STATEMENT OF

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DEPUTY DIRECTOR,
CENTER FOR MEDICAID AND STATE OPERATIONS
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

CONTROLLED SUBSTANCE ABUSE IN MEDICAID

BEFORE THE

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

SEPTEMBER 30, 2009

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

TESTIMONY OF
PENNY THOMPSON
DEPUTY DIRECTOR,
CENTER FOR MEDICAID AND STATE OPERATIONS
IN THE
CENTERS FOR MEDICARE & MEDICAID SERVICES
ON
"A PRESCRIPTION FOR WASTE: CONTROLLED SUBSTANCE ABUSE IN MEDICAID"
BEFORE THE
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Chairman Carper, Senator McCain, and distinguished Subcommittee members, thank you for inviting me here to discuss the Government Accountability Office (GAO)'s report on Medicaid Fraud and Abuse Related to Controlled Substances. Let me begin by stating that the President, Secretary Sebelius and the Department of Health and Human Services (HHS), and the Centers for Medicare & Medicaid Services (CMS) are committed to protecting our health care programs from fraud, waste, and abuse. While CMS realizes that we have to be constantly vigilant against new and emerging threats and schemes, the Agency believes it should insist on near perfect performance to assure that inappropriate payments are not made to ineligible providers or on behalf of ineligible beneficiaries. In addition, CMS expects States to utilize the wide variety of tools currently available to them to ensure Medicaid does not subsidize addiction to or diversion of controlled substances.

For our part, the Federal government must do a better job of measuring States' performance and results, drawing national attention to program vulnerabilities, deploying tools, and building capability to prevent and attack fraud. To this end, CMS agrees with each of the four

recommendations made by the GAO. However, CMS would like to point out that implementing the changes recommended by the GAO requires cooperation by other Federal agencies to facilitate data sharing and other technical assistance. CMS continues to evaluate its programs and will work to develop methods to address the identified issues found in the GAO study.

Federal-State Relationship in the Medicaid Program

Medicaid is a partnership between the Federal government and the States. State governments have a great deal of programmatic flexibility within which to tailor their Medicaid programs to their unique political, budgetary, and economic environments. As a result, there is considerable variation among the States in eligibility, services, and reimbursement rates to providers and health plans. The Federal government reimburses the States a portion of their costs through a statutorily determined matching rate called the Federal Medical Assistance Percentage, or FMAP, that normally ranges between 50 and 76 percent. The American Recovery and Reinvestment Act (ARRA, P.L. 111-5) temporarily increased FMAP rates by a minimum of 6.2 percent through December 31, 2010. In CY 2010, total Medicaid expenditures – those that include both Federal and State contributions – are estimated to be approximately $419 billion.[1]

While the Federal government sets broad guidelines and provides matching payments to the States, each State is responsible for administering and designing its own program within Federal parameters. The States enroll providers, set reimbursement rates, and negotiate managed care contracts. Each State, therefore, is primarily responsible for oversight of its Medicaid program.

[1] 2009 National Health Expenditures Data (Table 3)

Let me take this opportunity to talk about several steps CMS has taken to strengthen Medicaid program integrity with respect to all types of claims and services, including prescription drugs. Congress gave CMS new authority in the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) to establish and operate the Medicaid Integrity Program (MIP). This program parallels similar authority granted to the Medicare program roughly a decade ago. However, the Medicaid program differs in several important aspects, including authority to use some of the funding for hiring federal employees, not just contractors, and a requirement to provide support and assistance to States to combat provider fraud and abuse.

Medicaid Integrity Program

Section 6034 of DRA implemented the Medicaid Integrity Program within Section 1936 of the Social Security Act. The Act directs the Secretary to establish a 5-year comprehensive plan to combat fraud, waste, and abuse in the Medicaid program, beginning in FY 2006. The first comprehensive Medicaid Integrity Plan covering FY 2006-10 was released in July 2006; the second, covering FY 2007-11, was released in October 2007; the third, covering FY 2008-12, was released in June 2008; and the fourth, covering FY 2009-13, was released in July 2009.

Through MIP, CMS is committed to working with States to identify and eliminate fraud in the Medicaid program. The MIP offers a unique opportunity to prevent, identify, and recover inappropriate Medicaid payments. It also supports the efforts of State Medicaid agencies through a combination of oversight and technical assistance. Although each State works to ensure the integrity of its respective Medicaid program, the MIP provides CMS with the ability

to more directly ensure the accuracy of Medicaid payments and to deter individuals who would exploit the program.

