Testimony to United States Senate Special Committee on Aging

"Catch Me If You Can: Solutions to STOP Medicare and Medicaid Fraud"

Chairman Herb Kohl (D-WI)
Ranking Member Mel Martinez (R-FL)

By
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Chairman Kohl, Ranking Member Martinez, and Members of the Committee, thank you for the opportunity to share a few thoughts with you today. I commend you highly for holding this hearing and hope we will continue to share ideas well into the future. My oral and written remarks are my responsibility alone. They do not necessarily reflect the views of my employer, the Center for Health Transformation, any of its staff or members.

Think for a moment about how other large businesses operate in the modern world. FedEx and UPS track a combined 23 million packages each day in real time. You can go online, for free, and track the movement of your item from pickup to delivery. Exceedingly rare are stories of FedEx or UPS losing packages or about how those companies are rife with fraud.

Large, sophisticated retailers in the supermarket, clothing or auto parts industries can tell you every night how many cans of soup, pairs of pants, or spark plugs they sold that day in every one of their facilities all over the world.

The American credit card industry involves over $2 trillion in transactions per year which is nearly the size of the healthcare sector. There are over 700 million credit cards in circulation, millions of vendors, and countless items that can be purchased with a credit card. Yet total credit card fraud is a fraction of 1 percent. If you have ever made a large purchase in a city you do not typically frequent, you've probably been asked to show ID by the clerk.

Now look at healthcare. A Government Accountability Office study in January of 2009 estimated that a full 10 percent of paid Medicaid claims in 2007 were improper. That is a total of $32.7 billion. Several GAO studies have documented fraud and abuse in the durable medical equipment area that is several steps beyond laughable. Those GAO reports are consistent with OIG and state-level investigations too. Medicare and Medicaid lose billions of dollars annually to DME fraud, an industry that has attracted organized crime because the windfalls are so great and the risk is so low. There are shopping malls in Miami with over a dozen DME providers within 200 yards of each other.

(Appendix A is a partial list of just GAO studies of Medicare and Medicaid fraud for the past 15 years).

Examples of fraud are endless. Here is a tiny smattering:

- Miami-Dade County presently has 897 licensed home health agencies which is more than the entire state of California
- In 2005, there was $2.2 billion worth of claims submitted to Medicare for HIV drug infusion therapy. That was 22 times the amount submitted by the rest of the country combined, a trend that "continues to this day" according to the *Miami Herald* in August, 2008
- South Florida has 2 percent of the nation's Medicare beneficiaries, but 17 percent of the nation's inhalation drugs
- A dentist in Brooklyn had 991 claims in one day
- 150 *men* who received maternity benefits from New York Medicaid
- New York Medicaid may have well over $10 billion annual fraud and abuse *annually*. "40 percent of all claims are questionable." – former IG James Mehmet.
- The Vice President of the City of Angels medical center in Los Angeles was recently convicted of soliciting homeless people to his facility in order to provide them with unnecessary medical services
- HIV case managers allegedly double-dipping in Ryan White and Medicaid funds

Anyone with even a passing interest in this issue should take a few seconds and simply sign up for Google News Alerts on Medicare and Medicaid fraud. On any given day you will get up to a dozen stories from all over America. The biggest challenge is not gathering the tales, but is instead not becoming desensitized to the breathtaking scope, magnitude and pervasiveness of fraudulent behavior.

The Medicare and Medicaid systems we have in place today, in particular the fee-for-service portions which account for the majority of enrollees and dollars, simply beg for fraud, waste and abuse. They cheat taxpayers, honest doctors and hospitals, and most

importantly tens of millions of poor and elderly Americans who depend on these vital programs as their only lifelines to medical care. Fee-for-service the nickname “pay and chase” because fiscal intermediaries are judged primarily on how fast they crank out checks with relatively little regard to coordination of care and fraud.

My purpose here today however is not to dwell on articulating the amounts of fraud but instead to lay out 16 specific actions Congress could take that would save at least tens of billions of dollars annually.

Before getting to the solutions, it is important to emphasize that better law enforcement is only a small part of the solution. Even successful prosecutions tend to be expensive, take years, and end up capturing only a small fraction of the money lost, not to mention their deterrent effect appears to be negligible. It is much better to prevent the dollars from getting into the hands of criminals and fraudsters in the first place by employing technology and tactics that are common in advanced, non-health industries.

Recommendations:

1). Put all Medicare and Medicaid claims and patient encounter data online for public access. This data is the mother lode of everything you would ever want to know about both programs. It contains every key detail about health outcome data by facility, by fee-for-service vs managed care, by any comparison you want. The total amount of billing should match up with reported outlays from federal and state coffers.

