Testimony of
Dennis Smith
Director
Center for Medicaid Services
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Chairman Coburn, Senator Carper, distinguished Committee members, thank you for inviting me to discuss our initiatives to eliminate fraud in the Medicaid program. Medicaid is a partnership between the Federal government and the states. While the Federal government provides financial matching payments to the states, each state essentially designs and runs its own program within the Federal structure and each state is responsible for overseeing its Medicaid program.

Efforts to safeguard the Medicaid system can be divided into the areas of fraud or abuse and financial management. The former includes incidents of intentional illegal activity, while the latter consists of proper oversight of expenditures and financing systems to avoid inefficient operations or inadvertent errors.

Fraud and Abuse Activities

When considering fraud and abuse reduction efforts in the Medicaid program it is critical to remember that this is a joint Federal-state effort and that both levels of government have people and systems devoted to preventing and addressing fraud.

With the passage of the Deficit Reduction Act, CMS is now planning the implementation of the Medicaid Integrity Program. We are required to enter into contracts with eligible entities to carry out certain specified activities including reviews, audits, and identification and recovery of overpayments and education. For purposes of carrying out this Medicaid Integrity Program, an additional $5 million is appropriated for FY 2006, $50 million for FY 2007 and 2008 and $75 million for each year thereafter. From these amounts, the Secretary must add an additional 100 full-time equivalent employees whose duties consist solely of protecting the integrity of the Medicaid program. Besides providing oversight of Medicaid providers, CMS will increase its oversight of State program integrity efforts as well as provide training and best practices guidance to State program integrity units.

Federal regulations also require that each state Medicaid agency maintain a Medicaid Management Information System (MMIS). The MMIS is a claims processing and information retrieval system. A vital part of each state's MMIS is the Surveillance and Utilization Review Subsystem (SURS). SURS is a mandatory component of MMIS. The principal purpose of the SURS unit is to safeguard against inappropriate payments for Medicaid services. This is done by analyzing and evaluating provider service utilization to identify patterns of fraudulent, abusive, unnecessary and/or inappropriate utilization.

Each MMIS must be federally certified before funding is granted. The Centers for Medicare & Medicaid Services (CMS) utilizes multidisciplinary teams to conduct comprehensive, onsite reviews before such certification is granted. CMS funds 90 percent of the administrative costs associated with the start up of each state's MMIS and then continues to fund each state at a 75

percent Federal match for the ongoing operations of these systems. Projected expenditures for MMIS in FY '06 are slightly over $2 billion, with almost $1.6 billion coming from the Federal government.

Medicare-Medicaid Data Matching Project

In an effort to better coordinate Medicare and Medicaid program integrity, CMS, in partnership with the State of California, initiated a project, designed to share and analyze both Medicare and Medicaid data beginning in 2001. Now known as Medi-Medi, this work involves comparing data from both programs to reveal fraudulent patterns previously invisible to either program, independent of the other. Our Administrator, Dr. Mark McClellan, has publicly expressed his strong support for this program.

Another nine states have since either established Medi-Medi projects or are developing them. These states include: Florida, Illinois, Ohio, North Carolina, Washington, New Jersey, Texas, Pennsylvania and New York. In all of the projects, our federal and state law enforcement and program integrity partners work hand in hand with CMS to identify fraudulent behaviors. Since its inception, the Medi-Medi project has been allocated approximately $22.8 million in funds from the Health Care Fraud and Abuse Control Program (HCFAC) and $7.8 million in FBI funds, for a total of $30.6 million. During that same time, it has generated 335 investigations. Through FY 2005, it has also identified $253.94 million in potential overpayments, including payments at risk associated with those investigations, programmatic vulnerabilities, identified overpayments and denied claims.

With the enactment of the DRA, Medi-Medi will now be expanded nationally and will be provided a stable funding stream which peaks at $60 million annually by FY 2010 and each year thereafter.

These projects have uncovered a number of fraudulent schemes. In one of the most recent examples, the Pennsylvania Medi-Medi project has identified a significant vulnerability that may well exist in many, if not most, states. Data analysis of Medicaid and Medicare billings revealed that several pharmacies in the state had either inappropriately billed Medicaid first for Medicare-covered drugs or had double-billed both programs. Until the Medi-Medi review there had been no crosswalk between the Medicare and Medicaid codes. Further analysis and investigation identified overpayments to over 48 pharmacies on a small number of pharmaceutical codes. The State and the contractor estimate Medicaid overpayments alone at about $20 million; a conservative estimate given the large number of pharmaceutical codes yet to be analyzed.

The Medi-Medi projects in New Jersey, Ohio and California have found similar patterns. For example, the State of New Jersey has identified approximately $332,000 at risk as a result of problematic billings to both programs for just 28 dual eligible beneficiaries receiving just one drug, Neulasta, over the course of one year. Data analysis and follow-up work suggest that similar overpayments exist in Ohio and California, but further analysis and field work will be necessary to quantify the problem in those states. It should be noted that these are the types of patterns that a project like Medi-Medi, which shares and compares billings from both programs, is uniquely designed to discover. All Medi-Medi projects have been directed to conduct analyses to determine if, and to what extent, this vulnerability exists.