The DRA states that CMS must enter into contracts to perform four key oversight activities: 1) review provider actions; 2) audit claims; 3) identify overpayments; and 4) educate providers, managed care entities, beneficiaries, and others on payment integrity and healthcare quality. CMS has completed the process of awarding MIP review and audit contracts, which now cover the entire country. Audits completed between 2007 and 2009 have identified $8.5 million in final overpayments as of August 26, 2009. These overpayments were identified through both direct provider audits as well as automated reviews of State claims. CMS has identified an estimated $68 million in potential overpayments, mostly through similar automated reviews. These payments will be further evaluated by MIP contractors. It is important to note, however, that these overpayment amounts do not directly correlate to fraudulent payment amounts. Rather, many of these errors are the result of documentation and processing mistakes.

Also within Section 6034 of the DRA, CMS received enhanced funding for Medicaid fraud efforts, specifically the national expansion of the Medicare-Medicaid (Medi-Medi) Data Match Pilot Program. Matching Medicare and Medicaid claims data to find patterns of fraud, previously undetectable to the programs individually, has provided State and Federal law enforcement and program integrity units with dramatic insights into the overall practices of providers who are exploiting both programs. In FY 2008, 30 Medi-Medi cases were referred to law enforcement, over $27 million in overpayments were referred for collection, and $7 million in improper payments were caught before erroneous payments were made.

In addition to implementing key program integrity functions such as reviewing Medicaid providers and identifying inappropriate payments, the DRA requires CMS to provide effective support and assistance to States to combat fraud and abuse. CMS provides this support in the form of State program integrity reviews, training opportunities, resource support for special projects, and ongoing technical assistance. I would like to talk about a few specific support mechanisms that CMS has developed.

Training of State Program Integrity Staff – The Medicaid Integrity Institute

The Medicaid Integrity Institute (MII) was established in September 2006 to provide quality education on program integrity to State Medicaid employees free of cost. Through an interagency agreement with the National Advocacy Center of the U.S. Department of Justice (DOJ)'s Office of Legal Education, CMS supports training in all aspects of program integrity. Since February of 2007, more than 1,300 State employees have been trained at the MII. CMS and the MII have hosted 26 different classes during that time. In FY 2008 and 2009, CMS expended $2.05 million on the MII. The MII will sponsor at least 12 classes in FY 2010 which will provide program integrity education to an estimated 700 additional State employees.

State Program Integrity Reviews

In addition to the MII, CMS conducts comprehensive management reviews of each State's Medicaid program integrity procedures and processes on a triennial basis. Through these reviews, CMS assesses the effectiveness of State program integrity efforts and determines whether a State's policies and procedures comply with Federal regulations. CMS also uses the reviews to identify and disseminate effective practices.

The most common regulatory violations cited in these reviews include: the failure to collect required ownership, control, and criminal conviction disclosures; the failure to require disclosure of business transaction information; and the failure to report adverse actions on providers to the HHS' Office of Inspector General (OIG). The most common vulnerabilities, which can place State program integrity at greater risk than regulatory violations, include: inadequate protections in the provider enrollment process; lack of exclusion checking after initial enrollment; undocumented program integrity procedures; failure to disenroll inactive providers; inadequate oversight of Medicaid managed care organizations; and ineffective relationships with State Medicaid Fraud Control Units (MFCU).

The States have responded positively to the reviews, indicating that they will implement corrective actions in response to the regulatory findings identified in the reviews. CMS has posted an annual summary of effective practices, findings, and vulnerabilities on its website.[2] CMS has also identified States with effective practices by name so State Medicaid agencies may consult each other and collaborate on what may work in their State.

State Program Integrity Assessment

Following the groundwork laid by the State Medicaid program integrity reviews, the State Program Integrity Assessment (SPIA) is CMS's first national data collection on State Medicaid program integrity activities. The SPIA provides standardized data that can be used for program evaluation and technical assistance and support to States, and allows both the States and CMS to

[2] http://www.cms.hhs.gov/FraudAbuseforProfs/Downloads/2008pireviewannualsummaryreport.pdf

identify areas of opportunity to build on current practices, and areas where improvement is needed. The States and CMS will be able to use the SPIA to gauge our collective progress in improving the overall integrity of the Medicaid program. Thus far, CMS has taken information collected from the SPIA to develop individual reports for each State and the District of Columbia's FY 2007 data using 25 key questions from the SPIA data collection instrument.

States reported in FY 2007 that they employed 3,799 program integrity staff and expended $181 million on program integrity activities. States conducted 54,829 audits that resulted in the recovery of $568 million. While individual State performances are as varied as their operations, overall the States have reported robust recoveries and return on investment in program integrity. The States reported they recovered $1.3 billion from all program integrity-related activities, or a cumulative return on investment of $7 for every dollar spent on the programs.[3] The FY 2007 SPIA reports, along with a complete data set and high-level executive summary, are available on the CMS website.[4] CMS has recently begun FY 2008 data collection, and the Agency looks forward to continuing this valuable partnership with the States that will only improve State Medicaid program integrity.