Selected academics have access to Medicare data, for example, and produce excellent report such as the Dartmouth Health Atlas. Among their many key finding is that per capita Medicare spending by locality is *inversely* correlated with the likelihood of receiving recommended care.

As good as the Dartmouth team is, they are not better than the collective wisdom of everyone who would look at the data and come up with studies, patterns, and various findings heretofore not even considered.

Put simply, patients and taxpayers have the right-to-know the quality produced by every facility that receives taxpayer money and how and where scarce taxpayer dollars are spent. This data should only be released however after being vigorously patient de-identified, as is done in the academic world.

2). Change Medicaid from the open-ended federal match system to one in which the federal financial contribution is fully transparent upfront and based on the number of people in poverty in that state. The current system has a lengthy history of state-level accounting gimmicks to amplify the receipt of federal monies beyond the agreed percentage (Please see Appendix B). Taxpayers and program integrity would be better served by a federal partnership based on a clearly defined federal dollar amount which would free up state officials to focus exclusively on measuring and improving health outcomes for people on Medicaid.

Most people accept the inherent problem of a third party payer system. When Person A receives a service from Person B paid for by Person C, Person A is far more likely to spend with less discretion. Medicaid under the 40 year old federal match

arrangement is actually a *fourth* party payer system, making Persons A and C even less concerned about spending, especially considering that Person D (the federal government) is not particularly assertive about clamping down on abuses.

3). Allow seniors on Medicare the option of traveling to another city to receive major non-emergency surgeries. If a particular set of procedures is thousands of dollars less expensive in the next state over and the quality outcomes are as good or better, it makes sense to allow people the choice of facilities especially if the individual receiving care and taxpayers can split the savings.

The commercial insurer Wellpoint just launched a demonstration project that allows customers the option of traveling to *India* for non-emergent elective procedures like plastic surgery. Surely it is not too radical to take advantage of arbitrage opportunities here in America within our own Medicare system.

4). Enhance discovery of third party liability in Medicaid. Simply maximizing *self-reported* third party coverage by patients could save state Medicaid programs 1-2 percent per year. An attached GAO report shows up to 13% of people on Medicaid with other coverage.

5). Continue to move to a system of 100 percent electronic remittances. Paper and postage are unnecessarily costly and time consuming.

6). Use unique ID numbers for Medicare beneficiaries instead of their social security numbers. A stolen social security leaves a person much more vulnerable.

7). Require more timely updates from states on Medicaid enrollment data. Even senior Congressional staff as of April 2009 can only get state-by-state Medicaid enrollment data up to 2006. The latest available for Maine was 2004. Compare that to Fed Ex and UPS that track 23 million packages a day in real time.

8). Consider moving to biometric ID for Medicare and Medicaid beneficiaries. Cards are easily lost, stolen, copied and forged which contributes to uncoordinated care and fraud.

9). Recognize the shortcomings of fee-for-service arrangements and follow two of MedPAC's key recommendations: Expand the use of risk-adjusted plans in Medicare and expand the medical home model particularly for people with one or more chronic conditions. Enhanced use of medical homes would be particularly helpful in a Medicare system where specialists are overpaid relative to primary care. The standard fee-for-service model rewards volume first and foremost with coordination of care, improvement of patient health, and fraud as secondary considerations at best. The same recommendations are appropriate for Medicaid as well.

10). Encouraging better data analytics across programs and jurisdictions is a must. State Medicaid programs and medical licensing boards could benefit tremendously from the same level of inter-agency data sharing that is becoming increasingly common in law enforcement. When sex offenders move between states they are required to register

immediately with local law enforcement. If they miss their deadline, they are flagged instantly by sophisticated systems pulling information from public sources. Doctors, hospital administrators, DME salesman, criminal beneficiaries, etc are much freer to set up shop in a new state – or to send a new "unknown" member of a fraud ring into the system - without being targeted. The Medicare and Medicaid programs could benefit from enhanced data sharing for the dual eligibles as well.

11). Dramatically improve the authentication required of prospective Medicare Durable Medical Equipment providers. Currently the CMS-855S form that prospective DME providers must fill out lacks even a simple, "under penalty of perjury" line by the signature. That extremely minor tweak alone would be helpful to prosecutors and perhaps even have some deterrent effect. As would making the submission of bogus claims a clear reason for revocation of the supplier's billing number.

Otherwise, follow the example set by Medi-Cal which has done a good job of reigning in DME supplier abuses in the last five years. Medi-Cal is much more rigorous than Medicare and most other Medicaid programs in requiring thorough background checks of applicants. Or simply look to the anti-fraud efforts of commercial insurers.

In extreme problem areas like Miami, a flat out moratorium on new DME and home health providers may be appropriate.

