

TESTIMONY
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BEFORE

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Mr. Chairman and Members of the Committee, thank you for the opportunity to appear before you to discuss the role of the Medicaid Fraud Control Units in investigating and prosecuting Medicaid fraud, and their successes and obstacles. I am William Benson, Director of the Tennessee Medicaid Fraud Control Unit (MFCU). I am very pleased to appear before you as a representative of the MFCU and of the National Association of Medicaid Fraud Control Units' (NAMFCU) Executive Committee.

The skyrocketing costs associated with health care delivery and the continuing “graying” of our population have resulted in an increased reliance upon government-sponsored programs such as Medicare and Medicaid to provide much needed health insurance to those who would otherwise go without medical care.

The Medicaid program, which was established to provide health care to indigent patients, has seen its enrollment explode. When the program started in 1965, Medicaid expenditures were \$1.5 billion. Nationwide, the Centers for Medicare and Medicaid Services, formerly known as the Health Care Financing Administration (HCFA), expects to spend more than \$310 billion in FY 2004 to sustain the program. Medicaid recipients increased from about 10 million in 1967 to a projected 42 million in FY 2004, an increase of 320 percent. States are responsible for up to 50% of the cost of the Medicaid programs and some states now spend over 20% of their total budget to sustain the program.

This nation is expected to spend more than \$2.6 trillion on health care or 16.8% of our gross domestic product by the year 2010. Given these figures, it is not surprising that our health care delivery system has proven ripe for fraudulent activity.

The General Accounting Office (GAO) has estimated that fraud and abuse accounts for 10% of health care costs. Some states have conducted studies on Medicaid

fraud in their respective states. In Texas, for instance, a study released earlier this year estimated “potential overpayment rates”, which would include fraudulent expenditures, to be 13.5%. Even using the most conservative estimate, we are talking about many hundreds of millions of dollars of fraud and abuse in the Medicaid program alone.

During the past decade, in particular, we have literally seen a feeding frenzy on the Medicaid Program, an unprecedented period in which wave after wave of multimillion dollar frauds have swept through nursing homes, hospitals and home health care, clinics, transportation companies, pharmacies and pharmacy manufacturers, durable medical equipment (DME), radiology, labs and other providers. While we recognize that most providers try to offer an honest service and follow the appropriate rules and regulations, and although we do the best we can to put an end to program vulnerabilities, we still have profiteers who search and succeed in finding the next great loophole in the Medicaid program.

STATE MEDICAID FRAUD CONTROL UNITS

While the investigation and prosecution of health care fraud has only recently become a top national law enforcement priority, the states have been combating Medicaid fraud for more than 25 years and are viewed as leaders in the detection and prosecution of fraud in the health care industry. Medicaid, established by Congress in 1965 is, of course, the primary government health care program for approximately 42 million of America’s poorest and oldest citizens. For the first decade after Medicaid was created, the system operated with few controls against fraud. Inadequate safeguards combined with multi-billion dollar expenditure levels made a substantial amount of fraud inevitable.

The result was an unprecedented theft of government dollars as local prosecutors struggled with the difficult task of prosecuting these highly sophisticated crimes. Congress came to recognize an urgent need to address this loss after much media attention and Congressional hearings highlighted the theft of taxpayer dollars and the harm suffered by Medicaid patients who were deprived of basic medical care. The result was legislation to establish specialized state-based strike forces to police the Medicaid program.

In 1977, Congress enacted legislation, the Medicare-Medicaid Anti-Fraud and Abuse Amendments, P.L. 95-142, which established the state Medicaid Fraud Control Unit program and provided the states with incentive funding to investigate and prosecute Medicaid provider fraud and to prosecute the abuse or neglect of patients in all residential health care facilities which receive Medicaid funds. Federal financial participation (FFP) for the first three years of a Unit's existence is 90 percent of the costs incurred by a certified Unit in carrying out its responsibilities. Thereafter, the federal government continues to provide 75% of each Unit's costs after the three year start-up period with the proviso that the FFP for any one quarter may not exceed the higher of \$125,000 or 1/4 of the sums expended by the federal, state and local governments during the previous quarter in carrying out the state Medicaid program. All Units are now at 75% FFP.

This funding formula allows the federal government to insure that each Unit's activities are directed exclusively at provider fraud, fraud in the administration of the Medicaid program and patient abuse, and not crimes such as recipient fraud. Although the federal regulations require the MFCUs to be annually certified by the Secretary of the Department of Health and Human Services (HHS), the Office of the Inspector General

(OIG) of HHS has been delegated the administrative oversight responsibilities for the Units. HCFA was originally assigned the certification, recertification and general oversight responsibility of the MFCU program. However, it was soon recognized that the Units' activities were more closely related to the OIG investigative function.

The enabling federal legislation emphasizes the necessity of having an integrated multi-disciplinary team of attorneys, investigators, and auditors in one office in order to successfully prosecute these complex financial crimes. The Units are required to be separate and distinct from the state Medicaid programs to avoid institutional conflicts of interest, and are usually located in the state Attorney General's office, although some Units are located in other state agencies with law enforcement responsibilities such as the state police or the state Bureau of Investigation. The Omnibus Reconciliation Act of 1993 required all states to have a Medicaid Fraud Control Unit by January, 1995, unless a state can demonstrate to the Secretary of the Department of Health and Human Services (DHHS), that it has a minimum amount of Medicaid fraud and that residents of health care facilities that receive Medicaid funding will be protected from abuse and/or neglect. Currently all states and the District of Columbia, with exception of Idaho, Nebraska and North Dakota have federally certified MFCUs.

Beginning with FY 1993, when there were only 41 federally certified state Units, and in the ensuing ten years, the MFCUs have successfully prosecuted over 8700 corrupt medical providers and vendors and elder abusers – convictions that would not have occurred without this vital piece of legislation. These Units, now 48 strong, police most of the nation's Medicaid expenditures with combined staff of approximately 1452 and a total federal budget of \$119 million. This amount represents a small fraction of the total

Medicaid budget that the Units are responsible for policing. Unit size varies state-by-state and is dictated to some extent by the size of state's Medicaid program. In Tennessee, for example, our Medicaid budget is approximately \$5.9 billion and the Unit employs 37 staff members. New York is the largest Unit with approximately 303 staff and Wyoming is the smallest with four. In FY 2002, investigations conducted by the MFCUs resulted in 1147 convictions and recoveries of over \$288 million.

