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Uncovering Waste, Fraud, and Abuse in the Medicaid Program

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EXECUTIVE SUMMARY

More than 50 million Americans are currently enrolled in Medicaid, a joint federal-state health care program for poor and disabled Americans that is projected to cost American taxpayers \$457 billion this year. To put the size of the program in context, annual Medicaid spending now exceeds Wal-Mart's worldwide annual revenue and annual Medicaid spending is 40 percent larger than Greece's entire economy. Because of its enormous size and complexity, Medicaid is susceptible to substantial amounts of waste, fraud, abuse and mismanagement. No one knows how much of Medicaid's budget consists of waste, fraud, and abuse, but it may exceed \$100 billion a year. Policymakers in favor of increased taxation and growing government should first look inward at how government is functioning, and focus first on curtailing the excessive waste, fraud, abuse and mismanagement that is pervasive throughout programs such as Medicaid.

In 2003, the Government Accountability Office (GAO) added Medicaid to its list of high-risk programs. A major reason Medicaid is a high risk program is because of the open-ended federal reimbursement of state Medicaid spending. The open-ended reimbursement significantly reduces the incentives for states to act as wise stewards of federal taxpayer dollars. Because states lack adequate incentives to combat fraud and abuse in their Medicaid programs, the federal government's oversight role is even more critical. Unfortunately, CMS often fails to prioritize Medicaid program oversight. Without a significant incentive for government to crack down on Medicaid waste, fraud, and abuse, journalists and other watchdog groups – as opposed to state or federal agencies – often expose Medicaid fraud schemes

Over the past two decades, Medicaid spending has grown by 450 percent, so states are desperate to maximize the federal money flowing into the program. Since Medicaid spending is projected to more than double over the next decade, states are likely to increase their use of creative techniques and contingency-fee consultants to find new ways to leverage additional federal tax money into their programs. A key ingredient of Medicaid reform must be to realign the incentives of government and providers to ensure they act as wise stewards of taxpayer dollars. Reforming the open-ended federal Medicaid reimbursement and eliminating states' use of supplemental payments would cause states to obtain better value for the money spent through the program.

Minnesota provides a stunning example of how states are failing to properly ensure the appropriate use of taxpayer dollars spent on Medicaid managed care. The state was intentionally lowering the rates paid to the managed care companies for plans outside the Medicaid program and increasing the rates within the Medicaid managed care program. Minnesota was using this accounting trick in order to leverage the federal reimbursement of state Medicaid spending. At the end of 2010, Minnesota's four non-profit HMOs had a total surplus of \$1.6 billion. Since these companies were operating as non-profits, they essentially took their profits by increasing their reserves and paying their employees large bonuses. GAO has been very critical of CMS's oversight of how states' rate-setting for Medicaid managed care. For example, CMS was alerted of the problem in Minnesota's program over a year ago, but it failed to act. It is likely that Minnesota owes the federal government hundreds of millions of dollars for inappropriately leveraging the federal Medicaid reimbursement for years.

An example of journalists uncovering fraud was a major *New York Times* investigation in 2005, which uncovered massive fraud in New York City's Medicaid program. Although the *Times* had far fewer resources than the state to investigate Medicaid fraud, the newspaper uncovered egregious examples of misconduct that New York authorities failed to detect. James Mehmet, a former chief state investigator of Medicaid fraud and abuse in New York City, believes that at least 10% of Medicaid dollars are lost on fraudulent claims, while another 20% to 30% consist of abuse, or services that were delivered but that were unnecessary. Waste, fraud, and abuse in New York's Medicaid home-based health services are rampant. A Department of Health and Human Services Inspector General's (IG) audit, for example, estimates that between January 2004 and December 2006, New York City improperly claimed over \$275 million in Medicaid funds for personal care services. A second IG audit found that New York improperly claimed \$207 million for rehabilitative home care services provided between January 2004 and December 2007.

Over the past decade, the HHS IG has released 19 audits with the finding that the state improperly received over \$50 million in federal Medicaid reimbursement. Ten of the 19 audits and five of the six audits with the largest findings – each of which exceeded \$170 million in improper state receipts of federal Medicaid money – were the result of problems in just one state – New York. CMS often recovers only a small fraction of what the IG estimates damages to be.¹

Massive fraud was occurring in Texas's Medicaid dental and orthodontics program over the past few years. By 2010, Texas's Medicaid program was spending more on braces than the other 49 state Medicaid programs spent on braces combined. Texas's Medicaid program was also spending about as much on orthodontic services as the rest of the country's Medicaid programs spent on orthodontic services combined. No one at CMS failed to prevent or even publicize that Texas's Medicaid program was spending more on braces than the other 49 states combined. After years of fraud and a loss of hundreds of millions of dollars, an investigative journalist at a Dallas news station uncovered the scheme.

Unfortunately, these three cases demonstrate just a tiny fraction of the instances where daily occurrences of Medicaid waste, fraud, and abuse occur. The magnitude of taxpayer dollars wasted through Medicaid programs signifies the need for policymakers to immediately reform the program.

I. Medicaid's Misuse of Taxpayer Dollars

More than 50 million Americans are currently enrolled in Medicaid, a joint federal-state health care program for poor and disabled Americans.¹ Because of its enormous size and complexity, Medicaid – which is growing at a rapid pace and now costs American taxpayers \$457 billion per year² – is susceptible to substantial amounts of waste, fraud, mismanagement and abuse. The program’s federal-state partnership is at the heart of the program’s complexity. Although states make the majority of decisions pertaining to provider pay, managed care contracting and benefit packages, federal taxpayers pay for the majority of Medicaid spending. The federal government reimburses half of Medicaid spending in the states with the highest per capita income and about 75% of Medicaid spending in the states with the lowest per capita income. In the aggregate, the federal government reimburses about 60% of state Medicaid spending.³

States are primarily responsible for fighting Medicaid fraud and abuse with the Centers for Medicare and Medicaid Services (CMS) responsible for supporting and overseeing state fraud and abuse prevention activities.⁴ However, the policy of an open-ended federal reimbursement of state Medicaid spending significantly reduces the incentives for states to act as wise stewards of federal tax dollars. For example, in order to return \$1,000 in fraudulent Medicaid funding for state purposes, a state with a 60% federal Medicaid reimbursement rate would have to identify and recover \$2,500 of waste, fraud, and abuse in its program. Since 60% of the total recovery would have to be returned to the U.S. Treasury, the state would have to refund \$1,500 of the \$2,500 it recovered. Moreover, due to the open-ended federal Medicaid reimbursement, many states view Medicaid as an economic growth engine and therefore lack much interest in where the money is going. States would also have to increase resources to uncover the waste, fraud, and abuse. For these reasons, the federal Medicaid reimbursement demonstrates one of the core reasons the Medicaid program suffers from rampant waste, fraud, and abuse.

