

# A MEDICAID FRAUD VICTIM SPEAKS OUT: WHAT'S NOT WORKING AND WHY

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## JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON GOVERNMENT ORGANIZATION,  
EFFICIENCY AND FINANCIAL MANAGEMENT

AND THE

SUBCOMMITTEE ON HEALTHCARE, DISTRICT OF  
COLUMBIA, CENSUS AND THE NATIONAL ARCHIVES  
OF THE

COMMITTEE ON OVERSIGHT AND  
GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

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## **A MEDICAID FRAUD VICTIM SPEAKS OUT: WHAT'S NOT WORKING AND WHY**

**WEDNESDAY, DECEMBER 7, 2011**

HOUSE OF REPRESENTATIVES, SUBCOMMITTEE ON GOVERNMENT ORGANIZATION, EFFICIENCY AND FINANCIAL MANAGEMENT, JOINT WITH THE SUBCOMMITTEE ON HEALTHCARE, DISTRICT OF COLUMBIA, CENSUS AND THE NATIONAL ARCHIVES, COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,

*Washington, DC.*

The subcommittees met, pursuant to notice, at 10:07 a.m., in room 2154, Rayburn House Office Building, Hon. Todd Russell Platts (chairman of the Subcommittee on Government Organization, Efficiency and Financial Management) presiding.

Present: Representatives Platts, Issa, Lankford, Gosar, DesJarlais, Gowdy, Cummings, Towns, Norton, Connolly, and Davis.

Staff present: John Cuaderes, deputy staff director; Sery E. Kim, counsel; Mark D. Marin, director of oversight; Brian Blase, professional staff member; Will L. Boyington, staff assistant; Molly Boyl, parliamentarian; Tegan Millspaw, research analyst; Linda Good, chief clerk; Laura Rush, deputy chief clerk; Gwen D'Luzansky, assistant clerk; Suzanne Sachsman Grooms, minority chief counsel; Yvette Cravins, minority counsel; Devon Hill, minority staff assistant; Lucinda Lessley, minority policy director; Ashley Ettienne, minority director of communications; Jennifer Hoffman, minority press secretary; Jaron Bourke, minority director of administration; and Carla Hultberg, minority chief clerk.

Mr. PLATTS. This hearing will come to order. I appreciate everyone's attendance and welcome everybody here in this joint subcommittee hearing, the Subcommittee on Government Organization, Efficiency and Financial Management along with the Subcommittee on Health Care, District of Columbia, Census and the National Archives.

Today's hearing will examine the serious problem of fraud, waste and abuse in Medicaid. In fiscal year 2011, the Medicaid program issued \$21.9 billion in improper payments, higher than any program in government except Medicare. It is unknown how much of these improper payments are fraudulent or how much fraud goes undetected. The integrity program is responsible for identifying improper payments, educating providers about fraud and providing assistance to States in order to combat fraud, waste and abuse. The Patient Protection and Affordable Care Act of 2010 expanded funding for Medicaid program integrity. However, it also expands the

size of the Medicaid program and will increase Medicaid spending by over \$600 billion between 2014 and 2021.

Given this dramatic expansion, fraud detection and prevention will be all the more important.

Better data quality is essential in reducing waste, fraud and abuse. In 2006, CMS initiated two new data systems in an attempt to improve quality and access. GAO issued a report finding that both the new systems were inadequate and underutilized. GAO also could not find any evidence of financial benefits in implementing the new systems despite the fact that CMS has been using them for over 5 years. There are also problems with State-reported data.

Many States are not reporting all required data and there are often lag times for up to 1 year between when States report data and when CMS gets it and verifies it. This makes it extremely difficult and often impossible to prevent data fraud before payments are issued. And as I know, we will hear in the testimony here today from one of our witnesses some of the information is as old as 12 years, which is just unthinkable as far as usefulness of it.

As a result of poor data systems, CMS relies on contractors to identify fraud through audit work. CMS spent \$42 million on Medicaid integrity contractors in 2010. However, GAO has noted pervasive deficiencies in CMS's oversight of its contractors and has issued numerous recommendations to CMS.

Most of these recommendations have not been implemented. The Office of Inspector General has been on the front lines of investigating fraud through its work with the State Medicaid fraud control units, MFCUs.

In 2010, these units conducted 9,710 fraud investigations and recovered \$1.8 billion. This work is essential and would become even more crucial as Medicaid expands. But States have limited resources to combat the rising problem of Medicaid fraud, and there is also a question of the incentive of States to do so because of much of the money is coming back to Federal Government, not to their own treasury.

Health care fraud is sometimes called a faceless or victimless crime, and we also talk about it in terms of money lost. As a result, it can be easy to overlook what a devastating impact it can have on victims, beneficiaries who do not get the care that they need and deserve.

Today we are joined by one such individual, Mr. Richard West, a Vietnam war veteran and a victim of Medicaid fraud.

He and his lawyer, along with his son, will testify here today about their personal experiences and their efforts to uncover fraud within the Medicaid program.

And their case is going to show that this isn't just about money, this is about ensuring that we do right by every American citizen who is in need of medical assistance and is a part of the Medicaid program. As Mr. West will share, it wasn't just the millions of dollars that was being stolen from American taxpayers, it was because of that fraud that he was being denied care through the Medicaid program. It is not just about money, it is about people. We will also hear testimony from CMS, OIG and GAO on systemic problems

within Medicaid and what must be done to provide effective oversight and reduce fraud, waste and abuse in the Medicaid program.

And now I am honored to recognize the ranking member of our subcommittee, the gentleman from New York, Mr. Towns, for an opening statement.

Mr. TOWNS. Thank you very much, Mr. Chairman.

Let me thank the ranking member, Mr. Davis, as well for convening today's hearing on fraud in the Medicaid system. Weeding out fraud is a bipartisan goal that all stewards of taxpayers' dollars should share, so I truly appreciate this opportunity to explore this subject fully.

I thank the witnesses on both panels for joining us today to discuss their views. I especially would like to thank Mr. West for sharing his story and for his service to this country, the Vietnam War. Mr. West, I salute you.

There is no question that Medicaid is an essential program. It provides a vital safety net for many children, seniors, and the disabled who truly need it. It is unfortunate, however, that it has become a target for bad actors seeking to game the system. There is some positive news to note, even in this era of budget cuts. CMS, in its efforts to undercover fraud, are actually making money for the government and for taxpayers. For every \$1 invested in fraud prevention and detection, over \$16 is actually recovered. Much of this recovery came from cases like the very successful case brought by Mr. West.

We need to be certain that we are encouraging whistleblowers who become aware of these cases in the Medicaid program to bring them forward. This administration has done an admirable job of stepping up fraud detection in the Medicare and Medicaid programs. However, I understand that there have been a number of recommendations made by GAO that intends to address this issue but have not yet been adopted.

I look forward to exploring the limitations that CMS and HHS has so that we can work together to further prevent undercover and recover payments in the Medicaid system.

Thank you, Mr. Chairman, of course, and for this hearing and I look forward to working with you and I yield back the balance of my time.

Mr. PLATTS. Thank you, Mr. Towns. I am now honored to yield to the chairman of the subcommittee on Health Care, District of Columbia, Census and National Archives, the distinguished gentleman from South Carolina, Chairman Gowdy.

Mr. GOWDY. Thank you, Mr. Chairman. Today the committee will hear from Richard West, a man with firsthand knowledge of how easily government programs are defrauded and how the government all too often just doesn't seem to care. Mr. West acted responsibly and alerted the State of New Jersey Medicaid and his social worker to the fraudulent behavior of his health care provider, but none of the government agencies did anything. This is wholly unacceptable. And this is why people have lost trust in the institutions of government, and this is why our fellow citizens have so little trust that we are spending their money as carefully as we would spend our own.

Mr. West kept track of the nursing care received and was able to compare his records to the provider's records. He found discrepancies and because Medicaid capped the monthly services provided to Mr. West, he was not receiving the care he was entitled to. In other words, due to the fraudulent activities of the company providing Mr. West's care, he reached the cap and Medicaid told him his services were suspended. So not only was the provider ripping off taxpayers, but the provider was also not providing the obligated services to Mr. West.

It is impossible to believe that Mr. West's story is isolated. Medicaid is designated a high-risk program and is, therefore, highly susceptible to waste, fraud and abuse. Many experts believe the loss rates for Medicaid and Medicare due to fraud equals about 20 percent of the total program funding. So perhaps as much as one-fifth of the money spent is wasted, and ignoring legitimate calls for investigations into fraud when witnessed firsthand, has a chilling effect on other like-minded people who might be willing to alert authorities to abuse.

Most of the fraud occurs when providers bill for services never delivered to Medicaid patients. According to Malcolm Sparrow, a Harvard University expert on health care fraud, the rule for criminals is simple. If you want to steal from Medicare or Medicaid, or any other health care insurance program, learn to bill your lies correctly. Then for the most part, your claims will be paid in full and on time without a hiccup by a computer with no human involvement at all.

One reason for high rates of abuse might be that States do not appear to have an adequate incentive to root out waste and fraud. This is, in large part, due to the fact that a large part of what is recovered must be sent back to Washington. Another reason may be the Centers for Medicaid & Medicare Services doesn't typically analyze claims data for over a year after the date the claim was filed.

This lag time indicates CMS needs to update the tracking system used to root waste, fraud and abuse of the Medicaid system out.

Although every tax dollar inappropriately spent is a concern, the magnitude of waste, fraud and abuse in Medicaid elevates this problem.

Our country now spends \$430 billion on Medicaid a year. And CMS projects the total spending on Medicaid will double by the end of this decade. States are struggling to deal with Medicaid's growth and Medicaid is crowding out State priorities like education, transportation and public safety.

I look forward to today's hearing and hearing from our witnesses and hopefully flushing out ideas for eliminating the amount of tax dollars that are being wasted through the Medicaid program. When folks like Mr. West are being hurt and neglected due to fraud, it is time to find solutions and our fellow citizens, the ones who trust us enough to let us be their voice in this town are increasingly losing confidence that we are not serious about tackling waste, fraud and abuse. We must reclaim their confidence. We do that one episode at a time, and we might as well start with Mr. West. With that, I would yield back to the chairman.

[The prepared statement of Hon. Trey Gowdy follows:]



Opening Statement

Chairman Trey Gowdy

Subcommittee on Health Care, D.C., Census and Natl. Archives

December 7, 2011

Today the Committee will hear from Richard West, a man with first-hand knowledge of how easily government programs are defrauded and how the government too often does not seem to care. Mr. West acted responsibly and alerted the state of New Jersey, Medicaid, and his social worker to the fraudulent behavior of his health care provider. But none of the government agencies did anything. This is unacceptable. This is why people have lost trust in the institutions of government. This is why our fellow citizens have so little trust that we are spending their money as carefully as we would spend our own.

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It is impossible to believe that Mr. West's story is isolated. Medicaid is designated a high risk program and is therefore highly susceptible to waste, fraud and abuse. Many experts believe that loss rates from Medicare and Medicaid due to fraud equals about 20 percent of total program spending. So, perhaps as much as 1/5 of the money spent is wasted and ignoring legitimate calls for investigations into fraud – when witnessed firsthand – has a chilling effect on other likeminded people who might be willing to alert authorities to abuse.

Most of the fraud occurs when providers bill for services never delivered to the Medicaid patients. According to Malcolm Sparrow, a Harvard University expert on health care fraud: "The rule for criminals is simple: If you want to steal from Medicare, or Medicaid, or any other health care insurance program, learn to bill your lies correctly. Then, for the most part, your claims will be paid in full and on time, without a hiccup, by a computer, and with no human involvement at all."

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Centers for Medicare and Medicaid Services (CMS) doesn't typically analyze claims data for over a year after the date the claim was filed. This lag time indicates CMS needs to update the tracking system used to root out fraud and abuse of the Medicaid system

Although every tax dollar inappropriately spent is a concern, the magnitude of waste, fraud, and abuse in Medicaid elevates this problem. Our country now spends \$430 billion on Medicaid a year, and CMS projects that total spending on Medicaid will double by the end of this decade. States are struggling to deal with Medicaid's growth, and Medicaid is crowding out state priorities like education, transportation and law enforcement.

I look forward to hearing from today's witnesses and hopefully flushing out ideas for limiting the amounts of tax dollars that are being wasted through the Medicaid program. When folks like Mr. West are being hurt and neglected due to fraud, it is time to find solutions. And our fellow citizens – the ones who trust us enough to let us be their voice – are increasingly losing confidence that we are serious about tackling waste, fraud, and abuse. We must reclaim their confidence. We do that one episode at a time. And we might as well start with Mr. West.

Mr. PLATTS. I thank the gentleman. I am now pleased and honored and yield to the ranking member of the Subcommittee on Health Care, District of Columbia, Census and National Archives, the gentleman from Illinois, Mr. Davis.

Mr. DAVIS. Thank you very much, Chairman Platts, Chairman Gowdy, Ranking Member Towns, I thank all of you for holding today's hearing. Reducing waste, fraud and abuse in health care is a rare and desirable policy shared by Republicans and Democrats alike.

It is disturbing that some entrusted with caring for our most vulnerable populations would seek to defraud the government by falsely billing for services. It is the height of corporate greed. In this era of budget shortfalls and cuts, we can no longer stumble upon these bad actors. We must be vigilant in locating and weeding out fraud. The proper resources must be dedicated to root out waste and abuse. Our taxpayer dollars are too precious. The more funds expended on phantom services delay or extinguish the authentic and necessary health care programs and services that people depend upon daily.

As Medicaid is determined to be a high-risk program, I want to further encourage CMS to fully utilize and implement all of the tools available in this fight, including the Integrated Data Repository and the One Program Integrity. These technological programs are invaluable in consolidating the data necessary in fraud detection. The Patient Protection and Affordable Care Act further provides tools to fight Medicaid fraud. The licensure and background checks on providers and suppliers are a productive first step for program integrity.

In the enforcement arena, the new civil penalties created for falsifying information is evidence that the Federal Government takes fraud seriously. To that end, the Affordable Care Act adds \$10 million annually for fiscal years 2011 through 2020.

Simply put, fighting health care fraud is good fiscal policy.

And I might add that I am totally opposed to fraudulent practices in medicine, especially involving the most vulnerable, the most unsuspecting, and, in many instances, the most gullible members of our society. I have seen firsthand low-income communities deal with Medicaid meals where people are lined up to be taken advantage of. These are practices we should not, cannot and must not tolerate.

Therefore, I applaud the tireless efforts of Mr. Richard West. He serves as an example to others. He saw a wrong and tried to right it. And so we all thank you, Mr. West. I look forward to your testimony and the testimony of all the witnesses. And I thank you, Mr. Chairman, and yield back.

Mr. PLATTS. I thank the gentleman. We have also been joined by the distinguished ranking member of the full Committee on Oversight and Government Reform, the gentleman from Maryland, Mr. Cummings. And I recognize him for an opening statement.

Mr. CUMMINGS. Thank you very much, Mr. Chairman. I would also like to thank Mr. West for taking the time to come to Capitol Hill today to share his experience so we might apply the lessons learned from his case to future policy and law enforcement decisions. Last year, Medicaid provided critical health care services to

an estimated 56 million Americans in need, the vast majority of whom are seniors, individuals with disabilities, and children. Since so many Americans rely on this program, it is imperative that we root out fraud because every dollar squandered is a dollar that does not go to critical health care services for these vulnerable Americans.

Today's hearing focuses on a case that was brought to light by Richard West, a Medicaid beneficiary who asserted his rights under the False Claims Act to prosecute fraud against the Medicaid system by Maxim Healthcare Service. Mr. West's lawsuit retrieved nearly \$150 million for the U.S. taxpayers. We need support efforts by people like Mr. West to ensure that American citizens are empowered to take on corporate wrongdoing. The written testimony of our witnesses on the second panel also makes clear that we need better coordination between State and Medicaid programs and the Centers for Medicare & Medicaid Services to reduce duplicative efforts and better align resources.

Fortunately, the Affordable Care Act provides additional funding to fight waste, fraud and abuse in Medicaid. It also contains a number of provisions designed to improve data quality and promote data sharing between Federal agencies, the States and health care providers.

The fight against unscrupulous companies like Maxim Healthcare Services requires more resources, not less. When we invest in fraud prevention, government spending more than pays for itself. That is one reason why repealing the Affordable Care Act and cutting Medicaid's enforcement budget would be very short-sighted, and indeed, counterproductive.

I look forward to the testimony of our witnesses today, and I hope their recommendations will help reduce fraud, waste, and abuse and create a stronger Medicaid program for those who rely on it.

And with that, Mr. Chairman, I yield back.

[The prepared statement of Hon. Elijah E. Cummings follows:]

DARNELL E. ISSA, CALIFORNIA  
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**House of Representatives**

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**Opening Statement**

**Rep. Elijah E. Cummings, Ranking Member**  
**Committee on Oversight and Government Reform**

**Subcommittee on Government Organization, Efficiency and Financial Management and**  
**the Subcommittee on Health Care, District of Columbia, Census and the National Archives**  
**Joint Hearing on "A Medicaid Fraud Victim Speaks Out:**  
**What's Not Working and Why?"**

**December 7, 2011**

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The fight against unscrupulous companies like Maxim Healthcare Services requires more resources, not less. When we invest in fraud prevention, government spending more than pays for itself. That is one reason why repealing the Affordable Care Act and cutting Medicaid's enforcement budget would be shortsighted and counterproductive.

I look forward to the testimony of our witnesses today and hope their recommendations will help reduce fraud, waste, and abuse and create a stronger Medicaid program for those who rely on it.

Contact: Ashley Etienne, Communications Director, (202) 226-5181.

Mr. PLATTS. I thank the gentleman, and yield to the distinguished gentleman from Virginia, Mr. Connolly, for his opening statement.

Mr. CONNOLLY. Thank you Mr. Chairman and thank you for your leadership on this important subject.

Reducing Medicaid improper payments contributes directly to the long-term health of these essential health care programs. I appreciate our two subcommittees holding a hearing on the different anti-fraud programs within HHS and Centers for Medicare & Medicaid Services. While HHS and CMS are devoting unprecedented attention to reducing Medicaid fraud, it is clear we must do more to reduce improper payments and protect the economic security of individuals such as Richard West who have lost benefits temporarily as a result of attacking Medicaid and Medicare fraud.

As the written testimony of this hearing makes clear, Congress and the administration have devoted a great deal of effort to reducing improper payments within the last decade. In 2005, Congress passed the Deficit Reduction Act which established the Medicaid integrity program. The MIP provides States with technical assistance to identify and prevent fraud which is appropriate since States administer Medicaid.

The Deficit Reduction Act also requires CMS to work with Medicaid integrity contractors to ferret out overpayments, conduct audits and educate program participants about fraud prevention.

CMS uses this and other data for its Medicaid statistical information system which includes eligibility and claims information across the country. By maintaining a central data base, CMS can conduct analyses which identify possible fraud or areas where fraud is likely to occur. It also works with agencies to duplicate best practices and has identified 52 of them that could be replicated all across the country. Despite these laudable efforts, it is clear more can and must be done to reduce fraudulent Medicaid payments.

As the testimony of Mr. West today and Robin Page West demonstrates, CMS has not always been responsive to reports of fraud. I look forward to learning more from Ms. Brice-Smith and Mr. Cantrell about what CMS is doing to prevent such negligences from occurring in the future.

Continuing robust implementation of existing policies is essential because CMS also must implement important reforms enacted under the Affordable Care Act.

As Ms. Brice-Smith notes in her testimony, the Affordable Care Act sometimes referred to as ObamaCare significantly strengthens anti-fraud programs. These include elementary reforms such as requiring service providers and suppliers to document orders and referrals. The Affordable Care Act also established the Medicaid Recovery Auditor Contract [RAC] program to create incentives for contractors to reduce fraudulent payments and in conjunction with Secretary Sebelius' Center For Program Integrity, the Affordable Care Act is designed to identify improper fraud payments before they are issued by CMS.

I hope today's testimony illuminates the progress we have already made and additional administrative improvements which would reduce Medicaid fraud. Perhaps we should consider more

stringent punishments for companies and individuals who systematically defraud Medicaid. As Mr. West suggests in his testimony, consider harsher punishment for the management of such companies.

Again, I thank you Mr. Chairman for holding this very important hearing, part of a series of getting at so called improper payments from the Federal Government which total \$125 billion a year. So there is plenty of work to be done. Thank you.

Mr. PLATTS. I thank the gentleman. I thank all of our witnesses and guests, your patience while we gave our opening statements, but now we are going to move to why we are really here, and that is to hear from our witnesses, and we are honored in our first panel to have a true patriot, Mr. Richard West, who served our Nation not just in uniform during the Vietnam War, which we are all eternally grateful and indebted to you for that service, but also Mr. West's service as a private citizen who saw a wrong and sought to correct it, and when the government didn't take action to correct it, he did.

And so, Mr. West, we are honored to have you here along with your attorney, Attorney Page West and your son, Adam.

As is consistent with the rules of the committee, we need to swear all three of you in before we have your testimony. Ms. West and Adam, if you would stand and raise your right hands and we will swear all three of you in.

[Witnesses sworn.]

Mr. PLATTS. Let the record reflect all three witnesses have affirmed the oath.

And you may be seated.

And on behalf of Mr. Richard West, who I will save his voice for questions, we are going to have his son Adam read his opening statement. Adam, if you are ready, please begin.

**STATEMENTS OF RICHARD WEST, VICTIM OF MEDICAID FRAUD; AND ROBIN PAGE WEST, ATTORNEY, COHAN, WEST, & KARPOOK, P.C.**

**STATEMENT OF RICHARD WEST**

Mr. ADAM WEST. Thank you, Chairman Platts, Chairman Gowdy, Ranking Member Towns, Ranking Member Davis, and distinguished members of the subcommittees for inviting me to discuss Medicaid fraud. I received home health care and other services through the Community Resources For People With Disabilities Medicaid Waiver program. As a ventilator wheelchair and oxygen-dependent person, I qualified for the government-funded program that provides Medicaid benefits up to 16 hours per day of in-home nursing care. There's a limit on the services under this program each month, and benefits may be suspended or reduced if the monthly cap is exceeded.

Beginning in March 2003, I received home health care through Maxim Health Care Services under this program. Maxim billed the home health care services to Medicaid which paid for them with both State and Federal funds. In September 2004, I received a letter from the New Jersey Department of Human Services Division of Disability Services Home and Community Services telling me

that I had exceeded my monthly cap and that my Medicaid services were being temporarily reduced or suspended as a result. This prevented me from obtaining needed dental care.

I complained to the State of New Jersey, I complained to Medicaid, and I complained to a social worker who was assigned to me telling them that Medicaid had been billed for nursing care I had not received. None of them did anything about it. Since none of the government agencies I had contacted about this did anything, I hired a private attorney, Robin Page West, no relation, of Baltimore, Maryland, who filed on my behalf a whistleblower lawsuit under the False Claims Act that triggered an investigation of Maxim.

Somebody decided to make a profit on my disability and rip off the government. That was wrong and the right thing for me to do was to expose it. But because the case was under seal while the government investigated, I couldn't talk about it. Sometimes I had trouble getting nurses and I suspected word had gotten out that I was a troublemaker. Over the course of the government's investigation, viruses made me severely ill. Each day when I sat alone in my home and no nurse came, I got sicker and sicker. I was afraid of dying and leaving my son with a big legal mess. I feared that if I were no longer alive, the case might be dismissed. Meanwhile, the government investigation carried on, and investigators kept discovering more and more billing improprieties.

Finally after 7 years, the government reached a settlement with Maxim and the case went public with Maxim paying a civil settlement of approximately \$130 million and a criminal fine of approximately \$30 million. This was the largest home health care fraud settlement in history. Yet Maxim is still permitted to do business with the government and none of the executives went to jail. Details of the settlement are available at [www.homehealthcarefraudsettlement.com](http://www.homehealthcarefraudsettlement.com).

Maxim was overbilling and under delivering basic services to America's oldest, sickest and poorest. The goal was not to provide better services and products at lower prices, but rather to see if they could take advantage of weak Medicare and Medicaid oversight, to see if Uncle Sam could be ripped off and no one noticed, to see if patients who complained would not be taken seriously or would give up after a few calls to Medicaid. And guess what? They were right. Maxim's game went on for years and America's taxpayers were systematically ripped off.

But not only were taxpayers ripped off, when corporations rip off Medicare and Medicaid there are other victims besides taxpayers.

Maxim took services from people like me.

Despite the big monetary settlement, Maxim executives did not go to jail and the company was not excluded from doing future business with Medicare and Medicaid. The settlement received a lot of these covers that many folks asking why this was. How is it that a company that takes millions of government dollars is not entitled to continue along in business, while a shoplifter of a few \$100 worth of merchandise will be sent to jail. It is commendable that the government did take on Maxim, but until corporate executives receive harsher penalties, I do not think we will see the fraud stop.

Having the corporation pay some settlement money is just a cost of doing business for the fraudsters.

The settlement money does not even come out of their own pockets. Changing that and sending some executives to jail may actually make the fraud stop.

How many other companies got away with this same fraud for the last 7 years? How many other people saw this and did nothing? How many were afraid of losing their health care for being a troublemaker? That is what happened to me. At this time, I am being told my Medicaid will end because of this settlement. My whistleblower recovery is being paid over 8 years with half of it coming at the end of that period. In the intervening years, there will not be enough to pay for my in-home care. I will go broke or die.

This is the price of doing the right thing. Do I know of other companies doing fraud? Yes. Four. Can I tell anyone? No. I can't afford to lose any more services. I thought if you do the right thing that maybe things would work out in the end, but maybe not. I am a Vietnam veteran and never took or asked for any services I didn't need. I lived a productive life and raised my son, Adam West. This program allowed me to live in my own home, to see him graduate high school and college, and now he is living on his own. If someone is willing to steal from an old sick vet, I would think my government would help. If I had an HMO, who would help? Should I call their CEO? It took 7 years, but I had the full weight of the U.S. Government behind me. Many folks are not as fortunate.

I came to this hearing hoping to help Congress help other people who need help through no fault of their own. Thank you again for inviting me to testify. I look forward to answering your questions.

Mr. PLATTS. Thank you, Mr. West.

[The prepared statement of Mr. West follows:]

**Testimony of Richard W. West  
before the  
House Committee on Oversight and Government Reform  
Subcommittee on Government Organization, Efficiency and Financial Management  
and the  
Subcommittee on Healthcare, District of Columbia, Census and the National Archives  
December 7, 2011**

Thank you Chairman Platts, Chairman Gowdy, Ranking Member Towns, Ranking Member Davis and distinguished members of the Subcommittees, for inviting me to discuss Medicaid fraud.

I received home health care and other services through the Community Resources for People with Disabilities Medicaid waiver program (CRPD). As a ventilator and wheelchair and oxygen dependent person, I qualified for this government-funded program that provides Medicaid benefits and up to 16 hours per day of in-home nursing care. There is a limit on the services under this program each month, and benefits may be suspended or reduced if the monthly cap is exceeded.

Beginning in March of 2003, I received home health care through Maxim Healthcare Services under this program. Maxim billed these home health care services to Medicaid, which paid for them with both state and federal funds.

In September of 2004, I received a letter from the New Jersey Department of Human Services Division of Disability Services, Home and Community Services, telling me that I had exceeded my monthly cap and that my Medicaid services were being temporarily reduced or suspended as a result. This prevented me from obtaining needed dental care.

I had been keeping track of the number of hours of nursing care I had been receiving and I knew that I had not exceeded my cap. After examining my own records and the records Medicaid shared with me, it looked like Maxim had billed Medicaid for approximately 735 hours of nursing care at \$28.00

per hour that I never received during the period April 2003 to July 2004.

Based on conversations that I had had with my nurses, I did not believe that these were bookkeeping errors or accidental mistakes. I thought Maxim was deliberately billing for nursing care that it did not provide so that it could make more money.

I complained to the State of New Jersey, I complained to Medicaid, and I complained to a social worker who was assigned to me, telling them that Medicaid had been billed for nursing care that I had not received. None of them did anything about it.

Since none of the government agencies I had contacted about this did anything, I hired a private attorney, Robin Page West, (no relation), of Baltimore, Maryland, who filed on my behalf a whistleblower lawsuit under the False Claims Act that triggered an investigation of Maxim.

Somebody decided to make a profit on my disability and rip off the government. That was wrong, and the right thing for me to do was expose it. But because the case was under seal while the government investigated, I couldn't talk about it. Sometimes I had trouble getting nurses and I suspected word had gotten out that I was a troublemaker. Over the course of the government's investigation, viruses made me severely ill. Each day when I sat alone in my house and no nurse came, I got sicker and sicker. I was afraid of dying and leaving my son with a big legal mess. I feared that if I were no longer alive, the case might be dismissed. Meanwhile, the government investigation carried on, and investigators kept discovering more and more billing improprieties.

Finally, after seven years, the government reached a settlement with Maxim and the case went public, with Maxim paying a civil settlement of approximately \$130 million and a criminal fine of approximately \$30 million. This was the largest home healthcare fraud settlement in history. Yet Maxim is still permitted to do business with the government, and none of its executives went to jail. Details of the settlement are at [www.homehealthcarefraudsettlement.com](http://www.homehealthcarefraudsettlement.com).

Maxim was over billing and under delivering basic services to America's oldest, sickest and

poorest. The goal was not to provide better services and products at lower prices, but rather to see if they could take advantage of weak Medicare and Medicaid oversight--to see if Uncle Sam could be ripped off and no one would notice. To see if patients who complained would not be taken seriously or would give up after a few calls to Medicaid. And guess what? They were right. Maxim's game went on for years, and America's taxpayers were systematically ripped off. But not only were taxpayers ripped off. When corporations rip off Medicare and Medicaid, there are other victims besides taxpayers. Maxim took services from people like me.

It's hard to get the the government's attention without filing a False Claims Act case. I doubt I was the first person to call Medicaid about the billing fraud going on at Maxim. For all I know 20 or 30 other people called the Medicaid tip line before me, and they were simply ignored. My distinction is not that I called a tip line. My distinction is that I was the first person to assemble the physical, visible evidence of Maxim's fraud, and I was the first person to hire a good lawyer and file a False Claims Act case about that fraud. The government cannot simply ignore a False Claims Act as if it was just an email or a voice message left on the Medicaid tip line. The way you get the government's attention if you suspect fraud is *not* to call them on the telephone; it's to get a good False Claims Act lawyer and file a case. Then the government has to investigate. They simply cannot press the "delete" key and make it disappear.

Despite the big monetary settlement, Maxim executives did not go to jail, and the company was not excluded from doing future business with Medicare and Medicaid. The settlement received a lot of news coverage that had many folks asking why that was. How is it that a company that takes millions of government dollars it's not entitled to can continue on in business, while a shoplifter of a few hundred dollars worth of merchandise will be sent to jail? It is commendable that the government did take on Maxim, but until corporate executives receive harsher penalties, I do not think we will see the fraud stop. Having their corporation pay some settlement money is just a cost of doing business for the

fraudsters. The settlement money doesn't even come out of their own pockets. Changing that, and sending some executives to jail, might actually make the fraud stop.

How many other companies got away with this same fraud for the last seven years? How many other people saw this and did nothing? How many were afraid of losing their healthcare, for being a trouble maker? That is what happened to me, at this time I'm being told my Medicaid will end because of this settlement.

My whistleblower recovery is being paid over over eight years with half of it coming at the end of that period. In the intervening years, it will not be enough to pay for my in home care. I will go broke or die. This is the price of doing the right thing. Do I know of other companies doing fraud? Yes, four. Can I tell anyone? No, I can't afford to lose any more services! I thought if you do the right thing that things would work out in the end; maybe not.

I am a Vietnam veteran, and never took or asked for any services I didn't need. I have lived a productive life, and raised my son Adam R. West. This program allowed me live in my own home, to see him graduate high school and college, and now he is living on his own. If someone is willing to steal from a sick old vet I would like to think my government would help!

