. If you add in the possibility of similar occurrences in other states the amount is staggering.

I want to thank Chairman Gowdy, Chairman Jordan and members of the subcommittee for holding this hearing. I am pleased to answer any questions you may have.

[10] GAO -10-810

Mr. JORDAN. Thank you, doctor.
Ms. Cohen, you are recognized.
Ms. Sylvia, go ahead.

STATEMENT OF CLAIRE SYLVIA

Ms. SYLVIA. Chairman, Ranking Members, members of the Committee, thank you for the opportunity to speak with you today. My name is Claire Sylvia. I am a partner with Phillips & Cohen, which specializes in representing whistleblowers under the Federal and State False Claims Acts.

Much of the discussion today has been about auditing and oversight, and as important as those efforts are, even if they worked perfectly, and they don't always work perfectly, there would still be waste, fraud, and abuse. As many have acknowledged, that is sort of inevitable. And I would like to talk about a different way of addressing waste, fraud, and abuse, also a preventive method.

The Government's most important tool in fighting fraud against the Government is the Federal False Claims Act, with its qui tam whistleblower provisions, which provide incentives to private citizens to pursue lawsuits on behalf of the Federal Government to redress fraud.

The Act, first enacted in 1963, was substantially amended 25 years ago, when Senator Charles Grassley and Representative Howard Berman led successful efforts to amend it and to provide additional incentives for whistleblowers. The changes Congress made in 1986, which provided whistleblowers the opportunity to play an ongoing role in the cases that they initiate and enhance the resources of the Federal Government in pursuing these cases, have proven phenomenally successful in addressing fraud, including Medicaid fraud. The Department of Justice reported that more than $30 billion has been recovered under the False Claims Act since 1986.

The reason the Act is so successful and the State Acts are also successful is that they address two key problems in addressing fraud that are a problem for the Government, and the first is a lack of information. No matter how much auditing you do, what whistleblowers provide that the Government doesn't have is information about fraud.

As Congress recognized when first enacting the False Claims Act and again amending it in 1986, it is very difficult to detect fraud without the cooperation of close observers of the activity. The False Claims Act provides incentives to persons with knowledge of the fraud to report that information to the Government. Those incentives include not only the possibility of a reward, but the opportunity to have an ongoing role in the case, as well as protections against retaliation.

Without those incentives, few individuals would be willing to risk the cost to their careers of the type that we have heard about today. Other oversight methods, such as data mining and audit programs, can also serve an important role in detecting fraud, but the ability to harness the information of insiders has proven especially effective.

The False Claims Act qui tam provisions also address another important problem that the Government has in fighting fraud, and

that is resources. The Government would never have enough resources to pursue fraud. As Government recognized in 1986, large corporations that are the subject of fraud investigations are often able to devote significant resources to these cases and often outmatch the Government. The False Claims Act addresses that problem by providing incentives to whistleblowers and their lawyers to assist the Government. Cases under the False Claims Act can take a very long time, many years to develop and pursue, and typically require tremendous investment of legal resources. The combined efforts of the Federal Government and private resources have been uniquely effective in pursuing fraud.

The recent changes in Federal law will actually assist further in addressing Medicaid fraud. Congress amended the False Claims Act in 2009 to clarify a number of provisions of the Act that were inconsistent with Congress's original intent. The Affordable Care Act provided additional tools and, importantly, the Deficit Reduction Act in 2006 provided incentives to States to adopt their own False Claims Act acts and a number of done so, and together with the Federal Government they have been very effective in pursuing Medicaid fraud.

The success of these provisions in addressing Medicaid fraud is undeniable. According to the Department of Justice, in the fiscal year ending 2011, recoveries under the False Claims Act reached a record $3 billion, and the year before also was close to $3 billion. Of that amount, $2.8 billion in recoveries was attributable to claims brought under the whistleblower provisions of the False Claims Act and $2.4 billion of that amount involved fraud against Federal health care programs, including Medicaid.

Medicaid fraud takes a variety of forms and we have heard about a few of them today. They can be as simple as a single provider addressing Medicaid fraud, but they can also be incredibly complex. They can include things like unlawful pricing schemes offered by marketing and other types of complicated frauds, and all of those take resources beyond those that the States have to address them.

Not to be lost in all of this is the deterrence value that these suits can have on preventing future fraud.

So, in summary, this is a bipartisan effort, fighting fraud. Everyone wants to make sure that the money is spent on the people that it was intended to help, and the False Claims Act is one way to do that.

[Prepared statement of Ms. Sylvia follows:]

Statement of Claire Sylvia
Phillips & Cohen LLP

Submitted to
the Subcommittee on Health Care, District of Columbia, Census and the National Archives and
the Subcommittee on Regulatory Affairs, Stimulus Oversight and Government Spending of the House Committee on Oversight and Government Reform

Joint Hearing on
"Is Government Adequately Protecting Taxpayers from Medicaid Fraud?"

April 25, 2012

Chairmen and Members of the Subcommittees, thank you for the opportunity to appear before you today to address the critical role that private citizen whistleblowers play in combating fraud against Government programs, including Medicaid. My name is Claire Sylvia and I am a partner in the law firm of Phillips and Cohen LLP, which specializes in representing whistleblowers under the federal False Claims Act and state False Claims acts, as well as under the Dodd-Frank SEC whistleblower provisions and the IRS whistleblower provisions.

INTRODUCTION

The Government's most important tool in fighting fraud against the Government is the federal False Claims Act, with its "*qui tam*," or whistleblower provisions, which provide private citizens incentives to pursue lawsuits on behalf of the federal Government to redress fraud against the Government. The Act, first enacted in 1863, was substantially amended 25 years ago when Senator Charles Grassley and Representative Howard Berman led successful efforts to strengthen the False Claims Act and increase

the incentives for whistleblowers to bring information about fraud to the Government's attention. The changes Congress made in 1986, which provided whistleblowers the opportunity to play an ongoing role in cases they initiate and enhanced the resources of the federal Government in pursuing these cases, have proven phenomenally successful in attacking a notoriously difficult problem. The Department of Justice has reported that more than $30 billion has been recovered under the False Claims Act since the 1986 amendments.

THE FALSE CLAIMS ACT QUI TAM PROVISIONS

The False Claims Act *qui tam* provisions address two key problems inherent in the Government's efforts to combat fraud – lack of information and lack of adequate resources. Fraud against Government programs, including Medicaid, is difficult to detect and even when detected is difficult to prosecute. The False Claims Act *qui tam* provisions address the first problem by providing incentives to persons to report fraud to the Government. As Congress recognized when first enacting the False Claims Act, and again when amending the Act in 1986, it is very difficult to detect fraud without the cooperation of close observers of the activity. The False Claims Act provides incentives to persons with knowledge of the fraud to report that information to the Government. Those incentives include not only the possibility of a reward, but also the opportunity to have an ongoing role in pursuing the case, and protections against retaliation. Without those incentives, few individuals would be willing to risk the cost to their careers and personal lives that reporting fraud typically entails. While other oversight methods, such as data mining and audit programs can also serve important roles in detecting fraud, the ability to harness the information of insiders has proven especially effective. One study

prepared in 2006 for the Taxpayers Against Fraud Education Fund by Jack Meyer of the Economic and Social Research Institute, estimated that for every dollar spent to investigate and prosecute health care fraud in civil cases, $15 dollars is returned to the Treasury. And that study was prepared before the types of record-setting False Claims Act recoveries the Government has received in the last few years.

The False Claims Act *qui tam* provisions address the second problem – the Government's lack of adequate resources – by providing the opportunity for private citizens and their counsel to take an active role in pursuing these cases on behalf of the Government. As Congress recognized in 1986, large corporations that are the subject of fraud investigations are able to devote far more resources to these cases than the Government, which is often outmatched. The *qui tam* provisions of the False Claims Act enhance the Government's resources by leveraging the resources of whistleblowers and the private law firms that represent them. Cases under the False Claims Act can take years to develop and pursue and typically require a tremendous investment of legal resources. The combined efforts of the federal Government and private resources have been uniquely effective in pursuing large and complex fraudulent practices that might otherwise have gone unaddressed, even if detected.

Recent changes in federal law will further enhance the Federal Government's ability to combat Medicaid fraud. Congress amended the False Claims Act in 2009 in the Fraud Enforcement and Recovery Act to clarify a number of provisions of the Act and address court interpretations that were inconsistent with Congress's intent when it amended the Act in 1986. In the Affordable Care Act of 2010, Congress further strengthened provisions of the Act in several ways, including expressly providing that

violations of the healthcare Anti-Kickback Statute are violations of the False Claims Act and requiring that Medicare and Medicaid overpayments be reported and returned within 60 days. The Act also enhanced the Government's ability to prevent and deter fraud in other ways, including requiring more rigorous screening processes for providers before they are enrolled in the program, requiring States to withhold payments to Medicaid providers where there is a pending investigation of a credible allegation of fraud, and providing more resources to fight fraud and improve the coordination and sharing of information among agencies to combat fraud.

In addition to these changes to 2006 Congress provided incentives in the Deficit Reduction Act to encourage States to adopt their own Medicaid False Claims Act statutes and many have done so. The combined federal and state remedies and the coordination between the federal Government and the states provide an even more powerful means of redressing Medicaid fraud.

THE FALSE CLAIMS ACT AND MEDICAID FRAUD

The success of the *qui tam* provisions in helping the federal Government combat Medicaid fraud is undeniable. According to the Department of Justice, in the fiscal year ending in September 2011, recoveries under the False Claims Act reached a record $3 billion in settlements and judgments. That was the second year in a row that recoveries under the False Claims Act exceeded $3 billion. Of those total recoveries in fiscal year 2011, a record $2.8 billion in recoveries was attributable to claims brought under the whistleblower provisions of the False Claims Act, and $2.4 billion of that amount involved fraud committed against federal health care programs, and most of these recoveries are attributable to the Medicare and Medicaid programs.

Medicaid fraud takes a variety of forms from simple overcharging by a doctor for services not rendered to complex pricing and marketing schemes that affect multiple federal healthcare programs including Medicaid. While typical fraud schemes, such as billing for services never rendered, providing unnecessary services and paying illegal kickbacks have a long history, new ways of defrauding federal programs emerge, and often require insiders to explain them.

Some of the most significant recoveries in recent years have come from pharmaceutical and health care companies. The Government recovered nearly $2.2 billion in civil claims against the pharmaceutical industry in fiscal year 2011 alone, including $1.76 billion in federal recoveries and $421 million in state Medicaid recoveries. These recoveries included:

- $900 million from eight drug manufacturers to resolve allegations that they had engaged in unlawful pricing to increase their profits

- $750 million paid by GlaxoSmithKline to resolve criminal and civil allegations related to the submission of claims for payment to government health care programs for adulterated drugs and for drugs that failed to conform to the strength, purity or quality specified by the Food and Drug Administration

- $130 million paid by Maxim Healthcare Services, Inc. to resolve allegations that Maxim submitted false claims to Medicaid programs and the Department of Veterans Affairs for services not rendered, services that were not documented properly, and services performed by unlicensed offices

Since the end of the Government's fiscal year 2011, whistleblowers have helped achieve additional substantial recoveries for a variety of unlawful practices that have defrauded the Medicaid program. Those recoveries have included:

- $950 million from Merck to settle criminal charges and civil claims related to unlawful marketing of Vioxx and misleading statements about the safety of the drug

- $137.5 million from WellCare Health Plans, which provides managed health care services for Medicare and Medicaid beneficiaries, to settle whistleblower allegations that, among other things, it falsely inflated amounts it claimed to be spending on medical care to avoid returning Medicaid overpayments and engaged in certain marketing abuses, including cherry picking healthy patients to avoid future costs

- $11 million from Dava Pharmaceuticals Inc. to resolve allegations that it lowered the drug rebate amount owed to Medicaid by incorrectly classifying certain drugs

- $6.85 million from a residential youth treatment facility for Medicaid recipients in Virginia for providing substandard adolescent psychiatric services and falsifying records

All of these types of practices divert funds from the Medicaid program and its core mission.

Not to be lost in this discussion of actual dollars returned to the Treasury as a result of the efforts of private citizen whistleblowers is the deterrent effect that the False Claims Act has had, which although more difficult to quantify is undoubtedly substantial. Twenty-five years ago, there was not widespread awareness of the False Claims Act. Now, the Act is well known and an important part of internal healthcare compliance programs. While fraud in Government programs has been by no means eliminated, there is far more awareness of the consequences of defrauding federal health care programs and more awareness among potential observers of wrongful conduct that there is a way to ensure that fraud is stopped and addressed.

Mr. JORDAN. Thank you, Ms. Sylvia.

I now recognize the Chairman of the full Committee for a statement and his questions.

Mr. ISSA. I thank the Chairman. Thank you for going to me first.

Ms. Sylvia, since you were last, you shall be first. Three billion sounds like a lot of money. GAO indicates that Medicare alone, $100 billion; probably about $35 billion in Medicaid or greater; and a huge amount in dual eligibles. Is it really that effective if we are talking about small single digit percentages of the overall problem?

Ms. SYLVIA. Well, the $3 billion is only a part of the amount that is being recovered. That is the dollars and cents that you get back to the Treasury, but it is unknown how significant the deterrent effect is, how much fraud is being prevented.

Mr. ISSA. And I appreciate that, except the deterrent doesn't seem to be working if you have more than $100 billion in Medicare alone, according to the General Accountability Office. So, again, isn't it true that, in fact, qui tam looks, quite frankly, for cases. These cases often are about financial return to the law firms and to the individual, and that one of the challenges we have is we have lots of Federal workers and lots of people who are paid through Federal dollars who aren't living up to their basic responsibility to call foul when there isn't any money involved or when the money is unknown. And I think Dr. Feldman would be a good example of, yes, there were a lot of dollars involved, but ultimately the question is do we have the protections for the whistleblower who comes to us simply to stop a wrong.

Ms. SYLVIA. Most whistleblowers, I assume, come to the Government to stop the fraud. Most of the money isn't returned to the whistleblowers and the law firms, it is returned to the Government. So the qui tam provisions do provide an important role in addressing fraud. It is not perfect; there is always going to be more fraud, but they do provide an important deterrent effect.

Mr. ISSA. Dr. Feinwachs, I think you would say that we have a more rampant expansive problem that is not being addressed even at State level, wouldn't you?

Mr. FEINWACHS. Yes, sir, I would say exactly that. What we have discovered in Minnesota is a situation where there is a collaboration between the private parties to defraud and elements of State government.

Mr. ISSA. The Chairman was kind enough to come to me first. I will be brief.

This week we are going to be marking up on the House Floor the Data Act, literally changing the way reporting goes on so that every dollar, including Medicare, Medicaid dollars, the intention is the service providers will in fact be reported in a transparent way so that the public and the government, once and for all, will be able to see in real time, across all government services, where the money is being spent with a set of reporting. One of the challenges we are going to face is how do we leverage—and I am not asking for an answer here, but it is a challenge—how do we balance the private whistleblower's participation in this vast amount of new data versus cost effectiveness of employing Federal workers, if you would inspector general types, whose primary job will be to try to find most of that $100 billion in Medicare and probably half a tril-

lion dollars in unnecessary spending, not the least of which would be GSA conferences throughout the Country.

With that, Mr. Chairman, I respect the fact that you went to me first, and I yield back.

Mr. JORDAN. I thank the gentleman.

We will now recognize the Ranking Member of the full Committee, the gentleman from Maryland, Mr. Cummings.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

Mr. ISSA. You can have an opening statement and or your time.

Mr. CUMMINGS. I will be brief.

First of all, I want to thank all of our witnesses for being here. I think this is a very important hearing. I want to thank those who find it important to talk about the things that you see that are wrong.

Dr. Ellis, as you were talking, I could not help but think about a young man who you are probably familiar with from my State, who is now dead, the 12-year-old, Deamonte Driver, who died five years ago because he had an infected tooth that would have taken $80 worth of treatment, but could not find a Medicaid dentist to treat him. He is dead at 12.

And as I sat here and I listened to what we were saying, I could not help but think about something that Mr. Gowdy said, about and I agree with him, doing autopsies, but not coming up with results; doing autopsies, but not figuring out how to make sure we don't have to do future autopsies. We are going to have to address this issue and the False Claims Act may be a good tool. We need to figure out, Dr. Sylvia, how we make it even more effective. And I guess that is the one question that I would ask.

But I also want to be in fairness to the folks there in Minnesota. Dr. Feinwachs, you just said something that was very interesting. I am always very careful about when we say things that may be harmful to anyone. The reason why I am going to ask you this question is because Ms. McCollum talked about the differences in the administrations. She talked about the previous administration there in Minnesota and the present administration, and you just said something that I just want you to clear up. You said that you felt that the—and correct me if I am wrong—that some government people, employees, were working with some providers and causing some of these problems. Is that right? In other words, some of this fraud. I am not trying to put words in your mouth, it is just that I want to make it clear. You are going to be on national TV and we are making accusations, and I want to make sure we are clear as to who we are accusing of what. You can go ahead.

Mr. FEINWACHS. Mr. Chairman, Congressman, yes, it does appear from what has occurred in Minnesota that some public employees and our HMOs were in fact collaborating, if I may use a kind word, in the conduct that we are questioning today.

Mr. CUMMINGS. And that is under the previous administration and this administration, is that what you are saying?

Mr. FEINWACHS. Mr. Chairman, Congressman, it appears this has been going on for some years; it looks to me like at least from 2003.

Mr. CUMMINGS. Until the present day?

Mr. FEINWACHS. That is correct, sir.

Mr. CUMMINGS. I understand. Well, I just wanted to make it clear, and I am sure somebody will ask you some questions because we will be interested to know who these people are since you made this accusation. And if they are doing this as government employees, they ought to be fired, but, more importantly, they need to go to jail. That is why I am very careful with those kind of accusations.

Finally, let me say this. The reason why I started out by talking about Deamonte Driver is because when these resources are going places that they should not go, that is, in the pockets of other folks who are probably rich, and every time I think about this stuff it makes me mad because I live in the inner city of Baltimore, and if somebody steals a $30 bike, a bike for $30, they are probably going to go to jail, but at least they are going to get a record. So I want to make sure that some of these folks who are stealing hundreds of thousands, if not millions, get their chance to see their picture on a mug shot.

My simple question, Ms. Sylvia, is what can we do to enhance the False Claims Act?

And I am finished, Mr. Chairman. I just want to know the answer to the question.

Mr. JORDAN. She can answer the question.

Ms. SYLVIA. I think the Act is working quite well. One of the most important developments has been the adoption of the State Acts to create coordination between the States and the Federal Government. So I don't have recommendations for how to address it other than to have more States follow the lead of the ones that have already adopted their own False Claims Acts.

Mr. JORDAN. Thank you.

I now turn to the dentist on the panel, Dr. Gosar, the gentleman from Arizona, is recognized for five minutes.

Mr. GOSAR. Thank you, Chairman. Thanks for allowing me to go here.

As you know, before I came to Congress, I was a general dentist for 25 years. In fact, I was a dentist that served cleft lip and cleft palate for a number of years early on in my clinical life. I owned my own practice. I hired my own staff and cared for my own patients.

I also want to commend you, Dr. Ellis, for coming forward, because that is what we have to do; we have to police our own.

This is not unusual, what we see in raiding Medicaid and false providing accounts, but we need more people to do that. And it is not just limited to corporate entities, either; it is also community health centers, WIC reimbursements and stuff like that. So it across the board. You know, when you sit down with one child and do a procedure only on one tooth because that is all we are going to afford them, that is also disrespectful to the patient and that is fraud. Compensation through encounter forms, where it takes a woman seven or eight times to see a physician is also fraud on seven or eight different visits on seven to eight different weeks.

But I am also not surprised at the corporate dentistry's aspect and dental clinics as a central player. In Arizona, where I am from, we have had a number of problems. But a lot of that is State laws

and how we actually empower that. In fact, laws are worthless unless you have enforcement.

And that is where I come to you, Dr. Ellis. In your testimony you say that All Smiles Clinic in Dallas area is a majority owner by a private equity firm. Is that correct?

Ms. ELLIS. That is correct as far as I know.

Mr. GOSAR. Is that legal under the Texas law?

Ms. ELLIS. My reading of the Texas law is it is not.

Mr. GOSAR. I agree with you, I don't think it is.

Ms. ELLIS. I think there is a big debate over that issue right now in Texas.

Mr. GOSAR. Okay. So if a dental clinic, no only operating illegally, but collecting $10 million in 2010 for Medicaid, which is more than half the entire State of California collected in the same year, is that true?

Ms. ELLIS. They collected $10 million in orthodontics. They also—and I would say their primary business is actually in pediatric dentistry, so I do not know the numbers that they collected total for dental care.

Mr. GOSAR. And what was done about it?

Ms. ELLIS. What was done about it? Nothing. That is the problem.

Mr. GOSAR. So I am curious how many laws does one have to break before the State Dental Board and CMS cracks down. This is just one of the examples of a clinic that stole millions.

I just want to point out one more thing while I have some time. Part of the problem has to do with our oversight, and I think Ms. Sylvia may be able to answer this. Until we actually empower the private sector, the patients, we are not going to truly have reforms, are we?

Ms. SYLVIA. Well, I think the False Claims Act is one way of empowering patients to report fraud that——

Mr. GOSAR. But actually allowing patients to be selective in their care and empowering them, I think that is what is going to be necessary to get some total reform, would you not say that?

Ms. SYLVIA. I am not sure that I would say that that is the key to addressing fraud. I think the patients are an important part of it, but it is the providers that we are most focused on, their efforts to abuse the system.

Mr. GOSAR. Well, I may go a step further. I think that in Arizona we have a very active Dental Board, one of the most active in the Country. So this doesn't go passed very easily. We actually have empowered them to actually have oversight over corporation clinics because it puts providers in double jeopardy in many cases, particularly when they are brought in front of the board.

But State legislatures have been part of the problem. They have raided professional licensing fees, basically additionally taxing them. So what happens is it further restricts State boards into having that oversight. So in many cases it is the State board, and in our State of Arizona that is exactly what they have done, is they have raided those accounts, making it very, very impossible for them to have the financial funds, the manpower to actually go after them. And it is a form of additional taxation. So we have to have the ability for them to do that.

Second of all is also empower carveouts. Dentistry is very proud of their track record, and what carveouts basically do is give them better oversight of that population. And I think the States that have those types of carveouts, and I think Texas is now going through the process of doing a carveout so that they have better management of their funds, but you also need to have the funds to have that type of oversight as well.

So, Dr. Ellis, thank you for stepping forward. We need a lot more of you to do the same thing because we have to police our own.

I yield back the balance of my time.

Mr. JORDAN. I thank the gentleman.

I would now recognize the gentleman from Minnesota, and I apologize, I did not realize that the representative wanted to make an opening statement. So, Mr. Ellison, you are recognized.

Mr. ELLISON. Thank you, Mr. Chairman. Just one quick question. Is the time for opening statements or for questions? I can consolidate both.

Mr. JORDAN. If you can consolidate, that would be great.

Mr. ELLISON. All right. Thank you.

I would simply like to just say that I applaud this Committee, Mr. Chairman, and, of course, our Ranking Members for looking into the good use of the public dollar. The more efficiently we can use dollars for Medicaid, the more people we can help, and that is very important to me.

I do want to point out, however, that my State, Minnesota, is a leader in health care, providing in access one great example is of a Minnesota program is a program called Hennepin Health, run by Hennepin County in my district. This is an innovative program which integrates care for individuals with the highest need by identifying the holistic needs of the individual, whether those needs are medical, housing, mental health treatment, or finding a job. By combining social services with health care, Hennepin Health is making promising steps to reduce costs, while also providing better care.

Another example of the great work being done in Minnesota is the opening of the health plan contracts to competitive bidding. This has provided savings of over $500 million to taxpayers. In addition, the Dayton administration has negotiated a voluntary 1 percent cap on profits companies keep for reserves, resulting in a return of about $73 million to the State.

So right now we are spending time, as we should, regarding allegations of fraud in Minnesota under previous administrations for a program that doesn't exist anymore and for which both the Minnesota legislative auditor in 2008 and the current State administration have found no proof. I still support this process, but I will note that there are many important and innovative steps being made to improve the quality of health care in Minnesota of which I am very proud.

So that would lead me to a few questions I would like to ask, if I may.

Mr. Feinwachs, the current administration in Minnesota has made a number of changes to health plan reimbursement. For instance, Minnesota used to have one set of rates for the plans in each county, looking at factors such as historic rate claims. Now

the State has implemented a successful competitive bidding process that has achieved over $500 million in taxpayer savings. Do you agree that Minnesota's move to a competitive bidding has been beneficial?

Mr. FEINWACHS. Mr. Chairman, Congressman Ellison, no, sir, I do not. Minnesota's competitive bidding process began with four predominant HMOs controlling the market, and after the so-called competitive bidding the winners were the four predominant HMOs. The competitive bidding, as it has been initiated, appears to be nothing more than a market allocation among these four HMOs to maintain the mechanism that has been employed for many years.

Mr. ELLISON. Also, the State negotiated a voluntary 1 percent cap on profits for 2011, and this resulted in $73 million being returned to the State. Do you agree that the 1 percent voluntary cap was a win for the taxpayers?

Mr. FEINWACHS. Mr. Chairman, Congressman Ellison, I believe that the return of money is a good start, but I disagree with the characterization as a 1 percent cap. Last year the current administration asked the plans to follow the lead of UCare in giving back money that had been received from a clearly inflated Medicaid rate. They didn't want to do that, so an agreement was negotiated whereby it would be called a voluntary cap. The voluntary cap, of course, is subject to manipulation of administrative expenses in order to achieve the cap and to limit the amount. My characterization of what has occurred in Minnesota is because we said the word audit, we have recovered $103 million. Imagine what would happen if we did an audit.

Mr. ELLISON. You point out in your testimony that a 2008 report by Minnesota's legislative auditor found the State's payment rates to be high compared to other States. Do you agree that the State's recent efforts have improved its payment rates?

Mr. FEINWACHS. Mr. Chairman, Congressman Ellison, Minnesota's payment rates to the plans are high. Minnesota's payment rates to its providers are dismal. I don't think anything in recent history has changed that.

Mr. ELLISON. No further questions.

Mr. JORDAN. I thank the gentleman.

Now recognize the Chairman of the Subcommittee on Health Care, the gentleman from South Carolina, Mr. Gowdy.

Mr. GOWDY. Thank you, Chairman Jordan. I want to thank all of our witnesses.

Dr. Ellis, you used the word fraud twice. That word has legal consequences, it is not just a term of art. And then Dr. Gosar asked you about whether there had been any consequences. I think you used the phrase police your own, which is fine, although I probably don't trust somebody's own group to administer the punishment. Has there been any punishment, any consequences for what happened in Texas?

Ms. ELLIS. I will be the first to say there is probably a person better qualified to answer that. As far as I am aware, there have not been any consequences.

Mr. GOWDY. Who should I ask whether anyone has had their license to practice suspended, whether they are suffering the threat

of criminal liability, civil liability, disgorgement of their profits? Who would be the proper person for me to ask?

Ms. ELLIS. The Texas State Board would be the one that handles the licensure of dentists, and they would be the ones that would take away the license of a dentist. Part of the problem is the Texas State Board has said that they do not find any ability to bring any kind of action against a corporation because a corporation does not hold a license; that they can only bring action against the individual dentist. The allegations that I have made are against All Smiles as a corporation and not the individuals at All Smiles.

Mr. GOWDY. So dentists——

Ms. ELLIS. So I would guess it would be the attorney general. I am sorry, the short answer would be is the attorney general would probably be the place to go.

Mr. GOWDY. Which the frustration, which I do not mean to take out on you because you did the right thing, the frustration is that when poor people steal they go to prison; and when rich people steal, they keep their title, sometimes they get promoted, if they work for GSA, and every now and again they get invited to testify before a congressional committee. So it is this two-track justice system that the more you steal, the less likely you are to have any consequences at all. These were orthodontists or dentists who had to certify that it met the criteria for—I saw a sign that said free braces. I can't help but smile when I see the word free. Free to whom, I am not sure. But somebody had to certify that this case fit the program, didn't it?

Ms. ELLIS. Yes. The HLD index sheet that I referenced does require a provider signature, and the orthodontist or the dentist that holds the license would have signed that paperwork.