Dissemination of Best Practices and Review of Program Data

In response to an OIG audit report (A-05-05-00030), CMS provided guidance to the States to periodically identify deaths of Medicaid beneficiaries and prevent the approval of claims when appropriate. In a memo dated May 2008, guidance was given for State Medicaid agencies to work with other relevant agencies in their State to eliminate payments for services claimed to

[3] http://www.cms.hhs.gov/FraudAbuseforProfs/11_SPIA.asp
[4] Ibid.

have been provided to deceased beneficiaries. States were also provided information on the Arizona Medicaid agency's implementation of the Arizona Health Care Cost Containment System, which was identified by CMS for utilizing a noteworthy approach to addressing this problem.

Beginning in 2009, CMS has been working to make timelier the Medicaid Statistical Information System (MSIS), the primary source of national Medicaid program data. Working with the CMS Office of Information Systems (OIS) and the States, CMS has converted the quarterly tape submissions for the eligibility and claims data to Electronic File Transfers (EFT) systems. As of September 15, 2009, 47 States and the District of Columbia are now submitting their files electronically, reducing the delays associated with the mailing and processing of tape files. The 3 remaining States will submit their files electronically no later than the end of 2009.[5]

CMS has also worked to identify additional data collection needs beyond the data currently collected in MSIS to improve national Medicaid fraud and abuse reviews. CMS initiated a review to identify and request more detailed data to conduct national Medicaid fraud and abuse reviews. A cross-agency Data Element Workgroup was then established. The workgroup consists of representatives from CMS as well as the HHS OIG. The workgroup also consulted with State Medicaid agency representatives. The fundamental goal of the workgroup was to develop a list of Medicaid data elements that could be captured in a single submission of data from the states to fulfill the requirements of the MSIS, MSIS Plus, Medi-Medi and PERM programs. These data elements were identified for enhanced fraud detection and prevention,

[5] The three remaining States are: Colorado (CMS is in contact with State to begin testing); Nebraska (actively testing), and Utah (actively testing).

reduced costs and increased quality in information systems and increased efficiency and accuracy in data analysis. In fulfilling this goal, the burden on the States to provide data to CMS should be reduced and the ability of the Agency to work with Medicaid data should be improved.

Other CMS Program Integrity Efforts

While CMS has implemented a number of successful Medicaid program integrity initiatives, the Agency is committed to further strengthening these activities going forward. This commitment specifically includes comprehensive strategies to address on a national basis the vulnerabilities in Medicaid program integrity. Our efforts to combat problems identified in State provider enrollment processes offer examples of this approach.

States face significant challenges in their attempts to successfully monitor Medicaid claims and keep unscrupulous providers out of their Medicaid programs. There is a recognized advantage in a common provider enrollment system that would create efficiencies of scale and improve program integrity. CMS is laying some ground work for such a system now and will work with States to explore this concept further. Such a system may include automated file checks of Federal exclusions, Social Security numbers, date of death, and State licensing board records.

One of the most common problems we learned from our discussions with States was the need for manual entry of data. For example, Medicaid eligibility files include the beneficiary date of death when such information is received. A State Medicaid agency may obtain that information from data collected by another State agency, or it may possibly receive the Social Security Agency (SSA)'s death master file. In either case, however, the data on date of death often cannot be automatically integrated into the State's Medicaid payment system. Instead, because

of systematic issues, the date of death must be manually keyed-in, inevitably resulting in errors in data entry, such a data entry clerk inadvertently entering a date of death as 9-1-2009 instead of 1-9-2009. Errors like these would mistakenly allow payments to be made for several months after a beneficiary's true date of death.

To assist States in correcting these issues, CMS has: notified States of the need to review and correct claim payments that were made for services provided after the date of death; advised States to review system functions to determine if these payments were a result of system problems; and begun to set up a process to conduct periodic reviews of all State eligibility files against the SSA death master file to ensure continued compliance.

Concurrently, CMS has taken a variety of other actions to assist States with provider enrollment issues. In June 2008, CMS issued a letter to State Medicaid Directors (SMD) clarifying Federal policy prohibiting payment to providers excluded from participation in Medicaid. CMS advised the States that providers may become ineligible for participation in their Medicaid programs after enrollment, and strongly recommended States conduct monthly checks for exclusions from program participation. CMS issued another SMD letter in January 2009 that advised States to require providers to check the OIG exclusion list monthly for names of employees and contractors that were also subject to exclusion.

Our recent accomplishments illustrate CMS' program integrity strategy: CMS will continuously review and test States' program integrity capabilities through triennial program integrity reviews, our ongoing data analysis, and our use of the SPIA collection tool, all with the aim of identifying vulnerabilities as well as effective program integrity practices. When problems are identified,

CMS addresses them using a wide variety of available tools, including audits to collect overpayments; issuance of performance standards; other guidance documents; providing technical assistance to help States correct the problem; and program integrity reviews to ensure that the issue has in fact been addressed. And through the MII, CMS offers ongoing training to States' program integrity employees to provide them with the knowledge and tools they need to further improve their State program integrity efforts, and thus, protect Medicaid dollars.

