



National Association of State Medicaid Directors

an affiliate of the American Public Human Services Association

May 21, 2009

The Honorable Herb Kohl
U.S. Senate
330 Hart Senate Office Building
Washington, D. C. 20510

Dear Senator Kohl:

I am writing in response to the Senate Special Aging Committee hearing on Medicare and Medicaid fraud on May 6, 2009. I appreciate your Committee taking the time to hear testimony from federal, state and private industry officials detailing their efforts in combating fraud in the Medicare and Medicaid programs. While most often discussions regarding Medicaid fraud ignore the efforts undertaken by state Medicaid programs, I was particularly encouraged by the testimony of Robert A. Hussar, First Deputy Inspector General, State of New York Office of the Medicaid Inspector General, in which he described how his state is working to identify and prevent fraud, waste and abuse in the New York Medicaid program.

The purpose of my letter is to highlight the State Medicaid Directors' efforts to combat Medicaid fraud and abuse. Like New York and every other state, the Alabama Medicaid Agency actively works to combat Medicaid fraud and abuse to preserve taxpayer dollars for those who depend on Medicaid for their health care. Rooting out fraud and abuse is a team effort and should be conducting in that manner.

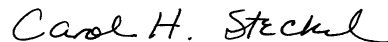
State Medicaid Directors, and our Program Integrity Directors, are becoming overwhelmed with overlapping and duplicative efforts to "ensure against fraud and abuse". We would recommend that these efforts be coordinated in such a

way as to enhance program integrity efforts, not just duplicate efforts conducted by state staff. In many cases, the multiple requests for data and information takes the state's staff away from their core function in program integrity. In addition, the Congressionally mandated rule that all identified overpayments be returned to the Federal government within 60 days inhibits states' efforts to aggressively go after those that have abused the program. For example, Alabama has sued 72 drug manufacturers and won jury verdicts in five trials. The awards granted by the Court are over \$200 million. CMS, under the current statute, has asked for the Federal share (over \$149 million) even though the verdicts are being appealed to the state's Supreme Court. Unless this rule is changed, states have an extreme disincentive to pursue these types of recoupments.

The State Medicaid Directors are true partners with the federal government in managing the Medicaid program. We stand ready to work with you and your Committee to improve our efforts to insure the program's integrity and to guarantee that the tax dollars entrusted to us are used to finance healthcare services for the most vulnerable of our population.

It is my pleasure to share the attached compilation of success stories from state officials as well as excerpts from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Program Integrity Review Annual Summary.

Sincerely,



Carol H. Steckel, MPH
Chair
National Association of State Medicaid Directors

The following are actual statements and best practices/success stories from various state officials regarding their program integrity efforts in combating fraud and abuse.

Alabama's Program Integrity (PI) Division is comprised of five units: Recipient Review, Provider Review, Pharmacy Audit, Quality Control and Investigations. Efforts to combat fraud and abuse include but are not limited to: working closely with program staff to ensure policy change and system edits recommendations, based on reviews of paid claims data and medical records, are made in a timely manner to prevent further overpayments; monitoring sanctioned providers and recipients to ensure no one is made eligible for Medicaid payments or services prior to the end of their sanction; monitoring lock-in recipients, ensuring correct eligibility determinations are made through MEQC reviews; monitoring and informing the fiscal agent responsible for provider enrollment of all federal and state provider sanctions; and investigating allegations of fraud and abuse made via the fraud and abuse hotline and written referrals in a timely manner.

Arizona's Medicaid Office of Program Integrity (OPI) takes a three-pronged approach to combating health care fraud in the Arizona Medicaid Program (AHCCCS): a strong civil enforcement through the use of civil monetary penalties, a criminal enforcement program in conjunction with the Arizona Attorney General and the various county prosecutors, and prevention efforts that encourage providers to adopt compliance programs and accept responsibility for policing their own activities.

A Loan officer earning \$180,000.00 lies, and is approved for medical benefits.