Mr. GOWDY. So dentists or orthodontists were certifying that something met the strictures of a program when in fact it did not.

Ms. ELLIS. That would be correct.

Mr. GOWDY. That just doesn't seem to be a hard case to win.

Ms. ELLIS. I don't disagree with that.

Mr. GOWDY. There are no studies that suggest there are more crooked teeth in Texas than there are other States, are there?

Ms. ELLIS. No.

Mr. GOWDY. And there certainly wouldn't be any studies that suggest there are more crooked teeth in Texas than all other States combined.

Ms. ELLIS. No.

Mr. GOWDY. And yet it took a reporter to unlock this mystery? No one at CMS happened to notice, gosh, we are spending more money on crooked teeth in Texas than we are the rest of the Country?

Ms. ELLIS. That is right. It is unbelievable.

Mr. GOWDY. Well, it may also come as something as a surprise to you, it did to me. We spend $500 billion a year to investigate and prosecute fraud in the health care system, and here we missed something that my 15-year-old daughter could have detected.

Mr. Feinwachs, I want you to help me understand an email, if you can, even though you didn't send it and you didn't receive it. In order to have a good chance of keeping all this money, it must be characterized as a donation. I find the word characterized to be

interesting. The writer did not say it must be a donation, it just must be characterized as a donation. Am I putting too much emphasis on the word characterized?

Mr. FEINWACHS. Mr. Chairman, no, I do not believe that you are. The donation was accompanied by a letter describing it as the refund of an overpayment, so to call it a donation would require some modification or recharacterization of the event.

Mr. GOWDY. Which then instructs the next line in the email, which is if a refund, Feds clearly get half. Can you work with Scott on redrafting? And then the final sentence is the one that I find most interesting: Also, I thought we were going to handle this through phone calls. I can't imagine why someone would prefer phone calls over emails unless perhaps it were to avoid a trail. Am I too cynical, Dr. Feinwachs?

Mr. FEINWACHS. Mr. Chairman, no. Let me say that what I have trouble imaging is why anyone would put a directive not to put things in writing in writing. But that is not for me to answer. The point you raise is quite interesting because redrafting suggests that there was in fact an original draft, and it would be fascinating to know what the original draft said.

Mr. GOWDY. And if we had a team of investigators who also were not in some way complicit or desirous of a State keeping the money, perhaps they would be just a tad bit more aggressive in finding out the answer to that question.

Thank you, Mr. Chairman.

Mr. JORDAN. I thank the Chairman for his good questions.

We will now recognize the Ranking Member of that same Health Committee, the gentleman from Illinois, Mr. Davis.

Mr. DAVIS. Thank you very much, Mr. Chairman, and again I want to thank all of the witnesses for being here.

I have always thought of myself as being sensitive to the question of waste, fraud, and abuse. But I have also attempted, in my own thinking, of trying to make sure that I wasn't guilty of throwing out the baby with the bath water, that is, throwing out things that might work, might be necessary.

So, Dr. Feldman, I am interested in hearing a little bit more about what the State of New York has done, or New York City, to try and ensure compliance with PCS regulations as was outlined in the settlement that you had mentioned.

Dr. FELDMAN. The City and the State have taken great measures to improve the program and to comply with regulations. I know because I work there every day; I will be there tomorrow. I see that folks are getting completely retrained. They are bringing in new staff. People were let go; many people retired. Many people who were in high positions are no longer there.

In fact, in some ways the program is run even closer to the regulations that I had anticipated. What I usually tell folks is that now the program that I work in is a little bit like working for the Green Bay Packers a couple of years after Lombardi came, because now it is extremely careful about how we approach each case and how PCS services are provided.

Throwing the baby out with the bath water, I really need to say very clearly I am not here to advocate slashing Medicaid spending or eliminating necessary Medicaid services, or even shrinking Med-

icaid or privatizing it, or throwing the elderly into nursing homes or to throw disabled children into snake pit institutions. These are the kids of things that I get hit with all the time. What I am trying to do here is to help both sides of the aisle realize that if we are going to have reasonable cost growth, we need reasonable oversight, so that people get better care.

The problem in New York City is not the same as in Minnesota. Minnesota has a wonderful reputation for providing health care; it is always known as a model. New York City is not. We spend the most in New York State; we spend $50 billion a year. I cannot tell you how much of that money is wasted; I can only assure you that in my program specifically I am fairly comfortable in knowing that in the old days we wasted more than $823,000 every day.

Mr. DAVIS. You know, you caused me to remember the days of the Medicaid meals that were rampant in many places, especially in inner city communities throughout America that I have spent a great deal of time in, and I certainly think that we have made progress since then and things have become more sophisticated, more complex.

So, Ms. Sylvia, can I ask you the schemes that you have mentioned that pharmaceutical companies sometimes might use, could you share what some of those may be and may have been?

Ms. SYLVIA. Sure. A lot of the emphasis at today's hearing has been on sort of simple frauds, but a lot of the frauds that affect Medicaid are things like off-label marketing. And we have several cases involving that, which would include using kickbacks and promotions to doctors and hospitals to recommend and use devices and drugs that are approved for those particular uses. And that costs Medicare and Medicaid money because they wouldn't pay for those goods or services if they had known that those practices were going on. And no amount of oversight is going to produce information about those practices that whistleblowers who actually work on the inside and can report the types of emails or the types of things that aren't being written down that whistleblowers can report.

Mr. DAVIS. Does the utilization of samples as promotional activity fall into any of this, to your knowledge?

Ms. SYLVIA. Well, use of kickbacks to encourage or induce the use of goods or services provide or paid for by Federal health care dollars can be a violation of law and can be a violation of the False Claims Act, so there are circumstances where samples could fit that model.

Mr. DAVIS. Thank you very much.

Thank you, Mr. Chairman. I yield back.

Mr. JORDAN. I thank the gentleman for his questions.

We now yield to the gentleman from Texas, Dr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman. Thank you for letting me be part of your hearing today. I sit on the Committee on Energy and Commerce, which does have a lot of jurisdiction over the Medicaid program, and I will just tell you that I have had a personal interest in this for some time because, Dr. Ellis, I have seen the billboards back home. My home is not too far from where you work, so I have been aware of there being some type of problem because generally, in my experience in the practice of medicine, it was not necessary to advertise for Medicaid patients, they found you if you

were willing to see them, and many providers, of course, will not because of the low reimbursement rates.

So generally how would a clinic like this, how would they go about patient recruitment?

Ms. ELLIS. Well, the billboards apparently worked pretty well. There have been offices accused of having solicitors go out and recruit business from places such as where they go to receive their food stamps or their State benefits. I have heard of the same thing going on at areas where children will be, like CC's Pizza; other areas wherever they feel that they can target a Medicaid population.

Mr. BURGESS. And let me just ask you this, because Mr. Gowdy asked a very important question about the enforcement action of all of this. Have you been contacted by the Attorney General's Office of the State of Texas regarding the things that you have brought to light?

Ms. ELLIS. I was contacted by both Texas OIG and the Attorney General within about a week's period after one of Byron Harris's stories ran and was basically told that I needed to work with just one, and the decision was made that OIG was the place where I could be best of service.

Mr. BURGESS. So that is the State Inspector General.

Ms. ELLIS. Yes, Texas OIG.

Mr. BURGESS. Has the Office of Inspector General at the Department of Health and Human Services talked to you?

Ms. ELLIS. The Federal?

Mr. BURGESS. Yes.

Ms. ELLIS. No.

Mr. BURGESS. Region 6 is down in Downtown Dallas, they are right next door to where you work at Children's Medical Center, but you have not talked with them?

Ms. ELLIS. No, I haven't talked with them.

Mr. BURGESS. And as far as anyone from the Fraud Division at the Department of Justice, have they visited with you?

Ms. ELLIS. No.

Mr. BURGESS. But it sounds like there may be a significant number of dollars that have been fraudulently transferred, so just to the man on the street it would seem likely that this would be something that would be of interest to the Fraud Division at Department of Justice, would it not?

Ms. ELLIS. I would agree with that, yes.

Mr. BURGESS. And, again, just following the reasonable person concept, I don't see how they have missed that. And you make such an important point about the risk and potential damage from unnecessary care. I mean, this is not a question of denying care to a needy child or a child who has a diagnosis that compels the care, but when you indiscriminately apply care across a population that is not in need, there is also the possibility that you are going to be causing future difficulties for these kids, is that not correct?

Ms. ELLIS. That is true.

Mr. BURGESS. And that is why it is so important that, yeah, people do the right thing, but not only that; if they are doing the wrong thing, that they be stopped and that they be held accountable. When I was in the practice of medicine, and I grant you it

has been a few years that I have been in active practice, but it seems to me you had a law on the book that prevented the corporate practice of medicine in the State of Texas. Now, that may have changed in the last legislative session, I am not sure. Is there also a similar prohibition on the corporate practice of dentistry in Texas?

Ms. ELLIS. There is a paper that has been provided to this Committee, and I can make it available to you, that actually summarizes the corporate practice of dentistry in all 50 States. The basic answer to your question, no, it is not legal.

Mr. BURGESS. And, again, since that is a State statute, it would appropriately be the attorney general's office that would prosecute those cases, would it not?

Ms. ELLIS. I don't know how to answer that.

Mr. BURGESS. You know, I am not asking this to be contentious, but we need to get the people who should be enforcing the law to be interested in enforcing the law. In all sincerity, that is the purpose in asking the question. I want this to happen. During the time I was in practice, I always felt that if I broke the law, something serious would happen to me; it would happen quickly, and I wasn't sure what would happen, but I knew it would likely be bad.

Now you have the situation completely turned on its head, where no one seems to care that it is illegal because not only is no one looking, but if it is put right in front of someone, there is no enforcement action. And, again, not just picking on the State here, because we are going to be hearing from the Center of Medicare and Medicaid Services in a little bit. They also bear a tremendous responsibility here about not just allowing the money to go out the door inappropriately, money that should be going to good purposes and taking care of people that we are obligated to care for, but people are being damaged in the process; and it is their dime that is allowing it to happen.

So, again, I am just frankly stunned that the Center for Medicare and Medicaid Services—I mean, what is involved in an audit? When I get audited by the IRS, again, I know that it is going to be pretty dreadful. What is involved in these audits? Is no one noticing the flight of dollars out the door? I realize Texas had some problems in the initiation of SCHIP, and when President Bush was a candidate back in 2000, he received a lot of criticism because his State spent less than other States. But in the process of trying to deal with that, we have now created the nightmare scenario for a lot of families in Texas that are receiving care that, again, not only unnecessary, but likely to be damaging to their future health.

Mr. Chairman, I appreciate the time that you have allowed me and appreciate the generosity. I am going to yield back, but we haven't heard the end of this, and this story is one that is important and we need to get the people who are supposed to be in charge of watching the hen house back to doing their job.

Mr. JORDAN. I thank the gentleman.

Before yielding to the gentleman from Connecticut, let me just ask Dr. Feldman and Dr. Feinwachs has anyone from CMS, the Inspector General from CMS or HHS, or anyone from the Justice Department contacted officials in New York City or State officials in Minnesota? And we will start with Dr. Feldman.

Dr. FELDMAN. I have encouraged them to; I have given them plenty of names and fodder. I don't know exactly what the follow-up was.

Mr. JORDAN. But, to your knowledge, no one has contacted the City of New York officials regarding the issue, Dr. Feldman?

Dr. FELDMAN. No.

Mr. JORDAN. Okay.

Dr. Feinwachs?

Mr. FEINWACHS. Mr. Chairman, in mid-year 2011, when the State of Minnesota's 1115 waiver came up for renewal, we contacted CMS and implored them not to renew the demonstration waiver because of problems. But our concerns, to the best of my knowledge, have not been addressed.

Mr. JORDAN. And no one from the Justice Department has contacted officials in the State of Minnesota, to your knowledge?

Mr. FEINWACHS. To my knowledge, no, sir.

Mr. JORDAN. All right, thank you.

We will now yield to the gentleman from Connecticut, Mr. Murphy.

Mr. MURPHY. Thank you very much, and thank you all for your testimony and for your courage in bringing all of this forward.

I think it is appropriate, Dr. Ellis, that a lot of the questioning has focused on the revelations that you have brought to light because it speaks to this much larger issue of an explosion of for-profit institutional care in this Country. It is not just for-profit dental clinics; we, today, have more for-profit hospitals than ever, more for-profit hospices, for-profit nursing homes, dialysis centers, outpatient surgical centers, walk-in clinics. And you have hinted at this in some answers to questions, but I might ask you sort of a broader one, which is that you speak to one of the solutions here being a crackdown on the private equity ownership of dental practices. In response to Mr. Burgess's question, you were talking about some of their innovative recruitment methods.

Let me ask you this question. What is that you think is unique about private equity ownership of a dental clinic or, frankly, of any other institution that makes it more likely that fraud will occur in that setting versus a nonprofit setting?

Ms. ELLIS. In my opinion, there is a conflict of interest in who holds the doctor's interest. Is it his employer and their investors or is the doctor's patients? There are plenty of private practitioners who are guilty of what has been going on in Texas as well. They just aren't able to leverage the dollars that the private equity companies are.

In my written statement I hope I don't throw all the blame on just private equity, but certainly they are part of the problem. But it just comes down to a conflict of interest. If you are the doctor and the patient is your patient, and you are interested in maintaining the integrity of your private practice, you have to make sure that you are delivering care or your reputation within the community is going to become not that that will attract patients to your business.

The private equity groups tend to operate by name, they don't identify themselves by dentist. The patient comes to the company. They are coming to an image, they are not coming to an individual.

And the dentists that are in their employment are under a contract, and in a lot of these companies they will have bonuses tied to production. The production is expected to be in the patient's best health, but the corporation is clearly in the interest of pursuing greater and greater profits.

Mr. MURPHY. Bonuses tied to production, not necessarily bonuses tied to quality.

Ms. ELLIS. Exactly.

Mr. MURPHY. Dr. Feinwachs, in Connecticut we have had a long history with Medicaid managed care, and I won't go through the song and dance of all the problems that we had, but eventually, last year, we decided to bring our Medicaid program back in-house, and that has resulted in a pretty substantial savings to taxpayers. Representative Ellison hinted at this question, I think, but can you talk about this broader issue of whether fraud is more likely under a Medicaid managed care system and whether, ultimately, we have a guaranty that we are saving taxpayer dollars by continuing to manage Medicaid dollars in a private HMO system versus a system run by a State government?

Mr. FEINWACHS. Mr. Chairman, Representative Murphy, let me say, first, before I address that question, I may have misspoken previously. While I have no personal knowledge, I believe there is a deal, a Department of Justice inquiry going on in Minnesota. I think there have been stories run about it in the newspaper. So I don't mean to suggest that that is not happening, but I know what I read about it.

Having said that, sir, let me address your question. I don't think that there is any guaranty of efficiency, network adequacy, or any of the hallmarks that we would attribute to a properly and efficiently run Medicaid system because of the presence of managed care, so-called. I think in Minnesota we have a tremendous health care system, which is due to the commitment and dedication of our health care providers; hospitals, physicians, dentists, podiatrists, chiropractors, across the board. That is the fuel which moves the engine of health care forward in our State.

What we need to do is to engage in auditing designed to answer exactly the question you have raised: What is the value of managed care in its involvement in this system, does it add value, does it add expense, what exactly does it do and how does it do it, in order to reach an intelligent conclusion to that very important question.

Mr. MURPHY. I know my time has expired here. I asked the question because the budget that we just voted on here proposes effectively doing the same thing for Medicare that we do in most State systems for Medicaid, essentially handing the system over to the private sector. And I think it is useful to look at both the equality experience and the fraud experience of States that have done the same thing with their Medicaid programs.

Mr. Chairman, thank you very much for the time.

Mr. JORDAN. I thank the gentleman.

Let me just start with you, Dr. Feinwachs. The overpayment/donation, the $30 million that was referenced several times in the hearing, that was just one company, right, that was UCare? You had four companies involved in the Medicaid managed care program, correct?

Mr. FEINWACHS. Mr. Chairman, that is correct, there are four companies and UCare is the smallest, and smallest by quite a——

Mr. JORDAN. Okay. So in your judgment, in your estimation, in your professional opinion, what is the potential overpayment/donation concerns if you factor in the other three managed care companies?

Mr. FEINWACHS. In the absence of complete data, it is somewhat difficult to answer, but assuming that the overpayment was for UCare alone, that would have been $30 million relative to six months for that company. If you work that math backwards, you come out with about a half a billion dollars. If the overpayment was to——

Mr. JORDAN. Half a billion dollars in a six month time frame?

Mr. FEINWACHS. No, sir, half a billion dollars——

Mr. JORDAN. Over several years.

Mr. FEINWACHS. —back to 2003.

Mr. JORDAN. All right.

Mr. FEINWACHS. If the $30 million was to represent the overpayment for six months to all companies, the result will be different. The problem is we have no audit trail, we have no——

Mr. JORDAN. Safe to say that it is significantly more than $30 million.

Mr. FEINWACHS. Much, much more.

Mr. JORDAN. Okay. Let me just ask. I assume you are all involved in some national association, with the hospital association. You probably travel to national events, conventions, or what have you. Dr. Feldman, Dr. Ellis, the same thing. When you are at those events or when you get a chance to interact with your colleagues from around the Country talking about this issue may come up, to what extent do you think this is across the Country, so it is not just isolated in Minnesota, Texas, and New York? And let me start with Dr. Feldman.

Dr. FELDMAN. I have no doubt whatsoever in my mind that if you go to the top five States—New York, Ohio, Florida, California, Texas—where a third of all Medicaid money is spent, you will find similar patterns. I think New York is probably the most egregious situation because of our sociopolitical situation, but I am very confident that you will find similar schemes, similar problems all across the Country. The point is to go where the money is, and, as you said, this program is going to cost over $7 trillion whatever time period you want to use. But it is important to understand most of that money over the next 10, 20, and 30 years is going to be spent on long-term care and custodial care and nursing home care. So you better be prepared to be lambasted by advocacy groups who are constantly saying you are just doing this because blah, blah, blah, blah, blah. So I would urge you all to start where the money is, in long-term care and personal home health care.

Mr. JORDAN. And if I could—and I will get to Dr. Ellis and Dr. Feinwachs, but while I have you, Dr. Feldman, you talked about the Medicaid industrial complex. Is that what you are referring to in those——

Dr. FELDMAN. Yes. I think that this is an absolutely terrific example of a joint situation; it is nonpartisan. I talked about the military industrial complex. Well, let me tell you something, in 1970

we spent about 6 percent of our GDP on defense and we spent about 6 percent of our GDP on health care. We now spend maybe 3, 4, 5 percent on defense and we spend 17 percent on health care. This is what the voters want and I support it. I am a physician. All I am asking is to understand and accept the fact that whenever there is money out there that is labeled Medicaid, and whenever you have deserving beneficiaries, it is so easy to defraud people.

Mr. JORDAN. And let me just ask you, and all those concerns and potential problems are exacerbated by the fact that if in fact the ObamaCare legislation becomes law and takes effect, approximately 20 million more individuals are going to be part of the Medicaid program.

Dr. FELDMAN. Yes. And I think both side of the aisle should be aware of this. If it passes, we are going to expand Medicaid greatly. And, believe me, you guys are going to be very busy and CMS will have to probably two, three times the amount of money worrying about fraud. And if it doesn't pass, I think the right side of the aisle is quite naive to think that that 17 percent GDP number isn't going to go to 25 percent in the next 25 years.

Mr. JORDAN. No, that has to be changed.

Dr. Ellis, while Texas, you understand the situation there, but in your opportunities where you have had to interact with colleagues around the Country, while it may not be as widespread as what you have seen in your State, do you think it exists in other States as well?

Ms. ELLIS. Well, Texas blows every other State away by a mile.

Mr. JORDAN. I understand that.

Ms. ELLIS. So, quite honestly, I don't—my feeling is that, no——

Dr. FELDMAN. I resent that. New York is far above everyone else in this.

[Laughter.]

Ms. ELLIS. When it comes to orthodontics, it is just such an obvious no-brainer. I just don't think that if it is not stopped, surely it will spread to other States, but right now I don't feel that that is the case.

Mr. JORDAN. Okay.

Dr. Feinwachs, quickly?

Mr. FEINWACHS. Not to be outdone, Minnesota's fraud is more massive and more clever than yours.

Mr. Chairman, I do believe the problem is widespread across the Country. I also believe that it is a bipartisan issue because whether your issue is deficit reduction or expansion of access to health services, our system is terribly broken and we have to repair it.

Mr. JORDAN. Great point. As Dr. Ellis and I think you have all pointed out, there are people who needed care and qualified for the care who didn't get the care because of the fraud that was taking place, and then there is just the waste and the unfair treatment of taxpayers. So I think that is well said.

And we have the gentlelady from Minnesota.

Ms. MCCOLLUM. Thank you, Mr. Chair. And I think you summarized why we need to address this really well, watch out for taxpayers and make sure that people who deserve access to these health care opportunities have them.

Mr. Feinwachs, I want to thank you for all the years of service. I remember when I was on Health and Human Services in Minnesota, you testifying; always straightforward, always answer questions directly like you are today, so thank you very much for everything that you have done.

I have three questions, and I am just going to put them out there altogether for you.

Minnesota's nonprofit, we have some things written into the law which has a little more transparency than other States do as to what is going on with their Medicare contracts. The State, right now, it will be at the governor's desk to provide a third independent party audit. If you can kind of give us some pointers of where you think we should be going as a Committee for looking for what type of audits.

The second point I would like to bring up, I am very concerned about block granting Medicaid because when you block grant it, it is just a dispersal out there; there aren't as many strings attached. And even with the strings that we have attached now, we are not doing a good job of watching taxpayers' dollars, making sure that those individuals have providers who can afford to give them treatment that they needed.

And I know Senator Hahn I believe was here promoting block grants. He stopped by our office, I believe, and it is something I am very skeptical of.

And then my third point is I agree, and I know that the Chair is going to ask a little more about the email and the returning of the money between the Federal and the State. I guess the State should, as a resident of Minnesota, we have a shortfall. If it gets returned to the State coffers, that is one thing, but we also have a shortfall here in the Federal, so having it returned to the Federal Government is as good as well. But the fact is that it was even caught in the first place. So if you can just talk a little bit about audits and maybe your opinion of block grants, it would be very helpful to me to hear from a fellow Minnesotan.

Mr. FEINWACHS. Mr. Chairman, Representative McCollum, I would be happy to try to address those questions.

First, let me say something about nonprofit status in Minnesota. Our HMOs are required by statute to be not-for-profit. In my estimation, corporate nonprofit status confers tax exemption, not sainthood. What is important in any organization is the integrity of its management and codes of ethics that are present in order to provide proper service and accountability.

To the issue of audits, the audit question I believe is relatively straightforward. You need rigorous oversight and audits by independent third parties. We also need to determine, in Minnesota and elsewhere, if the consulting actuary to the State has been permitted to consult with the State's vendors. This would seem to raise a problematic issue, a red flag, if you will.

We know now that in Minnesota that such things have been permitted in the past, historically, and even now the argument is made that it is not occurring anymore, but the safeguard I believe that is being proposed now is that different employees from the same firm will consult both with the State and the State's vendors, and that seems less than well advised.

So these audits need to be truly independent; they need to be accountable to the Federal Government; and, above all, they need to enforce the standards we have because all of the practices that you have heard described today, not only in Minnesota, but elsewhere, are in fact unlawful and should be addressed and dealt with.

So audits retrospective, prospective, and ongoing need to occur. In Minnesota we just enacted an audit bill. First audit won't start until 2015. And unless I miss my guess, because of funding problems in the future or arguments related to less accountability, perhaps due to block grants, perhaps not, but like all things political, when there is a delay, there is time to dismantle the good work that has been proposed. So our need for audits are immediate and prospective and retrospective, and done by a truly independent third party.

Ms. MCCOLLUM. Mr. Chair, in the time that is remaining, it used to be our county, we had a county system that delivered care to people who found themselves in the gap, and we were told that the private sector could deliver it better. And now I think we have to question as to, without proper oversight and penalty for defrauding taxpayers, if in fact a private sector business model is in the best interest of the taxpayers.

Mr. JORDAN. I thank the lady.

Now I will yield to the gentleman from Ohio, the Ranking Member in the Subcommittee.

Mr. KUCINICH. I am going to wait for the next panel.

Mr. JORDAN. We appreciate that.

We want to thank you all for——

Mr. DAVIS. Mr. Chairman?

Mr. JORDAN. Mr. Davis?

Mr. DAVIS. Can I just make a clarification?

Mr. JORDAN. Sure can.

Mr. DAVIS. One, I just need to clarify that there is current investigation taking place in Minnesota by the Department of Justice. There has been a settlement in the allegations in New York. Also, the CMS has no authority to determine or prosecute fraud; that falls to the Office of the Inspector General or to the Department of Justice, and CMS can only take financial action related to the Medicaid matching programs. I just wanted to make those clarifications.

Mr. JORDAN. Yes, but it is also true that CMS has to approve the waiver when a State decides that it is going to operate under this plan, the rate reimbursement that they are going to receive.

And they did in fact approve the request by the State of Minnesota, isn't that correct, Dr. Feinwachs?

Mr. FEINWACHS. Mr. Chairman——

Mr. JORDAN. They approved it after several provider groups had written and said, hey, you need to take a look at this and maybe think twice about doing this, and yet they went right ahead. Isn't that correct, Dr. Feinwachs?

Mr. FEINWACHS. Mr. Chairman, Representative Davis, that is correct. Also, we do something called Medicaid rate certification. We certify, we attest to the Government that the rates are correct. And even though CMS may lack enforcement, they should be

verifying and looking at that process to make sure that those certifications——

Mr. JORDAN. But don't they have to sign off on it before they have to pay it?

Mr. FEINWACHS. They do, sir.

Mr. JORDAN. So that took place, correct?

Mr. FEINWACHS. Correct.

Mr. JORDAN. Okay. I thank the gentleman.

I thank the gentleman from Illinois.

We want to thank our first panel for being here and for your work.

We will now ask the staff to prepare for our second panel.

[Pause.]

Mr. JORDAN. The Committee is in order.

We want to thank our second panel for being here. It is still this morning. We have with us Ms. Lucinda Jesson, who is the Commissioner of Minnesota's Department of Human Services; we have Ms. Cindy Mann, Director of Center for Medicaid State and Operations for the Centers for Medicare and Medicaid; and, of course, Ms. Carolyn Yocom, who is the Director for Health Care at the U.S. Government Accountability Office.

We have to do the same routine, so if you will stand up and raise your right hand.

Do you solemnly swear or affirm that the testimony you are about to give will be the truth, the whole truth, and nothing but the truth?

[Witnesses respond in the affirmative.]

Mr. JORDAN. Let the record reflect that all of our witnesses answered in the affirmative.

You get five minutes. You guys know the drill. We will include all of your written testimony in the record, but if you can keep it to five, approximately five, that would be great, because I know that Mr. Gowdy, Mr. Kucinich, and Mr. Davis, we have some questions for you.

So, Commissioner, we will go right down the list and you are up first.

STATEMENT OF LUCINDA JESSON

Ms. JESSON. Thank you, Mr. Chair. Mr. Chair and members, my name is Lucinda Jesson. I am Commissioner of the Department of Human Services for the State of Minnesota. Thank you for the opportunity to discuss Minnesota's Medicaid program.

You know, Minnesota is a leader, and has been, in using managed care to serve its Medicaid population, and I was happy to accept this invitation because, as more and more States move Medicaid populations into managed care, there are a lot of lessons to be learned from Minnesota; lessons about what works and lessons about what needs to be done differently, both types of lessons.

First let me talk about what works. Access, quality, innovation, delivery models. Minnesota has placed a high priority over many years in providing good access to health care for its low income citizens, and managed care is available to enrollees statewide through our nonprofit HMOs and county-based health plans. And let me be clear. Managed care has been critical to providing access to health

and long-term care services for our Medicaid population. You often hear in other States that having public insurance doesn't mean much if you can't see a doctor. Not in Minnesota. Overall, our enrollees have access to quality care.