In addition to the criminal consequences of MFCU cases (repayment of restitution, overpayments, state exclusions, incarceration, and often the loss of business and professional licenses), the criminal convictions of the Units are the basis for further federal actions. The federal actions that are reported by the Office of Inspector General (OIG) of the Department of Health and Human Services (DHHS) include the underlying state convictions, judgments, forfeitures, civil settlements, state program exclusions, and civil monetary penalties.

PATIENT ABUSE AND NEGLECT

While the MFCUs' success in detecting and prosecuting Medicaid provider fraud is widely recognized, it is perhaps less well known that the Units are the only law enforcement agencies in the country specifically charged with investigating patient abuse and neglect.

In the mid-1970s, allegations of nursing home patient abuse shocked the country, causing universal outrage and a demand for effective redress. Implicitly acknowledging that patient abuse matters were the "orphans" of local prosecutors' caseloads – since they had neither the time nor the expertise to prosecute such matters successfully – Congress

mandated “procedures for reviewing complaints of the abuse and neglect of patients of healthcare facilities which receive payments under the State [Medicaid] plan” and, where appropriate, prosecuting such cases or referring them to other state agencies for prosecution (42 U.S.C. §1396b(q) [4]; 42 CFR §1007.11[b]). In accordance with that mandate, today the 48 MFCUs devote a substantial portion of their caseload to patient abuse investigations. State Medicaid Fraud Control Units review thousands of referrals alleging patient abuse, neglect and the misappropriation of patient funds.

Patient abuse can be classified into several categories. For example, providing inadequate medical or custodial care or creating other health care risks may constitute patient neglect. Financial abuse includes the misappropriation of patients’ personal funds such as commingling patient and facility funds or using patient funds to pay for facility operations.

Scores of investigations and years of cumulative experience have made it clear that the abuse, neglect, mistreatment, and economic exploitation of nursing home residents is a problem of far greater magnitude than previously thought. Over fifteen years ago, our national association, in collaboration with the National Association of Attorneys General (NAAG), responded to the growing national concern about patient abuse by adopting *Guidelines and Commentary for Legislation to Prohibit Patient and Resident Abuse*. These Guidelines were designed to encourage states to enact patient abuse statutes that would not only provide the necessary prosecutorial tools and enhanced penal sanctions for combating this type of shocking misconduct, but would also serve as a powerful deterrent to potential patient abusers. In 1999, NAMFCU created a notebook

entitled *A Guide for Prosecuting Patient Abuse, Neglect, and Mistreatment in Nursing Homes* to provide further assistance to the MFCUs.

It is difficult to conceive of a more vulnerable and frail population than residents of long-term care facilities. Yet, too often, they are the target of cruel and, at times, sadistic violence and mistreatment. Most reprehensibly, in long-term care facilities, perpetrators of physical and sexual abuse are usually those charged with care and well-being of patients. For example:

- One nursing home chain settled civil and criminal complaints with the State of California after over 100 citations had been issued against one of the chain's nursing homes. The skilled nursing home lacked adequate air conditioning and had a history of poor ventilation and problems with elderly patients suffering from dehydration. Two nursing home patients died and six others suffered severe dehydration, heat exhaustion or heat stroke. On average, the body temperature of the eight frail, elderly patients rose to over 106 degrees. Another of the facilities entered a "no contest" plea to a felony violation of elder abuse relating to three victims, also related to heat conditions. As part of the civil settlement, the company agreed to meet state and federal regulations governing quality of care, significantly increase staff training, and develop more oversight/compliance mechanisms.
- The District of Columbia MFCU charged a certified nursing assistant (CNA) with one count of involuntary manslaughter in connection with the death of an 89-year-old patient of the nursing home where the CNA was employed. The patient drowned when she was left unattended in a tub of running water. The CNA pleaded guilty to

one count of attempted voluntary manslaughter and was sentenced to 90 days in jail and 2 years probation.

- In Kansas, a licensed practical nurse (LPN), pleaded guilty to one count of possession of Oxycodone, two counts of adulterating a drug, one count of mistreatment of a dependent adult, and one count of attempted mistreatment of an adult. It was alleged that the LPN took OxyContin pills from a nursing home resident's medication supply and replaced them with another drug. It was also alleged that, on another occasion, the LPN diluted a resident's prescribed liquid OxyContin with water and gave the mixture to the resident.
- In Ohio, a nurse aide improperly transferred a resident from a bed to a chair. Instead of utilizing a Hoyer lift, the nurse aide manually transferred the patient. The female patient had both of her legs broken and died the following day of bilateral leg fractures. The nurse aide was convicted on one count of patient neglect, a misdemeanor, and sentenced to 90 days in jail with all but 30 suspended and placed on 30 days house arrest with work release. She was also fined \$200, ordered to perform 100 hours of community service and placed on five years probation. She also agreed to relinquish her nurse aide's license.
- The death of a profoundly mentally retarded patient at a State Developmental Center in Tennessee resulted in the convictions of three facility employees on civil rights violations. Two of the defendants were originally charged with second-degree murder but the charges were eventually dismissed by the District Attorney's Office. After the dismissal, the investigation was referred to the U.S. Department of Justice. The subsequent investigation, conducted by the MFCU, FBI, U.S. Attorneys' Office and

Department of Justice led to the civil rights convictions for the three defendants involved in the death and the convictions of two other facility employees, also on civil rights violations, for other incidents of abuse.

- In Minnesota, the resident manager of a group home for mentally retarded adults pleaded guilty to one count of theft by swindle after an internal audit revealed unexplained withdrawals and expenditures from two residents' accounts. The manager would write checks drawn on the accounts payable to cash, endorse the checks, and then keep the cash. The manager was sentenced to 30 days in the county jail, five years supervised probation, ordered to pay \$2,662.95 in restitution to the facility, provide a DNA sample, to attend a money management class, prohibited from working with vulnerable adults, and from owning any credit cards.
- An Oregon caregiver was sentenced to serve 13 months in prison for misappropriating over \$40,000 from an elderly, deaf, legally blind, wheelchair-bound client and gambled most of it away. Over \$25,000 of the victim's money was withdrawn from an ATM located inside a gaming casino. The caregiver was also ordered to pay \$20,000 in partial restitution to the victim's estate upon her release.

In addition to these egregious cases, the Units have also uncovered thousands of incidents of individual nurses, aides, and orderlies, raping, sodomizing, beating, kicking, and force-feeding the helpless, often incompetent patients in their charge.