12). Allow Medicare (Medicaid too) to auto-enroll patients with outlier behavior into managed care. Individuals who are excessively billing at, say, emergency rooms are probably getting poor, uncoordinated, inefficient care, or their Medicare/Medicaid cards are being billed by fraudulent providers with our without the knowledge of the patient. In either case, both the individual in question and taxpayers would be better served by auto-enrollment in managed care of the tiny number of people with highly unusual patterns of billing.

13). Dramatically expand the scope, use, and distribution of the HHS OIG exclusion list. Consider direct financial penalties to facilities receiving Medicare or Medicaid dollars that choose to employ any physician, executive, or administrator convicted of Medicare or Medicaid fraud in any state or responsible for a settlement with the government.

14). Require hospital cost reports for Ambulatory Surgical Centers. These facilities are growing by leaps and bounds but are not even required to submit cost reports.

15). Move Medicare and Medicaid beneficiaries into account-based plans where each individual has direct and immediate financial incentives to engage in behaviors that improve health status. There are myriad ways to structure these, the least controversial being zero-balance accounts where beneficiaries are literally paid money for taking steps to improve health status. The vast majority of health care spending in the decades to come will be on people with chronic conditions. This means personal choices around care regimens will have a major, long-term impact on quality outcomes and cost. We must continue developing and deploying models of health care financing that maximize patient behavior change. Ultimately that is the only way to save American health care. Account-based plans are the most effective way to create incentives that will accomplish this.

16). Take Medicare and Medicaid fraud seriously. I certainly intend that with all due respect and do not mean it to be taken as any form of sarcasm. To say there are many tens of billions of dollars of waste, fraud, and abuse in Medicare and Medicaid annually is being conservative. Fortunately, there are a number of steps Congress can take that would dramatically upgrade fraud-fighting efforts while also improving patient care.

Thank you Chairman Kohl and Ranking Member Martinez for holding this hearing. I very much look forward to working with Senators and staff on both side of the aisle to come up with pro-active, creative, and effective ways to eliminate waste, fraud and abuse from Medicare and Medicaid. Taxpayers, and far more importantly poor and elderly Americans who depend on these programs, deserve our full attention.

Appendix A
Medicare and Medicaid Fraud and Abuse – GAO Reports and Testimony

March 2009 – Medicare – Improvements Needed to Address Improper Payments in Home Health
For a 12-month period ending September 30, 2007, the Comprehensive Error Rate Testing program estimated that more than $209 million in improper payments. GAO targeted several states that were identified as experiencing the highest growth in Medicare home health spending or utilization from 2002 through 2006. Inadequate administration of the Medicare home health benefit leaves Medicare vulnerable to improper payments, particularly upcoding. GAO recommends that CMS more effectively screen HHA's, more effectively partner with physicians to identify potentially fraudulent and abusive activities, and more effectively sanction providers engaging in improper billing practices.

January 2009 – Report to Congress – High-Risk Series: An Update
In FY2007, CMS estimates that the states made $32.7 billion in improper Medicaid payments. Although CMS has taken some steps to improve oversight of Medicaid, several oversight weaknesses identified by GAO have not yet been addressed. These include: Congress limiting Medicaid payments to government facilities to the costs of providing service; CMS identifying needed systems projects/taking certain recommended steps to improve payment oversight; and HHS developing methods to better ensure budget neutrality of Medicaid demonstrations.

July 2008 – Medicare Party D – Some plan Sponsors Have Not Completely Implemented Fraud and Abuse Programs, and CMS Oversight Has Been Limited
GAO states that, given the size, nature, and complexity of the Part D program, it is a particular risk for fraud, waste, and abuse. GAO selected five Part D sponsors, and found that all had not completely implemented all of CMS's seven required compliance plan elements and selected recommended measures for Part D fraud and abuse programs. GAO recommends that CMS conduct timely audits of Part D sponsors' fraud and abuse program implementation.

July 2008 – Medicare – Covert Testing Exposes Weaknesses in the Durable Medical Equipment Supplier Screening Process
GAO was easily able to set up two fictitious DME companies using undercover names and bank accounts, which were then approved for Medicare billing privileges despite having no clients and no inventory. CMS estimated that from April 2006 – March 2007, Medicare improperly paid $1 billion for DME supplies. More prevention controls must be implemented.

May 2008 – Medicaid – CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments

GAO examined the information states reported about supplemental payments, as well as how much of total Medicaid expenditures were distributed as supplemental, to what providers and for what purposes. GAO recommended that CMS expedite the final rule, implementing additional DSH reporting requirements and develop a strategy to identify all supplemental payment programs established in Medicaid plans.