This investigation was initiated based on an anonymous report to the Arizona Medicaid Fraud Website. The report stated that a female was working as a senior loan officer earning \$180,000.00 annually. The report stated that she and her family were receiving medical benefits and she was not reporting her income. The investigation proved the allegation was true. The loan officer earned approximately \$150,000.00 in wages and an additional \$30,000.00 as an independent contractor. This person was prosecuted and found guilty of two Class 6 Felony counts of, "Attempt to make a False Statement as to Financial Condition or Identity" She was sentenced to 3 years probation by the court and in a civil settlement required to pay \$18,000 restitution.

Colorado has 11 full time staff dedicated to fraud and abuse detection who are mining paid claims data, reviewing medical records, monitoring licensing boards' sanctions, checking for excluded providers, identifying overpayments, sanctioning providers and making active fraud and/or false claims referrals to the state AG's office, AUSA, OIG and MFCU. One recent DME case referred to the MFCU resulted in exclusion, a 10 year prison term and a million dollar restitution order. This provider was billing Medicaid for wheelchair repairs that never happened (but were needed) and for wheelchairs the clients never received. There's also the dentist that was found to be unbundling services and billing for services that were not rendered; or the physician using coding software that upcoded every office visit to the highest reimbursable evaluation & management code; and the DME provider that falsified invoices and billed Medicaid up to 600% higher prices than the original invoice indicated; and the supply provider billing for oxygen several months after clients died; or the dentist receiving reimbursement

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through OAP and billing Medicaid for the same services paid by OAP. There are many other stories to tell, too numerous to list.

Kentucky's Provider Services and Recovery Branch within the Division of Program Integrity employs 5 full time staff who identify potential provider and member fraud as well as overpayments through DSS SUR reports (MMIS system), algorithms, ad hocs and claim history reviews. Fraud and abuse cases are referred to the State AG's office, OIG and MFCU and other law enforcement agencies. Additionally, the Division of Program Integrity employs fourteen staff in the Provider Enrollment Branch who process provider enrollment applications and credential applications which includes but is not limited to monitoring licensing boards' sanctions. One of Kentucky's success stories is the court-ordered and the administrative recovery of overpayments from members. This effort was initiated in 2001 and has been an excellent proactive tool as well as a deterrent for members to commit fraud. Up to today's date we have collected a total of \$151,035.73 for the current fiscal year (SFY'09). The numbers are broken down as administrative collections of \$2,441.89 and court ordered collections of \$148,593.84.

To date, Kentucky Medicaid Surveillance and Utilization Review (KMS) has identified 12 physicians or physician groups for review during this fiscal year by comparing their utilization of new and established patient Evaluation and Management (E/M) Current Procedural Terminology (CPT) codes to their peers. The 12 identified providers billing was researched and 6 were recommended for an onsite visit while the remaining 4 are in the process of being evaluated. The onsite audits confirmed the concern that the providers were upcoding their E/M services and ongoing audit findings are far enough along to have an identified overpayment, totaling \$433,885.45. Another good example is the dental provider that billed for services not rendered which resulted in collection of \$557,861.79.

Louisiana's Program Integrity has five basic components – Provider Enrollment, Administrative Exclusions, Forensic Data Mining, Audits and Investigations and Payment Error Rate Measurement (PERM). We employ 2.5 state Staff and 11 FYI Staff for Provider Enrollment, 2.5 State Staff for Administrative Exclusions, 1 State Staff and 2 FI Staff for Forensic Data Mining, 4 State Staff and 40 FI staff in Audits and Investigations and 3 State Staff for PERM.

So far this State Fiscal year we have recovered over \$5 M. We work closely with MFCU both in terms of referrals and assistance with their investigations. As a result of joint efforts by MPI and MFCU over 50 arrests have been made on Direct Service Workers in our various Home and Community Based Services.

Maine's Division of Program Integrity has a staff of twelve to oversee the state's Medicaid Program with expenditures nearing \$3B. In the last 10 years the Division has averaged \$1M of identified overpayments per staff member. In this most current state fiscal year the Division has identified over \$20M of overpayments ranging from simple billing errors, to home health supplies billed with a 200% mark-up, to provider budgets that included phantom staff.