Congress enacted P.L.95-142, not only because of the widespread evidence of fraud in the Medicaid Program, but also because of the horrendous tales of nursing home patient abuse and resident victimization – and the Units are justly proud of their record in protecting the frail and vulnerable institutionalized elderly.

PROVIDER FRAUD SCHEMES

In the past decade, the MFCUs have seen a rapid increase both in the number of fraudulent schemes and the degree of sophistication with which they are committed. Although the typical fraud schemes such as billing for services never rendered, double billing, misrepresenting the nature of services provided, providing unnecessary services, false cost reports and kickbacks still regularly occur, new and often innovative methods of thievery have consistently occurred and are even just beginning to appear.

Medicaid fraud cases run the gamut from a solo practitioner who submits claims for services never rendered to large institutions, which exaggerate the level of care provided to their patients and then alters patient records in order to conceal that lack of care. MFCUs have prosecuted psychiatrists who have demanded sexual favors from their patients in exchange for prescription drugs, nursing home owners who steal money from residents, and even funeral directors who bill the estates of Medicaid patients for funerals they did not perform.

The following are typical schemes corrupt providers may use to defraud the Medicaid program.

1. *Billing for services not rendered* – A provider bills for services not rendered, x-rays not taken, a nursing home or hospital continues to bill for services for a patient who is no longer at the facility either due to death or transfer, or a transportation provider bills for trips not made.

2. *Double-billing* – A provider bills both the Medicaid program and a private insurance company (or the recipient) for treatment, or two providers request payment on the same recipient for the same procedure on the same date.
3. *Substitution of generic drugs* – A pharmacy bills the Medicaid program for a brand name prescription drug, when a low cost generic substitute was supplied to the recipient at a substantially lower cost to the pharmacy.
4. *Failure to refund unit dose prescriptions* – Many nursing home pharmacies dispense drugs using the “unit dose” method, where a month’s supply of pills are dispensed in sanitary bubble packs holding individual doses. The prescriptions are billed to Medicaid when dispensed, usually at a premium because of the extra effort involved in the unit dose packaging. Those medications, which are not used but should be, are often charged to Medicaid. The percentage of returned medication is high in a nursing home because of the large number of mid-month medication changes, hospitalizations, and “use as needed” medications in the nursing home industry.
5. *Unnecessary services* – A physician performs numerous tests, which are medically unnecessary, and result in great expense to the insurer. Extreme examples noted in many states include ‘gang banging,’ where a single optometrist, podiatrist or other specialist will be allowed to treat the entire nursing home population in a day, regardless of whether the service is medically necessary for the patient.
6. *Upcoding* – A physician bills for more expensive procedures than were performed, such as a comprehensive procedure when only a limited one was

administered, or a psychiatrist bills for individual therapy when group therapy was given.

7. *Kickbacks* – A nursing home owner requires another provider, such as a laboratory, ambulance company or pharmacy, to pay the owner a certain portion of the money the second provider receives from rendering services to patients in a nursing home. This practice is particularly costly because we find that it encourages the nursing homes, which act as gatekeepers for the ordered ancillary services, to subscribe to unnecessary ancillary services which are reimbursed by Part B Medicare and Medicaid.
8. *False Cost Reports* – A nursing home owner or operator includes inappropriate expenses for Medicaid reimbursement.

SCHEMES AND TRENDS

Over the past few years, these so-called “typical” schemes have given way to more innovative ones. Recently, the Units have identified serious fraud problems in several industries including laboratories, hospitals, home health care, medical transportation, durable medical equipment, pharmacies, and pharmaceutical manufacturers. The incidence of illegal drug diversion has risen sharply over the years, carrying with it a dramatic financial impact on the Medicaid program.

Some states have a portion or all of their Medicaid population enrolled into managed care plans. While proponents of the managed care system believe that it is the best method for providing low cost high quality health care to more people, the

experience of the Units reveal that no health care plan is immune from fraud and indeed fraud does occur in managed care plans.

Recent global settlements of cases involving multiple state and federal entities have encouraged cooperative federal/state efforts to protect the Medicare/Medicaid programs from health care providers or vendors whose activities know no borders.

FRAUD IN NURSING HOMES

The Medicaid program still continues to finance the largest percentage of total costs for nursing homes. In 2000, long term care spending from all sources was approximately \$137 billion, of which Medicaid paid about 45%. The number of skilled nursing facilities has been increasing since the 1970s and by the beginning of 2003 reached approximately 17,000.

Traditionally, nursing home prosecutions involve the filing of false cost reports, which were proven false because they claimed reimbursement for expenses which were not properly attributed to patient care. The following are examples of nursing home fraud:

- A Massachusetts nursing home agreed to repay the state Medicaid Program \$41,529 for allegedly providing substandard and neglectful care to five Medicaid residents over a three year period. Four of the five patients developed painful skin ulcers and complications which allegedly could have been prevented had the care plans and protocols been followed. As part of the settlement agreement, the nursing home also agreed to institute a compliance program, which will focus on improvement of patient

care and ensure that adequate levels of trained staff are available to properly meet the needs of all patients admitted to the facility.

- In North Carolina, seven people were convicted for their participation in a scheme to defraud the Medicaid Program of \$58,367 by inflating the nursing budget of a nursing home where one of the subjects was in charge of the payroll. The employee inflated the number of employees on the payroll by listing some of her family members on the payroll who did not work for the facility. These family members received payroll checks from the nursing home, kept a portion of the money for themselves, and gave the rest to the payroll employee as a kickback. The amount of the fraud was recovered for the Medicaid Program and those involved received varying lengths of probation and were ordered to make restitution.
- In Maryland, one nursing home pleaded guilty to overstating costs incurred in connection with treating Medicaid patients by \$23,000. The nursing home and its related corporation were family owned and included in its cost reports expenses that were personal to the owners and not facility related. These expenses included travel to Barbados, motorcycle expenses, entertainment and numerous clothing and household expenses for the owners and their families.
- In New Jersey, two individuals, the former owner and former administrator of one nursing home, received approximately \$106,000 in Medicaid payments, to which they were not entitled, by reporting false expenses on their cost reports. The defendants were ordered to pay restitution in the amount of \$106,000 and also ordered to pay civil false claims penalties of one and one half times that amount.