If I had an HMO who would help? Should I call their CEO ? It took seven years but I had the full weight of the United States of America, my government behind me. Many folks are not as fortunate.

I came to this hearing hoping to help Congress help the other people who need help through no fault of their own.

Thank you again for inviting me to testify. I look forward to answering your questions.

Mr. PLATTS. Ms. West, if you would like to share your testimony.

**STATEMENT OF ROBIN PAGE WEST**

Ms. PAGE WEST. Thank you, Chairman Platts, Chairman Gowdy, Ranking Member Towns, Ranking Member Davis and distinguished members of the subcommittees for inviting us to discuss Medicaid fraud. I represented Richard West in the Medicaid fraud lawsuit that resulted in the \$150 million settlement with Maxim. For the past 20 years, I have focused on bringing cases such as Mr. West's to recover money the government has lost to fraud. I am also the author of a book on this subject published by the American Bar Association entitled *Advising the Qui Tam Whistleblower*.

In examining ways to improve oversight and accountability of Medicaid, it is helpful to look at the process we followed in bringing Mr. West's Medicaid fraud lawsuit. As he testified, after Mr. West attempted to bring this matter to the government's attention by contacting the State, the Medicaid program and his social worker, all to no avail, he turned to a private lawyer. We then brought a lawsuit under the False Claims Act [FCA], which empowers an ordinary person to step into the shoes of the government and sue fraudsters to recover the amounts stolen plus civil penalties and trouble damages.

The person who sues on behalf of the government, the whistleblower, is known as a qui tam relater, based on a Latin phrase that translates as he who sues on behalf of the king as well as for himself.

The act provides for a whistleblower reward that in a successful intervened case can range from 15 to 25 percent of the government's recovery. In our case, using records Mr. West had kept, we showed how the number of hours Maxim had billed Medicaid exceeded significantly the number of hours Mr. West received. In addition, we gave the government information Mr. West had learned through discussions with various of his nurses that led him to believe Maxim was doing this on purpose.

The FCA provides 60 days for the government to decide whether to intervene in a case, and if it needs more time, it must request it from the court. This is quite different from hotlines that are not accountable for acting on callers' tips within a certain period of time, if at all. The FCA is also different from oversight programs and contractors that exist to identify improper payments and fraud. These cost the government money, sometimes more than they recover. For example, CMS's senior Medicare patrol program teaches seniors and others how to review Medicare notices and Medicaid claims for fraud and what to do about it.

Over 14 years, from 1997 to 2010, it saved \$106 million. But its current annual budget of \$9.3 million leads to the question whether it is even saving what it costs.

The incentive of earning a False Claims Act whistleblower reward, on the other hand, mobilizes private individuals and their attorneys to do the work without the need for any government programs. The FCA model also outperforms the Medicare Recovery Audit Contractor, RAC, program which although it pays contractors a percentage of the improper payments they recoup stills dips into the recouped fund to pay those contingencies.

Not so with FCA recoveries. Not one dime comes from taxpayers to pay for these recoveries because the statute allows recovery of triple damages from the fraudster so that the government can be made whole for the cost not only of the whistleblower rewards, but also the investigation, prosecution and lost interest over time, not to mention the savings caused by deterrence.

There is no doubt that the cases whistleblowers are bringing to the government are of high quality. As shown on this graph, which is based on Department of Justice statistics, recoveries from whistleblower-initiated cases by far outpace those in government-initiated cases. More than 80 percent of the False Claims Act cases now being pursued by the U.S. Department of Justice were initiated by whistleblowers, and the amounts of the recoveries are in the billions each year.

In closing, one aspect of Mr. West's case that I would like to highlight is that the waiver program capped his benefits at a monthly amount that if exceeded, triggered a denial of further Medicaid benefits. So when Mr. West went to the dentist, he was informed that he could not get treatment because he had supposedly exceeded his cap.

In most Medicare, Medicaid and other Federal and State health programs, that would not happen because there is no cap that stops benefits from being paid, so even if Medicaid beneficiaries noticed suspicious billing, they have no incentive to spend time questioning them because their future Medicaid benefits are not at stake. And this is one reason I believe we have not seen more health care fraud cases initiated by Medicare and Medicaid beneficiaries.

Thank you again for inviting us to testify. I look forward to answering your questions.

[The prepared statement of Ms. Page West follows.]

**Testimony of Robin Page West  
before the  
House Committee on Oversight and Government Reform  
Subcommittee on Government Organization, Efficiency and Financial Management  
and the  
Subcommittee on Healthcare, District of Columbia, Census and the National Archives  
December 7, 2011**

Thank you Chairman Platts, Chairman Gowdy, Ranking Member Towns, Ranking Member Davis and distinguished members of the Subcommittees for inviting me to discuss Medicaid fraud.

My name is Robin Page West. I am an attorney, and I represented Richard West (no relation) in the Medicaid fraud lawsuit that resulted in a settlement in September of this year in which Maxim Healthcare Services, Inc. agreed to pay \$150 million to the federal government and 41 states' Medicaid programs. For the past 20 years, I have focused on bringing cases such as Mr. West's to recover money the government has lost to fraud. I am also the author of a book on this subject published by the American Bar Association, now in its second edition, entitled Advising the Qui Tam Whistleblower: From Identifying a Case to Filing Under the False Claims Act.

In examining ways to improve oversight and accountability of Medicaid, it is helpful to look at the process we followed in bringing Mr. West's Medicaid fraud lawsuit. As he testified, after Mr. West attempted to bring this matter to the government's attention by contacting the state, the Medicaid program, and his social worker, all to no avail, he turned to a private lawyer. We then brought a lawsuit under the False Claims Act ("FCA"), a statute enacted during the civil war to stop unscrupulous defense contractors. This law allows the government not only to sue fraudsters and recover the amounts stolen, but also to collect civil penalties and treble damages.

What makes the law unusual, and so effective, though, is that an ordinary person can step into the shoes of the government and do it, too. If the case is successful, that person is entitled to a share of the recovery. The part of the law allowing this is called the qui tam provision, which stands for a Latin phrase "*Qui tam pro domino rege quam pro se ipso in hac parte sequitur.*" which translates as "He who sues on behalf of the King, as well as for himself." The person who sues on behalf of the government--the whistleblower-- is known as a "qui tam relator."

In 1986, the whistleblower rewards in the statute were strengthened by bipartisan amendment to create what sponsors Senator Charles Grassley and Representative Howard Berman called a "coordinated effort" between private citizens and the government to recover money lost through fraud. The reward to the whistleblower in a successful intervened case can range from 15 to 25% of the government's recovery.

To see just how effective the whistleblower reward provisions have been in driving recoveries under the False Claims Act, we can look at the numbers. According to Taxpayers Against Fraud, (TAF), a non-profit public interest organization that tracks these statistics, before the 1986 amendments, the Department of Justice recovered less than \$100 million a year under the False Claims Act. In Fiscal Year 2010, over \$3 billion was recovered under the False Claims Act—twice as much as was recovered in FY 2000. Of this amount, nearly 80% was recovered as a direct result of whistleblower lawsuits—a total of \$2.39 billion.\*

The whistleblower incentives have been so successful in recouping monies lost to fraud that over half the states plus New York City and the District of Columbia have passed their own versions of the federal False Claims Act in order to increase the amount of money coming back to them. As just one example, earlier this year, Quest Diagnostics Inc. agreed to pay \$241 million to resolve a California state false claims act lawsuit brought by a competitor that alleged Quest

overbilled the state's Medicaid program.

Mr. West's first step in using the FCA as a tool to stop Medicaid fraud was to locate an attorney with experience using this statute. Many attorneys are not familiar with the unique requirements for filing a False Claims Act suit. The procedures for bringing an action under the FCA are quite different from any other type of lawsuit, and failure to follow these procedures can result in dismissal of the case. For example, unlike most litigation where discovery happens *after* the case is filed, in a qui tam case, substantially all of the evidence the relator has of the fraud must be provided to the government at the very beginning of the case. Also unique to qui tam litigation is a requirement that the case be filed under seal, so that not even the defendant knows about it.

A crucial part of the process is to present the evidence of the fraud, as well as an explanation of the fraud and of the regulatory framework, to the government clearly and concisely. These cases can be complex, but it is not up to the government to figure out how the fraud works—that is the job of the relator and his lawyer. The purpose of qui tam cases is to assist the government's enforcement efforts, not to slough work onto the government. So an experienced FCA lawyer will not merely throw down a bare bones lawsuit. Rather, she will develop the evidence and the theory of the case as much as possible before presenting it to the government. If it does not find the case appealing, the government may choose not to become involved. In fact, the government chooses not to intervene in almost 80% of the qui tam cases filed.\* So the lawyer needs to understand what cases will be worthwhile to the government and how to convey their value clearly and concisely.

In Mr. West's case, we collected all the documentation he had that showed how many hours the nurses were in his home, and compared it to how many hours Medicaid was billed. The

documents we used consisted of the time sheets the nurses left with Mr. West after their visits, his day planner, and billing records obtained from Medicaid. We analyzed these records and presented them in a way that juxtaposed the number of hours of service against the number of hours billed to demonstrate how they did not match. In addition, Mr. West had learned, through conversations with various of his nurses, information that made him believe Maxim was doing this on purpose. We provided detailed information to the government about these conversations as well.

After we developed our case, assembled the evidence for the government, and filed the lawsuit under seal, members of the U. S. Attorney's office invited us to meet with them to discuss our submission. Subsequently, the government began its own investigation, which ultimately expanded beyond the Maxim office that was providing Mr. West's care to include all states in which Maxim did business.

The FCA provides 60 days for the government to determine whether to intervene in a case. It usually takes the government much longer to make this decision, so it must request the court to grant it additional time. It takes an average of thirteen months\* for the government to make its decision whether to pursue a matter, although in my personal experience, the time has averaged closer to three years. If the government chooses not to intervene, the relator may continue on with the case, and if successful, receive a larger reward of up to 30% of the government's recovery.

In Mr. West's case, the government ultimately chose to intervene. Its investigation took seven years, and throughout that time, the judge, on behalf of the court system, and I, on behalf of Mr. West, kept in contact with the government prosecutors to make sure the investigation was moving forward. The comprehensive investigation resulted not only in a civil settlement but in

criminal indictments of eight employees, a deferred prosecution agreement, and a corporate integrity agreement requiring Maxim to report to an independent monitor, who will review Maxim's business operations and regularly report concerning the company's compliance with all federal and state health care laws, regulations, and programs. Details of the settlement are at <http://www.homehealthcarefraudsettlement.com>.

One reason the False Claims Act is so effective is the court oversight that comes about as soon as the 60 day clock starts running on the intervention decision. This is quite different from hotlines that are not accountable for responding to callers or taking any action on their complaints and tips. But even though the False Claims Act requires the government to investigate every case swiftly, it has built-in safeguards against frivolous lawsuits so court and government resources are not squandered:

- Because most False Claims Act lawyers work on a contingency basis, they only get paid if they win. This means that they are unlikely to invest time, money and energy building a case that they themselves do not feel will be productive.
- Under the False Claims Act, a relator can be required to pay the defendant's attorney's fees if the court finds that the claim was frivolous or brought primarily for purposes of harassment, so whistleblowers with unpure motives have a huge disincentive to file a case.
- The FCA is rarely used to correct minor billing mistakes and errors that are not systematic because they do not amount to large sums of money, and such cases will not be chosen for intervention.

There is no doubt that the cases whistleblowers are bringing to the government are of high quality. According to TAF, more than 80 percent of the False Claims Act cases now being pursued by the U.S. Department of Justice were initiated by whistleblowers.\*

Many oversight programs and contractors exist to identify improper payments and fraud. These programs and contractors cost the government money, sometimes more than they recover. For example, CMS' Senior Medicare Patrol (SMP) program, which was launched in 1997,

teaches seniors, caregivers and beneficiary family members how to review Medicare notices and Medicaid claims for signs of fraudulent activity and what to do about it. According to its website, [http://www.aoa.gov/AoA\\_programs/Elder\\_Rights/SMP/index.aspx#data](http://www.aoa.gov/AoA_programs/Elder_Rights/SMP/index.aspx#data), from 1997 through December 2010, "About \$106 million in savings, including Medicare and Medicaid funds recovered, beneficiary savings and other savings have been attributed to the project as a result of documented complaints." This \$106 million saved over 14 years, in light of a current annual budget for the program of \$9.3 million, leads to the question whether this program, and others like it, are even saving what they cost.

One of the reasons the False Claims Act avoids this problem is that it uses very attractive incentives to mobilize private individuals and their attorneys to do the work at no cost to the government, completely independently of whatever government oversight may or may not be in place, without the need for funds for training or execution of the program. The FCA model is more effective in this regard than even the Medicare Recovery Audit Contractor (RAC) program, which, although it pays contractors a percentage of the improper payments they recoup from providers, still dips into the recouped funds to pay those contingent fees. This is not the case with FCA recoveries. Not one dime comes from taxpayers to pay for these recoveries, because the statute allows for recovery of triple damages *from the fraudster* so that the government can be made whole, not only for the cost of whistleblower awards, but also for the cost of investigations, prosecutions, and lost interest. A TAF study conducted in 2005 found that "For every dollar spent to investigate and prosecute health care fraud in civil cases, the federal government receives nearly thirteen dollars back in return." Moreover, the study found, "[t]he benefit/cost ratio of nearly thirteen to one is likely to be an underestimate of the real return that the taxpayers are receiving on outlays for civil health care fraud enforcement. The indirect

benefits associated with deterrent effects... undoubtedly add substantially to the public's benefit." <http://www.taf.org/MedicareFraud040805.pdf> A 2012 report by the HHS OIG reports an even higher ratio--\$16.7 to \$1 expected return on investment. [http://oig.hhs.gov/publications/docs/budget/FY2012\\_HHSOIG\\_Online\\_Performance\\_Appendix.pdf](http://oig.hhs.gov/publications/docs/budget/FY2012_HHSOIG_Online_Performance_Appendix.pdf)

In closing, one aspect of Mr. West's case that I would like to highlight is that the waiver program that provided his benefits was capped at a monthly amount that, if exceeded, triggered his suspension from the program and temporary denial of further Medicaid benefits. So when Mr. West went to the dentist, he was informed he could not get treatment because he had supposedly exceeded his cap by virtue of nursing services he knew he had not received. In most Medicare, Medicaid, FEHB, TRICARE or other federal and state health programs, that would not happen because there is no cap like this that triggers exclusion. So typically when Medicaid beneficiaries notice suspicious billings on their explanation of benefit forms, they have no incentive to expend time questioning them, because their future Medicaid benefits and healthcare services are not at stake. This is one reason I believe we have not seen more healthcare fraud cases initiated by Medicare and Medicaid beneficiaries.

Thank you again for inviting me to testify. I look forward to answering your questions.

\* The Department of Justice's statistics are available at <http://www.taf.org/statistics.htm>, <http://www.taf.org/FCA-stats-2010.pdf> and <http://www.taf.org/DOJ-HHS-joint-letter-to-Grassley.pdf>

Mr. PLATTS. Thank you, Ms. Page. We appreciate, again, all three of you being here with us to share your insights and the experiences you have had in helping to protect American taxpayer dollars as well as to ensure citizens like Mr. West get the care they need and deserve.

We will now begin questions, and I would yield to the subcommittee chairman, Mr. Gowdy, for the purpose of questions.

Mr. GOWDY. Thank you, Mr. Chairman.

Mr. West, on behalf of all of us, I want to thank you for your service to our country, both on this soil and on foreign soil. We are indebted to you. It strikes me, Mr. West, that you brought this to the attention of every single person that you could reasonably have known to bring it to.

Mr. RICHARD WEST. Yes.

Mr. GOWDY. And nobody did anything. You had to go get a private lawyer to do what either the State of New Jersey, CMS, or some social worker should have done, is that correct?

Mr. RICHARD WEST. That's right, yes.

The social worker asked Maxim if they could back up their billing with paperwork. They said yes. So she had no power to audit, or she had no power, so I took it to the State. And the State sat in my living room in August in 2003, I told them I was not getting the nursing they are telling me I'm getting. They did nothing. The person running the program retired. The only person sitting at my dining room table got promoted, and everybody just goes on. If people aren't held accountable, both Maxim and State and Federal workers, there is nowhere for me to go.

Mr. GOWDY. And that is exactly what I want to ask Ms. West. Do you have any criminal practice at all to go along with your civil practice? Have you ever done criminal defense work?

Ms. PAGE WEST. No, I haven't.

Mr. GOWDY. For those of us who are not smart enough to do civil work and had to do criminal work, it has always struck me that nothing gets people's attention quite like the fear of going to prison. And poor folk who steal do go to prison. Rich folk who steal have the corporation pay a fine and then they continue to participate in the Medicaid program. How in the world does that happen?

Ms. PAGE WEST. It is much more difficult to prove a criminal case. The standard is guilty beyond a reasonable doubt, it takes a lot of resources to investigate these cases.

Mr. GOWDY. Let me stop you right there. You have a Vietnam war veteran witness who says that this work was not done on me and you have a document that says that they were billed for it. I think you and I could win that case. I guess that there is a different standard of proof, but there is a different standard of proof in all criminal cases.

Ms. PAGE WEST. Someone in the government is making the decision of whether to prosecute these cases.

Mr. GOWDY. Do you know who that is? Do you know who it is?

Ms. PAGE WEST. The U.S. Attorney's Office.

Mr. GOWDY. In New Jersey?

Ms. PAGE WEST. Yes. And the Department of Justice.

Mr. GOWDY. So they went to a Civil Division to reach an agreement, pay a fine, the shareholders pay, none of the corporate ex-

ecutives go to jail, and then they continue as part of the settlement to be able to participate in the Medicaid program? That is as outrageous as anything I have heard in the 11 months I have been here and I have heard some outrageous things.

Let me ask you this: There have been civilizations that of been formed in less than 7 years. What took 7 years for this case to be resolved?

Ms. PAGE WEST. The investigation started locally and then it expanded to the State of New Jersey, and then it expanded to the States beyond New Jersey eventually expanding nationwide. And during that time, there were numerous audits going on of the documents, there was an independent audit company that was hired to determine what was, what type of document qualified as a proper claim and what was an improper claim. Maxim's attorneys were involved every step of the way. They were allowed to have input into this process, and then at the end, because fraud is difficult to quantify, the settlement had to be reached, and it is often likened to making sausage because there are so many elements that have to be brought together that so many people have to agree on, and that's what also took a long part of the time is the agreement on the various aspects of the settlement, and there was a criminal component to it as well.

Mr. GOWDY. And the criminal component went away as part of the civil settlement? Did anyone go to jail as a result of this?

Ms. PAGE WEST. My understanding is that there were nine indictments, eight of which were of Maxim employees, not executives, but managers.

Mr. GOWDY. And did they go to jail?

Ms. PAGE WEST. I don't know.

Mr. GOWDY. My time is expired, Mr. Chairman.

Mr. PLATTS. I thank the gentleman. I yield to the gentleman from Illinois, the ranking member, Danny Davis.

Mr. DAVIS. Thank you, Mr. Chairman. Mr. West, let me again thank you for taking time to come to Capitol Hill to testify. And I also thank you again for your service to this country during the Vietnam War. The coalition against insurance fraud estimates that 80 percent of health care fraud is committed by providers, 10 percent by consumers, and 10 percent by others such as insurance companies or their employees.

I applaud you for your diligence in maintaining records and keeping such a close eye on the actual number of hours you were receiving home health services and the number of hours Medicaid was being billed.

What I want to ask you is when you receive notice that your services, that you had reached or were going beyond your monthly cap, and your Medicaid services were being temporarily reduced or suspended, how did you feel when you read that letter or got that information?

Mr. RICHARD WEST. I was in a nursing home, and this program allowed me to live in my own home, and in 3 months, I knew what they were doing. I had always been an advocate for people with disabilities, and when I got that notice, I knew that it wasn't me, it was all the other people that these services that were getting screwed that they were going to take my service and I'm going to

fight them. Other people can't do that. I'm on oxygen. And I'm probably too stubborn and arrogant to give up.

But if you're the average person in my position, you can't fight. You're helpless. You are being abused. So, how I felt? I was being abused, and I needed to stand up for everybody.

Mr. DAVIS. And you knew that you were weren't going to take it sitting down?

Mr. RICHARD WEST. I started this as an advocate and through the 7 years, it became more patriotic.

Mr. DAVIS. Thank you very much. Ms. West, let me ask you, you indicate that you have handled any number of cases. What is the typical client or person who comes to you with a situation and asks for your assistance?

Ms. PAGE WEST. More often it's a person who works in the company that's committing the fraud, someone who sees something that seems amiss, and they will go to their supervisor and say, hey, why are we doing this, and the supervisor will try to brush it off, and oftentimes they will escalate it to another superior, and eventually oftentimes they get fired for being nosy, at which point they will come to me or close to the end of that process.

Mr. DAVIS. So they will come, they are whistleblowers who themselves have been abused in a way in terms of losing their jobs?

Ms. PAGE WEST. Exactly, and also in terms of being asked to do things in the job that they know are not right. And as Mr. West pointed out, many of their co-workers know the same thing but they won't come forward because they're afraid of losing their jobs and their health care.

Mr. DAVIS. Thank you very much, Mr. Chairman. My time is expired.

Mr. PLATTS. I thank the gentleman. I yield myself 5 minutes for the purpose of questions.

And again, the case that you shared with us, Mr. West, and your attorney, should not happen, and our efforts as focused here are in trying to ensure it doesn't happen again in the future.

If I understood your written testimony and your responses here today, when you reached out to the State of New Jersey Medicaid, social worker that, other than, if I understood, with the social worker, it looks like they looked at Maxim's records and said, well, they have paper to back up saying they provided this service and they basically took the company's word over your word. Is that a fair statement?

Mr. RICHARD WEST. Correct.

Mr. PLATTS. Did the State of New Jersey or Medicaid itself even get to that point? Or did they just pretty much do nothing?

Mr. RICHARD WEST. They did nothing. I wrote to Governor Corzine, Senator Menendez, they sent the paperwork to the same people that were doing nothing.

Mr. PLATTS. So in addition to your own contacts, to the State and Medicaid, you contacted your elected officials, Governor, U.S. Senator—

Mr. RICHARD WEST. Yes.

Mr. PLATTS. They contacted those entities and still nothing happened?

Mr. RICHARD WEST. Correct.

Mr. PLATTS. It is just as Mr. Gowdy said, just somewhat unbelievable that here you have a citizen trying to do the right thing and protect taxpayers and ensure he receives the services and the government collectively failed you terribly.

When they were denying your claim of fraud and failing to act on it, what was their response as far as how that then related to your care? Because of that fraud, you were being denied dental. Were they saying, we don't believe you that there is fraud, but we are going to provide you care or—

Mr. RICHARD WEST. They don't come out and say we don't believe you. They just don't—

Mr. PLATTS. They just don't do anything.

Mr. RICHARD WEST [continuing]. Return your calls, don't answer your letters, don't respond to your emails. You are a burden to them creating paperwork for them. It is easier for them to do nothing.

Mr. PLATTS. Push you to the side?

Mr. RICHARD WEST. Correct.

Mr. PLATTS. How about on the fact that that fraud was denying your services, did they correct that and ensure that you got the dental care, or did that continue to—

Mr. RICHARD WEST. Eventually, I got the dental care. But at that time, I had nursing 7 hours a day, 7 days a week, and nursing 3 nights a week totaling 18 hours. I lost those 18 hours for 7 years. So if you turn off my ventilator, I have a hard time breathing. But if you let me sit there, I slowly deteriorate, because I'm not getting the care I need.

Mr. PLATTS. I want to make sure I heard you correctly. While the investigation was going on for 7 years, they were denying you the services because saying you were not entitled to it because of the fraud?

Mr. RICHARD WEST. Right.

Mr. PLATTS. Outrageous.

Mr. RICHARD WEST. Yes.

Mr. PLATTS. Thank you for persevering and weathering the terrible care and treatment you received.

Ms. West, a question, and I'm not sure from, as a lawmaker, how our Federal whistleblowers were seeking to strengthen the whistleblower protections provided Federal employees because we want, as you referenced, more often than not, it's an employee who comes forward with what they know is going on in their company or their office.

We're trying to strengthen that law. We've passed legislation out of this committee, out of the full Oversight and Government Reform Committee and now working for a floor vote to give whistleblowers within the Federal Government more protection.

If a Federal employee came to you, I assume then that they are impacted differently going to you for this type of case and bringing forth fraud because they are a Federal employee, is that correct?

Ms. PAGE WEST. Historically in my experience, the government has been less receptive to intervening in whistleblower cases brought by Federal employees.

Mr. PLATTS. They keep it more internal?

Ms. PAGE WEST. It's hard for me for to understand the reasoning that goes behind how an intervention decision is made. I don't know why that is.

Mr. PLATTS. But your experience over 20 years is it's less common for them to intervene?

Ms. PAGE WEST. It's more difficult for them to be accepted as an intervened case.

Mr. PLATTS. So all the more unlikely, given that, for a Federal employee to pursue this type case because they're lease likely to succeed?

Ms. PAGE WEST. Yes. More difficult. Yes.

Mr. PLATTS. Thank you. My time is expired. I yield to the gentleman from New York, Mr. Towns.

Mr. TOWNS. Thank you very much, Mr. Chairman.

Let me, again, thank you, Mr. West, for coming and sharing your story with us, and of course, regret that you had to go through so much in order to make the point, but I appreciate your time here today.

Let me begin by just, can you tell me about the process you went through in trying to contact various agencies? Could you talk for just a moment about the process that you went through trying to reach agencies?

I know that you said that you sent out letters and e-mail and phone calls. Can you just talking talk about the process just briefly?

Mr. RICHARD WEST. The local county social worker comes to the house once a month. So once a month, I'm telling her I'm not getting my services, and I'm calling her in between those visits saying the nurses aren't showing up, I'm having to depend on family, friends. The State workers, the county workers the State workers supposedly, they didn't follow through, and the State program was telling me I had to have a caregiver in my home for when a nurse didn't show up. My son was in high school getting ready to graduate, and I wasn't about to put that burden on him because the nursing aid wasn't doing their job.

So the State decided they wanted to have a meeting in my home. So they all came down, sit at my table and tell me what services I've got. And I said I am not getting the hours of nursing you are telling me I'm getting.

And the State workers said, well, you need a caregiver and you don't have one, so maybe you don't qualify for the program. And I said, I'm not going to have a caregiver, and she said, you're not compliant and I said arrest me. She didn't appreciate that.

And the county social worker told her those discrepancies in the hours, they all went out, had a pow-wow out by the car and went back to Trenton and never followed through with any of it. When I realized the county and the State wasn't doing anything, I went to the Medicaid fraud hotline, called them. They said we'll give you an investigator and we'll look into it. Never heard a word.

So I figured I have to get out of the State of New Jersey because I have no idea who is involved, whether they're involved with Maxim or their own programs. So I went on the Web, looked up Medicaid fraud. That is when I found out that there is a whistleblower lawsuit. I had no idea. Then I read you could receive a por-

tion of the recovery. I figured, well, hey, I could fish my brain, maybe I will get \$5,000. And the first person I called was in Alabama, a whistleblower attorney. He said well if it's not \$10 million, I don't even want to talk to you. I was informed of a whistleblower lawyer in California. He said send me the documentation you have. I did. He called me back and said, I think you have a pretty good case but you need an attorney closer to where you're at. Then I found Robin on the Internet, and that's how we proceeded.

Mr. TOWNS. So you found someone with the same last name?

Mr. RICHARD WEST. When I called, her secretary said, who is calling? I said Richard West. And there was a silence. And I said no relation.

Mr. TOWNS. Thank you very much.

Mr. Chairman, I just ask for an additional 30 seconds. I want to ask Ms. Page to submit something to us.

In your written testimony, you indicated that the False Claim Act is both unusual and effective in uncovering fraud in the health care system. If you would be kind enough in writing to summarize your top three arguments for why this law is effective. I'm interested in that because we would like to strengthen the law to improve it so if you would be kind enough to submit that to us in writing, being my time is out.

Ms. PAGE WEST. The top three reasons why it's effective.

Mr. TOWNS. Yes. Thank you.

Mr. PLATTS. I thank the gentleman. The gentleman Mr. DesJarlais is recognized for 5 minutes for questions.

Mr. DESJARLAIS. Thank you, Mr. Chairman.

Mr. West, Admiral Mullens this past year was quoted as saying the biggest threat to our national security is our national debt, so not only did you fight for our country in Vietnam, you are fighting for our country again against a big threat which is spending and debt. So I applaud you for your courage and taking the time to come here and speak with us today.

I just wanted to ask you a few questions about your relationship with the people that spent a lot of time caring for you because with your condition with the trach ventilator I'm assuming you had a respiratory therapist that came to your home?

Mr. RICHARD WEST. No.

Mr. DESJARLAIS. No? You had home health nurses?

Mr. RICHARD WEST. I had nursing.

Mr. DESJARLAIS. And I'm assuming you had nurses aids to help with activities of daily living, they have to help you dress, they have to help you eat.

Mr. RICHARD WEST. Right.

Mr. PLATTS. They have to help you maintain your residence so it's safe?

Mr. RICHARD WEST. Yes.

Mr. DESJARLAIS. So they spent quite a bit of time in your home?

Mr. RICHARD WEST. Correct.

Mr. DESJARLAIS. Did you ever feel like you got close to any of these people? They take care of you. Were they caring people? Did you talk to them on a first name basis? Did any one, say, an aide, stay with you for several months at a time or was it different aides on different days?

Mr. RICHARD WEST. I have a nurse now that has been with me 4 years. Over the course of the 7 years, there have been different nurses, different agencies, but many have been there for extended time.

Mr. DESJARLAIS. So you knew them very well and they knew you very well and it was generally friendly and cordial? Did you like them and they liked you?

Mr. RICHARD WEST. Yes.

Mr. DESJARLAIS. When you first started noticing the fraud, were you able to talk to them about this, and share your concerns?

Mr. RICHARD WEST. They were part.

Mr. DESJARLAIS. I'm sorry?

Mr. RICHARD WEST. They were part of the fraud.

Mr. DESJARLAIS. Did you talk to them and ask them, did they try to make excuses or did they say they'd talk to their managers?

Mr. RICHARD WEST. No. I could tell by what they were saying, what they were telling me, they were getting paid but they weren't putting in for the hours in my home, they were putting in for additional hours. And the company, the nurses told me on several occasions that the Maxim office managers work on a bonus system so the more profitable they are the bigger their bonus.

So these people, despite having a relationship—you liked them, they liked you—you felt they were aware of the fraud that was going on but would do nothing?

Mr. RICHARD WEST. They knew.

Mr. DESJARLAIS. They knew.

Mr. RICHARD WEST. They knew.

Mr. DESJARLAIS. Did you feel like you were betraying them in a sense when you had to go over their head to try to fix this situation?

Mr. RICHARD WEST. You can't betray somebody that is abusing you.

Mr. DESJARLAIS. Okay. Well, I guess I just wonder, you know, how unusual you are.

Ms. West, how many other Medicaid beneficiaries have come to you such as Mr. West? How unusual is Mr. West?

Ms. PAGE WEST. It is very unusual. Just a handful of people have even inquired. And if memory serves, Mr. West is the only beneficiary case that I have taken.

Mr. DESJARLAIS. Okay. So given the success by whistle blowers, why do agencies and officials typically ignore people like Mr. West? What would be your opinion on that?

Ms. PAGE WEST. I don't think it's so much that the False Claims Act isn't serving them and that the government isn't picking up the cases. I think it's that there are not that many beneficiaries who are coming to the False Claims Act attorneys.

Mr. DESJARLAIS. Okay. So why then when someone like Mr. West, who obviously has a legitimate claim that was proven legitimate, why do you think Medicare just chose to ignore it? And I will ask you that and ask Mr. West that.

