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Good Morning Mr. Chairman and Members of the Committee. On behalf of the Office of Inspector General, we appreciate the Committee's devoting these two days to address important issues associated with the Medicaid program. We are pleased to have the opportunity to provide three witnesses during this hearing to discuss these issues.

My testimony describes the roles of our office, the Centers for Medicare & Medicaid Services (CMS), and the States in meeting the challenges of overseeing the Medicaid program. I will discuss issues associated with identifying and resolving fraud. I will also discuss some specific program vulnerabilities identified in our work, which we believe merit attention and corrective action.

### **FEDERAL AND STATE PARTNERSHIP TO SHARE COSTS**

A major responsibility of our office is to ensure that the Federal share of Medicaid is paid correctly and appropriately. Because Medicaid is a matching program, improper payments by States to providers always cause corresponding improper Federal payments. However, because the Federal Government does not routinely examine individual provider claims, inappropriate claims by States for a Federal share are not always easily identified. The Federal share of Medicaid outlays in fiscal year (FY) 2004 exceeded \$176 billion and is expected to exceed \$192 billion in FY 2006. In FY 2004, 43.7 million federally eligible children and adults were covered by Medicaid, and the number of federally eligible enrollees is expected to exceed 46 million in FY 2006.<sup>1</sup>

Medicaid operates as a vendor payment program. States may pay health care providers directly on a fee-for-service basis, and States may also have managed care arrangements. Most States have at least some portion of their beneficiaries in managed care. In total, about half of the Medicaid population nationwide is enrolled in managed care, with the other half remaining in fee-for-service. Within federally imposed upper limits and specific restrictions, States have broad discretion in determining the payment methodology and payment rate for services.

The Federal Government pays a share of each State's Medicaid program costs. That share, known as the Federal Medical Assistance Percentage (FMAP), is determined annually by a formula that compares the State's average per capita income level with the national income average. States with a higher per capita income level are reimbursed a smaller share of their costs. By law, the FMAP cannot be lower than 50 percent or higher than 83 percent. With certain exceptions, Federal payments to States for medical assistance have no set limit. Rather, the Federal Government matches (at FMAP rates) the States' outlays for covered items and services and also matches, at the appropriate administrative rate (typically 50 percent), all necessary and proper administrative costs.

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<sup>1</sup> CMS FY 2006 Budget in Brief.

## IDENTIFYING AND RESOLVING IMPROPER PAYMENTS AND FRAUD

Controlling the cost of Medicaid involves both identifying and resolving improper and fraudulent payments and improving the program through our audits, program evaluations, investigations, and the use of statutory authorities to sanction providers who have engaged in fraud. My testimony addresses each of these matters.

### Types of Improper Payments

While some improper payments are fraudulent, we believe most are not. Although we have no data on the amount of improper payments or the percentage of improper payments that are fraudulent, our sense is that the vast majority of providers are honest in their billings for Medicaid reimbursement. However, improper payments may arise because of clerical errors, misinterpretations of rules, or poor record keeping. Improper payments include both overpayments and underpayments and are generally adjusted or collected administratively. Common categories of improper payments include:

- Unsupported Services. Providers must maintain records that are sufficient to justify diagnoses, admissions, treatments performed, and continued care. When the records are insufficient or missing, claims reviewers cannot determine whether services billed were actually provided to beneficiaries, the extent of the services, or their medical necessity. An item or service that is not adequately documented should not be billed to Medicaid.
- Medically Unnecessary Services. The documentation in the medical records leads to an informed decision by a claims reviewer that the medical services or products received were not medically necessary.
- Incorrect Coding. Standard coding systems are used to bill State Medicaid programs for services provided. In a coding review, medical reviewers determine whether the documentation submitted by providers supports a lower or higher reimbursement code than was actually submitted.
- Noncovered Costs or Services. These are costs or services that Medicaid will not reimburse because they do not meet the State's Medicaid reimbursement rules and regulations. A Federal share would not be paid for such costs or services.
- Third-Party Liability. Medicaid inappropriately pays claims, and is generally not reimbursed, for beneficiaries who have other sources of payment, such as private insurance.

### Types of Fraudulent Activities

Some of the billings and related practices that are determined to be improper are also determined to be fraudulent. Fraudulent behavior may arise when enrollment procedures for

providers are inadequate, internal controls are deficient, payment rates are excessive (inviting fraudulent and abusive behavior), or when especially vulnerable beneficiaries can be exploited easily. The types of fraudulent schemes we see in the Medicaid program in many ways mirror those in Medicare:

- Billing for Services Not Provided. This is one of the most common types of fraud. Examples include a provider who knowingly bills Medicaid for a treatment or procedure that was not actually performed, such as blood tests when no samples were drawn or x-rays that were not taken.
- False Cost Reports. A nursing home owner or hospital administrator may intentionally include inappropriate expenses not related to patient care on cost reports submitted to Medicaid.
- Illegal Remunerations (Kickbacks). A provider (such as a nursing home operator) may conspire with another health care provider (such as a physician or ambulance company) to share a part of the monetary reimbursement the health care provider receives in exchange for the referral of patients. Such kickbacks include not only cash, but vacation trips, automobiles, or other items of value. The practice results in encouraging unnecessary tests and services to be performed for the purpose of generating additional income to both the referring source and the provider of the service.