LABORATORIES

Aggressive marketing techniques, not traditionally associated with the health care industry, have increased costs by adding marginally necessary or totally unnecessary tests to health care bills. One such example are the Labscam cases where physicians were misled into ordering rare, but expensive diagnostic tests when they needed only an inexpensive and basic blood chemistry test. Investigators found that several independent clinical laboratories induced doctors to order laboratory tests which were medically unnecessary by assuring that the additional tests would be free or of minimal cost. In fact, the laboratories were billing government insurers for these tests without the referring physician's knowledge. As a result of a three-year task force effort targeting unbundling schemes, federal and state governments were paid a total of \$642 million to settle potential civil and criminal liability.

- Billing for useless laboratory tests and cheating both government and private insurers is still occurring. In California, the co-owners of a laboratory and management company which controlled several clinics pled guilty to Grand Theft and, in addition to receiving jail time ordered to pay \$1,292,542 in restitution. The defendants billed Medi-Cal, the California Medicaid Program, for lab tests for "ghost" patients ostensibly referred by about one dozen physicians, who subsequently denied these referrals when they were interviewed.
- Also in California, one individual defrauded the Medi-Cal Program by offering to supply Medi-Cal beneficiary identification numbers and vials of human blood to an undercover laboratory in exchange for payment. The defendant was sentenced to 16 months in prison and ordered to pay \$25,000 in restitution.

- In Ohio, the owner of a laboratory pled guilty to one count of health care fraud after it was discovered that the laboratory was billing exceptional amounts of pulmonary tests. The owner was sentenced to five months in prison, five months house arrest, three years supervised release and order to make restitution of \$49,000 to Medicaid and \$150,500 to Medicare.

Defendants across the country have found a way to turn blood into money. Clinic owners purchase human blood from “blood brokers.” These brokers draw many vials of blood from people willing to sell it. These are often drug-addicted individuals. The clinic owners pair these samples with fictitious laboratory requisition forms, using Medicaid recipient numbers drawn from their files. They order an expensive panel of tests, which the laboratory performs. The laboratory then kicks back a portion of the Medicaid payment to the clinic owner.

HOME HEALTH CARE

This is one of the fastest growing areas of the Medicaid-funded health care system. State and federal outlays in the home health industry have ballooned in the last five years. Medicaid accounts for approximately 17% of home health care revenue nationwide. Increases in cost and coverage are due to an aging population, shorter hospital stays, increasing cost of nursing home care and an increase in technology. Since the 1970s, technology has advanced to the point of allowing more and more patients to remain in their homes and receive treatment. The profile of a typical home health care recipient is one who is elderly, disabled, has AIDS, heart disease, diabetes or has been discharged from the hospital and needs more care.

Not only are home health care agencies charged with grossly inflating the number of hours their employees worked, but, more importantly, in some cases with recklessly sending untrained, unqualified, and unlicensed aides into private homes of critically ill and care-dependent patients. It is an industry that contains all of the components for disaster, it is unregulated in the traditional medical sense, multiple agencies are involved with large amounts of government money and it is attractive to the consumer.

Let me highlight a few examples of the Units' work in this area:

- Three home health agency employees in Michigan were charged with causing skilled home nursing services to be provided to patients with illnesses that were not covered by Medicaid or participated in submitting claims that were not covered. It was also alleged that basic personal care was provided but fraudulently billed at a higher rate as a skilled nursing visit.
- In filing cost reports with the New York State Department of Health, one home health care company in that state erroneously included the costs for licensed practical nurse services when only personal care aide costs should have been included. The defendant agreed to repay \$1 million in Medicaid overpayments.
- The owner and president of a home health care company in Rhode Island pleaded nolo contendere to one count of Medicaid fraud stemming from charges that the defendant submitted false claims totaling \$56,000 to Medicaid. Some of the false claims were for work performed by unlicensed employees while others sought payment for services that were never rendered. The defendant was sentenced to six months home confinement, two and one half years probation, and payment of \$111,000.

Among the most rapidly growing segments within the home health care industry is home infusion. Home infusion treatments include more than the actual medication. In addition to drugs and nutritional formulas, supplies such as tubing, syringes, alcohol swabs, bottles, gloves and needles, and expensive equipment such as pumps, nebulizers, glucose monitors and blood pressure kits are regularly utilized by the victims of these serious illnesses, all of which are billed on a regular basis.

A large amount of the funds, too, are spent in the area of home care services. Home infusion patients often require regular visits, frequently more than once a day, by an R.N., nurse practitioner, home health aide, a physicians' assistant or even a physician, and these services are reimbursed by Medicaid. Further, regular visits to a physician for certification of continued need and dosage adjustment are necessary. Again, it is a classic recipe for fraud with fragmented billings; drugs are billed by the pharmacies, the supplies used to assist in administering the drugs are billed by the DME provider, professional services are billed by the home health service company or individual providers, and personal services may be billed to various agencies.

The potential for fraud in this rapidly expanding and highly expensive industry is clear. Kickbacks to doctors to authorize medically unnecessary treatment, services or supplies, whether provided or not, is cause for MFCU concern as well.

IDENTITY THEFT

While recent efforts have been made to protect the privacy of health care recipients, the potential for the misuse of the identity of Medicaid patients is enormous.

- In California, one individual was sentenced to jail and ordered to pay \$182,304.65 in restitution for her involvement in a scheme to steal patients' identities and bill for services which were never rendered.
- Also in California, more than \$1,390,000 was stolen from Medi-Cal when thousands of bogus claims for services to Medi-Cal patients were submitted when neither the patients nor their physicians were aware that their names were being used in the conspiracy. Medi-Cal paid the claims and sent payments to storefront addresses where the defendant then took the checks payable to the doctors to insiders at local banks who deposited the checks in accounts in the doctors' names. Checks were then written on the accounts and laundered at an unlicensed check cashier and convenience store.
- In Tennessee, in what could be described as a managed care fraud scheme as well, four individuals who contracted with one managed care organization as marketing representatives enrolled approximately 4500 non-existent individuals by creating fictitious Social Security numbers and using a homeless shelter address. All four individuals were prosecuted in federal court and the MCO repaid over \$1,800,000 in capitation payments to the Bureau of TennCare. In a separate scheme, another marketing representative was convicted of enrolling employees of an automobile manufacturing plant who, due to their having insurance through their employer, were ineligible to receive Medicaid benefits. The marketing representative was able to obtain enough personal information to enroll these individuals without their knowledge or consent.

