NASMD

National Association of State Medicaid Directors

an affiliate of the American Public Human Services Association

STATEMENT OF
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BEFORE THE
SENATE HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS COMMITTEE
SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT INFORMATION, FEDERAL SERVICES, AND INTERNATIONAL SECURITY

A PRESCRIPTION FOR WASTE: CONTROLLED SUBSTANCE ABUSE IN MEDICAID
SEPTEMBER 30, 2009

Introduction

Chairman Carper, Ranking Member McCain, and Distinguished Members of the Panel: Thank you for the opportunity to discuss current State Medicaid Agency activities to reduce fraud, waste and abuse of controlled substances, and to suggest ways to improve the ability of states to effectively identify, monitor and combat these issues. My name is Ann Clemency Kohler and I am the Director of The National Association of State Medicaid Directors (NASMD). NASMD is a professional, non-profit organization of representatives of state Medicaid agencies, including the District of Columbia, the Commonwealth of Puerto Rico, and the territories. The primary purposes of NASMD are to serve as a focal point of communication between the states and the federal government, and to provide an information network among the states on issues pertinent to the Medicaid program. Prior to NASMD, I was State Medicaid Director in New York and New Jersey, as well as in a management position in New Jersey's Office of Management and Budget.

When discussing fraud, waste, and abuse in Medicaid, it is important to remember that Medicaid is a jointly operated and jointly funded program. While the Federal government finances approximately 57% of Medicaid outlays, on average, the remaining funds come from State General Funds. In Many States, Medicaid represents the largest program in the State budget. States have as much of a vested interest in the integrity of the Medicaid Program as the Federal government. For that reason it is important to collaborate on productive ways to prevent fraud and abuse and to quickly identify and address problems when they occur.

It is also important to remember that abuse of controlled substances is not solely a Medicaid issue. According to a 2007 report by the Coalition Against Insurance Fraud, abuse and fraud related to drug-diversion scams costs private insurers nearly $25 billion annually. This represents over 1/3 of all costs related to drug-diversion scams[1]. The Medicare prescription drug benefit is not immune to provider and beneficiary fraud either, as several GAO recent reports suggest[2] [3]. Fraud, waste and abuse are significant issues that all insurance providers must address. Medicaid agencies, like other health insurers, are attempting to mitigate these issues through a variety of activities intended to identify and prevent fraudulent activities and to strengthen existing protections. Additionally, fraudulent behavior occurs in very small segments of the population. It is easy to become reactive to high-profile, worst-case examples, but Medicaid agencies must balance activities to identify fraudulent behavior with the need to ensure that the vast majority of honest providers and beneficiaries receive necessary services.

Current State Efforts

States are currently involved in a number of efforts to reduce the incidence of fraud and abuse related to controlled substances. All State Medicaid agencies engage in fraud and abuse prevention, detection and correction activities. According to self-reported data, States estimate that they expended $181 Million on program integrity activities during

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[1] http://www.insurancefraud.org/downloads/drugDiversion.pdf
[2] http://www.gao.gov/new.items/d08760.pdf
[3] http://oig.hhs.gov/oei/reports/oei-03-07-00380.pdf

Federal Fiscal Year 2007, which resulted in approximately $1.3 Billion in Medicaid recoveries due to improper payments, fraud and abuse. Some of these activities include:

- *The implementation of tamper-resistant prescription pads*
  In 2007, Congress passed a requirement that all Medicaid prescriptions be written on "tamper-resistant" pads. These pads are intended to prevent copying of blank prescriptions, prevent individuals from erasing or modifying information on the prescription, and prevent counterfeit prescriptions. On October 1, 2008, States were required to be in full compliance with these requirements.
- *Electronic prescriptions*
  Many states have been using Health Information Technology, funded through Medicaid Transformation Grants and other mechanisms, to develop E-prescribing technology. This technology not only reduces accidental provider error, but can also help identify patterns of abuse by providers and by beneficiaries.
- *Secret shoppers*
  Many States have also been involved in the development and implementation of "secret shopper" initiatives. In these programs, Medicaid investigators pose as beneficiaries to probe providers suspected of fraud and abuse. States have been able to identify and correct a number of instances of providers not complying with Medicaid policies through these projects.
- *Treatment Control Mechanisms*
  Medicaid agencies have established a number of mechanisms to monitor and control drug utilization within the program. Some of these mechanisms include requiring prior-authorization for certain classes of prescription drugs, performing utilization reviews on services provided, limiting the number of prescription drugs available in certain classes, and implementing Preferred Drug Lists for beneficiaries. These policies limit beneficiary access to drugs with high potential for abuse, and allow agencies to flag cases where exceptional treatments have been prescribed or acquired.
- *Establishing Lock-in Programs*
  One of the most common mechanisms for individual fraud and abuse is "Doctor-shopping," where individuals go to a number of doctors and pharmacies in order to receive multiple prescriptions of the same drug. Many states are establishing or enhancing lock-in programs, which restrict provider and pharmacy access for individuals suspected of fraudulent behavior.
- *Surveillance and Utilization Review Systems*
  States regularly utilize SURS systems to identify cases of inappropriate prescriptions, over-prescribing, provider malpractice and other potential instances of fraud and abuse. According to the CMS State Program Integrity Assessment, all 50 states engage in some type of SURS data mining to identify potential cases of fraud[4]. While not every single case is resolved, States are able to identify and mitigate a significant amount of abusive activity.
- *Program Data Matching*
  A variety of mechanisms exist to increase data integrity by matching information from other public programs. States are currently in the process of developing electronic data sharing systems with the Social Security Administration to process

[4] http://www.cms.hhs.gov/FraudAbuseforProfs/Downloads/spiaffy2007executivesummary.pdf

Medicare Part-D Low-income Subsidy Applications. Many LIS clients are also dual-eligible for Medicaid and this information can be used to ensure that client data is consistent across programs. States also have the ability, through the State Data Exchange, to receive timely information from the Social Security Administration regarding individuals receiving SSA Benefits. These programs are crucial for verifying Medicaid eligibility, including identifying individuals who have died since entering the program.

