TESTIMONY
OF
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BEFORE

HOUSE COMMITTEE ON ENERGY AND COMMERCE

"Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid"

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Mr. Chairman and Members of the Committee, thank you for the opportunity to appear before you today to discuss the role of the states in investigating and prosecuting Medicaid provider fraud. I am Kaye Lynn Wootton, Director of the Utah Medicaid Fraud Control Unit in the Office of the Utah Attorney General. I am pleased to speak to you today as the President of the National Association of Medicaid Fraud Control Units, which is a bipartisan organization that represents the fifty-three Medicaid Fraud Control Units.

INTRODUCTION

Medicaid Fraud Control Units (MFCUs) are state-based criminal law enforcement agencies. All MFCUs are located in State Attorney Generals' offices except for four which are located in other state agencies. MFCUs are required to be separate and distinct from the state Medicaid program to avoid institutional conflicts of interest.

MFCUs are comprised of multi-disciplinary teams of attorneys, investigators and auditors working full-time on Medicaid fraud cases, all who perform the work of investigating and prosecuting complex Medicaid fraud and abuse and neglect of vulnerable individuals. Many MFCU teams include nurses and other medical professionals to assist with this challenging work. Collectively, the MFCUs are staffed with approximately 2,000 employees. Since the inception of the national MFCU program in 1978, the fifty-three Medicaid Fraud Control Units have obtained thousands of convictions and recovered billions of dollars in restitution. These Units have also demonstrably deterred the loss of many more billions of dollars in Medicaid overpayments.

The Medicare-Medicaid Anti-Fraud and Abuse Amendments, enacted by Congress in the 1970s, established the state Medicaid Fraud Control Unit Program. States were given incentive funding to investigate and prosecute Medicaid provider fraud, to prosecute the abuse and neglect of

patients in all Medicaid-funded residential health care facilities and to investigate fraud in the administration of the Medicaid program. The Ticket to Work and Work Incentives Improvement Act of 1999 authorizes the MFCUs, with the approval of the Inspector General of the relevant federal agency, to investigate fraud in other federally-funded health care programs if the case is primarily related to Medicaid. This law authorizes the MFCUs, on an optional basis, to investigate and prosecute resident abuse or neglect in non-Medicaid board and care facilities.

MFCUs are now allowed to investigate and prosecute cases of resident abuse and neglect arising in non-institutional settings. HHS-OIG also has authorized MFCUs to investigate and prosecute fraudulent conduct relating to the diversion or misuse of pharmaceuticals, where the conduct involves a potentially fraudulent claim to Medicaid or another federal health care program.

The federal government provides 75 percent of each MFCU's funding with the remaining 25 percent provided by the state. Each MFCU operates under the administrative oversight of the Inspector General of the U.S. Department of Health and Human Services (HHS-OIG), and each Unit must be annually recertified. This funding formula and oversight allow the federal government to ensure that each Unit's activities are directed at Medicaid provider fraud, fraud in the administration of the program and resident abuse or neglect, rather than at crimes lacking an appropriate Medicaid nexus.

HISTORY OF THE MFCU PROGRAM

The lack of comprehensive safeguards in the initial Medicaid legislation gave a small but greedy group of individuals free rein to steal millions of taxpayer dollars during Medicaid's first decade of operation. Additionally, Medicaid's costs began an upward spiral shortly after the program began. Congressional hearings confirmed that this increase was partially due to the widespread misappropriation of public funds by a handful of unscrupulous health care providers.

While numerous Congressional hearings were bringing such abuses to light, it became clear that states such as New York, where a separate statewide investigative entity had been established, were able to substantially increase the rate of prosecutions and convictions and the recovery of taxpayer funds. Based on the New York model, Congress created the Medicaid Fraud Control Unit program.