Ms. PAGE WEST. Well, I think Mr. West is an extremely unusual person. Relaters need to be very tenacious, very intelligent, very persistent. And quite often, Medicare and Medicaid beneficiaries who are sick cannot bring all those qualities and have the stamina

to, you know, figure it all out and bring it to a lawyer. And I think that's basically the issue, is that they are not aware of it. They are not aware of the incentives, and they don't necessarily have the skill set to put it all together and follow through on it.

Mr. DESJARLAIS. Okay. Well, I will just say—and I know I am about out of time, if you will indulge me for a few seconds. As a practicing physician, primary care physician, for 18 years before coming to Congress, I dealt closely with home health. There was a lot of issues of fraud and abuse in the 1990's where people who did not have near your level of disabilities had aides and what not coming to the house. That was kind of reined in a little bit in the 1990's. But I see that it tends to be alive and well as we moved into the next decade as well.

Again, I applaud you, Mr. West, for your efforts. And clearly, I think that CMS and Medicare, who we will have on the next panel, we will get an opportunity to see why people like yourself are being ignored. Thank you so much for stepping forward and fighting again for your country.

I yield back.

Mr. RICHARD WEST. The people in my position don't have the support once they turn people in. If I was a government informant for a mob-related case, you would take care of me. But when I went to the special agent in charge and asked to get nurses so I could continue through this case, there was nothing he could do to help me. So why would those people turn somebody in, knowing they should die? So you have to give support to the patient, client—whatever you want to call me—so he can bring the lawsuit. If the threat is, "you complain, we take you services," where is the incentive? There isn't.

Mr. PLATTS. I thank the gentleman.

Mr. West, along the lines of what you just expressed, it sounds as if—whether through a need for a legislative change or regulatory change—that if you had a beneficiary, as in this case, that the government makes a determination, they are going to take on the case and go forward, that that decision should maybe include a provision, you know, that while the case is being pursued, 1 year or 7 years, in your case, you are given the services on a provisional basis, you know, while it is proceeding. Because, again, otherwise you have a disincentive from reporting it because of being at risk of further losing care.

Mr. RICHARD WEST. Correct.

Mr. PLATTS. I thank the gentleman.

I yield to the distinguished ranking member of the full committee Mr. Cummings from Maryland.

Mr. CUMMINGS. Mr. West, I thank you also for being here. And I agree with you, these folks needed to go to jail. And it's interesting that I now have done a little research to see what happened.

I want to follow up on some of Mr. Gowdy's concerns.

They did go to jail. One went to jail from Maxim, and he got—this was the highest sentence of eight or nine people—5 months in prison and 5 months of home confinement. Most of them got a fine and home imprisonment. That's what they got.

Now 40 miles away from here, I represent Baltimore. And about 6 months ago, I had literally thousands, thousands of young Afri-

can American boys, many of whom may have stolen a bike, may have done something wrong with drugs or whatever, and they got a record, Mr. West. They got a record.

And you know what, they can't get a job. If they live to be 99 years old, they will not be able to get a job. But here we have Maxim, a company that has basically stolen, stolen from the American people—Maxim, a company that has taken away the services, not only from you but so many others, but yet and still, they are in a position to continue to make millions. Something is absolutely wrong with that picture.

And I agree with you. When the people from the CMS and the IG come up, they have to explain to us—and by the way, every member of this panel, every Member of this Congress should be saying, Maxim should be put out of business with regard to doing business with the Federal Government. It is ridiculous how a young man in Baltimore can steal a \$300 bike and not be able to get a job for a lifetime, but Maxim can steal millions and continue to do the same thing over and over again. Yeah, they got sentenced. But this sentence is simply a slap on the wrist. If you can pay \$150 million fine, this is just a cost of business.

And so, you know, I am very concerned about this.

And I want to enter into the record, Mr. Chairman, the U.S. Attorney's Office, District of New Jersey—it's basically their summary of the sentencing. It is dated November 21, 2011. I would ask that that be made a part of the record.

Mr. PLATTS. Without objection, so ordered.

Mr. CUMMINGS. And a Reuters article dated—I ask that this be made a part of the record, too—dated Monday, September 12, 2011. And it says, in part, Maxim settled with the U.S. Department of Justice and 41 States. Their company entered into a deferred prosecution agreement with the Justice Department under which it paid—it will pay a \$20 million fine. If Maxim meets the agreement's requirements, it will avoid charges. And the government said it was willing to enter into an agreement with Maxim in part—in part because of its cooperation and significant personnel changes it has made since 2009.

Mr. PLATTS. Without objection, entered into the record.

Mr. CUMMINGS. Thank you very much.

Well, that's all well and good; but if you are paying people bonuses to screw people and mess them over—and you're right. Everybody's not like you. There are people who are sitting in wheelchairs right now, looking at this right now, who feel helpless, and many of them are going to die. That's why I cannot understand for the life of me how every Member of this Congress should not want to put Maxim out of business, at least with regard to its business with the Federal Government.

Now to you, Ms. West. Ms. West, you stated in your written testimony that you have over 20 years of experience in bringing cases such as Mr. West's to the government's attention. Can you explain how these False Claims Act cases help government work better and save taxpayer dollars?

I'm sorry. I didn't mean to get so upset, but this makes me want to vomit. Go ahead.

Ms. PAGE WEST. The False Claims Act gives the government a bird's eye view into the fraud. Without the whistleblowers, the government really has no way of knowing how the fraud is being committed. Every time there is a fraud that's detected, the government learns about it, comes in, kind of shuts it down. But then there's a new fraud that pops up. And it's a constant never-ending thing. And there is more creativity behind fraud because there is so much money to be made by it. And that's why the False Claims Act is so effective is because it reaches out to the people who are seeing the fraud and understand the fraud and giving them an incentive to tell about it and explain to the government how to stop it.

Mr. CUMMINGS. Ms. West, do you think there are too many False Claims Act lawsuits? And what disincentives are there for bringing a frivolous False Claims lawsuit?

Ms. PAGE WEST. Well, the disincentive for bringing a frivolous False Claims Act lawsuit is there's a provision in the statute that allows the defendant to recover its attorney's fees from the relater if it's shown that the suit was brought for purposes of harassment.

In addition, it's difficult to bring a frivolous lawsuit because the qui tam lawyers work on contingency. And if we don't think a case is really good, we're not going to bring it. Only about 20 percent of the False Claims Act cases brought are intervened in by the government. So we're looking at a very tiny window, and we are looking for the very best cases to bring to the government's attention.

Mr. CUMMINGS. I see my time is expired. Again, Mr. West, I want to thank you very much for you and all others who will benefit from what you are doing.

Mr. PLATTS. I thank the gentleman.

Before yielding to the gentleman from Virginia, Ms. West, the example of having a bird's eye view, the beneficiary goes out on the front lines being able to bring a False Claims Act, in the second panel, we're going to hear about a lot of expenditures of moneys for new technology, new analytical programs and things. Is it a fair statement to characterize your experience here that—rather than the investment of all this money in new programs, that if we had simply better listened to the beneficiary, we would have prevented the fraud?

Ms. PAGE WEST. Yes, I think so. And listen to Malcolm Sparrow, who has analyzed this and feels that the money should not be paid out first. It should be paid out properly, not paid and then followed after to be gotten back.

Mr. PLATTS. Right. So it is being more up front as opposed to the recovery type of audits. It's focus up front.

Ms. PAGE WEST. Exactly.

Mr. PLATTS. I yield to the gentleman from Virginia, Mr. Connolly, for the purpose of questions.

Mr. CONNOLLY. Thank you, Mr. Chairman.

And I want to thank Mr. West particularly for his courage, both serving his country and in serving his country a second time in trying to make sure taxpayers' investments are protected and are made secure and for the courage of persisting when many others might have been daunted and discouraged.

I also want to say to our colleague, if he's still here. I guess Mr. Gowdy isn't here. But if Mr. Gowdy is serious about toughening up

the criminal penalties, he will find allies on this side of the aisle. Our subcommittee has pointed out that there are, every year, \$125 billion in improper payments. Now sometimes it's innocent—you know, a mistake in billing. Somebody gets paid who shouldn't have or gets double paid; somebody who's not qualified to receive a benefit gets a benefit. But a lot of it's fraud.

I know that U.S. Attorney's Offices are consumed with Medicare and Medicaid fraud. The U.S. Attorney's Office in Boston just announced a \$3 billion recovery. That's 1 out of 99 U.S. Attorney's Offices. So we know it's out there.

If we eliminated improper payments, by the way, we could give a Christmas gift to the supercommittee of \$1.25 trillion over the next 10 years, without breaking a sweat, without affecting anyone's benefits, without having political drama, without having to gut any necessary investments.

Mr. PLATTS. Would the gentleman yield?

Mr. CONNOLLY. I yield to the chair.

Mr. PLATTS. I thank the gentleman for yielding.

As you well state, if you took the fraud and improper payments—again, we don't know how much is fraud—improper payments of Medicaid, as you are just discussing here today and as you know from our previous hearing on Medicare, these two programs alone account for about \$70 billion a year of that 125. So over 10 years, you are talking \$700 billion.

I yield back.

Mr. CONNOLLY. Thank you, Mr. Chairman.

Of course, as you know, some of that money was cited in the financing of the Affordable Health Care Act, some criticized us for that as if we were gutting the program. But in fact, we were simply trying to recover either improperly made payments or illicitly made payments.

I want to just make sure we get the narrative on the record, Ms. West, if you don't mind. I've heard Mr. West. When did Mr. West first discover something was wrong and how?

Ms. PAGE WEST. He testified—

Mr. CONNOLLY. If you could speak into the microphone.

Ms. PAGE WEST. Three months after he came out of the nursing home, he realized something was wrong.

Mr. CONNOLLY. And what made him realize something was wrong?

Ms. PAGE WEST. That he was not getting the care that he was entitled to get under the program. He was getting fewer hours of nursing care.

Mr. CONNOLLY. Okay. And maybe initially he thought that was a mistake?

Mr. RICHARD WEST. Initially, I thought that they were having a hard time servicing my case. But then it became apparent that they would send when they wanted, who they wanted.

Mr. CONNOLLY. Well, the testimony submitted on your behalf by your attorney, Ms. West, says, you attempted to bring the matter to the government's attention by contacting the State. What State was that?

Mr. RICHARD WEST. The State of New Jersey.

Mr. CONNOLLY. New Jersey. The Medicaid program itself—so you went to a local office, okay—and your social worker.

Mr. RICHARD WEST. Correct.

Mr. CONNOLLY. And the testimony says, all to no avail.

Mr. RICHARD WEST. Correct.

Mr. CONNOLLY. Meaning what, they ignored it?

Mr. RICHARD WEST. Yes.

Mr. CONNOLLY. Okay. So you then decided, this isn't right. I'm not getting anywhere, and I'm, therefore, going to turn to a private attorney. And you used actually something Congress did well, the False Claims Act.

Mr. RICHARD WEST. Correct.

Mr. CONNOLLY. Which gave you a vehicle for redress as a, as you put it, *qui tam* relater.

Mr. RICHARD WEST. Right.

Mr. CONNOLLY. Ms. West, if you could describe for us, what was the reaction of the Medicaid officialdom when faced with this potential fraud, at least on your initial contacts?

Ms. PAGE WEST. Are you asking me?

Mr. CONNOLLY. Yes. I'm asking you, Ms. West.

Ms. PAGE WEST. I did not contact Medicaid. I filed a lawsuit under the False Claims Act. So my first contact was with the U.S. Attorney's Office With the District of New Jersey.

Mr. CONNOLLY. Did Medicaid at any point react to the filing of the lawsuit or the claims contained therein?

Ms. PAGE WEST. Again, I didn't have any contact with anyone from Medicaid. I was coming in through the Department of Justice.

Mr. CONNOLLY. Did your client have any contact with Medicaid in terms of reaction to the filing of the lawsuit or the claims therein?

Ms. PAGE WEST. Well, once we filed the lawsuit, it's under seal, and we aren't allowed to talk about it.

Mr. CONNOLLY. Even with Medicaid?

Ms. PAGE WEST. Not unless there would be a partial lifting of the seal or if they would set up a meeting and Medicaid officials would be there. But there was nothing like that.

Mr. CONNOLLY. And presumably—you made repeated attempts with the Medicaid office, Mr. West. And I know my time is running out—to try to alert them to this and get them to act.

Mr. RICHARD WEST. Yes.

Mr. CONNOLLY. And they were indifferent?

Mr. RICHARD WEST. Correct.

Mr. CONNOLLY. We look forward to their testimony. Thank you. My time has run out.

Thank you, Mr. Chairman.

Mr. PLATTS. I thank the gentleman for yielding back.

Before we conclude, I yield myself just a final minute.

Mr. West, my understanding is, in giving an interview, you shared an example of the lack of cooperation you got as you tried to correct this and that you were in front of a judge or an adjudicative setting where you were told that—well, there's evidence that they did provide these services, and they were not agreeing with you or believing you, and that you made a statement that you would bet that while you were in front of this individual that

Maxim was probably falsely appealing for services to you. Could you share that?

Mr. RICHARD WEST. We went to Scranton to the Federal courthouse. I picked up Robin at the train station. We met with I believe it was Silverman and a special agent, and after they heard my story, I said, I'll bet Maxim bills for a nurse in my home while I'm sitting here with you. I left my home at 6:45 in the morning. My son was driving. We went to Scranton, met with the prosecutors. I said, I'll bet they bill for this time. And they said, no, they couldn't possibly do that.

In January, I sent an email to Robin saying, I told you so. They billed for 7 to 3 for an RN in my home. Me and Adam didn't get home until about 5 that night. They also billed for the same nurse Christmas Day. We were in Pennsylvania, the next State over. And this particular nurse was reading my mail, looking at my email. I had to tell my attorney, do not send anything to my home. All updates and emails, don't mention who they're from or who they're about. I lived in a closet because I couldn't—I had people spying on me in my home while they were stealing from you.

Mr. PLATTS. One more example of how you were being victimized by a very unscrupulous company.

Mr. RICHARD WEST. Yep.

Mr. PLATTS. And its employees. And the fact that while you were sitting with the very investigators, they're falsely billing for services to you just epitomizes the outrageousness of this case. And again, as you reference having left your home at quarter of 7 a.m., and not getting back until 5, another example of your persistency and willingness to do whatever it took to bring justice on behalf of the American people, the taxpayers and to ensure that you were properly provided the services you've earned and deserved, especially as a veteran of our Nation's Armed Forces. I thank each of you again for your testimony here today, but more so than just your testimony here today, your efforts over almost a decade of trying to bring justice on behalf of your fellow citizens.

And Adam, I think it probably goes without me saying, but I imagine you're a very proud son to be Richard West's son and know that he's a true servant of this Nation.

Mr. ADAM WEST. Very much so.

Mr. PLATTS. So God bless each and every one of you. We will recess for 5 minutes as we recess for the second panel.

Mr. RICHARD WEST. May I have 1 minute?

Mr. PLATTS. Yes, you may.

Mr. RICHARD WEST. Today is Pearl Harbor today. And I would like to say, my dad, Thomas L. West, served in the Pacific. My mom, Catherine B. West, worked in a factory during that war. We had a country that worked together for the country. We need that now. We need people like me, people like you to sit down and fix the government.

Mr. PLATTS. Well stated, Mr. West.

Mr. RICHARD WEST. Thank you. I'm honored to be here.

Mr. PLATTS. God bless you. Thank you. We will stand in recess.

[Recess.]

Mr. PLATTS. The hearing is reconvened.

And we thank our second panel of witnesses for being with us and again your knowledge and insights to help educate both of our subcommittees on this important topic of how do we prevent and protect and recover American taxpayers' dollars that have been defrauded through the Medicaid program.

We are delighted to have four witnesses with us: First Ms. Angela Brice-Smith, director of the Medicaid Integrity Group at the Centers for Medicare & Medicaid Services; Mr. Gary Cantrell, assistant inspector general for investigations at the Office of the Inspector General for Health and Human Services; Ms. Carolyn Yocom, director of health care at the Government Accountability Office; and Ms. Valerie Melvin, director of information management and technology resource issues at the Government Accountability Office.

We thank each of you for being with us. And again, as is pursuant to the committee rules, if I could ask each of you to stand and raise your right hand, swear you in before your testimony.

[Witnesses sworn.]

Mr. PLATTS. Thank you. You may be seated.

And the clerk will reflect that all four witnesses affirmed that oath. And again, we have had the chance of reviewing your written testimony and appreciate your providing that to us. It allows us to be a little better prepared for today's hearing, and we will set the clock for roughly 5 minutes for your oral testimony here today.

Ms. Brice-Smith, if you would begin.

**STATEMENTS OF ANGELA BRICE-SMITH, DIRECTOR, MEDICAID INTEGRITY GROUP, CENTERS FOR MEDICARE & MEDICAID SERVICES; GARY CANTRELL, ASSISTANT INSPECTOR GENERAL FOR INVESTIGATIONS, OFFICE OF THE INSPECTOR GENERAL, HEALTH & HUMAN SERVICES; CAROLYN YOCOM, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE; AND VALERIE MELVIN, DIRECTOR OF INFORMATION MANAGEMENT AND HUMAN CAPITAL ISSUES, GOVERNMENT ACCOUNTABILITY OFFICE**

**STATEMENT OF ANGELA BRICE-SMITH**

Ms. BRICE-SMITH. Thank you Chairmen Platts and Gowdy, Ranking Members Towns and Davis, and members of the subcommittees.

Thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' efforts to reduce fraud, waste, and abuse in the Medicaid program. Medicaid is the primary source of medical assistance for 56 million low-income and disabled Americans. Although the Federal Government establishes requirements for the program, States design, implement, administer, and oversee their own Medicaid programs. The Federal Government and States share in the cost of the program.

State governments have a great deal of programmatic flexibility within which to tailor their Medicaid programs. As a result, there is variation among the States in eligibility services reimbursement rates and approaches to program integrity.

Prior to 2005, States were solely responsible for the oversight of their Medicaid program. However, in 2005 with the passage of the

Deficit Reduction Act, Congress recognized the need for a greater focus on health care fraud and gave CMS new authority and funding to establish the Medicaid Integrity Program.

I am the director of the Medicaid Integrity Group which implements the Medicaid Integrity Program. The Medicaid Integrity Program is a Federal effort to prevent, identify, and recover inappropriate Medicaid payments. It also supports the program integrity efforts of the State Medicaid agencies through a combination of oversight and technical assistance.

The establishment of the Medicaid Integrity Program began a new era of combating waste and fraud in the Medicaid program, which was once again improved by the creation of the Center for Program Integrity. The Center for Program Integrity brings a coordinated approach to program integrity across all Federal health care programs.

This new focus on program integrity and anti-fraud efforts continue with the Affordable Care Act, which is the most comprehensive legislative step forward to fight health care fraud in over a decade. The administration has made an unprecedented investment to reduce improper payments, invest in program integrity strategies, and rein in waste, fraud, and abuse in Federal health care programs.

Our efforts within the Medicaid Integrity Program focus on protecting Medicaid resources at the beneficiary level, the State level and the national level. Beneficiary involvement is a key component to all of CMS's anti-fraud efforts. We strongly believe that alert and vigilant beneficiaries are one of the most valuable tools in our efforts to stop fraudulent activity.

We are committed to enlisting beneficiaries in our fight against fraud in several ways: For example, our Education Medicaid Integrity Contractor [EMIC], provide beneficiaries with quick facts and tips on how to prevent, spot, and report Medicaid fraud through social network sites, through electronic letters, through public service announcements, and other educational materials. We encourage Medicaid beneficiaries to report suspected fraud, waste, and abuse to their State's Medicaid fraud control unit or Medicaid agency or the HHS fraud tips hotline as examples.

CMS is also committed to supporting our State partners and their program integrity efforts and their efforts to reduce improper payments. Our Medicaid Integrity Institute provides substantive training and support to the States. We have trained more than 2,600 program integrity staff from all 50 States, D.C. and Puerto Rico.

CMS provides boots-on-the-ground teams that can assist States with special investigative audits and emerging threats. Since October 2007, CMS has participated in 10 projects in 3 States, which have resulted in \$33.2 million in savings through cost avoidance. In addition, CMS's review and audit MICs, or Medicaid Integrity Contractors, complement and support program integrity efforts underway in the States. Between 2009 and November 1st of this year, the audit MICs have initiated 1,663 audits in 44 States. In addition to the Federal audits, States report that they have recovered \$2.3 billion as a result of all Medicaid program integrity activities.

The Affordable Care Act has also strengthened Federal oversight for the Medicaid program by providing new tools to CMS and law enforcement officials to protect Federal health care programs from fraud, waste, and abuse. These tools include the new screening and enrollment requirements, strengthen authority to suspend potentially fraudulent payments, and increased coordination of the anti-fraud actions and policies between Medicare and Medicaid.

The Affordable Care Act expanded the Recovery Audit Contractors to Medicaid, which will help States identify and recover improper Medicaid payments. Over the next 5 years, we project that the Medicaid RAC effort will save the Medicaid program \$2.1 billion, of which \$910 million will be returned to the States.

CMS is committed to working with and sharing with our law enforcement partners, who take a lead in investigating, determining, and prosecuting alleged fraud. We also continue to work to address the concerns raised by the GAO that could reduce improper payments and potential vulnerabilities in the Medicaid program.

I am happy to announce that the fiscal year 2011 Medicaid's national improper payment rate is 8.1 percent, a drop from the 9.4 percent in fiscal year 2010. Despite this decrease, we remain focused on improving program integrity in Medicaid and are confident that the actions outlined today and in my written testimony as well as the continued efforts of our Federal, State, and public partners will continue to reduce improper payments.

I look forward to working with the subcommittee to ensure that CMS carries out this important work. Thank you.

[The prepared statement of Ms. Brice-Smith follows:]

**U.S. House Committee on Oversight & Government Reform**  
**Subcommittee on Government Organization, Efficiency, and Financial Management and**  
**Subcommittee on Health Care, District of Columbia, Census, and the National Archives**  
**December 7, 2011**

Chairmen Platts and Gowdy, Ranking Members Towns and Davis, and Members of the Subcommittees, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) efforts to reduce fraud, waste, and abuse in the Medicaid program.

The Affordable Care Act gives new tools to CMS and law enforcement officials to protect Federal health care programs from fraud, waste, and abuse. With this support, we are ramping up our Medicaid anti-fraud efforts by enhancing the quality of data used to detect fraud, investing in data analytics, and providing more "boots on the ground" to fight health care fraud. These efforts will increase our ability to prevent fraud before it happens, and to detect fraud when it does, allowing swifter recovery and corrective action. The Administration is strongly committed to ensuring that public resources are protected against losses from fraud and other improper payments by maintaining the integrity of the Medicaid program.

**Background**

Medicaid is the primary source of medical assistance for 56 million low-income and disabled Americans. Although the Federal government establishes requirements for the program, States design, implement, administer, and oversee their own Medicaid programs. The Federal government and States share in the cost of the program. 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 variation among the States in eligibility, services, reimbursement rates to providers and health plans, and approaches to program integrity. The Federal government reimburses a portion of State costs for medical services through a statutorily determined matching rate called the Federal Medical Assistance Percentage, or FMAP, which is based on each State's per capita income and normally ranges between 50 and 75 percent. The Federal government also reimburses the States a portion of their administrative costs through varying matching rates determined according to statute, ranging

from 50 percent to 90 percent. The total net Federal Medicaid outlays in fiscal year (FY) 2011 are approximately \$275 billion.

**Deficit Reduction Act Authorities to Prevent and Reduce Fraud, Waste, and Abuse**

Similar to all public and private health care programs, Medicaid can be a target for those who would abuse or defraud a health care program for personal gain. Recognizing the need for a greater focus on health care fraud at the public and private level, Congress gave CMS new authority and funding in the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) which modified section 1936 of the Social Security Act to establish and operate the Medicaid Integrity Program. The Medicaid Integrity Program protects Medicaid by administering the national Medicaid audit program while enhancing Federal oversight of State Medicaid programs. The Medicaid Integrity Program accomplishes this by providing States with technical assistance and support that enhances the Federal-State Partnership. Prior to the enactment of the DRA, States performed the majority of program integrity oversight in the Medicaid program.

Section 1936 of the Social Security Act, as modified by the DRA, provides CMS with ongoing authorities to fight fraud by requiring CMS to contract with Medicaid Integrity Contractors (MICs) to review provider claims, audit providers, identify overpayments, and educate providers, managed care entities, beneficiaries, and other individuals about payment integrity and quality of care. CMS works with partner agencies at the Federal and State levels to enhance these efforts, including preventing the enrollment of individuals and organizations that would abuse or defraud the Medicaid program and removing fraudulent or abusive providers when detected.

*Analyzing Data*

As part of Section 1936 of the Social Security Act, CMS uses “Review of Provider MICs” (Review MICs) to analyze Medicaid claims data provided by States to identify high-risk areas, potential vulnerabilities, and targets for audits. In April 2008, CMS began developing an information technology infrastructure comprised of a central data repository and analytical tools. The system became operational in January 2009. It is primarily populated with Medicaid Statistical Information System (MSIS) data, which is a subset of Medicaid eligibility and claims data from all 50 States and the District of Columbia. This State-submitted data includes over 40

million eligibility records and over 2 billion claims records per year. CMS uses algorithms and modeling to identify potential fraudulent, wasteful, or abusive payments based on analysis of the MSIS data.

CMS is aware of the limitations of the MSIS data because of our extensive use of the data, as well as from feedback from other groups such as the HHS Office of Inspector General (OIG) and State Medicaid Agencies. Limitations include deficiencies in the completeness, accuracy, and timeliness of the data, as well as lack of data standardizations among State programs. As a result, improving the data quality of the MSIS data is vital to program integrity efforts. CMS continues to improve access to better quality Medicaid data by leveraging the data available through the Medicare/Medicaid Data Match Expansion Project (Medi-Medi) and its participating States, as well as working directly with States to obtain Medicaid data for specific collaborative projects. While the MSIS data has limitations, CMS is able to use the MSIS data to identify trends and patterns that exist within individual States, as well as regionally and at the national level in an effort to detect and deter fraud, waste, and abuse in the Medicaid program.

In order to improve CMS and the States' data analysis efforts, the Medicaid and Children's Health Insurance Program (CHIP) Business Information and Solutions Council (MACBIS), an internal CMS governance body, provides leadership and guidance for a more robust and comprehensive information management strategy for Medicaid, CHIP, and State health programs. The council's strategy includes:

- Promoting consistent leadership on key challenges facing State health programs;
- Improving the efficiency and effectiveness of the Federal-State partnership;
- Making data on Medicaid, CHIP, and State health programs more widely available to stakeholders; and
- Reducing duplicative efforts within CMS and minimizing the burden on States.

CMS' Center for Medicaid and CHIP Services (CMCS) leads this effort. The MACBIS projects will lead to the development and deployment of enterprise-wide improvements in data quality and availability for Medicaid program administration, oversight, and integrity. As these efforts

mature, we will be able to better utilize our technical infrastructure and business intelligence tools for program integrity oversight by using analytics, algorithms, and queries.

In addition to efforts to improve the quality of the Medicaid data, CMS is actively pursuing ways to apply advanced data analytics technology, including predictive analytics, to the Medicaid Integrity Program. CMS' goal is to utilize predictive modeling to enhance its analytic capabilities and increase information sharing and collaboration among State Medicaid agencies to detect and deter aberrant billing and servicing patterns at the State level and on a regional or national scale.

#### *Auditing Claims*

Once claims have been analyzed through CMS' data system and shared with the State, the "Audit of Provider" MICs (Audit MICs) conduct post-payment audits of all types of Medicaid providers and advise States of potential overpayments made to these providers. Between the completion of the solicitation process for MICs in 2009 and November 1, 2011, Audit MICs have initiated 1,663 audits in 44 States. Those efforts have identified an estimated \$15.2 million in overpayments, through both direct provider audits and automated reviews of State claims. In addition to Federal audits, States reported that they conducted an additional 122,631 audits in FY 2009. Those State efforts have identified an estimated \$964 million in overpayments.

#### *Educating Providers and Others on Medicaid Program Integrity Issues*

The Medicaid Integrity Institute (MII) remains one of CMS' most significant achievements in fighting Medicaid fraud, in partnership with our colleagues at the U.S. Department of Justice (DOJ). In its four years of operations, the MII has offered numerous courses and trained more than 2,624 State employees at no cost to the States. Courses have included enhanced investigative and analytical skills, Medicaid program integrity fundamentals, and a symposium to exchange ideas, create best practice models, and identify emerging fraud trends.

States continue to report immediate value and benefit from the training offered at the MII. As a result of several MII courses, State staff from across the country have the opportunity to engage in productive dialogues about the challenges they face combating fraud, waste, and abuse issues

unique to their State Medicaid programs. This interaction permits participants to share their success stories, learn from others' best practices, give their Medicaid programs a wider range of perspectives on policy options, and help identify problem providers who attempt to migrate from one State Medicaid program to another. For example, one State recently reported it recovered \$3.15 million through provider audits it conducted as the direct result of knowledge gained at the MII. We have also sponsored intensive Certified Professional Coder training<sup>1</sup> and auditing courses for 359 additional State employees.

In addition, "Education MICs" assist in the education of providers and beneficiaries on program integrity efforts by developing materials and conducting training. For example, Education MICs help CMS enlist beneficiaries in our fight against fraud, including efforts such as the Protect Yourself, Protect Medicaid Campaign. CMS strongly believes that alert and vigilant Medicaid beneficiaries are one of the most valuable tools we have to stop fraudulent activity. Our Education MICs create public service announcements, distribute e-letters, and regularly update social networking sites to provide beneficiaries quick facts and tips about how to prevent, spot, and report Medicaid fraud. Education MICs encourage Medicaid beneficiaries to report fraud, waste, and abuse or criminal activities to their State's Medicaid Fraud Control Unit (MFCU) which is the State-administered law enforcement agency, Medicaid agency, the HHS fraud tips hotline, and the HHS OIG.

Due to the enactment of the DRA and Affordable Care Act, the creation of the Medicaid Integrity Program, and the establishment of our MICs, we have made great strides in combating Medicaid fraud. Today, thanks to increased funding and resources, we are able to investigate allegations of fraud quickly and competently, and report cases to law enforcement, as appropriate.

#### **Supporting State Efforts to Combat Fraud, Waste, and Abuse**

Because of Medicaid's unique Federal-State partnership, all of the strategies described above protect and enhance State Medicaid programs at a foundational level. We have also developed

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<sup>1</sup> The MII's Certified Coder Boot Camp teaches the fundamentals of Current Procedural Terminology (CPT), ICD-9, and Healthcare Common Procedure Coding System (HCPCS) Level II coding.

initiatives that specifically work to assist States in strengthening their own efforts to combat fraud, waste, and abuse.

To provide and gauge effective support and assistance to States to combat Medicaid fraud, waste, and abuse, CMS conducts triennial comprehensive reviews of each State's program integrity activities. We use the State Program Integrity Reviews to identify and disseminate best practices. The review areas include provider enrollment, provider disclosures, program integrity, managed care operations, and the interaction between the State's Medicaid agency and its MFCU. We also conduct follow-up reviews to evaluate the success of the State's corrective actions.

Through its reviews, CMS has identified 52 unduplicated program integrity "best practices" that we have publicized to all States through annual summaries of our efforts. The guidance includes specific examples of how States have created well-functioning and committed partnerships between the State Medicaid agency and its MFCU. CMS, working with State Medicaid agencies and MFCUs, issued guidance in September 2008 entitled "Performance Standard for Referrals of Suspected Fraud from a Single State Agency to a Medicaid Fraud Control Unit." CMS, State Medicaid agencies, and MFCUs developed this performance standard to provide State program integrity units with a clear understanding of how to comply with requirements for making referrals of fraud to MFCUs. In concert with the release of the performance standard, MIG issued a second guidance document, "Best Practices for Medicaid Program Integrity Units' Interactions with Medicaid Fraud Control Units." This document advises State program integrity units of the circumstances under which they should refer cases to their MFCUs, and provides guidance for interactions between State program integrity units and their MFCUs, with specific examples of actions taken by States that have created well-functioning and committed partnerships between the two entities.

