Testimony of
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Good Morning Mr. Chairman and Members of the Committee. On behalf of the Office of Inspector General (OIG) at the U.S. Department of Health and Human Services (HHS), I would like to thank you for this opportunity to contribute to today's hearing on eliminating fraud in Medicaid. I am accompanied by Michael E. Little, Deputy Inspector General for Investigations.

My testimony highlights OIG's role under the Medicaid program integrity provisions of the recently enacted Deficit Reduction Act of 2005 (DRA); the program integrity responsibilities of the Centers for Medicare & Medicaid Services (CMS), the States, and OIG in overseeing Medicaid; and the increased use of Federal and State civil and administrative litigation cases to address Medicaid fraud and abuse. I will close with a discussion of OIG's investigative priorities.

The Federal Government pays a share, known as the Federal Medical Assistance Percentage (FMAP), of each State's Medicaid costs. Because Medicaid is a matching program, improper payments by States to providers virtually always result in corresponding improper Federal payments, whether payments for medical services or for administrative cost reimbursement. The Federal share of Medicaid outlays is expected to exceed $192 billion in FY 2006 and could approach $200 billion in FY 2007. Medicaid currently represents over 28 percent of the total budget of the U.S. Department of Health and Human Services.[1]

MEDICAID INTEGRITY PROVISIONS IN THE DEFICIT REDUCTION ACT OF 2005, PUBLIC LAW 109-171

The recently-enacted DRA includes several provisions that build on existing efforts to strengthen Medicaid program integrity. The DRA includes the creation of a new Medicaid Integrity Program, which is modeled after the Medicare Integrity Program that was established by law a decade ago. The DRA also provides incentives for States to enact and enforce false claims acts; prohibits providers from billing Medicaid multiple times for the same drug; enhances third party liability enforcement; improves enrollment documentation requirements; and creates Medicaid transformation grants for States to use to adopt innovative cost-saving methods.

The new Medicaid Integrity Program provides funding for the Secretary to enter into contracts with eligible entities to carry out Medicaid program integrity activities and also funds contracts to expand the Medicare-Medicaid Data Match Pilot Program (Medi-Medi program) that compares billings to both the Medicare and Medicaid programs by the same provider to identify aberrant patterns. OIG welcomes the addition of new contracting entities to bolster Medicaid program integrity activities and Medi-Medi. I will defer to CMS for a description of its plans for implementing and managing the program integrity contracts and for evaluating their contributions to the overall process.

The DRA provides an additional Medicaid-specific funding stream for OIG, which will allow us to increase participation and exert leadership in a number of Medicaid integrity efforts. In designing and implementing projects like Medi-Medi, CMS works with OIG, the Department of Justice

[1] The HHS Budget in Brief estimates $199.3 billion (rounded) in Medicaid program outlays in FY 2007.

(DOJ), and other oversight entities to ensure that such projects operate efficiently and effectively. As resources allow, OIG participates in various projects to identify areas of vulnerability, questionable provider billings, and patterns of abuse and neglect that are then formally investigated. These projects include the use of data-mining, community outreach, and other quality of care monitoring tools.

Under the DRA, we plan to dedicate more resources to the Medi-Medi project so that a full time OIG presence on the project might encourage further focusing of the data-mining and increase the number and quality of the cases that are referred by the project to law enforcement. The targeted Medicaid resources in the DRA will increase OIG's ability to become a more active full-time participant and leader in this and similar Medicaid program integrity projects.

The same is true of the quality of care initiative OIG jointly conducts with DOJ and others. While our efforts to address "failure of care" cases are extensive, the targeted DRA resources will allow us to work even more closely with CMS, the State Survey and Certification teams, Medicaid Fraud Control Units (MFCUs), and the State Long Term Care Ombudsmen to identify entities where there appears to be abuse and neglect of such a nature as to justify further investigation. OIG works with Federal prosecutors, the FBI, and State and local law enforcement agencies to conduct investigations into these matters and remedy the wrongdoing.

Further, DRA resources will allow OIG to continue its work with the National Association of Medicaid Fraud Control Units (NAMFCU), MFCUs, and State Medicaid Agencies (State Agencies) to conduct training to better enable program administrators and claims examiners to identify questionable billing practices earlier and more effectively. Such training is designed to assist agencies in gathering the information that is needed by investigators and prosecutors to successfully prosecute these cases.