Medicaid Fraud Control Units are the law enforcement agencies primarily responsible for monitoring each state's Medicaid program. As managed care has become a larger component of the Medicaid system, MFCUs have been tasked with policing those operations. The MFCUs have investigated and prosecuted some of the largest and most sophisticated frauds ever committed against the program. The Units have uncovered fraud schemes being perpetrated by nursing homes and hospitals, clinics and pharmacies, laboratories, home health and hospice providers and durable medical equipment vendors and, more recently, behavioral health organizations. Each surge in Medicaid fraud has brought its own special brand of profiteer, searching for new vulnerabilities in the Medicaid program.

RESIDENT ABUSE

The MFCUs also focus significant resources on resident abuse and neglect cases. When Congress created the MFCU program, it did so not only because of the evidence of massive fraud in the Medicaid program but also because of the horrendous tales of nursing home abuse and resident victimization. The MFCUs are the only law enforcement agencies in the country specifically charged with investigating and prosecuting abuse and neglect of residents in nursing homes, other Medicaid-funded health care facilities, and board and care facilities.

Many MFCUs use their criminal and civil enforcement authority to enforce different types of resident abuse cases that underscore the insidious, hidden and often neglected concerns about the financial and physical safety of vulnerable, "at-risk" adults who can no longer care for themselves and who are disproportionately subject to abuse and debilitating injury. These cases include physical abuse, sexual abuse, corporate neglect, misappropriation of patient trust funds, and homicide and manslaughter cases.

In addition, the MFCUs across the country have launched innovative programs that include training and public outreach programs to help prevent resident and patient abuse. Other important activities by the MFCUs include legislative efforts to enhance and reform the laws that protect residents from these abuses and referring state criminal convictions, judgments and licensing actions to the HHS-OIG so that individuals who are convicted of these crimes may be excluded from working in any facility or program that receives federal funding for health care.

CRIMINAL AND CIVIL ENFORCEMENT

Criminal convictions and civil enforcement actions that hold persons accountable for complex fraud schemes achieve high deterrence impact, especially when they hold accountable those who direct or conspire to accomplish the fraud scheme. The investigative and prosecution work required to obtain successful dispositions requires significant resources because: (1) complex fraud schemes are often orchestrated by persons who control the fraud behind the scenes using many LLCs, bank accounts, and persons conspiring in the scheme; (2) these schemes often involve the manipulation of electronic records; and (3) defendants who have significant resources are often represented by sophisticated law firms who file many motions throughout the prosecution and trial, including appeal. When successful, these dispositions help protect the Medicaid program through significant deterrence.

MFCUs work closely with federal, state, and local agencies. At the federal level, we frequently conduct joint investigations with HHS-OIG, FBI, DCIS, IRS, DEA, USPS, and other investigative agencies. Our federal investigative partners often have resources that strengthen the investigations. Coordinating our efforts with our federal partners helps us to hold defendants more fully accountable for their crimes. In our prosecutions, MFCUs often coordinate with USDOJ and with our local U.S. Attorneys' Offices. Many MFCUs have attorneys on staff who are appointed as Special Assistant U.S. Attorneys. This has benefits for both the MFCUs and the U.S. Attorneys' Offices.

MFCUs have many partners at the state and local level, too. Our State Medicaid Agencies have Program Integrity Units that identify and investigate potential fraud. Our Program Integrity Units are one of our best sources of fraud referrals. MFCUs also coordinate with the State Survey Agency that oversees nursing facilities. The survey agencies are one of our best sources of resident abuse referrals. MFCUs frequently work with our state Bureaus of Investigation, Departments of Insurance, Boards of Pharmacy, medical and nurse licensing agencies, sheriffs' offices and police departments, county departments of social services, and other state and local agencies. These partnerships are vital.

When MFCU investigations develop sufficient evidence supporting charges under state penal laws, it is possible for MFCUs to obtain successful criminal convictions, either through trial or through guilty pleas. When MFCU investigations result in evidence supporting civil enforcement, it is possible for MFCUs to obtain successful civil trial verdicts of liability, or civil settlements.

Successful investigations and the appropriate use of civil and criminal remedies enable MFCUs to achieve a wide range of invaluable outcomes, including incarceration, fines, penalties, damages, restitution to victims, asset seizure, and civil and criminal forfeiture.

