U.S. SENATE COMMITTEE ON
Finance
SENATOR CHUCK GRASSLEY, OF IOWA - CHAIRMAN
http://finance.senate.gov

For Immediate Release
Wednesday, Aug.18, 2004

GAO finds insufficient Medicaid oversight and substantial financial losses;
Grassley asks CMS for more federal oversight to combat fraud and abuse

WASHINGTON — Today the Government Accountability Office (GAO) released a report conducted at Sen. Chuck Grassley's request, entitled: *Medicaid Program Integrity: State and Federal Efforts to Prevent and Detect Improper Payments* (GAO-04-707). The GAO found that Medicaid's size and diversity make it vulnerable to fraud and that oversight by the Centers for Medicare & Medicaid Services (CMS) may be insufficient relative to the risk of serious financial loss.

Responding to the GAO report, Grassley, chairman of the Committee on Finance, wrote CMS and asked for more intense oversight of Medicaid. "The GAO found that CMS allocated only $26,000 and had only eight employees working on Medicaid program integrity," Grassley said. "It doesn't make sense that CMS invests so little in federal oversight. I hope CMS will come back with a better plan to combat fraud and abuse so that more Medicaid dollars get to the millions of low-income Americans who need them."

The text of the letters to Secretary Thompson and Administrator McClellan follow:

August 18, 2004

The Honorable Tommy G. Thompson
Secretary
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Mark McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Thompson and Administrator McClellan:

The U.S. Senate Committee on Finance (Committee) has jurisdiction over the Medicare and Medicaid programs, and accordingly, a responsibility to oversee the proper administration of these programs which provide healthcare to more than 80 million Americans. As chairman of the Committee, I am writing because oversight of the Medicaid program by the Department of Health & Human Services (HHS), Centers for Medicare & Medicaid Services (CMS) needs to improve greatly. According to reports and information requested and gathered by the Committee, CMS has a problem with Medicaid fraud and its limited oversight is insufficient to protect the integrity of the program.

Today, the Government Accountability Office (GAO) released a report it conducted at my request, entitled: Medicaid Program Integrity: State and Federal Efforts to Prevent and Detect Improper Payments (GAO-04-707). According to the GAO, Medicaid's size and diversity make it vulnerable to improper payments that can result from fraud, abuse, and clerical errors. Today's GAO report concludes that "CMS's oversight of the states' Medicaid program integrity efforts may be disproportionately small relative to the size of the federal investment and risk of serious financial loss."

Specifically, the GAO states that "[i]n fiscal year 2004, CMS allocated $26,000 and 8 staff positions nationally to oversee the states' Medicaid program integrity activities, including the cost of compliance reviews." As elaborated more fully below, the history of rising costs and extensive fraud, waste and improper payments in the Medicaid program, suggests that allocating 8 employees to do the difficult work of overseeing Medicaid program integrity at the federal level is insufficient. The work of a number of different organizations bear out the fact that the Medicaid program warrants additional oversight, including, among others the GAO, the HHS Office of Inspector General (OIG), the State Medicaid Fraud Control Units (MFCUs), the non-profit organization, Taxpayers Against Fraud (TAF), as well as CMS itself. CMS should exercise more direct responsibility for overseeing the Medicaid program because the amount of federal taxpayer dollars at risk has grown enormously.

The Medicaid Program — the Single Largest Government Health Program

According to the GAO, in FY 2002, Medicaid benefit payments reached approximately $244 billion, of which the federal share was about $139 billion. In 2004, Medicaid spending is projected to be over $300 billion. Medicaid has surpassed Medicare as the single largest government health program in the United States, at least until the Medicare drug benefit goes into effect in 2006. Medicaid provides health care to an estimated 53 million low-income Americans, including children, pregnant women, individuals with disabilities and the elderly. Hundreds of billions of taxpayer dollars are at stake and oversight of the Medicaid program has not kept pace with the degree of Medicare oversight.