The MFCU, as a State-administered law enforcement agency independent of the State Medicaid Agency, investigates and prosecutes Medicaid fraud as well as patient abuse and neglect in health care facilities. The Federal government funds MFCUs on a 75 percent matching basis. The HHS OIG certifies, and annually recertifies, each MFCU.

CMS also developed the State Program Integrity Assessment (SPIA). Through the SPIA, CMS annually collects standardized, national data on State Medicaid program integrity activities for program evaluation and technical assistance support. The States and CMS use the SPIA to gauge their collective progress in improving the overall integrity of the Medicaid program. In FY 2009, States reported recovering \$2.3 billion through program integrity efforts funded at \$393.5 million, for a \$5.58 to \$1 return on investment.

CMS also provides States assistance with “boots on the ground” for special investigative audits. Since October 2007, CMS has participated in 10 projects in three States, with the majority of activity occurring in Florida. States reported these reviews have resulted in \$33.2 million in savings through cost avoidance. CMS helped States review 654 providers, 43 home health agencies and DME suppliers, and 52 group homes. During those reviews, CMS and States interviewed 1,150 beneficiaries and took more than 400 actions against non-compliant providers (including, but not limited to fines, suspensions, licensing referrals, and MFCU referrals). Besides identifying inappropriate provider activities, these reviews also result in an ongoing sentinel effect in these vulnerable areas of the Medicaid program.

Since 1998, the Medicaid Fraud & Abuse Technical Advisory Group (TAG) and its State subject matter experts have provided guidance to CMS on a variety of program integrity issues. The TAG is comprised of a chair and 10 regional representatives, all of whom are senior State program integrity officials. CMS meets with the TAG as well as other State program integrity officials in a monthly national teleconference and in annual face-to-face meetings. The Medicaid Fraud & Abuse TAG provides our State partners a critical voice in CMS’ program integrity efforts.

To further build on this support, the Office of Management and Budget recently approved \$2.9 million to fund a pilot project that tests an automated tool that screens providers for risk of fraud through the Partnership Fund for Program Integrity Innovation. Currently, HHS and the States lack standardized Medicaid provider data, which hampers the detection of potential fraud. This tool, which is being developed and tested in conjunction with four State partners,

could help prevent improper payments by weeding out fraudulent providers and focusing limited State resources on areas where fraud is most likely to occur. By reconfiguring how HHS and the States identify fraud trends, this new pilot aims to improve fraud detection capabilities and drive significant savings. Pilot results are expected in November 2012.

#### **The Affordable Care Act and new Fraud-Fighting Tools at CMS**

In addition to State and Federal efforts already underway, in March 2010, the President signed into law the Affordable Care Act, which included additional program integrity provisions that strengthened Medicaid integrity efforts. Several of these provisions were based on proposals from CMS, State Medicaid agencies, and law enforcement agencies. The Affordable Care Act also incorporated many provisions supporting the goal of the President's Executive Order 13520, *Reducing Improper Payments*, signed in November 2009.

Further, in April 2010, the Secretary of HHS created the Center for Program Integrity (CPI) to coordinate fraud, waste, and abuse prevention, detection, and enforcement efforts across CMS' Medicare, Medicaid, and CHIP programs. CPI's four major approaches to key anti-fraud activities are:

- **Prevention:** CPI will prevent fraud, waste, and abuse by expanding the breadth of the program integrity strategy beyond post-payment recoveries to preventing improper payments and resolving problems as they occur.
- **Detection:** CPI will focus on risk and reward compliance by targeting initiatives that identify bad actors while reducing the burden on legitimate providers and suppliers.
- **Increasing transparency and accountability:** CPI will be transparent and accountable to its stakeholders by sharing performance metrics on key program integrity activities.
- **Recovery:** CPI will focus on key strategies that increase recoveries to the Medicare Trust Funds and the Treasury.

#### *Enhanced Screening and Other Enrollment Requirements*

On January 24, 2011, CMS announced a final rule (CMS-6028-FC) implementing a number of the Affordable Care Act's powerful new fraud prevention legislative tools. The final rule:

- **Creates a rigorous screening process** for providers and suppliers enrolling in Medicare, Medicaid, and CHIP to keep fraudulent providers out of those programs. Categories of providers and suppliers that pose a moderate or high risk of fraud, for example durable medical equipment suppliers and home health agencies, are subject to additional screening requirements. States must follow the same screening procedure for Medicaid-only providers that CMS requires for Medicare providers. States may rely on CMS' screening results for providers enrolled in both Medicare and Medicaid. States may also rely on the results of the screenings provided by another State for the same provider. In addition, a provider must be terminated from any State Medicaid or CHIP program if the provider has been terminated from Medicare or another State's Medicaid or CHIP program for cause.
- **Permits temporary enrollment moratoria of new providers and suppliers.** Medicare and State Medicaid programs can temporarily stop enrollment of a category of providers or of providers within a geographic area that has been identified as high risk, as long as that will not impact access to care for patients.
- **Permits the suspension of payments** to providers and suppliers suspected of fraud. The Secretary of HHS or the State Medicaid Agency can suspend payments pending the investigation of a credible allegation of fraud, stopping the flow of money to potentially fraudulent providers.

CMS also issued rules on May 5, 2010 (CMS-6010-IFC) implementing Affordable Care Act provisions that require providers and suppliers who order and refer certain items or services for Medicare and Medicaid beneficiaries to enroll in Medicare and Medicaid, maintain documentation on those orders and referrals, and include the National Provider Identifier on all fee-for-service (FFS) enrollment applications and claims.

*Established State Medicaid Recovery Audit Contractor (RAC) Program*

On September 14, 2011, CMS released the final rule for the Medicaid Recovery Audit Contractor (RAC) program, a key part of the Affordable Care Act's initiatives to curb fraud, waste, and abuse. The Medicaid RAC program will help States identify and recover improper Medicaid payments, and States are required to have their RAC programs in place, absent an

exception, by January 1, 2012. Similar to the Medicare FFS Recovery Audit Program, States will pay the RACs a contingency fee out of any overpayments recovered. RACs review claims after payment, using both simple and detailed reviews that include medical records. RACs are required to employ trained medical professionals, certified coders, and a physician, unless CMS grants an exception. Further, CMS' Medicaid Recovery Audit Contractor At-A-Glance web page on the CMS website<sup>2</sup> provides basic information to the public and interested stakeholders about each State's Recovery Audit program.

The Affordable Care Act expanded RACs to Medicaid because of RACs' success within original Medicare – between October 1, 2010 and September 30, 2011, the Medicare FFS Recovery Audit Program has corrected a total of \$939 million in improper payments. Over the next five years, we project that the Medicaid RAC effort will save the Medicaid program \$2.1 billion, of which \$910 million will be returned to the States. This effort complements the other efforts described above that target fraud, waste, and abuse in the health care system.

#### **Partnering with Stakeholders to Improve Medicaid Program Integrity**

Many of the Affordable Care Act provisions increase coordination between States, CMS, and our law enforcement partners at the HHS OIG and the DOJ. CMS is committed to working with our law enforcement partners, who take a lead role in investigating, determining, and prosecuting alleged fraud. By sharing information and requiring all States to terminate any provider or supplier that Medicare or another State terminated for cause, the Affordable Care Act ensures that fraudulent providers and suppliers cannot easily move from State to State or between Medicare and Medicaid. We are also providing training in the use of data analytic systems to the HHS OIG and DOJ, enabling investigators and law enforcement agents to more quickly detect and prosecute fraud schemes.

We also appreciate the efforts of the Government Accountability Office (GAO) and their recommendations on how to improve Medicaid program integrity. We continue to work to address the concerns raised by the GAO and to reduce improper payments and potential vulnerabilities in the Medicaid program. As a reminder, improper payments include both

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<sup>2</sup> <https://www.cms.gov/medicaidracs/home.aspx>

overpayments and underpayments, and are not necessarily fraudulent in nature. CMS' commitment to reducing improper payments is demonstrated by the review and audit activities described above, as well as our collaborative efforts with the States, and the establishment of the RAC program and other Affordable Care Act initiatives. For FY 2011, Medicaid's national improper payment rate is 8.1 percent -- a drop from 9.4 percent in FY 2010. Despite this decrease, we remain focused on improving program integrity in Medicaid, and are confident that the actions outlined in this testimony, as well as the continued efforts of our Federal, State, and public partners, will continue to reduce improper payments.

**Conclusion**

CMS is committed to the integrity of the Medicaid program, and ensuring that we continue to advance in fraud prevention and detection. This Administration has made an unprecedented effort to reduce improper payments in Federal health care programs, invest in program integrity strategies, and rein in fraud, waste, and abuse. With the Affordable Care Act provisions, anti-fraud strategies, and partnerships discussed today, we have more resources than ever before to implement important strategic changes in pursuing fraud, waste, and abuse. Through partnerships between stakeholders, we have learned from each other how to protect our health care system. I am confident that the smarter we work today, with our partners, technology, and through training and education, the stronger our system will be for years to come. I look forward to working with you in the future as we continue to make improvements in protecting the integrity of Medicaid and safeguarding taxpayer resources.

Mr. PLATTS. Thank you Ms. Brice-Smith.  
Mr. Cantrell.

#### STATEMENT OF GARY CANTRELL

Mr. CANTRELL. I am Gary Cantrell, assistant inspector general for investigations with the U.S. Department of Health and Human Services Office of Inspector General. I appreciate the opportunity to testify today about our efforts to combat Medicaid fraud.

First and foremost, I would like to thank Mr. West for coming forward with allegations of billing fraud on the part of Maxim Health-care Services. OIG recognizes that our success is dependent upon cooperation with courageous individuals like Mr. West. The documentation that he provided was critical to us in helping us unravel a broader scheme within Maxim Health-care that spanned across the Nation.

Our investigation resulted in Maxim agreeing to pay more than \$150 million to resolve civil and criminal allegations of fraud, the largest-ever settlement relating to home health services. Nine individuals, including three senior managers, also pled guilty to felony charges. This example highlights the potential for citizens and government to collaborate and curtail schemes that are harming the Nation's most vulnerable citizens. OIG encourages citizens to report suspected fraud, so we can investigate and bring to justice those responsible.

Medicaid fraud drains vital Federal and State program dollars that harms both recipients relying on those services as well as the American taxpayers. OIG has a team of over 480 highly skilled criminal investigators located throughout the country. And in fiscal year 2011, our enforcement efforts resulted in record numbers that included over 720 criminal convictions and \$4.6 billion in expected recoveries. Nearly 400 of these actions addressed schemes related to Medicaid fraud, and over \$1.1 billion is expected to be returned to the program.

The types of schemes perpetrated in the Medicaid program in many ways mirror Medicare fraud schemes. For example, we see billing for services not rendered, medical identity theft, false statements, bribery and kickbacks. These have been especially common in relation to home health prescription drugs charitable medical equipment and transportation services.

Data access is critical to our enforcement efforts in both Medicare and Medicaid. OIG has worked closely with CMS to expand our access to national Medicare claims data. This improved access has enabled OIG to more effectively identify Medicare fraud trends. And that allows our agents to more efficiently investigate allegations of fraud. Unfortunately, this is not the case on the Medicaid side.

Our inability to access timely comprehensive data impedes effective oversight of the program. CMS's Medicaid statistical information system is the only source of nationwide Medicaid claims data, and weaknesses in the system limit its usefulness for effective oversight and monitoring of the program. For example, the system does not capture many of the data elements necessary for us to detect fraud, waste, and abuse.

As in the Maxim case, Medicaid presents our investigators with unique data challenges. Why? It's because the data does not exist in a single location. Rather, it exists in independent systems across 50 States and the District of Columbia. We understand that CMS is taking steps to collect more timely comprehensive data from the States, and we hope they move quickly to accomplish this goal.

State Medicaid fraud control units have been valuable partners in our investigative efforts. Our number of joint investigations has nearly doubled over the last 5 years. And to improve on our success, we believe that Medicaid fraud control units could also benefit from enhanced analytic capabilities with regard to their State Medicaid data. This will lead to improved oversight and enforcement.

In closing, we need to make a lasting impact on Medicaid fraud. The need has never been more important. The Congressional Budget Office estimates that in 2014, 16 million new recipients will be added to the Medicaid program. Therefore, it is especially critical that OIG have access to timely comprehensive data in order to protect these Federal and State dollars.

Together, we must work to eliminate vulnerabilities and ensure that we are positioned to effectively oversee this program for years to come. Thank you for your support of our mission and I would be happy to answer any questions you have.

[The prepared statement of Mr. Cantrell follows:]

Testimony of:  
Gary Cantrell  
Assistant Inspector General for Investigations  
U.S. Department of Health and Human Services  
Office of Inspector General

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### **INTRODUCTION**

Good morning Chairmen, Ranking Members, and other distinguished Members of the Subcommittees. I am Gary Cantrell, Assistant Inspector General for Investigations with the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG). Thank you for the opportunity to testify about OIG's efforts to combat Medicaid fraud. My testimony will provide an overview of certain areas of Medicaid fraud, describe our law enforcement efforts and investigative challenges, and make recommendations to improve Medicaid oversight.

### **BACKGROUND**

OIG's mission is to protect the integrity of over 300 HHS programs, as well as the health and welfare of program beneficiaries. In fulfillment of this mission, we investigate and hold accountable those who defraud and abuse the Department's programs, promote provider compliance, and recommend program safeguards.

OIG has a robust program of audits, evaluations, and investigations directed towards identifying, preventing, and stopping Medicaid fraud, waste, and abuse. OIG employs more than 1,700 dedicated professionals, including a cadre of over 480 highly skilled criminal investigators, trained to conduct criminal, civil, and administrative investigations of fraud related to HHS programs and operations. Our special agents have full law enforcement authority to effect a broad range of actions, including the execution of search and arrest warrants. We use state-of-the-art technologies and a wide range of tools in carrying out these important responsibilities. We are the Nation's premiere health care fraud law enforcement agency.

Our constituents are the American taxpayers, and we work hard to ensure that their money is not stolen or misused. In fiscal year 2011, OIG opened over 2,000 investigations. Enforcement efforts for the same fiscal year resulted in record numbers that included over 1,100 criminal and

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civil actions and \$4.6 billion in expected recoveries. Of this, nearly 400 criminal and civil actions are related to Medicaid and over \$1.1 billion in restitutions or recoveries are to be returned to Federal and State Medicaid programs.

#### **MEDICAID FRAUD OVERVIEW**

Medicaid is an important health care benefit for approximately 56 million Americans with limited incomes or disabilities that rely on the program for medical care. The program is funded jointly by Federal and State governments. Generally speaking, the Federal Government sets broad guidelines for Medicaid, and the States have flexibility to administer the program within those guidelines. The scope and composition of each Medicaid program vary significantly across States. In fiscal year 2011, the program accounted for nearly \$275 billion in Federal spending. Medicaid fraud drains vital Federal and State program dollars, in turn, harming both recipients and the American taxpayers.

#### ***OIG is leading the fight against health care fraud***

OIG brings a formidable combination of cutting edge techniques and traditional investigative skills to the fight against Medicaid fraud. This has been useful in uncovering a range of schemes, especially those relating to home health and personal care services, prescription drug diversion, durable medical equipment, and ambulance transportation. These schemes have involved many types of fraud, including billing for equipment not provided or for services not rendered, medical identity theft, false statements, bribery, and kickbacks.

We receive information related to these schemes through a variety of sources, including the Centers for Medicare & Medicaid Services (CMS) as well as qui tam referrals from the Department of Justice (DOJ).

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One such example is our recent investigation of Maxim Healthcare Services, Inc. (Maxim), which was initiated on the basis of Mr. Richard West's qui tam complaint against the company. Mr. West was a patient of Maxim, one of the Nation's leading providers of home health services. The settlement resolved allegations that between 1998 and 2009, Maxim filed false claims with State Medicaid programs and the Department of Veterans Affairs for services either not provided, not sufficiently documented to show they were provided, or delivered from unlicensed offices. Our investigation resulted in a settlement in which Maxim agreed to pay more than \$150 million to resolve civil and criminal charges. The settlement represents the largest-ever involving home health services. The company has also entered into a 5-year Corporate Integrity Agreement (CIA) with OIG, which requires additional reforms and monitoring under our supervision.

In addition, nine individuals--eight former Maxim employees, including three senior managers, and the parent of a former Maxim patient--have pleaded guilty to felony charges arising from the submission of fraudulent billings to government health care programs, the creation of fraudulent documentation associated with government program billings, or false statements to government health care program officials regarding Maxim's activities.

The Maxim case is also an example of a recent increase in fraud cases involving home health and personal care providers. According to data obtained from the Medicaid Fraud Control Units (MFCUs), as of the fourth quarter of 2010, we are now seeing more Medicaid fraud cases involving home health services than any other single program area. The vast majority involve personal care services, which are nonmedical services provided by unskilled aides who assist recipients with activities of daily living, such as bathing, meal preparation, and feeding.

As stated above, we are also witnessing persistent fraud trends surrounding misuse of prescription drugs. These cases are among the most deplorable because they involve the over-prescribing of dangerous narcotics and sometimes the diversion of dangerous narcotics to street drugs, often causing harmful or deadly results to those who abuse them. We saw a particularly

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egregious example of this in the State of Washington, which resulted in the death of a patient from an overdose of Oxycodone prescribed by the patient's physician. The physician had established relationships in the local heroin-user community and was writing medically unnecessary prescriptions to patients for narcotics, including Oxycodone and Vicodin. In this case, the physician was incarcerated and ordered to pay \$700,000 in restitution. The physician also lost her medical license and was excluded from all Federal health care programs.

***OIG is collaborating with Medicaid Fraud Control Units***

State MFCUs have played a significant role in helping us identify the fraudulent activities discussed above and other fraud trends in Medicaid. The number of our joint investigations with MFCUs nearly doubled in the past 5 years from 621 to over 1,100. The collaboration with MFCUs and other law enforcement partners has been critical, as many of the providers defrauding Medicaid have operations throughout the United States.

For nationwide investigations, the National Association of Medicaid Fraud Control Units (NAMFCU) plays a coordinating role in marshaling the investigative efforts of the many individual States affected by fraud. In a recent nationwide investigation, OIG collaborated with the MFCUs, through a NAMFCU committee, as well as other law enforcement partners, to investigate the pediatric dental clinic Small Smiles, managed by FORBA Holdings, LLC (FORBA). The investigation revealed that FORBA, among other things, allegedly caused the submission of claims to Medicaid for dental services that either were not medically necessary or did not meet professionally recognized standards of care. These unnecessary services included pulpomies (baby root canals), placing multiple crowns, administering anesthesia, performing extractions, and providing fillings and/or sealants. This investigation resulted in an agreement from FORBA to pay over \$24 million plus interest and enter into a 5-year quality-of-care CIA to settle allegations that it performed unnecessary and often painful services on children to maximize Medicaid reimbursement.

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*OIG is engaging health care providers and the public in the fight against fraud*

OIG is using a variety of tools to engage all our stakeholders in our efforts to prevent, detect, and combat health care fraud. OIG is extensively using the Internet to enlist the health care industry and the public in the fight against fraud. Our Web site, [www.oig.hhs.gov](http://www.oig.hhs.gov), offers a wide range of information to health care providers and patients about ways to reduce the risk of fraud and abuse. These resources include OIG's provider compliance training, voluntary compliance program guidance, fraud alerts, self-disclosure protocol, and advisory opinions on fraud and abuse laws.<sup>1</sup> OIG also offers a guide to prevent medical identity theft.<sup>2</sup> And we recently published *A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse*,<sup>3</sup> which summarizes five main Federal fraud and abuse laws and provides guidance on how physicians should comply with these laws in their relationships with payers, vendors, and fellow providers.

The OIG Hotline is another valuable fraud-fighting tool, which allows individuals to contact OIG directly through our Web site or by calling 1-800-HHS-TIPS to provide information regarding these and other types of fraud, waste, and abuse schemes in HHS programs.<sup>4</sup>

We have also posted OIG's list of the 10 most wanted health care fraud fugitives, including photographs and details about the individuals and their schemes.<sup>5</sup> One of our top most wanted fugitives, Dr. Gautam Gupta, is wanted for allegedly defrauding Medicaid and private insurance companies of millions of dollars. Gupta owned and operated several weight loss nutrition clinics in northern Illinois and the Chicago metropolitan area. According to the arrest warrant, the clinic defrauded Medicaid and private insurance companies of as much as \$24 million from unwarranted medical tests and false billings for doctor visits.

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<sup>1</sup> Available at <http://oig.hhs.gov/compliance/>.

<sup>2</sup> Available at <http://oig.hhs.gov/fraud/medical-id-theft/index.asp>.

<sup>3</sup> Available at <http://oig.hhs.gov/compliance/physician-education/index.asp>.

<sup>4</sup> Information about the OIG Hotline can be found at <http://oig.hhs.gov/fraud/report-fraud/index.asp>.

<sup>5</sup> Available at <http://oig.hhs.gov/fraud/fugitives/index.asp>.

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We are asking the public to help us bring these fugitives to justice by reporting any information about their whereabouts to our Web site or Fugitive Hotline (1-888-476-4453). A recent call to the Hotline led to the capture of one of OIG's top 10 most wanted fugitives; we hope, with the public's help, to also bring Gupta to justice in the near future.

#### **RECOMMENDATIONS TO IMPROVE MEDICAID OVERSIGHT**

OIG uses data to detect possible fraudulent billing at the earliest possible stage. In combating Medicare fraud, OIG has worked closely with its partners, including CMS, to provide our special agents with access to more data sources and real-time access to Medicare claims data. This has been critical in our enforcement efforts and has enabled us to develop a consolidated data analysis center, which integrates business intelligence tools and develops new data analytics to enhance our fraud detection efforts. This has improved OIG's ability to access, analyze, and share data with our law enforcement partners and accomplish this in a manner consistent with applicable privacy, security, and disclosure requirements. The centralized data analysis center has already enhanced the efficiency and coordination of our collective efforts by enabling law enforcement to identify a broader range of potentially fraudulent activities and more efficiently use our investigative resources. Much of our Medicare enforcement success can be attributed to our timely access to useful data, which has played a pivotal role in our recent enforcement results.

#### ***Inability to access useful, timely Medicaid data hinders oversight efforts***

In contrast to Medicare, our efforts to use data analytics to oversee Medicaid have been impeded by the lack of national-level, timely Medicaid data. Medicaid presents unique data challenges because key program operations occur across 50 States, the District of Columbia, and U.S. territories, rather than on a national level. The Medicaid Statistical Information System (MSIS) is the only source of nationwide Medicaid claims information, and weaknesses in MSIS data limit its usefulness for oversight and monitoring of the program. In a 2009 report, OIG

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determined that MSIS data were an average of 1 1/2 years old when released by CMS to users for data analysis purposes.<sup>6</sup> In law enforcement, a 1 1/2-year timelag is an eternity, especially when dealing with astute criminals who cash out quickly and move on to the next scheme. Moreover, MSIS was not designed for anti-fraud efforts and lacks many basic data elements that can assist in fraud, waste, and abuse detection. Additionally, MSIS does not include complete data received through managed care plans, despite the fact that the majority of Medicaid beneficiaries received their health care services through Medicaid managed care.<sup>7</sup>

Our investigation of Maxim illustrates challenges faced in conducting nationwide investigations involving Medicaid fraud. Maxim is a nationwide conglomerate providing home health services in over 40 States, which made it difficult to collect comprehensive Medicaid claims data in support of our investigation. We understand that CMS is working to address these and other data issues. We hope that CMS moves forward expeditiously to systematically collect comprehensive data and make the data available to us.

We further recommend that MFCUs' abilities to access data be enhanced. Our goal is to help them establish their own analytic capabilities with regard to their respective State Medicaid data. To support this, OIG issued a notice of proposed rulemaking to permit MFCUs, under certain conditions, to use Federal matching funds to identify fraud through screening and analyzing State Medicaid claims data.<sup>8</sup> We believe this will enhance our enforcement efforts and improve Medicaid oversight.

### **CONCLUSION**

The need to protect Medicaid from fraud has never been more important. The Congressional Budget Office estimates that in 2014, 16 million new recipients will join the Medicaid program.

<sup>6</sup> "MSIS Data Usefulness for Detecting Fraud, Waste, and Abuse," OEI-04-07-00240, August 2009, available at <http://oig.hhs.gov/oei/reports/oei-04-07-00240.pdf>.

<sup>7</sup> "Medicaid Managed Care Encounter Data: Collection and Use," OEI-07-06-00540, May 2009, available at <http://oig.hhs.gov/oei/reports/oei-07-06-00540.pdf>.

<sup>8</sup> 76 Fed. Reg. 52 (March 17, 2011), pp. 14637-14641.

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States and the Federal Government alike must work to eliminate vulnerabilities and ensure that we are positioned to effectively oversee the program in the years to come. It is critical that OIG have access to timely and accurate Medicaid data to protect program recipients and expenditures. As shown through our accomplishments in Medicare, data analysis is vital to fighting health care fraud. We believe comparable access to Medicaid data will yield similar successes.

To that end, OIG will continue moving forward to implement mechanisms to protect the integrity and vitality of Medicaid and punish those who defraud the program. We will continue partnering with those who share our objectives to safeguard the programs that protect the health of all Americans and provide essential health care to those in need.

Thank you for your support of OIG's mission. I would be happy to answer any questions.

Mr. PLATTS. Thank you Mr. Cantrell.  
Ms. Yocom.

#### STATEMENT OF CAROLYN YOCOM

Ms. YOCOM. Mr. Chairmen, ranking members, and members of the subcommittees, I am pleased to be here as you discuss improper payments in fraud in the Medicaid program. My remarks today will focus on an important challenge as well as opportunities that CMS faces, given its expanded role in Medicaid program integrity.

In 2005, GAO testified that CMS needed to increase its commitment to helping States fight Medicaid fraud, waste, and abuse. That year, Congress passed the Deficit Reduction Act, which provided for the creation of the Medicaid Integrity Program and other provisions. The Patient Protection and Affordable Care Act gave CMS and States added responsibilities and new oversight tools. Thus CMS's spending for and attention to Medicaid program integrity activities has grown, primarily through the creation of the Medicare Integrity Group or the MIG.

The MIG gradually hired staff and contractors to implement a set of core activities, such as reviewing and auditing Medicaid provider claims and providing education to State officials and Medicaid providers. In 2005, CMS had approximately 8 staff years focused on program integrity. Today it has over 80 of the 100 statutorily required positions authorized in the DRA.

However, more is not necessarily better. A key challenge faced by the MIG is the need to avoid duplication of Federal and State program integrity efforts, particularly in auditing provider claims, which has been primarily a State function. The amount of overpayments that the MIG identifies is not commensurate with its costs or with amounts identified by some States. For example, in a similar number of audits, New York reported identifying more than \$372 million in overpayments compared with \$15 million identified through the national provider audits.

In 2011, the MIG reported plans to redesign its national provider audit program to allow for greater coordination with States on data policies and audit measures. While it remains to be seen whether these changes would help identify additional overpayments, the proposed redesign appears promising. In particular, the collaborative projects currently underway in 13 States would first allow States to augment their own resources; second, address audit targets that States have too few resources to handle; and third, assist States with less analytic capability. These projects could help avoid duplication as well as strengthen Federal and State efforts.

CMS's expanded role also offers the opportunity to enhance State program integrity efforts, but more consistent data are needed. For example, two core activities of the MIG, triannual comprehensive reviews and annual assessments, collect similar information such as States' program integrity planning, prevention activities, and recoveries. However, some of the data that States report show implausible and/or inconsistent State responses. Improved data would allow CMS to further target assistance to States through the MIG's primary training initiative, the Medicaid Integrity Institute. Not only is the training offered at no cost to States, but such venues

provide opportunities for State program integrity officials to develop relationships with their counterparts in other States. Such relationships are critical in a program like Medicaid where providers and beneficiaries can cross State lines and repeat improper or even fraudulent behaviors.

Since fiscal year 2008, the institute has trained over 2,200 State employees. Instituted expenditures are a small portion of MIG's spending, just \$1.3 million of its \$75 million budget. Yet they could greatly increase networks across States and disseminate best practices for ensuring appropriate payments in Medicaid.

For many years, Medicaid has been a critical part of the health care safety, providing health care services to some of our Nation's most vulnerable populations. This heightens CMS's responsibility to ensure that billions of program dollars are appropriately spent. In these difficult economic times, it creates an even greater imperative. The challenges of coordination are significant for States and for CMS. No less significant is the need for improved data to prevent overpayments.

But there's also an opportunity for the MIG to work with States to disseminate and improve oversight of program spending and hopefully decrease the level of improper payments. This concludes my prepared remarks. I'd be happy to answer any questions you or members of the subcommittees may have.

[The prepared statement of Ms. Yocom follows:]

United States Government Accountability Office

**GAO**

**Testimony**

Before the Subcommittees on Government Organization,  
Efficiency and Financial Management and Health Care, District of  
Columbia, Census and the National Archives, Committee on  
Oversight and Government Reform, House of Representatives

For Release on Delivery  
Expected at 10:00 a.m. EST  
Wednesday, December 7, 2011

**MEDICAID PROGRAM  
INTEGRITY**

**Expanded Federal Role  
Presents Challenges to and  
Opportunities for Assisting  
States**

Statement of Carolyn L. Yocom  
Director, Health Care





Highlights of GAO-12-288T, a testimony before the Subcommittees on Government Organization, Efficiency and Financial Management and Health Care, District of Columbia, Census and the National Archives, Committee on Oversight and Government Reform, House of Representatives

### Why GAO Prepared This Testimony

The Centers for Medicare & Medicaid Services (CMS), the federal agency that oversees Medicaid, estimated that improper payments in the federal-state Medicaid program were \$21.9 billion in fiscal year 2011. The Deficit Reduction Act of 2005 established the Medicaid Integrity Program and gave CMS an expanded role in assisting and improving the effectiveness of state activities to ensure proper payments. Making effective use of this expanded role, however, requires that federal resources are targeted appropriately and do not duplicate state activities.

GAO was asked to testify on Medicaid program integrity. GAO's statement focuses on how CMS's expanded role in ensuring Medicaid program integrity (1) poses a challenge because of overlapping state and federal activities regarding provider audits and (2) presents opportunities through oversight to enhance state program integrity efforts.

To do this work, GAO reviewed CMS reports and documents on Medicaid program integrity as well as its own and others' reports on this topic. In particular, GAO reviewed CMS reports that documented the results of its state oversight and monitoring activities. GAO also interviewed CMS officials in the agency's Medicaid Integrity Group (MIG), which was established to implement the Medicaid Integrity Program. This work was conducted in November and December 2011. GAO discussed the facts in this statement with CMS officials.

View GAO-12-288T. For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

December 7, 2011

## MEDICAID PROGRAM INTEGRITY

### Expanded Federal Role Presents Challenges to and Opportunities for Assisting States

#### What GAO Found

The key challenge faced by the Medicaid Integrity Group (MIG) is the need to avoid duplication of federal and state program integrity efforts, particularly in the area of auditing provider claims. In 2011, the MIG reported that it was redesigning its national provider audit program. Previously, its audit contractors were using incomplete claims data to identify overpayments. According to MIG data, overpayments identified by its audit contractors since fiscal year 2009 were not commensurate with its contractors' costs. The MIG's redesign will result in greater coordination with states on a variety of factors, including the data to be used. It remains to be seen, however, whether these changes will result in an increase in identified overpayments. The table below highlights the MIG's core oversight activities, which were implemented from fiscal years 2007 through 2009.