- In Michigan, a nurse aide employed at a rehabilitation hospital and her partner were convicted on charges stemming from their actions in procuring enough personal information from hospital patients to conspire to, apply for and receive credit cards and telephone services in the patients' name.

MEDICAL TRANSPORTATION

Virtually every state MFCU has found egregious examples of fraud by non-emergency medical transportation companies. Medicaid will generally pay for a patient's transportation to a medical provider either when mass transit is unavailable in the recipient's area or when the patient, because of a debilitating physical or mental condition, cannot use this method of transportation. Examples of medical transportation fraud include billing for an inflated number of miles per trip for services actually provided, billing for recipients who drove themselves, paying kickbacks to recipients who used the medical transportation services, allowing non-eligible persons to use another recipient's card, submitting falsified appointment dates for round-trip transportation services to a provider's offices, charging billing for emergency transportation for non-emergency situations, billing for fictitious services not covered by the Medicaid program or for transportation that was not provided, creation of phony certificates of need ostensibly by doctors, and kickbacks to doctors for improperly certifying the need.

- In Colorado, the largest Medicaid transportation provider in the state was billing almost daily rides for almost all of the Medicaid recipients who were allegedly transported. The MFCU investigation revealed that most of the Medicaid

recipients rode with the company only one to two times per week, if at all. The owner of the company pleaded guilty to one count of Computer Crime and was sentenced to ten years in the Department of Corrections with five years of mandatory parole and ordered to pay \$400,000 in restitution.

- In Virginia, the owner of non-emergency transportation company was convicted of one count of money laundering as a result of a joint investigation by the Virginia MFCU, FBI, IRS, and Postal Inspection Service. The investigation revealed that the company billed Medicaid for services not provided, billed twice for the same service and billed at the more expensive wheelchair rate when patients could walk. The defendant was sentenced to 24 months in federal prison and ordered to pay \$449,186 to the Virginia Medicaid Program.
- During one two year time period, one transportation owner/operator in Ohio submitted 4,171 false transportation claims to the Medicaid Program. He was convicted of Medicaid Fraud and sentenced to three years incarceration, three years supervised probation, and was ordered to pay \$521,956.99 to the Medicaid Program and \$18,000 in costs of investigation to the Attorney General's Office.
- In Wisconsin, the owner of a specialized medical vehicle service which provided transportation services to Medicaid patients was charged with billing \$1,200,000 to the Medicaid Program for fraudulent claims. These claims included billing for services that had not been provided and for transporting someone who had died two days earlier. The defendant was convicted on the felony charges and ordered to pay restitution in the amount of \$1 million.

DRUG DIVERSION

In 1980, national expenditures for prescription drugs were \$12 billion. By 2000, these costs had risen tenfold, to over \$121 billion per year.

Drug diversion, which is the diversion of legal drugs for illegal purposes, has generated a supply of dishonest health care providers who both abuse their prescribing privileges and incur great costs to the Medicaid program. In large urban centers, it is not uncommon to find a so-called “pill mill” which has as its primary purpose the issuance of prescriptions for controlled drugs in exchange for cash or, in some cases, sexual favors. These drugs may then be resold “on the street” or sent abroad for black markets for several times their cost, sustaining the continued addiction of countless individuals. In some instances, we have found that the street addicts resold the prescription drugs to other pharmacies at a fraction of their original cost and at some risk to the unsuspecting customers of the second pharmacy.

However, while drug diversion is often used in the context of pill mills and script selling doctors, the definition should also include such cases as nurses who work in nursing homes who order prescriptions from pharmacies without a physician’s order and then obtain the prescription from the pharmacy delivery person and either sell the drugs or use the drugs for themselves.

The larger point-of-entry cities of the United States have noted so-called “hit and run” schemes in which foreign nationals fraudulently obtain a Medicaid provider number and then submit invoices for services not rendered. In larger cities, these fake providers often are able to obtain hundreds of thousands of Medicaid dollars before their detection, at which time they flee to their homeland.

Many states are experiencing crimes related to the abuse of OxyContin, a narcotic approved for the treatment of moderate to severe pain. States are investigating providers who overprescribe the drug, patients who abuse and sell the drug, and thieves who break into pharmacies to steal the drugs. Often, the investigations of Medicaid recipients who divert their prescriptions and physicians who overprescribe can overlap.

- In Vermont, a regional manager for a durable medical equipment supplier was sentenced to 16 months in prison of a three to ten year sentence, which includes conditions that he not work with vulnerable people or have access to narcotics. He also paid more than \$8000 in restitution to the victims, Medicaid and two hospice programs. The defendant pleaded guilty to three felony drug charges and six misdemeanor elder abuse charges for stealing pills such as OxyContin and morphine from chronically and terminally ill patients while he installed medical equipment in their homes.
- Also in Vermont, a registered nurse (RN) in a nursing home was found guilty of extracting morphine with a syringe out of an eighty-year-old terminally ill patient's 24 hour per day morphine pump which had been prescribed for his constant and severe pain. The RN also pleaded guilty to abusing another patient by using a syringe to withdraw Fentanyl, a narcotic, from a skin patch that had been applied to ease the patient's pain. In addition to jail time, the defendant was ordered to repay the nursing home \$1,000 for the value of the drugs that were diverted and make a \$5,000 donation in lieu of fines to the Victim's Compensation Fund.

- In Louisiana, an employee in a physician's office was forging the physician's name on prescriptions for drugs such as Prednisone, Lortab, Flomax, and Ambien. The employee would write these prescriptions in the name of her father, who was eligible for the Medicaid Program. The defendant pleaded guilty to all charges and received a three year suspended sentence, three years supervised probation, ordered to pay a fine of \$2500, ordered to pay restitution to the Medicaid Program in the amount of \$1586, \$250 for District Attorney investigative costs, \$100 to a drug abuse treatment plan, \$350 for an Indigent Defendant Board fee, and ordered to receive substance abuse treatment.

In many of the nation's larger urban centers, it is not uncommon to find so-called "pill mills" – medical centers whose primary purpose is the issuance of prescriptions for controlled drugs in exchange for cash. In a typical scenario, a "patient" will visit an unscrupulous doctor and buy, for instance, a prescription for 90 Valium (10 mg) tablets at a price of about \$1 a pill. After "busting" the 'scrip (having it filled) at an accommodating pharmacy, the patient will resell the pills to individuals at \$5 a pop and thereby net a profit of \$360. Not factored into this economic equation, however, is that each participant in the scheme is sustaining the continued addiction of countless individuals.