Without a significant incentive for states to crack down on Medicaid waste, fraud, and abuse, journalists and other watchdog groups – as opposed to state agencies – often expose Medicaid fraud schemes. This is true even when the cases of fraud should be obvious to any competent government official. For example, between 2008 and 2010, Texas’s Medicaid program spent more on orthodontics, particularly braces, than all 49 remaining states combined.⁵ However, no one at Texas’s Medicaid agency or at CMS failed to prevent or even publicize that several Texas providers were fraudulently bilking taxpayers out of tens of millions of dollars until an investigative journalist at a Dallas news station uncovered the scheme.⁶ Another

¹ Kaiser Family Foundation, “Medicaid Enrollment: December 2010 Data Snapshot” (December 2011), available at <http://www.kff.org/medicaid/upload/8050-04.pdf>.

² In last year’s National Health Expenditures report, CMS projected that the nation spent \$456.8 billion on Medicaid in 2012 (CMS: NATIONAL HEALTH EXPENDITURE PROJECTIONS 2010-2020, available at <http://www.cms.hhs.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/proj2010.pdf>).

³ The American Recovery and Reinvestment Act raised the average reimbursement rate to nearly 70% for fiscal years 2009 through 2011.

⁴ *Medicaid Waste, Fraud and Abuse, Threatening the Healthcare Safety Net: Hearing Before the Senate Comm. on Finance*, 109th Cong. (2005) (written statement of Leslie G. Aronovitz, Health Care Director, Government Accountability Office), available at <http://finance.senate.gov/imo/media/doc/LATest0628051.pdf>.

⁵ Byron Harris, *Crooked Teeth: Medicaid Millions*, WFAA-TV News (December 27, 2011), available at <http://www.wfaa.com/news/investigates/Crooked-Teeth-Medicaid-Millions-136287563.html>.

⁶ *Id.*

example of journalists uncovering fraud was a major *New York Times* investigation in 2005, which uncovered massive fraud in New York City’s Medicaid program.⁷ Although the *Times* had far fewer resources than the state to investigate Medicaid fraud, the newspaper uncovered egregious examples of misconduct that New York authorities failed to detect.

Medicaid fraud is not a new problem. In 1982, Congress held hearings on how the majority of states were failing to prevent Medicaid fraud, and the House Select Committee on Aging issued a report concluding that “state enforcement of the Medicaid program has been an unmitigated disaster.”⁸ Unfortunately, 30 years later, the same problems exist although the dollars involved are much greater. In CMS’s FY 2010 Annual Report to Congress on the Medicaid Integrity Program, CMS noted that Medicaid is “a target for those who would abuse or defraud a health care program for personal financial gain,” and that “fraud, waste, and abuse represent a persistent, pervasive threat” to the integrity of Medicaid and other health care programs.⁹

Techniques to Pass Medicaid Costs to Federal Taxpayers

In 2003, the Government Accountability Office (GAO) added Medicaid to its list of high-risk programs.¹⁰ GAO has devoted considerable attention to the various techniques used by state governments – many of which are legal – that leverage additional federal money into state Medicaid programs without real state contributions. The most common type of state technique requires providers, such as nursing homes, to contribute money to the state. The state will take the provider contribution and spend the money back on the provider. While this may not make sense, since the state is now spending the money it can submit a receipt for the spending to CMS. CMS will then provide the state a refund based on the state’s Medicaid reimbursement rate, and the state will then share the federal refund with the provider. As this example illustrates, the scheme enables the state to compensate the provider without any net contribution of state tax dollars. The extra payment made to the provider, often called supplemental payments, are made to certain providers and are separate from and in addition to those payments made at a state’s standard Medicaid reimbursement rates.¹¹

According to GAO, “[o]nce states receive the returned funds, they can use them to supplant the states’ own share of future Medicaid spending or even for non-Medicaid purposes.”¹² Moreover, GAO found that “[a]s various schemes involving [intergovernmental transfers] have come to light, Congress and CMS have taken actions to curtail them, but as one approach has been restricted, others have often emerged.”¹³ Over the past two decades,

⁷ Clifford Levy and Michael Luo, *New York Medicaid Fraud May Reach Into Billions*, N.Y. TIMES, July 18, 2005, available at <http://www.nytimes.com/2005/07/18/nyregion/18medicaid.html?pagewanted=print>.

⁸ Robert Pear, *Panel Says Most States Fail on Policing Medicaid Fraud*, N.Y. TIMES, March 27, 1982, available at <http://www.nytimes.com/1982/03/27/us/panel-says-most-states-fail-on-policing-medicare-fraud.html>.

⁹ CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS): ANNUAL REPORT TO CONGRESS ON THE MEDICAID INTEGRITY PROGRAM 5 (2011), available at <http://www.cms.gov/DeficitReductionAct/Downloads/fy10rtc.pdf>.

¹⁰ See *Medicaid Waste, Fraud and Abuse, Threatening the Healthcare Safety Net: Hearing Before the Senate Comm. on Finance*, 109th Cong. (2005) (written statement of Kathryn G. Allen, Health Care Director, Government Accountability Office), available at <http://www.gao.gov/new.items/d05836t.pdf>.

¹¹ U.S. GOV’T ACCOUNTABILITY OFFICE (GAO): CMS NEEDS MORE INFORMATION ON THE BILLIONS OF DOLLARS SPENT ON SUPPLEMENTAL PAYMENTS (2008), available at <http://www.gao.gov/new.items/d08614.pdf>.

¹² See *Medicaid Waste, Fraud and Abuse, Threatening the Healthcare Safety Net*, *supra* note 10.

¹³ *Id.*

Medicaid spending has grown by 450 percent, so states are desperate to maximize the federal money flowing into the program. Since Medicaid spending is projected to more than double over the next decade, states are likely to increase their use of supplemental payments and create new ways to leverage additional federal tax money into their programs.

Because of the incentive for states to maximize Medicaid dollars, most states employ contingency-fee consultants to figure out how to maximize federal Medicaid money.¹⁴ As a result, taxpayers shell out hundreds of millions of dollars each year for lawyers whose sole job is to legally “beat the system.”¹⁵ These lawyers produce nothing of real value. Instead, their job, for which they are highly compensated out of funds that are supposed to go to the poor, is to figure out how to make federal taxpayers pay for state spending.