FEDERAL AND STATE ROLES AND RESPONSIBILITIES

In 1977, Public Law 95-142 (the Medicare-Medicaid Antifraud and Abuse Amendments of 1977) was enacted to strengthen the capability of the Government to detect and prosecute fraudulent activities under the Medicare and Medicaid programs. CMS has a key role in Medicaid program integrity as the Federal program manager, and the State Agencies and MFCUs are responsible for protecting the integrity of the Medicaid program. State Agencies and MFCUs each perform unique roles in carrying out program integrity activities. OIG's authorities with regard to all of the Department's programs to prevent and detect waste, fraud, and abuse, and to promote economy, efficiency, and effectiveness apply fully to Medicaid.

CMS Responsibilities

CMS is responsible for overseeing each State's comprehensive State Medicaid Plan to ensure State compliance with Federal laws, regulations, and departmental policies, including the detection, development, and referral of suspected fraud cases. CMS is required to review State Agency performance through onsite reviews and examination of individual case records.[2] In 1996, CMS established a program integrity group to address fraud and abuse issues within the Medicare and Medicaid programs. This group conducts and oversees many projects that are intended to reduce program fraud.

[2] 42 CFR § 430.32(a).

State Agency Responsibilities

State Agencies are responsible for establishing policies, computer systems and edits to process Medicaid claims and for conducting analyses of providers' patterns of practice (data-mining). Federal regulations require State Agencies to conduct preliminary investigations when they identify questionable practices or receive complaints of suspected Medicaid fraud or abuse.[3] When the results of a preliminary investigation give a State Agency reason to believe that fraud has occurred, typically it must refer the matter to the State's MFCU for investigation.[4] Overpayments that are not the result of fraud generally remain in a State Agency's jurisdiction for collection.

To accomplish these tasks, State Agencies must have certain information processing systems, including a Medicaid Management Information System and a Surveillance and Utilization Review Subsystem (SURS).[5] Automated mechanized claims processing and information retrieval systems are used not only to process Medicaid claims for medical services, but also are used by the SURS staff to retrieve and produce service utilization and management information for program administration and audit purposes.

States establish various structures to carry out program integrity functions. Some State Agencies exclusively use staff within the SURS unit to conduct required analyses, while others have established comprehensive program integrity or Inspector General units to oversee these functions. In smaller States, the SURS units may operate the program integrity units, conducting preliminary reviews of potential Medicaid fraud or abuse and referring appropriate cases for full investigations.

In all States, the SURS units apply automated post-payment screens to Medicaid claims to identify aberrant billing patterns that may indicate fraud or abuse. When potential fraud cases are detected, the State Agency is required to refer the cases to the State's MFCU. Despite SURS being an important detection mechanism, OIG has found that the quality and quantity of referrals need improvement in many States. However, OIG has also observed that positive interagency and staff relationships between State Agencies and their respective MFCUs tend to contribute to successful referrals and resolution of fraud.

Medicaid Fraud Control Unit Responsibilities

MFCUs are responsible for investigating and prosecuting provider fraud and patient abuse and neglect.[6] They integrate the skills of criminal investigators, attorneys, and auditors to carry out their mission. Section 1903(q)(6) of the Social Security Act requires that MFCUs be composed of at least one investigator, one attorney, and one auditor.[7] MFCUs must be single identifiable entities of the State government and certified annually by OIG as meeting Federal requirements, including location within State government, staffing, roles, and responsibilities.[8] MFCUs receive at least 75 percent of their funding from a Federal grant managed by OIG. Forty-eight States and

[3] 42 CFR § 455.14.
[4] 42 CFR § 455.15.
[5] 42 CFR § 456.3.
[6] Social Security Act, § 1903(q)(3).
[7] See also 42 CFR § 1007.13.
[8] 42 CFR § 1007.15.

the District of Columbia have established MFCUs.[9] Most MFCUs are located within the State Attorney General's office.

Under a 1999 amendment to the MFCU statute, the jurisdiction of the MFCUs was expanded to allow them to investigate and prosecute Medicare or other health care fraud, in addition to Medicaid, if the following conditions are met: (1) the OIG of the relevant Federal agency (such as HHS OIG for the Medicare program) approves the case, and (2) the "suspected fraud or violation of law" primarily concerns Medicaid, i.e., the Medicare and other health care fraud allegation is a part of a case that is primarily a Medicaid fraud case. The same statutory amendment also authorized MFCUs to investigate patient abuse and neglect in non-Medicaid "board and care" facilities.