FRAUD IN DRUG PRICING

It is estimated that by 2010, prescription drugs will account for 16% of healthcare costs, up from 9.4% in 1999. Spending is increasing by 12.6% per year. Unlike Medicare, Medicaid covers virtually all prescription drugs.

The fundamental standard for Medicaid drug reimbursement is set forth at 42 CFR 447.331 and limits reimbursement to the lower of “estimated acquisition costs plus dispensing fees” or “Providers’ usual and customary charges to the general public”. State statutes and regulations apply these standards in different ways. The majority of states use “AWP”, which stands for “average wholesale price”, less a percentage (usually 10%), while other states use “WAC”, which stands for “wholesale acquisition cost”. Nearly all the states rely on First Data Bank, which obtains these prices from the manufacturers and transmits them to the states, who then determine what price their state Medicaid program will pay providers for the drugs.

If manufacturers inflate the numbers they report to First Data Bank about the costs they charge providers, the states may end up paying inflated prices to the providers. As a result, it is the manufacturers who are actually setting the government reimbursement for drugs, since the “spread” is also inflated- that’s the difference between the amount the manufacturer actually charges providers to the providers versus the cost the manufacturers actually reports to the government through First Data Bank. There is substantial evidence that the manufacturers are aggressively marketing the “spread” as a strategy to sell their products. One company recently reached an agreement with the federal government to pay \$875 million for their manipulation of the spread, the use of kickbacks and improper marketing for just one prostate cancer drug the company manufactured. Several other companies are currently in settlement negotiations with the state and federal governments on similar cases.

The states’ Medicaid programs also receive rebates from drug manufactures, based on “best price”. However, the manufacturers can conceal the “best price” through

a variety of ways, and as a result, the states' Medicaid programs have been defrauded of millions of dollars in rebates.

In recent years, the MFCUs have had significant experience with investigations and prosecutions involving fraudulent activity in the sale and marketing of pharmaceutical products which affects the state Medicaid programs, which are significantly and uniquely affected by fraudulent conduct involving pharmaceutical marketing and pricing practices.

It is important that federal and state statutes address potential unlawful conduct involving pharmaceutical products. Areas that are critical include integrity of data, the strengthening of anti-kickback statutes and effective training.

FRAUD IN MANAGED CARE

Both the Medicaid and Medicare programs use managed care delivery systems. In some states, managed care has been in existence since the early 1980s. Currently, many states require a portion or all of their Medicaid population to participate in their managed care programs.

Proponents of the managed care system believe that it is the best method for providing low cost, high quality health care to more people. Managed care is supposed to save money not only in the delivery of services but by cutting down on the amount of paperwork. While many observers point out that the very nature of managed care prevents fraud, the experience of the Medicaid Fraud Control Units demonstrates otherwise. Rather, fraud simply takes different forms in response to the way the program is structured.

In the traditional fee-for-service fraud, the healthcare provider is generally the one who commits the fraud. However, in managed care, fraud can be committed by a managed care organization (MCO), a contractor, subcontractor, provider, state employee, or beneficiary.

Managed care fraud includes the following:

- Fraud in the procurement of the contract with the state Medicaid agency by the MCO;
- Fraud committed in procuring provider subcontracts;
- Falsification of financial solvency by the MCO;
- Marketing and enrollment fraud, such as, enrolling ineligible or non-existent individuals;
- Kickbacks for referrals to specialty physicians; and
- Underutilization or the failure to provide adequate or timely reasonably accessible medical services to a patient for whom the provider has accepted a duty care.

Marketing abuses are among the most prevalent type of managed care fraud. In almost all instances, this type of fraud occurs in the Medicaid HMO setting. Marketing agents fraudulently enroll Medicaid recipients by giving providing false information, often without the recipients' knowledge. In many instances, persons are enrolled who are not Medicaid eligible, such as prisoners. Many states have taken active measures to prevent, or at least reduce, this type of fraud, such as forbidding the direct solicitation of recipients by the HMO.

- One of the largest health maintenance organizations in Florida settled allegations that the company charged both Medicaid and Medicare for the same services. The company cooperated fully with the investigation and agreed to repay almost \$8 million for all funds collected from Medicaid for which compensation was also provided through Medicare.
- In New York, a physician's assistant who operated two medical clinics was arrested on charges of stealing Medicaid funds. Patients were consistently complaining that the clinics, which were subcontracted by an HMO to provide health care services, were largely providing the services by unsupervised physician assistants or nurse practitioners, patients were have difficulty getting services or being seen by a physician, and the patients were being seen at unauthorized locations. In addition to the criminal charges filed against the physician's assistant, the HMO agreed to repay \$2 million to the Medicaid Program for services that the state paid for but recipients never received at the clinics.

The National Association of Medicaid Fraud Control Units (NAMFCU) adopted *Model Criminal Enforcement Statutes for Managed Care* in October 1996 and *Model Managed Care Civil Statutes* in 2000. These models are designed to provide a framework for the states to redress fraud in a managed care environment. In considering the adoption of any or all of the proposed models, states should examine their respective existing laws to determine whether new laws are needed. NAMFCU also provided a notebook to the MFCUs in 1999, entitled *Managed Care Fraud Research Manual* to assist those that are transitioning into managed care.

In 2000, the Health Care Financing Administration (now called CMS) published *Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care*. This publication, which several MFCU Directors were involved in, provided valuable information as to the types of fraud to be seen in a managed care setting, the roles of HCFA (CMS), SSAs, MCOs, MFCUs, and DHHS OIG, data needed to detect and prosecute managed care fraud, and key components needed for an effective managed care fraud and abuse program.

Managed care fraud is more difficult to detect, investigate and prosecute than the traditional fee-for-service Medicaid provider fraud. There are a number of reasons that make managed care fraud cases more difficult. These include the complexity of the contractual agreements, the lack of referrals from the Medicaid agency and of reporting requirements, and many times, the failure by the Medicaid agency to recognize that fraud does occur in managed care.