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.”¹⁶ In addition to these concerns, GAO explained three key reasons why states’ use of supplemental payments was inappropriate or in violation of relevant statutes.¹⁷

- Inappropriate state financing arrangements effectively increase the federal matching rate established under federal law by increasing federal expenditures while state contributions remain unchanged or even decrease.¹⁸
- Although federal Medicaid matching funds are intended for Medicaid-covered services for Medicaid-eligible individuals, CMS cannot verify that increased federal matching payments were retained by the providers and used to pay for Medicaid services.¹⁹
- State financing arrangements undermine the fiscal integrity of the Medicaid program because they enable states to make payments to government providers that could significantly exceed their costs despite a statute requiring states ensure Medicaid payments are economical and efficient.²⁰

There are two other key reasons why states’ pervasive use of supplemental payments is problematic. First, states devote considerable resources figuring out how to pass costs from the state to the federal government, rather than focusing on increasing the efficiency of their Medicaid programs. Second, these schemes hide the true cost of services delivered through the

¹⁴ According to GAO testimony, “as of 2004, 34 states—up from 10 states in 2002—used contingency-fee consultants for this purpose” (*id.*).

¹⁵ According to the GAO, “In Georgia and Massachusetts, where we focused our review of specific projects, selected projects that involved the assistance of contingency-fee consultants generated a significant amount of additional federal reimbursements for the states: from fiscal year 2000 through 2004, an estimated \$1.5 billion for Georgia and nearly \$570 million for Massachusetts. For those additional reimbursements, Georgia paid its consultant about \$82 million in contingency fees, and Massachusetts paid its consultants about \$11 million in contingency fees” (*id.*).

¹⁶ *Id.*

¹⁷ *H.R. 5613, Protecting the Medicaid Safety Net Act of 2008: Hearing Before the Subcomm. On Health of the H. Comm. on Energy and Commerce, 110th Cong. (2008)* (written statement of James Cosgrove, Acting Health Care Director, Government Accountability Office), available at <http://www.gao.gov/assets/120/119542.pdf>.

¹⁸ *Id.* at 7.

¹⁹ *Id.* at 9.

²⁰ *Id.* at 10.

Medicaid program. Since resources are most efficiently allocated when prices are transparent, state schemes that effectively make certain Medicaid services appear “free” inevitably generate significant waste.

CMS Oversight

Because states lack adequate incentives to combat fraud and abuse in their Medicaid programs, then the federal government’s oversight role is even more critical. Unfortunately, CMS often fails to prioritize Medicaid program oversight. Such disregard by CMS was noted by GAO in a 2005 report entitled, “Medicaid Fraud and Abuse: CMS’s Commitment to Helping States Safeguard Program Dollars is Limited.” In the report, GAO revealed:

[T]he resources CMS expends to support and oversee states’ Medicaid fraud and abuse control activities remain out of balance with the amount of federal dollars spent annually to provide Medicaid benefits. In fiscal year 2005, CMS’s total staff resources allocated to these activities was about 8.1 full-time equivalent (FTE) staffing units. . . . Moreover, the placement of the Medicaid fraud and abuse control staff at headquarters—apart from the agency’s office responsible for other antifraud and abuse activities—as well as a lack of specified goals for Medicaid fraud and abuse control raise questions about the agency’s level of commitment to improving states’ activities in this area.²¹

At the time only eight out of the Department of Health and Human Services’ 65,000 employees were tasked with combating Medicaid fraud and abuse when the program had a nearly \$300 billion annual budget.²² Clearly one could argue that the federal government essentially abdicated its responsibility to protect taxpayer dollars spent through the Medicaid program.

As part of the Deficit Reduction Act of 2005, Congress created a Medicaid Integrity Program (MIP)²³ and increased CMS resources directed toward combating Medicaid fraud and abuse. Within a year of MIP’s creation, CMS developed two data systems in an effort to improve data quality and to better detect waste, fraud, and abuse.²⁴ In July 2011, GAO conducted an analysis of the effectiveness of CMS’s new Medicaid data systems and concluded there was insufficient evidence to support any notion that either system had thus far provided a financial benefit.²⁵ In addition, GAO identified significant problems with state-reported Medicaid data. CMS generally cannot conduct any substantive analysis until at least one year has passed since the date of the Medicaid service. Moreover, the Office of the Inspector General noted that the state data “has not captured many data elements that can assist in fraud, waste, and

²¹ *Medicaid Waste, Fraud and Abuse, Threatening the Healthcare Safety Net*, *supra* note 4.

²² CMS: NATIONAL HEALTH EXPENDITURE PROJECTIONS, *supra* note 2.

²³ MIP is responsible for hiring contractors to review Medicaid provider activities, audit claims, identify overpayments, and educate providers and others on program integrity issues. MIP is also responsible for providing effective support and assistance to States in order to combat provider fraud and abuse (CMS: MEDICAID INTEGRITY PROGRAM, OVERVIEW (accessed November 28, 2011), available at <https://www.cms.gov/medicaidintegrityprogram/>).

²⁴ GAO: FRAUD DETECTION SYSTEMS, CENTERS FOR MEDICARE AND MEDICAID SERVICES NEEDS TO ENSURE MORE WIDESPREAD USE 2 (2011), available at <http://www.gao.gov/new.items/d11475.pdf>.

²⁵ The new IT systems were put into use in September 2006. GAO’s study analyzes the program through the end of FY 2010 (*id.*).

abuse detection.”²⁶ Despite spending hundreds of millions of dollars on information technology,²⁷ CMS still cannot effectively analyze state Medicaid data.

The remainder of this staff report highlights three examples in which taxpayers have been victims of Medicaid fraud. In each of the three cases, the federal government failed to detect significant schemes that cheated the program. In at least two of the cases, states appear to have complicity enabled the fraud. Unfortunately, these three cases demonstrate just a tiny fraction of the instances where daily occurrences of Medicaid waste, fraud, and abuse occur. The magnitude of taxpayer dollars wasted through Medicaid programs signifies the need for policymakers to immediately reform the program. A key ingredient of Medicaid reform must be to realign the incentives of government and providers to ensure they act as wise stewards of taxpayer dollars. Reforming the open-ended federal Medicaid reimbursement and eliminating states’ use of supplemental payments would cause states to obtain better value for the money spent through the program.

II. Case Study #1: Minnesota and Medicaid Fraud in Managed Care

Two years ago, GAO studied whether CMS was consistently reviewing states’ rate setting for compliance with Medicaid managed care actuarial soundness requirements, which specify that rates must be developed in accordance with actuarial principles and appropriate for the population and services.²⁸ Knowing whether rates are actuarially appropriate is extremely important since 39 million people are enrolled in Medicaid managed care.²⁹ GAO found significant problems with how states set these rates and CMS’s oversight efforts of the rate-setting process. According to GAO, CMS was “inconsistent in reviewing states’ rate setting for compliance with the Medicaid managed care actuarial soundness requirements which specify that rates must be developed in accordance with actuarial principles, appropriate for the population and services, and certified by actuaries.”³⁰ GAO found that CMS did not make efforts to ensure the quality of the data used to set rates and that CMS officials did not focus on data reliability.³¹ According to GAO, CMS’s failure “places billions of federal and state dollars at risk for misspending.”³²

Minnesota provides a stunning example of how states are failing to properly ensure the appropriate use of taxpayer dollars spent on Medicaid managed care. In fiscal year 2009, Minnesota spent nearly \$4,400 on Medicaid managed care per person in poverty,³³ almost two

²⁶ *Id.*

²⁷ *Id.*

²⁸ GAO: CMS’S OVERSIGHT OF STATES’ RATE SETTING NEEDS IMPROVEMENT 1 (2010), available at <http://www.gao.gov/new.items/d10810.pdf>.