What needs improvement? Better contracting, being a smarter purchaser of health care, and, frankly, increased oversight. And let me address each of these concerns and briefly outline the steps Minnesota has taken over the past 15 months, since Governor Mark Dayton took office, to address them.

When Governor Dayton and I took office last year, we had serious concerns about how the Department of Human Services under the previous administration had purchased health care for its Medicaid managed care program. We also had concerns about the transparency and oversight of the contracting process itself. Our concerns stemmed from increasing profit margins that health plans earned from public programs, the particularly high level of health plan reserves—and I attached some charts on these things to my written testimony—which resulted in part, these reserves, from profits on public programs, and we had concerns about the contracting process itself.

We were struck that the contracts we inherited from the previous administration offered few incentives for improving quality and reducing costs. Moreover, at a time when the private sector was making considerable progress on payment reforms, doing more creative things, the State contracts remained stuck in the old way of doing business.

We also felt that the actuarial soundness requirement was inherently inflationary, because you ended up setting rates in the future based upon primarily what had happened in the past, and we questioned where the incentives were for more efficiency.

So while there are and were many positive aspects to managed care, there was also a lack of creativity and a lack of focus on value on how health care was purchased in Minnesota, and we moved very quickly to address those. First, we addressed the 2011 contracts we inherited by asking all four major health plans to voluntarily agree to cap their 2000 earnings at 1 percent of operating margins for our programs, and I want to thank the plans for agreeing to that.

Earlier this month we announced that an estimated $73 million will be returned to the Federal and State governments due to this cap on excess profits. And when you add to the $30 million from UCare, which we have agreed with CMS to treat under that 1 percent cap so that the Federal Government is returned its share, when you add those two together, you have over $100 million we recovered for Federal and State taxpayers from the previous administration's 2011 contracts.

But we didn't stop there. Just a little over a month after I took office, we put the major health plan contracts for the Twin Cities metropolitan area out for bid. In the past, DHS, working with its actuaries, basically set the capitation rates, and any plan could participate if they accepted those rates. Those rates were approved by CMS. But under competitive bidding, we changed the incentives. Plans had an incentive to give us their best proposal in terms of cost and quality.

And there were winners and losers among the health plans, but the real winners were the Federal and State taxpayers who, under the new contracts, had $175 million in savings to the State and an equal $175 million to the Federal Government. When you combine this with our other managed care reforms that we passed with strong legislative support, our managed care reforms totaled over $600 million, and that is in addition to the $100 million from the cap, in savings to the State and Federal Government.

But we need to not only be a smarter purchaser of health care; we need to increase the oversight of these large contracts, and no one believes that more than I do. In Minnesota, there are, as you have heard, very real questions and some mistrust over where these billions of dollars are going, and that is why Governor Dayton, just two months into office, ordered additional audits of the health plans, and those audits started this month. They are being conducted by outside vendors contracted by the Minnesota Department of Commerce.

Additionally, at DHS, I created the Office of Inspector General to enforce increased program fraud detection and prevention efforts. We also changed the contracts we had with the health plans to have better compliance, and we added reporting requirements about what they were doing on their own program integrity office.

Finally, as someone mentioned, the Human Services Bill, which just passed our legislature and is headed to Governor Dayton's desk, requires a requirement for third-party financial audits in addition to the ones the governor has ordered. These audits will strengthen our oversight that we have conducted through our legislative auditor's office and Governor Dayton strongly supports this requirement.

Minnesota has long been a leader in how managed care plans serve our Medicaid enrollees, but changes needed to be made in the way we do business now and in the future. We have made an unprecedented number of them just in the last 15 months, and we are not done.

Thank you.

[Prepared statement of Ms. Jesson follows:]

Testimony of Lucinda Jesson
Minnesota Commissioner of Human Services

Introduction

Thank you for the opportunity to discuss Minnesota's Medicaid program. Since taking office in January 2011 the Dayton Administration has made significant changes to improve Minnesota's Medicaid program. This includes providing increased health care coverage for low-income Minnesotans, making the state a better purchaser of health care services and providing better value and accountability to taxpayers.

Minnesota is justly proud of its nonprofit health care environment that has brought high quality, low cost care to its citizens. Frequently cited as a model for health system efficiency, we rank among the top in the country in overall population health, and our providers rank among the most effective and efficient in the country, as shown in the Dartmouth Atlas analysis. Further evidence of Minnesota's health systems effectiveness was recently demonstrated in the Commonwealth Funds Scorecard on Local Health System Performance, which ranked 4 of Minnesota's local areas (St. Paul (1st), Rochester (3rd), Minneapolis (4th), and St. Cloud (7th)) in the Top 10 in the country for overall system performance. Minnesota has a long history of providing good access to health care for all of its citizens and requiring a high bar for quality for providers and health plans. We have one of the nation's lowest rates of uninsured. The state also enjoys a health care system where both provider organizations and health plans work collaboratively to improve health care services and health outcomes of our population, such as requiring statewide reporting on quality measures, credentialing, evidence-based decision-making and reducing hospital readmissions.

Minnesota's Medicaid Program

Minnesota's Medicaid program has served as a model for other states over the past few decades. We have focused the program to ensure access to health care for our citizens, but are equally proud that we have done so with integrity and as smart stewards of state and federal resources. Our Medicaid program has focused on providing coverage well over the federal poverty guidelines. Minnesota currently operates both a fee-for-service and managed care Medicaid program, including an early expansion for adults without children that Governor Dayton signed into law January 2011 and became effective March 2011. Minnesota has also operated a Medicaid 1115 waiver since the early 1990's called MinnesotaCare that is a sliding scale premium health care program that serves families with children and single adults at income levels higher than regular Medicaid eligibility. Minnesota began this program long before the federal enactment of the Children's Health Insurance Program (CHIP).

Of Minnesota's 850,000 enrollees on public programs, approximately 580,000 are enrolled in managed care, which includes most families, single adults, and seniors and spends approximately

$3.2 billion per year (state and federal funds). The remaining 230,000 are enrolled in fee-for-service, which is primarily disabled individuals and spends approximately $2.0 billion per year (state and federal funds). Prior to the Medicaid expansion for single adults, Minnesota operated a state funded program for several years called General Assistance Medical Care (GAMC). Managed care delivery of GAMC was eliminated in March 2010 and GAMC was repealed in February 2011 when the Medicaid expansion was enacted.

Minnesota has also placed a high priority for many years on providing good access to health care for its low-income citizens on the state's Medicaid program and other state public health care programs. The state requires participation by our health plans and providers in its public health care programs if they also participate in the state employees' group insurance program, workers compensation, and other local government insurance programs. Managed care is available to enrollees statewide through non-profit HMOs and county-based health plans and has been critical to providing access to health care, behavioral health and long-term care services to our Medicaid population. Our enrollees can be assured of access to quality care in Minnesota.

Addressing Past Practices in the Medicaid Program

Although Minnesota has enjoyed good access to quality care for its Medicaid enrollees and a collaborative health care system that has benefited the health of Minnesotans overall, there were specific areas of serious concern Governor Dayton and I had regarding how the Minnesota Department of Human Services (DHS), under the previous administration, purchased health care for its Medicaid managed care program. We also had concerns regarding the transparency and oversight of its contracting process. In particular, we believed the state needed to be a smarter purchaser of health care for the Medicaid program and was not getting the best value for the taxpayers.

Our concerns stemmed from the increasing profit margins health plans earned from public programs, particularly during a recession with its attendant budget crises; the level of health plan reserves which resulted, in part, from profits on public programs; and with the contracting process itself. We were struck that the contracts offered few incentives for improving quality and reducing costs. Moreover, at a time when the private sector was making considerable progress on payment reform in Minnesota (to begin to move away from piecemeal payments to "total cost of care" payments) the state contracts remained static. While there were positive aspects to managed care in terms of bringing needed access to services, there was lack of creativity and focus on value in how health care was purchased in our Medicaid program.

We set about taking rapid action to get more accurate, complete information, make the process more open to the public and to make Minnesota a better purchaser of health care.

First, on March 23, 2011, Governor Dayton issued an Executive Order on disclosure and accountability for managed care contracts. The Executive Order specifically required: 1) all contracts and data on health plans serving public programs open to full public disclosure through a newly created managed care reporting website; 2) a comprehensive annual report on managed care that included information on health plan administrative costs, provider payments

arrangements, enrollee satisfaction, quality and performance measures; and 3) regular audits by the Minnesota Department of Commerce, the state's regulator of health insurance.

DHS began full and immediate implementation of this Executive Order. The website, at www.dhs.state.mn.us/ManagedCareReporting launched April 2011 includes all current managed care contracts and reports and data on health plan quality, performance, enrollment, finances, and capitation rates. The first annual comprehensive report will be available in the summer of 2012 for the 2011 contract year. We also began work with the Minnesota Department of Commerce on April 16, 2012 to begin the first round of audits of health plans under contract to serve Medicaid enrollees, based on the annual audited financial filings submitted to the state Departments of Health and Commerce on April 1. I attach this Executive Order as Exhibit 1.

Second, the Governor proposed and signed legislation in 2011 that provided more comprehensive financial reporting requirements for health plans contracting with Medicaid, including more detailed information on administrative costs and payments to providers. I attach a copy of this language as Exhibit 2. This will allow DHS to provide better oversight of health plan finances and gain a better understanding of how the health plans participating in Medicaid are spending their dollars. This information will help ensure that health plans are accountable for providing need services to our enrollees and paying providers in a way that brings value to the program and rewards them for good outcomes.

Third, while we inherited the 2011 contracts from the previous administration, we sought changes to them to address the overall concern regarding the level of health plan profits from the Medicaid program. We asked all four major health plans to voluntarily agree to cap their 2011 earnings at one percent of operating margin for public health care programs. We amended the contracts to reflect this cap and CMS approved the amendments. Any amount over the one percent will be returned to the state and the corresponding federal share to the Centers for Medicare & Medicaid Services (CMS). When the 2011 health plan financials were released April 2, we estimated that **$73 million** would be returned to the federal and state government due to the one percent cap.

Taken together we believe these efforts around improving transparency and public disclosure in our Medicaid managed care program can serve as a clear model for the nation as other states move more of their Medicaid populations into managed care.

Changing the Medicaid Managed Care Contracting Process

One of the largest and most important changes Governor Dayton and I made is changing the way we contract for managed care services under the Medicaid program. Governor Dayton proposed under his 2012-13 budget and successfully implemented a competitive bidding process for the 2012 managed contracts in the Twin Cities metropolitan area for approximately half (275,000) of the parents, children, and single adults enrolled in our Medicaid program and the 1115 Medicaid waiver program, MinnesotaCare.

In previous years, DHS set capitation rates and any health plan could participate in any county if they accepted rates set by the state. The state's contracted actuary developed one set of rates for each program in the aggregate for all plans contracting in each county. The rates would vary by demographics factors (e.g. age, gender, eligibility status) and by geographic area based on historic aggregate health plan claims experience by program, adjusted for the health risk of a health plan's population. As rates were set in the aggregate for each program, profit margins were as well, creating a situation where some plans may see a very healthy margin and others plans would see less or a loss. Minnesota has set rates using this method for Medicaid enrollees in managed care (fee-for-service providers are paid directly) as well as for MinnesotaCare and, in the past, GAMC. All program rates used this same methodology but rates were set separately.

Although this is a valid method of setting capitation rates, it did not incentivize value. For example, some of the state's health plans have created more efficient and higher quality networks of providers that would bring the state a better value. Under the previous method, the state would pay the same rate to plans contracting in the same area of the state even when one health plan had a lower cost, equal value network. We needed to create the right incentive for plans to bid their lowest cost for serving Medicaid enrollees in their networks and for the state and federal governments to realize savings from these efficiencies. In short, we needed to be smarter stewards of public dollars.

DHS started competitive bidding with our families and children population in the metropolitan area for two reasons: 1) this population is the largest group enrolled in managed care and their health risk is the most predictable which would encourage better bids; and 2) half of the population resides in this area where four of the major health plans already participate, also resulting in more robust competition. The competitive bidding RFP was issued in April 2011. Decisions on contract awards were based on an overall score of cost (50 percent) and network, quality and county-specific evaluations (50 percent). Consideration was also given to county board recommendations. To ensure adequate enrollee access, two plans were selected in each county and three plans for three of the more heavily populated counties. There were winners and losers among the health plans, which is the nature of competition. Because of the change in the number of plans, an unprecedented number of enrollees (approximately 78,000) were successfully transitioned to a new plan without any significant disruptions to our enrollees' continuity of care.

DHS awarded contracts in late August 2011 which resulted in $175 million in savings to the state (approximately $175 million federal share) for state fiscal years 2012 and 2013, a 6.9 percent reduction in managed care spending from previous projections. Our competitive bidding process received strong legislative support. Competitive bidding was part of a package of managed care reforms that totaled $300 million in savings for the state, and an additional $300 million in savings to the federal government. The other $125 million in savings came from rate reductions, trend caps and 5% reduction targets on hospital admissions, re-admissions and ER use.

Under both methods of contracting (rate-setting and competitive bidding), the state used its contracted actuaries to develop managed care capitation rates and provide actuarial certification of the rates according to federal Medicaid requirements. The state has always maintained compliance with submission of managed care contracts and rates to CMS and always received

approval. The state provides detail regarding changes to its contracts and description and documentation of its rate-setting methodology and ensures we are meeting all requirements and are responsive to CMS.

Going forward, our intention is to continue competitive bidding in other parts of the state where it is appropriate based on population and network access. We want to use it to produce more effective and efficient health care services and promote innovation. We are currently working with the University of Minnesota to conduct an evaluation of the 2012 competitive bidding process that will inform our future efforts.

In addition to providing better value to enrollees and the state through the competitive bidding process, several new and significant changes were made to 2012 Medicaid managed care contracts in an effort to increase the oversight of health plans as it relates to enrollee rights and program integrity. Specifically, DHS changed contract terms to: 1) allow for more flexibility to target financial penalties in accordance with the magnitude of the violation, increase the amount of the penalty to a potential $5,000 per day, and $15,000 per day related to violations of enrollee due process rights, in order to better achieve compliance on crucial requirements; and 2) added more detailed requirements to the health plans' annual report on program integrity, to provide more information on the number and types of penalties and sanctions assessed by the health plans, cases opened and resolved, funds recovered, and cases referred for criminal investigation.

New Ways of Purchasing and Bringing Accountability to Medicaid

Just as it is important to correct practices of the past and change the current process as it relates to purchasing health care for Medicaid, it's equally if not more important to improve and innovate with new purchasing models and strategies. In an effort to bring greater innovation to our health care purchasing, Minnesota has introduced a new payment demonstration called the Health Care Delivery Systems (HCDS) Demonstration that contracts directly with providers in a new way, allowing them to share in savings (and holds them accountable in the future for losses) for improving quality of care and patient experience and reducing the total cost of care for Medicaid enrollees.

The overall goal of this new purchasing model is to improve patient health and experience by leveraging the innovative work of Minnesota's provider organizations on new care delivery models and reducing the cost of care, providing better value to our enrollees and the state. We are also seeking to provide consistency in how we pay our providers so they can provide consistent and quality care to all patients and to effectuate the change needed in the health care systems by aligning with other payers. This includes requiring our Medicaid managed care plans to participate in the demonstration as a new 2012 contract requirement, as well as aligning with the Medicare Shared Savings and Pioneer ACO programs and other total cost of care arrangements that are currently occurring in Minnesota's commercial market.

DHS developed this new payment model with broad community input from providers, plans, counties, social service and other community organizations through a Request for Information (RFI) in April of 2011 to seek input on the major policy and design components. The final

model and Request for Proposals (RFP) were released in June and provider selection occurred in late November. We received an unexpectedly high response from nine large provider organizations representing both metro and rural areas of the state and providing care to an estimated 150,000 Medicaid enrollees. All nine organizations who submitted proposals to participate were ultimately selected to move forward.

We are currently in the process of contract negotiations with nine provider organizations with the expectation of executing our first round of provider contracts in July of 2012 with the goal of having all contracts complete by the end of 2012. We see this as the first step in significantly changing the way we pay for health care and improve health outcomes. We will continue to evaluate our progress and expand to other providers and populations.

Lastly, we continue to look for ways to enhance the transparency and integrity of our Medicaid managed care contracting process, even beyond Governor Dayton's March executive order. A bill is currently making its way through Minnesota's legislative process, strongly supported by Governor Dayton and Health and Human Services legislative leadership. The bill will bring outside third-party financial audits of Minnesota's Medicaid managed care plans, conducted through the State's Office of the Legislative Auditor; bring additional assurance of the independence of the state's actuarial certification process; and enhance and assure the accuracy of data submitted by Minnesota's managed care plans operating in Medicaid. A copy of this bill language, which we anticipate will become law shortly, is attached as Exhibit 3.

The Office of Inspector General

Another important step we took was the creation of the Office of the Inspector General this past August. This is the same model used by the U.S. Department of Health and Human Services as well as 16 other states and builds on 2011 bipartisan legislative initiatives that gave DHS additional authority and resources, including funding for data analytics, increased use of audit contractors and additional staff. This model has independence and strong mechanisms to monitor and report abuse. The establishment of this Office within DHS allows us to increase our focus on fraud prevention and recovery, streamline its external program integrity operations, and more effectively structure staff that investigate, audit and evaluate others.

This office, while still in its infancy, has already made great strides in increasing collaboration with other local and federal oversight entities, expanding data sharing agreements, and contracting with external vendors to expand our investigations.

I believe it is of particular interest to this committee that the Office of Inspector General is now enforcing increased accountability for the program integrity efforts of the managed care organizations under contract with the state. Starting this year, managed care organizations are required to report to the DHS Office of Inspector General on all cases they investigate to learn of the level and scope of their efforts. In the past they only reported fraud referrals. This new information, at a minimum, will provide a baseline and more data for us to compare their program integrity efforts in managed care with our investigations related to fee-for-service cases.

UCare Donation

I know there is interest among this committee about the recently settled issue of UCare's $30 million dollar contribution to the state in 2011, and so I would take this opportunity to say a few words about that. First off, it is important to make clear that we dealt transparently and in good faith with CMS around this issue. We notified them when we received the contribution, informed them of how we intended to characterize the contribution, and responded fully and in a timely fashion to all of their requests. Over the past months we were in earnest and productive discussions, and were able to resolve the issue to the satisfaction of both parties.

We have a strong partnership with CMS, and our disagreement over the UCare donation was one of any number we have with the federal government over jointly funded programs. In that regard we did not feel there was anything novel about the disagreement. In nearly every case of disputed funds the state will argue to keep the money in the state and the federal government will argue for what it believes it's entitled to. The UCare issue was a particularly complicated issue as there was no clear precedent for it, and from the very beginning we were open that there may be different interpretations about what to do with it. Oftentimes these disputes end up going to an appeals process, but in this case we are happy we were able to resolve the issue before that. Ultimately we agreed that the initial $30 million donation would have ended up being added to what UCare returned based on the one percent caps we negotiated, and decided that the fair way to handle it would be to treat it as if it were part of that return, thus entitling the federal government to its share. Since we didn't know what, if anything, the plans would be returning until early this month, we were unable to make any decision before then.

We are happy to say that, when added to the dollars received as a result of the voluntary, one percent cap, the Dayton Administration was able to recover over $100 million dollars in taxpayer dollars attributed to the 2011 managed care contracts we inherited from the previous administration.

Closing Remarks

Minnesota has long been a leader in how managed care plans serve our Medicaid enrollees. But changes needed to be made in the way we do business now and in the future. We have made an unprecedented number of reforms in purchasing and accountability in just the past 15 months. And we are not done.

Few understand the fiscal pressures of our current budget predicament and their effect on human service delivery better than Governor Dayton, the Minnesota Department of Human Services, the Minnesota Legislature, and most importantly, the clients we serve who are ultimately impacted by these decisions. We understand that every public dollar is more precious than ever, and in order to serve the people of Minnesota to the utmost of our ability, we need to be able to continue to do more with less. This includes how we pay for health care.

We are proud of the integrity with which Minnesota has operated our Medicaid program. We believe Minnesota is a national model, and the changes implemented under the Dayton Administration, working with the Minnesota Legislature, only serve to enhance our program. We understand that members of Congress may be interested in examining ways to bring even more accountability and transparency to the Medicaid program. We look forward to working with members moving forward on ideas you may have. Thank you again for the opportunity to discuss the changes we've made and our commitment to continuing to improve Minnesota's Medicaid program.

EXHIBIT 1

STATE OF MINNESOTA

EXECUTIVE DEPARTMENT

MARK DAYTON
GOVERNOR

Executive Order 11-06

Creating Public Disclosure for Minnesota's Managed Care Health Care Programs

I, Mark Dayton, Governor of the State of Minnesota, by virtue of the authority vested in me by the Constitution and applicable statutes, do hereby issue this Executive Order:

Whereas, over 500,000 Minnesotans receiving public health insurance coverage are enrolled in managed care; and

Whereas, the State spends approximately $3 billion annually on purchasing health care from managed care plans for state public programs; and

Whereas, it is critical for public trust that Minnesota's taxpayers understand how public dollars for health care are being used; and

Whereas, the State needs greater disclosure and accountability of managed care plan spending on health care and long-term care services and administrative expenses for state public programs;

Now, Therefore, I hereby order the Commissioner of Human Services to:

1. Establish a managed care website for all publicly available information and reports that relate to the managed care procurement, financials, health outcome performance measures, contracts, and other public information for state public programs.

2. Develop an annual comprehensive managed care report in consultation with the Commissioners of Health and Commerce that includes detailed information on administrative expenses, premium revenues, provider payments and reimbursement

rates, contributions to reserves, enrollee quality measures, service costs and utilization, enrollee access to services, capitation rate-setting and risk adjustment methods, and managed care procurement and contracting processes.

3. Submit data from the managed care plans for state public programs to the Commissioner of Commerce so that regular financial audits of data will be conducted.

Under Minnesota Statutes, section 4.035, subdivision 2, this Executive Order is effective 15 days after publication in the State Register and filing with the Secretary of State.

In Testimony Whereof, I have set my hand on March 23, 2011.

Mark Dayton
Governor

Filed According to Law:

Mark Ritchie
Secretary of State

EXHIBIT 2

Subd. 9c.**Managed care financial reporting.**

(a) The commissioner shall collect detailed data regarding financials, provider payments, provider rate methodologies, and other data as determined by the commissioner and managed care and county-based purchasing plans that are required to be submitted under this section. The commissioner, in consultation with the commissioners of health and commerce, and in consultation with managed care plans and county-based purchasing plans, shall set uniform criteria, definitions, and standards for the data to be submitted, and shall require managed care and county-based purchasing plans to comply with these criteria, definitions, and standards when submitting data under this section. In carrying out the responsibilities of this subdivision, the commissioner shall ensure that the data collection is implemented in an integrated and coordinated manner that avoids unnecessary duplication of effort. To the extent possible, the commissioner shall use existing data sources and streamline data collection in order to reduce public and private sector administrative costs. Nothing in this subdivision shall allow release of information that is nonpublic data pursuant to section 13.02.

(b) Each managed care and county-based purchasing plan must annually provide to the commissioner the following information on state public programs, in the form and manner specified by the commissioner, according to guidelines developed by the commissioner in consultation with managed care plans and county-based purchasing plans under contract:

(1) administrative expenses by category and subcategory consistent with administrative expense reporting to other state and federal regulatory agencies, by program;

(2) revenues by program, including investment income;

(3) nonadministrative service payments, provider payments, and reimbursement rates by provider type or service category, by program, paid by the managed care plan under this section or the county-based purchasing plan under section 256B.692 to providers and vendors for administrative services under contract with the plan, including but not limited to:

(i) individual-level provider payment and reimbursement rate data;

(ii) provider reimbursement rate methodologies by provider type, by program, including a description of alternative payment arrangements and payments outside the claims process;

(iii) data on implementation of legislatively mandated provider rate changes; and

(iv) individual-level provider payment and reimbursement rate data and plan-specific provider reimbursement rate methodologies by provider type, by program, including alternative payment arrangements and payments outside the claims process, provided to the commissioner under this subdivision are nonpublic data as defined in section 13.02;

(4) data on the amount of reinsurance or transfer of risk by program; and

(5) contribution to reserve, by program.

(c) In the event a report is published or released based on data provided under this subdivision, the commissioner shall provide the report to managed care plans and county-based purchasing plans 30 days prior to the publication or release of the report. Managed care plans and county-based purchasing plans shall have 30 days to review the report and provide comment to the commissioner.

EXHIBIT 3

Sec. 14. Minnesota Statutes 2010, section 256B.69, is amended by adding a subdivision to read:

Subd. 9d. Financial audit. (a) The legislative auditor shall contract with an audit firm to conduct a biennial independent third-party financial audit of the information required to be provided by managed care plans and county-based purchasing plans under subdivision 9c, paragraph (b). The audit shall be conducted in accordance with generally accepted government auditing standards issued by the United States Government Accountability Office. The contract with the audit firm shall be designed and administered so as to render the independent third-party audit eligible for a federal subsidy, if available. The contract shall require the audit to include a determination of compliance with the federal Medicaid rate certification process. The contract shall require the audit to determine if the administrative expenses and investment income reported by the managed care plans and county-based purchasing plans are compliant with state and federal law.

(b) For purposes of this subdivision, "independent third-party" means an audit firm that is independent in accordance with government auditing standards issued by the United States Government Accountability Office and licensed in accordance with chapter 326A. An audit firm under contract to provide services in accordance with this subdivision must not have provided services to a managed care plan or county-based purchasing plan during the period for which the audit is being conducted.

(c) The commissioner shall require in the request for bids and resulting contracts with managed care plans and county-based purchasing plans under this section and section 256B.692, that each managed care plan and county-based purchasing plan submit to and fully cooperate with the independent third-party financial audit of the information required under subdivision 9c, paragraph

(b). Each contract with a managed care plan or county-based purchasing plan under this section or section 256B.692, must provide the commissioner and the audit firm contracting with the legislative auditor access to all data required to complete the audit. For purposes of this subdivision, the

contracting audit firm shall have the same investigative power as the legislative auditor under section 3.978, subdivision 2.

(d) Each managed care plan and county-based purchasing plan providing services under this section shall provide to the commissioner biweekly encounter data and claims data for state public health care programs and shall participate in a quality assurance program that verifies the timeliness, completeness, accuracy, and consistency of the data provided. The commissioner shall develop written protocols for the quality assurance program and shall make the protocols publicly available. The commissioner shall contract for an independent third-party audit to evaluate the quality assurance protocols as to the capacity of the protocols to ensure complete and accurate data and to evaluate the commissioner's implementation of the protocols. The audit firm under contract to provide this evaluation must meet the requirements in paragraph (b).

(e) Upon completion of the audit under paragraph (a) and receipt by the legislative auditor, the legislative auditor shall provide copies of the audit report to the commissioner, the state auditor, the attorney general, and the chairs and ranking minority members of the health and human services finance committees of the legislature. Upon completion of the evaluation under paragraph (d), the commissioner shall provide copies of the report to the legislative auditor and the chairs and ranking minority members of the health finance committees of the legislature.

(f) Any actuary under contract with the commissioner to provide actuarial services must meet the independence requirements under the professional code for fellows in the Society of Actuaries and must not have provided actuarial services to a managed care plan or county-based purchasing plan that is under contract with the commissioner pursuant to this section and section 256B.692 during the period in which the actuarial services are being provided. An actuary or actuarial firm meeting the requirements of this paragraph must certify and attest to the rates paid to the managed care plans and county-based purchasing plans under this section and section 256B.692, and the certification and attestation must be auditable.