The GAO's Findings

In January 2003, the GAO added Medicaid to its list of high-risk programs, "owing to the program's size, growth, diversity, and fiscal management weaknesses. Limited oversight has afforded states and health care providers the opportunity to increase federal funding inappropriately." The full scope of Medicaid fraud and abuse has not been fully ascertained.

However, today's GAO report and other reporting support the conclusion that fraud is undeniably a substantial and growing problem in the Medicaid program. Today's GAO report states:

> Various forms of Medicaid fraud and abuse have resulted in substantial financial losses to states and the federal government. Fraudulent and abusive billing practices committed by providers include billing for services, drugs, equipment, or supplies not provided or needed. Providers have been found to bill for more expensive procedures than were actually provided.

Noting that abusive and fraudulent practices appear to be "deliberate," "covert," and "difficult to quantify," the GAO cites examples to illustrate the substantial size of the financial losses, including the following recent cases:

- 15 clinical laboratories in one state billed Medicaid for $20 million for services that had not been ordered;
- one optical store falsely claimed $3 million for eyeglass replacements; and
- a medical supply company agreed to repay states nearly $50 million because of fraudulent marketing practices.

While identifying and prosecuting Medicaid fraud is a difficult job, the GAO states that CMS conducts few onsite reviews of state program integrity activities. The difficulty of the job underscores the need for increased oversight and further indicates that the resources CMS presently devotes to Medicaid oversight are insufficient. As the GAO reports, "between January 2000 and December 2003, CMS has conducted reviews of 29 states, and at its current pace, would not begin a second round of reviews before fiscal year 2007." The GAO also says, however, that these reviews do not even evaluate the effectiveness of state activities on reducing improper payments. The GAO concludes that "CMS will not obtain a program-wide picture of states' prevention and detection activities more than once every 6 years."

State Medicaid Fraud Control Units (MFCUs)

This past Monday, August 15, 2004, the OIG posted its annual report on the operations of the state MFCUs. The MFCUs are responsible for combating fraud and abuse at the state level. In FY 2003, the MFCUs were awarded over $119 million in federal grant funds and employed over 1500 individuals. All together, the state MFCUs recovered $268 million in court-ordered restitutions, fines, penalties and civil settlements and achieved 1096 convictions. In addition, more than 500 individuals and entities were excluded from participating in the Medicare and Medicaid programs based on referrals made to the OIG by the MFCUs last year.

While the MFCUs accomplishments are noteworthy, the scope and breadth of the fraud leading to these recoveries is astounding. Fraud is apparent in many independent and diverse areas, including billing services, transportation services, pharmacy services, as well as in nursing home and home health care, to name just a few. The OIG's report highlights many case narratives of independently and successfully prosecuted Medicaid fraud and patient abuse and neglect cases. It is perfectly clear from these narratives that fraud and abuse in the Medicaid

program is not concentrated in any specific area. Rather, fraud and abuse is widespread throughout the entire program and the MFCUs are fighting an uphill battle.

Over the past year, my Committee staff has met with several MFCUs from across the country. Based on concerns aired at these meetings, my Committee staff sent a questionnaire to all state MFCUs requesting information about, among other things: what practices and activities were of particular concern in the Medicaid program; what limitations were encountered when investigating and/or prosecuting Medicaid fraud; and how many case referrals came from state Medicaid agencies. According to the survey responses, the MFCUs confirm that there are numerous practices and activities that are of immediate concern to them, including in the areas of durable medical equipment, home health, transportation and drug pricing. CMS must scrutinize these high risk areas where significant Medicaid fraud and abuse is taking place and do more to protect the program from providers willing to exploit weaknesses in these areas.

The MFCUs also raised an important concern regarding the noticeable lack of referrals from state Medicaid agencies. The Committee's survey shows that provider fraud referrals from state Medicaid agencies make up a small percentage of the total number of provider fraud referrals received by MFCUs, at least for most states. Some state Medicaid agencies clearly do a better job than others at referring cases to MFCUs. For instance, a MFCU sent us data showing that it had only received two provider fraud referrals from its state Medicaid agency in a 3-year period; yet it received about 70 referrals from other sources during the same period. CMS should be holding state Medicaid agencies accountable and making sure that they are stepping up to the plate to identify Medicaid fraud and passing this information onto the MFCUs for investigation.

