TO: The Senate Special Committee on Medicaid Reform
PRESENTED BY: Amber Smock, Director of Advocacy
Judy Panko Reis, Health Access Policy Analyst
Marilyn Martin, Health Access Policy Analyst
Tom Wilson, Healthcare Community Organizer
Access Living, 115 West Chicago Avenue, Chicago, IL 60654
RE: Position Paper, strategies to combat Medicaid fraud, waste, and abuse
DATE: December 21, 2010

Access Living is a nonprofit, nonresidential Center for Independent Living in Chicago, devoted to fostering independent lifestyles working to support the self-determination and full community integration of people with disabilities. Governed and staffed by a majority of people with disabilities, Access Living strongly advocates for and promotes community-based, consumer-controlled services and programs and the right of people with disabilities to make their own decisions about quality-of-life issues. The Access Living Health Team, comprised of policy analysts as well as a community health development specialist, proposes the following strategies to combat Medicaid fraud, waste, and abuse in Illinois.

Access Living agrees with this Committee that fraud, waste, and abuse of taxpayer funds in the Illinois Medicaid program require a firm set of standards and rules. However, a single-minded strategy of tightening eligibility requirements for low-income persons who need medical care, such as the many clients of Access Living in that position, is too narrow in scope. While recipients who abuse Medicaid should, of course, be rooted out and penalized, corporate fraud accounts for massive loss of Medicaid funds and needs also to be addressed.

Examples of the hundreds of millions of Medicaid dollars lost to corporate fraud and abuse abound.

- In March 2008, CVS Caremark Corporation agreed to pay back $36.7 million to the United States and various states based on its illegal switching of drugs. The State of Illinois received an amount of $241,000 from that settlement. http://www.justice.gov/usao/iln/pr/chicago/2008/pr0318_01.pdf
- In June 2008, Walgreens agreed to pay back $35 million of Medicaid funds to the United States and various states based on its illegal switching of drugs. The State of Illinois received approximately $1.25 million from that settlement. http://www.justice.gov/usao/iln/pr/chicago/2008/pr0604_01.pdf
- In August 2008, the U.S. Department of Justice settled claims of fraud with Amerigroup Corporation for $225 million, **to the Illinois Medicaid program alone,** based on Amerigroup's systematic refusal to enroll pregnant women and unhealthy patients in their managed care program in Illinois while accepting federal and state dollars to enroll all

eligible beneficiaries. The settlement reduced the award from the original judgment of $335 million. http://www.justice.gov/opa/pr/2008/August/08-civ-723.html

- In November 2009, Omnicare, a provider of pharmaceuticals for older adults, paid $98 million to settle a $120 million claim of Medicaid fraud, initiated in Chicago, consisting of taking kickbacks from pharmaceutical manufacturer Johnson & Johnson to induce pharmacies to switch to its antipsychotic medication, Risperdal. http://www.pharmacyfraudsettlement.com/Omnicare2009/Omnicare-Behn-Wyetzner-News-Posting.pdf

On November 22, 2010, the U.S. Department of Justice announced that it had recovered **$3 billion** in false claims during fiscal year 2010. Of that amount, **$2.5 billion** was attributable to health care fraud – the largest in U.S. history. Of that health care amount, the largest recovery was attributable to fraud on Medicare and Medicaid programs, including a $2.3 billion settlement with Pfizer, Inc., a settlement that reaped $331 million in recoveries for state Medicaid programs (an amount not included in the $3 billion recovery announced). http://www.justice.gov/opa/pr/2010/November/10-civ-1335.html

While false Medicaid claims by individuals are certainly reprehensible and must be controlled and punished, corporate Medicaid fraud must also be eliminated. Indeed, the Missouri Medicaid Fraud Unit reports that it has recovered more than $77 million in Medicaid fraud since January 2009, and **that unit does not even investigate fraud committed by recipients.** http://ago.mo.gov/divisions/medicaid-fraud-control-unit-faqs.htm

Access Living proposes that this Committee include in its bill specific and aggressive mechanisms to address corporate Medicaid fraud. Those mechanisms should include the five steps to combat Medicaid fraud recommended by Inspector General Daniel R. Levinson of the U.S. Department of Health and Human Services in May 2009 (as revised on December 13, 2010), based on the OIG's investigations, audits, and evaluations. http://www.hhs.gov/asl/testify/2009/05/t20090506d.html. Those five steps are the following:

1. Scrutinize individuals and entities that want to participate as providers and suppliers prior to their enrollment in health care programs. Implement effective screening measures, such as the use of accreditation standards, proof of business integrity or surety bonds, periodic recertification, onsite verification, full disclosure of ownership and control interests, and enhanced oversight during an early provisional period, with the idea of making participation in Medicaid programs a privilege rather than a right. The cost of these screening mechanisms could be covered by charging application fees.
2. Establish payment methodologies that are reasonable and responsive to changes in the marketplace. Link payments closely to changes in the marketplace, medical practice, and technology to avoid wasteful overspending and assure appropriate payments for the items and services covered.
3. Assist health care providers and suppliers in adopting practices that promote compliance with program requirements, including quality and safety standards. The OIG has published on its webpage extensive resources to assist providers and suppliers in designing and implementing effective compliance programs. http://oig.hhs.gov/fraud/mfcu/; http://oig.hhs.gov/fraud/complianceguidance.asp. Follow

the example of New York in requiring providers and suppliers to implement an effective compliance program as a condition of participation in its Medicaid program. See, e.g., compliance alerts provided by the State to Medicaid providers. http://www.omig.ny.gov/data/images/stories/compliance_alerts/2010-02.pdf. Follow the example of Medicare Part D that requires that prescription drug plan sponsors have compliance plans that address requirements to control fraud, waste, and abuse by pharmaceutical suppliers. https://www.cms.gov/PrescriptionDrugCovContra/Downloads/PDBManual_Chapter9_FWA.pdf. Follow Mr. Levinson's recommendation of a consultation with the HHS Office of the Inspector General on standards for mandatory compliance programs.

4. Vigilantly monitor the programs for evidence of fraud, waste, and abuse. Use effective claims-processing mechanisms, data collection and coordination, and information technology to catch improper claims before they are paid. Coordinate the Medicaid databases with other relevant databases. Provide public access to Medicaid actions and sanctions, and provide access by law enforcement to Medicaid data. Assist in coordinating Medicaid fraud tracking at a national level to prevent fraudulent providers and suppliers from moving from state to state unnoticed.
5. Respond swiftly to detected frauds, impose sufficient punishment to deter others, and promptly remedy program vulnerabilities. Invest in a rapid-response detection system which, while costly at the outset, will result in huge savings in catching fraudulent claims.

http://www.hhs.gov/asl/testify/2009/05/t20090506d.html

In summary, focusing merely on restrictive eligibility requirements for Medicaid mistakenly addresses only one part of the problem. Together with monitoring recipient abuse and waste, the State of Illinois should set in place all of the recommendations of the HHS Office of Inspector General in order to deter the loss of hundreds of millions of dollars as a result of corporate fraud.