As I will outline below, the responsibility for detecting improper payments and investigating and prosecuting fraud and abuse in the Medicaid program is shared between the Federal and State governments.

### **Role of the Centers for Medicare & Medicaid Services**

In 1996, CMS established a program integrity group to address fraud and abuse issues within the Medicaid and Medicare programs. This group conducts and oversees many projects that are intended to reduce program fraud. June 1997 marked the beginning of a national intergovernmental initiative to reduce Medicaid fraud and abuse. Accomplishments include presenting intergovernmental executive seminars and issuing a comprehensive plan for program integrity; guidelines for addressing fraud and abuse in Medicaid managed care; and a resource guide of State fraud and abuse systems. This initiative is now known as the Medicaid Alliance for Program Safeguards. Among other activities, the Alliance is conducting a series of program integrity reviews at State Medicaid agencies designed to help States strengthen their program integrity operations to prevent, identify, and resolve improper and fraudulent Medicaid payments. CMS is also leading the development of a methodology to measure the national and State-level Medicaid program error rate. Another effort, called the Medi-Medi pilot, compares Medicare and Medicaid billing data to identify aberrant provider billings, such as situations in which both programs are billed for the same items and services.

## **Role of State Medicaid Agencies in Identifying Fraud**

Each of the State Medicaid agencies is required to have a program integrity (PI) unit or other office that conducts preliminary investigations of suspected fraud and refers cases to the State's Medicaid Fraud Control Unit or other appropriate law enforcement officials for a full investigation. In addition, each of the State Medicaid agencies has a data system, called the Surveillance and Utilization Review Subsystem (SURS), which is a part of the State's Medicaid Management Information System. In smaller States, the SURS units may also operate the PI units, conducting preliminary reviews of Medicaid fraud or abuse and referring appropriate cases for a full investigation. In all States, SURS applies automated post-payment screens to Medicaid claims to identify aberrant billing patterns that may indicate fraud or provider abuse. When potential fraud cases are detected, the State agency refers the cases to the State's Medicaid Fraud Control Units.

## **Role of State Medicaid Fraud Control Units**

State Medicaid Fraud Control Units are part of the State Attorney General's office or other State agency that is separate and distinct from the Medicaid State agency. The purpose of the Units is to investigate and prosecute Medicaid provider fraud, patient abuse or neglect, and fraud in the administration of the program.

As noted above, by regulation, States' Medicaid agencies are required to refer appropriate cases to the Medicaid Fraud Control Units for a full investigation. We continuously receive comments from the Medicaid Fraud Control Units indicating that Medicaid agency referrals are inadequate in many States. Such statements demonstrate that our findings in a 1996 inspection, in which we determined that the number and percentage of suspected fraud referrals to the Medicaid Fraud Control Units from the SURS units had declined during the preceding 10 years, continue to be a problem. At the time, officials at the State Medicaid Fraud Control Units were divided in their opinions as to the extent and quality of SURS development of fraud allegations and computer edits. Our anecdotal experience is that the lack of referrals is still viewed as a serious problem in many States.

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

Financial fraud. Over the years, the Units have recovered hundreds of millions of dollars. The following chart shows the Units' funding and statistical accomplishments for the past 10 years. Recoveries include settlements or court-ordered restitution, fines, and penalties.

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

<b>Year</b>	<b>Federal Expenditure*</b>	<b>Federal/State Recoveries</b>	<b>Convictions</b>
2004	\$131,086,294	\$572,585,322	1,160
2003	119,831,000	268,481,661	1,096
2002	116,979,079	288,315,524	1,147
2001	106,699,505	252,585,423	1,002
2000	95,979,000	180,941,872	970
1999	89,703,745	88,738,327	886
1998	85,793,887	83,625,633	937
1997	80,557,146	147,642,299	871
1996	77,453,688	57,347,248	753
1995	73,258,421	88,560,361	684

\* Amount of Federal grant award that was received by the Units.

Patient Abuse. While not the focus of this hearing, investigating patient abuse and neglect in Medicaid-funded facilities and in board and care facilities is another major responsibility for the State Medicaid Fraud Control Units. In most instances, these cases do not generate monetary returns, but are critical to the provision of high quality and appropriate care, especially for our Nation's frail elderly.