The MFCU survey also revealed differing responses as to the limitations placed on investigating and prosecuting Medicaid fraud. There appears to be little consistency state to state on MFCUs authority to investigate and prosecute Medicaid fraud. Few MFCUs identified no limitations on their ability to effectively investigate and prosecute. Many expressed frustration due to limitations, such as: inadequate administrative rules; lack of jurisdiction and/or law enforcement authority; absence of a state False Claims Act; and insufficient staffing and funding. The MFCUs bear much responsibility for recovering millions of dollars lost to fraud each year. They must have adequate authority and resources to effectively prosecute fraud and recover funds. Every case MFCUs investigate and prosecute acts as a deterrent to providers engaging in fraudulent or abusive behavior. CMS must also do more to assess whether states are giving the MFCUs the powers they need to fight fraud and abuse and protect federal taxpayers' dollars.

Taxpayers Against Fraud (TAF)

A TAF report released last summer stated that "although the federal government in FY 2001 spent less than twice as much on Medicare as it spent on Medicaid, its collection from fraudulent Medicare providers or contractors that year were more than 20 times the amounts it

recovered from fraudulent Medicaid providers or contractors."[0] TAF pointed out that because the federal government spends more on Medicare than the federal share of Medicaid (with Medicare averaging about twice Medicaid during 1997-2001), it is logical that Medicare recoveries would be higher. However, TAF added that recoveries from Medicare fraud are more than 12 times the amount of federal collections from Medicaid fraud—over a 5 year period, federal Medicaid fraud collections totaled $115 million compared to $2.85 billion for Medicare. Therefore, TAF argued, "[t]here is no reason to believe that the amount of recoverable fraud in the Medicare program is 12 times as large as that in Medicaid, much less 25 times as large." The large gap between the amount of Medicare recoveries compared to Medicaid recoveries is another indicator that more active oversight is necessary to protect the integrity of the Medicaid program.

Medicaid fraud involving drug pricing practices is one of the most notable, egregious, and troubling problems in the Medicaid program because of the vast profits some drug companies are reaping at the expense of taxpayers. According to a separate report released by TAF last year[0]:

> Since 2001, the Department of Justice (DOJ) has settled seven cases involving allegations of Medicare and Medicaid drug pricing and marketing fraud against six pharmaceutical manufacturers: AstraZeneca, Bayer, Dey, GlaxoSmithKline, Pfizer, and TAP Pharmaceuticals . . . [a]mong these are three of the top five companies (by sales volume) in the industry: Pfizer (#1), GlaxoSmithKline (#2), and AstraZeneca (#5). The total paid out by these manufacturers to settle these cases is nearly $1.66 billion. ... Remarkably, these recoveries resulted from allegations involving just a handful of drug products...

In addition to these settlements, Schering-Plough bargained for a $345 million settlement just last month. While an article running in today's USA Today, entitled "Drugmaker admitted fraud, but sales flourish," reports on the $430 million settlement that Pfizer's Warner-Lambert division obtained in May. Pfizer's most recent settlement included a $240 million criminal fine and $190 million in civil settlements. The USA Today reporter begins the article with a question: "What happens to drug companies that commit federal crimes? For the nation's No. 1 drug company, the answer is: some pain, more gain." This question is neither unreasonable nor unwarranted. The answer rings true, of course, because the vast drug profits at hand make the cost-benefit analysis a no-brainer for unscrupulous drug companies.