EXCLUSIONS

Health care providers paid by federal health care programs, including Medicare and Medicaid, may be excluded from participation in these programs by the HHS-OIG. Often this sanction has a greater impact on the convicted provider than any civil or criminal penalty. HHS-OIG has both mandatory and discretionary authority to exclude unfit, unscrupulous or abusive health care practitioners from participating in federally-funded health care programs.

Those individuals or entities convicted of program-related crimes or resident abuse or neglect must be excluded from participation in government health care programs for a minimum of five years, although the period may be longer. Permissive exclusions, which are imposed for a minimum of three years, are for convictions of federal and state crimes relating to fraud, theft, embezzlement, financial abuse, interfering with a health care fraud investigation or for a revoked or suspended health care license.

MFCUs are required to report all convictions to HHS-OIG for exclusion. In federal fiscal year (FY) 2024, there were 1,042 HHS-OIG exclusions.

PROGRAM RECOMMENDATIONS

HHS-OIG has issued guidance regarding the standards that are used in assessing the performance of MFCUs. These standards are known as the Performance Standards for Medicaid Fraud Control Units. These Standards provide helpful guidance to MFCUs in their operations and assist OIG with its recertification process and periodic reviews of the MFCUs. One of the MFCU Performance Standards states that a Unit should make "statutory or programmatic recommendations, when warranted and appropriate, to the State government." MFCUs make program recommendations based on our experience and the information obtained in the course of our investigations and prosecutions.

MFCUs sometimes identify vulnerabilities in the Medicaid programs that could be remedied by changes in Medicaid policy, statutory amendments, or other actions. We recognize that preventing fraud is more cost-effective than investigating and prosecuting it. Through MFCU program recommendations, the Units suggest ways to strengthen Medicaid program integrity.

NATIONAL ASSOCIATION OF MEDICAID FRAUD CONTROL UNITS

The National Association of Medicaid Fraud Control Units (NAMFCU) was established in 1978 to provide a bipartisan forum for the nationwide sharing of information concerning the challenges of Medicaid fraud control. The Association serves: to provide a forum for the mutual exchange of views and experiences on subjects of importance to the state Medicaid Fraud Control Units; to foster interstate cooperation on legal and law enforcement issues affecting the Units; to improve the quality of Medicaid fraud and resident abuse investigations and prosecutions by conducting training programs and providing technical assistance for Association members; to facilitate communication among the Medicaid Fraud Control Units; and to provide the public with information about the Medicaid Fraud Control Units. The Association also gathers, coordinates and disseminates information to the MFCUs, maintains resource materials and provides informal advice and assistance to its member Units.

NAMFCU is called upon regularly to supply speakers for numerous health care fraud training programs. More information about NAMFCU and the MFCU program can be found at the Association's website at https://www.naag.org/about-naag/namfcu/.

EXAMPLES OF PROVIDER FRAUD SCHEMES

During the past decade, MFCUs have seen a rapid increase in both the number of fraudulent schemes targeting the Medicaid program and the degree of sophistication with which they are perpetrated. Although the typical fraud schemes – billing for services not rendered, double-billing, misrepresenting the nature of services provided, providing unnecessary services, submitting false cost reports and paying illegal kickbacks – still regularly occur, new and often innovative methods of fraud continue to appear.

Perpetrators of Medicaid fraud run the gamut from the solo practitioner who submits claims for services never rendered to large institutions that exaggerate the level of care provided to their patients and then alter patient records to conceal the resulting lack of care.

One of the MFCU Performance Standards states that a Unit should seek to have a broad mix of cases among the significant provider types in the Unit's state. For states with a significant number of Medicaid enrollees under managed care plans, the MFCUs' case mix should include an appropriate number of cases arising in managed care settings.