**Role of OIG in Overseeing the State Medicaid Fraud Control Units**

The State Medicaid Fraud Control Units grant program was originally managed within CMS (then the Health Care Financing Administration (HCFA)). Because the Units' activities were determined to be more closely related to the OIG's investigative function than to HCFA's program management role, in 1979, the grant management and oversight responsibilities for the program were transferred to the Office of Inspector General. The States are reimbursed for the operation of the Units at a rate of 90 percent of costs for the first 3 years after the Unit's initial certification by OIG and 75 percent thereafter. During FY 2005, OIG will administer approximately \$149.4 million in grant funds to the Units.

The OIG's responsibilities for oversight of the funding and operating standards of the Medicaid Fraud Control Units include monitoring their overall performance and productivity and ensuring that they devote their full-time efforts to Medicaid fraud and patient abuse, rather than being deployed to other matters.

Our duties also include the initial certification and yearly recertification of the Units. Regulations require the Units to submit an application to our office with an annual report and a budget request. The Unit's application, annual report, budget, and quarterly statistical reports are reviewed to determine if the Units are in conformance with performance standards that were developed jointly by OIG and the Units themselves. Another mechanism our office uses to assess the Units' performance is feedback from the State Medicaid Agency

and our own Office of Investigations field offices. Our staff is now conducting between 8 and 14 on-site inspections annually. We maintain ongoing communication with individual State Units and the National Association of Medicaid Fraud Control Units related to the interpretation of program regulations and other policy issues.

Our office, the Medicaid Fraud Control Units, and other law enforcement agencies work closely together on fraud cases and other activities, and these partnerships have greatly enhanced OIG's ability to carry out its mission. Generally, the State Medicaid Fraud Control Units focus on Medicaid fraud, and OIG's own investigators focus on Medicare fraud. However, many providers who are involved in illegal activities are found to be defrauding both programs at the same time. Therefore, an investigation of either program may reveal fraud in the other program as well. In FY 2004, OIG conducted joint investigations with the Units on 314 criminal cases and 91 civil cases and achieved 64 convictions. The amount of civil recoveries by the Medicaid Fraud Control Units has been increasing since 1999, and at least two of the States have designated special sub-units to develop civil fraud cases.

One area of increasing activity by the Medicaid Fraud Control Units is in civil litigation. Under a 1999 policy interpretation by our office, the Units are expected to investigate any potential criminal violations first and must then consider if there is a civil fraud case. Civil fraud cases may be pursued under State laws, including false claims acts in those States that have such laws, or under the Federal Civil False Claims Act, which has been a longstanding and powerful tool in the fight against health care fraud and abuse. Under the False Claims Act, the Department of Justice may pursue False Claims Act penalties and damages. Under our own administrative sanction authorities, OIG may pursue civil monetary penalties and exclusion of providers for violations of health care laws.

OIG, along with the Department of Justice and other Federal law enforcement agencies, has achieved major successes in using the False Claims Act, and in particular its qui tam<sup>2</sup> provisions, in pursuing fraud in both the Medicare and Medicaid programs. Many of these cases have been brought against pharmaceutical companies, as will be further explained in testimony tomorrow by Regional Inspector General Robert Vito.

### **OIG and State Medicaid Audit Partnerships**

In addition to our oversight of and assistance to the State Medicaid Fraud Control Units, our office has initiated a number of partnerships with State auditors. Several years ago, OIG began an initiative to work more closely with State auditors in reviewing the Medicaid program. A partnership plan was created as a way to provide broader coverage of the Medicaid program by partnering with State auditors, State Medicaid agencies, and State internal audit groups. The level of involvement of each partner is flexible and can vary depending on specific situations and available resources. In one instance, the OIG role may

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2 The qui tam provisions allow whistle blowers to bring suit under the False Claims Act seeking recoveries against defrauders of government programs. The Department of Justice (DOJ) determines whether or not to intervene in the case; the case may proceed without DOJ. In either case, the whistle blower, or "relator," may share in any later recoveries, whether ordered by a court, or as the result of a settlement.

entail the sharing of our methodology and experience in examining similar Medicare issues. In other cases, we may join together with State teams to audit suspected problems.

Issues examined in this partnership initiative include Medicaid outpatient prescription drugs, unbundling of clinical laboratory services, outpatient nonphysician services already included as an inpatient charge, excessive costs related to hospital transfers, excessive payments for durable medical equipment, acquisition costs for Medicaid drugs, and program issues related to managed care.

This partnership approach provides broader coverage of the Medicaid program and maximizes the impact of scarce audit resources by both the Federal and State audit sectors. To date, these joint efforts have been developed in 25 States. Completed reports have identified \$263 million in Federal and State savings and included recommendations for improvement in internal controls and computer systems operations.