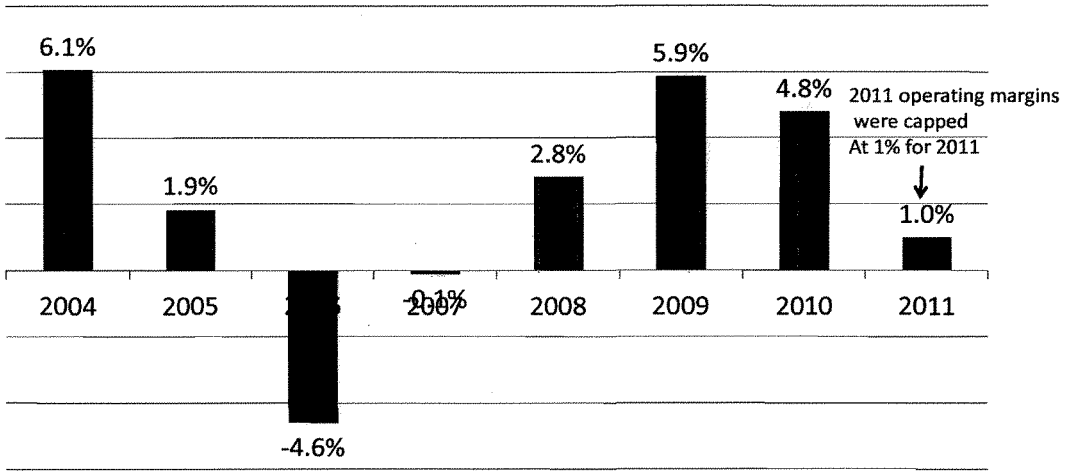
(g) Nothing in this subdivision shall allow the release of information that is nonpublic data pursuant to section 13.02.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to the managed care and county-based purchasing plan contracts that are effective January 1, 2014, and biennially thereafter.

EXHIBIT 4

Historic Operating Margins in Minnesota's Prepaid Medical Assistance (PMAP) and MinnesotaCare Programs

2004-2011



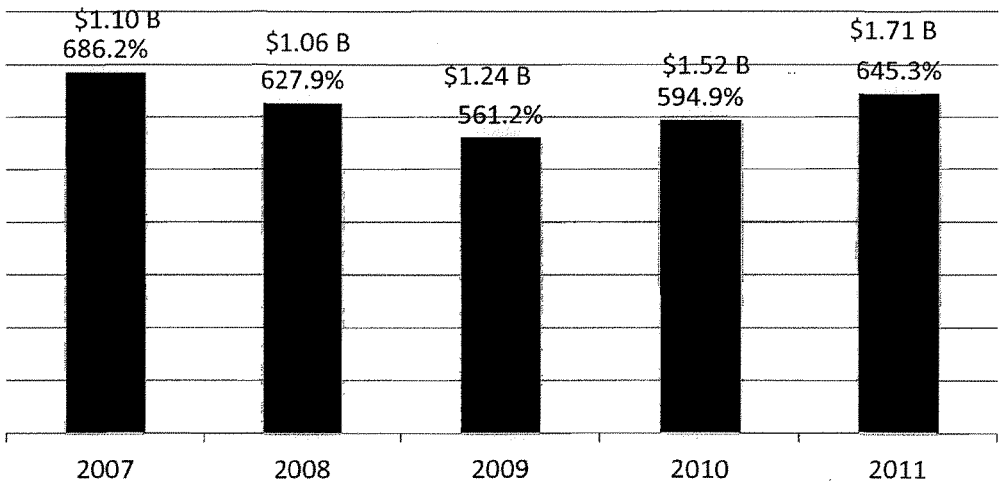
Margins associated with 4 largest non profit HMOs subject to the 2011 contract year 1% operating margin cap

EXHIBIT 5

Health Plan Reserves

(in total dollars, and as a percent of authorized control level)

2004-2011



Margins associated with 4 largest health plans subject to the 2011 contract year
1% operating margin cap

Mr. JORDAN. Thank you, Commissioner.

Director Mann?

STATEMENT OF CINDY MANN

Ms. MANN. Good morning, Chairman Gowdy and Gordon, Ranking Members Davis and Kucinich, and members of the Committee. Thank you for the invitation to discuss Medicaid's financial management.

No matter could be more central or important to the Medicaid program, or indeed to any health care program. Medicaid, as you all know, is the primary source of medical assistance for millions of low income, disabled, and elderly Americans, children and adults alike. In fiscal year 2012, an estimated 56.6 million people will receive their health care coverage through the Medicaid program.

The Medicaid program establishes, at the Federal level, we establish minimum requirements. States design, implement, oversee their Medicaid programs and federalism is the hallmark of the program. Our basic financial management arrangement works as follows: States pay for the health care benefits provided to eligible individuals and the Federal Government, in return, matches qualified State expenditures at a rate that varies between 50 and 75 percent. On average, States are responsible for about 43 percent of program costs. The matching structure ensures that both the States and the Federal Government have a very strong fiscal interest in assuring that the program operates efficiently.

I am going to use my time this morning to briefly describe our methods of financial oversight that relate specifically to the issues raised at this hearing, but let me first make a few quick observations.

Medicaid, like other payers, is very interested in supporting new ways of delivering and paying for care to promote better care at lower costs. Fortunately, we have at our side something most payers don't have, which is 50 State partners. We have a number of States that have been approved to operate and create health homes that are looking for shared savings arrangements with their providers, and States as diverse as Texas and Massachusetts that are redesigning in fundamental ways their Medicaid delivery systems.

Second, because Medicaid, like the marketplace, generally is experiencing significant change, our goal is not just to manage the issues that were identified last year or five years ago, but, rather, to develop new tools and methods to respond to and, indeed, to anticipate the changing landscape. Therefore, like many prudent purchasers, we value in our investing in data and measurement to assess what is working, to rapidly adjust when things aren't working, and to rapidly scale when things are going well. Improved data and measurement will take a while for us to fully implement, but it will allow us to better track costs, utilization, integrity, and quality.

Third, nothing that has been talked about today is unique to Medicaid. Orthodontists doing improper billing, health plans overcharging, those aren't unique to the Medicaid program, sadly. The work that the Attorney General of the United States, that Secretary Sebelius have done to aggressively fight health care fraud with the private sector, has focused on health care fraud more broadly and the notion that it is a broad issue that affects public,

as well as private payers. We have a major responsibility to do so, but it is not a problem that is unique to either Medicaid, Medicaid, or commercial payers.

I am going to now turn to a general description of our methods for overseeing the payment of Federal matching funds.

States report their expenditures to us on a quarterly basis through an online system, and a team of accountants and financial management specialists review those States' submissions of expenditures. They review them carefully and approve them or defer them before we pay our Federal matching payments.

Our teams also coordinate with State auditors and with the HHS Office of Inspector General to ensure that State expenditures and corresponding claims for Federal funds are allowable, and every year we also establish with our regional offices a work plan for an in-depth financial management review that reflects our assessments or risk. We might follow up with an OIG report that suggest a problem that might be widespread; we might focus on an area of spending that we think is prone to abuse. When we question expenditures, we defer payment; we defer the Federal funds to the States pending resolution, and then we disallow the funds for claims for which adequate documentation or justification is lacking.

We are not, as Congressman Davis pointed out, we are not the fraud office; we are not the law enforcement office. But we, of course, work very closely with those offices as appropriate. And I might say, in that regard, that the Office of Inspector General, the HHS Office of Inspector General, the Department of Justice has been involved in each and every one of the matters that we have discussed today, both in New York, in Minnesota, as well as in Texas.

Let me turn next to our oversight of plans and provider payment rates. Under Federal Medicaid law, States are responsible for setting their rates to providers and plans in a fair and efficient manner, and assuring that plans and providers are paid enough so that Medicaid beneficiaries have access to care. Both of these elements of the equation are really critical. We and States must have measurement systems in place to assure that rates are sufficient to provide our beneficiaries with access to care.

This relates directly to the matter that Representative Cummings mentioned earlier with respect to Deamonte Driver, who died for lack of being able to find dental care in the State of Maryland. We issued proposed rules on how we might monitor access last year and plan to finalize that rule later this year.

At the same time, plans and providers must not be paid more than what is fair and efficient, or else the program is wasting money or spending money inappropriately. As a result, we set outer bounds in the Medicaid program. For example, we won't pay more than the upper limit of what Medicare would pay for certain classes of providers, and we require rates paid to plans to be actuarially sound and certified.

And one very important control that is embedded in the structure of the program itself is that because States are spending their own money, as well as the Federal Government's money, they will take every opportunity to act as prudently purchasers. We know, of course, that States also will seek to maximize Federal funding,

and so we have measures in place to ensure that States in fact pay their State share of costs.

Turning specifically to the payment rates in managed care, we are grateful to the GAO for its work over the years and its recommendations specifically in 2010. We have taken those recommendations very seriously and we are working towards implementation. We have made good progress, but more needs to be done. We have supported our regional offices through training and guidance; we are creating a stronger database for the evaluation of rates; we are developing an online system of contract review; and we are planning to strengthen our financial management and oversight to move more toward a risk-based approach, modulating the depth of review based on risk factors.

With respect to Minnesota—and I will just be a moment—we are pleased to report, as the Commissioner noted, that Minnesota determined that it will provide, appropriately, we believe, the Federal Government with its share of the UCare $30 million that was received by the State, and we also have added, contrary to, I think, the implications earlier, in the terms and conditions to the waiver in Minnesota, very specific provisions to assure that there is increased oversight in the Minnesota plans, and we continue to work very closely with the State as we move forward.

Thank you.

[Prepared statement of Ms. Mann follows:]

STATEMENT OF

CYNTHIA MANN

DIRECTOR
CENTER FOR MEDICAID AND CHIP SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

MEDICAID FINANCIAL MANAGEMENT

BEFORE THE

U.S. HOUSE COMMITTEE ON OVERSIGHT & GOVERNMENT REFORM
SUBCOMMITTEE ON HEALTH CARE, DISTRICT OF COLUMBIA, CENSUS AND THE NATIONAL ARCHIVES
SUBCOMMITTEE ON REGULATORY AFFAIRS, STIMULUS OVERSIGHT AND GOVERNMENT SPENDING

APRIL 25, 2012

U.S. House Committee on Oversight & Government Reform
Subcommittee on Health Care, District of Columbia, Census and the National Archives and the Subcommittee on Regulatory Affairs, Stimulus Oversight and Government Spending
April 25, 2012

Chairmen Gowdy and Jordan, Ranking Members Davis and Kucinich, and Members of the Subcommittees, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) oversight over Medicaid's financial management.

Medicaid Background

Medicaid is the primary source of medical assistance for millions of low-income, disabled, and elderly Americans and is a central component of our nation's medical safety net, providing health coverage to many of those who would otherwise be unable to obtain health insurance. In fiscal year (FY) 2012, an estimated 56.6 million people on average will receive health care coverage through Medicaid.

Although the Federal government establishes minimum requirements for the program, States design, implement, administer, and oversee their own Medicaid programs. In general, States pay for the health benefits provided, and the Federal government, in turn, matches qualified State expenditures based on the Federal medical assistance percentage (FMAP), which can be no lower than 50 percent. Administrative expenses are generally matched at a 50 percent rate for all States, although the rate is higher for certain administrative expenditures. On average, the Federal government expects to pay nearly 58 percent of State Medicaid expenditures in FY 2013 for Medicaid benefits, and in FY 2013, the Federal share of current law Medicaid outlays is expected to be nearly $283 billion.

States that choose to participate in the Medicaid program and receive Federal matching payments are required to cover individuals who meet certain minimum categorical and financial eligibility standards. Medicaid beneficiaries include children, pregnant women, adults in families with dependent children, the aged, and people with disabilities who meet certain minimum income eligibility criteria that vary by eligibility category. States have the flexibility to extend coverage

to other groups, such as women who have breast and cervical cancer, through State plans and under demonstration authority. States that participate must cover certain medical services, such as nursing home care, and are provided the flexibility to offer additional benefits to beneficiaries, such as home- and community-based long-term services and supports. States also have broad flexibility on how they will design their service delivery system; most Medicaid beneficiaries are served through managed care but for some States and for some populations, the program relies on a fee-for-service system. State governments have a great deal of programmatic flexibility within which to tailor their Medicaid programs to their unique political, budgetary, and economic environments. As a result, there is variation among the States in eligibility, services and service delivery, as well as reimbursement rates to providers and health plans.

Medicaid is currently undergoing significant change as CMS implements reforms to modernize and strengthen the program and its services. Beginning in 2014, the Affordable Care Act eliminates long-standing limitations on coverage that have prevented many of the lowest-income uninsured Americans from qualifying for Medicaid. In 2014, Medicaid will be available to most individuals (subject to citizenship and immigration status) under age 65 with family incomes below 133 percent of the Federal poverty level (FPL) with an additional 5 percent income disregard (for an effective eligibility level of 138 percent FPL, or approximately $15,415 for a single individual in 2012). The final rule (CMS-2349-F) released on March 23, 2012, significantly streamlines many of the complex eligibility categories currently in statute, implements simpler rules for determining income eligibility, and requires modernized and coordinated systems for processing applications for most Medicaid applicants. These proposed changes build on successful State efforts to streamline eligibility, enrollment, and renewal processes, and apply these administrative improvements nationally.

As we prepare for the Medicaid eligibility changes, CMS is also moving towards data-driven decision-making with newly expanded data sets, such as the Transform Medicaid Statistical Information Systems (MSIS) pilot project, which is currently being tested in 10 States and will be nationally implemented in 2014. CMS is also working to strengthen the program through active engagement with States through initiatives such as our Medicaid Integrity Institute and our Value-Based Purchasing Collaborative and the resources provided through the new

Medicaid.gov website. These, and many other changes, will modernize the program and strengthen program operation, while ensuring that beneficiaries receive better care and that Federal taxpayer dollars are used effectively and efficiently.

Financial Management in Medicaid

Since the enactment of Medicaid in 1965, the Federal government has given States the option of receiving Federal matching funds to help them pay the costs of health care and long-term care for their low-income residents. Medicaid's Federal-State matching arrangement reflect the fiscal commitment on the part of the Federal government towards paying for part of the cost of health and long-term care services for certain categories of low-income Americans, regardless of the number of eligible individuals or the extent of their medical needs. The matching arrangement depends on States' own contributions, which ensure their commitment to managing costs and quality. It also facilitates States' ability to extend coverage for health and long-term care services to their low-income residents beyond the minimum standards. CMS takes seriously our responsibility to ensure that States correctly report their Medicaid expenditures so that we can ensure Federal Medicaid funds are appropriately spent.

CMS tracks State expenditures to compute the amount of Federal Financial Participation (FFP), or the match CMS will provide to the State to fund medical expenditures and program operations. CMS tracks State expenditures through the Medicaid Budget and Expenditure System (MBES) and State Children's Health Insurance Budget and Expenditure System (CBES). The MBES/CBES is a web-based application the Medicaid State agencies use to report budgeted and actual expenditures for Medicaid and the Children's Health Insurance Program (CHIP). The MBES/CBES also stores the State's historical budget and expenditure records for data analysis purposes.

To ensure financial stewardship over Federal taxpayer money, CMS verifies that actual State expenditures reconcile with the monetary advance CMS gives to States for their anticipated quarterly budgeted costs. States may submit a revised request for Federal funds if their original request proves insufficient, but they must provide justification for doing so. Thirty days after the end of the budget quarter, States must report actual expenditures and include supporting

documentation such as invoices, cost reports, and eligibility records to ensure that the FFP matches with States' actual expenditures.

CMS employs a team of accountants and financial management specialists in regional offices to review these submissions, look for anomalies, and request additional documentation or justifications as necessary. These individuals also perform focused financial management reviews of specific Medicaid service and administrative expenditures. Focused financial management reviews generally involve selecting a sample of paid claims for review related to certain types of Medicaid provided services. These reviews are useful in identifying unallowable costs and in highlighting where additional policy clarification or oversight may be needed. These accountants and financial management specialists also perform audit resolution tasks and coordinate with State auditors and the Department of Health and Human Services' Office of Inspector General (HHS OIG) to ensure State expenditures and corresponding claims for Federal matching funds are allowable.

CMS issues deferrals and disallowances to States that provide inadequate documentation or justification for Medicaid claims. A deferral withholds funds from the States until additional clarification or documentation is received from the States regarding Medicaid expenditures claimed. A disallowance is a determination by CMS that a claim or portion of a claim by a State for Federal funds is unallowable (States have the right to appeal, in whole or in part, a disallowance). CMS oversight over State expenditures is a careful balance of ensuring that States receive the guaranteed Federal share, while also ensuring the FFP is only spent on appropriate, documented activities in the Medicaid program. As part of achieving that goal, CMS removed, in FY 2011, an estimated $949 million (with approximately $915 million recovered and $34 million resolved) in deferrals, disallowances, and recoveries of approximately $6.3 billion identified in questionable Medicaid costs. Furthermore, an estimated $223 million in questionable reimbursement was averted due to CMS funding specialists' preventive work with States to promote proper State Medicaid financing.

Rate-Setting and Program Oversight

In conjunction with CMS' review of State expenditures, CMS also oversees and approves State coverage and payment policies through the State plan and amendments. States establish their own Medicaid provider payment rates within broad Federal requirements. States generally pay for services on a fee-for-service basis or through managed care contracts with private health insurers. Under fee-for-service arrangements, States pay providers (for example, physicians and hospitals) directly for services. States develop their payment rates based on many factors, including consideration of local health care markets, the underlying costs of providing the services, and payment rates by Medicare or commercial payers in the local community. Regardless, Medicaid payment rates set by the States must be consistent with efficiency, economy, and quality of care.

CMS sets an outer bound for how much States can pay providers in certain fee-for-service arrangements. The Medicaid Upper Payment Limit (UPL) requirements provide that payments for inpatient hospital, outpatient hospital, clinic, nursing facility, and other services in the aggregate are not allowed to exceed an estimate of what Medicare would have paid for the same services. The UPL is calculated in the aggregate for each Medicaid service and for each provider type (private, non-State government, and State government-owned). A State plan amendment that proposes to increase payment rates for these services will typically require the State to demonstrate that the increase in payment rates will not result in the total payments for any provider type exceeding the UPL.

Under managed care arrangements, States contract with organizations (typically, private managed care plans) to deliver care through networks of providers. States are required to have actuarially sound capitation rates, which means the rates have been developed in accordance with generally-accepted actuarial principles and practices, are appropriate for the population and services, and are certified by actuaries. States are also required to use utilization and cost data derived from the Medicaid population or a comparable population and set requirements on special risk-sharing arrangements. Managed care plans must have in place quality assessment, reviews, and measures to ensure that Medicaid beneficiaries are accessing and receiving quality care. CMS Regional Offices are required to review and approve States' managed care contracts

and capitation rates, using established standard operating protocols for review and approval of contracts as well as contract and rate review checklists.

Disproportionate Share Hospitals

Disproportionate Share Hospital (DSH) payments are made by States to qualifying hospitals that treat low-income and Medicaid patients. The Medicaid statue limits a qualifying hospital's DSH payments to the amount of eligible uncompensated care costs and this limit is commonly referred to as the hospital-specific limit. CMS is in the process of implementing new audit requirements for DSH payments. For States to receive FFP for DSH payments, Federal law requires States to submit an independent certified audit and an annual report to the Secretary of the Department of Health and Human Services (HHS) describing DSH payments made to each DSH hospital. The report must identify each disproportionate share hospital that received a DSH payment adjustment, and provide information to CMS to ensure the appropriateness of the payment amount. The annual certified independent audit includes specific verifications to make sure hospital DSH payments are within the hospital-specific limit.

The final rule CMS (CMS-2198-F) published on this requirement in 2008 specifies the elements for the required DSH report and the verifications required for the audit. CMS also developed additional guidance, including the General DSH Audit and Reporting Protocol and the DSH Report Format, to help States meet statutory and regulatory requirements. Audits and reports were required beginning with Medicaid State plan rate year 2005. The initial audit years of 2005, 2006, and 2007 were due to CMS on December 31, 2010. Each subsequent audit and report is due on December 31, 3 years after the completion of the State plan rate year. For example, State plan rate year 2009 audits and reports are due to CMS on December 31, 2012.

In FY 2011, CMS conducted in-depth reviews of a State and hospital in eight different regions of the country in an attempt to obtain a nationwide representation of audit implementation. Continuing this effort, CMS is conducting similar in-depth reviews for FY 2012 of a State and hospital in two additional regions. The reviews are intended to produce a greater understanding of how States, hospitals, and auditors completed the initial DSH audits and reports. CMS also plans to use this information to issue additional guidance to States to ensure

proper implementation and compliance with the auditing and reporting requirements. On April 5, 2012, CMS issued the first FY 2011 draft financial management review report to the State of Texas relating to its Medicaid DSH independent certified audit and report.

Oversight of State Funding Sources for State Portion of the Medicaid Program

As noted, Federal Medicaid matching payments are made based on actual State expenditures and, as such, our oversight responsibility includes ensuring that States appropriately fund their share of Medicaid expenditures for the care and services available under their State plan. As the States share in the cost of their Medicaid program, the State-Federal partnership in the Medicaid program builds in a natural incentive for States to use Federal Medicaid money judiciously. However, CMS is committed to ensuring the State-Federal financial partnership is not manipulated and States are complying with all statutory and regulatory requirements. Therefore, CMS carefully oversees and evaluates State funding sources for the non-Federal share of the State Medicaid program in order to ensure the balance set by statute between the State and Federal share of Medicaid funding is enforced.

Before CMS approves a State plan, a State must verify its funding sources meet statutory and regulatory requirements. Recognized sources of funding for the State share of Medicaid payments include:

- State legislative appropriations to the single state agency;
- Inter-governmental transfers (IGTs);
- Certified public expenditures (CPEs); and
- Permissible taxes and provider donations.

As part of the State plan amendment review process, CMS requires States to provide detailed information and assurances regarding the source of the non-Federal share. In addition to this review process, funding specialists are engaged in the regular review of all sources of the State match. In FY 2011, $223 million in questionable reimbursement was averted due to the funding specialists' preventive work with States to promote proper State Medicaid financing methods.

Since August 2003, CMS has been requesting information from States regarding details on how States are financing their share of the Medicaid program costs under the Medicaid reimbursement State plan amendment review process. Through this review process, CMS noticed that the enhanced payments some States make to health care providers are not financed in a manner consistent with the Federal statute. Specifically, CMS discovered that several States made claims for Federal matching funds associated with certain Medicaid payments, which the health care providers were not ultimately allowed to retain. Instead, through the guise of the intergovernmental transfer process, State and/or local governments required the health care provider to forgo and/or return certain Medicaid payments to the State, which effectively shifted the cost of the Medicaid program onto the Federal taxpayer. CMS continues to work with States to identify permissible sources of non-Federal share funding and will not approve a Medicaid State plan amendment if there is not a permissible non-Federal share funding source.

CMS also reviews State plan amendments that involve Medicaid payments that would be funded by a health care-related tax, as well as State legislation enacting a health care-related tax to ensure that all other statutory and regulatory requirements are met. This involves also analyzing the taxing structure in conjunction with the associated reimbursement methodology to ensure there are no hold harmless arrangements. If a waiver of the broad-based and/or uniformity requirements of the health care-related tax is necessary, then the State must also submit a formal waiver to CMS for review and approval. This review includes a detailed analysis of the necessary statistical tests as well as analysis of entire taxing structure to ensure compliance with the other statutory and regulatory requirements. CMS also learns of health care-related taxes through other avenues, including States asking CMS to review draft legislation or asking for other technical advice. Historically, the provision of early input and early feedback is the most effective and efficient way to develop a health care-related tax that is consistent with Federal requirements. CMS has a careful process in place to review and approve State plans and amendments.

Medicaid Program Integrity

Although States are primarily responsible for policing fraud in the Medicaid program, CMS provides technical assistance, guidance, and oversight in these efforts. CMS is committed to

detecting, deterring, monitoring, and combating fraud and abuse, as well as taking action against those that commit or participate in fraudulent or other unlawful activities.

This commitment is centralized in CMS' Center for Program Integrity, where the Medicaid Integrity Program is housed.

Because of Medicaid's unique Federal-State partnership, CMS has developed initiatives that specifically work to assist States in strengthening their own efforts to combat fraud, waste, and abuse. For the continuing education of State program integrity employees, the Medicaid Integrity Institute (MII) stands out as one of CMS's most significant achievements. The MII provides a unique opportunity for CMS to offer substantive training, technical assistance, and support to States in a structured learning environment. In its three years of existence, the MII has offered numerous courses and trained over 2,464 State employees at no cost to the States.

In addition, CMS has provided regulatory and sub-regulatory guidance to States in connection with the States' Medicaid audit activities. One example is the Medicaid Recovery Audit Contractor (RAC) Program. On September 16, 2011, CMS published the final rule for the Medicaid RAC program (CMS-6034-F). The Medicaid RAC program is administered by the States and involves the auditing of claims for services furnished by Medicaid providers. RACs review claims after payment, using both simple and detailed reviews that include medical records. Medicaid RACs must identify both overpayments and underpayments. States are required to pay the RACs a contingency fee for the identification of overpayments, and have discretion to determine the fee methodology for the identification of underpayments. All fees paid to Medicaid RACs must be out of the amounts recovered. States were required to have their RAC programs in place, absent an exception, by January 1, 2012, and all States have submitted State plan amendments to establish State-level Medicaid RAC programs or have requested and been granted an exception.

In addition to providing regulatory and sub-regulatory guidance, CMS has hosted a number of activities to assist States in the implementation of their Medicaid RAC programs. During FY 2011, CMS hosted a series of technical assistance webinars and teleconferences for States to aid

them in their RAC program implementation. Topics included an overview of the Medicaid RAC final rule, Medicare RAC best practices, RAC fraud referrals, and State reporting on performance metrics. CMS also launched the Medicaid RACs At-A-Glance webpage[1] in February 2011 that shows a U.S. map providing basic information on the status of implementation for each State's RAC program.

Another example of CMS working with States to prevent and recover inappropriate payments is the Audit Medicaid Integrity Contractors (MICs). Audit MICs are CMS contractors that conduct audits to identify Medicaid overpayments. Between 2009 and November 1, 2011, Audit MICs initiated 1,663 audits in 44 States. Through both direct provider audits and automated reviews of State claims, those efforts have identified an estimated $15.2 million in overpayments. During FY 2011, CMS made a dramatic shift in the way it develops MIC audits, working more collaboratively with the States in ways designed to achieve stronger results. All the audits assigned in the second half of FY 2011 were collaborative audits that benefit from both State and Federal resources and insight. In addition to Federal and collaborative audits, States reported they conducted an additional 122,631 audits in FY 2009. Those State efforts have identified an estimated $964 million in overpayments. CMS also provides States assistance with "boots on the ground" for special investigative audits. Since October 2007, CMS has participated in 10 projects in three States, with the majority of activity occurring in Florida. States reported these reviews have resulted in $40 million in savings through cost avoidance. CMS helped States review 654 providers, 43 home health agencies and DME suppliers, 52 group homes, and 192 assisted living facilities. During those reviews, CMS and States interviewed 1,150 beneficiaries and took more than 540 administrative actions against non-compliant providers. Besides identifying inappropriate provider activities, these reviews also result in an ongoing sentinel effect in these vulnerable areas of the Medicaid program.

CMS is actively pursuing ways to apply advanced data analytics technology, including predictive analytics, to the Medicaid Integrity Program. CMS' goal is to utilize predictive modeling to enhance its analytic capabilities and increase information sharing and collaboration among State

[1] http://www.cms.gov/medicaidracs/

Medicaid agencies to detect and deter aberrant billing and servicing patterns at the State level and on a regional or national scale.

CMS is committed to working with our law enforcement partners at the HHS OIG, the Federal Bureau of Investigation (FBI), and the Department of Justice (DOJ), who take a lead role in investigating and prosecuting alleged fraud. By sharing information and requiring all States to terminate any provider or supplier Medicare or a State terminated for cause, CMS and its partners are ensuring that fraudulent providers and suppliers cannot easily move from State to State or between Medicare and Medicaid. We are also providing training in the use of data analytic systems to the HHS OIG and DOJ, enabling investigators and law enforcement agents to more quickly analyze data, detect fraudulent trends, and prosecute fraud schemes. Our partnership with the HHS OIG and the DOJ continues to lead to the successful resolution of fraud cases, such as the recent settlement with WellCare, a health maintenance organization, which has agreed to pay $137.5 million to the Federal government and the States with which it contracted to resolve four lawsuits alleging that WellCare participated in a number of schemes to submit false claims to Medicare and various Medicaid programs and engaged in marketing abuses, such as cherrypicking of healthy patients in order to avoid future costs.

Looking Forward

CMS is committed to ensuring State compliance and financial integrity within the Medicaid program through many different types of activities. CMS is also committed to moving forward to a modern Medicaid program that rewards good outcomes and high-quality care instead of simply paying for the volume of health care provided. Many States are actively engaged with us and are leading the change to make Medicaid a leader in this industry-wide transformation.