²⁹ According to CMS, there were 39,020,325 people enrolled in managed care programs (CMS, CENTERS FOR MEDICARE AND MEDICAID: 2010 MEDICAID MANAGED CARE ENROLLMENT REPORT (2010), available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/Downloads/2010July1.pdf>).

³⁰ *Id.* at 2.

³¹ *Id.*

³² *Id.*

³³ Kaiser Family Foundation, “State Health Care Facts: Distribution of Medicaid Spending on Acute Care, FY 2009” (accessed April 19, 2012), available at <http://www.statehealthfacts.org/comparetable.jsp?ind=179&cat=4>; Alemayehu Bishaw, POVERTY: 2009 AND 2010 - AMERICAN COMMUNITY SURVEY BRIEFS, U.S. CENSUS BUREAU (2011), available at <http://www.census.gov/prod/2011pubs/acsbr10-01.pdf>.

and a half times the national average of spending on Medicaid managed care per person in poverty.³⁴ In 2010, David Feinwachs, then a senior employee with the Minnesota Hospital Association, started asking where all the managed care dollars were going.³⁵ Mr. Feinwachs' questions were largely motivated by his secret participation in a conference call in August 2010 in which he heard Karen Peed, then-Minnesota's Director of Managed Care and Payment Policy, say that the state was intentionally lowering the rates paid to the managed care companies for plans outside the Medicaid program and increasing the rates within the Medicaid managed care program.³⁶ Minnesota was using this accounting trick in order to leverage the federal reimbursement of state Medicaid spending. Shortly after Mr. Feinwachs began his investigation, Ms. Peed was removed from her position as Director of Managed Care and Payment Policy.³⁷

Over the past few months, a cascade of events suggest Minnesota's state government and the four HMOs operating in the state have been inappropriately leveraging federal tax dollars to fund state-only health plans. As evidence, in 2010 Minnesota's managed care companies averaged an 8.9% margin for their Medicaid book of business, roughly four times the corresponding operating margins in Wisconsin and Michigan.³⁸ Of the Minnesota companies' high operating margins for Medicaid plans, Rick Murdock, the executive director of the Michigan Association of Health Plans, said: "I'm just surprised that anyone would have that high a margin in the Medicaid area. Quite frankly, [even] in the commercial area, that would be a high margin."³⁹

Minnesota contracts with four non-profit HMOs, which provide networks of providers and insurance for Medicaid recipients. The four plans that participate in Minnesota's Medicaid managed care program are UCare, Medica, HealthPartners, and Blue Cross Blue Shield. In order to participate in Medicaid, the HMOs must also participate in state-only health plans, such as the state employee health plan. In March 2011, UCare, the smallest of the four HMOs operating in the state, returned \$30 million to the state.⁴⁰ In a letter dated March 16, 2011, UCare's CEO, Nancy Feldman, attributed the repayment to excess 2010 operating margins, resulting from Medicaid overpayments. According to Feldman's letter:

Historically, DHS [Department of Human Services] rates set for General Assistance Medical Care⁴¹ resulted in health plan losses which were offset by higher Medical Assistance [Medicaid] payments. When GAMC moved out of managed care in mid-year 2010, Medical Assistance [Medicaid] rates were not lowered to reflect this overpayment.⁴²

³⁴ *Id.*

³⁵ Minnesota Prepaid Medical Assistance Program (PMAP) Reform Advocacy Group, "PMAP Presentation," (November 17, 2010) available at <http://vimeo.com/17156418>.

³⁶ David Feinwachs, Deposition of Matthew Anderson (April 27, 2011).

³⁷ Telephone Interview with David Feinwachs (April 23, 2012).

³⁸ Editorial, *Is state overpaying health plans?*, STAR TRIBUNE, February 16, 2012, available at <http://www.startribune.com/opinion/editorials/139483223.html>.

³⁹ *Id.*

⁴⁰ Letter from Nancy Feldman, President and CEO, UCare, to Minnesota State Senator David Hann (March 16, 2011).

⁴¹ GAMC was a state-only health insurance program for individuals ages 21-64 who did not have dependent children under the age of 18 and did not qualify for federally funded health care programs.

⁴² Letter from Nancy Feldman, *supra* note 40.

UCare's letter shows that it was losing money on its GAMC plan, but that these losses were recouped by the state paying more than the actuarially appropriate amount for Medicaid enrollees. Since this occurred during a period when Minnesota's reimbursement rate was over 60%, the federal government is owed at least \$18 million from this scheme alone. Moreover, since the \$30 million repayment is from the state's smallest HMO for only a six-month period, the federal government is likely owed hundreds of millions of dollars in additional overpayments made to all the state's HMOs over the past several years.

Several months ago, US Senator Charles Grassley began an investigation of the managed care companies in Minnesota. Information obtained through his investigation shows that the four HMOs in Minnesota were offsetting significant losses in state-only health plans with earnings derived through the Medicaid program. Moreover, Minnesota was overpaying the HMOs for their Medicaid portfolio to such a large extent that Medicaid overpayments in Minnesota may even have offset commercial losses these companies endured. At the end of 2010, Minnesota's four non-profit HMOs had a total surplus of \$1.6 billion.⁴³ Since these companies were operating as non-profits, they essentially took their profits by increasing their reserves and paying their employees large bonuses.

On March 15, 2011, the day before UCare sent its letter regarding the refund, Lucinda Jesson, Commissioner of Minnesota's Department of Human Services (DHS) emailed Dan Pollock, a high-level staffer in Minnesota's DHS about the proper way to message the UCare contribution:

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.⁴⁴

This email raises two serious questions. First, why was Minnesota's DHS Commissioner providing input to the letter UCare would send the state on how the \$30 million repayment would be characterized? Second, why was Minnesota's DHS Commissioner attempting to keep the federal government from receiving their share of the money?