### **Role of OIG in Identifying Improper Payments**

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

## **IMPROVING THE MEDICAID PROGRAM**

In addition to identifying misspent funds, OIG's audits are always intended to bring about program improvements and thus help reduce the cost of providing necessary services to Medicaid beneficiaries. OIG also has an active evaluation function focused on finding ways to improve the program. These evaluations focus on whether the Medicaid program is managed properly and pays a fair price in the health care marketplace.

Over the years, our audits and evaluations have addressed numerous vulnerabilities in the Medicaid program. We provide a complete list of our unimplemented recommendations in our "Red Book"<sup>3</sup> and "Orange Book"<sup>4</sup> that are published annually on our Web site. Below are some of the more notable topics that we believe still merit attention and require corrective action.

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<sup>3</sup> The Red Book is the OIG's Cost Saver Handbook.

<sup>4</sup> The Orange Book is the OIG's Program and Management Improvement Recommendations.

Following are examples of audits and evaluations of Medicaid practices and policies:

- OIG audited enhanced payments made to local public hospitals and nursing facilities under upper payment limit (UPL) rules in several States and found that billions of Medicaid dollars were, in effect, at risk of being diverted from their intended purpose. These practices disproportionately shift the cost of Medicaid to the Federal Government, contrary to Federal and State cost-sharing principles. In accordance with our early work, regulatory improvements were made. However, additional changes are needed to curb ongoing abuses. Recent OIG work at individual nursing facilities has demonstrated that States still divert enhanced funding from poorly functioning facilities to other purposes, with negative implications for quality of care. This work will be described by our Assistant Inspector General for CMS Audits, George Reeb, during the next panel.
- OIG's audits and evaluations of Medicaid drug pricing issues over the past decade have clearly demonstrated that Medicaid pays too much for prescription drugs and that implementing a variety of options could improve States' programs and lead to substantial savings. In accordance with our findings, States have made a number of changes in their reimbursement amounts and methods, but more improvements are needed. At tomorrow's hearing, our Regional Inspector General from Philadelphia, Robert Vito, will review our body of work and introduce new reports regarding the potential impact if Medicaid were to change its basis of reimbursement from certain published prices (including the commonly used average wholesale price) to a sales-based price. The ultimate goal of this work is to help ensure that Medicaid's prescription drug programs pay a fair price that reasonably reflects actual acquisition costs.
- OIG recently reviewed internal controls in 48 States and the District of Columbia to determine whether drug rebates are collected properly. A national rollup report of findings and recommendations is being prepared with the goal of encouraging States to improve their rebate collection systems. Of the States audited, only four had no weaknesses in accountability and internal controls over their drug rebate programs. For the remaining States and the District of Columbia, we identified the following weaknesses: (1) unreliable information submitted to CMS on Form CMS 64.9R (37 States), (2) improper accounting for interest on late rebate payments (27 States), (3) an inadequate rebate collection system (17 States), and (4) an inadequate dispute resolution and collection process (15 States).
- In 2000, OIG issued three reports on evaluations of Medicaid's program safeguards. The first report described activities that occur before claims for payment are generated; the second described methods to ensure that submitted claims are properly adjudicated; and the third contained information about post-payment safeguards. The reports were issued in concert with CMS's efforts to invigorate the States' interest in better program integrity practices.



- Several years ago, OIG studied tax and donation schemes and the practice of transferring assets to attain eligibility for Medicaid long term care. The OIG's work helped bring about regulatory and statutory improvements at that time. Now, the Administration and Congress are revisiting these policy areas to determine how they can be strengthened to further control program costs. At the request of CMS, OIG is in the process of conducting a new review of Medicaid provider tax issues.
- OIG conducted a third party liability evaluation that estimated that \$367 million is at risk of being lost when Medicaid pays pharmacy claims for beneficiaries who have other insurance. Even though Medicaid is the payer of last resort, Medicaid sometimes pays the pharmacy claim and then attempts to recover the payment from the third-party health insurance in an approach referred to as "pay and chase." Almost three-quarters of States reported that third parties refuse to process or pay pharmacy claims that Medicaid has already paid.

### CONCLUSION

In conclusion, Mr. Chairman, our office will continue to devote considerable resources to auditing and evaluating the Medicaid program to identify payment issues and errors, to improve the program, and, when necessary, to pursue appropriate law enforcement actions to recover funds paid to fraudulent providers. We also will continue to collaborate with CMS, State auditors, the State Medicaid Fraud Control Units, the Department of Justice, and other intergovernmental enforcement agencies to identify and resolve fraud and abuse. The management and fiscal integrity of the Medicaid program is one of OIG's top priorities. I appreciate this opportunity to testify, and I welcome your questions.