In a recent case, the Division reviewed billings from an MR agency whose hourly rate of reimbursement was established from the estimated budget it submitted for each member to be served. The provider's estimated budget included the cost for a 24/7 staffing level of 1:1 for

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several beneficiaries. The Division's review of the provider's progress notes, payroll records, and staffing schedules determined that the actual staffing level was 1:2 and that the agency had never provided 1:1 staffing. The overpayment in this case exceeded \$300,000 and the Division referred the case to the Medicaid Fraud Control Unit.

Maryland condensed its fraud and abuse efforts by moving Program Integrity (PI) to the Office of Inspector General in July 06. Cost avoidance and recoveries have increased from \$13 million in fiscal year 06 to almost \$25 million for this current fiscal year 09. The amount of referrals to MFCU has increased to an average of 15 cases per year since 2006. Part of the Department's effort to combat fraud and abuse is to actively engage in training of providers on the importance of compliance and efforts to prevent fraud and abuse. The OIG conducted seminars for hundreds of providers to raise the awareness and importance of good billing practices and due diligence in combating fraud and abuse since PI was moved to the OIG. With the assistance of CMS Program Integrity the OIG has increased training for auditors and investigators in identifying fraud, waste and abuse and improved quality of referrals to MFCU. PI has sought to increase communications with Medicaid Programs, MFCU, Office of Health Care Quality and state only programs by initiating bi-weekly meetings to review open cases in the OIG and receive input of all potential impacted programs. This has contributed significantly to PI cost avoidance and referrals to MFCU.

New Hampshire's SURS has a staff of 8 (1 vacant secondary to a hiring freeze). We are actively involved with provider enrollment, and receive all Board actions as part of our process of screening all potential new, and currently enrolled providers. We work closely with our fiscal agent to identify and correct systems issues that may impact claims payment, either resulting in erroneous payment, or allowing providers to fraudulently bill. We also work closely with our policy/rules units to help implement changes/updates in our rules and regulations, as a result of our review findings. Our pharmacy lock-in program also includes careful physician prescribing review, to identify providers that enable our clients to abuse medications. These providers are routinely referred to the MFCU for further action.

One of our nurses is 100% dedicated to the review of mental health providers, and she has identified a number of issues ranging from systems edit problems, to program regulations errors. She has made significant recoveries, referred providers to the MFCU, had providers sanctioned, and one provider incarcerated. In other provider reviews, we have identified 40 providers that have billed incorrectly for maternity services, ranging from double billing to billing the global fee in addition to individual visits.

Tennessee –

In response to CMS initiatives following the passage of the Deficit Reduction Act of 2005, the State of Tennessee formed a Provider Fraud Task Force (PFTF) in 2007. The PFTF is a collaborative effort of the Tennessee Bureau of Investigation's Medicaid Fraud Control Unit (MFCU), the State Attorney General and the Bureau of TennCare.

Since inception, the PFTF has increased coordination among the State Agencies that have jurisdiction over provider fraud. The task force meets monthly to review potential cases, no

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matter what source, and determine the appropriate action on each. It also meets quarterly with each MCO to review cases they have independently developed. The task force determines whether the State will pursue civil or criminal penalties against these providers, or permit the MCOs to recoup funds directly.

Giles County resident is accused of fraud for using TennCare benefits to pay for a forged prescription for the addictive painkiller Hydrocodone. She was indicted on one count of TennCare fraud and obtaining a controlled substance by fraud. The Maury County Sheriff's Office assisted in the arrest. A Lewisburg resident, was indicted by a Giles County Grand Jury for one count of TennCare fraud for willfully making a false statement.

“With the help of local officers and healthcare providers, we are waging war on TennCare fraud of any kind, from prescription drug fraud to folks who aren't truthful about their employment, income, or other status,” Inspector General Deborah Y. Faulkner said. Illegally obtaining TennCare medical benefits is a Class E felony that carries a maximum penalty of two years in prison.