MFCUs have identified serious incidents of fraud in numerous sectors of the health care industry, including hospitals, home health and hospice agencies, medical transportation companies, durable medical equipment suppliers, pharmacies and medical clinics. They have prosecuted individual providers such as physicians, dentists, nurses and mental health professionals.

Examples of provider fraud schemes follow:

Behavioral Health Fraud

MFCUs investigate and prosecute many types of behavioral health fraud schemes. This section will focus on a specific behavioral health service known as substance use disorder treatment. Substance use disorder (SUD) treatment fraud involves unethical, illegal practices committed by

both residential and out-patient providers. Common scams include paying for referrals, billing for services never rendered or rendered by unqualified providers and offering free travel to out-of-state facilities. In response to the opioid crisis and other needs, SUD treatment has increased significantly. Investigations reveal that Medicaid funds are being paid for these critical services, but Medicaid patients are not actually receiving the care they need.

Nursing Home Fraud

Nursing home fraud schemes are complex and include stratagems through which nursing home owners fraudulently transfer Medicaid and Medicare funds from the nursing home: (1) to themselves through no-show jobs; (2) to related party landlords through fraudulent loans at inflated interest rates or through inflated alleged rents; (3) to related party purported management or consulting companies for sham services of little to no value; or (4) to other related parties for nonexistent or fraudulent alleged services. Typically, owners of for-profit nursing homes that engage in these fraudulent schemes operate the nursing homes with chronic insufficient staffing and illegally admit residents despite lacking adequate staff to care for them, which causes preventable neglect, abuse and suffering of vulnerable nursing home residents.

Pharmacy Fraud

Pharmacy fraud schemes often involve an operation in which a person who controls multiple pharmacies through "straw owners" orchestrates schemes through which the pharmacies: (1) bill Medicaid for refills of expensive medications that they do not dispense to patients; or (2) pay kickbacks to Medicaid recipients to induce them to allow the pharmacies to bill Medicaid for expensive medications, deliver the medications to them, and accept kickback payments in exchange for selling their medications back illegally so they can be sold illegally again on the black market as adulterated medications.

Historically, pharmacy fraud often involved the fraudulent prescribing and dispensing of opioid medications. Recently, however, MFCU cases often involve high dollar non-controlled substances. These schemes typically focus on maximizing profits by billing for expensive, but medically unnecessary, medicines.

Non-Emergency Medicaid Transportation Fraud

Non-Emergency Medicaid Transportation fraud schemes include providers illegally billing Medicaid for: (1) "ghost rides" that were never provided; (2) tolls that were never incurred during trips, (3) individually billed rides when group rides were actually provided; (4) trips that were falsely billed when recipients were deceased, incarcerated or hospitalized; (5) trips provided by providers that paid kickbacks to Medicaid recipients to induce them to choose that provider to provide transportation; and (6) trips that never occurred but for which the provider paid the recipient a kickback.

Therapeutic Behavioral Services and Community Psychiatric Support Services Fraud

Therapeutic behavioral services and community psychiatric support services schemes may involve the collection of Medicaid IDs from children through community programs such as afterschool programs, sports camps, and summer camps. These IDs are then used to bill for therapeutic behavioral services and community psychiatric support services, which were not ordered. Providers often collaborate with billing companies to fabricate Electronic Medical Record (EMR) notes and apply a one-size-fits-all diagnosis of "adjustment disorder." Medicaid claims data show that claims are submitted before and after actual program dates. Parents are unaware of any diagnoses or services, and investigations indicate no assessments or therapy are provided to the children.

Hospice Fraud

Hospice fraud schemes typically involve providers enlisting marketers to find beneficiaries to enroll into hospice care despite not being eligible for hospice services. The beneficiaries typically do

not know they were enrolled in hospice, are not dying, and do not know what hospice is. Fraudulent providers frequently enlist the assistance of a doctor to sign off on the certification of terminal illness in exchange for payment. Since a beneficiary enrolled in hospice care for over six months sets off red flags, many fraudulent providers own multiple hospice companies and will cycle the beneficiaries through their different companies every six months to avoid detection. Additionally, the hospice companies are commonly held by shell corporations and multiple layers of LLCs.