Before a state legislative committee in February 2012, Commissioner Jesson testified that she was in Baltimore the week UCare notified the state of its intent to return \$30 million to Minnesota and that she told CMS about the "donation". She stated her belief was that CMS was satisfied with the characterization and therefore the state did not have to pay its federal share.⁴⁵ Cindy Mann, CMS's Medicaid director, sent a letter on July 1, 2011 to Minnesota's Medicaid Director David Godfrey, which demonstrates that CMS was interested in recovering its share of the \$30 million.⁴⁶ It appears that either the state disregarded CMS's letter or CMS failed to follow up with the state. On March 21, 2012, nearly nine months after her first letter and after

⁴³ Pioneer Press, "Dayton HMOs Agrees to Profit Cap" (April 6, 2011).

⁴⁴ E-mail from Lucinda Jesson, Commissioner, Minnesota Department of Human Services (DHS) to Dan Pollock, Staff, DHS (March 15, 2011).

⁴⁵ *Joint Hearing on Healthcare Transparency Before the Minnesota State H. Comms. on Health Finance and Reform*, 2011-2012 Minnesota House of Representatives (February 14, 2012).

⁴⁶ Letter from Cindy Mann, Director, Center for Medicaid and State Operations, CMS, to David Godfrey, State Medicaid Director, State of Minnesota (July 1, 2011).

Senator Grassley initiated his investigation and Minnesota news media began reporting heavily on this controversy, Ms. Mann sent a follow-up letter to David Godfrey.⁴⁷

CMS was alerted of the problem in Minnesota's program over a year ago, but it failed to act. For example, CMS ignored a request from Minnesota's state Senators Sean Nienow and John Marty asking CMS to perform an independent audit of Minnesota's Medicaid managed care program.⁴⁸ Despite the GAO report and evidence presented by the state senators, CMS refused to take action to protect federal taxpayers. On a conference call, CMS told the state senators that they thought Minnesota was doing independent audits. CMS's failure to provide even minimal oversight of Minnesota's Medicaid program raises serious questions about the agency's competency and priorities.

Although Minnesota has decided to return half of UCare's \$30 million overpayment,⁴⁹ many questions remain, including:

- How was UCare's \$30 million payment determined?
- If UCare had such a gross overpayment, why did the other three HMOs not provide a similar refund?
- Is a state allowed to underpay insurance companies for state-only plans and offset that underpayment by overpaying the insurance company for the Medicaid managed care population? Is that a goal of the Medicaid program?
- Did CMS know that Minnesota was subsidizing state-only health care plans and possibly commercial plans with federal dollars flowing through the Medicaid program?
- How long has the state of Minnesota been overpaying health insurance plans for the state's Medicaid population?
- How much does the state owe federal taxpayers over the entire time period when Minnesota was overpaying health insurance plans for the state's Medicaid population?

III. Case Study #2: New York City and Medicaid Fraud in Personal Care Services

Over the past decade, the state of New York has become the poster child for Medicaid waste, fraud, and abuse. James Mehmet, a former chief state investigator of Medicaid fraud and abuse in New York City, believes that at least 10% of Medicaid dollars are lost on fraudulent claims, while another 20% to 30% consist of abuse, or services that were delivered but that were unnecessary.⁵⁰ Medicaid fraud and abuse in New York is enabled, in part, by a culture of corruption among New York's elected officials. In the past decade, at least a half dozen elected officials, including a former New York Senate Majority Leader, have been charged with crimes relating to Medicaid fraud.⁵¹

⁴⁷ Letter from Cindy Mann, Director, Center for Medicaid and State Operations, CMS, to David Godfrey, State Medicaid Director, State of Minnesota (March 21, 2012).

⁴⁸ Telephone Interview with Senator Sean Nienow, Minnesota State Senate (April 2, 2012).

⁴⁹ Telephone Interview with Kristin Wikelius and Jennifer Boulanger, Office of Legislation, CMS (April 13, 2012).

⁵⁰ Levy and Luo, *supra* note 7.

⁵¹ In 2004, for example, former New York Senator Guy Velella was charged with a 25-count indictment alleging the solicitation of \$250,000 in bribes – \$137,000 of which were accepted – for steering public works contracts to those who paid the bribes. He pled guilty to one count of bribery and was sentenced to one year in prison for the felony conviction. In 2009, former New York

A year-long investigation of New York Medicaid fraud by *The New York Times* in 2005 culminated in an extensive article detailing the rampant fraud occurring in the state’s program – fraud which should have been detected by any competent government official.⁵² According to the *Times*, “the program has been mispending billions of dollars annually because of fraud, waste, and profiteering.”⁵³ The *Times* found several examples of egregious fraud:

- Dr. Dolly Rosen built the biggest Medicaid dental practice in New York between 2001 and 2003. Medicaid paid Dr. Rosen and an associate \$5.4 million in 2003 alone, by far the most of the 50,000 doctors and dentists in the program. In just one month, Dr. Rosen billed Medicaid for 9,500 individual dental procedures; on a single day that month, she billed for 991 procedures. Criminal investigators estimate that 80% of the procedures were either not performed, unnecessary, or improper.⁵⁴
- Sheryl Carswell, former Director of Special Education for the City of Buffalo, rubber-stamped 4,434 special education students – nearly 60% of the district’s special education population – onto the Medicaid rolls in a single day. Carswell did so without evaluating more than a few of the students. According to the *Times* investigation, school districts collect millions in taxpayer-funded Medicaid dollars by placing students in health and speech programs, “often without any apparent effort to see if the students really need them.” These services, which cost taxpayers \$800 million annually and account for 44% of national Medicaid spending of this type, have created a Medicaid monster in New York schools. A number of audits in recent years indicate that 86% of Medicaid claims paid to New York City schools from 1993 to 2001 either lacked any explanation as to why the services had been ordered or violated some other regulation or requirement.
- According to the *Times* investigation, prescription drug fraud was rampant in New York’s Medicaid program. In 2001, New York’s Medicaid program paid \$50 million – up from \$7 million in 2000 – for Serostim, an expensive synthetic growth hormone intended to treat wasting syndrome associated with AIDS. The increase was due to a series of scams in which Medicaid patients would fraudulently obtain Serostim prescriptions – which cost Medicaid \$6,400 a month – only to subsequently sell them to body-builders. Dr. Mikhail Makhlin, a Brooklyn physician, prescribed \$11.5 million

Senate Majority Leader Joseph Bruno was indicted on two counts of fraud for taking bribes or kickbacks. Bruno’s initial indictment alleged eight federal felony counts for accepting \$240,000 from a businessman – who managed the assets of a health and welfare fund – that sought the then-Senator’s influence in legislative matters. That same year, New York State Assemblyman Anthony Seminerio pled guilty to a single fraud count for influence peddling and was sentenced to six years in prison. Seminerio admitted to promoting the interests of Jamaica Hospital Medical Center, from which he received over \$300,000 for obtaining state financing and lobbying legislators on behalf of the hospital’s efforts to take over other hospitals. New York State Assemblyman William Boyland, Jr. was indicted in 2011 for conspiring to accept \$175,000 in bribes in exchange for influence peddling on behalf of MediSys Health Network, a health care organization that runs hospitals in the state. In 2011, former New York Senator Carl Kruger pled guilty to two counts of conspiracy to commit honest services fraud, as well as two additional counts of conspiracy to commit bribery. Kruger could face upwards of twenty years in prison as a result. Former New York Senate Majority Leader Pedro Espada allegedly stole over \$500,000 from a non-profit clinic he runs – one that receives federal funding in excess of \$1 million each year – for his own personal use. He also made false claims to the U.S. Department of Health and Human Services underreporting the clinic’s profits. Espada’s trial began last month, on March 15, 2012.