The OIG, a law enforcement agency separate from TennCare, began full operation in February 2005 and has worked cases leading to the arrest of over 860 individuals for TennCare fraud, with nearly \$1 million paid in restitution to TennCare, and total estimated cost avoidance in TennCare of over \$122 million, according to latest figures.

Vermont's Program Integrity investigative finding was that the provider was billing excessive units for anesthesia services. Program Integrity's Anesthesia project has a recoupment of \$341,000 as of May 2009. Through collaboration with and education to the provider, internal changes have been made by the provider to ensure accurate billing based on units of service. Actions taken by the provider – changed billing contractor, implemented a self audit process. PROVIDER GOAL: Compliance to Vermont Medicaid rules. The Anesthesia project is a good example of recovery for the State of Vermont for over-billing, as well as self-directed actions by the provider to bring them into ongoing compliance Vermont State rules/billing procedures.

Multiple cases are being investigated including Broker issues, Driver Issues and Beneficiary Issues. Currently PI is investigating about 100 Transportation Cases. Current actions implemented: Vermont's Medicaid office and Transportation Office is participating in the education of the *Transportation Brokers* with a focus on how to detect aberrant behaviors with a goal of early detection and reporting of misuse, educating their drivers to the rules and reporting procedures, scheduling in a manner that provides the least costly/appropriate mode of transportation. Brokers are showing ownership of their responsibilities and as a result are reporting more cases of aberrant behaviors. Potential *Cost Avoidance savings(COS)*: EX: **Eight Bene cases netted: \$51,482.55 (COS)**. Resources for PI investigations are broadening: For ex. - A business agreement between the *Agency of Transportation* and PI allows for quicker access to motor vehicle registration information. The PI unit and OVHA's Transportation unit are collaborating in ways to restructure process and services while maintaining appropriate access to those appropriately eligible.

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Washington State recognized that, in order to improve the integrity of our program, we needed to make a significant investment in both staff and technology. From 1999 to the present we have almost doubled our program integrity staff, adding data mining/algorithm development analysts and additional on-site and desk auditors. In 1999, Washington entered into a contract with HWT, Inc. (now Ingenix) to provide a Decision Support System, as well as data mining services which utilize complex algorithms and modeling for identification of cost savings. Staffing and technology investments have resulted in over \$145 million in program integrity savings over the last 7 state fiscal years. Our most recent program integrity initiative is a voluntary Provider Self Review process – the investment in technology provides a secure web site where providers can review claims data that appear to be aberrant. Our first Provider Self-Review pilot on upcoding of neonate accommodation codes produced \$284,000 in recoveries.

In addition to cost savings, Medical audit referrals to the Washington State Medicaid Fraud Control Unit have aided in 12 successful prosecutions of healthcare fraud by MFCU; medical audit referrals to our internal Medical Dental Advisory Committee have resulted in termination of over 16 core provider agreements; a successful joint audit with Medi-Medi partners which identified overpayments exceeding \$150,000 in Medicaid dollars and over \$190,000 in Medicare funds.

The following are excerpts from Health and Human Services Centers for Medicare and Medicaid Services, Program Integrity Review Annual Summary.

Arkansas has undertaken a time-dependent analysis of mental health providers who are suspected of billing for simultaneously providing different kinds of services in different places. It has also initiated similar analyses of overlapping provider billings in several home and community-based services waiver programs.

Georgia initiated a project to validate the physical business address of all DME suppliers by performing a visual check. The suppliers with questionable addresses are reviewed for possible fraudulent practices. The State will continue to utilize this verification process method on all newly enrolled DME suppliers. Another initiative involves an audit of the top five power wheelchair suppliers. Georgia determines if the supplier billed for a more expensive wheelchair than actually provided. A survey is sent out to selected clients to complete. As part of the survey, the clients review pictures of wheelchairs and scooters and identify the type of equipment they received by circling the appropriate picture. Based on the discrepancies detected, the investigators conduct an onsite visit comparing the equipment with the DME supplier's billing.