Skin Substitutes Fraud

Skin substitutes fraud schemes typically involve billing Medicare and Medicaid for very expensive skin substitute products provided to patients without medical necessity. Skin substitutes (cellular and/or tissue-based products) are bioengineered or human-derived materials applied to chronic wounds, burns, or surgical defects to promote healing. Investigations into allegations of skin substitute fraud often reveal that these skin substitutes were never applied, were not utilized as intended, were applied by unqualified individuals, or were utilized without first trying cheaper, more appropriate treatments. This fraud scheme has demonstrated the value of close collaboration between MFCUs and federal partners, given that Medicare and Medicaid programs have both been targeted.

CIVIL FALSE CLAIMS ACT ENFORCEMENT AND GLOBAL CASES

NAMFCU has effectively coordinated a large number of multistate/federal investigations and settlements since 1992. These cases typically arise under the federal False Claims Act, 31 U.S.C. § 3730(b), when a private person (whistleblower or Relator) brings a civil *qui tam* action in the name of the United States. Over the past twenty years, most states have enacted state False Claims Acts modeled after the federal Act. Currently, 33 states and territories have False Claims laws with *qui tam* provisions. *Qui tam* cases are filed under seal, allowing the Government to investigate the

whistleblower's allegations and decide if it wants to intervene and litigate the case. If the Government does not intervene, the whistleblower may litigate on the Government's behalf. If a *qui tam* case results in a monetary recovery, the whistleblower may be entitled to a share – from 15 to 30 percent – of the Government's recovery. The enactment of state False Claims Acts allowed whistleblowers to directly name the States in their federal actions, which in turn has led to greater coordination between federal and state governments to combat fraud.

Qui tam actions often provide the governments with valuable "insider" evidence about fraud schemes that would otherwise be difficult to detect, because they are frequently filed by employees or former employees of the alleged fraudfeasors who have first-hand knowledge of the fraud scheme. *Qui tam* cases also can result in criminal prosecutions. When an investigation develops evidence that would also support criminal prosecution, MFCUs and/or our U.S. Attorneys' Office colleagues can open parallel criminal investigations.

An important NAMFCU objective is cultivating close working relationships between state and federal agencies combatting fraud, waste and abuse in the Medicaid program. These cooperative efforts have grown out of the relationship between MFCUs and HHS-OIG, which has oversight over the MFCUs. In *qui tam* cases alleging fraud against multiple states' Medicaid programs, the MFCUs frequently coordinate with USDOJ, HHS-OIG, and other partners in the joint investigation such as the FBI, DEA, DCIS, IRS, and the U.S. Postal Service. In *qui tam* cases alleging multi-state or nationwide schemes, the states' investigations are often coordinated by formal teams of attorneys and analysts from various MFCUs through processes developed by NAMFCU over the years. We refer to these as "global" cases. Global teams allow the states to avoid duplicative investigative work, leverage resources, and provide a means to identify additional Medicaid dollars which might be impacted by

alleged fraud schemes. MFCUs also actively participate in state-federal health care fraud task forces and working groups that operate in virtually every state.

These federal-state cooperative efforts are highly effective in protecting Medicaid, Medicare, and other federal programs from health care providers or vendors who defraud these programs. Global cases in which the MFCUs played a role have resulted in the recovery of over $12 billion to the Medicaid program. Examples of recent state-federal global settlements follow:

Gilead Sciences

A *qui tam* case alleged that Gilead Sciences, Inc. paid kickbacks to providers to improperly promote its HIV drugs, Stribild®, Genvoya®, Complera®, Odefsey®, Descovy®, and Biktarvy® (the "Gilead HIV Drugs"), and that from January 1, 2011 through November 17, 2017, it offered and paid remuneration in the form of honoraria payments, meals, and travel expenses to healthcare practitioners who spoke at or attended Gilead speaker events to induce them to prescribe the Gilead HIV Drugs in violation of the Anti-Kickback Statute. The company agreed to settle the case and paid the states and the federal government $202 million, of which $49,045,600 went to state Medicaid programs. As part of the settlement, Gilead also made extensive factual admissions regarding its conduct.