April 2008 – Medicaid Financing – Long-standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight
In 2003, CMS began an oversight initiative that by August 2006 resulted in 29 states ending one or more inappropriate financing arrangements. GAO reported in 2007 that although CMS's initiative was consistent with Medicaid payment principles, it was not transparent in implementation. In May 2007, CMS issued a final rule that would limit payments to government providers' costs. GAO has not yet reviewed that rule.

January 2008 – Medicaid Demonstration Waivers – Recent HHS Approvals Continue to Raise Cost and Oversight Concerns
GAO examined whether Medicaid demonstrations were budget neutral to the federal government and maintained Medicaid's fiscal integrity. GAO recommends that Congress require HHS to improve demonstration review and approval process and address HHS's authority to approve demonstrations, such as Vermont's. GAO recommends HHS reexamine FL's spending limit.

February 2007 – Prescription Drugs – Oversight of Drug Pricing in Federal Programs
There is a lack of CMS oversight of the prices manufacturers report to CMS to determine the statutorily required rebates owed to states. Oversight inadequacies, inaccurate prices, lack of transparency and the potential for abuse are all areas that the GAO encourages an increase in emphasis.

January 2007 – Medicare – Improvements Needed to Address Improper Payments for Medical Equipment and Supplies
GAO found that three shortfalls in reviewing Medicare claims: no automated prepayment controls to identify questionable claims part of an atypically rapid increase in billing; no controls in place to identify claims for items unlikely to be prescribed in the course of routine quality medical care; and no requirement of contractors to share information on the most effective automated prepayment controls with other contractors or consider adopting them.

September 2006 – Medicaid Third-Party Liability – Federal Guidance Needed to Help States Address Continuing Problems
Using Census Bureau statistics, an average of 13 percent of respondents who reported having Medicaid coverage for the entire year also reported having private health coverage at some time during the same year. GAO recommends that CMS provide guidance to states on when states must have law in place to implement the Deficit Reduction Act's requirements related to third party liability, and which entities are required to provide states with coverage and other data.

March 2006 – Medicaid Integrity – Implementation of New Program Provides Opportunities for Federal Leadership to Combat Fraud, Waste, and Abuse

Table 1: CMS Activities to Support and Oversee States' Fraud and Abuse Control Efforts, Fiscal Year 2004

CMS initiatives	Description
PAM/ Payment Error Rate Measurement (PERM)	CMS conducted a 3-year pilot called PAM to develop estimates of states' accuracy in paying Medicaid claims. During fiscal year 2006, PAM will become a permanent program—to be known as the PERM initiative—in order to measure improper payments in Medicaid, to fulfill a requirement of the Improper Payments Information Act of 2002.* Under PERM, states will be expected to ultimately reduce their payment error rates over time by better targeting program integrity activities in their Medicaid and SCHIP programs.
Medi-Medi	Under this pilot program, CMS facilitates the sharing of health benefit and claims information between the Medicaid and Medicare programs. Medi-Medi is a data match pilot designed to identify improper billing and utilization patterns by matching Medicare and Medicaid claims information on providers and beneficiaries to reduce fraudulent schemes that cross program boundaries.
TAG	Through telephone conferencing, CMS provides a forum for states to discuss issues, solutions, resources, and experiences on fraud and abuse issues. Any state may participate; roughly one-third do so regularly. States have also used the TAG to propose policy changes to CMS.
Compliance reviews	CMS conducts on-site reviews to assess whether state Medicaid fraud and abuse control efforts comply with federal requirements, such as those governing provider enrollment, claims review, utilization control, and coordination with each state's Medicaid Fraud Control Unit. If reviewers find a state that is significantly out of compliance, they may encourage it to develop a corrective action plan and revisit the state to verify actions taken.

September 2005 – Medicare – More Effective Screening and Stronger Enrollment Standards Needed for Medical Equipment Suppliers

In 2004, CMS reported that Medicare improperly paid $900 million for DME; they hired the National Supplier Clearinghouse to verify that suppliers meet 21 standards before billing. GAO found that NCS was weak in 1) checking state licensure and 2) conducting on-site inspections, thereby leaving Medicare open to fraud and abuse. This oversight must be strengthened.

June 2005 – Medicaid Fraud and Abuse – CMS's Commitment to Helping States Safeguard Program Dollars is Limited

GAO contends that the resources CMS expends to support and oversee states' Medicaid fraud and abuse control activities remain out of balance (in terms of dollar and staff resources allocated) with the amount of federal dollars spent annually to provide Medicaid benefits.

June 2005 – Medicaid Financing – States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight

GAO recommends that CMS improve oversight of contingency-fee projects and states' reimbursement-maximizing methods. An increasing number of states are using consultants on a contingency-fee basis to maximize their federal Medicaid reimbursements. GAO reviewed 2 states (GA & MA) and identified concerns in each of the 5 categories of claims, including *targeted case management, rehabilitation services, supplemental payment arrangements, school-based services, and administrative costs,* generating more than $2B from 2000-2004.