MIG's Core Oversight Activities and Fiscal Year Implemented

MIG activities	Description
Comprehensive program integrity reviews (fiscal year 2007)	Every 3 years, the MIG conducts a comprehensive management review of each state's Medicaid program integrity procedures and processes. Through the reviews, CMS assesses the effectiveness of the state's program integrity efforts and determines whether the state's policies and procedures comply with federal regulations.
Technical assistance (fiscal year 2007)	In fiscal year 2009, the MIG responded to 504 requests for technical assistance from 49 states, providers, advocates and others. Common topics included policy/regulatory requirements on disclosures, law enforcement activities, and fraud detection tools.
Medicaid Integrity Institute (fiscal year 2007)	The institute is the first national Medicaid integrity training program. CMS executed an interagency agreement with the Department of Justice to house the institute at the Department's National Advocacy Center, located at the University of South Carolina. The institute offers substantive training, technical assistance, and support to states in a structured learning environment.
National Provider Audit Program (fiscal year 2009)	Separate contractors (1) analyze claims data to identify aberrant claims, and potential billing vulnerabilities; and (2) conduct post-payment audits based on data analysis leads in order to identify overpayments to Medicaid providers.
State program integrity assessments (fiscal year 2009)	These annual assessments represent the first national baseline collection of data on state Medicaid integrity activities for the purposes of program evaluation and technical assistance support. The data provided by states are used to populate a one-page profile covering topics such as program integrity staffing and expenditures, audits, fraud referrals, and recoveries.
Education contractors (fiscal year 2009)	The education contractors develop materials in order to educate and train providers on payment integrity and quality of care issues.

Source: CMS.

The MIG's core oversight activities present an opportunity to enhance state efforts through the provision of technical assistance and the identification of training opportunities. The MIG's assessment of state program integrity efforts during triennial onsite reviews and annual assessments will need to address data inconsistencies identified during these two activities. Improved consistency will help ensure that the MIG is appropriately targeting its resources. The Medicaid Integrity Institute appears to address a state training need and create networking opportunities for program integrity staff.

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Chairmen Platts, Gowdy, and Members of the Subcommittees:

I am pleased to be here today to discuss Medicaid program integrity, that is, preventing improper payments that result from fraud, waste, and abuse.<sup>1</sup> Until the Deficit Reduction Act of 2005 (DRA) expanded the role of the Centers for Medicare & Medicaid Services (CMS), the federal agency that oversees Medicaid, Medicaid program integrity had been primarily a state responsibility.<sup>2</sup> CMS's expanded role presents an opportunity to assist and improve the effectiveness of state activities, but also requires that federal resources are targeted appropriately and do not duplicate state activities.

Medicaid is jointly funded by federal and state governments. It is one of the largest social programs in the federal budget—covering about 67 million people in fiscal year 2010—and one of the largest components of state budgets. In fiscal year 2010, Medicaid expenditures totaled about \$401 billion, with a federal share of \$270 billion and a state share of \$132 billion. As a result of flexibility in the program's design, Medicaid consists of 56 distinct state-based programs.<sup>3</sup> The challenges inherent in overseeing a program of Medicaid's size and diversity make the program vulnerable to improper payments, which may be the result of fraud, waste, and abuse.<sup>4</sup> Because of the program's risk of improper payments as well as insufficient federal and state oversight, we added Medicaid to

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<sup>1</sup>Medicaid is the federal-state program that covers acute health care, long-term care, and other services for certain categories of low-income individuals.

<sup>2</sup>See Pub. L. No. 109-171, § 6034, 120 Stat. 3, 74-78 (2006).

<sup>3</sup>The federal government matches states' expenditures for most Medicaid services using a statutory formula based on each state's per capita income. The 56 Medicaid programs include one for each of the 50 states, the District of Columbia, Puerto Rico, Samoa, Guam, the Commonwealth of the Northern Mariana Islands, and the United States Virgin Islands.

<sup>4</sup>Fraud involves an intentional act or representation to deceive with the knowledge that the action or representation could result in gain. Waste results from clerical errors or the provision of medically unnecessary services. Abuse typically involves actions that are inconsistent with acceptable business and medical practices that result in unnecessary program costs. See, e.g., 42 C.F.R. § 455.2 (2010).

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our list of high-risk programs in January 2003.<sup>5</sup> CMS estimated that Medicaid improper payments were \$21.9 billion for fiscal year 2011.<sup>6</sup>

States are the first line of defense against Medicaid improper payments. Specifically, they must comply with federal requirements to ensure the qualifications of the providers who bill the program, detect improper payments, recover overpayments, and refer suspected cases of fraud and abuse to law enforcement authorities. At the federal level, CMS, an agency within the Department of Health and Human Services (HHS), is responsible for supporting and overseeing state Medicaid program integrity activities.

In 2005, we testified that CMS needed to increase its commitment—both the alignment of resources and strategic planning—to helping states fight Medicaid fraud, waste and abuse.<sup>7</sup> Subsequently, the DRA established the Medicaid Integrity Program and included other provisions designed to increase CMS's support for state activities to address Medicaid fraud, waste, and abuse. The DRA provided appropriations to implement the Medicaid Integrity Program, and the Patient Protection and Affordable Care Act (PPACA) enacted in March 2010 gave CMS and states additional provider and program integrity oversight tools.<sup>8</sup>

You asked GAO to testify today on Medicaid program integrity. My remarks focus on how CMS's expanded role in ensuring Medicaid program integrity (1) poses a challenge because of overlapping state and federal activities, particularly in the area of auditing provider claims; and (2) presents opportunities through oversight to enhance state program

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<sup>5</sup>See GAO, *Major Management Challenges and Program Risks: Department of Health and Human Services*, GAO-03-101 (Washington, D.C.: January 2003).

<sup>6</sup>In its *Fiscal Year 2011 Agency Financial Report*, HHS calculated and reported the 3-year (2009, 2010, and 2011) weighted average national payment error rate for Medicaid of 8.1 percent. See *Department of Health and Human Services FY 2011 Agency Financial Report* (Washington, D.C.: Nov. 15, 2011).

<sup>7</sup>See GAO, *Medicaid Fraud and Abuse: CMS's Commitment to Helping States Safeguard Program Dollars Is Limited*, GAO-05-855T (Washington, D.C.: June 28, 2005).

<sup>8</sup>Pub. L. No. 111-148, 124 Stat. 119, as amended by the Health Care Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, 124 Stat. 1029. For example, PPACA required states to have Medicaid Recovery Audit Contractors, increased provider ownership reporting requirements, and allowed CMS to suspend payments to providers on the basis of a credible allegation of fraud.

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integrity efforts. To do this work, we reviewed CMS reports and documents on Medicaid program integrity as well as our own and others' reports on this topic. In particular, we reviewed CMS reports that documented the results of its state oversight and monitoring activities. We also interviewed CMS officials in the agency's Medicaid Integrity Group, which was established to implement the Medicaid Integrity Program. We conducted our work in November and December 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. The data presented in this statement were obtained from CMS and we did not independently verify their reliability. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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## Background

CMS is responsible for overseeing Medicaid and state Medicaid agencies are responsible for administering the program. Although each state is subject to federal requirements, it develops its own Medicaid administrative structure for carrying out the program including its approach to program integrity. Within broad federal guidelines, each state establishes eligibility standards and enrolls eligible individuals; determines the type, amount, duration, and scope of covered services; sets payment rates for covered services; establishes standards for providers and managed care plans; and ensures that state and federal funds are not spent improperly or diverted by fraudulent providers. However, state Medicaid programs do not work in isolation on program integrity; instead, there are a large number of federal agencies, other state entities, and contractors with which states must coordinate.

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## State Medicaid Program Integrity Activities

Generally, each state's Medicaid program integrity unit uses its own data models, data warehouses, and approach to analysis. States often augment their in-house capabilities by contracting with companies that specialize in Medicaid claims and utilization reviews. However, as program administrators, states have primary responsibility for conducting program integrity activities that address provider enrollment, claims review, and case referrals. Specifically, CMS expects states to

- collect and verify basic information on providers, including whether the providers meet state licensure requirements and are not prohibited from participating in federal health care programs

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- maintain a mechanized claims processing and information system known as the Medicaid Management Information System (MMIS). MMIS can be used to make payments and to verify the accuracy of claims, the correct use of payment codes, and a beneficiary's Medicaid eligibility.<sup>9</sup>
  - operate a Surveillance and Utilization Review Subsystem (SURS) in conjunction with the MMIS that is intended to develop statistical profiles on services, providers, and beneficiaries in order to identify potential improper payments. For example, SURS may apply automatic post-payment screens to Medicaid claims in order to identify aberrant billing patterns.
  - submit all processed Medicaid claims electronically to CMS's Medical Statistical Information System (MSIS). MSIS does not contain billing information, such as the referring provider's identification number or beneficiary's name, because it is a subset of the claims data submitted by states. States provide data on a quarterly basis and CMS uses the data to (1) analyze Medicaid program characteristics and utilization for services covered by state Medicaid programs, and (2) generate various public use reports on national Medicaid populations and expenditures.
  - refer suspected overpayments or overutilization cases to other units in the Medicaid agency for corrective action and refer potential fraud cases to other appropriate entities for investigation and prosecution.

Our reports and testimonies from 2001 through 2006 identified gaps in state program integrity activities and noted that the support provided by CMS to states was hampered by resource constraints.<sup>10</sup> For example, in 2004, we reported that 15 of 47 states responding to our questionnaire

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<sup>9</sup>States provide CMS with claims data for use in estimating a Medicaid payment error rate. CMS developed the Payment Error Rate Measurement program to comply with the Improper Payments Information Act of 2002. The error rate is not a "fraud rate" but simply a measurement of payments made that did not meet statutory, regulatory, or administrative requirements.

<sup>10</sup>See GAO, *Medicaid: State Efforts to Control Improper Payments Vary*, GAO-01-662 (Washington, D.C.: June 7, 2001); *Medicaid Program Integrity: State and Federal Efforts to Prevent and Detect Improper Payments*, GAO-04-707 (Washington, D.C.: July 16, 2004); GAO-05-855T; *Medicaid Integrity: Implementation of New Program Provides Opportunities For Federal Leadership to Combat Fraud, Waste, and Abuse*, GAO-06-578T (Washington, D.C.: March 28, 2006).

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did not affirm that they conducted data mining, defined as analysis of large data sets to identify unusual utilization patterns, which might indicate provider abuse.

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**Recent Legislation Has  
Conferred New  
Responsibilities on CMS  
and States**

The DRA established the Medicaid Integrity Program to provide effective federal support and assistance to states to combat fraud, waste, and abuse. To implement the Medicaid Integrity Program, CMS created the Medicaid Integrity Group (MIG), which is now located within the agency's Center for Program Integrity. The DRA also required CMS to hire contractors to review and audit provider claims and to educate providers on issues such as appropriate billing practices.

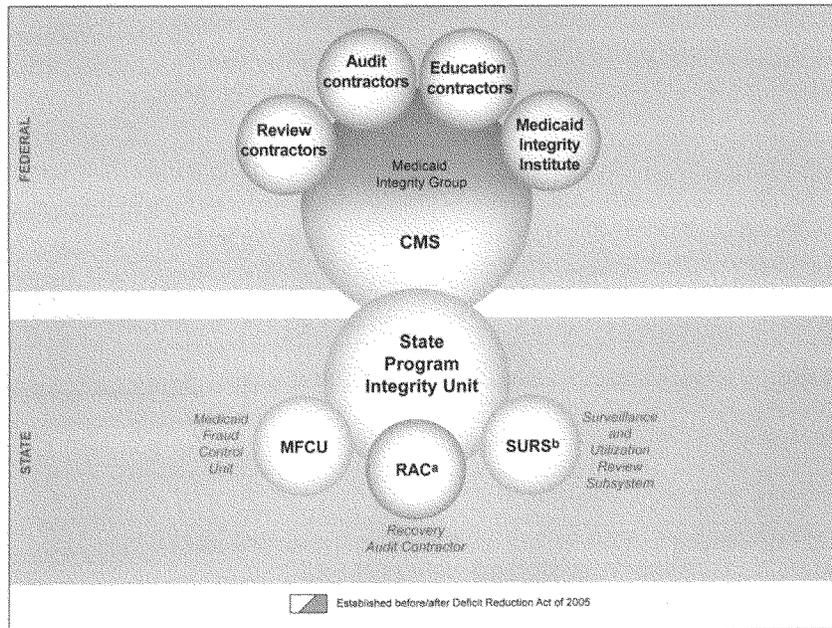
The Medicaid Recovery Audit Contractor (RAC) program was established by PPACA.<sup>11</sup> Each state must contract with a RAC, which is tasked with identifying and recovering Medicaid overpayments and identifying underpayments. Each state's RAC is required to be operational by January 1, 2012. Medicaid RACs will be paid on a contingency fee basis—up to 12.5 percent—of any recovered overpayments and states are required to establish incentive payments for the detection of underpayments.<sup>12</sup> Figure 1 identifies the key federal and state entities responsible for Medicaid program integrity.

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<sup>11</sup>Pub. L. No. 111-148, §6411, 124 Stat. 119,773.

<sup>12</sup>CMS will not provide federal financial participation for administrative expenditure claims if a state establishes a RAC contingency fee that is in excess of the highest Medicare RAC contingency fee rate, unless a state requests an exception from CMS and provides an acceptable justification. Any additional fees must be paid out of state-only funds.

Figure 1: Key Federal and State Entities Responsible for Medicaid Program Integrity before and after the Deficit Reduction Act of 2005



Source: GAO.

Notes: Other federal entities involved in Medicaid program integrity not included in this figure include: CMS's Office of Financial Management and its Center for Medicaid, CHIP, Survey and Certification; the Department of Health and Human Services' Office of Inspector General; the Federal Bureau of Investigation; and the Department of Justice.

<sup>a</sup>States are required to contract with at least one RAC, which must be operational beginning January 2012.

<sup>b</sup>SURS may be performed by an outside contractor (as depicted here) or state program integrity staff may carry out the SURS function, in which case it would be integral to the State Program Integrity Unit.

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**Fraud Investigation and Prosecution**

Fraud detection and investigations often require more specialized skills than are required for the identification of improper payments because investigators must establish that an individual or entity *intended* to falsify a claim to achieve some gain. As a result, fraud is more difficult to prove than improper payments and requires the involvement of entities that can investigate and prosecute fraud cases. In 1977, Congress authorized federal matching funds for the establishment of independent state Medicaid Fraud Control Units (MFCU).<sup>13</sup> MFCUs are responsible for investigating and prosecuting Medicaid fraud. In general, they are located in State Attorneys General's offices. MFCUs can, in turn, refer some cases to federal agencies that have longstanding responsibility for combating fraud, waste, and abuse in Medicare and Medicaid—the HHS's Office of Inspector General (HHS-OIG), the Federal Bureau of Investigation (FBI), and the Department of Justice.

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**CMS's MIG Implemented Core Activities from 2006 through 2009 but Effective Coordination Is Needed Because of Overlap with Ongoing State Efforts**

A key challenge CMS faces in implementing the statutorily required federal Medicaid Integrity Program is ensuring effective coordination to avoid duplicating state program integrity efforts. CMS established the MIG in 2006 and it gradually hired staff and contractors to implement a set of core activities, including the (1) review and audit of Medicaid provider claims; (2) education of state program integrity officials and Medicaid providers; and (3) oversight of state program integrity activities and provision of assistance. Because states also routinely review and audit provider claims, the MIG recognized that coordination was key to avoiding duplication of effort. In 2011, the MIG reported that it was redesigning its national provider audit program to allow for greater coordination with states on data, policies, and audit measures. According to MIG data, overpayments identified by its review and audit contractors over the first 3 years of the national audit program were not commensurate with the contractors' costs.

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**Core MIG Activities Were Implemented Gradually from 2006 to 2009**

The DRA provided CMS with the resources to hire staff whose sole duties are to assist states in protecting the integrity of the Medicaid program. The MIG's core activities were implemented gradually from fiscal year 2006 to 2009. The DRA provided start up funding of \$5 million for fiscal

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<sup>13</sup>Medicare-Medicaid Anti-Fraud and Abuse Amendments, Pub. L. No. 95-142, §91 Stat. 1175, 1201.

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year 2006, increasing to \$50 million for each of the subsequent 2 fiscal years, and \$75 million per year for fiscal year 2009 and beyond.<sup>14</sup> One of the first activities initiated by the MIG in fiscal year 2007 was comprehensive program integrity reviews to assess the effectiveness of states' activities, which involved eight, week-long onsite visits that year.<sup>15</sup> One of the last activities to be implemented was the statutorily required National Provider Audit Program where MIG contractors review and audit Medicaid provider claims. In fiscal year 2005, we reported that CMS devoted 8.1 full time equivalent staff years to support and oversee states' anti-fraud-and-abuse operations, which, in 2010, had grown to 83 out of the 100 DRA authorized full time equivalent staff years.<sup>16</sup> Table 1 describes six core MIG activities and the fiscal year in which those activities began.

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<sup>14</sup>HCERA provided that for each fiscal year after 2010 the amount appropriated would be adjusted to take into account inflation. §1303(b)(3), 124 Stat. at 1058.

<sup>15</sup>The states the MIG visited included Arkansas, Connecticut, Delaware, Michigan, Missouri, Nevada, Oregon, and Virginia.

<sup>16</sup>See GAO-05-855T.

**Table 1: Medicaid Integrity Group's Core Oversight Activities, by Fiscal Year Implemented**

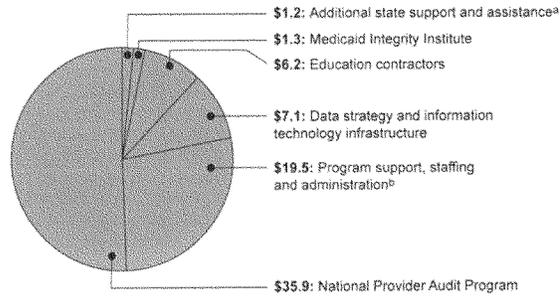
<b>MIG activities</b>	<b>Description</b>
	<b>Fiscal year 2007</b>
Comprehensive program integrity reviews	Every 3 years, the MIG conducts a comprehensive management review of each state's Medicaid program integrity procedures and processes. Through the reviews, the MIG assesses the effectiveness of the state's program integrity efforts and determines whether the state's policies and procedures comply with federal statutes and regulations. The review areas include provider enrollment, provider disclosures, program integrity, managed care operations, and the interaction between the state's Medicaid agency and its Medicaid Fraud Control Unit (MFCU). Each review results in a report which is posted on CMS's Web site that summarizes best practices, compliance issues, and vulnerabilities. The MIG also conducts follow-up reviews to evaluate state's corrective action plans addressing any identified vulnerabilities.
Technical assistance	In fiscal year 2009, the MIG responded to 504 requests for technical assistance from 49 states, providers, advocates and others. Common topics included the National Provider Audit Program, policy/regulatory requirements on disclosures, law-enforcement activities, and fraud detection tools. Examples of other assistance provided to the states included (1) hosting regional State Program Integrity Director conference calls to discuss emerging issues and best practices, and (2) issuing a State Medicaid Director letter in January 2009 which provided guidance to Medicaid providers on screening their employees and contractors for individuals excluded from participation in the program.
Medicaid integrity institute	The institute is the first national Medicaid integrity training program. CMS executed an interagency agreement with the Department of Justice to house the institute at the National Advocacy Center, located at the University of South Carolina. The institute offers substantive training, technical assistance, and support to states in a structured learning environment. In time, the institute intends to create a credentialing process to elevate the professional qualifications of state Medicaid program integrity staff.
	<b>Fiscal year 2009</b>
National Provider Audit Program <sup>a</sup>	Separate contractors (1) analyze claims data to identify aberrant claims and potential billing vulnerabilities, and (2) conduct post-payment audits based on data analysis leads in order to identify overpayments to Medicaid providers.
State program integrity assessments	These annual assessments represent the first national baseline collection of data on state Medicaid integrity activities for the purposes of program evaluation and technical assistance support. The data provided by states are used to populate a one page profile covering topics such as program integrity staffing and expenditures, audits, fraud referrals to the state's MFCU, and recoveries.
Education contractors	The education contractors develop materials in order to educate and train providers on payment integrity and quality of care issues.

Source: CMS

<sup>a</sup>To gain a better understanding of audit processes and procedures as well as variation across the states, the MIG initiated test audits in fiscal year 2007, prior to the implementation of the National Provider Audit Program.

Figure 2 shows MIG expenditures by program category for fiscal year 2010. The Medicaid Integrity Institute accounted for about 2 percent of the MIG's fiscal year 2010 expenditures, while the National Provider Audit Program accounted for about half of expenditures.

**Figure 2: MIG Expenditures by Program Category, Fiscal Year 2010, in Millions**



Source: CMS

<sup>a</sup>These activities include courses as well as technical assistance and outreach to states specific to the implementation of PPACA.

<sup>b</sup>These activities include the comprehensive program integrity reviews, state program integrity assessments, and technical assistance.

**The MIG Recognized the Need for Effective Coordination**

At the outset, the MIG recognized that effective coordination with internal and external stakeholders was essential to the success of the Medicaid Integrity Program. In a report issued prior to establishment of the program, we found that CMS had a disjointed organizational structure and lacked the strategic planning necessary to face the risks involved with the Medicaid program.<sup>17</sup> We identified the need for CMS to develop a strategic plan in order to provide direction to the agency, its contractors, states, and its law enforcement partners. In designing and implementing the program, the MIG convened an advisory committee consisting of

<sup>17</sup>See GAO-05-855T.

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(1) state program integrity, Medicaid, and MFCU directors from 16 states; and (2) representatives of the FBI, HHS-OIG, and CMS regional offices. This committee provided planning input and strategic advice and identified key issues that the MIG needed to address, including

- The MIG's efforts should support and complement states' Medicaid integrity efforts, not be redundant of existing auditing efforts.
- Program integrity activities of the MIG and other federal entities require coordination with states regarding auditing and data requests.
- The focus of state activities should be shifted from postpayment audits to prepayment prevention activities.

The advisory committee also highlighted the lack of state resources for staffing, technology, and training. CMS's July 2009 Comprehensive Medicaid Integrity Plan, the fourth such plan since 2006, stated that fostering collaboration with internal and external stakeholders of the Medicaid Integrity Program was a primary goal of the MIG.

In implementing more recent statutory requirements, CMS again stressed the need for effective coordination and collaboration. CMS's commentary accompanying the final rule on the implementation of Medicaid RACs acknowledged the potential for duplication with states' ongoing efforts to identify Medicaid overpayments. States have been responsible for the recovery of all identified overpayments, including those identified since fiscal year 2009 by the MIG's audit contractors. The new requirement for states to contract with an independent Medicaid RAC introduces another auditor to identify and collect Medicaid overpayments. The Medicaid RAC program was modeled after a similar Medicare program, which was implemented in March 2009 after a 3-year demonstration.<sup>18</sup> Because Medicare RACs are paid a fixed percentage of the dollar value of any improper payments identified, they generally focused on costly services such as inpatient hospital stays. Our prior work on Medicare RACs noted

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<sup>18</sup>The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 directed CMS to conduct a project to demonstrate how effective the use of RACs would be in identifying underpayments and overpayments, and in recouping overpayments in Medicare. Pub. L. No. 108-173, § 306, 117 Stat. 2066, 2256. Subsequently, in December 2006 the Tax Relief and Health Care Act of 2006 required CMS to implement a national Medicare RAC program by January 1, 2010. Pub. L. No. 109-342, div. B, title III, § 302, 120 Stat. 2924, 2991 (codified at 42 U.S.C. § 1395ddd(h)).

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that the postpayment review activities of CMS's other contractors would overlap less with the RACs' audits if those activities focused on different Medicare services where improper payments were known to be high, such as home health.<sup>19</sup> Because Medicaid RACs are not required to be operational until January 1, 2012, the extent to which states will structure their RAC programs to avoid duplication and complement their own provider review and audit activities remains to be seen.

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**The MIG Is Redesigning the National Provider Audit Program, Whose Returns Were Not Commensurate with Contractors' Costs**

In its most recent annual report to the Congress, the MIG indicated that it was redesigning the National Provider Audit Program. According to the MIG, the National Provider Audit Program has not identified overpayments in the Medicaid program commensurate with the related contractor costs. About 50 percent of the MIG's \$75 million annual budget supports the activities of its review and audit contractors. From fiscal years 2009 through 2011, the MIG authorized 1,663 provider audits in 44 states. However, the MIG's reported return on investment from these audits was negative. While its contractors identified \$15.2 million in overpayments, the combined cost of the National Provider Audit Program was about \$36 million in fiscal year 2010. The actual amount of overpayments recovered is not known because states are responsible for recovering overpayments and the MIG is not the CMS entity that tracks recoveries. Actual recoveries may be less than the identified overpayments.

The National Provider Audit Program has generally relied on MSIS, which is summary data submitted by states on a quarterly basis that may not reflect voided or adjusted claims payments. As a result, the MIG's audit contractors may identify two MSIS claims as duplicates when the state has already voided or denied payment on one of these claims. For their program integrity efforts, states use their own MMIS data systems, which generally reflect real-time payments and adjustments of detailed claims for each health care service. States are required to have a SURS component that performs data mining as a part of their program integrity efforts. The MIG's review contractors use data mining techniques that may be similar to those employed by states, and they may not identify any additional improper claims.

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<sup>19</sup>See GAO, *Medicare and Medicaid Fraud, Waste, and Abuse: Effective Implementation of Recent Laws and Agency Actions Could Help Reduce Improper Payments*, GAO-11-409T (Washington, D.C.: Mar. 9, 2011).

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Moreover, MIG officials told us that the National Provider Audit Program did not prioritize the activities according to the dollar amount of the claim, that is, it did not concentrate its efforts on audits with the greatest potential for significant recoveries. Although the amount of overpayment identified from any given audit can vary by thousands or millions of dollars, the MIG's comprehensive reviews of several states' Medicaid integrity programs show that these states identified significantly higher levels of overpayments in 1 year than the National Provider Audit Program identified over 3 years. For example, the number of national provider audits (1,663) over three fiscal years was similar to the number that New York conducted in fiscal year 2008 (1,352), yet CMS reported that New York had identified more than \$372 million in overpayments—considerably more than the \$15.2 million identified through national provider audits.<sup>20</sup>

The MIG's proposed redesign of the National Provider Audit Program appears to allow for greater coordination between its contractors and states on a variety of factors, including the data to be used.<sup>21</sup> In fiscal year 2010, the MIG launched collaborative audits in 13 states. For these audits, the states and the MIG agreed on the audit issues to review and, in some cases, states provided the MIG's audit contractors with more timely and complete claims data. These collaborative projects (1) allowed states to augment their own audit resources, (2) addressed audit targets that states may not have been able to initiate because of a lack of staff, and (3) provided data analytic support for states that lacked that capability. Although these activities are ongoing and the results have not yet been finalized, such collaborative projects appear to be a promising approach to audits that avoids a duplication of federal and state efforts. It remains to be seen, however, whether these changes will result in an increase in identified overpayments.

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<sup>20</sup>Department of Health and Human Services, Centers for Medicare & Medicaid Services, *New York Comprehensive Program Integrity Review: Final Report* (Washington, D.C.: 2010).

<sup>21</sup>Kathleen Sebelius, Secretary of Health and Human Services, *Annual Report to Congress on the Medicaid Integrity Program for Fiscal Year 2010* (Washington, D.C.: 2011).

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**Expanded Role Offers Opportunity to Enhance State Efforts, but More Consistent Data Are Needed**

While the MIG's audit program is challenged to avoid duplicating states' own audit activities, its other core functions present an opportunity to enhance states' efforts. The MIG's state oversight activities are extensive and labor intensive. Although the data collected during reviews and assessments are not always consistent with each other, these oversight activities have a strong potential to inform the MIG's technical assistance and help identify training opportunities. The Medicaid Integrity Institute appears to address an important state training need.

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**MIG's Core Oversight Activities Are Broad, but the Data Collected During Reviews and Assessments Were Not Always Consistent with Each Other**

The MIG's core oversight activities—triennial comprehensive state program integrity reviews and annual assessments—are broad in scope and provide a basis for the development of appropriate technical assistance. However, we found that the information collected during reviews and the information collected from assessments was sometimes inconsistent with each other.

As of November 2011, the MIG had completed the first round of reviews for 50 states and had initiated a second round of reviews in 10 states. The reviews cover the entirety of a state's program integrity activities and assess compliance with federal regulations. In advance of the MIG's week-long onsite visit, state program integrity officials are asked to respond to a 71-page protocol containing 195 questions and to provide considerable documentation.<sup>22</sup> Table 2 summarizes the topics covered in the protocol. Typical compliance issues and vulnerabilities identified during the reviews include provider enrollment weaknesses, inadequate oversight of providers in Medicaid managed care, and ineffective fraud referrals to state MFCUs.

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<sup>22</sup>The MFCU and managed care entities receive separate protocols and requests for documentation.

**Table 2: Topics Covered in MIG's Comprehensive State Program Integrity Review Protocol**

Modules	Number of questions
Program integrity organization and staffing	29
Claims payment review	10
Prepayment review	37
Post-payment review	13
Recovery audit contractors	6
Payment error rate measurement	6
Sampling and extrapolation	14
Fraud identification, investigation, and referral	
Methods	10
Preliminary investigation	4
Full investigation	8
Resolution of full investigation	7
Reporting requirements	3
Provider statements	7
Recipient verification	9
Cooperation with MFCUs	16
Withholding payments	4
Federal reimbursement for operation of data systems	3
False Claims Act requirements	4
Technical assistance	5

Source: CMS's fiscal year 2011 comprehensive state program integrity review protocol

Much of the information collected during the assessments—Medicaid program integrity characteristics, program integrity planning, prevention, detection, investigation and recoveries—is also collected during the triennial comprehensive reviews.<sup>23</sup> In addition, we found inconsistencies between the information reported in the comprehensive reviews and in the assessments for several states that were conducted at about the same time. For example, there was a significant discrepancy for one state in the number of staff it reported as being dedicated to program integrity activities. According to the MIG, knowing the size of state program

<sup>23</sup>The MIG collects the data for the assessments through an online questionnaire that has 56 questions. The responses are used to develop a one-page profile on state activities.

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integrity staff helps it to more appropriately tailor content during training events. Improved consistency will help the MIG ensure that it is targeting its training and technical assistance resources appropriately. Despite the frequency of the annual assessments, the most current data cover fiscal year 2008, which the MIG began collecting in fiscal year 2010.

Although the MIG provides states with a glossary explaining each of the requested data elements, it is not clear that the information submitted is reliable or comparable across states. Our review of a sample of assessments revealed missing data and a few implausible measures, such as one state reporting over 38 million managed care enrollees. In other states, there were dramatic changes in the data reported from 2007 to 2008, which either raises a question about the reliability of the data or suggests that states be allowed to explain significant changes from year to year. For example, the number of audits in one state declined from 203 to 35.

According to MIG officials, the comprehensive reviews and the assessments inform the MIG's technical assistance activities with the states. For example, we found that the MIG published best practices guidance in 2008 after finding weaknesses in coordination between state program integrity officials and their respective MFCU's in a number of states. In its report to Congress on fiscal year 2010 activities, the MIG indicated it completed 420 requests for technical assistance from 43 states, providers, and others. The most common topics included the National Provider Audit Program, policy and regulatory requirements on disclosures, provider exclusions and enrollment, and requests for statistical assistance related to criminal and civil court actions. Examples of assistance provided to the states by the MIG included (1) hosting regional state program integrity director conference calls to discuss program integrity issues and best practices; and (2) helping develop a State Medicaid Director Letter (issued in July 2010) on the return of federal share of overpayments under PPACA.

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**Medicaid Integrity Institute  
Trains State Staff and  
Facilitates Networking**

The federally sponsored Medicaid Integrity Institute not only offers state officials free training but also provides opportunities to develop relationships with program integrity staff from other states. The institute addresses our prior finding that CMS did not sponsor any fraud and abuse workshops or training from 2000 through 2005.<sup>24</sup> From fiscal years

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<sup>24</sup>See GAO-05-855T.

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2008 through 2012, the institute will have trained over 2,265 state employees at no cost to states. Given the financial challenges states currently face, it is likely that expenditures for training and travel are limited. Expenditures on the institute accounted for about \$1.3 million of the MIG's \$75 million annual budget. MIG officials told us that states uniformly praised the opportunity to network and learn about best practices from other states. A special June 2011 session at the institute brought together Medicaid program integrity officials and representatives of MFCUs from 39 states in an effort to improve the working relations between these important program integrity partners.