In addition to receiving referrals of allegations from the State Agencies, MFCUs 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 referred to a MFCU is determined to involve 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 MFCU fully investigates and ensures appropriate resolution, including prosecution. Outcomes may include convictions, restitution, fines, penalties, or corporate integrity agreements, as well as incarceration.

The following chart shows MFCUs' funding and statistical accomplishments for the past 10 years. The Federal/State investigative receivables include settlements or court-ordered restitution, fines, and penalties.

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

Year	Federal Grants*	Federal/State Receivables	Convictions
2005	$144,330,097	$709,619,411	1,123
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

* Amount awarded to MFCUs.

This chart provides a rough measurement of MFCU accomplishments and does not reflect the responsibilities MFCUs have for investigating patient abuse and neglect in Medicaid-funded

[9] North Dakota and Idaho have not established MFCUs, and, in these two States, the State Agency is responsible for conducting investigations and referring cases to State or local prosecutors.

facilities and in board and care facilities. 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. Later in my testimony, I will describe nursing home quality of care, which includes patient abuse, as a priority concern of OIG as well.

OIG Responsibilities

Protecting the integrity of all HHS programs is at the core of OIG's mission. Accordingly, OIG initiates audits, evaluations, and investigations of the expenditure of Medicaid dollars and the operation of the Medicaid program as appropriate. We have developed good working relationships with the agencies responsible for identifying, preventing, and curbing fraud in Medicaid. In addition to CMS, the State Agencies, and MFCUs, OIG partners with the NAMFCU, State and local law enforcement, the HHS Administration on Aging, State Long Term Care Ombudsmen, the FBI, and DOJ.

Currently, approximately 23 percent of OIG's resources under the Health Care Fraud and Abuse Control account are focused on Medicaid matters. With regard to our investigative work, many of these matters are investigated jointly with MFCUs and/or the FBI. By working with these agencies to identify questionable provider billings, we maximize the impact of the resources available and focus on the providers that are causing the most harm to the program and to its beneficiaries. The structure of these relationships is different in each State because the Medicaid program structure is unique to each State.

OIG's Role in State Medicaid Audit Partnerships

One of OIG's major outreach initiatives has been to work more closely with State auditors in reviewing the Medicaid program. To this end, a partnership plan was developed to foster joint reviews and provide broader coverage of the Medicaid program. The partnership approach has proven an overwhelming success in ensuring more effective use of scarce audit resources by both the Federal and the State audit sectors. To date, partnerships on such issues as prescription drugs, clinical laboratory services, the drug rebate program, school-based services, durable medical equipment, hospital transfers and transportation have been developed in 25 States. Reports have resulted in identification of more than $262 million in Federal and State savings and have led to joint recommendations for savings at the Federal and State levels, as well as improvements in internal controls and computer system operations.

OIG's Role in Identifying Improper Payments

Improper or fraudulent payments result in a substantial drain on State and Federal funds. Therefore, OIG directly conducts a large number of Medicaid audits and evaluations on our own initiative or at the request of CMS, the Department, or Congress. Intended to identify improper payments, these audits and evaluations not only reveal questionable billings, but sometimes also expose fraud, program management deficiencies, 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 seeks to recover the Federal share from the States. If possible fraud is found, our investigators review the matter and determine whether to open an investigation. Our auditors may also assist in the ongoing investigations being conducted by our office or other law enforcement agencies.

OIG's Oversight of MFCUs

In addition to OIG's general Medicaid oversight work, as mentioned previously, the Secretary delegated to OIG the responsibility for administering grants to fund MFCUs' ongoing operations. The States are reimbursed for the operation of MFCUs 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. Thus far in FY 2006, OIG has awarded approximately $159.1 million in grant funds to MFCUs.