June 2005 – Medicaid Drug Rebate Program – Inadequate Oversight Raises Concerns about Rebates Paid to States

To help control Medicaid spending, states receive rebates from pharmaceutical manufacturers through a drug rebate program. GAO recommended that CMS issue clear, updated guidance on manufacturer price determination methods and price definitions. It also recommended that CMS implement systematic oversight of manufacturer methods and a plan to ensure accuracy of reported prices and rebates to states.

June 2005 – Medicaid – States' Efforts to Maximize Federal Reimbursements Highlight Need for Improved Federal Oversight

This is testimony before the Senate Committee on Finance. The testimony addresses how some states have inappropriately increased federal reimbursements; ways states have increased federal reimbursements for school-based Medicaid services and administrative costs; and how states are using contingency-fee consultants to maximize federal Medicaid reimbursements. GAO recommends that CMS improve oversight of contingency-fee projects and states' reimbursement-maximizing methods.

July 2004 – Medicaid Program Integrity – State and Federal Efforts to Prevent and Detect Improper Payments

According the GAO, 15 clinical laboratories in one state billed Medicaid $20M for services that had not been ordered, an optical store falsely claimed $3M for eyeglass replacements, and a medical supply company agreed to repay states nearly $50M because of fraudulent marketing practices. Thirty-four of 47 states that completed a GAO inventory reported using one or more measures to control enrollment of high-risk providers (such as on-site inspections, background checks, etc.) CMS has initiatives designed to support states' "program integrity" efforts, but its oversight is limited.

March 2004 – Medicaid – Intergovernmental Transfers Have Facilitated State Financing Schemes

IGTs are used to create the illusion of a valid state Medicaid expenditure to a health care provider. This report summarizes the various schemes, as well as what has been done about them. Some states, for example, receive federal matching funds on the basis of large Medicaid payments to certain providers, such as nursing homes operated by local governments, which greatly exceed established Medicaid rates. In reality, large payments

are often temporary, since states can require the local-government providers to return all or most of the money to the states, which states then use at their own discretion.

February 2004 – Medicaid – Improved Federal Oversight of State Financing Schemes Is Needed

GAO was asked to examine CMS's oversight of nursing home UPL arrangements. Although efforts by Congress and CMS have narrowed the UPL loophole, it has not been eliminated. In phasing out UPL schemes, CMS has granted provisional transition periods to states. GAO estimates that the 10 states with 5- or 8-year transition periods could receive about $9 B in excessive federal matching funds. GAO suggests that Congress consider a recommendation to prohibit Medicaid payments to government-owned facilities that exceed costs. It also recommends expediting financial reviews, establishing uniform guidance for states, and improving state reporting.

June 2002 – Medicaid Financial Management – Better Oversight of State Claims for Federal Reimbursement Needed

This is House testimony. GAO found that CMS has financial oversight weaknesses that leave Medicaid vulnerable to improper payments. While it is trying to improve financial oversight, the increasing size and complexity of Medicaid, coupled with diminishing oversight resources, requires a new approach. GAO encourages CMS to develop baseline information on Medicaid issues at greatest risk for improper payments, and then measure improvements in program management.

October 2001 – Medicaid – HCFA Reversed Its Position and Approved Additional State Financing Schemes

This report addresses how the Health Care Financing Administration's actions to implement UPL regulation permitted additional states to establish the same type of financing schemes that it was attempting to curtail, and the estimated additional costs to the federal government of the largest two of these newly established schemes.

Table 2: Overview of Process for Exploiting Upper Payment Limit

Step	Activity
1	State calculates difference in upper payment limit amount (what Medicare would have paid for comparable services) and what the state actually pays nursing homes for Medicaid services.
2	County government takes out a bank loan that is based on calculation in step 1. The loan covers the full amount, both the state and the federal share, of the excessive Medicaid payment.
3	County wires the loaned money from its bank account directly to the state.
4	State creates an official "Medicaid payment" by immediately wiring the loaned funds back to the county bank account.
5	County uses money returned by the state to pay off the loan.
6	State can then claim the federal share of the payment that it made to the county.

GAO found that HCFA's actions to revise UPL regulations were troubling, as it allowed additional states to engage in the very schemes it was trying to shut down, at a substantial additional cost to the federal government.

October 2001 – Strategies to Manage Improper Payments – Learning from Public and Private Sector Organizations
This report details specific practices to manage improper payments: data sharing, data mining, neural networking, recovery auditing, contract audits, and prepayment investigations. The control activities (listed above) are highlighted with different case studies.