For example, CMS is working to improve the quality and lowering the cost of care for the 9 million Americans enrolled in both Medicare and Medicaid (known as Medicare-Medicaid enrollees or "dual eligibles"). The Affordable Care Act created the new Federal Coordinated Health Care Office, referred to as the Medicare-Medicaid Coordination Office, to more effectively integrate benefits and services between the two programs and to improve the coordination between the Federal Government and States for Medicare-Medicaid enrollees.

Through our work and with our State partners, our efforts are advancing access to seamless, coordinated care programs for Medicare-Medicaid enrollees.

Another priority is helping State Medicaid agencies buy better value by linking quality, payment reform, and integrated care models through the Value-Based Purchasing Medicaid and CHIP (MAC) Collaborative. As the largest insurer in the country in terms of covered lives, Medicaid can better leverage its value-based purchasing power to achieve high quality at lower cost. Phase 1 of the Value-Based Purchasing MAC Collaborative, which focuses on ways to improve care and lower costs in non-risk based arrangements, began in February 2012, and will run through August 2012 or later.

Finally, CMS is modernizing its data systems, which will provide better and faster accountability and enforcement for the compliance issues and fraud detection systems described earlier. The activities delineated here reflect the strong Federal-State partnership upon which the Medicaid program is based as well as CMS' long-standing commitment to ensuring the accountability of the Medicaid program while protecting and improving the services provided to beneficiaries who rely on Medicaid for their health care needs.

Mr. JORDAN. Thank you, Director.

Director YOCOM?

STATEMENT OF CAROLYN L. YOCOM

Ms. YOCOM. Chairman Jordan and Gowdy, Ranking Members Kucinich and Davis, and members of the Subcommittee, I am pleased to be here today as you discuss oversight of the Medicaid program.

The Medicaid program has been on GAO's list of high-risk programs for nearly 10 years, in part because of concerns about the program's fiscal management. CMS and its State partners continue to face challenging finding the proper balance between Federal oversight and States' flexibility to administer their Medicaid programs. Both the States and the Federal Government must take responsibility for managing program finances efficiently.

My remarks today summarize some of GAO's prior work on CMS's oversight of three areas of the Medicaid program: States' rate setting methodologies for capitated managed care, supplemental payments, and program integrity. Overall, our prior work has shown that that CMS has faced challenges with the fiscal management of Medicaid in these three areas.

First, with regard to rate setting methodologies, in August of 2010, we reported on CMS's oversight of States' compliance with actuarial soundness requirements which govern the process used to develop capitated managed care rates. At the time of our reporting, we found significant gaps in CMS's oversight of two States. In particular, CMS had not reviewed one State's rate setting for multiple years, nor had it completed a full review of another State's rate setting since the actuarial soundness requirements became effective, which was in August 2002. Beyond these two States, we identified additional inconsistencies in oversight, raising concerns that CMS was not ensuring other States' compliance with actuarial soundness.

In this same report, we noted that actuarial certification does not ensure that the data used to set the rates are reliable because actuaries may not audit or independently verify these data. CMS's efforts to ensure the quality of the data used to set the rates were generally limited to requiring assurances from States and health plans. From GAO's perspective, these efforts do not provide enough information to ensure the quality of the data used to set rates. With limited information on data quality, billions of Federal and State dollars are at risk for misspending.

Second, for over a decade we have reported on various financing arrangements involving supplemental payments that shift the cost from the States to the Federal Government. Our work has found that while a variety of congressional and CMS actions have helped curb such arrangements, gaps in oversight remain. Statutory changes have resulted in recent regulations that have the potential to improve oversight of some, but not all, supplemental payments.

Effective in 2011, there are improved transparency and accountability requirements for supplemental payments to hospitals that treat large numbers of low income and Medicaid patients. However, these requirements, such as facility-specific reporting, are not in place for other types of supplemental payments, which appear to be

increasing. Because such financing arrangements effectively increase the Federal Medicaid share above what is established by law, they threaten the fiscal integrity of the Medicaid program and they damage the Federal-State partnership.

Last, in December 2011, we testified that a key challenge CMS faced in implementing its Medicaid Integrity Program was ensuring effective coordination to avoid duplicating States' program integrity efforts, particularly in the area of auditing provider claims. The largest component of the Medicaid Integrity Program, the National Provider Audit Program, has had disappointing results, as these overpayments identified by its audit contractors were not commensurate with its contractors' costs.

For example, CMS's audit contractors identified about $15.2 million in overpayments in fiscal year 2010, but the combined cost of the National Provider Audit Program is over twice that amount, about $36 million. CMS has announced plans to redesign this program, but it remains to be seen if this redesign will achieve improved results.

CMS's other core activities are broad in scope and raise similar concerns regarding duplication.

On a more positive note, its collaborative efforts on auditing with States and CMS's Medicaid Integrity Institute, a national training program for State program integrity officials, both show promise. In particular, these efforts appear to promote effective State coordination and collaboration, and show more promising results.

Mr. Chairman, this concludes my prepared remarks.

[Prepared statement of Ms. Yocom follows:]

United States Government Accountability Office

GAO

Testimony

Before the Subcommittees on Health Care, District of Columbia, Census and the National Archives and Regulatory Affairs, Stimulus Oversight and Government Spending, Committee on Oversight and Government Reform, House of Representatives

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MEDICAID

Federal Oversight of Payments and Program Integrity Needs Improvement

Statement of Carolyn L. Yocom
Director, Health Care

GAO-12-674T

April 25, 2012

GAO
Accountability * Integrity * Reliability

Highlights

Highlights of GAO-12-674T, a testimony before the Subcommittees on Health Care, District of Columbia, Census and the National Archives and Regulatory Affairs, Stimulus Oversight and Government Spending, Committee on Oversight and Government Reform, House of Representatives

MEDICAID

Federal Oversight of Payments and Program Integrity Needs Improvement

Why GAO Did This Study

Medicaid, a joint federal-state health care program, financed care for about 67 million people at a cost of $401 billion in fiscal year 2010. At the federal level, CMS, an agency within the Department of Health and Human Services, is responsible for overseeing the design and operations of states' Medicaid programs, while the states administer their respective programs' day-to-day operations. The shared financing arrangement between the federal government and the states presents challenges for program oversight and Medicaid has been on GAO's list of high-risk programs since 2003, in part, because of concerns about the fiscal management of the program. Our prior work has shown that CMS continues to face challenges overseeing the Medicaid program.

GAO was asked to testify on CMS's oversight of Medicaid. GAO's testimony is based on prior work conducted from June 1993 through December 2011 related to CMS's oversight of (1) states' rate setting methodologies for certain managed care arrangements, particularly the requirements that rates be actuarially sound; (2) supplemental payments, which are payments made to certain providers that are separate from and in addition to standard Medicaid payments for services; and (3) program integrity, which focuses on ensuring that payments made are in the correct amount, to the correct provider, for an eligible beneficiary.

View GAO-12-674T. For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

What GAO Found

Oversight of managed care rate-setting has been inconsistent. In August 2010, GAO reported that the Centers for Medicare & Medicaid Services (CMS) had not ensured that all states were complying with the managed care actuarial soundness requirements that rates be developed in accordance with actuarial principles, appropriate for the population and services, and certified by actuaries. For example, GAO found significant gaps in CMS's oversight of 2 of the 26 states reviewed—CMS had not reviewed one state's rates in multiple years and had not completed a full review of another state's rates since the actuarial soundness requirements became effective. Variation in practices across CMS regional offices contributed to these gaps and other inconsistencies in the agency's oversight of states' rate setting. GAO's previous work also found that CMS's efforts to ensure the quality of the data used to set rates were generally limited to requiring assurances from states and health plans—efforts that did not provide the agency with enough information to ensure the quality of the data used. With limited information on data quality, CMS cannot ensure that states' managed care rates are appropriate, which places billions of federal and state dollars at risk for misspending. GAO made recommendations to improve CMS's oversight.

Oversight of supplemental payments needs improvement. GAO has reported on varied financing arrangements involving supplemental payments—disproportionate share hospital (DSH) payments states are required to make to certain hospitals, and other non-DSH supplemental payments—that increase federal funding without a commensurate increase in state funding. GAO's work has found that while a variety of federal legislative and CMS actions have helped curb inappropriate financing arrangements, gaps in oversight remain. For example, while there are federal requirements designed to improve transparency and accountability for state DSH payments, similar requirements are not in place for non-DSH supplemental payments, which may be increasing. From 2006 to 2010, state-reported non-DSH supplemental payments increased from $6.3 billion to $14 billion; however, according to CMS officials, reporting was likely incomplete. GAO made numerous recommendations aimed at improving oversight of supplemental payments.

Challenges exist related to CMS's role ensuring program integrity. In December 2011, GAO testified that the key challenge CMS faced in implementing the statutorily established federal Medicaid Integrity Program was ensuring effective coordination to avoid duplicating state program integrity efforts, particularly in the area of auditing provider claims. GAO found that overpayments identified by its audit contractors since fiscal year 2009 were not commensurate with its contractors' costs, and CMS reported in 2011 that it was redesigning its audit program to achieve better results. Data limitations may have hampered the contractors' ability to identify improper claims beyond what states had already identified. With regard to CMS's other core oversight activities—annual assessments and triennial comprehensive state program integrity reviews—GAO found that much of the information collected from the annual assessments duplicated information collected during triennial reviews. Finally, CMS's Medicaid Integrity Institute, a national training program, appears to promote effective state coordination and collaboration.

Chairmen Gowdy and Jordan, Ranking Members Davis and Kucinich, and Members of the Subcommittees:

I am pleased to be here today as you explore oversight of Medicaid—a joint federal-state program that in 2010 financed health care for about 67 million people. Given the size and complexity of this $401 billion program, the federal government and its state partners continue to face challenges finding the proper balance between states' flexibility to administer their Medicaid programs and the shared federal-state responsibility to manage program finances efficiently and economically. Ensuring the program's long-term sustainability is critical as Medicaid plays a crucial and growing role in providing health care coverage for a variety of vulnerable populations, including certain low-income children, families, and individuals who are aged or disabled.

Medicaid is jointly funded by the federal and state governments. At the federal level, the Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS), is responsible for overseeing the design and operations of states' Medicaid programs, while the states administer their respective programs' day-to-day operations. Within broad federal requirements, states have some flexibility in deciding the range of medical services to provide, which individuals to cover, and the amount to pay providers. The federal government matches state expenditures for most Medicaid services using the Federal Medical Assistance Percentage, a statutory formula that is based, in part, on each state's per capita income.[1]

The shared financing arrangement between the federal government and the states, however, presents challenges for program oversight and requires sustained vigilance on the part of CMS and the Congress. Our prior work has shown that CMS continues to face challenges overseeing the fiscal management of the Medicaid program. Because of concerns about the program's fiscal management, size, growth, and diversity, Medicaid has been on GAO's list of high-risk programs since 2003.[2]

[1]Under this statutory formula, the federal government's share of Medicaid expenditures can range from 50 to 83 percent.

[2]See GAO, *High-Risk Series: An Update*, GAO-11-278 (Washington, D. C.: Feb. 2011).

You asked GAO to testify today on our previous work related to CMS's oversight of the Medicaid program. My remarks will focus on our findings related to CMS's oversight of the following three areas of the Medicaid program:

1. states' rate-setting methodologies for capitated managed care arrangements, particularly the statutory and regulatory requirements that rates be actuarially sound;[3]

2. supplemental payments, which are payments made to certain providers that are separate from and in addition to standard Medicaid payments for services; and

3. program integrity, which focuses on ensuring that payments made are in the correct amount, to the correct provider, for an eligible beneficiary.

My testimony is based on our previous work assessing federal oversight of Medicaid managed care rate-setting, and supplemental payment arrangements, as well as our work assessing CMS's program integrity activities. We conducted this body of work from June 1993 through December 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives.

Background

The federal government and the states share responsibilities for financing and administering Medicaid. As a result of flexibility in the program's design, Medicaid consists of 56 distinct state-based programs.[4] The challenges inherent in overseeing a program of Medicaid's size and diversity make the program vulnerable to inappropriate program spending. CMS is responsible for overseeing state Medicaid programs. For example, CMS is responsible for ensuring that states' capitated managed care payments meet actuarial soundness requirements, that supplemental payments are appropriate, and for supporting and

[3]See 42 U.S.C. § 1396b(m)(2)(A)(iii), 42 C.F.R. 438.6(c).

[4]The 56 Medicaid programs include 1 for each of the 50 states, the District of Columbia, Puerto Rico, Samoa, Guam, the Commonwealth of the Northern Mariana Islands, and the United States Virgin Islands.

overseeing state program integrity activities—activities intended to address Medicaid fraud, waste, and abuse.[5]

Managed Care Rate Setting and Actuarial Soundness

Managed care is a significant component of the Medicaid program, with nearly half of all Medicaid enrollees—approximately 20.7 million individuals—enrolled in capitated managed care in 2008.[6] In 2007, there was a total of over $62 billion in federal and state spending for managed care. Under managed care, states use capitation payments to prospectively pay health plans to provide or arrange for services for Medicaid enrollees. Such capitation payments are required by federal law to be actuarially sound.[7] CMS regulations, first issued in 2002, define actuarially sound rates as those that are (1) developed in accordance with generally accepted actuarial principles and practices, (2) appropriate for the populations to be covered and the services to be furnished, and (3) certified as meeting applicable regulatory requirements by qualified actuaries.[8] In order to receive federal funds for their managed care programs, states must submit documentation to CMS regional offices for review, including a description of their rate-setting methodology and data used to set rates. This review, completed by CMS regional office staff, is designed to ensure that a state complies with the regulatory requirements for setting actuarially sound rates.

[5]Fraud involves an intentional act or representation to deceive with the knowledge that the action or representation could result in gain. Waste results from clerical errors or the provision of medically unnecessary services. Abuse typically involves actions that are inconsistent with acceptable business and medical practices that result in unnecessary program costs.

[6]Throughout this report, the term managed care refers only to capitated managed care arrangements, which are arrangements through which a health plan is prospectively paid a fixed monthly rate per enrollee to provide or arrange for most health services. States may also have primary care case management (PCCM) programs under which a primary care provider is paid a nominal monthly, per person, case management fee to coordinate care for beneficiaries, in addition to fee-for-service (FFS) reimbursement for any health care services they provide. While some consider PCCM programs to be managed care, we consider those programs to be FFS-based arrangements because participating providers are predominately paid on a FFS basis.

[7]See 42 U.S.C. § 1396b(m)(2)(A)(iii).

[8]See 42 CFR §438.6(c)(1)(i).

Supplemental Payments

Most state Medicaid programs make supplemental payments to certain providers in addition to the standard payments states make to these providers for Medicaid services. For purposes of this testimony, we have grouped supplemental payments into two broad categories: (1) Disproportionate Share Hospital (DSH) payments, which states are required to make to hospitals that treat large numbers of low-income uninsured people and Medicaid patients;[9] and (2) non-DSH supplemental payments, which are not required by statute or regulation. In fiscal year 2010, states made more than $31 billion in supplemental payments; the federal share was more than $19 billion. CMS is responsible for overseeing these payment arrangements to ensure the propriety of expenditures for which states seek federal reimbursement, including whether states were appropriately financing their share.

Program Integrity

Program integrity activities are designed to prevent, or detect and recover, improper payments throughout the Medicaid program. The Deficit Reduction Act of 2005 expanded CMS's role regarding Medicaid program integrity, establishing the Medicaid Integrity Program to provide effective federal support and assistance to states to combat fraud, waste, and abuse.[10] CMS's core program integrity activities include:

- National Provider Audit Program—a program through which separate CMS contractors analyze claims data to identify aberrant claims and potential billing vulnerabilities, and conduct postpayment audits based on data analysis leads in order to identify overpayments to Medicaid providers.
- Comprehensive program integrity reviews—comprehensive management reviews that are conducted every 3 years to assess the effectiveness of each state's program integrity efforts and determine whether the state's policies and procedures comply with federal law and regulations.

[9]See 42 U.S.C. §§ 1396a(13)(A)(iv), 1396r-4. States' DSH programs are subject to limits on overall annual federal expenditures, on the amount of DSH payments a state may make, and on the DSH payments individual hospitals may receive.

[10]See Pub. L. No. 109-171, § 6034, 120 Stat. 4, 74-78 (2006).

- State program integrity assessments—annual assessments in which CMS collects data on state Medicaid integrity activities—including program integrity staffing and expenditures, audits, fraud referrals, and recoveries—for the purposes of program evaluation and technical assistance support.

CMS also provides training and technical assistance to states. For example, CMS's Medicaid Integrity Institute is the first national Medicaid integrity training program and offers state officials training and opportunities to develop relationships with program integrity staff from other states.

CMS's Oversight of Managed Care Rate Setting Was Inconsistent and Did Not Ensure the Quality of the Data Used to Set Rates

We found that CMS had not ensured that all states were complying with the actuarial soundness requirements and did not have sufficient efforts in place to ensure that states were using reliable data to set managed care rates.[11] Specifically, in August 2010, we reported that there were significant gaps in CMS's oversight of 2 of the 26 states included in our review.

- First, CMS had not reviewed one state's rate setting for multiple years and only determined that the state was not in compliance with the requirements through the course of our work.
- Second, at the time of our work, CMS had not completed a full review of a second state's rate setting since the actuarial soundness requirements became effective in August 2002, and therefore may have provided federal funds for managed care rates that were not in compliance with all of the requirements.

In addition to these gaps in oversight, we found inconsistencies in the reviews CMS completed. For example, the extent to which CMS ensured state compliance with some of the actuarial soundness requirements was unclear because CMS officials did not always document their review or cite evidence of the state's compliance. When officials did cite evidence, the evidence did not always appear to meet the actuarial soundness requirements. Variation in practices across CMS regional offices contributed to these gaps and other inconsistencies in the agency's

[11]See GAO, *Medicaid Managed Care: CMS's Oversight of States' Rate Setting Needs Improvement*, GAO-10-810 (Washington D.C.: Aug. 4, 2010).

oversight of states' rate setting. For example, regional offices varied in the extent to which they tracked state compliance with the actuarial soundness requirements, their interpretations of how extensive a review of a state's rate setting was needed, and their determinations regarding sufficient evidence for meeting the actuarial soundness requirements.

We also reported in 2010 that CMS's efforts to ensure the quality of the data used to set rates were generally limited to requiring assurances from states and health plans—efforts that did not provide the agency with enough information to ensure the quality of the data used. CMS regulations require states to describe the data used as the basis for rates and provide assurances from their actuaries that the data were appropriate for rate setting. The regulations do not include requirements for the type, amount, or age of the data used to set rates, and states are not required to report to CMS on the quality of the data. When reviewing states' descriptions of the data used to set rates, CMS officials focused primarily on the appropriateness of the data rather than their reliability. Additionally, we found that actuarial certification does not ensure that the data used to set rates are reliable. In particular, our review of rate-setting documentation found that some actuaries' certifications included a disclaimer that if the data used were incomplete or inaccurate then the rates would need to be revised. Furthermore, some actuaries noted that they did not audit or independently verify the data and relied on the state or health plans to ensure that the data were accurate and complete. With limited information on data quality, CMS cannot ensure that states' managed care rates are appropriate, which places billions of federal and state dollars at risk for misspending. States and other sources have information on the quality of data used for rate setting—information that CMS could obtain. In addition, CMS could conduct or require periodic audits of data used to set rates; CMS is required to conduct such audits for the Medicare managed care program.

CMS took a number of steps that may address some of the variation that contributed to inconsistent oversight, such as requiring regional office officials to use a detailed checklist when reviewing states' rate setting; use of the checklist had previously been optional. However, we found variations in CMS oversight even when the checklist was used. Thus, to improve oversight of states' Medicaid managed care rate setting, we recommended that CMS (1) implement a mechanism for tracking state compliance, including tracking the effective dates of approved rates; (2) clarify guidance for CMS officials on conducting rate-setting reviews, such as identifying what evidence is sufficient to demonstrate state compliance with the actuarial soundness requirements, and how officials

should document their reviews; and (3) make use of information on data quality in overseeing states' rate setting. HHS agreed with these recommendations, and as of June 2011, CMS officials indicated they were investigating ways to create an easily accessible database to help them more closely monitor the status of rate-setting approvals, reviewing and updating its guidance, and looking into incorporating information about data quality into its review and approval of Medicaid managed care rates.

CMS Oversight of Medicaid Supplemental Payments Needs Improvement

In our prior work, we have reported on varied financing arrangements involving supplemental payments that shifted costs from the states to the federal government. In some cases, the providers did not retain the full amount of the payments as some states required providers to return most, or all, of the supplemental payment to the state. Our work found that while a variety of federal legislative and CMS actions have helped curb inappropriate financing arrangements, gaps in oversight remain. Because such financing arrangements effectively increased the federal Medicaid share, they could compromise the fiscal integrity of Medicaid's federal and state partnership.

Our most recent reports on supplemental payments underscore these gaps in federal oversight. In May 2008, we reported that CMS had not reviewed all supplemental payment arrangements to ensure that these payments were appropriate and used for Medicaid purposes.[12] In November 2009, we found that ongoing federal oversight of supplemental payments was warranted, in part, because two of the four states reviewed did not comply with federal requirements to account for all Medicaid

[12]See GAO, *Medicaid: CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments,* GAO-08-614 (Washington D.C.: May 30, 2008).

payments when calculating DSH payment limits for uncompensated hospital care.[13]

Recently implemented requirements have the potential to improve oversight of some supplemental payments, but concerns about other payments remain.[14] For example, there are now improved transparency and accountability requirements in place for DSH payments. However, these requirements are not in place for non-DSH supplemental payments, which may be increasing. Specifically, in 2006, states reported making $6.3 billion in non-DSH supplemental Medicaid payments, of which the federal share was $3.7 billion, but not all states were reporting their payments. By 2010, this amount had grown to $14 billion, with a federal share of $9.6 billion. However, according to CMS officials, states' reporting of non-DSH supplemental payments was likely incomplete.

As a result of our prior work, we have made numerous recommendations aimed at improving federal oversight of supplemental payments. Some key recommendations we made have not been implemented by CMS. We have recommended that CMS adopt transparency requirements for non-DSH supplemental payments and develop a strategy to ensure all state supplemental payment arrangements have been reviewed by CMS. CMS has taken some action to address some of these recommendations but we continue to believe additional action is warranted. CMS has raised concern that congressional action may be necessary to fully address our concerns. Additionally, given continued concerns associated with Medicaid supplemental payments, we have work under way related to states' reporting and CMS's oversight of DSH and non-DSH supplemental payments.

[13]See GAO, *Medicaid: Ongoing Federal Oversight of Payments to Offset Uncompensated Hospital Care Costs Is Warranted,* GAO-10-69 (Washington D.C.: Nov. 20, 2009). Federal Medicaid law caps the amount of DSH supplemental payments a state may pay to an individual hospital each fiscal year. DSH supplemental payments cannot exceed the unreimbursed cost of furnishing hospital services to Medicaid beneficiaries and the uninsured. In determining a hospital's unreimbursed costs, states must offset costs with all Medicaid payments received by the hospital. See 42 U.S.C. § 1396r-4(g). Thus, other Medicaid payments—including all supplemental payments—count against a hospital's DSH cap.

[14]See the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 1001(d), 117 Stat. 2066, 2430-2431 (2003) (codified, as amended, at 42 U.S.C. § 1395r-4(j)) and Medicaid Program, Disproportionate Share Hospital Payments, Final Rule, 73 Fed. Reg. 77,904 (Dec. 19, 2008).

CMS's Expanded Role in Ensuring Medicaid Program Integrity Presents Challenges to and Opportunities for Assisting States

In December 2011, we testified that the key challenge CMS faced in implementing the statutorily established federal Medicaid Integrity Program was ensuring effective coordination to avoid duplicating state program integrity efforts, particularly in the area of auditing provider claims.[15] At the outset of the Medicaid Integrity Program, CMS stressed the need for effective coordination and acknowledged the potential for duplication with states' ongoing efforts to identify Medicaid overpayments.

However, the National Provider Audit Program results—the largest component of the Medicaid Integrity Program—call into question the effectiveness of CMS's communication, and its ability to avoid duplication with state audit programs. After examining CMS's program expenditures, we found that overpayments identified by its audit contractors since fiscal year 2009 were not commensurate with its contractors' costs. From fiscal years 2009 through 2011, CMS authorized 1,663 provider audits in 44 states. However, CMS's reported return on investment from these audits was negative. While its contractors identified $15.2 million in overpayments in fiscal year 2010, the combined cost of the National Provider Audit Program was about $36 million. In addition, CMS reported in 2011 that it was redesigning the National Provider Audit Program to achieve better results. Data limitations—in particular, the use of summary data that states submit to CMS on a quarterly basis—may have hampered the contractors' ability to identify improper claims beyond what states already identified. It remains to be seen, however, whether CMS's redesign of the National Provider Audit Program will result in an increase in identified overpayments.

CMS's other core oversight activities—triennial comprehensive state program integrity reviews and annual assessments—are broad in scope and were conceived to provide a basis for the development of appropriate technical assistance. However, we found that much of the information collected from the annual assessments duplicated information collected during triennial reviews. Further, our review of a sample of assessments revealed missing data and a few implausible measures, such as one state reporting over 38 million managed care enrollees. Improved data collection activities and dialogue with states will help CMS ensure that it

[15]See GAO, *Medicaid Program Integrity: Expanded Federal Role Presents Challenges to and Opportunities for Assisting States*, GAO-12-288T (Washington, D.C.: Dec. 7, 2011).

has complete and reliable state information on which to direct its training and technical assistance resources appropriately.

Finally, we found that the Medicaid Integrity Institute appears to promote effective state coordination and collaboration. We reported that states have uniformly praised the institute and a special June 2011 session brought together Medicaid program integrity officials and representatives of Medicaid Fraud Control Units—independent state units responsible for investigating and prosecuting Medicaid fraud—in 39 states to improve working relations between these important partners.

As we testified in December 2011, CMS's expanded role in ensuring Medicaid program integrity has presented both challenges to and opportunities for assisting states with their activities to ensure proper payments. We have ongoing work reviewing CMS's Medicaid program integrity activities that will provide additional information about CMS's oversight efforts in this area.

Chairmen Gowdy and Jordan, this concludes by prepared statement. I would be happy to answer any questions that you or other Members may have.

GAO Contact and Staff Acknowledgments

For further information about this statement, please contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Michelle B. Rosenberg, Assistant Director; Eagan Kemp; Drew Long; Peter Mangano; Christina Ritchie; and Hemi Tewarson were key contributors to this statement.

Appendix I: Abbreviations

CMS	Centers for Medicare & Medicaid Services
DSH	Disproportionate Share Hospital
FFS	fee-for-service
HHS	Department of Health and Human Services
PCCM	primary care case management

Related GAO Products

Medicaid Program Integrity: Expanded Federal Role Presents Challenges to and Opportunities for Assisting States. GAO-12-288T. Washington, D.C.: December 7, 2011.

Fraud Detection Systems: Additional Actions Needed to Support Program Integrity Efforts at Centers for Medicare and Medicaid Services. GAO-11-822T. Washington, D.C.: July 12, 2011.

Fraud Detection Systems: Centers for Medicare and Medicaid Services Needs to Ensure More Widespread Use. GAO-11-475. Washington, D.C.: June 30, 2011.

Improper Payments: Recent Efforts to Address Improper Payments and Remaining Challenges. GAO-11-575T. Washington, D.C.: April 15, 2011.

Medicare and Medicaid Fraud, Waste, and Abuse: Effective Implementation of Recent Laws and Agency Actions Could Help Reduce Improper Payments. GAO-11-409T. Washington, D.C.: March 9, 2011.

Opportunities to Reduce Potential Duplication in Government Programs, Save Tax Dollars, and Enhance Revenue. GAO-11-318SP. Washington, D.C.: March 1, 2011.

High-Risk Series: An Update. GAO-11-278. Washington, D.C.: February 2011.

Medicaid Managed Care: CMS's Oversight of States' Rate Setting Needs Improvement. GAO-10-810. Washington D.C.: August 4, 2010.

