U.S. SENATE COMMITTEE ON
Finance
SENATOR CHUCK GRASSLEY, OF IOWA - CHAIRMAN
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For Immediate Release
Friday, Feb. 13, 2004

Grassley Seeks Answers on States' Use of Consultants to Increase Medicaid Funds

WASHINGTON – Sen. Chuck Grassley, chairman of the Committee on Finance, has asked the Department of Health and Human Services and the General Accounting Office to explain and examine consulting firms that charge states to help states increase their Medicaid reimbursement. Such arrangements in New Jersey and Georgia have raised questions about their appropriateness, and Grassley is seeking details about the size and scope of the problem nationwide.

"Medicare spending generates a lot of headlines and oversight from Congress, the General Accounting Office, and inspectors general," Grassley said. "There's a lot less scrutiny of Medicaid spending, and it looks like we're paying the price. In the absence of strong oversight, it's easy for consultants to peddle questionable money-making products to cash-starved states. It's important to find out whether consultants are playing a legitimate role in state budgeting or making the financial situation worse for all taxpayers by consuming money meant to help each state's poorest residents. That's why I'm asking for answers."

The text of Grassley's letters to the Health and Human Services Department and the General Accounting Office follows.

January 30, 2004

VIA FACSIMILE: (202) 690-7380
ORIGINAL BY U.S. MAIL
The Honorable Tommy G. Thompson
Secretary
Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Thompson:

The Senate Finance Committee (Committee) has primary jurisdiction over federal health

programs in the United States Senate. The Committee is investigating Medicaid revenue-maximizing or -enhancing arrangements between states and private consulting firms. As chairman of the Committee, I am extremely disconcerted that Medicaid monies intended to benefit low-income Americans, pregnant women and poor children, may instead be lining the coffers of consulting firms.

When states enter into contingency fee contracts to increase federal Medicaid reimbursement, it appears that a perverse incentive is created for consulting firms to opportunistically inflate states' Medicaid claims. Such revenue-maximizing or -enhancing contracts may sever the direct link between federal Medicaid payments and the delivery of health care services because Medicaid funds are being diverted to purposes other than intended. Not surprisingly, some consulting firms appear to be devising creative billing practices, which under scrutiny prove to be improper or potentially fraudulent.

The Department of Health & Human Services (HHS), Office of Inspector General (OIG) has identified Medicaid claims totaling over $586 million, including a federal share over $293 million, associated with a contingency fee contract between the state of New Jersey and Deloitte Touche Consulting Group LLC (Deloitte).[1] The OIG reports that the purpose of that contract, known as the "Federal Fund Revenue Enhancers For All Federal Programs" (Deloitte contract), was to generate increased federal reimbursement by identifying and submitting expenses not previously claimed by New Jersey. Under the terms of its contract, "Deloitte was to receive a percentage ranging from 6 to 7½ percent of the Federal funds recovered." Based on the significance of its initial audit work,[2] the OIG began a series of four audits reviewing Medicaid claims associated with the Deloitte contract "to determine if the claims were allowable, reasonable, and in accordance with CMS regulations."

The OIG's first report, issued last February, identified over $30 million (including interest) in erroneously duplicated federal Medicaid claims submitted to the Centers for Medicare & Medicaid Services (CMS). New Jersey told the OIG this duplication occurred because of a Deloitte computer system error. However, the OIG concluded that New Jersey, "relied solely on Deloitte to prepare and document the . . . [Medicaid] claims and, contrary to federal requirements, failed to ensure the veracity of the claims prior to submitting them for federal reimbursement." New Jersey has acknowledged the duplicate claims, but disagreed with the OIG about how any refund, including earned interest, should be handled.

On January 9, 2004, the OIG issued its third audit, reporting to CMS that the state of New Jersey owes the federal government over $11 million for unallowable prison inmate health care costs paid for under Medicaid.[3] As the OIG points out in its reports, the Code of Federal Regulations stipulate that Medicaid state plans are comprehensive, written commitments by the states to

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[1] A-02-01-01037, February 2003.

[2] A-02-02-09006

[3] A-02-02-01028, January 2004.

supervise and administer the Medicaid program.[4] However, the New Jersey State plan approved by CMS specifically excluded federal funding claims for prison inmate health care. Further, the Medicaid claims submitted by New Jersey to CMS for reimbursement required state officials' signatures certifying that the expenditures were allowable in accordance with federal regulations and the approved state plan. The OIG concluded again that New Jersey, "relied solely on Deloitte to prepare these claims and, contrary to Federal requirements, failed to ensure the veracity of the claims prior to submitting them for Federal reimbursement."