June 2001 – Medicaid – State Efforts to Control Improper Payments Vary
GAO states that the exact amount lost in improper Medicaid payments is unknown because few states actually measure the overall accuracy of their payments. Lax administration increases the risk, and efforts by state Medicaid programs to address improper payments are modestly and unevenly funded.

September 2000 – Medicaid – State Financing Schemes Again Drive Up Federal Payments
This testimony describes funding schemes and how these compromise the agreement for federal/state sharing of Medicaid. Current schemes inappropriately increase federal Medicaid payments by paying certain providers more than they would normally receive and then having providers return the bulk of the extra monies to the state (excess payments). As of July 2000, 17 states have plans that could allow them to use this practice, and 11 other states have drafted plans for doing so. GAO says this "violates the integrity of Medicaid's federal/state partnership."

July 2000 – Health Care Fraud – Schemes to Defraud Medicare, Medicaid, and Private Health Care Insurers
In the *rent-a-patient scheme*, organizations pay for individuals to go to clinics for unnecessary diagnostic tests and cursory exams. Physicians then bill insurers for those services and often for other services or medical equipment never provided. Or, physicians buy individual health care insurance identification numbers for cash.

In the *pill mill scheme*, separate health care individuals and entities, usually including a pharmacy, collude to generate a flood of fraudulent claims that Medicaid pays. After a prescription is filled, the beneficiary sells the medication to pill buyers on the street who then sell the drugs back to the pharmacy.

The *drop box scheme* uses a private mailbox facility as the fraudulent health care entity's address, with the entity's "suite' number actually being its mailbox number. The fraudulent health care entity then uses the address to submit fraudulent claims and to receive insurance checks.

The *third-party billing scheme* revolves around a third-party biller who prepares and remits claims to Medicaid for health care providers. This person can add claims without the providers' knowledge and keep remittances.

July 2000 – Medicaid – HCFA and State Could Work Together to Better Ensure the Integrity of Providers

It is critical to protect program funds by making efforts to ensure that only legitimate providers bill Medicare and Medicaid. Different state agencies report differing practices to ensure provider integrity, and only nine states report that they perform comprehensive provider enrollment activities. At the time of the report, HCFA was redesigning its Medicare provider enrollment process, and it was suggested that developing a joint Medicare/Medicaid provider enrollment process would be beneficial.

April 2000 – Medicaid in Schools – Improper Payments Demand Improvements in HCFA Oversight

Some methods used by school districts and states to claim reimbursement for school-based services do not ensure that health services are provided, or that administrative activities are properly identified and reimbursed. Bundled rate methods used by school districts to claim reimbursement have frilled in some cases to take into account variations in service needs among children and have often lacked assurances that services paid for were provided. These poor controls have resulted in improper payments.

November 1999 – Medicaid – Federal and State Leadership Needed to Control Fraud and Abuse

Common fraud and abuse schemes include improper billing practices (upcoding, ghost billing, and delivering more treatment than is necessary/appropriate), misrepresenting qualifications (submitting false credentials to get provider number and performing treatments outside the bounds of what is permitted by one's license) and improper business practices (kickbacks for referring patients to a particular provider or product).

March 1997 – Medicaid Fraud and Abuse – Stronger Action Needed to Remove Excluded Providers From Federal Health Programs

Over the years, thousands of providers have been excluded from participating in federal health care programs b/c of health care fraud or abuse. However, there are several weaknesses: (1) lack of control at OIG field offices to ensure that all state referrals received are reviewed and acted on promptly; (2) inconsistencies among OIG field offices as to the criteria for excluding providers; (3) lack of oversight to ensure that states make appropriate exclusion referrals to the OIG; and (4) problems states experience in attempting to identify and remove from their programs providers that appear on the OIG's exclusion list.

March 1996 – Fraud and Abuse – Providers Excluded From Medicaid Continue to Participate in Federal Health Programs

OIG has worked to exclude thousands of providers; GAO finds several weaknesses that leave them on the rolls for federal programs. There are (1) lengthy delays in the OIG's decision process, even in cases where a provider has been convicted of fraud or patient abuse or neglect; (2) inconsistencies among OIG field offices regarding which providers will be considered for nationwide exclusion; (3) states not informing OIG about providers who agree to stop participating in Medicaid even though reason for agreeing to withdraw

is sometimes egregious patient care or abusive billing; and (4) how states use information from the OIG to remove excluded providers from state programs.