⁵² Levy and Luo, *supra* note 7.

⁵³ *Id.*

⁵⁴ *Id.*

worth of the drug, which accounted for more than 12% of all Serostim purchased by New York Medicaid from 2000 to 2003.⁵⁵

- The *Times* investigation also found pervasive fraud in transportation services reimbursed through New York's Medicaid program. Journalists at the *Times* following individuals using Medicaid transportation services at one company found that almost all of their passengers walked easily and required no assistance. Moreover, one doctor billed Medicaid 153 times for transportation for a single patient in 2003. Despite the widespread evidence of fraud and abuse by transportation providers, New York's Medicaid officials often looked the other way.

The *Times* investigation revealed that New York had virtually no oversight of its Medicaid program, which, in 2004, cost \$42 billion with more than half the money coming from Washington.⁵⁶ In response to the bad publicity associated with the *Times* story, New York hired James Sheehan as its Medicaid Inspector General. Although Sheehan's efforts recovered significant money for the state,⁵⁷ New York's Medicaid program continued to grow rapidly. One area that experienced especially rapid growth was home-based health services. In fiscal year 2009, New York's Medicaid program spent nearly \$10 billion on home health and personal care services, accounting for nearly 20% of the nation's Medicaid spending on home health and personal care services.⁵⁸

Waste, fraud, and abuse in New York's Medicaid home-based health services are rampant. A Department of Health and Human Services Inspector General's (IG) audit, for example, estimates that between January 2004 and December 2006, New York City improperly claimed over \$275 million in Medicaid funds for personal care services.⁵⁹ A second IG audit found that New York improperly claimed \$207 million for rehabilitative home care services provided between January 2004 and December 2007.⁶⁰

New York offers a Personal Care Services (PCS) program through Medicaid, which is by far the most generous in the nation. This program is designed to assist qualifying Medicaid beneficiaries with services such as cleaning, shopping, grooming and basic aid. Since 2000, approximately 17,500 New Yorkers have received personal care services in the City's 24-hour-care PCS program, which costs either \$75,000 a year if the individual had an in-home sleep aid or \$150,000 a year if the individual had three workers, each have an 8-hour shift.⁶¹

⁵⁵ *Id.*

⁵⁶ Kaiser Family Foundation Commission on Medicaid Facts, "Medicaid and the Uninsured: Federal and State Share of Medicaid Expenditures, FFY 2004" (accessed April 23, 2012), available at <http://www.kff.org/medicaid/upload/kcmu032106table1.pdf>.

⁵⁷ Gale Scott, *Calling Dr. Fraud*, CRAIN'S NY BUSINESS, March 21, 2010, available at <http://www.crainsnewyork.com/article/20100321/SUB/303219992>.

⁵⁸ Kaiser Family Foundation State Health Facts, "Distribution of Medicaid Spending on Long-Term Care, FY 2009" (accessed April 23, 2012), available at <http://www.statehealthfacts.org/comparetable.jsp?typ=4&ind=180&cat=4&sub=47>.

⁵⁹ Daniel R. Levinson, HHS OIG REVIEW OF PERSONAL CARE SERVICES CLAIMS MADE BY PROVIDERS IN NEW YORK (A-02-07-01054), OFFICE OF THE INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (June 3, 2009), available at <http://www.oig.hhs.gov/oas/reports/region2/20701054.pdf>.

⁶⁰ Daniel R. Levinson, HHS OIG REVIEW OF MEDICAID PERSONAL CARE SERVICES CLAIMS MADE BY PROVIDERS IN NEW YORK CITY (A-02-08-01006), OFFICE OF THE INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (December 30, 2010), available at <http://oig.hhs.gov/oas/reports/region2/20801006.pdf>.

⁶¹ First Amended Complaint-In-Intervention of Plaintiff-Intervenor United States of America, United States of America *ex. rel.* Dr. Gabriel Feldman v. The City of New York, 09 Civ. 8381 (JSR) (S.D.N.Y. 2011).

In 2010, Dr. Gabriel Feldman, alleging massive fraud in New York City's Medicaid PCS Program, filed a federal lawsuit against the City of New York under the False Claims Act. Feldman, a local medical director (LMD) employed by the New York County Health Services Review Organization, alleged:

[The City created] a culture of non-compliance with state and federal regulations wherein an individual's medical qualifications or suitability for the PCS Program is not considered and the overriding goal is to strive to admit as many clients as possible who apply for the PCS Program regardless of his or her condition, fitness or qualification for the program; and to that end, the decisions of Local Medical Directors, who legally possess final authority over a beneficiary's admission to the PCS Program, are knowingly, intentionally and routinely being overridden without legal basis.⁶²

The United States Attorney for the Southern District of New York (US Attorney) intervened in the suit on Feldman's behalf in January 2011, further alleging that the city knowingly failed to comply with the requirements for the approval of 24-hour home care,⁶³ falsely authorizing such care and falsely certifying to state and federal officials that Medicaid reimbursement was warranted.⁶⁴ According to Feldman and the United States Attorney's joint complaint, "the City improperly authorized and reauthorized 24-hour care for a substantial percentage of the thousands of Medicaid beneficiaries enrolled in the PCS program" by disregarding the requirements for enrollment in the program.⁶⁵

According to Timothy Wyant, the expert hired by the US Attorney to calculate the extent of the damages, "the total damages caused by the City's conduct ranges from \$990 million to \$2,581 million" using conservative assumptions.⁶⁶ Mr. Wyant based his analysis on a sample of 500 case files that the US Attorney's Office identified at random. As a stunning example of the problem in New York's Medicaid program, 11% of the files selected for the US Attorney's sample could not be located by the City and 12% of the files selected for the United States Attorney's sample had insufficient information to review.⁶⁷ According to the US Attorney, New York City consistently obstructed the Government's investigation. Although the amount of the fraud may have been close to \$3 billion, the City eventually settled the lawsuit late last year, agreeing to pay the federal government \$70 million in damages.⁶⁸

The Office of Audit Services at the Health and Human Services Inspector General (HHS IG) conducts frequent audits of various aspects of state Medicaid programs. The audits typically

⁶² *Id.*

⁶³ State regulations set forth the requirements for PCS 24-hour home care authorization or reauthorization: 1) the City must determine that the individual meets certain medical standards; 2) the City must obtain and review each of a physician's order, a social assessment, and a nursing assessment; and 3) the City must obtain an independent medical review from a LMD when necessary (*See* First Amended Complaint-In-Intervention, *supra* note 61).