Illinois conducts site visits on all non-emergency medical transportation (NEMT) providers, during which the State verifies the address and inspects licenses. New transportation providers are also subject to mandatory criminal background checks, and are placed on probation for 180 days, during which time Illinois' Office of Inspector General (OIG) monitors their claims. All DME providers also receive onsite reviews, during which the State checks inventory to determine whether it is reasonably related to billings. Moreover, both NEMT and DME providers must re-enroll in the Medicaid program on a periodic basis.

Iowa has a robust lock-in program through a contractor. The program has a cost savings of approximately \$2 million annually. Recipients abusing the program are locked into a primary care physician, pharmacy, and hospital/emergency room. The lock-in program creates a safety net approach and limits the recipient's ability to obtain drugs. The program also identifies providers who may be engaging in unsound medical practices.

Michigan can impose a summary suspension (i.e., in high-dollar or otherwise egregious cases of fraud) that temporarily abrogates the existing Medicaid provider agreement and freezes all Medicaid payments until a provider has exhausted all administrative remedies or has been convicted in a court of law. The passage of a State Whistleblower Law in 2005, which offers

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incentives to the public to report serious cases of fraud and abuse directly to the MFCU, has enhanced the State's ability to combat fraud, waste, and abuse. State Whistleblower Law

North Carolina follows up on every returned explanation of medical benefits (EOMB) by documenting each EOMB returned and telephoning the recipient. The State also recently added four questions to EOMBs which the State believes has increased the rate of return from 12 percent in 2005 to 50 percent currently.

North Dakota's staff, both within the Fraud and Abuse Unit and in other parts of the State agency, communicate well with each other. There are no artificial barriers between organizational units which limit the ability of the program integrity staff to gather information and work cohesively to resolve fraud and abuse issues.

Oregon's SURS staff perform creative data analysis in identifying different types of fraud schemes, provider abuse, and overpayment situations, and staff generate backup confirmation for queries developed through the Office of Payment Accuracy and Recovery's data warehouse. The data warehouse provides many components within the State much faster access to standard and customized reports and the ability to do innovative data-mining.

South Carolina's SURS Unit works with two contractors to develop algorithms to assist in advanced fraud analytics. The State has a library that consists of approximately 350 algorithms. These algorithms are used to identify potential cases of providers who may fall outside of the normal range. The Program Integrity Unit and SURS Unit meet biweekly to discuss patterns and open cases for further investigation.

South Dakota's SURS Unit reviews a randomly sampled paid claims report from MMIS on a weekly basis to ensure that the MMIS is paying according to existing rules and regulations and that providers are billing in accordance with program guidelines. The reports have identified areas of questionable billing practices and payment issues resulting from MMIS enhancements and other changes that would otherwise not have been detected.

Texas highlighted its establishment of an OIG within the State agency as an effective practice. The OIG has 530 staff, excluding vacant positions. As one of the largest OIG offices in the country, all four divisions of the State OIG contribute to the integrity of the Texas Medicaid program.

Utah's Bureau of Program Integrity, immediately following its reorganization, placed major emphasis on the development of policies and procedures to promote programmatic continuity and consistency. A detailed manual with written policies and procedures is already in place.

Virginia has focused on program integrity as an agency-wide priority, reorganizing the Program Integrity Division and hiring a new management team. In addition, the agency targeted durable medical equipment (DME), home health care and pharmacy services as priority areas. The State increased program integrity staffing, while contracting with nationally recognized companies to undertake specialized audits. Other activities initiated to strengthen the Commonwealth's program integrity efforts include: enhancing tracking systems and processes; playing a larger

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role in Federal program integrity activities (such as participation in the Medicaid Fraud and Abuse Technical Advisory Group); and improving its relationship with its MFCU.

Wyoming instructs its fiscal agent to terminate all providers whose mailings have been returned to the contractor, eliminating the ability of those providers to bill Medicaid unless and until the fiscal agent gets the correct mailing address, enhancing the provider enrollment and system maintenance capabilities. The process began approximately two years ago and has resulted in a dramatic decrease in the number of providers with inaccurate addresses. In addition, the fiscal agent terminates providers who have not filed a claim within the past 365 days or providers who have not updated their license.