OIG's responsibilities for oversight of the funding and operation standards of MFCUs include monitoring their overall performance and productivity and ensuring that they devote their full-time efforts to Medicaid-covered health care fraud and patient abuse. Our oversight also includes responsibility for the initial certification and yearly recertification of MFCUs. Regulations require MFCUs to submit an application to our office with an annual report and a budget request. The MFCUs' applications, annual reports, and budget requests are reviewed to determine if they are in conformance with performance standards that were developed jointly by OIG and MFCUs. OIG also relies on feedback from the State Agency and OIG's Office of Investigations field offices to assess MFCUs' performance. OIG staff are now conducting between 8 and 14 on-site reviews annually. We maintain ongoing communication related to the interpretation of program regulations and other policy issues with individual State MFCUs and NAMFCU.

For example, OIG works with NAMFCU to train MFCUs on the importance and effectiveness of using the exclusion process to ban problem providers from participating in Federal and State health care programs. In addition to providing speakers at NAMFCU's annual conferences, OIG staff routinely conduct outreach and training with individual State Agencies and MFCUs, as well as licensing boards and State and local prosecutors, to establish case referral processes and to develop the working relationships that will allow potential exclusion matters to reach OIG.

Our office, MFCUs, 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 our mission. Generally, the MFCUs focus on Medicaid fraud, and OIG's 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 2005, OIG conducted joint investigations with MFCUs on 331 criminal cases and 95 civil cases and achieved 54 convictions and 28 settlements or judgments in civil cases.

FEDERAL AND STATE CIVIL LITIGATION INVOLVING MEDICAID

OIG, along with DOJ and other Federal law enforcement agencies, has achieved major successes in using the civil False Claims Act, and in particular its *qui tam*[10] provisions, in pursuing fraud in both the Medicare and Medicaid programs. Many major cases have been brought against pharmaceutical manufacturers in particular.

[10] The *qui tam* provisions allow whistleblowers to bring suit under the civil False Claims Act seeking recoveries against defrauders of government programs. DOJ, with input from OIG, determines whether or not to intervene in the case; the case may proceed without DOJ. In either case, the whistleblower, or relator, may share in any later recoveries, whether ordered by a court or as the result of a settlement.

States are increasing their own efforts in civil litigation. The amount of civil recoveries by MFCUs has been increasing in recent years. Under a 1999 policy interpretation by OIG, MFCUs are expected to investigate any potential criminal violations 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, DOJ may seek penalties and damages. Under our own administrative sanction authorities, OIG may impose civil monetary penalties and exclude providers for violations of Federal health care laws.

The DRA specifies that OIG, in consultation with the Attorney General, will review State laws relating to false and fraudulent claims to determine that the laws (1) establish liability to the State for false or fraudulent claims described in the Federal False Claims Act with respect to Medicaid expenditures; (2) contain provisions that are at least as effective in rewarding and facilitating *qui tam* actions as those in the Federal False Claims Act; (3) contain a requirement for filing an action under seal for 60 days with review by the State Attorney General; and (4) contain a civil penalty that is not less than the amount authorized by the Federal False Claims Act. If a State has in effect a law relating to false or fraudulent claims that meets Federal requirements, the State is entitled to a greater share of the recoveries in any action brought under such a law. This provision is effective January 1, 2007.

The DRA requires certain Medicaid providers to educate their employees about false claims recoveries. Entities meeting certain criteria are required, as a condition of receiving Medicaid payments, to establish written policies, procedures, and protocols for training all employees, contractors, or agents of the entity. This training must include a detailed discussion of the Federal False Claims Act, Federal administrative remedies for false claims and statements, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws. We anticipate that this employee education will result in better awareness of fraud in the work place and may help prevent fraud and abuse of the Federal health care programs.

OIG'S INVESTIGATIVE PRIORITIES

OIG's criminal investigations and related activities supplement MFCUs' efforts to curb Medicaid fraud. In the current and coming fiscal year, OIG's antifraud priorities in Medicaid will include:

- working more closely with MFCUs and CMS in the States that participate in Medi-Medi projects;
- focusing on areas of the Medicaid program that are known to be vulnerable in the Medicare arena;
- working with MFCUs and State Agencies to identify patterns of potential fraud;
- initiating projects that cross State and program lines–such as reviewing billing data from providers that bill more than one State or that bill both Medicare and Medicaid (outside the Medi-Medi project States) to determine if the volume of claims reveals the potential for false billing;
- continuing to expand our work on quality of care;

- partnering with MFCUs, the State Survey and Certification teams, DOJ, and State prosecutors to bring to justice those providers who abuse this vulnerable population;
- supporting outreach and education efforts to MFCUs, Attorneys General Offices and licensing boards to refer matters to OIG for exclusion action.