Each of these settlements involved Medicaid liability and likely represent just the tip of the proverbial iceberg. At least six top drug companies—AstraZeneca, Bayer, Pfizer, Schering-Plough, GlaxoSmithKline, and TAP—are presently operating under corporate integrity

---

0 [1]Andy Schneider, *Reducing Medicaid Fraud: The Potential of the False Claims Act* (June 2003), p. 7, www.taf.org

0 [2]Andy Schneider, *Reducing Medicare and Medicaid Fraud by Drug Manufacturers: The Role of the False Claims Act* (November 2003), p. 12, www.taf.org.

agreements, which allow the companies to continue participating in federal health care programs. Meanwhile, numerous other pharmaceutical fraud investigations are ongoing. As drug company settlements soar well over $2 billion to date, more settlements loom on the horizon. Despite these sizable recoveries, taxpayers will continue to pay the price because drug fraud settlements represent little more than a slap on the wrist—some pain, more gain.

Inter-governmental Transfers (IGT)

Another area of great concern involves inter-governmental transfers (IGTs) of Medicaid funds. At a recent Congressional hearing, the OIG discussed the use of IGTs. The OIG stated that "some fund transfers and financing mechanisms are designed solely to maximize Federal reimbursements to States and serve to obfuscate the source and final use of both Federal and State funds." For example, a recent OIG report entitled, Adequacy of Medicaid Payments made to Albany County Nursing Home (A-02-02-01020), illustrated how the State of New York used IGTs to, in effect, ensure that the Federal Government provided almost all of a nursing home's Medicaid funding. The OIG deemed the transfer contrary to the principle that Medicaid is a shared responsibility of the Federal and State Governments. The transfer benefited the State and the county more than the nursing home because the State received $20 million more than it expended for the nursing home's Medicaid residents. States' should not be transferring properly allocated funds away from nursing home residents. While I realize that CMS is working to address inappropriate IGTs, CMS must establish consistent, clear-cut guidelines about states' financing arrangements. Until CMS clarifies publicly what is acceptable, the integrity of the federal-state relationship and of the Medicaid program itself is at stake. In the meantime, taxpayers are paying the price.

Medi-Medi Pilot Program

Today's GAO report notes that CMS does have some initiatives designed to support state Medicaid agencies' program integrity efforts. Specifically, the GAO pointed to CMS's so-called "Medi-Medi" pilot, which was designed to link Medicaid and Medicare claims information and thereby identify aberrant provider billing. According to the GAO, after one year of testing in California, CMS reported $58 million in savings and over 80 cases against suspected fraudulent providers. While the Medi-Medi pilot shows great promise, it also speaks to how much fraud remains unidentified by the states and how much further CMS needs to take its oversight initiatives.

The inescapable conclusion, in light of all of the aforementioned information, is that without a more coherent and comprehensive approach to oversight directed from the federal level, the Medicaid program in all likelihood will continue to provide fertile ground for fraudulent activity. In closing, today's GAO report states:

> Financial management and program integrity, while related functions are not interchangeable . . . [P]rogram integrity—the focus of this report—addresses federal and state efforts to ensure the propriety of payments made to providers. Unlike the commitment to expand resources for Medicaid financial management

activities, CMS has not indicated a similar commitment to enhancing its support and oversight of states' program integrity efforts.

As chairman of the Committee, I am pleased that the GAO has flagged these issues. I agree with the GAO's conclusion that we need more intense oversight of Medicaid. As chairman, I am concerned about Medicaid in both the short and long term. Congress must also work with CMS to direct more attention to oversight. The sheer size of the Medicaid program today and the federal share of taxpayer dollars involved—as well as the scope of fraudulent activity—demands that CMS devote more than 8 employees and $26,000 to Medicaid program integrity. Accordingly, please advise how CMS will specifically address the GAO's findings, as well as the issues and concerns highlighted in this letter. As we think about ways to improve Medicaid, I look forward to working with you to address these concerns.

Please respond to this letter by no later than September 13, 2004, and provide a detailed plan of action, including implementation dates for addressing the oversight weaknesses identified in the GAO report. Thank you for your attention to this important matter.

Sincerely,

Charles E. Grassley

Chairman