In addition to the institute, the MIG has a contractor that provides (1) education to broad groups of providers and beneficiaries, and (2) targeted education to specific providers on certain topics.<sup>25</sup> For example, the education contractor has provided outreach through its attendance at 17 conferences with about 36,000 attendees. These conferences were sponsored by organizations devoted to combating health care fraud such as the National Association of Medicaid Program Integrity and National Health Care Anti-Fraud Association, as well as meetings of national and regional provider organizations (hospital, home care and hospice and pharmacy). An example of a more targeted activity is one focused on pharmacy providers. The MIG's education contractor is tasked with developing provider education materials to promote best prescribing practices for certain therapeutic drug classes and remind providers of the appropriate prescribing guidelines based on FDA approved labeling. The education program includes some face-to-face conversations, mailings to providers, and distribution of materials on a website and at conferences and meetings. These activities are collaborative efforts with the states so that states are aware of the aberrant providers, participate in the education program, and can implement policy changes to address these issues, as appropriate.

We discussed the facts in this statement with CMS officials.

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<sup>25</sup>The MIG has two education contractors, however, it has only issued task orders to one of the contractors.

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Chairmen Pratts and Gowdy, this concludes my prepared remarks. I would be happy to answer any questions that you or other Members may have.

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**GAO Contact  
and Staff  
Acknowledgments**

For further information about this statement, please contact Carolyn L. Yocom at (202) 512-7114 or [yocomc@gao.gov](mailto:yocomc@gao.gov). Contact points for our Offices of Congressional Relation and Public Affairs may be found on the last page of this statement. Walter Ochinko, Assistant Director; Sean DeBleick; Iola D'Souza; Leslie V. Gordon; Drew Long; Jessica Smith; and Jennifer Whitworth were key contributors to this statement.

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## Appendix I: Abbreviations

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CMS	Centers for Medicare & Medicaid Services
DRA	Deficit Reduction Act of 2005
FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
HCERA	Health Care Education and Reconciliation Act of 2010
HHS	Department of Health and Human Services
MFCU	Medicaid Fraud Control Unit
MIG	Medicaid Integrity Group
MIP	Medicaid Integrity Program
MMIS	Medicaid Management Information System
MSIS	Medicaid Statistical Information System
OIG	Office of Inspector General
PERM	Payment Error Rate Measurement
PPACA	Patient Protection and Affordable Care Act
RAC	Recovery Audit Contractor
SURS	Surveillance and Utilization Review Subsystem

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## Related GAO Products

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*Fraud Detection Systems: Additional Actions Needed to Support Program Integrity Efforts at Centers for Medicare and Medicaid Services.* GAO-11-822T. Washington, D.C.: July 12, 2011.

*Fraud Detection Systems: Centers for Medicare and Medicaid Services Needs to Ensure More Widespread Use.* GAO-11-475. Washington, D.C.: June 30, 2011.

*Improper Payments: Recent Efforts to Address Improper Payments and Remaining Challenges.* GAO-11-575T. Washington, D.C.: April 15, 2011.

*Status of Fiscal Year 2010 Federal Improper Payments Reporting.* GAO-11-443R. Washington, D.C.: March 25, 2011.

*Medicare and Medicaid Fraud, Waste, and Abuse: Effective Implementation of Recent Laws and Agency Actions Could Help Reduce Improper Payments.* GAO-11-409T. Washington, D.C.: March 9, 2011.

*Medicare: Program Remains at High Risk Because of Continuing Management Challenges.* GAO-11-430T. Washington, D.C.: March 2, 2011.

*Opportunities to Reduce Potential Duplication in Government Programs, Save Tax Dollars, and Enhance Revenue.* GAO-11-318SP. Washington, D.C.: March 1, 2011.

*High-Risk Series: An Update.* GAO-11-278. Washington, D.C.: February 2011.

*Medicare Recovery Audit Contracting: Weaknesses Remain in Addressing Vulnerabilities to Improper Payments, Although Improvements Made to Contractor Oversight.* GAO-10-143. Washington, D.C.: March 31, 2010.

*Medicaid: Fraud and Abuse Related to Controlled Substances Identified in Selected States.* GAO-09-1004T. Washington, D.C.: September 30, 2009.

*Medicaid: Fraud and Abuse Related to Controlled Substances Identified in Selected States.* GAO-09-957. Washington, D.C.: September 9, 2009.

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**Related GAO Products**

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*Improper Payments: Progress Made but Challenges Remain in Estimating and Reducing Improper Payments.* GAO-09-628T. Washington, D.C.: April 22, 2009.

*Medicaid: Thousands of Medicaid Providers Abuse the Federal Tax System.* GAO-08-239T. Washington, D.C.: November 14, 2007.

*Medicaid: Thousands of Medicaid Providers Abuse the Federal Tax System.* GAO-08-17. Washington, D.C.: November 14, 2007.

*Medicaid Financial Management: Steps Taken to Improve Federal Oversight but Other Actions Needed to Sustain Efforts.* GAO-06-705. Washington, D.C.: June 22, 2006.

*Medicaid Integrity: Implementation of New Program Provides Opportunities for Federal Leadership to Combat Fraud, Waste, and Abuse.* GAO-06-578T. Washington, D.C.: March 28, 2006.

*Medicaid Fraud and Abuse: CMS's Commitment to Helping States Safeguard Program Dollars Is Limited.* GAO-05-855T. Washington, D.C.: June 28, 2005.

*Medicaid Program Integrity: State and Federal Efforts to Prevent and Detect Improper Payments.* GAO-04-707. Washington, D.C.: July 16, 2004.

*Medicaid: State Efforts to Control Improper Payments.* GAO-01-662. Washington, D.C.: June 7, 2001.

Mr. PLATTS. Thank you, Ms. Yocom.  
Ms. Melvin.

#### STATEMENT OF VALERIE MELVIN

Ms. MELVIN. Chairmen Platts and Gowdy, Ranking Members Towns and Davis and members of the subcommittee, thank you for inviting me to testify at today's hearing on fraud and improper payments in the Medicaid program. At your request, my testimony will summarize findings from a report that we issued earlier this year on CMS's efforts to protect the integrity of the Medicare and Medicaid programs through the use of information technology.

Specifically, in June 2011, we reported on two programs that CMS initiated in 2006 to help improve the ability to detect fraud, waste, and abuse: The integrated data repository or IDR, which is intended to provide a single source of data on Medicare and Medicaid claims and the one program integrity or one PI system, a Web-based portal that is to provide CMS staff and contractors with a single source of access to the data contained in IDR as well as tools for analyzing that data.

Our work examined the extent to which IDR and one PI had been developed and implemented as well as CMS's efforts to identify, measure, and track benefits resulting from these programs. We also provided recommendations on actions CMS should take to achieve its goals of reduced fraud and waste.

Regarding IDR, we noted that this data repository had been in use since 2006. However, it did not include all of the data that were planned to be in the system by 2010. For example, IDR included most types of Medicare claims data but no Medicaid data. IDR also did not include data from other CMS systems that can help analysts prevent improper payments. Moreover CMS had not finalized plans or developed reliable schedules for efforts to incorporate these data.

Further, while one PI had been developed and deployed, we found that few analysts were trained in using the system. Program officials had planned for 639 analysts to be using the system by the end of fiscal year 2010. However, as of October 2010, only 41 were actively using the portal and tools. None of these users included Medicaid program integrity analysts.

We pointed out that until program officials finalized plans and schedules for training and expanding the use of one PI, the agency may continue to experience delays. With one PI, CMS anticipated that it would achieve financial benefits of about \$21 billion. As we have previously reported, agencies should forecast expected benefits and then measure the actual results accrued through the implementation of programs.

However, CMS was not positioned to do this. As a result, it was unknown whether the program had provided any financial benefits. CMS officials told us that it was too early to determine whether the program had provided benefits since it had not met its goals for widespread use.

To help ensure that the development and implementation of IDR and one PI are successful in helping CMS meet the goals of its program integrity initiatives and possibly save tens of billions of dollars, we made several recommendations to CMS. Among our rec-

ommendations was that the agency finalized plans and schedules for incorporating additional data into IDR, finalized plans and schedules for training all program integrity analysts intended to use one PI, and establish and track outcome-based performance measures that gauge progress toward meeting program goals. In commenting on a draft of our report, CMS agreed with our recommendations. The agency's timely implementation of these recommendations could lead to reduced fraud and waste and overall substantial savings in the Medicare and Medicaid programs. This concludes my oral statement. I look forward to addressing your questions.

[The prepared statement of Ms. Melvin follows:]

United States Government Accountability Office

**GAO**

Testimony before the Subcommittees on  
Government Organization, Efficiency and Financial  
Management; and Health Care, District of Columbia,  
Census and the National Archives; Committee on  
Oversight and Government Reform,  
House of Representatives

For Release on Delivery  
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## FRAUD DETECTION SYSTEMS

### Centers for Medicare and Medicaid Services Needs to Expand Efforts to Support Program Integrity Initiatives

Statement of Valerie C. Melvin, Director  
Information Management  
and Technology Resources Issues



GAO-12-292T

December 2011

## FRAUD DETECTION SYSTEMS

## Centers for Medicare and Medicaid Services Needs to Expand Efforts to Support Program Integrity Initiatives



Highlights of GAO-12-292T, a testimony for Subcommittees of the Committee on Oversight and Government Reform, House of Representatives

### Why GAO Did This Study

The Centers for Medicare and Medicaid Services (CMS) is responsible for administering and safeguarding its programs from loss of funds. As GAO reported in June 2011, CMS utilizes automated systems and tools to help improve the detection of improper payments for fraudulent, wasteful, and abusive claims. To integrate claims information and improve its ability to detect fraud, waste, and abuse in these programs, CMS initiated two information technology system programs: the Integrated Data Repository (IDR) and One Program Integrity (One PI).

GAO was asked to testify on its June 2011 report that examined CMS's efforts to protect the integrity of the Medicare and Medicaid programs through the use of information technology (GAO-11-475). In that prior study, GAO assessed the extent to which IDR and One PI have been developed and implemented, and CMS's progress toward achieving its goals and objectives for using these systems to detect fraud, waste, and abuse.

### What GAO Recommends

GAO recommended in June 2011 that CMS take actions to finalize plans and schedules for achieving widespread use of IDR and One PI, and to define measurable benefits. CMS concurred with GAO's recommendations.

View GAO-12-292T or key components. For more information, contact Valerie Melvin at (202) 512-6304 or melvinv@gao.gov.

### What GAO Found

GAO previously reported that CMS had developed and begun using both IDR and One PI, but had not incorporated into IDR all data as planned. IDR is intended to be the central repository of Medicare and Medicaid data needed to help CMS and states' program integrity staff and contractors prevent and detect improper payments. Program integrity analysts use these data to identify patterns of unusual activities or transactions that may indicate fraudulent charges or other types of improper payments. IDR has been operational and in use since September 2006 but did not include all the data that were planned to be incorporated by fiscal year 2010. For example, IDR included most types of Medicare claims data, but not the Medicaid data needed to help analysts detect improper payments of Medicaid claims. According to program officials, these data were not incorporated because of obstacles introduced by technical issues and delays in funding. Until the agency finalizes plans and develops reliable schedules for efforts to incorporate these data, CMS may face additional delays in making available all the data that are needed to support enhanced Medicare and Medicaid program integrity efforts.

Additionally, CMS had not taken steps to ensure widespread use of One PI to enhance efforts to detect fraud, waste, and abuse. One PI is a web-based portal that is to provide CMS staff and contractors, and Medicaid analysts with a single source of access to data contained in IDR, as well as tools for analyzing those data. While One PI had been developed and deployed to users, no Medicaid analysts and only a few Medicare program integrity analysts were trained and using the system. Specifically, One PI program officials planned for 639 program integrity analysts, including 130 Medicaid analysts, to be using the system by the end of fiscal year 2010; however, as of October 2010, only 41—less than 7 percent—were actively using the portal and tools. According to program officials, the agency's initial training plans were insufficient and, as a result, they were not able to train the intended community of users. Until program officials finalize plans and develop reliable schedules for training users and expanding the use of One PI, the agency may continue to experience delays in reaching widespread use of the system.

While CMS had made progress toward its goals to provide a single repository of data and enhanced analytical capabilities for program integrity efforts, the agency was not yet positioned to identify, measure, and track benefits realized from its efforts. As a result, it was unknown whether IDR and One PI as implemented had provided financial benefits. According to IDR officials, they did not measure benefits realized from increases in the detection rate for improper payments because they relied on business owners to do so; One PI officials stated that, because of the limited use of that system, there were not enough data to measure and gauge the program's success toward achieving the \$21 billion in financial benefits that the agency projected.

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Chairmen Platts and Gowdy, Ranking Members Towns and Davis, and Members of the Subcommittees:

I am pleased to participate in today's hearing on fraud and improper payments in the Medicaid program. At your request, my testimony will focus on our report earlier this year that examined the Centers for Medicare and Medicaid Services' (CMS) efforts to protect the integrity of the Medicare and Medicaid programs through the use of information technology. Specifically, in June 2011 we reported on CMS's utilization of automated systems and tools to help improve the detection of fraudulent, wasteful, and abusive claims that contribute to the billions of taxpayers' dollars lost each year to improper payments within these programs.<sup>1</sup>

Operating within the Department of Health and Human Services, CMS conducts reviews to prevent improper payments before Medicare and Medicaid claims are paid and to detect claims that were paid in error. These activities are predominantly carried out by contractors who, along with CMS personnel, use various information technology solutions to consolidate and analyze data to help identify the improper payment of claims. For example, these program integrity analysts may use software tools to access data about claims and then use those data to identify patterns of unusual activities by attempting to match services with patients' diagnoses.

In 2006, CMS initiated activities to centralize and make more accessible the data needed to conduct these analyses and to improve the analytical tools available to its own and contractor analysts. Our June 2011 report discussed two of these initiatives—the Integrated Data Repository (IDR), which is intended to provide a single source of data related to Medicare and Medicaid claims, and the One Program Integrity (One PI) system, a web-based portal<sup>2</sup> and suite of analytical software tools used to extract data from IDR and enable complex analyses of these data. According to CMS officials responsible for developing and implementing IDR and One PI, the agency had spent approximately \$161 million on these initiatives by the end of fiscal year 2010.

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<sup>1</sup>GAO, *Fraud Detection Systems: Centers for Medicare and Medicaid Services Needs to Ensure More Widespread Use*, GAO-11-475 (Washington, D.C.: June 30, 2011).

<sup>2</sup>The One PI portal is a web-based user interface that enables a single login through centralized, role-based access to the system.

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My testimony summarizes the results of our prior study, which specifically assessed the extent to which IDR and One PI had been developed and implemented, and CMS's progress toward achieving its goals and objectives for using these systems to detect fraud, waste, and abuse. The information presented is based primarily on our previous work at CMS. Additional information on our scope and methodology is available in the issued report.<sup>3</sup> We also obtained and conducted a review of more recent documentation pertaining to the agency's efforts to develop and implement the systems. We conducted this work in support of our testimony during November and December 2011 at CMS headquarters in Baltimore, Maryland. All work on which this testimony is based was conducted in accordance with generally accepted government auditing standards.

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## Background

Like financial institutions, credit card companies, telecommunications firms, and other private sector companies that take steps to protect customers' accounts, CMS uses information technology to help predict or detect cases of improper claims and payments. For more than a decade, the agency and its contractors have used automated software tools to analyze data from various sources to detect patterns of unusual activities or financial transactions that indicate payments could be made for fraudulent charges or improper payments. For example, to identify unusual billing patterns and support investigations and referrals for prosecutions of cases, analysts and investigators access information about key actions taken to process claims as they are filed and the specific details about claims already paid. This would include accessing information on claims as they are billed, adjusted, and paid or denied; check numbers on payments of claims; and other specific information that could help establish provider intent.

CMS uses many different means to store and manipulate data and, since the establishment of the agency's program integrity initiatives in the 1990s, has built multiple disparate databases and analytical software tools to meet individual and unique needs of various programs within the agency. In addition, data on Medicaid claims are scattered among the states in multiple systems and data stores, and are not readily available to CMS. According to agency program documentation, these

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<sup>3</sup>GAO-11-475.

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geographically distributed, regional approaches to storing and analyzing data result in duplicate data and limit the agency's ability to conduct analyses of data on a nationwide basis.

CMS has been working for most of the past decade to consolidate its disparate data and analytical tools. The agency's efforts led to the IDR and One PI programs, which are intended to provide CMS and its program integrity contractors with a centralized source of Medicare and Medicaid data and a web-based portal and set of analytical tools by which these data can be accessed and analyzed to help detect cases of fraud, waste, and abuse.

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#### CMS's Initiative to Develop a Centralized Source of Medicare and Medicaid Data

In 2006, CMS officials expanded the scope of a 3-year-old data modernization strategy to not only modernize data storage technology, but also to integrate Medicare and Medicaid data into a centralized repository so that CMS and its partners could access the data from a single source. They called the expanded program IDR.

According to program officials, the agency's vision was for IDR to become the single repository for CMS's data and enable data analysis within and across programs. Specifically, this repository was to establish the infrastructure for storing data related to Medicaid and Medicare Parts A, B, and D claims processing,<sup>4</sup> as well as a variety of other agency functions, such as program management, research, analytics, and business intelligence. CMS envisioned an incremental approach to incorporating data into IDR. Specifically, it intended to incorporate data related to paid claims for Medicare Part D by the end of fiscal year 2006, and for Medicare Parts A and B by the end of fiscal year 2007. The agency also planned to begin to incrementally add all Medicaid data for the 50 states in fiscal year 2009 and to complete this effort by the end of fiscal year 2012.

Initial program plans and schedules also included the incorporation of additional data from legacy CMS claims-processing systems that store

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<sup>4</sup>Medicare Part A provides payment for inpatient hospital, skilled nursing facility, some home health, and hospice services, while Part B pays for hospital outpatient, physician, some home health, durable medical equipment, and preventive services. Further, all Medicare beneficiaries may purchase coverage for outpatient prescription drugs under Medicare Part D.

and process data related to the entry, correction, and adjustment of claims as they are being processed, along with detailed financial data related to paid claims. According to program officials, these data, called "shared systems" data, are needed to support the agency's plans to incorporate tools to conduct predictive analysis of claims as they are being processed, helping to prevent improper payments. Shared systems data, such as check numbers and amounts related to claims that have been paid, are also needed by law enforcement agencies to help with fraud investigations. CMS initially planned to have all the shared systems data included in IDR by July 2008.

Table 1, presented in our prior report, summarized CMS's original planned dates and actual dates for incorporating the various types of data into IDR as of the end of fiscal year 2010.

**Table 1: Data Incorporated into IDR as of the End of Fiscal Year 2010**

Type of data	Original planned date	Actual date
Medicare Part D	January 2006	January 2006
Medicare Part B	September 2007	May 2008
Medicare Part A	September 2008	May 2008
Shared systems	July 2008	Not incorporated (planned for November 2011)
Medicaid for 5 states	September 2009	Not incorporated (planned for September 2014)
Medicaid for 20 states	September 2010	Not incorporated (planned for September 2014)
Medicaid for 35 states	September 2011	Not incorporated (planned for September 2014)
Medicaid for 50 states	September 2012	Not incorporated (planned for September 2014)

Source: GAO analysis of CMS data.

#### CMS's Initiative to Develop and Implement Analytical Tools for Detecting Fraud, Waste, and Abuse

Also in 2006, CMS initiated the One PI program with the intention of developing and implementing a portal and software tools that would enable access to and analysis of claims, provider, and beneficiary data from a centralized source. The agency's goal for One PI was to support the needs of a broad program integrity user community, including agency program integrity personnel and contractors who analyze Medicare claims data, along with state agencies that monitor Medicaid claims. To achieve its goal, CMS officials planned to implement a tool set that would provide a single source of information to enable consistent, reliable, and timely

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analyses and improve the agency's ability to detect fraud, waste, and abuse. These tools were to be used to gather data from IDR about beneficiaries, providers, and procedures and, combined with other data, find billing aberrancies or outliers. For example, an analyst could use software tools to identify potentially fraudulent trends in ambulance services by gathering the data about claims for ambulance services and medical treatments, and then use other software to determine associations between the two types of services. If the analyst found claims for ambulance travel costs but no corresponding claims for medical treatment, it might indicate that further investigation could prove that the billings for those services were fraudulent.

According to agency program planning documentation, the One PI system was also to be developed incrementally to provide access to IDR data, analytical tools, and portal functionality. CMS planned to implement the One PI portal and two analytical tools for use by program integrity analysts on a widespread basis by the end of fiscal year 2009. The agency engaged contractors to develop the system.

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### **IDR and One PI Were in Use, but Lacked Data and Functionality Essential to CMS's Program Integrity Efforts**

IDR had been in use by CMS and its contractors who conduct Medicare program integrity analysis since September 2006 and incorporated data related to claims for reimbursement of services under Medicare Parts A, B, and D. According to program officials, the integration of these data into IDR established a centralized source of data previously accessed from multiple disparate system files.

However, although the agency had been incorporating data from various data sources since 2006, our prior report noted that IDR did not include all the data that were planned to be incorporated by the end of 2010 and that are needed to support enhanced program integrity initiatives. For example, IDR did not include the Medicaid data that are critical to analysts' ability to detect fraud, waste, and abuse in this program. While program officials initially planned to incorporate 20 states' Medicaid data into IDR by the end of fiscal year 2010, the agency had not incorporated any of these data into the repository. Program officials told us that the original plans and schedules for obtaining Medicaid data did not account for the lack of funding for states to provide Medicaid data to CMS, or the variations in the types and formats of data stored in disparate state Medicaid systems. Consequently, the officials were not able to collect the data from the states as easily as they expected and did not complete this activity as originally planned.

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In December 2009, CMS initiated another agencywide program intended to, among other things, identify ways to collect Medicaid data from the many disparate state systems and incorporate the data into a single data store. As envisioned by CMS, this program, the Medicaid and Children's Health Insurance Program Business Information and Solutions (MACBIS) program, was to include activities in addition to providing expedited access to current data from state Medicaid programs. According to agency planning documentation, as a result of efforts to be initiated under the MACBIS program, CMS would incorporate Medicaid data for all 50 states into IDR by the end of fiscal year 2014.

However, program officials had not defined plans and reliable schedules for incorporating these data into IDR. Until the agency does so, it cannot ensure that current development, implementation, and deployment efforts will provide the data and technical capabilities needed to enhance efforts to detect potential cases of fraud, waste, and abuse.

In addition to the Medicaid data, initial program integrity requirements included the incorporation of the shared systems data by July 2008; however, all of these data had not been added to IDR. According to IDR program officials, the shared systems data were not incorporated as planned because funding for the development of the software and acquisition of the hardware needed to meet this requirement was not approved until the summer of 2010. Subsequently, IDR program officials developed project plans and identified user requirements. In updating us on the status of this activity, the officials told us in November 2011 that they began incorporating shared systems data in September 2011 and plan to make them available to program integrity analysts in spring 2012.

Beyond the IDR initiative, CMS program integrity officials had not taken appropriate actions to ensure the use of One PI on a widespread basis for program integrity purposes. According to program officials, the system was deployed to support Medicare program integrity goals in September 2009 as originally planned and consisted of a portal that provided web-based access to software tools used by CMS and contractor analysts to retrieve and analyze data stored in IDR. As implemented, the system provided access to two analytical tools—a commercial off-the-shelf decision support tool that is used to perform data analysis to, for example, detect patterns of activities that may identify or confirm suspected cases of fraud, waste, or abuse, and another tool that provides users extended capabilities to perform more complex analyses of data. For example, it allows the user to

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customize and create ad hoc queries of claims data across the three Medicare plans.

However, while program officials deployed the One PI portal and two analytical tools, the system was not being used as widely as planned because CMS and contractor analysts had not received the necessary training. In this regard, program planning documentation from August 2009 indicated that One PI program officials had planned for 639 analysts to be trained and using the system by the end of fiscal year 2010, including 130 analysts who conduct reviews of Medicaid claims.<sup>5</sup> However, CMS confirmed that by the end of October 2010, only 42 Medicare analysts who were intended to use One PI had been trained, with 41 actively using the portal and tools. These users represented fewer than 7 percent of the users originally intended for the program.

Further, no Medicaid analysts had been trained to use the system. While the use of One PI cannot be fully optimized for Medicaid integrity purposes until the states' Medicaid claims data are incorporated into IDR, the tools provided by the system could be used to supplement data currently available to Medicaid program integrity analysts and to enhance their ability to detect payments of fraudulent claims. For example, with training, Medicaid analysts may be able to compare data from their state systems to Medicare claims data in IDR to identify duplicate claims for the same service.

Program officials responsible for implementing the system acknowledged that their initial training plans and efforts had been insufficient and that they had consequently initiated activities and redirected resources to redesign the One PI training plan in April 2010; they began to implement the new training program in July of that year.

As we reported in June, One PI officials stated that 62 additional analysts had signed up to be trained in 2011, and that the number of training classes for One PI had been increased from two to four per month. Agency officials, in commenting on our report, stated that since January

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<sup>5</sup>This group of analysts included state Medicaid program integrity personnel along with CMS analysts who implement the Medi-Medi data match program. This program was established in 2001 and was 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.

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2011, 58 new users had been trained; however, they did not identify an increase in the number of actual users of the system.<sup>6</sup>

Nonetheless, while these activities indicated some progress toward increasing the number of One PI users, the number of users reported to be trained and using the system represented a fraction of the population of 639 intended users. Moreover, One PI program officials had not yet made detailed plans and developed schedules for completing training of all the intended users. Agency officials concurred with our conclusion that CMS needed to take more aggressive steps to ensure that its broad community of analysts is trained, including those who conduct analyses of Medicaid claims data. Until it does so, the use of One PI may remain limited to a much smaller group of users than the agency intended and CMS will continue to face obstacles in its efforts to deploy One PI for widespread use throughout its community of program integrity analysts.

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### CMS Was Not Yet Positioned to Identify Financial Benefits or to Fully Meet Program Integrity Goals and Objectives through the Use of IDR and One PI

Because IDR and One PI were not being used as planned, CMS officials were not in a position to determine the extent to which the systems were providing financial benefits or supporting the agency's initiatives to meet program integrity goals and objectives. As we have reported, agencies should forecast expected benefits and then measure actual financial benefits accrued through the implementation of IT programs.<sup>7</sup> Further, the Office of Management and Budget (OMB) requires agencies to report progress against performance measures and targets for meeting them that reflect the goals and objectives of the programs.<sup>8</sup> To do this, performance measures should be outcome-based and developed with stakeholder input, and program performance must be monitored, measured, and compared to expected results so that agency officials are

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<sup>6</sup>In further updating these data, on November 30, 2011, CMS officials reported to us that a total of 215 program integrity analysts had been trained and were using One PI, including 51 Medi-Medi and state Medicaid analysts. However, we did not validate the data provided to us by program officials on November 30, 2011.

<sup>7</sup>GAO, *Secure Border Initiative: DHS Needs to Reconsider Its Proposed Investment in Key Technology Program*, GAO-10-340 (Washington, D.C.: May 5, 2010) and *DOD Business Systems Modernization: Planned Investment in Navy Program to Create Cashless Shipboard Environment Needs to be Justified and Better Managed*, GAO-08-922 (Washington, D.C.: Sept. 8, 2008).

<sup>8</sup>Office of the President, Office of Management and Budget, *Guide to the Program Assessment Rating Tool* (Washington, D.C.: January 2008).

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able to determine the extent to which goals and objectives are being met. In addition, industry experts describe the need for performance measures to be developed with stakeholders' input early in a project's planning process to provide a central management and planning tool and to monitor the performance of the project against plans and stakeholders' needs.

While CMS had shown some progress toward meeting the programs' goals of providing a centralized data repository and enhanced analytical capabilities for detecting improper payments due to fraud, waste, and abuse, the implementation of IDR and One PI did not yet position the agency to identify, measure, and track financial benefits realized from reductions in improper payments as a result of the implementation of either system. For example, program officials stated that they had developed estimates of financial benefits expected to be realized through the use of IDR. Their projection of total financial benefits was reported to be \$187 million, based on estimates of the amount of improper payments the agency expected to recover as a result of analyzing data provided by IDR. With estimated life cycle program costs of \$90 million through fiscal year 2018, the resulting net benefit expected from implementing IDR was projected to be \$97 million. However, as of March 2011, program officials had not identified actual financial benefits of implementing IDR.

Further, program officials' projection of financial benefits expected as a result of implementing One PI was reported to be approximately \$21 billion. This estimate was increased from initial expectations based on assumptions that accelerated plans to integrate Medicare and Medicaid data into IDR would enable One PI users to identify increasing numbers of improper payments sooner than previously estimated, thus allowing the agency to recover more funds that have been lost due to payment errors.

However, the implementation of One PI had not yet produced outcomes that positioned the agency to identify or measure financial benefits. CMS officials stated at the end of fiscal year 2010—more than a year after deploying One PI—that it was too early to determine whether the program had provided any financial benefits. They explained that, since the program had not met its goal for widespread use of One PI, there were not enough data available to quantify financial benefits attributable to the use of the system. These officials said that as the user community expanded, they expected to be able to begin to identify and measure financial and other benefits of using the system.

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In addition, program officials had not developed and tracked outcome-based performance measures to help ensure that efforts to implement One PI and IDR would meet the agency's goals and objectives for improving the results of its program integrity initiatives. For example, outcome-based measures for the programs would indicate improvements to the agency's ability to recover funds lost because of improper payments of fraudulent claims. However, while program officials defined and reported to OMB performance targets for IDR related to some of the program's goals, they did not reflect the goal of the program to provide a single source of Medicare and Medicaid data that supports enhanced program integrity efforts. Additionally, CMS officials had not developed quantifiable measures for meeting the One PI program's goals. For example, performance measures and targets for One PI included increases in the detection of improper payments for Medicare Parts A and B claims. However, the limited use of the system had not generated enough data to quantify the amount of funds recovered from improper payments.

Moreover, measures of One PI's program performance did not accurately reflect the existing state of the program. Specifically, indicators to be measured for the program included the number of states using One PI for Medicaid integrity purposes and decreases in the Medicaid payment error rate; however, One PI did not have access to those data because they were not yet incorporated into IDR.

Because it lacked meaningful outcome-based performance measures and sufficient data for tracking progress toward meeting performance targets, CMS did not have the information needed to ensure that the systems were useful to the extent that benefits realized from their implementation could help the agency meet program integrity goals. Until the agency is better positioned to identify and measure financial benefits and establishes outcome-based performance measures to help gauge progress toward meeting program integrity goals, it cannot be assured that the systems will contribute to improvements in CMS's ability to detect and prevent fraud, waste, and abuse, and improper payments of Medicare and Medicaid claims.

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**CMS Needs to Take  
Actions to Achieve  
Widespread Use of  
IDR and One PI**

Given the critical need for CMS to reduce improper payments within the Medicare and Medicaid programs, we included in our June 2011 report a number of recommended actions that we consider vital to helping the agency achieve more widespread use of IDR and One PI for program integrity purposes. Specifically, we recommended that the Administrator of CMS

- finalize plans and develop schedules for incorporating additional data into IDR that identify all resources and activities needed to complete tasks and that consider risks and obstacles to the IDR program;
- implement and manage plans for incorporating data in IDR to meet schedule milestones;
- establish plans and reliable schedules for training all program integrity analysts intended to use One PI;
- establish and communicate deadlines for program integrity contractors to complete training and use One PI in their work;
- conduct training in accordance with plans and established deadlines to ensure schedules are met and program integrity contractors are trained and able to meet requirements for using One PI;
- define any measurable financial benefits expected from the implementation of IDR and One PI; and
- with stakeholder input, establish measurable, outcome-based performance measures for IDR and One PI that gauge progress toward meeting program goals.