MULTI-STATE/FEDERAL COOPERATIVE EFFORTS

Cooperative efforts between state and federal authorities have proven very effective in protecting Medicaid and Medicare from health care providers or vendors whose activities involve both programs and cross state lines. Joint federal and state task forces have been established in states throughout the nation, and agents increasingly are working together to detect fraud against government insurers. One side effect of these efforts has been the recognition by seasoned practitioners that *all* parties must be at the table when any case resolution is discussed. A settlement reached with a state Medicaid Fraud Control Unit in which all Medicaid claims are resolved, for example, does not

necessarily resolve those in other states or any outstanding Medicare claims or their attendant sanctions. The result has been an unprecedented willingness on the part of state and federal authorities to reach “global” settlements in which all outstanding claims by government insurers can be resolved, and in which all administrative sanctions can be addressed. Unlike state consumer protection or antitrust multi-state settlements, where the states determine that a market problem exists and appoint a lead Attorney General as negotiator, MFCU global settlements are generally based upon a federal Medicare investigation and prosecution. The federal government realizes that the states must be included in these cases because they would be unable to settle the Medicaid portion without them.

The federal government also understands that defense attorneys are unlikely to settle a case without the affected states’ settlement agreements. Most states, like the federal government, have the authority to exclude a convicted provider from their health care programs. It would make the settlement of these cases impossible if defense attorneys had to obtain settlement agreements from individual states and had to negotiate separate terms with each state.

1992 was the first time the state MFCUs participated in a global settlement, *U.S. v. National Health Laboratories, Inc.* (NHL). Since that time, the MFCUs have participated in the successful conclusion of ten global settlement cases with a total Medicaid recovery of over \$360 million dollars.

TENNESSEE'S EXPERIENCE

Tennessee's MFCU was started in 1984 with a staff of twelve, which included eight investigators and has grown to thirty-seven staff members, including twenty investigators. The Medicaid Program at the time of the Tennessee MFCU's creation was a fee-for-service system with the providers contracting directly with the Single State Agency (SSA), called the Bureau of Medicaid. The MFCU had a close relationship with the Bureau of Medicaid's Surveillance and Utilization Review Subsystem (SURS), a subsystem of the Medicaid Management Information System (MMIS), the Unit that referred suspected fraud cases to the MFCU. While in existence, the SURS would attempt to review the billings of approximately 10% of each provider group per year. The SURS would obtain the billing information from a particular provider over a given period of time and then randomly select a number of patient files to compare to these billings. The actual files would be reviewed in the provider's office in what the SURS described as an "office review". Any aberrant billing patterns were reported to the MFCU, occasionally while the office reviews were still underway. On numerous occasions, when allegations were received from other sources, the SURS and MFCU would perform the office review together.

The MFCU and SURS, along with representatives from the State of Tennessee's Health Related Boards and Medicare Fiscal Intermediary, would meet monthly to discuss common cases and new referrals. During this fee-for-service system, the MFCU received the majority of quality referrals from the SURS.

In 1994, Tennessee converted to a managed care delivery system, where providers contract with managed care organizations (MCOs) who in turn contract with the SSA,

now called the Bureau of TennCare. The MCOs receive a capitated payment for every TennCare beneficiary, or recipient, in its network. In addition to covering the Medicaid population, TennCare also covers Tennessee residents who are uninsured or uninsurable. TennCare currently covers over 1.2 million recipients, an increase from approximately 800,000 prior to implementation of the managed care delivery system.

As the population of the recipients in the Medicaid program increased, so did the complexity of the program in general, and fraud investigations specifically, as they relate to the MFCU. While under the “old” fee-for-service system, the primary source of fraud referrals was the SURS. Under the new managed care system, many of the SSA responsibilities, not the least of which was detecting fraud, was passed on to the MCOs. In this managed care setting, providers submit claims for payment directly to the MCOs, instead of directly to the SSA. In theory, with the MCOs having access to claims and payment information, the MCOs would be the primary source of fraud referrals to the MFCU. In reality, this did not prove to be the case. While TennCare has had as many as twelve MCOs at any given time, only one has had what could be described as a true fraud unit.

This new managed care system, while giving access to healthcare coverage to many more Tennesseans who otherwise would not have had any, created numerous new issues for the MFCU. With the large number of MCOs located throughout the State of Tennessee, it has been impossible for MFCU management to meet with each one on a monthly basis, as was done with the SURS. To overcome this, each of the MFCU investigators is assigned at least one MCO to meet with on a regular basis. The purpose of these meetings is to help educate the MCOs as to what fraud is, how to detect it, and

how to report it. We have found, in the case of almost all of the MCOs, there was initially, and continues to be, a high level of ignorance concerning fraud investigations. We have also had to overcome a reluctance by the MCOs to report suspected fraud. This was partly due to the MCOs not having dealt with law enforcement before, and possibly due to the MCO's concern that the knowledge that the respective MCO is aggressive in combating fraud might cause providers (and their patients) to leave their network. Within the past couple of years, language has been included in the Bureau of TennCare/MCO contracts requiring that the MCOs have a compliance plan in place that addresses fraud. It is hoped that, by following their compliance plans, the MCOs will become more aggressive in identifying and reporting incidents of fraud.

In addition to the MFCU investigators meeting with each MCO, the MFCU and Bureau of Medicaid's Program Integrity Unit (PIU) also host quarterly "Round Table" meetings where representatives of all MCOs are invited to discuss problems and issues relating to fraud. While specific cases are not discussed in this forum, problem provider groups or new problems or solutions to problems are. When training topics arise, the MFCU and PIU provide the requested training in conjunction with the Round Table meetings.

Usually, in May of each year, the MFCU and PIU host an all day training seminar for the MCOs. The agenda covered basic concepts of fraud identification and reporting as well as issues such as drug diversion. The MFCU and PIU continue to be very receptive to providing training in any areas requested by the MCOs.

In the early years of the managed care system, the SURS duties were greatly diminished, if not completely dissolved. Even though some areas such as long term care

were “carved out” with the providers continuing to contract directly with the SSA instead of an MCO, the SURS no longer performed in a proactive capacity. While representatives of the SURS attempted to educate the MCOs as to how proactive measures, such as office reviews, were performed, the majority of the duties of the SURS became more reactive in nature.

The remaining employees of the SURS eventually became the founding members of what became the PIU. The PIU has evolved into a Unit that the MFCU works extremely closely with has come to depend on greatly. Much of the success of the relationship between the MFCU and PIU can be attributed to management of both units establishing parameters in which communication and cooperation are expected of all members of both units. Representatives of both the MFCU and PIU often provide training to outside agencies. The Directors from both Units have begun meeting with drug task forces and local prosecutors to provide education about how the MFCU and PIU can work with them on drug diversion cases. With the ever rising costs associated with pharmacy billings, drug diversion by recipients and overprescribing by providers are important issues. Members of these task forces have indicated that, on many occasions, the prescription drugs they are purchasing on the street are coming from Medicaid/TennCare recipients. By working with the drug task forces, the PIU can focus on the drug diversion and the MFCU can concentrate on the oversprescribing by the provider. Often these two issues go hand in hand.