Medicaid: Ongoing Federal Oversight of Payments to Offset Uncompensated Hospital Care Costs Is Warranted. GAO-10-69. Washington D.C.: November 20, 2009.

Medicaid: Fraud and Abuse Related to Controlled Substances Identified in Selected States. GAO-09-1004T. Washington, D.C.: September 30, 2009.

Medicaid: Fraud and Abuse Related to Controlled Substances Identified in Selected States. GAO-09-957. Washington, D.C.: September 9, 2009.

Improper Payments: Progress Made but Challenges Remain in Estimating and Reducing Improper Payments. GAO-09-628T. Washington, D.C.: April 22, 2009.

Medicaid: CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments. GAO-08-614. Washington D.C.: May 30, 2008.

Medicaid Financing: Long-standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight. GAO-08-650T. Washington D.C.: April 3, 2008.

Medicaid Demonstration Waivers: Recent HHS Approvals Continue to Raise Cost and Oversight Concerns. GAO-08-87. Washington, D.C.: January 31, 2008.

Medicaid Financing: Long-standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight. GAO-08-255T. Washington D.C.: November 1, 2007.

Medicaid Financing: Federal Oversight Initiative Is Consistent with Medicaid Payment Principles but Needs Greater Transparency. GAO-07-214. Washington D.C.: March 30, 2007.

Medicaid Financial Management: Steps Taken to Improve Federal Oversight but Other Actions Needed to Sustain Efforts. GAO-06-705. Washington D.C.: June 22, 2006.

Medicaid Integrity: Implementation of New Program Provides Opportunities for Federal Leadership to Combat Fraud, Waste, and Abuse. GAO-06-578T. Washington, D.C.: March 28, 2006.

Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight. GAO-05-748. Washington, D.C.: June 28, 2005.

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

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

Medicaid: State Efforts to Control Improper Payments. GAO-01-662. Washington, D.C.: June 7, 2001.

Mr. JORDAN. Thank you. Thank all the witnesses.

I will now yield five minutes to the Chairman of the Subcommittee, the gentleman from South Carolina, Mr. Gowdy.

Mr. GOWDY. Thank you, Chairman Jordan.

Director Mann, since 9:30 this morning we have learned, in that whopping less than three hours, that there is an expert witness who will testify that perhaps as many as 90 percent of the cases in Texas were outside the guidelines. We have providers who were certifying otherwise in writing. You have before and after pictures. You have photographs of providers who were advertising free braces. So it would not be tough, I don't suspect, to send an investigator to these free braces clinics to find out what percentage of patients they actually denied, as opposed to accepted. You have no study showing any hirer rate of malocclusion in Texas than any other State.

So, with that bevy of evidence, what has CMS done about the Texas orthodontia scandal?

Ms. MANN. Well, several things that I would like to note. First, there is an HHS Office of Inspector General is conducting an investigation now, as well as the Department of Justice. They are deeply involved and actually just made an announcement about some agreement——

Mr. GOWDY. Have you talked to the attorney general recently about this case to get an update on its status?

Ms. MANN. I have not talked to the attorney general recently.

Mr. GOWDY. Have you talked to the United States attorney and the appropriate district in Texas to get an update on the status of the case?

Ms. MANN. Yes. We have been in touch with the Office of Inspector General. Our regional office has been in touch with them and I have been in daily, well, regular contact, I should say, with the State Medicaid director and with the commissioner——

Mr. GOWDY. Have any orthodontists lost their license to practice medicine?

Ms. MANN. I don't know that. You asked that earlier and I thought that was an important question, and I have sought the answer to that. We don't oversee that, but I don't know the question. I do know that the orthodontists, if they have bilked the Medicaid program, not properly billed the Medicaid program, they should be terminated not just from that Medicaid program, but from any Medicaid program across the Country.

Mr. GOWDY. Which would be debarment, right? That is the phrase we use, debarred.

Ms. MANN. Well, our jurisdiction is to terminate them form participating in the program. We don't honestly control——

Mr. GOWDY. How about to disgorge them of the profits? Has there been any attempt at restitution or disgorgement of the profits?

Ms. MANN. My understanding—you will have to talk to the Department of Justice, we can get you that information, but my understanding is, at least as to the corporation for whom they worked, some of them, that is part of it. Certainly from our point of view—again, we are not the law enforcement arm——

Mr. GOWDY. I understand that. That is why——

Ms. MANN. From our point of view——

Mr. GOWDY. That is why I haven't asked you who has gone to jail. But you do have a role in getting restitution, do you not?

Ms. MANN. That is exactly right. And we will——

Mr. GOWDY. So all I can ask you about—I will just ask you how much money you have collected in restitution.

Ms. MANN. We are looking at which claims were improperly paid and we will defer all those claims and any that were improper——

Mr. GOWDY. How long do you think that will take? Because it just doesn't strike me as being that difficult of a case, to be honest with you.

Ms. MANN. Generally, when the Department of Justice is involved in an investigation, we usually wait until their investigation is complete so that we don't get in the way, but we will defer the claims pending the investigation.

Mr. GOWDY. So you are going to insist that restitution be part of any criminal settlement with any of these orthodontists or corporations?

Ms. MANN. I can't comment on what will happen with respect to the criminal actions——

Mr. GOWDY. But you are going to ask for it?

Ms. MANN. I can commit that our authority is, and we will, defer and disallow any claims that were improperly paid.

Mr. GOWDY. All right, Commissioner Jesson, do you know a Christopher Ricker?

Ms. JESSON. Mr. Chair, that name sounds familiar, but I don't know who it is.

Mr. GOWDY. Well, I don't either, but this is what he wrote in an email: We do not want to give any appearances that the money might be coming to DHS, parenthetically, it bolsters our argument with CMS that this wasn't a provider return and, therefore, doesn't need to be shared with them. I guess them being CMS, which may go to why you want to have telephone calls as opposed to emails.

So I will ask you why your preference for telephone calls and not emails.

Ms. JESSON. Mr. Chair, actually, that email was talking—if you look at the whole chain of them, about two things. One of them, I was correcting a draft press release, and that was where I said it should be a donation. But it was also in my emails——

Mr. GOWDY. Well, let me ask you about that. The context of it is in order to have a good chance of keeping all this money, it must be characterized as a donation. It doesn't read in order to keep the reader of our press release from getting the misapprehension, it must be corrected, it clearly is calculated to be able to keep all the money, agreed?

Ms. JESSON. Mr. Chair, UCare, when they came to tell me about this call to the donation, I was trying to characterize it the same way they characterized it to me——

Mr. GOWDY. Well, if it were just to correct a press release, why would you say, if a refund, Feds clearly get half? Why wouldn't you say we just have to get the press release right?

Ms. JESSON. Mr. Chair, there is, as you know, a difference between a bona fide donation, which I believe this was, and a return of money, and I was trying to make that clear.

Mr. GOWDY. Is there a strict policy on emailing press releases? Is that why you asked for telephone calls instead of emails?

Ms. JESSON. No, Mr. Chair. Actually, the reference to telephone calls was going back to an earlier part of that email where we were talking about informing the chairs of the legislative committees——

Mr. GOWDY. You certainly can understand how it might read otherwise, can't you, Commissioner?

Ms. JESSON. If you only read that portion of the email chain and not the entire one, I understand that.

Mr. GOWDY. Well, what I am reading is in order to have a good chance of keeping all this money, it must be characterized as a donation; not that it must be a donation, it must be characterized as a donation. If a refund, Feds clearly get half. Can you work with Scott on redrafting? Also, I thought we were going to handle this through phone calls. Surely you can see how a casual reader might get the impression that this was calculated to keep the full $30 million, and not to correct some press release, can't you?

Ms. JESSON. What I was doing, Mr. Chair, was what I think my job calls for when someone makes a donation, and I think have a good faith basis that it is a donation.

Mr. GOWDY. Do you have a lot of people making $30 million donations?

Ms. JESSON. That is a really good point, sir.

Mr. GOWDY. So how many $30 million—if it is a good point, what is a good answer? How many $30 million donations did you have that you sent emails to make sure they were characterized correctly?

Ms. JESSON. Congressman, I think that is an excellent point, because this was a very unique situation, and one which we didn't have a play book for, where there wasn't a clear answer. We took one position; CMS took another. And I am glad we are able to resolve this by basically——

Mr. GOWDY. Well, I don't know that we have resolved it. The only thing that has been resolved to me is that there is a perverse incentive to keep as much of other people's money as you possibly can, even if it means re-characterizing something. That is the impression I got.

Mr. Chairman, I am out of time.

Mr. JORDAN. I thank the gentleman for his important question.

Before going to the Ranking Member, Mr. Kucinich, let me just ask you, Director Mann, when did you first learn about the situation in Texas? Was it through the media, through the press accounts?

Ms. MANN. It was——

Mr. JORDAN. After it had become public knowledge, is that when you first learned about it?

Ms. MANN. After it had become public knowledge——

Mr. JORDAN. What about the situation in Minnesota, when did you first learn about the——

Ms. MANN. Through the commissioner also of Texas; we talked about the problem.

Mr. JORDAN. After it had become public. What about the situation in Minnesota, when did you first learn about that, was it after

it had become public knowledge through the efforts of Mr. Feinwachs and others?

Ms. MANN. Yes, after it had become public knowledge.

Mr. JORDAN. How many people work at Health and Human Services?

Ms. MANN. I don't have that number off the top of my head, but I would be happy to give you——

Mr. JORDAN. I think it is 65,000 is what I have been told. How many people work at CMS?

Ms. MANN. A little over 300.

Mr. JORDAN. So of that 65,000 folks, 300 folks at CMS, do you have anyone who—I mean, it would seem to me someone would be watching particularly the Texas situation, where you have one State doing more of this than the rest of the Country combined, and yet the first time you found out about it is when the press broke a story on it?

Ms. MANN. Chairman, we do not pay claims directly; we——

Mr. JORDAN. Do you have anyone who does oversight at HHS?

Ms. MANN. The State pays claims and then we would look and see what happens to those claims and whether those claims are legitimate claims. There were $200 million, as I understand it, in orthodontia claims in an account of about $2 billion spent for dental care that was rising. It should have been detected; it was clearly an outlier claim. The State did not, in its surveillance of outlier claims, did not specifically look at the coding for orthodontia claims. It expected——

Mr. JORDAN. So it was the State's problem?

Ms. MANN. It is certainly in the first——

Mr. JORDAN. It was their fault that it wasn't recognized and no fault rests with CMS, even though we just heard from Director Yocom, who had all kinds of concerns about what goes on at CMS and how you fail to audit, how you——

Ms. MANN. I think we have joint responsibility. What I am saying is that in the first instance——

Mr. JORDAN. It sounded like what you were saying is you were blaming Texas.

Ms. MANN. I am saying we have joint responsibility. In the first instance the State had——

Mr. JORDAN. You have 65,000 employees——

Ms. MANN. I don't have 65,000 employees.

Mr. JORDAN. Sixty-five thousand employees at HHS and you just said it was joint responsibility, even though you said Texas has the responsibility.

Ms. MANN. We have joint responsibility.

Mr. JORDAN. Okay. Sixty-five thousand employees and no one could see this? No one saw this coming? Until it was public, no one knew about it?

Ms. MANN. We did not know about it until it was revealed. We are working in many States and many States are doing predictive modeling, where you can track the expenditures on different codes and you would identify outliers. That was not done in this circumstance.

Mr. JORDAN. We will be generous for the time for the Ranking Member. We now recognize Mr. Kucinich from Ohio.

Mr. KUCINICH. Thank you very much, Mr. Chairman.

I want to follow up on a line of questioning that my friend, Mr. Gowdy, began of Commissioner Jesson.

Commissioner, until just the day before yesterday you maintained that the Federal Government was not entitled to any part of the $30 million UCare transfer, isn't that right?

Ms. JESSON. That is correct.

Mr. KUCINICH. Okay. Now, after CMS pursued this matter with you, you have apparently changed your mind and you intend to give the Federal Government its share of the UCare transfer. I have questions about how you got to the point of believing and acting to keep all of the UCare funds from Minnesota, when many believed at the time, and you now concede, that the funds needed to be divided with the Federal Government.

Now, you note in a letter to CMS a discussion of the donation announcement with Ms. Mann while you were attending a conference in Baltimore in March of 2011. Is it your testimony that you provided Ms. Mann with full information on the matter at that encounter and that Ms. Mann then gave you an approval of your intention to keep all the funds from Minnesota?

Ms. JESSON. No, Congressman, that is not what I am saying. I did—Nancy Feldman, who is CEO of UCare, came to my office and told me on March 14th that they were going to make this donation. I was in Baltimore on the 16th and 17th of that week; during that time I met with Cindy Mann and people from CMS, and it was more of a here is a heads-up; we are issuing a press release today about this donation.

Mr. KUCINICH. So when this discussion occurred, were you at a reception, was it a formal business meeting, were either present? Did you present a legal analysis? Help me understand this. How did that come up?

Ms. JESSON. This came up during, it was a scheduled meeting; we were there for what was called a pace car event and we were meeting with CMS about exchange-related matters about the health exchange. So there was a group of people from Minnesota and a group of people with CMS. It was not on the agenda of the meeting; I just said it to let her know what was going on. I have never said that she said that is fine. As a matter of fact, I believe when I said it I said something along the lines of——

Mr. KUCINICH. So you are saying now that you didn't believe that you had some form of approval from Ms. Mann, or indirectly from CMS, of your characterization of the funds as a donation solely to the State be placed in the Minnesota general fund, is that right?

Ms. JESSON. That is right.

Mr. KUCINICH. Where did you get the idea, then, that it was a donation? How did that come up?

Ms. JESSON. Congressman, it came up because UCare, when they came in, they said, we are making a donation to the State of Minnesota of $30 million from our reserves; and that was really just two days before I talked to Ms. Mann, and that was what I knew. I did look at the contracts myself to see did they owe us this money? They didn't owe us this money under the contract and we hadn't asked for the money. So from my perspective——

Mr. KUCINICH. They didn't owe you the money, you hadn't asked for it, but you wanted $30 million to go to the general fund of Minnesota. How does that happen? I don't understand.

Ms. JESSON. Congressman, what UCare told me when they came to meet with me was Minnesota had a historic budget deficit of $5.3 billion. They felt like they had the money available in the reserves; they made a donation. But, if I may, Congressman, I just want to be clear, as far as changing my mind. We believed we had a bona fide donation, and there are disagreements——

Mr. KUCINICH. But what is a bona fide donation? I don't understand that. I mean, the rule is you would have to give half to the Federal Government. Now, in fact, as early as July 2011, according to what we have, Ms. Mann began to question you, asking you for your justification in keeping the entirety of the UCare transfer for Minnesota. Now, to me, that doesn't seem consistent with this notion that somehow CMS had known, signed off. Help us with this. Help us understand this.

Ms. JESSON. Congressman, we took the position that it was a donation. CMS took the position that it was a refund and had to be shared with the Federal Government. After we got the donation, we provided additional information to CMS. We have differences with CMS over large amounts of money often. Sometimes if we don't——

Mr. KUCINICH. Really? Such as what? Give me another example of a difference you have with CMS on a large amount of money, and are you withholding that money from CMS?

Ms. MCCOLLUM. Mr. Chair, if the Commissioner could finish the thought, please.

Mr. KUCINICH. Excuse me. The gentlelady from Minnesota, I have a line of questioning here which is important for the work of this Committee, and I would ask the gentlelady to suspend.

Would you answer the question, please?

Ms. JESSON. Congressman, it is frequent that we will have disagreements where there are unique situations, which this was, or ambiguity in interpretations. For example, just a couple of examples, in 2006 CMS disallowed over $19 million in the Federal match regarding a supplemental payment to nursing homes. We disagreed about that; we couldn't resolve it. We went to the appeals board and that board found in favor of the State. In 2008 there was a disagreement about $8 million in Federal funds, which we, once again, went to the appeals board and the appeals board came down somewhere in the middle between the Feds and the State.

These are discussions that frequently happen. What I am happy about here is that we were able to, because of the one percent cap, resolve this, I think, appropriately with CMS.

Mr. KUCINICH. So there was nothing unusual about the kind of exchange where the State claims $30 million as a donation, you go back to CMS and you work it out, is that what you are saying?

Ms. JESSON. A $30 million donation, Congressman, is certainly unusual.

Mr. KUCINICH. Well, this is why we are here to discuss it. I think it is unusual, but I am just trying to find out how it happened and I am still not sure.

I just would like to conclude, Mr. Chairman, and say that based on the testimony that is presented here and other information given to the Subcommittee, I think that the chronology of events went like this: the commissioner or the State claimed all $30 million of a transfer from a Minnesota Medicaid managed care organization; the Federal Center for Medicare and Medicaid Services questioned the justification for claiming the entire amount for the State, rather than returning to the Federal Government its share of the transfer; and ultimately you, Commissioner, reversed yourself and you are now returning about $15 million to the Federal Government.

Now, I am not saying that you did any wrong, perhaps you thought you were doing the right thing; somebody else is going to have to determine that. But I think in this instance the Federal Center for Medicare and Medicaid Services did something right, and it is important to go over the sequence to sustain that view.

So I thank the gentleman for his indulgence with time here.

Mr. GOWDY. [Presiding.] I thank the gentleman from Ohio.

The Chair would now recognize the gentleman from Illinois, Mr. Davis.

Mr. DAVIS. Thank you very much, Mr. Chairman.

Commissioner Jesson, let me just ask you did you seek a legal opinion relative to the status of the contribution?

Ms. JESSON. Congressman, after we got the July letter from CMS taking the position that this was not a donation, I did seek a legal opinion about this.

Mr. DAVIS. This was afterwards that you sought it.

Ms. JESSON. After we got the July letter, but it was still before we actually received the donation, Congressman.

Mr. DAVIS. Let me just say that I think there has obviously been some mistake in judgment in terms of this whole matter. But I also want to indicate that I have been looking at Minnesota for a long time in terms of its health care, and there is a great deal that is right with Minnesota. It has been a model for efficiency as a result of this tremendous nonprofit health care system efficiency that I have observed. But I would like to hear about improving the contracting operation. Can you speak to us about the competitive bidding process now and what it is that you have done to improve that?

Ms. JESSON. Thank you, Congressman. Actually just a month and two weeks after I started in the governor's budget, Governor Dayton proposed competitive bidding for really half an area that included half of our Medicaid enrollees, and the reason we did that is because, as I said earlier, we had serious questions about the excess money that the health plans were making and we really wanted to reset and get the best rate we could, but also looking at quality.

So what we did was issued an RFP, request for proposals, for all the health plans to bid on our Medicaid population by county. They had to give us both the cost bids, but also, importantly, include a lot of quality information. And when we sat back to judge those bids, we judged them half on their quality and half on their cost, and after doing that we ended up reducing the number of health plans that served most of the counties. So we took the best bids

and we reduced the projected cost to the State and the Federal Government for those plans by I think it was almost 7 percent and saved over $300 million just on the competitive bidding.

But then what we did was we took what we learned about the fact that obviously these rates could be a lot lower than people had thought in the past, a lot lower.

Mr. DAVIS. So you recouped $73 million this year and you have shared that with the Federal Government?

Ms. JESSON. Correct.

Mr. DAVIS. Can I ask why were the UCare funds of 2011 initially handled differently?

Ms. JESSON. Congressman, they were initially handled differently because we were told and believed it was a donation. But once we looked at the one percent cap, we realized that if UCare hadn't made that donation, then they would be paying back $38 million, instead of just $8 million, to the State and Federal Government. So we thought it was only fair to share that $30 million with the Federal Government, as well as the $73 million, as well as the over $600 million that we have saved in our managed care reforms.

Mr. DAVIS. So this transaction came as a result of prior contractual relationships under the former administration?

Ms. JESSON. Yes, Congressman, the one percent cap did because we inherited the contracts. We thought they were too generous, so we negotiated a cap with the health plans.

Mr. DAVIS. Did you have the feeling that there had been any cross-subsidizing of Minnesota's program by improperly inflating the Medicaid costs?

Ms. JESSON. The program, General Assistance Medical Care, that is being accused of—it is a State-funded program, so the allegation, as I understand it, is they were paying more for Medicaid to pay less for the State-funded program. That program is no longer in existence when I started as commissioner, so I didn't work at the department, so I do not have firsthand knowledge of whether that happened; and actually, Congressman, when I started, I brought in a whole new team in this part of the department because I thought we needed to change direction.

But I will say I very clearly thought that the State of Minnesota and the Federal Government were paying too much money under our Medicaid contracts. That is why I put them out for competitive bids.

Mr. DAVIS. Thank you very much.

Director Mann, can I ask you if there is a separate office of CMS responsible for fighting fraud?

Ms. MANN. Yes, there is. Also, let me try and be clear on my answer on numbers before. CMS itself has 4500 full-time employees; Medicaid office, which I oversee, has about 350; and we have the Center for Program Integrity, Congressman, about 150 people. They are primarily responsible for fraud, but really it is—I would certainly, as the director of the program itself, see it as also good strong financial management as my responsibility, as well as the Center for Program Integrity.

Mr. DAVIS. So you have 150 people fighting fraud. That is for the entire Country?

Ms. MANN. Well, that is for the Center for Program Integrity, that is actually Medicare and Medicaid.

Mr. DAVIS. Yes.

Ms. MANN. There are about 60 within that for Medicaid.

Mr. DAVIS. Thank you very much.

And thank you, Mr. Chairman. I yield back.

Mr. GOWDY. I thank the gentleman.

The Chair would now recognize the gentleman from Texas, Mr. Burgess.

Mr. BURGESS. I thank the Chairman for the recognition and again appreciate the opportunity to be here with you. Obviously, I am on another committee, but this issue is so important that I wanted to participate today.

Ms. Mann, we have heard three specific cases here today, every one of which is startling in and of its own right, but tell us what you are doing and going to do at CMS to prevent this from happening and to deal with the issues that have already occurred.

Ms. MANN. Well, in terms of the issues that have already occurred, there are investigations going on in all three situations. Actually, reports have already been issued in the New York case and investigations going on in both Minnesota and Texas by the HHS Office of Inspector General and the Department of Justice involved.

To the extent that we determine that there are questions about any particular expenditures, we defer those expenditures; we won't pay until there has been full resolution, and then we disallow if we do not feel that there is justification for paying for those——

Mr. BURGESS. How many payments have you disallowed so far in Texas on dental procedures?

Ms. MANN. We have not taken the disallowance yet; it is still within the regional office to consider the disallowance.

Mr. BURGESS. So these clinics are still being paid?

Ms. MANN. I believe the State has moved forward and the clinics are not being paid. So I don't think the problem is continuing. The State has taken a number of different steps to change their process; they had a prior authorization, a company that did prior authorization to review those claims. That company should have screened out and not allowed the kind of claims that went in. They obviously didn't do their job.

The State has changed that contract. The State has also changed its method of payment for orthodontia services so you weren't getting the situation where, if you came in 22 times, you got paid 22 times, but has moved to a global payment.

So there have been a number of changes that the State itself has made to stop the problem going forward, but we still need to see what claims were paid that should not have been paid.

Mr. BURGESS. Well, I certainly appreciate the work that the State is doing and of their understanding of the fact that they had a problem. But you had a problem.

Ms. MANN. Correct.

Mr. BURGESS. And I guess my interest at the Federal level is what is being done right now to correct that problem and to prevent it from happening again.

Ms. MANN. Well, what we first do is make sure that the problem stops going forward. So that is an important part——

Mr. BURGESS. So the State guys are doing that.

Ms. MANN. State does that in consultation with us, but yes. That was our first line of——

Mr. BURGESS. Forgive me, but it just seems like there was a big failure at whoever was in charge of oversight, the OIG. This is OIG 101. Mr. Gowdy pointed out that his 15-year-old daughter could have probably picked up the problem here. This was not obscure. There is plenty of fraud that is obscure, but this was not; it was out in the open for all to see. And we talk about audits and we talk about actuarial soundness, but really that never came into play, did it? All we got were assurances that, hey, we are okay; we are doing everything the right way, and the checks continued to go out. That is a massive failing on the part of the Federal partners who were responsible for providing those funds.

Ms. MANN. We do do audits of State Medicaid programs. We do look at outlier claims of State Medicaid programs. We do not do audits of every single claim in every State.

Mr. BURGESS. Why wouldn't these have, then, come to the top of the radar screen? I mean, they seem pretty obvious.

Ms. MANN. Because they were not separately coded. What was growing overall was the dental account in Texas because of major changes that the State did in its dental account. These were basically hidden claims within that. So neither we nor the State identified them as an outlier. We do that in many instances. It is a lesson learned in terms of how to break out certain codes and make sure we are all examining those codes in a very particular way.

Mr. BURGESS. I will be the first to admit that Texas used to be its own country and in many ways we behaved that way. But here you had Texas charging or paying more than the rest of the Country combined. Seems like that had to get someone's attention at some level, because that is just such a stark difference. I mean, Texas was paying more than Florida. Texas was paying more than California.

Ms. MANN. And the problem, which is a lesson learned in terms of moving forward, is that it was not pulled out as a separate code, but inside the broader dental claiming, and so neither Texas nor CMS identified it in a timely way as to something that we should all look at.

Mr. BURGESS. Two years ago the president identified McAllen, Texas, as an outlier with Medicare spending and criticized the State because of that. And this was happening right under your noses and no one said anything about it. Where was the integrity at the Office of Inspector General? Consequently, why has the Department of Justice been so slow to get involved in this?

I respect the fact that a lot of the problems were State specific, but you had a duty, you had an obligation as well, as the steward of these funds, that were going out. I mean, here you have the dentists testifying that there were recruitment activities going on at a pizza parlor to get patients to be inappropriately referred, to have procedures they might not have needed on children. I mean, that should be assault and battery. People should be going to jail for this, not just we are looking into it and we hope to have some better answers for you in the future.

I am stunned by the revelations that we have had today. You have spent enormous money and press time focusing on a public hospital in Dallas, Texas, and this was happening right under your nose. You criticized the hospital because it wasn't following procedures, because it wasn't doing things correctly, and your own procedures aren't being followed. I mean, this is a classic case of take care of your own problems first, before you start criticizing someone else. This is an enormous problem. We are not, obviously, anywhere near the end of it, and I am just so grateful to the Committee for initiating this. I promise you that this will continue to get my full attention in my office and at our Committee. We have to do right by the taxpayers. We have to do right by the people who have, in fact, been harmed by these activities.

Mr. Chairman, you have been indulgent. I will yield back the balance of my time.

Mr. GOWDY. I thank the gentleman from Texas.

The Chair will now recognize the gentlelady from Minnesota, Ms. McCollum.

Ms. MCCOLLUM. Thank you.

Commissioner, this was an unusual thing to have UCare come and say we would like to give you $30 million, and it was a contribution. There is Federal money that goes into Medicare disbursements and there is State taxpayers' money. So I am glad you had a discussion with CMS. And as a resident of Minnesota and as a person who looks after the Federal purse strings, I think we have come to a good conclusion with that. So thank you to everyone for their work on that. But I don't think we are going to see many donations coming forward again in the future.

Could I maybe shift this a little bit to CMS and to GAO while we have them here? And I am going to combine two questions and then just ask your professional opinion.

The Affordable Care Act, which was just passed into law, will streamline Medicaid eligibility as part of the health exchanges. It is going to standardize quality measurements for adults; it is going to provide new tools to provide fraud, waste, and abuse. So if you could maybe tell me a little bit about how you two can see, and, Commissioner, if you have anything to add, how these tools included in the Affordable Care Act, will improve State and Federal oversight in the Medicaid program.

And then to GAO specifically, has GAO ever looked at the differences between for-profit and nonprofit health plans in respect to fiscal management and quality outcomes within Medicare managed programs?

And then to GAO—this also goes to CMS—150 employees. Every Medicare contract is different between it is different between the two States, they are constantly being renewed and refreshed, so can you provide me maybe a little more information about the challenges that you have? Maybe some of the successes that you can identify in CMS's Medicaid Integrity Institute, especially as it relates to States investigating and prosecuting Medicaid fraud? Or perhaps this is grossly understaffed, grossly staffed so that we can't do the very things that I agree with Chairman Gowdy on, we need to be handing things over for prosecution. A hundred and fifty em-

ployees for 50 States, all the contracts different and constantly changing.