In commenting on a draft of our report, CMS agreed with the recommendations and indicated that it planned to take steps to address the challenges and problems that we identified during our study.

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In conclusion, CMS's success toward meeting goals to enhance program integrity efforts through the use of IDR and One PI depends upon the incorporation of all needed data into IDR, and effective use of the systems by the agency's broad community of Medicare and Medicaid program integrity analysts. It is also essential that the agency identify measurable financial benefits and performance goals expected to be attained through improvements in its ability to prevent and detect

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fraudulent, wasteful, and abusive claims and resulting improper payments. In taking these steps, the agency will better position itself to determine whether these systems are useful for enhancing CMS's ability to identify fraud, waste, and abuse and, consequently, reduce the loss of billions of dollars to improper payments of Medicare and Medicaid claims.

Chairmen Platts and Gowdy, Ranking Members Towns and Davis, and Members of the Subcommittees, this concludes my prepared statement. I would be pleased to answer any questions that you may have.

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**GAO Contact and  
Staff  
Acknowledgments**

If you have questions concerning this statement, please contact Valerie C. Melvin, Director, Information Management and Technology Resources Issues, at (202) 512-6304 or [melvinv@gao.gov](mailto:melvinv@gao.gov). Other individuals who made key contributions include Teresa F. Tucker (Assistant Director), Amanda C. Gill, and Lee A. McCracken.

Mr. PLATTS. Thank you, Ms. Melvin.

We will begin questions. I will yield myself 5 minutes to begin this round of questions. And I certainly appreciate all four of your testimonies and your efforts in regard to protecting American taxpayer funds and ensuring that we are properly caring for and providing services.

Ms. Brice-Smith, I am going to begin with you. And I certainly appreciate the breadth and depth of your testimony on what we are trying to do. I have to be honest with you that I am surprised after hearing the testimony of Mr. West that as a representative of CMS, you did not acknowledge how badly we failed him and how I believe CMS—specifically our government in total—owes him an apology. And I worry that that's a sign of trouble for us in trying to address this issue because we can have great programs in place, but if we're not listening to the beneficiaries—I mean, having a hotline's great. Teaching beneficiaries how to detect and report fraud is great. He did. And we didn't do anything in response.

So I do have to express that I was disappointed that you did not acknowledge what he went through to make sure that we, as a government, did right by the taxpayers and by him. Because if he was denied services, how many other citizens are out there who are being denied services because of fraudulent conduct? So more of a statement there than a question, I guess.

But specific to his case is, to the best of your knowledge, has CMS begun and conducted any investigation of why we did not heed Mr. West's claims of fraud and that it resorted to him hiring a private attorney to have it investigated?

Ms. BRICE-SMITH. When I heard Mr. West's story, I was very much touched by what he said. And I was trying to figure out what was the root cause and how did that happen. But when he said that he communicated with State officials, I felt like that was appropriate. Medicaid is run by the States. And he indicated he spoke with local people. That was in 2004. And as Ms. Melvin indicated, we had less than six full-time equivalents that even—there was no Medicaid Integrity Group back in 2004. The DRA didn't happen until 2005. We started the building of that infrastructure for staff in 2006. So there was no existence of Federal level contact, if you will. We had—prior to 2005—six full-time equivalents that had no funding, that supported the States when questions came into CMS. So there was really no structural vehicle at the Federal level in 2004.

Mr. PLATTS. I think the point's well made. And that's what your testimony is for, we are trying to do much better today at the Federal level.

But I guess while we didn't have it in 2004 in place, New Jersey, as the operator or the provider of the Medicare services that we're helping to fund, did and was responsible. And I guess what I'm saying, have we even gone back to New Jersey and said, Listen, this is a case where you blatantly failed somebody that we're paying you know a huge share of you to provide this service; and because of your failure, you know, tens of millions of dollars was being lost and but for that private citizen's efforts would have been forever lost. So what has New Jersey done—in other words, what did New Jersey do to better ensure that it's not repeated?

And even though that may be at the State level in addition to what we're doing, CMS has a responsibility to make sure they are doing that. Have we made those types of inquiries to New Jersey to make sure they're doing much better?

Ms. BRICE-SMITH. Yes, we have. We did contact New Jersey and request information about what happened and what was their information in terms of how the communications took place. We're still looking at that information to understand what actions that they plan to take to mitigate that in the future.

In the meantime, CMS has taken a number of actions related to how to report fraud, who are the contacts in the State, even through the 1-800 Medicare line. There's a clear vehicle for people to be able to reach us at any time.

Mr. PLATTS. And I think that's critically important because of the efforts of trying to encourage beneficiaries who, as we talked with the previous panel, are truly on the front lines. They are the ones who see the inaccurate information, you know, if they're diligent as Mr. West was and those are the ones who are suffering the consequences if they're fraudulently taken advantage of because of denying services.

So having a system in place is one thing, but making sure we respond to the information that comes in to that system is going to be key.

A final question here and then my time is going to be up. Regarding Maxim itself. Can you—I don't know if you have it here with you today or if can estimate. For this year, fiscal year 2011 that just ended, roughly how much money did Maxim receive under the Medicaid program nationally?

Ms. BRICE-SMITH. I would have to research that question. I don't have that information.

Mr. PLATTS. If you could provide that. My guess is it's hundreds of millions, if not billions of dollars as a provider in 41 States, they're probably receiving. And as Mr. Cummings in the previous round specified, it just is, to me, incredible that someone who knowingly, intentionally a company defrauded the American people to the tune of tens of millions and if not more—this is what we know of—and would never have known of but for the heroic efforts of a private citizen that that company is still receiving hundreds of millions, if not billions, of dollars from the American taxpayers to provide a service. And it just, to me, sends a terrible message, as Mr. Cummings said, that companies are going to just look at this as the cost of doing business. Hey, if we get caught, we just pay a fine and we just factor that in, but we keep getting the business. And in the real world, the private sector, if you defrauded somebody \$130—\$150 million, I guarantee you, you are not going to be doing business with that company anymore. And they shouldn't be doing business with the American taxpayers. So we need to do much better. And I know there's also a criminal side that we may get into with Mr. Gowdy.

So my time is well expired. I yield to the ranking member, Mr. Davis from Illinois.

Mr. DAVIS. Thank you very much, Mr. Chairman. The Affordable Care Act put into place various provisions. And of course, it was just passed last year to help fight fraud and abuse in Medicare and

Medicaid. The Congressional Budget Office estimates that these provisions, when fully implemented, will save the American taxpayers \$7 billion over the next 10 years.

Ms. Brice-Smith, can you describe the tools and technical changes to the anti-fraud laws that are included in the Affordable Care Act that will directly benefit your office?

Ms. BRICE-SMITH. Sure. In the Affordable Care Act, it offered up several things related to provider enrollment and screening. And we believe that that's the best tool for making sure that we keep people who are more fraudulent or fraudsters out of the program and also be in a place to reverify and validate them over time to make sure that we can keep them out of the program or adjust our scrutiny of them through risk assessments, if you will, over time. So that's part of that.

Then there is the payment of suspension activity with respect to changing the level of proof, if you will, from a reliable evidence-based allegation to a credible allegation; that will also give us additional flexibility.

Then there's also the opportunity for a temporary moratorium that can be effectuated through that vehicle as well.

And also Congress recognized the shortcomings of the data, as we've recognized the shortcomings of the data, in the Medicaid program and offered up section 6504 that will allow us to strengthen the data elements that we desire and need for program integrity purposes.

Mr. DAVIS. Thank you. Mr. Cantrell, what specific aspects of fraud detection do you think will be most positively impacted by the activity that has been included or the provisions included in the Affordable Care Act?

Mr. CANTRELL. One of the things that was included in the Affordable Care Act are stiffer penalties, stiffer sentences for those convicted of health care fraud. And we believe, as was discussed during the first panel, that stiffer sentences are important in deterring ongoing fraud.

Mr. DAVIS. Let me ask you and Ms. Brice-Smith, knowing that there are some of our colleagues who have put forth efforts and have continued to push for a repeal of the Affordable Care Act, if that was to happen, do you see your organizations being affected in any way, certainly negatively affected if we were to repeal the Affordable Care Act?

Ms. BRICE-SMITH. Before the Affordable Care Act, we had improper payments. One would argue that I think we would still have the concerns around improper payments. I think we are working very diligently to address them.

I think many of the concerns I think around repeal seem to be around the growth or the expansion of the programs, and what I have seen from Congress is a recognition that you have provided commensurate administrative tools and authorities to expand our efforts commensurate with that growth.

Mr. CANTRELL. We did receive additional funding for our organization through the Affordable Care Act, and we were able to hire almost 100 new investigators so that was certainly welcome.

Mr. DAVIS. Could I suggest that the Affordable Care Act strengthens your ability to weed out fraud and abuse in Medicare and Medicaid?

Ms. BRICE-SMITH. I would agree with that, yes.

Mr. CANTRELL. Some of the tools and certainly the additional agents on the ground will definitely assist us in weeding out additional fraud.

Mr. DAVIS. Thank you very much and thank you Mr. Chairman.

Mr. PLATTS. I thank the gentleman for yielding back.

I recognize the subcommittee chairman Mr. Gowdy.

Mr. GOWDY. Thank you, Mr. Chairman.

Ms. Brice-Smith, which States have the highest rate of improper payments?

Ms. BRICE-SMITH. That is a very good question. We are aware of which States they are. We do what we refer to as a payment error rate measurement that bans 17 States on a 3-year cycle. We engage those States and expect corrective actions from those individual States. But we do not release it publicly.

Mr. GOWDY. Well, I was looking for the name of a State because it strikes me that you want to put your law enforcement/prosecutorial resources where there is the highest level of graft or fraud or waste or abuse.

So which five States would have the highest improper payment ratios?

Ms. BRICE-SMITH. We would gladly share any of those data with our law enforcement partners, but we usually do not disclose them.

Mr. GOWDY. Why? There are four States being sued right now by the Department of Justice for having the unmitigated temerity to want to enforce immigration laws. Why the reluctance to say which States can't get their act together with respect to Medicaid payments? What is the reluctance?

Ms. BRICE-SMITH. I think it could be perceived as somewhat punitive. I think there is a desire by CMS to work with our State partners to address the improper payments in a meaningful way. We are continuing to do that. The States know who they are. We work with them on a corrective action plans. We follow up on that.

Mr. GOWDY. Do this for me then: Tell me are there any States that on an annual basis just don't seem to get their act together? I can understand not wanting to dime out an episodic State that just had one bad year but then later engaged in corrective actions. Are there any States that just have a history of Medicaid overpayments?

Ms. BRICE-SMITH. I cannot for certain give you the repeated findings because it is early in the per-measurement cycles. We have now completed the fourth year of measuring the States, so we have passed the cycle of the first 17 States now being examined for the second time.

Mr. GOWDY. So you know who the States are, agreed?

Ms. BRICE-SMITH. I do not personally know who the States are, but my colleagues do.

Mr. GOWDY. Someone does know, and they've made the decision to not publicize the States that are doing the worst job?

Ms. BRICE-SMITH. I think our desire is to work with our State partners, and we are continuing to do that in a meaningful way, and we will continue to do so.

Mr. GOWDY. Mr. Cantrell, I was under the mistaken impression, apparently, that the amount of loss impacted the amount of time you went to jail. Apparently, that's not the case, because in the Maxim case, other than watching television at home for 3 months, I only saw one person go to a Federal Bureau of Prison. And that was for what, 5 months? So has that changed since I left the U.S. Attorney's Office? Is the amount of loss or the amount of the fraud no longer a factor in the length of a prison sentence?

Mr. CANTRELL. The amount of fraud is a factor in the prison sentence, and it would depend though on the individuals who were convicted the amount of fraud that was actually attributed to them.

Mr. GOWDY. They still don't have relevant conduct.

Mr. CANTRELL. There is relevant conduct that is taken into consideration.

Mr. GOWDY. They do in the drug cases, they take the lowest mule in a cocaine conspiracy, and they dump all the drugs they can possibly dump on them. But it doesn't happen when it's rich folk committing the crime.

Mr. CANTRELL. I don't think that is the case, sir. I think a recent example we are seeing increased sentences throughout the country—

Mr. GOWDY. Let me ask you about that. Let me ask you about that. How many motions for upward departure are you aware of being filed?

Mr. CANTRELL. I don't have that information, sir. That would be the Department of Justice.

Mr. GOWDY. Can you get that for me? Can you find out? Because that is a really good indicator to me about how serious someone is about criminal activity, whether or not they are going to move that the sentence be higher than what the guideline was? If you can tell me where to find that, I will be happy to do that myself.

Mr. PLATTS. If the gentleman would yield.

Mr. Cantrell, if you could submit that to the committee for the record, that would be great.

Mr. CANTRELL. We will have to get that information from the Department of Justice, but we will work with them to identify what we need to get and provide it to you.

Mr. PLATTS. I thank the gentleman for yielding.

Mr. GOWDY. Thank you, Mr. Chairman.

My final question is, do you believe there is a presumption in favor of criminal prosecution over civil enforcement? When you prosecute somebody criminally, not only can you recoup the losses, but you also get to punish people. So is there a presumption in favor of criminal over civil?

Mr. CANTRELL. That is our presumption in the Office of Inspector General, Office of Investigations.

Mr. GOWDY. What about the U.S. Attorney's Office in the Department of Justice?

Mr. CANTRELL. I believe that is also the case with the U.S. Attorney's Office when there is evidence to support a criminal indictment.

Mr. GOWDY. You heard the facts of Mr. West's case. That wouldn't be a hard case for you and I to win would it?

Mr. CANTRELL. I can't comment on the specifics of that.

Mr. GOWDY. Sure you can. He just announced it to the whole world. Even you and I can win a case where you are billing someone while they're at the U.S. Attorney's Office for a meeting; you and I could win that, couldn't we?

Mr. CANTRELL. That case, it sounds obvious, there are I'm sure several factors that we went into decisions at the U.S. Attorney's Office to determine who to prosecute and who not to prosecute.

Mr. GOWDY. I yield back.

Mr. PLATTS. I thank the gentleman for yielding back.

The ranking member of the full committee, Mr. Cummings, recognized for 5 minutes.

Mr. CUMMINGS. To Ms. Brice-Smith and to Mr. Cantrell, as you heard, I was very upset that a kid from Baltimore, thousands of them by the way, thousands, can face a lifetime of economic punishment over a few hundred dollars stolen, yet a company like Maxim can be found guilty of stealing from taxpayers, pay a fine and continue to bill the Federal Government for millions of dollars of services each year.

Ms. Brice-Smith, do you share that sentiment? Something is wrong with that picture.

Ms. BRICE-SMITH. I'm equally concerned about the equity that you have pointed out.

Mr. CUMMINGS. Yeah, and who has the power, by the way, do you all have the power, who has the power to debar these companies?

Mr. CANTRELL. We do have the power to exclude providers.

Mr. CUMMINGS. Have you ever done it can?

Mr. CANTRELL. Certainly, we do.

Mr. CUMMINGS. Why not this company?

Mr. CANTRELL. The decisions on who to exclude is based on several factors, including access to care as well as the specific conduct and the expectation of whether they will continue the bad behavior or not. We utilize, in cases where we do not exclude corporations, we utilize corporate integrity agreements, in this case, there was a deferred prosecution agreement where we will monitor this corporation in hopes to—

Mr. CUMMINGS. To hell with monitoring. They've already done it. If you had somebody working in your house, cleaning your house and you came home and your wife's bracelet that was worth \$50 is missing, you don't hire them again. Duh.

What do mean deferred prosecution? This company needs to go. How many other companies are like this or, in other words, have defrauded the people of the United States of America, have taken away services from people like our witness, our earlier witnesses, and are still doing business with Medicaid? How many?

You're the IG. You sat up here and you said all these wonderful things, sounds nice, oh we're doing this, and we're doing that. That's real nice. But what I'm trying to tell you is that your normal is not good enough. If you're going to come in here with a badge on your chest and talk about what you've done in a company that's taken millions of dollars away from taxpayers is still doing busi-

ness, and they come in 41 States and have said, all right, we're ready to do business again, yeah, we've stolen from you, but we're ready to go. And we say, okay, all right, we'll do it. Something is wrong with that picture, and you're the IG. So is that the normal that we should expect?

Here we are slashing budgets, people talking about slashing Medicare, slashing Medicaid, slashing Social Security, and we've got some greedy folks who are out there stealing money from people, and you're going to tell me that we have the power to debar, and we're not using it? In what case will we use it?

Mr. CANTRELL. We use it, on average, nearly 3,000 times every year.

Mr. CUMMINGS. Well, why not this company?

Mr. CANTRELL. As I said, there are factors that play into the decision, depending on whether they are criminally convicted or whether there's going to be an impact to access to care going forward and their expectation of whether or not they will continue to commit the fraud or whether we believe that, through compliance monitoring, we can bring them into the fold and allow them to continue to provide services to the population that they are serving.

Mr. CUMMINGS. Oh. Oh. The fact that maybe they steal your wife's broach, you say to her, or the cleaning person, you say to her, oh, Ms. Jane or Mr. Johnson, yeah, you have stolen a broach, but we want you to come back in because we think you can be rehabilitated. We think the next time you have a cleaning assignment, you won't take the diamond ring. Something is wrong with that picture. And I guess what I'm trying to get through to you is that that is not the normal. Our country is better than that.

And there are people in my district that are suffering because they can't get the services they need, but yet and still, we are letting these companies do this.

And by the way, there are other situations in government where people did much less than this, and they'd be out. Again, I go back to the young boys and girls in my district, some of whom live in my block and if they stole a \$300 bike, they would be punished for a lifetime, not a day, not an hour. And they damn sure wouldn't get a multimillion dollar contract and multimillion dollar contracts in 41 States.

I would be embarrassed to even come in here and stick out my chest talking about what I have accomplished when the company is still—they've got to be looking at us like we're fools. So I'm hoping that we'll be able to work in a bipartisan way to get rid of Maxim because see, all of this stuff you're talking about, it does not matter if the end result, Mr. Gowdy said part of it—I'm almost finished, Mr. Chairman—part of it is making sure somebody goes to jail, but there is another part.

That other part is saying to them that we are not going to allow you to do business and screw over the American people any more. That's the second part. And you can do all these things you're talking about, bring in all the technology you want to talk about all these wonderful things you're doing, but if there's not that end result, do you know what they do? They just come right back, and they pay the price, but they come right back.

Thank you, Mr. Chairman.

Mr. PLATTS. I thank the gentleman.

The gentleman from Arizona, Dr. Gosar, is recognized.

Mr. GOSAR. I got to tell you, this is great playing the closer on these two gentlemen right here. I couldn't agree more. Being a health care provider who did Medicaid for 7 years and left it for all the reasons they talked about, I did not stop; I just provided it for free.

This system, we are starting to talk about access to care, and the only provider is those that are thieving in one of the most densely populated parts of the country is absurd to me folks, absolutely absurd to me.

So I'm going to ask you something real quickly. I want to give you the opportunity to give yourself a grade in front of the American people on how you think you have done this job in regards to policing yourself.

Mrs. Brice-Smith, give yourself a grade.

Ms. BRICE-SMITH. In light of our youngness of our program—

Mr. GOSAR. I don't really care. Give me a grade.

Ms. BRICE-SMITH. C.

Mr. PLATTS. Mr. Cantrell.

Mr. CANTRELL. I would give us a B. I know—we know there is much more fraud out there that we need to attack, but we are improving every year. This last year was a record year with 720-plus criminal convictions, which is over 50 more than our previous record year, and \$4.6 billion in recoveries through these criminal and civil fraud investigations.

Mr. GOSAR. I'm going to interrupt you there, because I think what you have to do is you are working on behalf of the American people, and I doubt that they would give you a above a D. Don't you agree with me?

I think so. I have been out there on Main Street walking this, and so I understand this very well. Because there is a missing component; the process, the whole process is broken here because the problem for this gentleman, Mr. West, here would have been a lot less if he was empowered to help make those decisions on the ground. And we have failed to do that.

Let me ask you a question, Ms. Brice-Smith, when we were looking at these innovative ideas of making some change, did you contact Visa or MasterCard on what may be some ideas they may have to reduce some of the fraud, waste and abuse?

Ms. BRICE-SMITH. CMS has engaged credit card companies in using the analytics and tools that they have available and try to apply that in the Medicare claims.

Mr. GOSAR. How would you look at that as far as the IT systems? I know that in a lot of the States in the IT system its lowest bid buys. That is not usually a good investment, as far as I'm concerned. Dentists love their toys, okay, and the better the IT, the better, and so sometimes it's not the most frugal decision that is always is better.

Would you agree?

Ms. BRICE-SMITH. Yes.

Mr. GOSAR. Do you work with the States in allowing them to have the flexibility to working with that?

Ms. BRICE-SMITH. Yes, we do. In fact, we have incentivized the States to upgrade and enhance their IT systems for the future. We have done that through setting what we refer to as a matching a 90–10 match, where they get additional funding, but we apply criteria or expectations to that funding so we can have a better system at the State level for the Medicaid claims.

Mr. GOSAR. So when you start looking at, I look at these two gentlemen looking at criminal prosecution, and very few people or fewer people, I should say, in the criminal division really want to renege on their rules of parole. And the reason I look at that and I bring it to point is called bounty hunters, is because they have a lot more eyes on the prize. There are some incentives. And it seems to me when you lot these F maps on reimbursement rates, we ought to be engaging the States for activity, as well as patients.

The first person who is going to know is the patient. And giving them some oversight on their bill. That's why it needs to be in hand. And I think that what we are trying to do is we're putting a Band-Aid here. And I will tell you I'm one of these people speaking I'm tired of Band-Aids here. I came to Congress to recorrect things. I think trying to reconstruct doing the same things over and over and expecting a different result is insanity, absolutely insanity.

But we need to start empowering patients. And that's not what you've done. There is no part of this—that does not empower these patients. And I can tell you I have firsthand knowledge of that. I served our dental patients who couldn't be seen by a federally qualified health center. I can repeat stories, not as bad as this because they're dental, but I can repeat this all day long. It's sad. Because I think what we ought to be doing is sharing that information all across the sandbox, not playing and not explaining who is a bad player here, and allowing them to be still participating to the rules is criminal. And it is criminal on our part for not changing it.

That's what's wrong here.

So let me ask you a question, I want to see thinking outside the box, how could you envision something that we could empower patients like Mr. West to have some skin in the game, to be one of those whistleblowers and to uphold their ability and right? Give me some ideas, Ms. Brice-Smith.

Ms. BRICE-SMITH. We have already observed that there are a handful of States that have developed sort of reward programs, if you will, that are short of sort of the *qui tam* approach of the False Claims Act but will give cash for tips, if you will, related to health care fraud.

So there are already a handful of innovative States that have recognized that that is an additional insight and benefit to fighting fraud.

Mr. GOSAR. Do you have an insider newsletter that says, hey, listen, these State are on cutting edge, days to crime, days to time?

Ms. BRICE-SMITH. We are using our education to be able to communicate and outreach that information. We also use best practices summaries for the States so that we can inform other states of what States that are being innovative are doing. So we use our

Web sites, we use forums and meetings and our Medicaid institute to communicate that information.

Mr. GOSAR. Thank you. I'm out of time.

Mr. PLATTS. I thank the gentleman.

I'm going to go to a second round here, while we have the opportunity for a few more questions. Yielding myself 5 minutes. First, to follow up on the questions of Mr. Gowdy about the States that are most egregious as far as improper payments. It sounds like your contention is that information is not subject to the Freedom of Information Act [FOIA].

Ms. BRICE-SMITH. I am not sure FOIA, but we could certainly, I could certainly look into that.

Mr. PLATTS. Because I've shared his, I guess, statements regarding the fact that American taxpayers are sending \$275 billion to States to handle properly, and I think the American taxpayers have a right to know which States are doing it well and which States are not. And I'm not sure, I would be interested in any additional feedback from CMS as to why we don't want to share—often in cases of deadbeat dads, one of the ways we can get them to pay is we publicize that they are not paying. We shame them into paying.

Well, maybe we need to shame these States into doing a better job of protecting the American people's money. So I do look forward to further interaction with you and CMS on that.

Mr. Cantrell, on the specific case of Mr. West, appreciate various factors. I find it somewhat unbelievable that we are still doing business with this entity.

Can you tell me when, the 41 States, as part of the agreement, in addition to Mr. West's case in New Jersey, was there evidence of other similar misconduct in other States regarding this company?

Mr. CANTRELL. Yes, there was. The \$250—\$150 million was not related specifically to Mr. West's scenario. It was a broader issue.

Mr. PLATTS. In how many States would, if you know, or estimate that we found this misconduct?

Mr. CANTRELL. I don't know specifically. The answer to that.

Mr. PLATTS. That, to me, would go to, if it was just New Jersey, and we had some bad apples in one subdivision of this large company, that is one thing to say we're not going to punish the whole company. But if we found similar misconduct in half, 20 of the 41 States, that's a very different story.

So if you could provide to the subcommittee how many States and how many different States do we find similar misconduct by Maxim?

Mr. CANTRELL. I don't believe our evidence suggested that they were committing 100 percent fraud across the country, but I don't know how many States. But we will get back to you on that.

Mr. PLATTS. We would welcome that information.

Also, looking at an analogy to the private individuals in a criminal sense, when we have a victim, because most of our focus has been about the money, which is very important, but it is also about the care provided. As we heard from the testimony of Mr. West, because of the fraud Maxim committed, it wasn't just the money being lost; it was care to an individual. And that is an even more

serious crime in my opinion; because of their intentional fraudulent conduct, they denied medical care.

Given that he was a victim directly, taxpayers in total were victim, but he was a victim directly of their misconduct, was he consulted or any other similar victims consulted as to whether they felt the settlement with Maxim was acceptable punishment for their wrongdoing?

Mr. CANTRELL. I believe, as in most of these cases, the attorneys for Mr. West, Ms. Page, would probably have been participating in some of those discussions, yes. I don't know specifically in this case how it was, but that is, I believe, the routine.

Mr. PLATTS. So and they are given the opportunity to say, yes, I sign off on this, or they are just aware of this.

Mr. CANTRELL. I think they're aware of it. I don't know that they have the ability to stop, stop it from happening.

Mr. PLATTS. In a sentencing in a court, there is a formal process where the victims can offer testimony to the final decider. Do you know if there is any formal process of that nature where a victim can make a presentation to the U.S. attorney directly that is going to make that decision?

Mr. CANTRELL. Certainly, there is the opportunity. I don't think there was a sentencing hearing in this case, so there was no, may not have been the opportunity to do it in a courtroom, but I believe it have would been conversations between U.S. Attorney's Office and the assistant U.S. attorney, Mr. West.

Mr. PLATTS. My hope is that we make sure that is a formal process, a routine part of any settlement. Because I do acknowledge that you can have somebody who had some bad apples in a small way, that's got to be factored in versus a more deliberate across-the-board fraudulent case. But we have to remember there are victims here that aren't just about money; it is about care being denied, and that is a very serious crime in my opinion.

I want to quickly get to two other issues. In your testimony, Mr. Cantrell, you talk about the Medicaid statistical information service, and you reference in your testimony about some of the data is 12 years old? How common is that?

Mr. CANTRELL. Sir, let me correct the record. That is 1 and a half years old.

Mr. PLATTS. Twelve years just seems so outrageous. But even 1 and a half, when you talk about then trying to correct it, it goes to the point of I guess what you talked about and Ms. Brice-Smith of trying to much more quickly identify, respond to and prevent, because 1 and a half years even is the money is long gone.

Mr. CANTRELL. We agree. The more timely the data, as close as we can get to real time, the better we are. On the Medicare side, as I said, we have a lot more success to talk about. We use that data, which is much more timely to mine for fraud, identify areas where we have hotspots of fraud. We had the strike force model, which we utilized. We deploy those to areas of the country where there is high instances of the fraud, such as south Florida, Bronx, New York, Detroit, Los Angeles, Dallas, Houston.

Mr. PLATTS. Seeking to replicate where you have had success for Medicare to Medicaid?

Mr. CANTRELL. Absolutely.

Mr. PLATTS. And that's one of the things that came through to me in preparing for this is that it seems like there is almost a conscious decision within CMS to devote much more attention and resources to Medicare fraud than to Medicaid fraud. Is that a fair, until the last, say, 5 years. Is that a fair statement?

Mr. CANTRELL. I would have to defer to my colleague on that question.

Mr. PLATTS. Ms. Brice-Smith, is that it, that we are kind of late to the game on the Medicaid side?

Ms. BRICE-SMITH. I think you're recognizing certainly the support that Congress gave us through DRA in that 5 year period.

But I think one could take that a step further. The Medicaid program was structured to be administered day to day by the States, so those claims are going to the States or their fiscal agents. And we are engaged at the postpay with the subset of data to try to oversee the——

Mr. PLATTS. I think a very valid point. In the Deficit Reduction Act and as Mr. Davis well reflected in the Affordable Care Act, there is a greater understanding here in Washington in the last 5 years that maybe it's State administered, but bottom line is we are paying the majority of the bill. And so we need to be a little more proactive in protecting the taxpayer funds. And that is why I said I think we're late to the game, but we are finally getting there and being more, I think, hands on in trying to protect those dollars.

I know, I'm one last question. I appreciate my colleagues' indulgence here with being way over my time, and Ms. Yocom, in your testimony, you talk about the, again, the Medicaid statistical information system and you talk about what States are supposed to provide. But it says MSIS does not contain billing information such as referring provider's identification number or beneficiary's name. The less information provided, the harder it is to say, hey, this provider, obviously, is billing for an inordinate number, and that would be one of the flags that would jump out that there may be something askew here.

Can you try to address, based on your knowledge, why aren't we requiring States to provide all of that information to make the MSIS system a more useful tool, to be more timely, but also more comprehensive?

Ms. YOCOM. I can't speak to why we don't require it, but I can speak to the effect of not having that information available. As you say, it's impossible to do some of the data mining techniques on things that are done routinely on the Medicare program.

GAO does have some work underway right now, and that is just looking at the States' capabilities and their activities in this regard.

Mr. PLATT. Thank you.

Ms. BRICE-SMITH. May I speak a little bit to that?

Mr. PLATTS. Yes.

Ms. BRICE-SMITH. I just want you to be aware that we are taking active actions to actually enhance that data. We are referring to it as transformed MSIS data, which is largely expanded. We're currently pilot testing it now to test drive, if you will, if that data will give us a better output in terms of program integrity activity among 10 volunteer States. So we are very excited about that.

Mr. PLATTS. My hope is that that is successful, and I will say more successful than IDR and the one program integrity, which many years in doesn't seem that we're getting the results that were intended and certainly not in the timeframe, and I am way over my time.

Mr. Davis, I don't know if you had other questions. I yield to the ranking member, Mr. Davis.

Mr. DAVIS. Thank you very much, Mr. Chairman.

The cap on services and denial of his dental needs were a major red flag to Mr. West that something was awry, that something was wrong, something was not right with his benefits.

Ms. Brice-Smith, to those patients without a similar cap, are they less likely to ensure that their services are properly being rendered and billed to Medicaid correctly?

Ms. BRICE-SMITH. I think what we've learned about fraud if you, many fraudsters can submit a very clean looking claim. And you have to examine many other factors, such as complaints from beneficiaries, such as our own data analytics in terms of patterns and trends to see, does this really make sense? Is this even feasible that he could have used that many services for example.

Mr. DAVIS. The 1-800 Health and Human Services tips hotline is widely publicized as an avenue that individuals can use to provide information that assist in combating fraud waste or abuse in Federal health care programs.

While the extent of health care fraud is estimated to be in the billions of dollars each year, HHS emphasizes that Medicare and Medicaid beneficiaries are the frontline of defense in detecting Medicare and Medicaid fraud because they have firsthand knowledge of the health care services they have received.

Mr. West contends that there was no follow-up to his hotline calls.

So, Mr. Cantrell, could you provide information on the 800 HHS tips hotline, what procedures are followed, and any timeframes there might be to handling or responding to complaints?