GlaxoSmithKline

A *qui tam* case alleged that GlaxoSmithKline knowingly and intentionally manufactured, marketed, imported, prepared, and sold ranitidine (brand name Zantac) despite contentions that their experiments and data showed that ranitidine could react to form a known carcinogen (NDMA). The company agreed to settle the case and paid the states and the federal government $67,500,000, of which $61,931,540 went to the federal government for Medicare and the federal share of Medicaid, and $5,568,459 for the states' share of Medicaid went to state Medicaid programs.

Biogen

A *qui tam* case alleged that Biogen improperly submitted claims for payment to state Medicaid programs for prescriptions that were tainted by the payment of kickbacks to prescribers for its multiple sclerosis drugs Avonex®, Tysabri® and Tecfidera®, as part of an alleged scheme to preserve the eroding market share of its oldest product, Avonex®, increase the market share of its biological product Tysabri®, and ensure that its newest oral drug, Tecfidera®, would be prescribed at a high rate. The Governments declined to intervene, and the Relator moved forward with litigating the matter. The company later agreed to settle the case for $900,000,000. The total Medicaid recovery for the named plaintiff States was $113,456,113.

MFCU DATA MINING

Since 2013, with a waiver from HHS-OIG, MFCUs have been allowed to conduct data mining to identify aberrant Medicaid billing practices. To date, 26 MFCUs have obtained data mining waivers and are using data mining techniques to find potential subjects for investigation based on analysis of the Medicaid utilization data. Data mining enables MFCUs to quickly and efficiently identify emerging fraud schemes. It also helps MFCUs diversify their case mix. Examples of fraud schemes evaluated through MFCU data mining efforts include:

- Pharmacies' billing of high-cost non-controlled substances without dispensing the medications
- Billing of skin substitutes without medical necessity
- Overutilization of Applied Behavior Analysis therapy for children with autism
- Overcharging by durable medical equipment (DME) providers

- Ambulance services' submission of transportation claims without corresponding inpatient, outpatient, or long-term care encounters
- Submission of transportation claims for fake toll expenses, inflated mileage, and services provided by unlicensed, under-licensed, or suspended drivers
- Home care workers making Electronic Visit Verification (EVV) entries documenting services at levels beyond what is physically possible, resulting in large reimbursement amounts
- DME providers billing for accessories already included in capped rental agreements for equipment
- Billing for dental services that were not provided
- Physician billing for vein treatments without sufficient documentation to support which procedures were performed and to document medical necessity
- Prescribing or dispensing large quantities of high-cost multivitamins
- DME providers billing maximum allowable fees for high-cost codes
- Providers billing Urine Drug Screens at the highest testing levels and/or at a frequency that was not medically necessary

While we are enthusiastic about MFCU data mining, it is important to note that we continue to rely on our program integrity partners for many of our strongest fraud referrals. These partners include the State Medicaid Agencies' Program Integrity Units and, increasingly, the Medicaid Managed Care Organizations' special investigations units. MFCU data mining is conducted in coordination with our State Medicaid Agency partners.

CONCLUSION

As they have done for over forty-five years, state Medicaid Fraud Control Units continue to play a national leadership role in investigating and prosecuting health care fraud and resident abuse, neglect, and misappropriation of resident funds, and will continue to do so in the future. MFCUs aggressively identify and prosecute, both civilly and criminally, those who seek financial gain at the expense of the Medicaid program. By doing so, MFCUs deter health care fraud, identify program savings, and remove practitioners who commit these crimes from the health care system. Equally important, the MFCUs protect our nation's most vulnerable citizens – the poor and the frail elderly – by prosecuting those who abuse and neglect them in our nation's nursing homes, thereby ensuring that our nursing homes are safe places to live.

Thank you again for giving me the opportunity to testify today.