One investigation, referred to the MFCU by the Program Integrity Unit, resulted in one doctor being charged with multiple counts of illegal distribution of prescription narcotics including OxyContin, Adderall, and Hydrocodone. The investigation was

worked jointly by the MFCU, PIU and various other agencies including the DEA, HHS-OIG, TVA Inspector General and the local Sheriff's Department. To date the investigation has resulted in a guilty plea by the doctor on one count of illegal distribution of narcotics, for which he has yet to be sentenced. Additionally, as a result of the investigation, one pharmacist has pled guilty on a count of obstruction of justice and two recipients have pled guilty on narcotics charges. Trial is pending on two remaining defendants.

Another area of managed care that is more complex than in fee-for-service involves the added number of contractors within the system. In the fee-for-service system, the TennCare provider contracted directly with the SSA. In managed care, the MCOs contract with the SSA and the numerous providers contract with the various MCOs. MCOs could also have subcontractors, such as pharmacy benefits managers or other intermediaries. When conducting an investigation, the MFCU often must identify these contractors and review the actual contracts to analyze any potential impact on the investigation. While the MCOs are required to provide accurate encounter data to the Bureau of TennCare, the actual claims are submitted by the provider to the MCO, rather than directly to the Bureau of TennCare. This often means that the MFCU investigators, after obtaining the original computer billing data possessed by the Bureau of TennCare, must go to the various MCOs to gather the claims data. As providers often contract with more than one MCO, this usually means that the investigator must gather claims data from several entities.

The meetings between the MFCU investigators and their assigned MCOs are helpful when the need for gathering claims data exists. Because of the meetings, the

MFCU has established contacts at each of the MCOs who are often able to help in the data gathering. While these contacts are a benefit to the MFCU, success gathering accurate data is dependant upon the respective MCO. In one particular case, prosecuted in federal court, a non-emergency transportation provider contracted with several MCOs. When gathering the claims and payment data from the MCOs, the response time varied from approximately one month (from the MCO that had a fraud unit) to upwards of one year. Also, the MCO that took the longest to provide the data was also unable to provide evidence of how particular claims were paid. Since the MCO could not provide this information, restitution was not ordered for claims paid by this MCO. Issues such as this, which took place several years ago, are addressed in the quarterly meetings and annual fraud seminar so that they can be corrected and other MCOs can learn from them.

Medicaid/TennCare data relevant to the MFCU investigations is possible to get in-house but often takes days and occasionally weeks due to the technology of the mainframe system. Currently, an experienced programmer is required to run "simple" queries. Effective in late 2003, the Bureau of TennCare is expected to roll out a new computer system, called TennCare Management Information System (TCMIS). Beginning in 2002, representatives of the MFCU, along with the PIU, were invited to participate in meetings to prepare this system to address fraud and abuse issues. Both the MFCU and PIU have had the opportunity to provide input on the types of reports and queries necessary to identify and assist in the investigation and prosecution of fraud. It is anticipated that this new program will be much more user friendly and accessible to all MFCU and PIU staff. The system will continue to be dependant on the quality of the data provided by the MCOs.

While Tennessee's Attorney General's Office is involved in any civil settlements resulting from MFCU investigations, this agency has limited criminal prosecutorial authority. With the MFCU housed in the Tennessee Bureau of Investigation, criminal cases can be referred to local prosecutors, U.S. Attorneys, or to the State Attorney General's Office for the civil cases. Being able to prosecute cases in more than one jurisdiction is an advantage but until recently there were few state statutes under which to prosecute fraudulent providers, leaving the MFCU to seek federal prosecution in most of the fraud cases. Within the past three years, amended language has allowed the MFCU to refer more provider fraud cases to local prosecutors and the PIU to refer findings of recipient fraud as well.

**NATIONAL ASSOCIATION OF MEDICAID FRAUD CONTROL UNITS
(NAMFCU)**

The National Association of Medicaid Fraud Control Units (NAMFCU) was established in 1978 to provide a forum for the nationwide sharing of information concerning the problems of Medicaid fraud control, to foster interstate cooperation on law enforcement and federal issues affecting the MFCUs, to improve the quality of Medicaid fraud investigations and prosecutions by conducting training programs and providing technical assistance for association members, and to provide the public with information on the MFCU program. All forty-eight MFCUs comprise the Association. Forty-one of the Units are located in the Office of the State Attorney General and seven are located in other state agencies.

The Association employs a Counsel and a Paralegal, located at the National Association of Attorneys General in Washington, D.C. The Association coordinates and disseminates information to the various Units, maintains a library of resource materials, and provides informal advice and assistance to its member Units and to those states considering establishing a Unit. NAMFCU has provided extensive training for MFCU staff over the years through annual and mid-year conferences and is called upon regularly to supply speakers for numerous health care fraud seminars. It has also co-sponsored training programs with the F.B.I. and the American Bar Association and conducts Introduction and Advanced Medicaid Fraud Training Programs for MFCU staff members. The Introduction and Advanced programs, formerly held at the Federal Law Enforcement Training Center, and now held at various locations across the country, have provided training to almost 750 MFCU employees since 1997. Most Medicaid Fraud Control Units provide training regularly within their own states for local law enforcement and for social service employees, community and provider groups on billing fraud issues as well as patient abuse. The *Medicaid Fraud Report*, published ten times a year, is the Association's newsletter. The newsletter contains information concerning prosecutions by various states, reports of legal decisions affecting fraud control prosecution, and analyses of legislation affecting the Medicaid program and MFCUs. NAMFCU also serves as a clearinghouse for state/federal cooperative efforts and provides a responsive voice to Congressional inquiries. NAMFCU's *Frequently Asked Questions* (FAQ), a document that answers many questions about the Association and the MFCUs is attached to my testimony.

In closing, I want to emphasize that the Medicaid Fraud Control Units are viewed as having a national leadership role in detecting and prosecuting fraud and abuse in government funded health care programs. The Units have been successful in serving as a deterrent to health care fraud, in identifying program savings, removing incompetent practitioners from the health care system, and in preventing physical and financial abuse of patients in health care facilities.

Thank you again for the opportunity to testify today.