Mr. CANTRELL. Sure. We have the 1-800 HHS tips telephone line, which in this case, Mr. West, we don't believe he contacted that. I think he called the State and local offices. But we have that phone number. We also have a Web site, where we collect complaints via Web forum. And between those two mechanisms, we receive thousands of complaints every year. And we have a process for evaluating those complaints, determining the—whether there's enough information there to proceed with an investigation or whether there isn't enough information.

In some cases, we refer those complaints out to our regional offices for our investigators to look at further, and in other cases, we refer them directly to CMS for administrative review.

Mr. DAVIS. While our focus today has been on Medicaid fraud, I will just point out that there is also fraud in the private sector, in private health care. For example, in 2009, United Health paid \$350 million to settle lawsuits related to the intentional manipulation of the reasonable and customary rate. And also Pfizer, in 2009, paid a \$2.3 billion civil and criminal penalty for unlawfully marketing medications for conditions that they had not been approved for by the Food and Drug Administration.

Ms. Melvin, Ms. Yocom, could you comment on the challenges, from GAO's perspective, of looking seriously into the private sector fraud and abuse situations?

Ms. YOCOM. Well, one of the challenges of looking into the private sector, I think, particularly on Medicaid, might be the Federal State partnership. That is an unusual circumstance to begin with.

Data is also a huge challenge in terms of combating fraud. And the steps that CMS is taking right now are in the right direction, but there is a lot of work to be done there.

Mr. DAVIS. Ms. Melvin.

Ms. MELVIN. From a technical perspective, in looking at moving data, for example, from the States into the integrated data repository, a lot of the key challenge stems or surrounds having to make sure that the data is of a format, that the their data elements follow formats that are consistent with the IDR requirements for a file format. So there are technical challenges in being able to do that.

One of the concerns we raised in our report is CMS's plan, as we understand it, to try to bring all of the 50 States or 50 plus programs data into IDR by September 2014, I believe. The concern we have is what type of planning they will have in place to make sure that they can, in fact, bring that data, consolidate it, identify all the data elements that are very different.

We talked previously about disparate systems in all of the different State programs, and those have to be addressed, the differences in data have to be addressed and brought into the system in a common format.

We have not seen plans yet. We haven't done the work that would allow us to know how effectively CMS is handling that particular challenge.

Mr. DAVIS. Thank you very much.

I want to thank all of the witnesses.

And thank you, Mr. Chairman, for this hearing. And I yield back.

Mr. PLATTS. I thank the gentleman.

Dr. Gosar.

Mr. GOSAR. So let me ask you a question. We are talking about fraud. Is it just limited to the private sector, or is it also for public health? Ms. Brice-Smith.

Ms. BRICE-SMITH. I believe that there are equally concerns in private and public sector in terms of fraud, waste and abuse. And I think evidence of that certainly is the American Medical Association's own fourth annual report card on health insurers, which showed their error rate was double, more than double certainly the Medicaid error rate.

So when you think about extrapolating even that out, you're talking about a savings in the private sector of \$70 billion right there. So I think that is an example.

I think with Medicaid and Medicare, two big high priority programs, we certainly recognize that we tend to report and disclose, and we are transparent, as we should be, but many private companies don't have to be transparent about the fraudulent activities that might be occurring.

Mr. GOSAR. I also want to highlight federally qualified health centers. I'm a dentist, just to make sure that we all get that out

there, that when we work a rule, for example, a child, we numb up the whole quadrant, and then we only do one tooth at a time because of the reimbursement rate. Would you call that fraud? I do.

Ms. BRICE-SMITH. It sounds like there are a lot of things going on that we would have to take into consideration in terms of how that billing is occurring. It sounds like that might be an effort to unbundle services possibly. It might draw some suspicions depending on how—

Mr. GOSAR. Do we have the same scrutiny on federally qualified health centers as we do everybody else?

Ms. BRICE-SMITH. Certainly, they are inclusive. Although I think our efforts tend to be focused on where we relieve the greater Medicaid expenditures and the greater vulnerabilities are and the categories of services that tend to drive the error rate as we know it today.

Mr. GOSAR. Ms. Yocom, do you believe that the Medicaid, the State Medicaid systems are maybe too big and unwieldy the way they are?

Ms. YOCOM. Too big—

Mr. GOSAR. To oversee properly? We're finding a big problem here, and it just seems like it is unwieldy.

Ms. YOCOM. I think the actions taken by the Congress under the Deficit Reduction Act and under the Patient Protection and Affordable Care Act meant a lot of activity which can help oversee these programs in a better fashion.

To speak to the States on this, this is a partnership, but CMS also needs to be able and willing to—

Mr. GOSAR. Give up some of the rules.

Ms. YOCOM. Yeah.

Mr. GOSAR. It seems to me like we're talking about a broken system. It is very obvious to me. I'm from rural Arizona. We don't get paid. I can tell you right now, in dentistry, you might be getting paid in 6 months. So I don't know too many people that can make a business work that way. Somehow we do.

But in this government take-over of health care, that's the only way I can talk about it, okay, we are going to dump another 20 million people into this, into a broken system. I don't see a lot of urgency in fixing this situation and looking outside the box for solutions.

Do you agree with me?

Ms. YOCOM. Well, it's not my position to agree or disagree.

Mr. GOSAR. Do you agree it's broken right now?

Ms. YOCOM. I think the facts are we need to do better on program integrity, yes.

Mr. GOSAR. And it's going to be problematic when you dump another 20 million people in there.

Ms. YOCOM. And the best approaches are, frankly, to keep the payment from happening at the beginning.

Mr. GOSAR. In Medicare, most of our Medicare patients are older, right? They are very responsible, and they have been empowered to look at bills, which gets back to my point about empowering people in being part of that.

I want to go back to that and ask you a question.

Do any States use the advanced analytics, like the credit card industry, that would spot in realtime an outlier of billing practice before payment goes out the door?

Ms. MELVIN. We have just started work to look at that, so I'm not in a position yet to say exactly what States are doing. We do know there are analytical tools that are being used in some capacity by them at this point, but I couldn't speak to how much or to what extent they are using them.

Mr. GOSAR. Are there any rewards to utilizing the analytic tool?

Mr. MELVIN. The analytic tools, as I understand them, are to be used in particular to help prevent improper payment so that it allows them to analyze, say, if you will, mined data and really make calls on data that would help them to prevent fraud and improper payments on the front end versus, for example, the integrated data repository and one PI tools that we have currently assessed, which are, at this point at least, focused on the back end in terms of identifying improper payments after they've been made.

Mr. GOSAR. Indulge me just for a second. To me, it seems like there is a common tool here I want to get to. It's on the front end with a card empowering the patient to pay to make the system a lot faster.

Because here is another part to this. There's also the State board because when you defraud a patient on a billing process directly when they're paying for it, it is also a standard of care issue. So, therefore, there is a better penalty that we're talking about.

So I think that there should be some aspect that we look at the front end more so the back end in empowering patients. And I think you've got something that works very, very well.

I come from a State that the dental board is extremely active. Arizona is not one, two or three in the country for population, but we are for activity, because patients are empowered. And that's where we need to go. And I think that's what we're failing to do is empowering people.

And I see constantly, I'm approached by the WIC program, saying, Dr. Gosar, we need you to sign a contract? And I say, why are we signing a contract? What's the deal? Why is it taking a WIC mother six or seven visits just to see the doctor? Something is wrong there. But there's also something right because women are speaking out about that process.

And I think the more eyes on the prize, the stiffer the penalties, I think the better opportunity that that happens in empowering States to make those jurisdictions really helps and I think standard of care is a remarkable tool.

Mr. PLATTS. I thank the gentleman.

And I would just comment, as we heard Mr. West's testimony, it seems like not only empowering the patient, the beneficiary, but in this case, we heard we discouraged and prevented them from taking hold. So we do certainly do need to do much better.

And I think as we wrap up here kind of a final comment and that's that we need to remember that there are two issues at hand here. First, it's protecting tax dollars, and while certainly we're glad to have the improper payment rate for Medicaid to be down, we're still talking about \$22 billion of improper payments this last past year that we know of. And again, using Mr. West's case, but

for his individual heroic efforts to uncover the fraud, we would not have known about Maxim. And so how many other Maxims are out there that we don't know about? The \$22 billion is what we do know about of improper payments. So when we talk about the whole number of \$125 billion, there are some estimates that that is probably at least \$200 billion, but we only know of \$125 billion. So we certainly have a lot of work to do.

I want to thank each of our witnesses for your testimony here today, both your written testimony, which is, again, very helpful in preparing, and your oral testimony here today, and most importantly, for your efforts day in and day out.

I know we are all on the same page, that we are trying to seek the same result, and I think that with the Deficit Reduction Act of 2005, the Affordable Care Act language on trying to better go after fraud, we're all collectively better acknowledging and starting to commit the resources necessary to protect ours, ensure the care that is earned and deserved is provided and not denied inappropriately.

So I commend you for your efforts, and we certainly as a committee look forward to continuing to work with you, both subcommittees, work with you and your respective agencies on this important issue.

We will keep the record open for 2 weeks for additional information as was requested to be submitted, and we stand adjourned.

[Whereupon, at 1 p.m., the subcommittees were adjourned.]

[The prepared statement of Hon. Gerald E. Connolly and additional information submitted for the hearing record follow:]

Statement of Congressman Gerald E. Connolly  
Preventing Medicaid Fraud  
December 7<sup>th</sup>, 2011

Reducing Medicaid improper payments contributes directly to the long term health of these essential health care programs. I appreciate our two subcommittees holding a hearing on the different anti-fraud programs within Health and Human Services (HHS) and Centers on Medicare and Medicaid Services (CMS). While HHS and CMS are devoting unprecedented attention to reducing Medicaid fraud, it is clear that we must do more to reduce improper payments and protect the economic security of individuals such as Richard West who have lost benefits temporarily as a result of attacking Medicaid and Medicare fraud.

As the written testimony for this hearing makes clear, Congress and the administration have devoted a great deal of effort to reducing improper payments within the last decade. In 2005 Congress passed the Deficit Reduction Act, which established the Medicaid Integrity Program (MIP). The MIP provides states with technical assistance to identify and prevent fraud, which is appropriate since states administer Medicaid. The Deficit Reduction Act also requires CMS to work with Medicaid Integrity Contractors (MICs) to ferret out overpayments, conduct audits, and educate program participants about fraud prevention. CMS uses this and other data for its Medicaid Statistical Information System (MSIS), which includes eligibility and claims information across the United States. By maintaining a central database CMS can conduct analyses which identify possible fraud or areas where fraud is likely to occur. CMS also works with agencies to duplicate best practices, and has identified 52 best practices that could be replicated.

Despite these laudable efforts, it is clear that more can be done to reduce fraudulent Medicaid payments. As the testimony of Richard West and Robin Page West demonstrates, CMS has not always been responsive to reports of fraud. I look forward to learning more from Ms. Brice-Smith and Mr. Cantrell about what CMS is doing to prevent such negligence from occurring in the future. Ensuring robust implementation of existing policies is essential because CMS also must implement important new reforms enacted under the Affordable Care Act.

As Ms. Brice-Smith notes in her testimony, the Affordable Care Act, sometimes referred to as "ObamaCare," significantly strengthens anti-fraud programs. These include elementary reforms such as requiring service providers and suppliers to document orders and referrals. The Affordable Care Act established the Medicaid Recovery Audit Contractor (RAC) program to create incentives for contractors to reduce fraudulent payments. In conjunction with Secretary Sebelius' Center for Program Integrity, the Affordable Care Act is designed to identify improper fraud payments before they are issued by CMS.

I hope today's testimony illuminates the progress we have already made and additional administrative improvements which would reduce Medicaid fraud. Perhaps we should consider more stringent punishments for companies which systematically defraud Medicaid, as Mr. West suggests in his testimony, or consider harsher penalties for the management of such companies. Thank you again for holding this hearing and to the witnesses for their attendance.

HHS OIG (Gary Cantrell) Responses to Questions for the Record  
“A Medicaid Fraud Victim Speaks Out: What’s Not Working and Why?”  
12/7/11

- Q: How many states was Maxim committing fraud in?
- A: The Department of Justice (DOJ) entered into a Deferred Prosecution Agreement (DPA) with Maxim; therefore, fraud was not adjudicated against the corporate entity and thus there is not a list of States in which fraudulent conduct can be attributed. To date, nine individuals--eight former Maxim employees, including three senior managers, and the parent of a former Maxim patient--have pleaded guilty to felony charges and been sentenced for conduct arising out of the submission of fraudulent billings to government health care programs, the creation of fraudulent documentation associated with government program billings, or false statements to government health care program officials regarding Maxim's activities. The charges involved conduct in the States of Arizona, Florida, Georgia, New Jersey, Texas, and South Carolina. The Committee may find helpful the DPA, available at <http://www.justice.gov/usao/nj/Press/files/pdffiles/2011/Maxim%20DPA.pdf>, and the settlement agreement, available at <http://www.justice.gov/usao/nj/Press/files/pdffiles/2011/Maxim%20SA.pdf>.
- Q: What was the total amount of fraudulent claims from Maxim that OIG found in its investigation?
- A: DOJ entered into a DPA with Maxim; therefore, fraud was not adjudicated and thus there is not a dollar amount that can be attributed to fraudulent claims. However, the DPA, available at <http://www.justice.gov/usao/nj/Press/files/pdffiles/2011/Maxim%20DPA.pdf>, notes that “[Maxim] received more than \$61 million to which the Company was not entitled as a result of its conduct as described in the Criminal Complaint and the Statement of Facts.” The Committee may also find helpful the Maxim settlement agreement, available at <http://www.justice.gov/usao/nj/Press/files/pdffiles/2011/Maxim%20SA.pdf>.
- Q: Are victims allowed to make recommendations or negotiate in whistleblower cases in order to help arrange damages in a settlement?
- A: DOJ administers the False Claims Act (FCA) and is responsible for all aspects of the Government’s coordination with whistleblowers. In OIG’s experience, whistleblowers often provide information that may be used, along with other information gathered during the Government’s investigation, to determine the damages in the case.

- Q: Were Mr. West and/or his attorney, Robin Page West, involved in the settlement negotiations with Maxim?
- A: As described above, DOJ takes the lead with respect to any negotiations involving whistleblowers. In OIG's experience, whistleblowers are often involved in the settlement negotiations and typically sign the civil settlement agreement, as Mr. West and his counsel did in this case.
- Q: How often does the government file a motion for upward departure when prosecuting health care fraud cases?
- A: OIG does not have record of this information, as DOJ is responsible for filing motions for upward departure. We contacted DOJ in an effort to collect this information but they do not track the number of times the government files a motion for upward departure. If, however, the Subcommittees are interested in the number of times defendants actually received upward departures, DOJ has advised that it can provide this information through DOJ's Office of Policy and Legislation.

Angela Brice-Smith  
“A Medicaid Victim Speaks Out: What’s Not Working and Why?”  
Hearing on December 7, 2011

Questions from Rep. Todd Rusell Platts, Chairman,  
Subcommittee on Government Organization, Efficiency and Financial Management

Lead-In

*In 2004, Richard West filed a whistleblower lawsuit resulting in an investigation of Maxim Healthcare Services, Inc., which found that Maxim was submitting fraudulent claims to the Centers for Medicare and Medicaid Services (CMS). In September 2011, Maxim reached a \$150 million settlement for committing Medicaid fraud.*

**1. How much money has Maxim received from CMS since the investigation of Maxim began? How much money has Maxim received since Maxim reached a settlement?**

**Answer:** CMS continues to work with the committee to identify the claims associated with billings from Maxim, and will respond to that request accordingly.

**2. How did New Jersey and other states where Maxim had been committing fraud address this failure in oversight? Did CMS issue any recommendations, and if so, what were they?**

**Answer:** Frauds such as the one perpetrated by Maxim are often inordinately hard to detect because the underlying fraud schemes are meant to operate covertly, with submitted claims intended to look clean and subvert claims processing systems’ edits and fraud analytics. Nevertheless, continually improving automated fraud analytics that CMS (with respect to Medicare) and the States (with respect to Medicaid) are increasingly deploying are better able to discern, in real time, aberrancies that should enable such conduct to be detected earlier.

CMS has been a leader in piloting the use of predictive analytics to detect aberrancies in Medicare claims. CMS intends to rigorously scrutinize this emerging technology, subject it to continuous quality improvement cycles, ensure it delivers the best value for the taxpayers, and actively engage in technology transfer to share lessons learned and help diffuse this technology to the States. Further, CMS is aware that the HHS/OIG has proposed a rule to enable State Medicaid Fraud Control Units (MFCUs) to engage in data mining to further enhance the States’ ability to detect potential fraud as early as possible. (With respect to Maxim in particular, we are fortunate that a beneficiary—who only incidentally hails from NJ, which is why the enforcement action arose there—had carefully compared his services received against his statements and discerned and reported the fraud.)

Moreover, CMS’ Medicaid Integrity Group (MIG) has a proactive agenda to continually analyze and recommend improvement to State Medicaid program integrity (PI) operations. CMS conducts triennial reviews of State program PI operations to identify areas of non-compliance and program vulnerabilities as well as highlight effective PI practices by States. Because the

reviews are broad in scope, they do not probe down to an analysis of individual provider billing behavior. CMS requires States to submit corrective action plans (CAPs) in response to findings and other vulnerabilities identified through the review process, and staff reviews the CAPs with the States. Likewise, CMS reviews and evaluate the CAPs that States submit in response to findings in CMS' Payment Error Rate Measurement program. Through both of these processes, States have instituted significant quality improvement initiatives.

CMS also issued Fraud Referral Performance Standards in September 2008 that set minimum standards for adequacy of information that State PI units provide in making referrals to MFCUs. Since the issuance of the Standards, MFCUs have reported substantial improvements in the quality of referrals from States' PI units and both the PI Units and the MFCUs report better collaboration. Under provider screening regulations promulgated February 2, 2011 to implement provisions of the Affordable Care Act, these Standards are now required for all referrals to MFCUs.

**3. Has CMS worked with New Jersey and other states where Maxim had committed fraud? If so, what did CMS do to strengthen oversight in those states?**

**Answer:** CMS sponsors ongoing training at MIG's Medicaid Integrity Institute (MII), which is based at the Department of Justice's National Advocacy Center in Columbia, South Carolina. Since its establishment in 2008, the MII has provided training to over 2,600 State Medicaid employees through a variety of courses. New Jersey has had 44 staff attend training courses at the MII. This training includes:

- PI fundamentals;
- emerging trends in home health care and durable medical equipment;
- emerging trends in managed care, investigative techniques, and data analysis;
- correct coding, with training leading to coder certification to ensure that State Medicaid program staff that conduct claims reviews are well qualified; and,
- interactions between MFCUs and PI Units Symposium designed to foster better PI unit/MFCU collaboration and coordination, and where PI and MFCU representatives from each State paired and worked together throughout the course.

All costs associated with MII training, including transportation, lodging, and tuition, are provided free of charge. As a result of the work accomplished by the MII, we believe that many fraud schemes such as that perpetrated by Maxim would now be identified more rapidly at the State level. CMS has also established a secure website through the MII which allows States to exchange best practices as well as to share sensitive information confidentially. This tool has allowed the level and degree of communication across State Medicaid programs to increase significantly in the last few years.

CMS has also engaged several States in discussions about undertaking joint field investigations of problem providers in home and community based care programs. Since October 2011, CMS has jointly undertaken two such investigations with Florida and participated in test site visits to selected facilities in New York, and we expect to expand such activities significantly over the next two fiscal years. By spreading an awareness of how to prevent and detect fraud and abuse across the full range of Medicaid-funded programs, CMS is strengthening its oversight capabilities and making it less likely that future Maxim-style fraud schemes will go unnoticed.

**Lead-In**

***States have some freedom in creating and implementing plans to administer and oversee Medicaid. However, not all states are reporting all required data to CMS.***

**4. Are there reporting requirements that states *must* follow in order to participate in the Medicaid program, and if so, what are those requirements?**

**Answer:** States are required to submit Medicaid Statistical Information System (MSIS) data to CMS on a quarterly schedule. The MSIS is an automated reporting database system that is used to maintain information about enrollment, utilization, and expenditures. It provides program utilization and expenditure forecasts, analysis of policy alternatives, and program management support at both the Federal and State levels. Once the State files are received, CMS submits the MSIS data through a review and validation process before it is made available to our PI staff.

**5. Why are some states not reporting all required data to CMS, and what is CMS doing to address that problem?**

**Answer:** As noted above, States submit MSIS data to CMS on a quarterly schedule. However, there are challenges associated with bringing together data from 56 independent Medicaid programs, and the accuracy, timeliness, and availability of the data, as well as the data standardizations among State programs can be improved. We are working with the States to improve the timeliness of their reporting as well as the consistency of the data across States.

CMS is actively working to improve the quality and accuracy of data reported by States to CMS. In order to do so, CMS established the Medicaid and CHIP Business Information Solutions (MACBIS) Council to provide leadership for the development and deployment of enterprise-wide improvements in the accuracy, timeliness and availability of data. The MACBIS Council has proposed an expansion of the MSIS data set, called Transformed-MSIS (T-MSIS), including additional data elements useful for the detection of fraud, waste, and abuse.

CMS is currently introducing the expanded T-MSIS data set for testing in a pilot project involving Medicaid data from 10 States, representing approximately 40 percent of the nation's Medicaid expenditures. Those ten States are California, Oregon, Washington, Texas, New Mexico, Arizona, Arkansas, Tennessee, North Carolina, and New Jersey. After intensive analysis and assessment is conducted to verify and validate the data and framework to ensure standardization and quality of data of the T-MSIS data set, we hope to use the results and lessons learned from these 10 States as the basis for national implementation.

Additionally, in the more near term, CMS will continue working to improve access to better quality Medicaid data by leveraging the data available through the Medicare/Medicaid Data Match Expansion Project (Medi/Medi) and its participating States, as well as working directly with States to obtain Medicaid data for specific collaborative projects.

**Lead-In**

*The federal and state Medicaid partnership makes program integrity more challenging than for most federal programs. States have disparate programs to maintain program integrity, and poor data quality is a key problem in many States.*

**6. Which states have the highest rates of improper payments? Which states have the lowest?**

**Answer:** The Payment Error Rate Measurement (PERM) program methodology is designed to use statically valid estimates of improper payments in the States to estimate a national Medicaid improper payment error rate. CMS does not publish the State-by-State rates, but works closely with States with high PERM rates to identify the causes for errors and to determine if the errors were caused by conflicting State policies or operational problems. Under CMS regulations, States are required to submit and implement CAPS no later than 90 days from the date the State receives its error rates. CMS monitors States' implemented corrective actions to determine whether the actions are effective and whether milestones are being reached.

**7. Why does CMS not publicize Medicaid improper payment rates by state?**

**Answer:** The PERM program methodology is designed to use statically valid estimates of improper payments in the States to estimate a national Medicaid improper payment error rate. PERM's underlying purpose is not to show State-by-State error rates.

**8. Which states have the worst information technology systems and program integrity? Which states have the best?**

**Answer:** States have made varying investments in their information systems based on available State dollars, the availability of Federal resources, and program requirements. As the States' partner, CMS works diligently to ensure States have the resources they need to improve their information systems.

CMS continues to work with all States to ensure their information systems are able to meet Medicaid program obligations.

**9. Are any states using advanced analytics to detect fraud and improper payments?**

**Answer:** States are in varying stages, ranging from those that are investigating feasibility for predictive analytics to those that are currently developing and implementing advanced analytics technologies. Illinois is an example of a State taking action on this front. Using a CMS grant

from 2007, Illinois is partnering with two universities to begin implementing predictive modeling analytics, including assessing provider risk scores. The project is currently in the validation stage with plans to expand the program once fully operational. CMS brought together States to discuss their progress, challenges and successes in implementing predictive analytics at the MII this year. Moreover, as we indicated in response to Question 2, CMS has deployed this technology in the Medicare program and intends to rigorously scrutinize it, subject it to continuous quality improvement cycles, ensure it delivers the best value for taxpayers, and to actively engage in technology transfer to share lessons learned and help diffuse it to the States.

**10. What are states and CMS doing to increase prepayment review?**

**Answer:** States have responsibility for paying claims in the Medicaid program. As part of this responsibility, States are obligated to comply with Federal regulations. Under current regulation (42 CFR §447.45), States are required to conduct prepayment claims review in order to verify such items as beneficiary eligibility, provider eligibility, third party liability, and duplicate or conflicting claims.

As required by the Small Business Jobs Act, CMS is exploring the use of predictive analytic technologies for identifying and preventing improper payments under Medicaid and CHIP. CMS is working with the States to identify the most effective ways to implement additional prepayment controls. In order to meet these requirements, CMS is currently working on developing advanced analytics techniques including predictive analytics, linkage analysis, outlier analysis, network analysis, behavioral analysis, and other statistical techniques that will generate alerts and triangulate the results to identify claims and providers most likely to be engaged in fraudulent or wasteful behavior.

**11. What are the problems with MSIS data that arise from Medicaid managed care? Does CMS consider Medicaid managed care data in MSIS reliable?**

**Answer:** CMS strives to continually improve the quality, reliability, and consistency of data reported by the States. Two years ago, CMS established the MACBIS Council to bring an enterprise focus to Medicaid and CHIP data and information needs and to bring about improvements overall to Medicaid and CHIP data capabilities, including those for PI. Substantial improvements in current capabilities have resulted, including improved analytic capabilities and timeliness of the data.

There are some substantial challenges that States face in providing data to CMS. These include the need for proprietary formats and State MMIS modernization efforts. Part of our MACBIS effort is aimed at addressing these challenges and improving the timeliness, completeness and reliability of Medicaid and CHIP program data. Our initial 10-state pilot should provide results later in 2012.

The Affordable Care Act made an important addition to the data reporting requirements by including a requirement that Medicaid managed care encounter data be reported to CMS. CMS, with the implementation of this provision and efforts under way to improve data reporting, is

working to ensure that all State Medicaid data are readily available to support program objectives and PI goals. While some States do report encounter data, and those that do generally provide complete and accurate data, we plan to use this new authority to ensure that we are able to obtain complete data from all State managed care programs.

**Questions from Rep. Trey Gowdy, Chairman  
Subcommittee on Health Care, District of Columbia, Census & the National Archives**

**Lead-In**

*In a 2006 article in the City Journal, Steve Malanga wrote that at least half of the states spend less than one-tenth of one percent of their Medicaid budget on combating fraud.*

**1. How much of each state's Medicaid budget is spent on combating Medicaid fraud?**

**Answer:** Medicaid's financing structure encourages robust State program integrity (PI) activities. Medicaid is a Federal-State partnership supported by both Federal and State funds, and States have an incentive to ensure program requirements are in place that safeguard the program and protect vital State resources.

States must fulfill the PI requirements of the Medicaid statute and receive financial participation from the Federal government for these efforts.

CMS also provides oversight over State programs through Medicaid State Plan Amendments, as well as through the State Program Integrity Assessment (SPIA), which annually collects standardized, national data on State Medicaid PI activities. According to the SPIA data, States reported spending approximately \$393 million collectively on PI efforts during FY 2009. CMS also conducts triennial comprehensive reviews of each State's PI activities as part of the Medicaid error rate calculation.

**2. Has any state successfully incentivized Medicaid beneficiaries to report fraud? Where do these beneficiaries go to report fraud?**

**Answer:** Beneficiary involvement is a key component of all of CMS' anti-fraud efforts. CMS believes that alert and vigilant beneficiaries are among the most valuable tools in our efforts to stop fraudulent activity, and we seek to inform and educate our beneficiaries, including those dually eligible for Medicare and Medicaid, to report fraud.

CMS works to enlist beneficiaries in our fight against fraud in several ways. For example, our Education Medicaid Integrity Contractor (MIC) provides informational materials that give examples of common types of fraud, waste, and abuse and informs beneficiaries on how they can report Medicaid fraud. The Education MIC also created easily disseminated postcards that explain how beneficiaries can report fraud, waste, and abuse, and it is working on a public service announcement that conveys the same message. Further, the MIC is developing all-purpose fraud reporting forms for both a beneficiary and a provider audience. In addition, the Education MIC is expanding its use of social media and "news blasts" to give wider circulation to anti-fraud and abuse messages and information about preventing and reporting Medicaid fraud.

There are a variety of ways in which Medicare and Medicaid fraud tips can be reported. In March of 2011, the Medicaid Integrity Program posted a list of Medicaid fraud reporting contacts on the CMS website: <http://www.cms.gov/FraudAbuseforConsumers/>.

This page includes:

- State-by-State contact information for reporting suspected Medicaid fraud or abuse. Generally there are two contacts provided for each State (State Medicaid agency & MFCU).
- HHS OIG National Fraud Hotline number (1-800-HHS-TIPS)
- Information to have ready when reporting suspected fraud
- Common Medicaid fraud schemes
- Tips to help prevent fraud

The fraud reporting contact list is updated quarterly.

As of July 2011, 28 States (including the District of Columbia) had State false claims act laws with *qui tam* provisions. These provisions provide an opportunity for individuals with knowledge of high dollar Medicaid offenses to collect part of the recovery amount if a successful court action against the fraudulent party occurs. In addition, six States (Arkansas, Florida, Louisiana, Missouri, New Jersey, and Tennessee) have regulations that provide for rewards for the reporting of Medicaid fraud without filing a *qui tam* lawsuit. The rewards in these programs vary from \$50 to \$500,000, depending on the State, the amount recovered, and the severity of the offense.

***Lead-In***

*According to the recent reports, very little of the information that individuals place on their Medicaid applications is verified.*

**3. How do states verify individual information in order to accurately assess program eligibility?**

**Answer:** States are required to maintain eligibility systems to accurately assess an individual's eligibility for Medicaid benefits. States use their Mechanized Claims Processing and Information Retrieval Systems to assess an individual's eligibility.

**4. What is CMS doing to address this problem of eligibility verification in many parts of the country?**

**Answer:** We recognize that Medicaid eligibility workers play an important role in ensuring that Federal and State Medicaid dollars are spent providing health care to eligible individuals and protected against abusers. State Medicaid programs periodically remind employees about the ethical and legal obligations they have when speaking to and advising a potential applicant. CMS also directly supports eligibility workers with free training for State eligibility workers at the Medicaid Integrity Institute (MII). Since its inception, the MII has trained more than 2,600 State PI staff from all 50 States, DC, and Puerto Rico.

Further, CMS recently finalized the regulation, CMS-2346-F, which supports State efforts to ensure appropriate expenditures in the Medicaid program. The [Final Rule] provides for enhanced Federal funds, at 90 percent match rate through calendar year 2015, for State investments in the design, development, installation or enhancement of eligibility determination and enrollment activities, as long as they meet certain requirements.

**THE SUCCESS OF THE FALSE CLAIMS ACT**

*The government's partnership with private citizens in the fight against fraud was cemented in 1986, when Congress amended the False Claims Act, the United States' primary tool against government fraud.*

— Tony West, Assistant Attorney General of the United States

The False Claims Act is the most successful fraud-fighting tool ever developed. Its success is due to the efficiency of law enforcement, made possible by the public-private partnership that exists between whistleblowers, their attorneys, and the United States Government.

Since the 1986 Amendments were passed, with bipartisan support in both houses of Congress, fraud recoveries have risen dramatically. Today, whistleblower actions under the False Claims Act are the primary vehicle for fraud recoveries for both federal and state governments.

An analysis of recoveries in the health arena finds that the U.S. Government gets back \$15 for every \$1 invested in False Claims Act investigations and prosecutions.

In Fiscal Year 2010, over \$3 billion was recovered under the False Claims Act—twice as much as was recovered in FY 2000. Of this amount, nearly 80% was recovered as a direct result of whistleblower lawsuits—a total of \$2.39 billion.

Since the 1986 amendments to the False Claims Act, more than \$30 billion has been recovered in judgments and settlements.

**Amounts Recovered in Government-Initiated FCA Suits Versus Whistleblower-Initiated FCA Suits**