March 1995 – Medicare and Medicaid – Opportunities to Save Program Dollars by Reducing Fraud and Abuse

Medicaid participants face strong incentives to over-provide services, weak fraud/abuse controls to detect questionable billing practices, few limits on those who can bill, and little chance of being prosecuted or having to repay fraudulently obtained money. Solving these problems will require exploring options to make greater use of managed care strategies, such as PPOs or HMOS, greater investment in the people and technology needed to ensure that federal dollars are spent appropriately, more demanding standards for gaining authority to bill the federal programs, and exploring administrative reform options proposed in various bills introduced in Congress.

August 1993 – Medicaid Drug Fraud – Federal Leadership Needed to Reduce Program Vulnerabilities

Medicaid prescription drug fraud is widespread; a common scheme is the "pill mill" in which physicians, clinic owners, and pharmacists collude to defraud Medicaid by prescribing and distributing drugs for the primary purpose of obtaining reimbursement. States have instituted both up-front controls and measures to facilitate pursuit, punishment, and financial recovery. However, state officials told GAO that most leads are not pursued, cases take too long to resolve, and penalties are light even for those convicted. HCFA should display more leadership in developing an overall strategy to address prescription drug diversion and heighten states' sensitivity to the financial benefits of effective preventive measures.

Appendix B
State Schemes to Game the Federal Match – GAO Reports and Testimony

May 2008 – Medicaid – CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments
GAO examined the information states reported about supplemental payments, as well as how much of total Medicaid expenditures were distributed as supplemental, to what providers and for what purposes. GAO recommended that CMS expedite the final rule, implementing additional DSH reporting requirements and develop a strategy to identify all supplemental payment programs established in Medicaid plans.

April 2008 – Medicaid Financing – Long-standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight
In 2003, CMS began an oversight initiative that by August 2006 resulted in 29 states ending one or more inappropriate financing arrangements. GAO reported in 2007 that although CMS's initiative was consistent with Medicaid payment principles, it was not transparent in implementation. In May 2007, CMS issued a final rule that would limit payments to government providers' costs. GAO has not yet reviewed that rule.

March 2007 – Medicaid Financing – Federal Oversight Initiative is Consistent with Medicaid Payment Principles but Needs Greater Transparency
GAO examined the number and fiscal effects of states ending financing arrangements; the extent to which CMS's initiative (to end inappropriate arrangements) represents a change in agency approach or policy; and transparency and consistency of the initiative. GAO found that CMS had not implemented its initiative transparency, contributing to concerns about consistency of reviews of state financing arrangements. GAO says CMS should issue written guidance to clarify.

June 2006 – Medicaid Financial Management – Steps Taken to Improve Federal Oversight but Other Actions Needed to Sustain Efforts
In this report, GAO examined (1) the extent to which CMS has improved its ability to identify and address emerging issues that put federal Medicaid dollars at risk, and (2) how CMS used fund for Medicaid from the HCFAC fund. GAO recommends CMS creates permanent funding specialist positions and determine what systems projects are needed to further enhance data analysis capabilities. (What CMS had done was hired, in 2004, 100 new funding specialists to perform in-depth reviews of high-risk issues.)

June 2005 – Medicaid Financing – States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight
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supplemental payment arrangements, school-based services, and administrative costs, generating more than $2B from 2000-2004.

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IGTs are used to create the illusion of a valid state Medicaid expenditure to a health care provider. This report summarizes the various schemes, as well as what has been done about them. Some states, for example, receive federal matching funds on the basis of large Medicaid payments to certain providers, such as nursing homes operated by local governments, which greatly exceed established Medicaid rates. In reality, large payments are often temporary, since states can require the local-government providers to return all or most of the money to the states, which states then use at their own discretion.

February 2004 – Medicaid – Improved Federal Oversight of State Financing Schemes Is Needed
GAO was asked to examine CMS's oversight of nursing home UPL arrangements. Although efforts by Congress and CMS have narrowed the UPL loophole, it has not been eliminated. In phasing out UPL schemes, CMS has granted provisional transition periods to states. GAO estimates that the 10 states with 5- or 8-year transition periods could receive about $9 B in excessive federal matching funds. GAO suggests that Congress consider a recommendation to prohibit Medicaid payments to government-owned facilities that exceed costs. It also recommends expediting financial reviews, establishing uniform guidance for states, and improving state reporting.

June 2002 – Medicaid Financial Management – Better Oversight of State Claims for Federal Reimbursement Needed
This is House testimony. GAO found that CMS has financial oversight weaknesses that leave Medicaid vulnerable to improper payments. While it is trying to improve financial oversight, the increasing size and complexity of Medicaid, coupled with diminishing oversight resources, requires a new approach. GAO encourages CMS to develop baseline information on Medicaid issues at greatest risk for improper payments, and then measure improvements in program management.