Drug Utilization Review Program

CMS also believes that drug monitoring and drug utilization reviews should be effective in promoting program integrity, just as they are in promoting safety, quality care and preventing prescription errors. The enactment of the Omnibus Reconciliation Act (OBRA) of 1990 created the Medicaid Drug Utilization Review (DUR) Program to implement these types of reviews within the Medicaid program and its use is required for providers to receive Medicaid reimbursement for covered outpatient drugs. States were also encouraged by enhanced Federal funding to set up DUR programs and design and install point-of-sale electronic claims management systems that interface with their MMIS operations. Federal regulations also require States to submit an annual DUR report. These reports provide an excellent measurement tool to assess how well efforts to address issues of patient safety and provider prescribing habits are working. In addition, the DUR reports identify dollars saved by avoidance of problems, such as drug-drug interactions, drug-disease interactions, therapeutic duplication, and over-prescribing by providers, and outline statements of purpose that specify working relationships with other State units, such as the MFCUs.

Prescriptions undergo DUR both before they are dispensed (prospective DUR) and after they are dispensed (retrospective DUR). Prospective DUR takes place by automatically prescreening the prescription prior to its being dispensed. Retrospective DUR is a broader analysis of prescribing patterns and may focus on a specific provider or specific drug use in individual patients. The State Medicaid plan must provide for a retrospective DUR program for ongoing examinations, at least quarterly, of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and Medicaid recipients. The DUR program also looks for suspicious patterns associated with specific drugs or groups of drugs. This examination must involve pattern analysis, using predetermined standards of physician prescribing practices, drug use by individual patients and, where appropriate, dispensing practices of pharmacies.

That said, the GAO report has identified some cases where DUR procedures did not appear to work. CMS is already in the process of updating the DUR annual report instructions used to measure State performance. We are adding new sections to address fraud and abuse detection practices, and will provide States with a list of best practices so that all States may learn from fraud and abuse deterrence and detection practices that other States have initiated.

Health Care Fraud and Abuse Control (HCFAC) Funding

Program integrity and fiscal oversight is an integral part of CMS' financial management strategy and a high priority is placed on detecting and preventing improper or fraudulent payments. To that end, CMS has made significant changes to our program integrity activities in recent years.

These changes include the creation of new divisions within CMS to focus on identifying problem areas through trend analysis of claims data.

Title II of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) established the Health Care Fraud and Abuse Control Program (HCFAC) program to detect, prevent, and combat health care fraud and abuse. HCFAC is comprised of three separate funding streams, and HCFAC funding supports four key CMS program integrity strategies: prevention, early detection, coordination, and enforcement. Each of these strategies is designed to ensure that CMS can address payment issues as quickly and efficiently as possible, and allows the Agency to coordinate with our colleagues at OIG, DOJ, and the Federal Bureau of Investigation (FBI) in identifying, fighting, and prosecuting fraud and abuse.

The President has made increased HCFAC funding a strong priority by requesting $311 million in additional discretionary resources in his FY 2010 Budget Request. This fund will enable CMS to expand our existing efforts against fraud and abuse in the Medicaid and CHIP programs. This appropriation will supplement existing HCFAC programs, such as our regional HCFAC satellite offices, and strengthen combined HHS/DOJ investigatory efforts into Medicaid (through the MIP), and CHIP. CMS appreciates the $198 million in new discretionary funding Congress provided for HCFAC in the Omnibus Appropriations Act of 2009 (P.L. 111-8) and again asks that Congress fully fund our request for FY 2010.

Conclusion

Finally, I would like to point to larger reforms such as electronic health records and medical homes which, if successful, not only may hold promise for reducing overall health care costs, improving care coordination, and improving health care outcomes, but may also strengthen program integrity and address identified vulnerabilities such as doctor shopping and drug diversion.

CMS is strongly committed to protecting taxpayer dollars and ensuring the sound financial management of the Medicaid program. As evidenced by my testimony today, the Agency recognizes the need for stronger guidance for State Medicaid agencies to address the issues raised by the GAO. CMS has made progress, but there remains more work to be done to root out waste, fraud and abuse in the Medicaid program. We appreciate the discretionary HCFAC funding appropriated by Congress in FY 2009, and ask that Congress fully fund the President's FY 2010 HCFAC Budget request. CMS will use any funds appropriated by Congress to build upon our work and rapidly respond to emerging program integrity vulnerabilities. CMS looks forward to continuing to work cooperatively with the Congress and this Subcommittee in protecting taxpayer dollars and improving the fiscal integrity of the Medicaid program.

I look forward to answering any questions you might have.