And I yield my time to you to have a discussion.

Ms. MANN. Well, thank you, Congresswoman. Let me just respond to the first part of your question about what the Affordable Care Act does in terms of providing some new tools. Let me identify a few of them that I think are really directly relevant to some of the issues we have discussed here. First, it requires that every State have a RAC program to look at fraud and have modeled after the Medicare program, which has been successful in terms of bringing in a rate of return that is effective now. States are implementing that requirement as of January 2012 and it allows payments of basically dollars for collections identified by the contractors. So it is an encouragement for States to move forward and a new method for them to identify and pursue improper payments.

Secondly, we have a new provider enrollment requirements in the Affordable Care Act that assure that if a provider has been terminated, for example, in Texas, for improperly billing in the Texas program, that they can't start billing in Oklahoma; that we have set up a system so that States know about terminations from one State to another, as well as from Medicare to Medicaid, so that if we have problems in South Florida in the Medicare program, the Medicaid program in Florida or elsewhere also takes action to ensure that that provider is no longer participating in the program.

We also have, in the Affordable Care Act, an emphasis on program analytics to be able to detect fraud, improper payments before it occurs. That is certainly all of our goal; not just to detect it afterwards and get repayment, but to avoid it going forward.

Ms. MCCOLLUM. Thank you. I have about 42 seconds left for GAO. And all that oversight disappears with repeal of the Affordable Care Act.

If GAO would like to comment

Ms. YOCOM. To my knowledge, we have not done work that has looked specifically at profit versus nonprofit, so I can get that question out quickly.

With regard to the Medicaid Integrity Institute, some of the promising practices that we have heard from States is really just a chance to be educated on ways to detect improper payments, ways to recover, ways to analyze; and that has been an extreme benefit. State Medicaid programs are widely varied in size and in support, so having a Federal role to provide instruction and oversight has been helpful.

Lastly, I want to underscore something that Director Mann said, which is being able to look across States. That capability is quite limited right now in the Medicaid program and it needs to be developed. Until this program has good data and strong data that allows for comparisons that can be more easily done, we won't be successful in combating improper payments and other types of fraud.

Mr. GOWDY. I thank the gentlelady from Minnesota.

I want to follow up on something the gentlelady from Minnesota made reference to. I think she said that we would not be having anymore donations in the future. My question is a little different,

which is how many had you had in the past. How many $30 million donations from corporations had you had in the past?

Ms. JESSON. Mr. Chair, this is the only one I am aware of.

Mr. GOWDY. So there is only one, and we are left to conclude that it was either donated out of the beneficence of the corporate heart, which isn't that likely, or maybe there is another alternative explanation, which leads me to ask this: Was there a letter that accompanied that check or was it just a check in the mail? Did they offer any explanation in writing as to why they may make a $30 million donation?

Ms. JESSON. Mr. Chair, there was a letter from the CEO in July, I believe, she sent to the State of Minnesota. The check actually we received in November.

Mr. GOWDY. And what was the explanation that the giver of the donation actually gave?

Ms. JESSON. That it was just that, a donation to help the State during this budget crisis.

Mr. GOWDY. Right. Is there any evidence that perhaps UCare had been overpaid in any way by the State of Minnesota?

Ms. JESSON. Mr. Chair, as I said, I believed that the contracts that had been negotiated during the previous administration were too generous. I don't think they were overpaid in the sense that those were not actuarially sound contracts——

Mr. GOWDY. So there is no evidence that UCare was overpaid and that maybe a State health plan may have underpaid.

Ms. JESSON. Mr. Chair, I think the evidence would say that those contracts were actuarially sound and approved by CMS, so I don't think there was an overpayment. But I do understand that the health plans historically have said—this is, once again, before I was commissioner—that they lost money on the State-funded program.

Mr. GOWDY. So they lost money on the State. Okay. Well, can you understand at all the cynicism of maybe questioning the motive behind the corporate heart making a once in a lifetime $30 million donation?

Ms. JESSON. Mr.——

Mr. GOWDY. Am I the only one that has any amount of cynicism about that?

Ms. JESSON. Mr. Chair, I was certainly surprised when they came into my office to tell me about the donation; it was highly unusual.

Mr. GOWDY. Director Yocom, do you have any experience with the beneficence of the corporate heart making a $30 million donation simply because a State was unable to manage its finances appropriately?

Ms. YOCOM. No, sir, I don't.

Mr. GOWDY. Do you happen to have a copy of the letter that accompanied the $30 million donation?

Ms. JESSON. Mr. Chair, I don't have a copy of the letter here. As I said, I know that there was a letter in July and we got the donation in November.

Mr. GOWDY. And is there any chance that letter referenced overpayments?

Ms. JESSON. I——

Mr. GOWDY. Actually, I think there is a really good chance that letter referenced overpayments. I think there may be like a 100 percent chance it referenced it. So given the fact that the donation was for overpayments, why would there be any argument that CMS wasn't entitled to half of it?

Ms. JESSON. Mr. Chair, they characterized it as a donation. They were not—under the contract, they were not required to——

Mr. GOWDY. Well, I mean, it doesn't——

Ms. JESSON.—pay it back to us.

Mr. GOWDY. Does it really matter what you call something? I mean, I could call the check I just had to write the IRS a donation. It is not a donation. I mean, come on, it is $30 million. No corporation is ever going to give a State $30 million out of the benevolence of their shareholders' hearts.

Ms. JESSON. Mr. Chair, it's a nonprofit corporation. I thought it was very generous. I acknowledge there are reasonable positions on both sides of that——

Mr. GOWDY. Well, would you acknowledge that it may very well have been because they had been overpaid systematically? Isn't that a little better explanation than beneficence?

Ms. JESSON. Mr. Chair, I believe they were paid according to the terms of the contract——

Mr. GOWDY. Well, then why would they——

Ms. JESSON.—but I believe those contracts were too generous.

Mr. GOWDY. Why would they say they were overpaid?

Ms. JESSON. You would have to ask UCare about why they phrased it that way. They told me it was a donation. They weren't required to make it.

Mr. GOWDY. Okay.

The gentleman from Minnesota.

Mr. ELLISON. Thank you, Mr. Chairman.

Commissioner Jesson, could you talk a little bit about what Minnesota has done in the Dayton administration to try to be more efficient and to give greater value to the taxpayer vis-a-vis the Medicaid program?

Ms. JESSON. Certainly, Congressman Ellison. I spoke earlier about competitive bidding and really trying to get better value and recovering a lot of money for the taxpayers through that, and the 1 percent cap where we, in addition to the $600 million through our managed care reforms, about $73 million through the 1 percent cap, there are some additional things that go beyond just money, but that we believe will save money as well, that we are doing in Minnesota.

You mentioned one of them, our Hennepin health projects. That is where we are contracting with Hennepin County on a capitated basis to serve some of the poorest people who make less than $8,000 a year, those who use a lot of our social services. We just started that in January, just one year after the governor took office, but preliminarily we believe they will better serve those folks and save money, because we are actually integrating social services with our health care.

We are starting health care demonstration projects, where we will, by the end of the year, we hope, have contracts with nine different provider groups, where we are directly contracting with pro-

viders, changing the incentives once again so that they share any savings that they get, as long as they meet our quality measures. And those are providers that are agreeing to care for populations, kind of Medicaid ACOs, all around our State, very different types of populations. We believe there is a lot to learn from what we are doing.

Mr. ELLISON. Now, earlier on, one witness, when I asked him, do you agree that Minnesota's move to competitive bidding is beneficial, that witness's response was no. It was a pretty flat no. I guess my question is do you agree with that? And do you think that the competitive bidding process can be improved even more by maybe even allowing more bidders? I think the witness said that it was limited to the four HMOs. I think I got that right. So could it be improved if there were more bidders and allowed access to the program?

Ms. JESSON. Congressman, I think that the competitive bidding was a success. It was a success for quality care. I know it was clearly a success for taxpayers.

Mr. ELLISON. Five hundred million dollars, right?

Ms. JESSON. Yes. But I think we can improve it, and we are going to be expanding it. We are expanding it into Greater Minnesota, where there is enough competition, and we are opening it up. Those who won the bids, and there were typically two in each county, were some of the major health plans, but we are opening this up. We want to increase competition because we think it is a good way to get better value for taxpayers.

Mr. ELLISON. Commissioner, I have a little less than two minutes. I was hoping to get your impression on this question. I believe that the witness that I was referring to, Mr. Feinwachs, and I do want to thank him for being a vigilant steward of the public dollar; we want to encourage people to step up. But I am trying to understand this, so I just want to get your opinion. He pointed out in his testimony that a 2008 report by Minnesota's legislative auditor found the State's payment rates to be high compared to other States. What do you think about that? Are we doing better? Are they high? Are they getting lower? Could you comment on that?

Ms. JESSON. Congressman, I agree, actually, with what the legislative auditor said in that report, which is that Minnesota's rates are higher, but they are probably higher because we cover more people with disabilities in Minnesota than in many other States, and that is more expensive; and we also cover a lot more benefits. That is a choice our legislature in Minnesota has made, to have broader coverage, and that is, I think, a major reason that it is more expensive.

Mr. ELLISON. Okay.

I yield back, Mr. Chair.

Mr. GOWDY. The gentleman from Minnesota yields back.

On behalf of all of us, we want to thank our panel of witnesses for taking time out of their busy schedules to appear before us. We look forward to seeing you again soon, either at this Committee or another.

With that, the Committee stands adjourned.

[Whereupon, at 12:49 p.m., the subcommittee was adjourned.]

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COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

2157 RAYBURN HOUSE OFFICE BUILDING

WASHINGTON, DC 20515–6143

MAJORITY (202) 225-5074
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Statement of Dennis J. Kucinich, Ranking Member
Subcommittee on Regulatory Affairs,
Stimulus Oversight and Government Spending

Joint Hearing on
"Is Government Adequately Protecting Taxpayers from Medicaid Fraud?"

April 25, 2012

Thank you, Chairman Jordan and Chairman Gowdy, for holding this hearing today. According to Harvard University scholar Malcolm Sparrow, the health care industry's complexity and volume of automated health care payments presents a "business opportunity" to "a few bad actors, suitably placed, [to] steal hundreds of millions of dollars" from Medicare and Medicaid. The Government Accountability Office estimates that in 2010, Medicaid and Medicare made about $70 billion in improper payments. Improper payments include overpayments, underpayments and fraudulent payments.

Fortunately, the Center on Medicare and Medicaid Services under Director Cindy Mann, and the U.S. Department of Justice, are taking the threat of health care fraud very seriously. CMS has moved quickly and aggressively to stand-up its office of Medicaid Program Integrity, utilize high speed computing and data analysis to identify patterns of fraudulent billing in real time, and adapt to Medicaid successful anti-fraud initiatives developed to deal with Medicare. The Department of Justice has increased health care fraud prosecutions since FY 2008 by nearly 75%. In Fiscal Year 2011, DOJ and the Department of Health and Human Services recovered a record $4.1 billion from health care fraud judgments and settlements. Almost $600 million of that came from Medicaid anti-fraud efforts. The Affordable Care Act made a significant contribution to federal anti-fraud efforts, both in terms of increased resources and authority to enhance oversight and screening measures, clarifying law enforcement access to claims and payment data, and expanding key anti-fraud programs to Medicaid, among other things.

But federal anti-fraud efforts face a number of threats. At this moment, the U.S. Supreme Court is considering striking down the Affordable Care Act. If they do, aggressive federal anti-fraud activities authorized and financed by the Act will be compromised. The House Republican budget also targeted the Affordable Care Act, calling for its repeal and banking on cuts of $106 billion in new Medicaid spending created by the law. The budget also would change the

financing of Medicaid to block grants, which would leave the states to manage all aspects of Medicaid, including the bulk of anti-fraud efforts.

As one health care fraud expert testified to the Senate last year, "Health care fraud is an exceptionally complex crime… The perpetrators of this crime have proven themselves to be creative, nimble and aggressive. Therefore, investing in and employing the most effective fraud prevention and detection techniques is critical to achieving success." That level of investment can only come from the Federal government. Today, Federal Medicaid, the Inspector General for the Department of Health and Human Services and Justice Department prosecutors are mounting anti-fraud efforts with more success than ever before. Yet, the House Republican budget and the U.S. Supreme Court pose grave threats to their continued existence and development.

Contact: Ashley Etienne, Communications Director, (202) 226-5181.

David Feinwachs
ATTORNEY AND COUNSELOR AT LAW
2227 University Ave.
St. Paul, Minnesota 55114

651-265-7884 telephone
651-646-1389 fax

May 14, 2012

The Honorable Trey Gowdy
Chairman
Subcommittee on Health Care,
District of Columbia, Census
And the National Archives

The Honorable Jim Jordan
Chairman
Subcommittee on Regulatory
Affairs, Stimulus Oversight and
Government Spending

Dear Chairmen Gowdy and Jordan:

Thank you for the privilege of presenting testimony before the Committee on Oversight and Government Reform on April 25, 2012 at the hearing entitled "Is Government Adequately Protecting Taxpayers from Medicaid Fraud?"

Pursuant to the direction Chairman Issa I am submitting my responses to the additional questions you have posed to me in correspondence dated May 2, 2012.

If any additional information is required or if there remain unanswered questions please contact me and I will do my best to provide additional answers or clarification. Once again, accept my thanks. I consider it an honor to participate in our legislative process.

Respectfully submitted,

David Feinwachs, M.H.A., M.A., J.D., Ph.D.

1. **Who certified Minnesota's Medicaid managed care rates to the federal government?**

There appears to be no simple answer to this question.

On Feb 8, 2011, in testimony to the Minnesota House Health and Human Service Finance Committee, (1:15:00 Audio File http://ww2.house.leg.state.mn.us/audio/mp3ls87/healthfin020811.mp3) Ms. Karen Peed, then Director of Managed Care Contracting for the Minnesota Department of Human Services (DHS), said that the information which DHS receives for the setting of rates is attested to by the Chief Financial Officer (CFO) of each HMO vendor health plan which submits data.

Ms. Peed then went on to explain that it is the state's consulting actuary, Milliman, who sets and ``certifies the rates" to the federal government. On August 30, 2011, Ms. Peed in a sworn deposition stated that the state of Minnesota contracts with Milliman to set the rates which are certified to the federal government (Peed deposition pages 58-62).

If one examines any specimens of the Milliman Rate Certification letters you will notice that Milliman disclaims any and all responsibility for the accuracy and veracity of the data which it receives from the managed care organizations. Milliman and the American Academy of Actuaries have repeatedly stated it is not the job of the actuary to do any of the following:

1. Determine whether data or other info supplied by others are false or intentionally misleading;
2. Develop additional data compilations solely for the purpose of searching for questionable or inconsistent data; or
3. Audit the data (correspondence from the American Academy of Actuaries to Ms. Camille Dobson CMS Jan 14 2011, pg. 6). http://www.actuary.org/pdf/health/American_Academy_of_Actuaries_Letter_on_Rate_Setting_Checklist_to_CMS.pdf

The managed care vendors contend that rate setting is entirely the responsibility of the state and its consulting actuary and that they have no involvement or culpability. This argument was advanced on the record by attorneys for the HMOs in Ramsey County District Court on October 11, 2011 in the case of *David Feinwachs VS Minnesota Council of Health Plans, Blue Cross Blue Shield of Minnesota, Health Partners Inc. and UCare,* No. 62-CV-11-910.

Therefore, it appears that there is general agreement that the consulting actuary "certifies" the Medicaid rates to the Federal Government, but disclaims any and all obligations as to the integrity of the underlying data; rather, they rely totally on summary and trend information from the HMOs. This brings us full circle. No one ever audits or examines the integrity of the data provided to CMS. This appears to include CMS.

This situation is made even more perilous because we now know that Minnesota does not prohibit the state's consulting actuary from consulting with the HMO venders. Thus, one must ask: Does the state's actuary have a role in the preparation of HMO information for which they disclaim any and all

responsibility? How is this potential conflict of interest addressed in the Medicaid rate certification process?

2. Why do you believe that Minnesota's manipulation of the Medicaid rate certification process would not be detected by CMS?

There are no actual independent audits of the data the HMOs give to the Minnesota Department of Human Services, and CMS had no awareness of the fraud scheme to subsidize state-only programs with Medicaid money.

In order to detect the manipulation of the Medicaid rate certification process CMS would have to determine whether data or other information supplied by the HMOs was false or intentionally misleading. CMS would have to engage in this determination by actually and truly auditing the data. CMS does neither of these things, because they believe that the state of Minnesota and/or its consulting actuary are responsible for these activities when in fact they are not and actually they have an incentive not to engage in these activities.

According to a report of the Department of Health and Human Services Office of Inspector General entitled Medicaid Managed Care Encounter Date: Collection and Use, dated May 2009, (OEI-07-06-00540) http://oig.hhs.gov/oei/reports/oei-07-06-00540.pdf , Minnesota does not use Medicaid managed care encounter data in the monitoring of program expenditures, (appendix D, page 21). Furthermore, Minnesota does not require that Medicaid managed care encounter data pass edit checks, (appendix B page 17). Without edit checks and the monitoring of program expenditures, and given the complete absence of independent, third party audits, CMS likely could never detect this manipulation of the rate certification process.

Finally, of critical importance, is the fact that this type of fraud is insidious and unique. For many years states have used financing schemes to inappropriately increase federal Medicaid matching payments. All of these schemes had certain factors in common. First these schemes involved states paying public providers (other government entities) amounts that well exceeded the cost of services provided. Then upon receipt of federal matching funds for these inflated payments, money was returned to state treasuries. All such schemes involved units of state and local government and were in fact, transparent because CMS could observe their occurrence and take action to prevent the further exploitation of these "loopholes" (http://www.gao.gov/new.items/d04574t.pdf).

The risk adjustment fraud which has come to light in Minnesota differs significantly from past Medicaid "loophole exploitation". This is not an arrangement between two units of government, but rather is collaboration between a state agency and private non-profit HMO corporations. Equally important in this fraud is that the money is not returned to the state treasury. The private corporations retain it.

CMS would never have discovered this fraud without routine independent third party audits unless, as is the case currently, someone explicitly brought it to their attention.

3. According to your investigation when did federal officials first become aware that the state was overpaying for Medicaid enrollees in order to cross subsidize state only health insurance plans?

I cannot answer this.

4. Why do you believe this cross subsidization has been occurring since 2003?

In November of 2003 the Minnesota Department of Human Services received a letter from the US Dept. of Health and Human Services Office of Inspector General. This document noted that Minnesota had included administrative costs and a profit factor for its state-funded, prepaid General Assistance Medical Care (GAMC) program in the actuarial rate calculations for the Medicaid program in both the years 2001 and 2002. This document also informed Minnesota that "this was contrary to federal cost principles and misstated the actuarial calculations available for future rate setting. "

The office of inspector general noted that Minnesota rates for the year 2000 did not include costs shifted from the GAMC program. Therefore, we know that there was no cost shift or manipulation in the year 2000, and we know that the attempted manipulation for the years 2001 and 2002 was detected and stopped, leaving the conclusion that the risk reserve manipulation has been in place continuously from 2003. (See letter to Commissioner Goodno 2003)
http://oig.hhs.gov/oas/reports/region5/50200056.pdf

5. According to your testimony Minnesota may have improperly billed federal taxpayers for over half a billion dollars during the period it was inflating Medicaid reimbursement rates. Please explain how you estimated this amount.

In 2011, UCare the smallest of the Minnesota's four predominant HMO venders returned $30 million to the state of Minnesota representing, according to UCare's own description, a refund of overpayment occasioned by the elimination of the GAMC program which had been subsidized with an inflated Medicaid rate. The GAMC program was eliminated midyear (June) 2010. The UCare return of overpayment represented a sixth month period for one year. It is unclear whether UCare's refund of overpayment included both state and federal money. Assuming UCare's refund included both state and federal money, and considering that this was a refund of overpayment of six months of year 2010, then logically, UCare's overpayment for the entire year 2010 would have been $60 million. Assuming the inflated Medicaid rate had been employed and in use since 2003, UCare's refund for the entire time period in question would have been $480 million ($60 million times 8 years). Assuming that this included both, state and federal money, the federal share would be one-half or $240 million.

This assumes UCare refunded only for itself and not for all the other HMOs. If Ucare refunded only on behalf of itself and the other HMOs are in fact eight times larger than UCare, the numbers change dramatically (upwards of $4 billion). Therefore, the half a billion dollar estimate is very conservative and favorable toward the HMOs and more than takes into account budget fluctuations over the time period in question. However, only a complete and thorough audit can determine the exact amount appropriate for UCare and the other HMOs. The critical question is: Is anyone doing or planning such an audit?

6. In your testimony you stated that the state's 1% cap on profits for the states nonprofit HMOs will not help remedy the problem in Minnesota's Medicaid program. Please explain.

In 2011, Governor Mark Dayton requested that Minnesota's other HMOs return money as Ucare had done. The other HMOs refused and at the suggestion of the HMOs Governor Dayton issued an executive order that capped 2011 profits for the HMOs at one percent. Any excess revenue would be returned to the state's general fund. There are no limits, and no disclosure of what health plans can charge off as administrative expense or overhead, so what is the accurate "profit" number? CMS and Minnesota's DHS really won't know. Plus, there is no way of determining if income is fairly and appropriately allocated among and between an HMO's public and private lines of business. In addition, the so-called cap is only in place for one year and, of course, there are no outside independent audits.

As Senator Sean Nienow (R-Cambridge) said, "The one percent cap is absolutely meaningless. On paper it looks good, it's something that makes everybody feel good but doesn't really do anything." Referring to the past relationships between the DHS commissioner and the Executive Director of the Minnesota Council of Health Plans, Senator Nienow also asked, "If friends are negotiating deals with other people's money, are we getting the best negotiation?".

The HMOs have stated that for the one year in question, 2011, that this cap applied, their average profit was approximately 1.5 percent. However, in prior years their profit on average was approximately 9%. What caused the sudden and precipitous change? Was it to limit the HMO liability under the negotiated 1% cap agreement? Did the HMOs manipulate their administrative expense to artificially lower the reported profit? No one knows.

Equally troubling is the fact that special legislation was enacted in 2011 in an apparent attempt to further manipulate the Medicaid rate certification process. The Special Session laws of 2011 had a provision that was enacted in July of 2011which stated the following:

Chapter 9 article 10
Sect. 13 Donations to State
A donation to the state from a health care organization to reduce the projected state budget deficit for the fiscal year 2012 - 2013 biennium shall qualify as an authorized expense from a health maintenance organization under Minnesota statute sect. 62D.12 subd. 9a clause 4 and shall be deposited in the general fund.

This would seem to indicate that the donation would be built into the Medicaid rate certification in subsequent years.

7. <u>During the course of your investigation have you obtained any information about whether this scheme to defraud taxpayers is going on in other states?</u>

I have attached a presentation made to the state of Florida on August 5, 2010 suggesting a manner of operation for their Medicaid program which bears a resemblance to what is occurring in Minnesota ("Florida Non Reform HMO Program" http://www.scribd.com/doc/92727363/Florida-HMO-Program). I direct your attention specifically to slide number 20 and the last bullet point which states, "Milliman did not audit the data but went through a validation and resubmission process with Mercer, the HMOs, and AHCA, relied on HMOs to provide accurate data as certified by the HMOs. (emphasis added)

One of the entities involved in the Florida scenario is of course Minnesota's consulting actuary. Minnesota's consulting actuary also consults with many other states regarding their Medicaid program as is noted in the GAO report of August 4, 2010.

8. <u>What recommendation do you have so federal policymakers can ensure that states don't misuse the federal Medicaid reimbursement by overpaying insurance companies for Medicaid enrollees and underpaying for state only health insurance plans?</u>

The answer to this question is best found in the correspondence of January 14, 2011 to Ms. Camille Dobson of CMS from the American Academy of Actuaries. The federal government must do what the state and its consulting actuary do not, that is federal policy makers must:

A. Determine whether data or other info supplied by HMOs is false or intentionally misleading;

B. Develop additional data compilations solely for the purpose of searching for questionable or inconsistent data; and

C. Independently audit and verify the data as an alternative to complete and blind reliance on the HMOs and state agencies.

This activity will be facilitated by the real time utilization of payment /claims and encounter data which could be employed by independent third party auditors and consulting actuaries to test the data and actuarial assumptions which are submitted to the federal government. As Minnesota's consulting actuary, Milliman has repeatedly stated in their rate certification letters, "No party should rely upon these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals."

Federal audit and intervention represents the only hope of effectively dealing with this Medicaid rate certification fraud. This fact is clearly demonstrated in the statutory language apparently crafted by the Minnesota Department of Human Services, and recently enacted, which creates independent third party audits commencing three years in the future and only applies such audits to managed care contracts occurring on or after January 1, 2014. Neither the legislative auditor not the independent third party auditor with which they contract will have statutory authority for any audits pertaining to activity which occurred before January 1, 2014. https://www.revisor.mn.gov/laws/?id=247&year=2012&type=0 (Chapter 247, H.F. No. 2294, Article 1, Section 14) Ironically, Minnesota's governor Mark Dayton signed this measure into law on April 27, 2012, two days after I provided testimony to the Committee on Oversight and Government reform.

LEVY, PHILLIPS & KONIGSBERG, LLP
ATTORNEYS AT LAW
800 THIRD AVENUE
NEW YORK, N.Y. 10022

(212) 605-6200
FAX: (212) 605-6290
E-MAIL: lpk@lpklaw.com

NEW JERSEY OFFICE
QUAKERBRIDGE EXECUTIVE CENTER
101 GROVERS MILL ROAD
LAWRENCEVILLE, NJ 08648
TELEPHONE: (609) 720-0400
FAX: (609) 720-0457

Writer's Direct E-Mail
tvitello@lpklaw.com

GOSHEN OFFICE
42 PARK PLACE
GOSHEN, NEW YORK 10924
TELEPHONE: (845) 294-2002

May 10, 2012

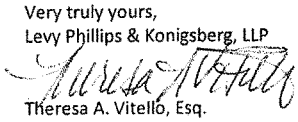
Via Electronic Mail & First Class Mail
Mr. Michael Bebeau
2157 Rayburn House Office Building
Washington, DC 20515

Dear Mr. Bebeau,

On behalf of Dr. Gabriel Feldman, we enclose his responses to the supplemental questions posed in connection with Chairman Issa's May 2nd letter.

Should you have any further questions, please do not hesitate to contact me.

Very truly yours,
Levy Phillips & Konigsberg, LLP



Theresa A. Vitello, Esq.

TAV/ag

cc: Gabriel Feldman, MD

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Hearing on "*Is Government Adequately Protecting Taxpayers from Medicaid Fraud?*"

Answers to Additional Questions Posed by Representatives Gowdy and Jordan
By Dr. Gabriel Ethan Feldman

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1. The term "Medicaid Industrial Complex," as used in my testimony, refers to the New York State Government, the healthcare providers and the unions essentially operating as one unified entity and making any enforcement and recovery actions largely unsuccessful.

   The following supports the existence of the "Medicaid Industrial Complex" in New York State:

   - New York State currently spends over $10,000 per year per client – a sum large enough to simply buy each recipient basic private medical, dental, vision and long term care insurance through Congress' FEHB own health insurance program.
   - New York State picks winner and losers regarding Medicaid funding – the elderly receive a disproportionately far higher share of funds than other groups.
   - About 70% of all the jobs offered by the 40 largest employers in New York City are in government or health care.
   - If Medicaid were a private company, it would be the state's single largest firm doing business solely in the State of New York.
   - About a third of all U.S. Medicaid home health care spending is spent in New York State.
   - Medicaid annual spending represents 40% of New York State's budget.
   - Medicaid generates tens of thousands of jobs including pharmaceutical revenues, durable medical equipment, graduate medical education fees, home health care aides and the largest spending on long term care services in the world.
   - Politicians, union leaders, advocacy groups constitute a "Big Healthcare" lobby that is one of the three most powerful lobbying groups in New York State.
   - Taxpayer advocacy groups are weak in New York State – if Medicaid benefits are threatened, advocacy groups file suit to stop any "cuts."
   - New York State long term care spending is approaching $25 billion a year, and its management in New York State has failed to ensure quality and efficient spending or resources since the 1970s because it is driven by extremely misguided reimbursement patterns, along with emotional and political factors that are not in concert with federal and state guidelines promoting appropriate and cost effective care

Hearing on "*Is Government Adequately Protecting Taxpayers from Medicaid Fraud?*"

Answers to Additional Questions Posed by Representatives Gowdy and Jordan
By Dr. Gabriel Ethan Feldman

2. In a response to a question posed by Congressman Jordan, I stated that I contacted federal officials and encouraged them to investigate problems in New York City's Medicaid program, but I was unsure as to whether there was any response.