October 2001 – Medicaid – HCFA Reversed Its Position and Approved Additional State Financing Schemes
This report addresses how the Health Care Financing Administration's actions to implement UPL regulation permitted additional states to establish the same type of

financing schemes that it was attempting to curtail, and the estimated additional costs to the federal government of the largest two of these newly established schemes.

Table 2: Overview of Process for Exploiting Upper Payment Limit

Step	Activity
1	State calculates difference in upper payment limit amount (what Medicare would have paid for comparable services) and what the state actually pays nursing homes for Medicaid services.
2	County government takes out a bank loan that is based on calculation in step 1. The loan covers the full amount, both the state and the federal share, of the excessive Medicaid payment.
3	County wires the loaned money from its bank account directly to the state.
4	State creates an official "Medicaid payment" by immediately wiring the loaned funds back to the county bank account.
5	County uses money returned by the state to pay off the loan.
6	State can then claim the federal share of the payment that it made to the county.

GAO found that HCFA's actions to revise UPL regulations were troubling, as it allowed additional states to engage in the very schemes it was trying to shut down, at a substantial additional cost to the federal government.

September 2000 – Medicaid – State Financing Schemes Again Drive Up Federal Payments

This testimony describes funding schemes and how these compromise the agreement for federal/state sharing of Medicaid. Current schemes inappropriately increase federal Medicaid payments by paying certain providers more than they would normally receive and then having providers return the bulk of the extra monies to the state (excess payments). As of July 2000, 17 states have plans that could allow them to use this practice, and 11 other states have drafted plans for doing so. GAO says this "violates the integrity of Medicaid's federal/state partnership."

Appendix C
Medicaid Financing Schemes Used to Inappropriately Generate Federal Payments and Federal Actions to Address Them, 1987-2005

Financing arrangement	Description	Action taken
Excessive payments to state health facilities	States made excessive Medicaid payments to state-owned health facilities, which subsequently returned these funds to the state treasuries.	In 1987, the Health Care Financing Administration (HCFA) issued regulations that established payment limits specifically for inpatient and institutional facilities operated by states.
Provider taxes and donations	Revenues from provider-specific taxes on hospitals and other providers and from provider "donations" were matched with federal funds and paid to the providers. These providers could then return most of the federal payment to the states.	The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 essentially barred certain provider donations, placed a series of restrictions on provider taxes, and set other restrictions for state contributions.
Excessive disproportionate share hospital (DSH) payments	DSH payments are meant to compensate those hospitals that care for a disproportionate number of low-income patients. Unusually large DSH payments were made to certain hospitals, which then returned the bulk of the state and federal funds to the state.	The Omnibus Budget Reconciliation Act of 1993 placed limits on which hospitals could receive DSH payments and capped both the amount of DSH payments states could make and the amount individual hospitals could receive.
Excessive DSH payments to state mental hospitals	A large share of DSH payments were paid to state-operated psychiatric hospitals, where they were used to pay for services not covered by Medicaid or were returned to the state treasuries.	The Balanced Budget Act of 1997 limited the proportion of a state's DSH payments that can be paid to state psychiatric hospitals.
Upper payment limit (UPL) for local government health facilities	In an effort to ensure that Medicaid payments are reasonable, federal regulations prohibit Medicaid from paying more than a reasonable estimate of the amount that would be paid under Medicare payment principles for comparable services. This UPL applies to payments aggregated across a class of facilities and not for individual facilities. As a result of the aggregate upper limit, states were able to make large supplemental payments to a few local public health facilities, such as hospitals and nursing homes. The local government health facilities then returned the bulk of the state and federal payments to the states.	The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 required HCFA to issue a final regulation that established a separate payment limit for each of several classes of local government health facilities. In 2002, CMS issued a regulation that further lowered the payment limit for local public hospitals.
Restocking and double billing of prescription drugs	Unused prescriptions were returned by hospitals or nursing homes to pharmaceutical companies or pharmacies. Unopened and meeting other standards, these drugs were then resold and build again to Medicaid.	The Deficit Reduction Act of 2005 prohibited federal matching payments for the ingredient cost of a covered outpatient drug for which the pharmacy has already received payment (other than a reasonable re-stocking fee).
Managed Care Organization provider tax	States were able to tax health care providers as a way to raise their share of the Medicaid matching payment. These funds, used to draw down Federal Medicaid dollars, were then returned to the provider, in effect, holding them harmless for the tax they originally paid. This loophole permitted states to shift the cost of their Medicaid programs directly to the Federal government,	DRA of 2005 demanded that MCOs are treated the same as other classes of healthcare providers with respect to provider tax uniformity requirements. Specifically, states would be required to tax all managed care organizations, not just those with Medicaid contracts, in order to meet the uniformity requirements. States are prevented from guaranteeing that tax revenues paid to states by MCOs be returned.