It appears from the OIG reports released to date that at times New Jersey and Deloitte placed financial gain above compliance with Medicaid law and policy. The OIG's fourth audit regarding the Deloitte contract is ongoing and over $110 million in contractual services are under review. By this letter I am requesting that the OIG keep my Committee staff informed about the progress and findings of that audit. Further, I am requesting that the OIG brief my staff about any other reviews, audits, and/or investigations involving Deloitte, or any other private consulting firm, associated with federal health care programs.

In addition, a series of investigative articles run by *The Atlanta Journal-Constitution* (AJC) last fall, reported that CMS is reviewing a "Revenue Maximization Enhancement" contract between the state of Georgia and the consulting firm Copeland Glenn. According to the AJC, "Minnesota-based Copeland Glenn was hired in 1999 to maximize Georgia's federal funding, primarily Medicaid . . . Georgia received more than $2 billion in increased federal funds during the project." However, Copeland Glenn's negotiated contingency fee was 12.9 percent of federal Medicaid funds recovered. The AJC reported that last year Copeland Glenn "demanded $188 million to resolve the major Medicaid dispute," but ultimately *compromised for $84 million*. The AJC's investigative reporting on the contingency fee contract between Georgia and Copeland Glenn, raised a host of extremely troubling questions and concerns.

With billions of taxpayer dollars at stake, some states, unwittingly or not, may be promoting waste and abuse, if not outright fraud, of federal Medicaid funds. Contingency fee contracts between states and consulting firms – the clear purpose of which is to generate increased federal reimbursement – need to be closely scrutinized. Given the importance of Medicaid to millions of Americans and the financial resources at stake, by this letter I am also requesting that the General Accounting Office (GAO) begin a broad review of states' revenue-maximizing or -enhancing contracts. Finally, I request that CMS provide the Committee with the following information by February 17, 2004:

a. How many states have entered into contingency fee contracts with a private consulting firm to generate increased federal reimbursement by identifying and submitting to the federal government unclaimed state expenses? Please identify each state and consulting firm.

b. What is CMS policy with respect to contingency fee contracts between states and private consulting firms, e.g., is there a reporting requirement for states to advise

[4] 45 C.F.R. § 95.505

CMS of such contracts? Has CMS policy changed in light of the OIG's findings?

c. What steps has CMS taken to verify the accuracy of claims prepared for states by private consulting firms?

d. What specific action will CMS take to review all work performed by consultants to ensure the veracity of future federal Medicaid claims?

e. Has New Jersey refunded the $30 million in duplicate claims, including interest earned by the state on the overpayment? If not, why not? What steps will CMS take to recover the $11 million Medicaid costs claimed by New Jersey to cover the health care of prison inmates?

f. What steps has New Jersey taken to verify the accuracy of its claims, both past and present?

g. What steps has CMS taken to review the "Revenue Maximization Enhancement" contract between the state of Georgia and the consulting firm Copeland Glenn? Have any questions been raised about improper claims associated with that contract?

h. What steps has CMS taken or will take to recover improper Medicaid costs associated with contingency fee contracts claimed by other states?

In complying with this request for information, please respond to each question in the context of the past five years (January 1, 1999 to December 31, 2003). Also, please repeat the enumerated question followed by the appropriate response.

Thank you in advance for your assistance. I request responses from HHS, CMS, and OIG by February 17, 2004. Please do not hesitate to contact me if you have any concerns.

Sincerely,

Charles E. Grassley
Chairman

cc: Dennis G. Smith, CMS Acting Administrator
Dara Corrigan, Acting Principal Deputy Inspector General
David M. Walker, Comptroller General

January 30, 2004

VIA FACSIMILE: (202) 512-5507
ORIGINAL BY U.S. MAIL

The Honorable David M. Walker
Comptroller General
U.S. General Accounting Office
441 G Street NW
Washington, D.C. 20548

Dear Mr. Walker:

Today I wrote to Secretary Tommy Thompson, Department of Health & Human Services, to inform him that the Senate Finance Committee (Committee) is investigating Medicaid revenue-maximizing or -enhancing arrangements between states and private consulting firms (letter attached). It is extremely disconcerting to me that Medicaid monies intended to benefit low-income Americans, pregnant women and poor children, may instead be lining the coffers of consulting firms. Therefore, as Chairman of the Committee, I am writing to request that the General Accounting Office (GAO) undertake a broad review of revenue-maximizing or -enhancing arrangements between states and private consulting firms to generate increased federal reimbursement by identifying and submitting state expenses not previously claimed to funding agencies for federal financial participation.

The Committee appreciates the GAO's assistance on issues that are of great importance in ensuring accountability in government. Please have your staff coordinate with my Committee staff to discuss in detail the proposed scope and methodology for this work in the near future.

Sincerely,

Charles E. Grassley
Chairman