

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

The Office of Inspector General

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

The Medicaid Program

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

Medicaid Fraud Investigations

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

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

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

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

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

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

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

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

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

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

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

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

State Medicaid Audit Partnerships

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

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

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

OIG Audits of Medicaid Issues

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

State Abuses of Medicaid Payment Systems

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

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

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

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

- In general, enhanced payments to city- and county-owned providers were not based on the actual cost of providing services to Medicaid beneficiaries or directly related to increasing the quality of care provided by the public facilities that received the enhanced payments.
- Enhanced payments to nursing home facilities were not retained by the facilities to provide services to Medicaid beneficiaries. Instead, billions of Federal Medicaid dollars were returned by the providers to the States through intergovernmental transfers.
- Some of the money sent back to the State governments were deposited in the general fund or earmarked for use in health related service areas, but not necessarily for the Medicaid services approved in the State plan. Those funds that were used for Medicaid purposes were used as the States' share to match more Federal funds.
- Unlike nursing facilities, public hospital providers retained the majority of the Medicaid enhanced payments but still returned millions of dollars in disproportionate share payments to the States for other uses through intergovernmental transfers.

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

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

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

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

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

Medicaid Prescription Drug Pricing

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

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

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

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

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

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

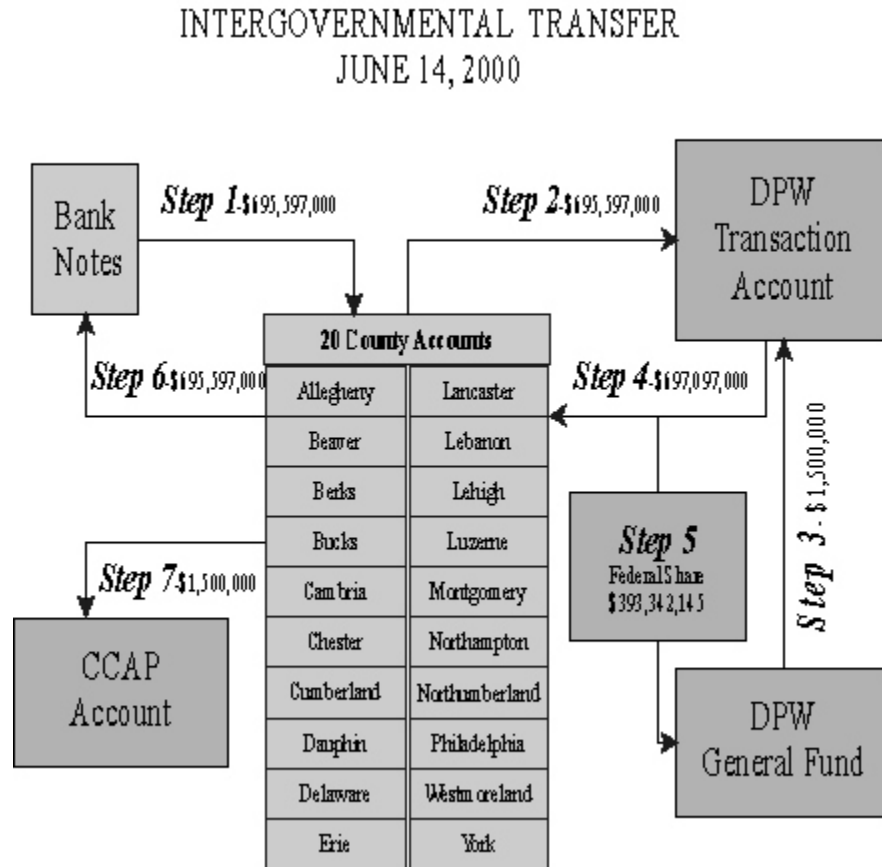
Because of interest shown by the States and some industry groups, we will provide a more comprehensive breakdown of the above noted discount percentages as part of a new report planned for later this summer.

Conclusion

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

APPENDIX

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



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

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

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

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