OIG has historically focused on three Medicaid program vulnerabilities: nursing home quality of care, pharmaceutical manufacturer fraud, and drug diversion. These areas continue to be investigative priorities for our office.

Nursing home quality of care. Matters for which OIG initiates quality of care investigations include patient abuse, neglect, and deaths. While such cases are usually pursued by MFCUs under State laws, OIG typically becomes involved when there is either a pattern of abuse and neglect or egregious single instances. At the Federal level, remedies under the False Claims Act are available if the investigation demonstrates that a nursing home (its staff and/or its administrator) provided to Medicaid residents services that were so poor as to constitute billing for services not rendered. Claims or cost reports may also be considered false if the nursing home does not provide the level of care or the number of staff as reported on the cost report. Abuse may also be considered a criminal case on the Federal level if the investigation reveals the submission of false adverse event reports, for example, if a patient was reported to have fallen but was, in fact, abused.

In one example, OIG investigated and participated in the prosecution of a matter that led to Federal indictments of a nursing facility and its administrators on local and Federal charges involving the death of a resident. The resident, a person with Alzheimer's Disease who needed supervision, wandered out of the nursing home and froze to death. Prior to reporting the death, employees of the nursing home brought her body back into the home, dressed her, put her into a bed, and reported to the family that the woman had died of natural causes while asleep. The defendants were convicted of the Federal charges of health care fraud and making false statements; they are awaiting sentencing. The State trial is set to convene in late April, with one of the subjects facing involuntary manslaughter charges.

Pharmaceutical manufacturer fraud. These investigations often involve the price of the drugs as set and reported by the manufacturers. Medicaid reimbursement of drugs is often based on the Average Wholesale Price (AWP) of the drug as reported by the manufacturers. OIG has found that companies report AWPs that often far exceed actual acquisition costs, resulting in inflated payments made by the Medicaid programs. There are also fraudulent practices relating to misreporting and underpaying of the Medicaid rebates for drugs and the promotion of drugs for non-FDA approved uses. OIG also investigates kickbacks paid to prescribing physicians and others for drugs covered by the Medicaid program. Often the damages associated with this conduct are substantial. For example, in 2001 a pharmaceutical manufacturer entered into a global settlement to resolve its criminal, civil, and administrative liability for sales, marketing, and pricing practices. The total settlement amount in that case was $875 million in payment to the Federal and State governments. More recently, in 2004 and 2005, other pharmaceutical manufacturers settled large fraud cases involving Federal health care and other programs, including Medicaid. Through these settlements, pharmaceutical manufacturers agreed to pay more than $523 million to the States for Medicaid-related issues.

Drug diversion. OIG conducts many investigations involving Medicaid prescription drug fraud issues in addition to pricing. These cases—many of which involve prescription pain medications

such as oxycontin—focus on the following providers: physicians who unnecessarily prescribe these drugs in exchange for cash or in-kind kickbacks; physicians who buy back and either self medicate or sell the diverted drugs; and pharmacists who are in collusion with the doctors or with the beneficiaries. In such fraudulent schemes, the pharmacists buy back and resell the drugs, agree to fill prescriptions in exchange for kickbacks from physicians, short the amount of the drug provided and then sell the "excess" pills, or pay kickbacks to doctors for referring the patients to them. The Medicaid program, which pays for the drugs, and Medicaid beneficiaries are both victims of these schemes. These matters are worked jointly with the Drug Enforcement Administration, MFCUs, local law enforcement, and FBI and are prosecuted at both the Federal and State levels.

CONCLUSION

In conclusion, Mr. Chairman, thanks to the targeted funding provided by DRA, OIG will continue to devote substantial resources to auditing, evaluating, investigating, and prosecuting abuses in the Medicaid program. OIG identifies payment issues and errors, uncovers program vulnerabilities, recommends improvements to the program, and, when necessary, pursues appropriate law enforcement actions to recover funds paid to fraudulent providers. OIG will also continue to collaborate with CMS, State auditors, MFCUs, DOJ, and other government enforcement agencies to identify, prevent, and deter fraud and abuse. The management and fiscal integrity of Medicaid is a top priority for OIG. I appreciate this opportunity to testify, and I welcome your questions.