   In providing this answer, I was referring to complaints that I made to federal officials outside of my False Claims Act lawsuit. Other contacts that I made outside of the legal complaint, included:

   - I did contact congressional and senate members and oversight committees over the last year, via confidential email, and they did follow up with this hearing, and I am very grateful.

   - I also wrote in the last year or so to Congresswoman Ann Marie Buerkle from New York about my concerns, but I have as of yet to have any substantial or direct contact with her.

   In my messages I let officials know that I believed that New York State's Medicaid program was likely to be the easiest target for fraud, waste and abuse in the country. I also mentioned that I believed that billions are being wasted or misspent in New York State because the current system of quality assurance, oversight, and rate setting was completely dysfunctional. I also raised questions about the way the current laws and DOJ treat Whistleblowers against municipalities.

   In that regard, I also strongly encouraged the federal DOJ attorneys I met with to take a more aggressive and formal approach in both New York State and New York City, and of course offered my assistance. I was told that a corporate integrity type agreement may be set in place to do so, however I have not been updated on whether this has been done, or whether increased resources would be committed, or if I would have any role. As the whistleblower who raised these concerns, I was hoping to be included on any negotiations, or policy formulation decisions at the state level regarding the revisions of the Personal Care Services regulations.

   Finally, I would like to note that whistleblowers against municipalities, as opposed to corporations, take on a greater risk, since speaking out may not just affect their jobs, but also their daily lives in the city in which they live. Perhaps, DOJ Policy could recognize these unique challenges by affording "Municipal Whistleblowers":

   - Expedited case review and better access to senior DOJ staff;
   - Earlier discussions with all parties regarding settlement before formal discovery and depositions;

   - Formal meeting with the Judge where all evidence substantiating the settlement size and potential damages is presented prior to the whistleblower being asked to approve the settlement.

Hearing on "*Is Government Adequately Protecting Taxpayers from Medicaid Fraud?*"

Answers to Additional Questions Posed by Representatives Gowdy and Jordan
By Dr. Gabriel Ethan Feldman

3. In my opinion, the following are the major obstacles that exist to properly overseeing how taxpayer money is spent through New York City's Medicaid program:

   - Basic lack of commitment to stewardship of public taxpayer dollars from the New York State Assembly, Office of Temporary and Disability Assistance's ("OTDA") ALJ system, New York State Department of Health and local officials. All are under great pressure to expand services and aid to programs since New York State prides itself on providing a very generous safety net. Also, long term care and skilled nursing facility reimbursements and benefits are set at dysfunctional levels.

   - There are insufficient resources and staff in the Inspector General's Office and in New York City's Human Resource Administration ("HRA"), devoted to enforcing fiscal discipline and fraud oversight in the system.

   - The New York State OTDA's ALJ system has never had an independent physician based outside audit. ALJs continue to harbor a blatant bias against the taxpayer, since there is no accountability to taxpayers or voters who fund the safety net.

   - Most Medicaid dollars are now spent on long term and custodial care – not on acute, primary or preventive care. No one wants to be taken to task by the public, by client families, politicians or advocacy groups, or to be seen as being mean, miserly, punitive or heartless regarding the disabled, the poor, children or seniors.

   - Lobbying and advocacy groups are often indifferent to expanding access to more people, and instead engage their immense resources in fighting for more resources to be redirected to their special interest or voting block groups.

   - Any effort to improve quality, effectiveness, and access to public entitlement programs by redirecting, privatizing, or increasing scrutiny of the way funds are spent is met with great outrage via media, news and TV ad blitzes.

   - "Sympathy-based overuse", "Robin Hood Syndrome" and out and out fraud likely make up 10-20% of all NY state health care spending billed to the taxpayer.

   - NYC culture dictates that more care is always better re health care, and the presumption is that whatever a patient or family demands is medically necessary.

   - Private physicians will often initiate a request for personal care services by signing off on a request form even if they have not seen the patient or the patient does not meet the medical criteria for the program. These physicians do this without fear of adverse consequence because there is little to no consequence for their misconduct.

- The general perception in New York City and HRA, in particular, is that Medicaid money is "New York City money" and is not derived from federal general funds or tax money.

4. The primary oversight mechanism I believe should be put in place to limit waste, fraud and abuse in the Medicaid home health program is to place the overall oversight function in the hands of the Attorney General's Office or the State Comptroller's Office. The Commissioner of the New York State Department of Health is presently appointed by the Governor. The Attorney General and Comptroller are separately elected officials. The New York State Department of Health has utterly failed in their oversight functions, thus I believe that functional oversight needs to be turned over to a separate state entity that will take on the role with the goal to root out waste, fraud and abuse.

   In addition, other oversight mechanisms that I believe should be put in place to limit the waste, fraud and abuse in the Medicaid home health program, include:

   - Direct Federal CMS or DOJ Takeover of the ALJ Fair Hearing appeals system in New York State for Personal Care Services and Managed Long Term Care. The current system has a proven bias as rates of appellant success vary wildly from upstate to downstate in New York.

   - Federal intervention in establishing new, more explicit, less burdensome New York State Personal Care Services Regulations, along with easing of technicalities in the regulatory demands of local districts at appeals hearings.

   - Federal Government should immediately issue an explicit directive or guidelines regarding cost effectiveness of home health care spending. There should be strict oversight of or the complete elimination of split-shift service to disoriented, non self-directing clients.

   - Federal takeover of reimbursement rates for nursing homes in New York State.

   - Federal mandate to demand more dedicated funds to identify fraud, ethics violations, physicians that sign forms without seeing the patient, kickbacks and moral hazard issues in managed care groups.

   - Federal mandate to move all clients personal care services to Managed Long Term Care by June 2014.

   - Put New York State on notice or probation. Any further violations, fraud and mismanagement may result in complete Federal takeover of Medicaid Long Term Care in New York State.

   - Independent audit of all New York home health care skilled nursing facilities, long term care and New York State OTDA ALJs.

- Each Managed Long Term Care program must have a full expert staff of community mental health professionals, including psychiatrists who are available and willing to make frequent home visits and to recommend brief admissions for behavioral issues or short term rehabilitation stays when appropriate.

- Each client should be graded on quality of life issues - MLTC clients with serious mental health or behavioral issues, paranoia, confusion, violence, endangering and wandering must be evaluated frequently and aggressively.

- MLTC clients must sign an agreement for a power of attorney or health proxy, and that admission for stabilization or rehabilitation may be mandatory at some point to continue in Medicaid MLTC.

5. Since the conclusion of my False Claims Act lawsuit, I have observed the following measures being taken by New York City and New York State to ensure proper compliance with federal and state regulations:

   - Average service hours to clients seems to have dropped drastically because of the new attention being paid to regulatory requirements.

   - Throughout the course of my lawsuit and since it has concluded, I have engaged in extensive informal discussions with senior staff at HRA. In addition, many senior staff have been removed and replaced.

   - Now, regular training and retraining of all nurses and physicians occurs with some regularity. In addition, all staff is now being actively trained to grasp that the program functions under state and federal regulations.

   - Explicit memos and written directives have replaced vague "case by case" basis policies that were not put in writing nor were a part of the regulations.

   - Case files are now being checked and re-checked by nursing supervisors and CASA directors are more accountable.

   - Assessments done for the eligibility of clients in the program is becoming more standardized and less is being left to the discretion of the individual conducting the evaluation.

Hearing on "*Is Government Adequately Protecting Taxpayers from Medicaid Fraud?*"

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6. While, I do not believe that the $70 million recovered in the lawsuit I filed is a fair representation of the total waste, fraud and abuse in New York City's personal care services program, the case settled by the U.S. Government did not encompass all of the waste, fraud and abuse in the program. The government's case dealt only with the 24 hour care aspect of the program and not the broader issue of initial eligibility, for example.

   Based on the circumstances, at the time the settlement was presented to me, I felt it was a strong step in the right direction. Moreover, the changes I have seen in the program since the settlement of my suit only prove to me that change is happening. Millions of dollars that would have been wasted in the future, had my case not been pursued, are now being saved because of the impact of my suit.

   However, I do believe that *before* a settlement is presented to a Relator for approval, there should be a formal hearing, before the Judge overseeing the case, in which the DOJ should have to explain the basis for the settlement and why it is fair, reasonable and adequate. Under the current procedures, the Relator is asked to agree that the settlement is fair based on somewhat limited information and if he/she is dissatisfied the explanation provided, the only option is make a formal objection in Court after an agreement in principal has already been reached between the parties. This puts the Relator in the awkward position of being a dissident and not someone who has worked and risked all along to get a maximum recovery and see justice done.

United States Government Accountability Office
Washington, DC 20548

May 15, 2012

The Honorable Trey Gowdy
Chairman
Subcommittee on Health Care, District of Columbia, Census and the National Archives
Committee on Oversight and Government Reform
House of Representatives

The Honorable Jim Jordan
Chairman
Subcommittee on Regulatory Affairs, Stimulus Oversight and Government Spending
Committee on Oversight and Government Reform
House of Representatives

It was a pleasure to appear before your Subcommittees on April 25, 2012, to discuss oversight of the Medicaid program. The attached enclosure provides responses to the two questions for the record you posed. If you or your staff have any additional questions related to this matter, please contact me at (202) 512-7114 or yocomc@gao.gov.

Carolyn L. Yocom
Director, Health Care

Enclosure

Questions for Director Cindy Mann
Center for Medicaid and Medicare Services

Rep. Trey Gowdy
Rep. Jim Jordan
Committee on Oversight and Government Reform

Hearing on "Is Government Adequately Protecting Taxpayers from Medicaid Fraud?"

General Questions on Medicaid oversight

Introduction for Questions 1-2:
In your testimony before the Committee, you stated "[W]e value in our investing in data and measurement to assess what is working, to rapidly adjust when things aren't working." One widely acknowledged and long-standing problem with Medicaid program oversight is that states cannot effectively use state Medicaid data for the purposes of detecting waste, fraud, and abuse.

1. **Can CMS effectively use state Medicaid data for the purposes of data mining? If so, what are the top five examples of CMS's use of state Medicaid data that has recovered money to the federal government since 2009?**

CMS currently is taking a multifaceted approach to more effectively use Medicaid data for data mining purposes. These initiatives include a 10-State pilot that is underway to develop and test a transformed Medicaid Statistical Information System (MSIS) data set. The goal of the pilot is to improve data for purposes of program operations, including data mining. This pilot is on track to be completed in the second half of 2012 and an evaluation will be conducted shortly thereafter to move our data initiative forward. Second, CMS is also redesigning its National Audit Program in its Medicaid Integrity Program. This redesign emphasizes the use of collaborative audits with States, whereby CMS works directly with the State, and the State's data, to conduct audits on specific providers. Thus far, collaborative audits have been successful and have resulted in a more effective use of State Medicaid data.
Examples of CMS' use of state Medicaid data to recover money to the Federal government include the Payment Error Rate Measurement Program (PERM); state expenditure report reviews; Medicaid Integrity Contractor Federal audits; and the Medicaid Integrity Contractor Federal-State collaborative audits. The newly formed state Recovery Audit Contractors (RACs) will also utilize Medicaid data for purposes of recovering overpayments and identifying underpayments.

2. **Are all states providing the electronic transmission of encounter data as required? If not, which states are not?**

Timely collection of reliable encounter data is a priority for CMS. Currently, many States do submit encounter data to CMS, but some do not, and some do not send all encounter data to CMS. To address this issue, emphasis on the reporting of encounter data along with FFS claims is included in the Transformed-MSIS (T-MSIS) project, and CMS validates the collection of encounter data through the 10-state pilot, which is the initial phase of the T-MSIS project. We plan to issue more detailed guidance on data submission for an expanded Fee-For-Service dataset and managed care encounter data in 2012 and to then proceed with a national implementation of the collection of the T-MSIS dataset by 2014. The T-MSIS project also includes implementation of automated tools and processes for assessing the quality of submitted data; this process will help to ensure that submitted encounter data consistently meets CMS requirements. CMS is also exploring the use of managed care contract approvals and terms and conditions for waivers to ensure encounter data submissions from States.
Five States do not report encounter data because they do not have managed care arrangements (AK, AR, NH, SD, WY). Four States (LA, ME, MS, MT) have limited managed care services (e.g. PCCM or transportation) and do not currently submit encounter data. Thirty-seven States are submitting encounter data with varying completeness. The remaining five States (ID, PA, WV, NC, SC) do have managed care arrangements but have not yet begun reporting any encounters and are at various stages of implementing system changes to report encounters to MSIS.

Introduction for Questions 3-5:
According to the GAO, as of 2004, 34 states-up from 10 states in 2002-used contingency-fee consultants for the purpose of maximizing federal money flowing into the state through the Medicaid program. GAO reports that "some claims from contingency-fee projects ... appear to be inconsistent with current CMS policy and some ... were inconsistent with federal law; [GAO] also found claims that undermined the fiscal integrity of the Medicaid program."

3. **Which states currently employ contingency-fee consultants in order to maximize federal money flowing into the state through the Medicaid program?**

CMS does not collect State by State information on contingency-fee contracts. As we've responded in the past to GAO States are not required to seek CMS approval for these contracts. However, we fully recognize that their use can be a factor associated with risk in the Medicaid program. When the use of such a contract raises concerns, we have the necessary tools through financial management review activities to question any associated expenditures..

4. **How much money do taxpayers spend each year for these contingency-fee consultants?**

See #3.

5. **Are you troubled that significant amount of taxpayer dollars are diverted through the Medicaid program to well-paid consultants?**

We fully recognize that the use of contingency-fee consultants can be a factor associated with risk in the Medicaid program. Through our existing expenditure review processes (including financial management reviews), State plan reviews and waiver reviews we actively work with States on their proposals which also includes conversations with their contractors to ensure allowability of Medicaid claims. Single State audits and OIG audits are also an important tool in monitoring the allowability of contractor costs and reasonableness of payments for services.

Questions 6-19 pertain to the problems in Minnesota's Medicaid managed care program

6. **Would it be an appropriate use of federal tax dollars if a state, which has contracted with an insurance company for both state-only health programs and Medicaid, was overpaying the-insurance company for people enrolled in Medicaid to cross-subsidize the state's underpayments for state-only health insurance programs?**

CMS does not consider overpayment of providers – whether managed care organizations, hospitals, dentists or any other category of Medicaid providers – to constitute an appropriate use of Federal funds, regardless of a State's intended purpose for doing so. Federal statute and regulations require that managed care organizations (MCOs) are paid capitated rates that are actuarially sound. CMS reviewed, for compliance with CMS regulations, the expert actuarial finding submitted by Minnesota in connection with its Medicaid managed care program. The CMS review focused on whether the rates the State proposed to pay the MCOs were actuarially sound as required by CMS regulations, and it was on this basis that the rates were approved by CMS.

There are no CMS regulations regarding how a health care provider, including an MCO, uses any reasonable profit or reasonable operating margin. CMS is currently conducting a comprehensive investigation regarding Minnesota's use of Federal match during the period of time that the state-only managed care program (GAMC) was in operation, including the rates that the State paid MCOs to operate the Medicaid line of business and the state-only program, respectively, the reserves that each plan accumulated in connection with these respective lines of business, and a comparison of the profits or losses that each plan experienced with respect to the state-only program versus the program serving Medicaid beneficiaries. If CMS determines that the rates paid during this period of time were not actuarially sound, we will determine, what, if any, impact that has on Federal funds claimed for this time period

7. **Is it legal for a state to use federal tax dollars in the manner described in Question #6?**

See response to Question #6 above.

Introduction for Question 8:
On March 15, 2011, Commissioner Jesson wrote an email concerning UCare's $30 million repayment to the state. Her email stated, "In order to have a good chance of keeping all this money, it must be characterized as a donation. If a refund, feds clearly get half. Can you work with Scott on redrafting? Also, I thought we were going to

handle this through phone calls."

8. **Are you troubled that the Commissioner of Minnesota's Department of Human Services was advising UCare on how to message the repayment?**

CMS questioned Minnesota characterization of the UCare contribution, and the State has ultimately agreed to return the associated Federal share of the contribution as an overpayment of Medicaid payments. CMS has been clear in our communications with the State that we presumed the UCare transaction as a refund of payments and thus should be treated as an applicable credit. On April 23, 2012 the State specified that it would return the Federal share of the $30 million and treat it as a refund of a Medicaid payment. Since then, the State has made the needed adjustment on its quarterly expenditure report to return the applicable Federal share.

9. **Has CMS contacted Minnesota's other three managed care companies- Blue Cross Blue Shield, Medica, and HealthPartners – about whether they will be making repayments to the state? If so, what has CMS learned? If not, please explain why CMS has not contacted the state's other three large managed care companies.**

CMS is currently conducting an inquiry focusing on whether the rates that Minnesota paid to the MCOs in the state were reasonably and appropriately considered actuarially sound, which is the standard against which managed care capitation payments are judged. CMS is in the process of analyzing data provided by Minnesota regarding the rates paid by the State to each of the MCOs for both the Medicaid managed care program, as well as GAMC, along with information regarding the plans' reserves and profits/losses during the period on these two lines of business. We will determine whether further information is needed from the health plans themselves. CMS does not interface directly with the MCOs that are contracting with a State; we work with and through the State.

Introduction for Questions 10-12:
In response to a question from Congressman Danny Davis, Commissioner Jesson stated that she "very clearly thought that the state of Minnesota and the federal government were paying too much under our Medicaid contracts."

10. **Do you share Commissioner Jesson's view that the federal government was paying too much under Minnesota's Medicaid managed care contracts?**

CMS' investigation into the rates, reserves and profits of the Minnesota MCOs is not yet complete, but CMS is committed to ensuring that rates paid to those plans during the period in question were actuarially sound and that Federal match was not claimed by Minnesota for improper rates.

11. **When did you first learn about the accusation that Minnesota was subsidizing state-only health insurance plans and possibly even commercial plans with federal dollars flowing through the Medicaid program?**

In March 2011 CMS' regional office team was contacted by our Office of General Counsel concerning a Federal investigation into UCare's return of $30 million to Minnesota.

12. Since you became aware of the accusation, what specific steps, in chronological order, has CMS taken to investigate the veracity of the accusation?

Upon learning of UCare's intent to make a contribution to the State of Minnesota, CMS questioned whether the payment derived from UCare's excess 2010 operating margins were related to Medicaid profits. UCare's official correspondence with the State indicated that the contribution would occur sometime after July 1, 2011. CMS promptly advised the State of the CMS position regarding the receipt of such contribution. On July 1, 2011, CMS issued a letter advising the State that any such contribution based on what we knew about the payments details described in the press and UCare's official correspondence would be considered a refund of Medicaid payments and as such, the applicable Federal share would have to be returned to the Federal Government. The State, in a letter dated February 17, 2012, informed CMS that it had received a contribution from UCare on November 1, 2011, and that the State would be reporting this contribution as a bona fide donation which would not require a return of Federal dollars.

After review of the State's response, CMS, in a letter dated March 21, 2012, requested further information from the State in order to better evaluate the transaction between UCare and Minnesota. CMS and the State held a face-to-face meeting on March 27, 2012, to discuss this issue as well as their overall approach to managed care rate setting and improvements they have made to their process. The State indicated that they would provide the information requested by CMS in its March 21, 2012, letter in early April.

On April 23, 2012, the State indicated in response to the March 21, 2012, letter they would return the Federal share of the $30 million. The State has made the necessary adjustment on its quarterly expenditure report to return the applicable Federal share. .

Introduction for Questions 13-15:
According to David Feinwachs' testimony, "[I]n mid-year 2011, when the State of Minnesota's 1115 waiver came up for renewal, we contacted CMS and implored them not to renew the demonstration waiver because of problems. But our concerns, to the best of my knowledge, have not been addressed."

CMS worked with the State to obtain information regarding the capitation rates for all of its Medicaid managed care programs as a condition of the June 2011 renewal of the State's section 1115 demonstration. As part of the special terms and conditions for that renewal, CMS required an annual report that must include: (1) a description of the managed care contract bidding process; (2) financial information on Medicaid managed care plans administrative expenses, premium revenues, provider payments and rates, reserve levels; and (3) a managed care financial audit report on each Medicaid managed care plan. This report must also include the number of contract submissions, information on administrative expenses, premium revenues, provider payments and reimbursement rates, contributions to reserves, service costs and utilization, and capitation rate-setting and risk adjustment methods submitted by each bidder. We expect the first report to be submitted in October 2012.

13. Please provide all documents that Minnesota provided CMS when the state applied for its 2011 renewal of its 1115 waiver for its Medicaid managed care program.

Minnesota submitted its initial request to extend the PMAP+ Demonstration in June 2010, and submitted a revised extension request in March 2011. We will work with the Committee to respond to your question.

14. Please provide all comments CMS received when the state applied for its 2011 renewal of its 1115 waiver for its Medicaid managed care program.

As mentioned above, we will work with the Committee to respond to your question.

15. The Minnesota PMAP program has been authorized under a demonstration waiver for two decades. Please detail what the PMAP program has demonstrated with respect to outcomes, costs, and access.

The goal of Minnesota's health care reform effort is to provide organized and coordinated health care that includes pre-established provider networks and payment arrangements, administrative and clinical systems for utilization review, quality improvement, patient and provider services, and management of health services. We will work with the Committee to respond to your question.

16. How often does CMS approve the rates that states pay for Medicaid managed care?

Every time a State implements new or revised rates, CMS must review them to ensure that they have been set in an actuarially sound manner, consistent with the regulations at 42 CFR 438.6

17. Have you requested information from Minnesota's insurance companies about their profits or losses with respect to state-only health insurance programs and Medicaid?

CMS is in the process of analyzing data provided by Minnesota regarding the rates paid by the State to each of the MCOs for both the Medicaid managed care program, as well as GAMC, along with information regarding the plans' reserves and profits/losses during the period on these two lines of business. We will determine whether further information is needed from the health plans themselves. CMS does not interface directly with the MCOs that are contracting with a State; we work with and through the State.

18. Is it appropriate for the same firm that performs actuarial work for a state's Medicaid program also performs actuarial work for the health insurance companies that the state contracts with?

There are a very limited number of firms who have expertise in Medicaid rate-setting processes, which makes it difficult for States to hire actuarial firms that do not have business relationships

with health plans. We agree that it is preferable for a State to use a firm that does not do actuarial work for health plans in their own State.

19. Which staff member at CMS, if any, have you directed to take the lead on understanding how the breakdown in oversight occurred in Minnesota's managed care program?

The Disabled and Elderly Health Programs Group (DEHPG) at the Center for Medicaid and CHIP Services has primary responsibility for the review of managed care programs in the States, along with the appropriate CMS staff in our Regional offices. DEHPG will be more closely examining managed care rate setting in Minnesota, but the Director of the Center for Medicaid and CHIP Services is responsible for this review.

Questions 20-26 pertain to the problems in Texas's Medicaid dental program

Introduction for Questions 20-21:
At the Committee's hearing Congressman Gowdy asked you about government actions to punish providers who perpetrated the fraud in Texas's program. You responded that "[w]e are looking at which claims were improperly paid and we will defer all those claims."

20. Who were you referring to when you said "we"?

"We" in this context referred to CMS. We are working with the State and the Office of Inspector General as they determine the allowability of any of these claims. Once the OIG issues its findings, CMS will take appropriate actions to seek a refund of any Federal funds that were not allowable. The State will take action to recover any payments from providers who were inappropriately reimbursed, as well as consider any further action against them. The State has indicated that it will return the Federal share of any associated unallowable claims. We are also working with the State to understand how they are ensuring appropriateness of current claims for Federal matching funds. CMS has issued a letter to the State regarding their plan of action and depending upon that response may initiate deferrals if CMS does not believe the State has put the proper controls in place.

21. What does it mean to defer a claim?

To the extent that CMS determines that Federal expenditures are not available for certain medical services claimed by a State, CMS may defer payment for those expenditures until such time as the State is able to satisfy CMS that such expenditures conform to the statute or until such time as the State takes corrective action and satisfies CMS that it is in compliance with the statute. If CMS determines that expenditures are not in compliance with the statute, CMS will issue a disallowance which is the Agency's final determination on the allowability of a expenditure.

22. How could the degree of fraud that we heard about in Texas's Medicaid dental program go undetected by CMS? Who is responsible for this failure?

CMS and the States share responsibility in overseeing the state-administered Medicaid program. The State is the first line of management control; providers submit their claims to the State, who reviews and pays them. Both CMS and the States conduct audits to identify vulnerabilities in the program and pursue improper payments. Both CMS and the States use cases like Texas to improve audit strategies and methodologies.

23. Which staff member at CMS, if any, have you directed to take the lead on understanding how the breakdown in oversight occurred in Texas's dental program?

The Financial Management Group at the Center for Medicaid and CHIP Services, in coordination with CMS' Regional Offices, has primary responsibility in ensuring that States claims for expenditures for medical assistance are compliant with the statute and CMS regulations. The Director of the Center for Medicaid and CHIP Services has overall responsibility for this work.

Introduction for Questions 24-26
In answering a question from Congressman Burgess, you stated, "[w]e do look at outlier claims of State Medicaid programs." In response to his follow-up about why the problem in Texas was undetected, you said "because they were not separately coded. What was growing overall was the dental account in Texas because of major changes that the state did in its dental account.
These were basically hidden claims within that. So neither we nor the State identified them as an outlier."

24. Please detail the process by which CMS looks at outlier claims. Does CMS outsource this responsibility to private sector companies? If so, which companies does CMS contract with and how much did CMS pay to each company for the last three years?

It is first useful to distinguish between two kinds of claims – the claims that providers submit to States for payment and the claims that States submit to CMS for Federal matching.

With respect to the claims that providers submit to States, States use a variety of tools to help identify aberrant or unusual patterns of billings that may need further examination before payment is made. Private contractors are used by States as well as State employees to review claims, analyze trends, and initiate further examinations or site visits to explore the appropriateness of provider claims and services.

CMS also looks at outlier claims through the National Audit Program housed in the Medicaid Integrity Program. In accordance with section 1936 of the Social Security Act, CMS exclusively hires contractors to identify program vulnerabilities, including outliers, using Medicaid Statistical Information System (MSIS) data and to conduct audits of Medicaid providers. We currently hire contractors to work with specific CMS regions defined by the Medicaid Integrity Program. To conduct data analytics and identify potential payment aberrancies, we currently contract with Thomson Reuters and AdvanceMed. To conduct audits, we currently contract with Booz Allen Hamilton, Health Integrity, IPRO, and IntegriGuard.

With respect to claims submitted by States to CMS for Federal matching, States submit their claim for Federal matching funds on a quarterly basis. This report (CMS-64) contains aggregate expenditure information by various service categories. These reports are reviewed first by our Regional Offices and then submitted to Central Office. As part of the standard quarterly review process, we apply a variance analysis by expenditure to determine if there is an anomaly in expenditures. If CMS has reason to question a category of expenditures, it may issue a deferral. This allows CMS to obtain additional information to support the allowability of the claim for Federal matching funds. This quarterly expenditure report does not contain individual provider claim information.

In addition, CMS has an annual financial management review work plan where we identify areas of high risk or claiming anomalies and conduct a more in-depth review of associated expenditures. In addition, we work closely with the OIG in the review and resolution of their audits. The OIG's audits may focus on areas where they have seen a dramatic change in claiming under the Medicaid program.

25. According to the Committee's research, there were separate billing codes for individual dental and orthodontic procedures. Are you sure that there were not separate billing codes for individual dental and orthodontic procedures?

My written testimony refers to the way that claims for Federal matching are submitted by States, not how providers bill States.

26. If you were mistaken in your testimony and there were separate billing codes for individual dental and orthodontic procedures, what explains the failure of both Texas and the state to have uncovered the problem in Texas's dental program?

See #25.

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