Challenges and Recommendations

As I discussed, States are engaged in a number of activities to prevent fraud, waste, and abuse; however, there are still significant issues that must be addressed to improve the effectiveness and efficiency of integrity activities. While States are committed to further reducing incidence of fraud, waste and abuse, several structural issues create significant challenges when states attempt to establish these projects. These include:

- *The 60-Day Repayment Rule*
  When a State or Federal audit reveals an improper payment, and overpayment, or an instance of provider/beneficiary fraud, States are required to repay the Federal share of the money within 60 days. This requirement exists regardless of whether the State is able to recoup the claim from the provider within the 60 day period, or at all. In effect, strong program integrity activities can actually be detrimental to State budgets. Not only do States have to expend money investigating, identifying, and attempting to recoup the payments, they are also required to pay additional funds as a repayment to the Federal government. While this does not prevent States from engaging in integrity activities, it is a serious detriment to Medicaid programs at a time when funding is already severely limited. Congress should modify the rule to require States to repay the Federal share within 60 days of recovery, not identification. On September 23rd, The Senate Finance Committee approved an amendment to the Chairman's Mark of the America's Healthy Future Act of 2009 that would resolve this disconnect in overpayment collections. NASMD supports the ultimate passage of this policy fix.
- *Coordination of Federal Integrity Activities*
  The Centers for Medicare and Medicaid Services currently have a broad range of integrity activities that are intended to identify cases of fraud and abuse. However, these initiatives often overlap with each other and are not appropriately coordinated. The lack of coordination in these programs creates administrative inefficiency and increases the burden on State staff, who often have to respond to multiple similar requests from different parts of CMS. Improving the coordination of these activities can improve the overall efficiency and outcomes of Federal-State integrity projects.
- *Improve Data Sharing Between Medicare and Medicaid*
  Many individuals enrolled in Medicare are also dually eligible for Medicaid. Although prescription drug coverage for this population has shifted from Medicaid to Medicare with the enactment of Part-D, many Medicaid agencies still provide wrap-around pharmaceutical benefits for dual eligibles. State agencies do this because the Part-D approved formularies and prescription limits do not always meet the needs of beneficiaries. However, without adequate knowledge of

the benefits provided from Part-D, Medicaid agencies can be susceptible to individuals who attempt to receive the same prescriptions from both programs simultaneously. Improving data sharing regarding beneficiary encounters in Part A Hospital Benefits, Part B Physician Benefits and Part D Drug Benefits would greatly increase Medicaid's ability to identify potential cases of fraud and abuse. Congress should pass legislation to allow more comprehensive data-sharing for Medicare and Medicaid within CMS and the States.

- *Information Technology/Data Collection*
  Many States have been working to improve their data systems in order to collect more comprehensive information regarding individuals in health and human services programs. This can be used to verify eligibility across programs, to ensure that personal information is accurate, and to increase coordination of benefits and decrease administrative complexity. Superior information technology can also be used to improve data analysis to identify potential cases of fraud, waste and abuse. While system upgrades are desirable, State Medicaid IT systems are currently under a tremendous amount of stress due to several major revisions, including the move to the ICD-10 disease classification system, adoption of the 5010 transaction standards, and upgrade to the Nursing Home Minimum Data Set v3.0. Combined, these IT upgrades will consume millions of dollars and thousands of hours of labor – leaving little time for other upgrades.
- *State Finances*
  At a time when States are experiencing record budget shortfalls, funds are not readily available to finance system upgrades. We thank Congress for passing the American Recovery and Reinvestment Act (ARRA), which provided significant funding to avoid drastic Medicaid cuts and to implement Health Information Technology. However, State budgets are still strained, and fraud detection activities require substantial investments. States are committed to ensuring the integrity of the programs, but current economic conditions require difficult funding decisions. Due to the Maintenance of Effort Requirements in ARRA, which prevent states from restricting Medicaid eligibility, States don't have their usual Budget flexibility – creating significant strains on programs, services and activities that are not directly related to eligibility and acute care.

Conclusion

Although cases of fraud, waste and abuse exist in Medicaid, they are also a significant problem for all health insurance providers. It is also important to note that instances of fraud or abuse generally occur in very small portions of the Medicaid population. However, the State and Federal Governments continue to share responsibility for the administration of Medicaid, and need to work collaboratively to increase the integrity of the program.

I would like to thank the panel for the opportunity to speak today, and am enthusiastic that Congress, the Centers for Medicare and Medicaid Services and the States can effectively collaborate to reduce instances of fraud, waste and abuse in Medicaid – especially abuse of controlled substances. We look forward to working with you in the future. At this time, I would be happy to answer any questions you have.