⁶⁴ First Amended Complaint-In-Intervention, *supra* note 61.

⁶⁵ *Id.*

⁶⁶ *Id.* at 4.

⁶⁷ *Id.*

⁶⁸ Anemona Hartocollis, *City to Pay \$70 Million in Medicaid Suit*, N.Y. TIMES, October 31, 2011, available at <http://www.nytimes.com/2011/11/01/nyregion/new-york-settles-medicaid-fraud-suit-for-70-million.html>.

result in the HHS IG both making recommendations and listing an amount of money the state owes the Federal government for past improper claims against the federal Medicaid reimbursement. Over the past decade, the HHS IG has released 19 audits with the finding that a state improperly received over \$50 million in federal Medicaid reimbursement. Ten of the 19 audits and five of the six audits with the largest findings – each of which exceeded \$170 million in improper state receipts of federal Medicaid dollars – were the result of problems in just one state – New York.

The HHS IG reports show that the problems in New York’s Medicaid program are widespread, ranging from speech therapy in schools, to personal care services delivered in the home, rehabilitation services, transportation services, and day treatment services.⁶⁹ New York disagreed with the HHS IG’s findings of the state’s financial liability in every report.⁷⁰ It is unclear whether CMS has taken actions to recover these funds and the resources that CMS has devoted to implement the HHS IG’s recommendations. Unfortunately, the case brought by Dr. Feldman illustrates that the federal government often settles with New York for far less than the actual amount of damages. For example, in New York’s 2009 settlement over false reimbursement claims for speech therapy services delivered in New York schools, New York agreed to pay the federal government \$540 million to settle the lawsuit.⁷¹ Although this amount is the largest Medicaid recovery in history, the actual amount of damages was likely three times higher.⁷² If the federal government has a reputation for accepting only a fraction of what it is owed for fraud and abuse committed or enabled by state Medicaid programs, then states are even further disincentivized from fighting waste, fraud, and abuse in their programs.

IV. Case Study #3: Texas and Medicaid Fraud in Orthodontia

Federal law requires states to cover basic dental benefits to children enrolled in Medicaid, although states have the option to cover orthodontic services through the program.⁷³ If a state chooses to cover orthodontic services, only those services that are determined as medically necessary by the state are eligible for federal reimbursement.⁷⁴ States that provide orthodontic services to children through Medicaid generally limit the coverage to children with severe conditions, such as children born with cleft lip and palate or children with dental problems that result from conditions such as Down Syndrome or Muscular Dystrophy. The final determination of medical necessity is supposed to be made after expert dental consultants review a child’s case file.⁷⁵

⁶⁹ Levinson, *supra* note 59; Levinson, *supra* note 60.

⁷⁰ *Id.*

⁷¹ Nicholas Confessore, *City and State Agree to Repay U.S. for Improper Medicaid Claims*, N.Y. TIMES, July 21, 2009, available at <http://www.nytimes.com/2009/07/22/nyregion/22whistle.html>.

⁷² *Id.*

⁷³ CMS, “Dental Care,” Medicaid.gov (accessed April 12, 2012), available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Dental-Care.html>.

⁷⁴ CMS: POLICY ISSUES IN THE DELIVERY OF DENTAL SERVICES TO MEDICAID CHILDREN AND THEIR FAMILIES (2008), available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Policy-Issues-in-the-Delivery-of-Dental-Services.pdf>.

⁷⁵ *Id.*

CMS provides guidance for states on prior authorizations and on provider reimbursement.⁷⁶ Providers must submit proper documentation and receive prior authorization in order to receive reimbursement through the program. Despite CMS's requirements, there are numerous examples of egregious fraud and abuse within the Medicaid dental program. In addition to the example of Dr. Dolly Rosen, discussed in Section III, we now know that massive fraud was occurring in Texas's Medicaid dental and orthodontics program over the past few years. Indeed, the state has admitted that widespread fraud was occurring and that the organization the state hired to assess prior authorization forms was essentially rubber stamping forms for approval.⁷⁷ An orthodontist brought in by the Texas Office of the Inspector General for the Department of Health and Human Services to audit the prior authorization forms found that about 95% of approved authorizations should have been denied.⁷⁸

During the last decade, the state of Texas was accused of limiting dental service access for children enrolled in Medicaid. As a result, a Consent Decree and Corrective Action Plan⁷⁹ was brought against the state, which required Texas to increase participation rates of dentists in the program.⁸⁰ The state raised payment rates for dental services, and, as a result, the number of dentists participating in the program increased from 45.4% in fiscal year 2007 to 63.4% in fiscal year 2010.⁸¹ As expected, spending on Texas's dental services increased dramatically. According to Billy Millwee, Texas's Medicaid director, the rise in spending in Medicaid's dental program masked the stunning increase in claims Texas was paying for orthodontic services, which did not receive a payment rate increase as part of the state's Corrective Action Plan.⁸²

By 2010, Texas's Medicaid program was spending more on braces than the other 49 state Medicaid programs spent on braces combined. Texas's Medicaid program was also spending about as much on orthodontic services as the rest of the country's Medicaid programs spent on orthodontic services combined.⁸³ For the vast majority of children, braces are not medically necessary. In 2010 several individual orthodontists in Texas billed the Medicaid program for an amount greater than the entire state of Florida spent on orthodontics through Medicaid that year.⁸⁴ Mr. Millwee has admitted that Texas failed to effectively oversee and manage its Medicaid orthodontia program, particularly the prior authorization process. According to Mr.

⁷⁶ CMS: GUIDE TO CHILDREN'S DENTAL CARE IN MEDICAID, (2004) available at <http://www.cms.gov/MedicaidDentalCoverage/Downloads/dentalguide.pdf>.

⁷⁷ E-mail from Billy Millwee, State Medicaid Director, State of Texas, to Committee staff (March 30, 2012).

⁷⁸ Telephone Interview with Christine Ellis, Texas Orthodontist (April 17, 2012).