Other Provisions of the Deficit Reduction Act

- States are provided an incentive to enact State False Claims Acts (FCA) that meets certain Federal requirements. States whose FCA law meets those requirements will receive additional federal matching funds for any amounts recovered as a result of enforcing their state False Claims Acts.
- Any entity which receives or makes annual Medicaid payments under the state plan of at least $5 million must provide Federal False Claims Act education to their employees.
- Medicaid payment is prohibited for the ingredient cost of a drug for which the pharmacy has already received payment under Medicaid (other than a reasonable restocking fee).
- The Office of Inspector General within the Department of Health and Human Services is appropriated an additional $25 million for each of FYs 2006 through 2010 for Medicaid fraud and abuse control activities.
- Before making payment for health care services, state Medicaid programs are required to seek payment from other third parties that may be responsible for those costs. Maintaining Medicaid's status as the payer of last resort reduces overall expenditures. The DRA clarified that the list of third parties from which state or local agencies must seek payment includes self-insured plans, pharmacy benefit managers, and other parties that are by statute, contract, or agreement legally responsible for payment of a claim. States are required to enact laws that mandate that all such parties provide information to the state needed to facilitate determination of liability, cooperate with the state in determining liability, and except the state from administrative timing and other procedural requirements for claims if the claims are submitted within 3 years and pursued within 6 years.

- Beginning on July 1, 2006, individuals who declare themselves to be US citizens or nationals are now required to provide satisfactory documentary evidence of citizenship or national status.

CMS is working to implement these various provisions in accordance with their specific statutory effective dates and will release more information to the states and the public about these efforts when as they are completed.

Strengthening Financial Management Activities

In addition to our efforts to control fraud, CMS works to ensure that Medicaid payments to states are based on legitimate and legal expenditures. These efforts have resulted in greatly reduced improper payment to states.

In 2002, we created a new team within CMS to specifically review state plan amendments (SPAs) that involved reimbursement to institutional providers such as nursing homes and hospitals. We subsequently created another group to review plans affecting non-institutional providers such as physicians and clinics. Over time, these teams evolved into the Division of Reimbursement and State Financing (DRSF), consolidating in one CMS component responsibility for all payment policy and state Medicaid funding issues. A central responsibility of this Division is to ensure consistency in the nationwide application of Medicaid payment and funding policy. The Division now comprises three teams, which are responsible for institutional reimbursement, non-institutional reimbursement, and state funding policy and oversight.

As part of this integrated approach, DRSF holds monthlly conference calls with the CMS Regional Offices, in which we discuss pending Medicaid reimbursement State Plan Amendments (SPAs) and Medicaid financial management issues in the respective Regional Offices. Through these monthly calls, we develop a cross-representational team that is equipped to address the full range of Medicaid reimbursement and financial issues in each state within each region. These calls began on February 7, 2005.

From August of 2003 through mid-March of this year, CMS has reviewed and approved nearly 1,100 SPAs. Our review of these SPAs has reduced inappropriate payment of Federal matching funds in the past and will continue to do so into the future.

To improve the internal controls related to the Medicaid program to ensure a strong oversight function, beginning in late 2004 and into 2005, CMS hired 100 new financial management staff to monitor state activities, enforce compliance with CMS financial management procedures and improve Medicaid financial management oversight. The funding specialists enforce compliance with Medicaid financing requirements by proactively monitoring the State Medicaid budget process and reviewing claimed expenditures in order to identify, resolve, and avert State Medicaid financing proposals/practices that are inconsistent with the Social Security Act. Almost all of these individuals were assigned to specific states and 10 were based in our Central Office. Extensive training for these new hires was conducted beginning in late 2004 and running through 2005.

The additional staff have made the necessary contacts with their respective Medicaid agencies to gain a thorough understanding of the overall organizational structure of the state's Medicaid program; the programmatic structure of the state's Medicaid program; and the state budget, expenditure, and financial management processes. They have been working closely with Regional Office and state financial management staff on these activities.

These new employees have met with numerous health officials in their respective states, attended public hearings regarding state budgets, have performed significant research of public records, and participated in financial management reviews with current Regional Office staff. They have assisted with the review of Medicaid reimbursement state plan issues, performed reviews of state funding issues, assisted in the resolution of OIG and GAO audit findings, and performed other financial oversight activities. Through their work, and through coordination with the Regional Offices, we expect to prevent new versions of inappropriate financing arrangements before they are put in place and replicated.

Florida's Efforts

States can take significant actions on their own to reduce Medicaid fraud within their jurisdiction. Florida has experienced some significant successes in this area within the past few years. The following offers anecdotal examples of what can happen when states focus on bolstering the integrity of their Medicaid program.

In 2005, Florida identified 627 pharmacies, including national chain outlets, which were inappropriately submitting claims for in-house preparation of unit dose packaging when in fact the manufacturer had prepared

the unit dose packaged product. Thanks to their diligence, a National Medicaid Fraud Alert was issued. Several other states indicated this could be a significant problem for them as well.

Florida's FY 2003-2004 Medicaid Program Integrity report identified savings of $16.5 million over 18 months as the result of a special review of high billing providers for Intravenous Immune Globulin (IVIG) claims in South Florida. The state had previously addressed the issue by requiring that physician claims for this service be restricted to specific diagnosis claims, causing expenditures to fall by approximately half. Over time, however, the billings crept back up at which time Florida cracked down with its special reviews of 80 high billing providers. The overall effect of those reviews was a sharp and sustained drop in billings.

Florida's FY 2004-2005 MPI report also documented the results of its year long project, again in South Florida, involving DME site visits. The state examined medical documentation, licensure and ownership documents and thoroughly inspected the facilities to determine compliance. State officials believe those reviews caused an approximate $2.1 million reduction in DME expenditures in FY 2005.

That same report also reported a remarkable 140% increase in the number of potential fraud referrals by the Medicaid program to the Medicaid Fraud Control Unit. In FY 2004-2005, the MPI staff provided the MFCU with 230 referrals compared to 96 in FY 2003-2004.

Conclusion

CMS has made significant progress in protecting the integrity of the financing of the Medicaid program. We know our work is not over and we must remain vigilant and proactive. Thank you again for the opportunity to speak with you today. I look forward to answering any questions you might have.