⁷⁹ In 1993, a class action lawsuit, *Frew v. Hawkins*, was filed against the state of Texas alleging that Texas did not provide adequate Early and Periodic Screening, Diagnosis and Treatment services for children enrolled in their Medicaid program. In 1996, the parties entered into a consent decree to resolve the issues brought in the suit. An agreed set of corrective actions was agreed upon by the parties (See STATE OF TEXAS HEALTH AND HUMAN SERVICES COMMISSION: HOUSE BILL 15, *FREW EXPENDITURE PLAN* (2007), available at http://www.hhsc.state.tx.us/medicaid/ExpenditurePlan_0907.pdf).

⁸⁰ See Corrective Action Order: Health Care Provider Training, *Frew v. Harkins*, No. 3:93-cv-00065-WWJ (E.D.TX), available at http://www.hhs.state.tx.us/MotionCorrectiveActions/CA_Docs/9HealthCareProviderTraining.pdf.

⁸¹ E-mail from Billy Millwee, *supra* note 77.

⁸² *Id.*

⁸³ Harris, *supra* note 5.

⁸⁴ Dr. Steven Chu, All Smiles Dental Clinic received \$2.7 million in 2010. This is as much as the entire state of Florida's Medicaid orthodontia program costs. Dr. Richard Malouf's All Smiles Dental Clinics, operating 51 clinics, received \$10.2 million in 2010 (3 times as much as entire state of Georgia's Medicaid dental program and 5 times that of Florida's). Navarro Orthodontics received \$22 million in 2010 (an increase of \$7 million from 2009 and \$2.5 million more than the state of California's Medicaid orthodontia program). Drs. Sheila Birth & Charles Stewart received more than \$5.4 million (\$2.1 million more than the state of Florida's program), and treated 4,300 more patients in 2010 than Florida's Medicaid orthodontia program (Harris, *supra* note 5).

Millwee, the state of Texas failed to detect or prevent flagrant abuses of the system, which should have been “low hanging fruit.”⁸⁵ The failure of Texas to detect an abuse that should have been “low hanging fruit” does not engender confidence in either the states or CMS’s oversight of the Medicaid program.

Texas contracted with a private contractor, Texas Medicaid and Healthcare Partnership (TMHP), to process the prior authorization applications. However, TMHP had only one dentist on staff, Dr. Jerry Felkner, who, along with the remainder of his mostly clerical staff, was tasked with assessing thousands of prior approval applications coming in each month. Although the number of dental reimbursement claims increased by 240% between 2007 and 2010, TMHP did not hire additional experts to process the prior approvals.⁸⁶ Mr. Harris learned during his investigation and Mr. Millwee confirmed to Committee staff that TMHP did not actually assess whether the medical necessity criteria was being met.⁸⁷ TMHP was only determining whether all the appropriate boxes were checked.⁸⁸ As long as all portions of the forms were completed, the prior authorizations were processed.⁸⁹ Since the prior authorizations were not effectively reviewed by qualified dental professionals, the problem grew and both Texas and federal taxpayers became victims of a massive Medicaid fraud scheme.

While Texas’s Medicaid director admitted that Texas failed to protect its taxpayer dollars and allowed this massive fraud to occur, the federal government failed in its oversight responsibilities as well. No one at CMS failed to prevent or even publicize that Texas’s Medicaid program was spending more on braces than the other 49 states combined. The Medicaid Fraud and Abuse Detection System (MFADS) did not consider orthodontia in its Surveillance and Utilization Review System (SURS), a system designed to identify providers that have service utilization patterns outside the practice of their peers.⁹⁰ Even if SURS had included orthodontia in its criteria, however, it is doubtful that CMS would have detected the fraud occurring in Texas program. This is likely the result of some combination of CMS failing to prioritize the detection of waste, fraud, and abuse; the poor quality data CMS receives from the states and an inability to properly analyze it; and the fact that fraud and abuse is so widespread in the Medicaid program that orthodontia slips under the radar.

Last year, the Texas Office of the Inspector General for the Department of Health and Human Services launched an audit of Medicaid spending on dental services.⁹¹ The audit, currently in progress, will review payments from September 1, 2008 through May 28, 2011.⁹² While the IG’s audit is a positive development and will shed helpful light on how this type of fraud occurred for years, policymakers must also examine the types of controls that states and CMS should put in place to deter this type of fraud. With a proper system in place, this type of fraud, which consists of dramatic overbilling of a particular service, should be the easiest type to

⁸⁵ Telephone Interview with Billy Millwee, State Medicaid Director, State of Texas (March 30, 2012).

⁸⁶ *Id.*

⁸⁷ *Id.*

⁸⁸ Harris, *supra* note 5.

⁸⁹ *Id.*

⁹⁰ *Id.*

⁹¹ *Id.*

⁹² *Id.*

detect. It is imperative that the government catch the fraud that is “low hanging fruit” before billions more taxpayer dollars are lost forever.

V. Conclusion

To put the size of the program in context, annual Medicaid spending now exceeds Wal-Mart’s worldwide annual revenue⁹³ and annual Medicaid spending is 40 percent larger than Greece’s entire economy.⁹⁴ The program has grown so large and so complex that it is unmanageable at the federal level and is highly vulnerable to waste, fraud, and abuse. No one knows how much of Medicaid’s budget consists of waste, fraud, and abuse, but it may exceed \$100 billion a year.⁹⁵ If private-sector companies allowed even a fraction of this type of mismanagement, their stockholders would demand immediate reform and that the individuals responsible for the mismanagement be fired. Americans who work hard and pay the taxes that fund the Medicaid program deserve no less from their government. Rather than adding more people into a broken program, Congress should consider policies that realign state and provider incentives so that our nation’s limited tax resources are targeted to those individuals who genuinely need public assistance.

ⁱ A previous version of the report had the line “According to the IG, CMS is often less than helpful in recovering money from the states.”

⁹³ In fiscal year 2011, Wal-Mart’s revenue was \$422 (Seeking Alpha, “10 Undervalued Companies Paying You While You Wait for Their Valuations to Grow” (June 28, 2011), available at <http://seekingalpha.com/article/276935-10-undervalued-companies-paying-you-while-you-wait-for-their-valuations-to-grow>).

⁹⁴ Greece’s estimated GDP for 2011 is \$308 billion. (U.S. Central Intelligence Agency, “World Factbook” (accessed April 23, 2012), available at <https://www.cia.gov/library/publications/the-world-factbook/geos/gr.html>).

⁹⁵ On May 20, 2009, Malcolm Sparrow, a leading scholar on health care fraud at Harvard University, testified at a congressional hearing that “losses due to healthcare fraud and abuse in this country are hundreds of billions of dollars per year. We just don’t know the first digit. It might be as low as one hundred billion. More likely two or three. Possibly four or five.” (*Criminal Prosecution as a Deterrent to Health Care Fraud: Hearing Before the Subcomm. on Crime and Drugs of the Senate Comm. on the Judiciary*, 111th Cong. (2009) (statement of Malcolm Sparrow, Harvard University)).