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Congress of the United States
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MEMORANDUM

May 22, 2016

To: Subcommittee on Oversight and Investigations Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Hearing on "Medicare and Medicaid Program Integrity: Combatting Improper Payments and Ineligible Providers"

On Tuesday, May 24, 2016, at 10:15 a.m. in room 2322 of the Rayburn House Office Building, the Subcommittee on Oversight and Investigations will hold a hearing titled "Medicare and Medicaid Program Integrity: Combatting Improper Payments and Ineligible Providers." The hearing will focus on fraud prevention efforts in Medicare and Medicaid and several recent reports on these efforts by the Department of Health and Human Services Office of Inspector General (HHS OIG) and the Government Accountability Office (GAO).

I. BACKGROUND

The Medicare program provides federally financed health insurance for persons age 65 or over and certain individuals with disabilities or other medical conditions.[1] In FY 2015, Medicare served about 55 million beneficiaries at a cost of $634 billion.[2]

Medicaid is a joint federal and state program for low-income and medically needy individuals. In FY 2015, Medicaid had estimated expenditures of $529 billion for about 69 million beneficiaries.[3] Medicaid consists of 56 distinct state-based programs. As a result of

[1] Government Accountability Office, *Medicare Program: Additional Actions Needed to Improve Eligibility Verification of Providers and Suppliers* (June 25, 2015) (GAO-15-448).

[2] Government Accountability Office, *2016 Annual Report: Additional Opportunities to Reduce Fragmentation, Overlap, and Duplication and Achieve Other Financial Benefits* (April 13, 2016) (GAO-16-375SP).

[3] Government Accountability Office, *Medicaid Program Integrity: Improved Guidance Needed to Better Support Efforts to Screen Managed Care Providers* (April 22, 2016) (GAO-16-402).

flexibility in the program's design, each state establishes its own eligibility standards, benefit packages, payment rates, and program administration under broad federal guidelines. States are the first line of defense against Medicaid improper payments; state program integrity units are responsible for complying with federal requirements to ensure the qualifications of providers who bill under the program, detecting improper payments, recovering overpayments, and referring suspected cases of fraud and abuse to law enforcement agencies.[4]

II. IMPROPER PAYMENTS RATE

In 2002, Congress passed the Improper Payments Information Act (IPIA) requiring agencies to assess federal programs for improper payment risk and annually report on improper payments. Improper payments are "any payment that should not have been made or that was made in an incorrect amount (either overpayments or underpayments)."[5] An improper payment rate is a measurement of payments that do not meet statutory, regulatory, or administrative requirements; it is not considered a "fraud rate."[6] According to the U.S. government reporting website, the vast majority of improper payments are due to unintentional errors rather than fraud.[7]

In FY 2015 Medicare improper payment rates were 12.1 percent for Fee-for-Service, 9.5 percent for Medicare Advantage, and 3.6 percent for Medicare Part D.[8] Medicaid's improper payment rate in FY 2015 was 9.8 percent.[9]

A May 2016 report for the OIG found that while HHS met many requirements of the IPIA in FY 2015, it did not fully comply in some areas, including parts of Medicare and Medicaid.[10] The report found that Medicare fee-for-service had an error rate above the 10 percent threshold set by the Act and that Medicare Advantage and Medicaid did not meet their FY 2015 targets for reduced improper payments (target rates of 8.5 percent for Medicare

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[4] Government Accountability Office, *Medicaid Program Integrity: Expanded Federal Role Presents Challenges to and Opportunities for Assisting States* (Dec. 7, 2011) (GAO-12-288T).

[5] Department of Health and Human Services Office of Inspector General, *U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 But Did Not Fully Comply for Fiscal Year 2015* (May 2016).

[6] Center for Medicare & Medicaid Services, *The Standard Operating Procedure for States' Role in the Payment Error Rate Measurement (PERM) Program* (June 2014).

[7] Payment Accuracy.gov, *Improper Payments Overview* (online at: paymentaccuracy.gov/about-improper-payments) (accessed May 20, 2016).

[8] Payment Accuracy.gov, *High-Error Programs* (online at: paymentaccuracy.gov/high-priority-programs) (accessed May 20, 2016).

[9] *Id.*

[10] Department of Health and Human Services Office of Inspector General, *U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 But Did Not Fully Comply for Fiscal Year 2015* (May 2016).

Advantage and 6.7 percent for Medicaid). The report recommends HHS focus on the root causes for improper payment rates, which in many cases appear to be insufficient documentation, and proactively take action to hit its improper payment target rates, including better communicating documentation requirements and working with state and local agencies to bring their systems into compliance with new requirements.[11]

III. NEW FRAUD AUTHORITIES UNDER THE AFFORDABLE CARE ACT

The Affordable Care Act (ACA) included a number of provisions to strengthen program integrity in the Medicaid and Medicare program. The most important provisions involve a shift from the traditional "pay and chase" model to a preventive approach, by keeping fraudulent suppliers out of the program before they can commit fraud. On February 2, 2011, CMS issued final rules that dramatically changed how providers and suppliers enroll in the Medicaid and Medicare programs. The new regulations implement Section 6401 of the ACA, which requires the Secretary to establish procedures to conduct risk-based screenings of providers and suppliers in the Medicare, Medicaid, and CHIP programs.[12]

The regulations divide providers into three categories of risk: limited, moderate, and high. Providers and suppliers are divided among the risk categories based upon historical patterns of fraud and abuse and the relative risk each provider type poses to the integrity of the program. Screening of "low" risk providers must include, at a minimum: 1) verification that a provider meets federal regulations and state requirements for the provider type prior to making an enrollment determination; 2) licensure verification; and 3) federal database checks, including checking against the Social Security Administration's Death Master File (DMF), the National Plan and Provider Enumeration System, the HHS-OIG's List of Excluded Individuals/Entities (individuals barred from billing participation in federal healthcare programs), and the Excluded Parties List System (U.S. General Services Administration's list of individuals barred from federal contracts). Providers that are designated as "moderate" or "high" risk are also subject to an on-site visit to verify that the information submitted to the state Medicaid agency or to Medicare is accurate and to determine compliance with federal and state enrollment requirements.[13] "High" risk providers are subject to criminal background checks and fingerprinting.[14]

The final regulations require that all participating providers in the Medicare, Medicaid, and CHIP programs be screened upon enrollment and revalidated at least every five years. States

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[11] *Id.*

[12] Department of Health and Human Services, *Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers*, 76 Fed. Reg. 5862 (Feb. 2, 2011).

[13] *Id.*

[14] *Id.*

can rely on the results of Medicare program provider screening by accessing the Medicare Provider Enrollment, Chain, and Ownership System (PECOS).[15]

Additional anti-fraud provisions in the ACA affecting Medicaid include:

- **New and enhanced penalties for fraudulent providers.** The ACA adds and imposes new civil monetary penalties on individuals who fail to grant timely access to information required for audits or investigation, individuals who have been excluded from federal health care programs who order or prescribe services provided by that program, individuals who make false statements on enrollment applications or bids, and individuals who know of, but do not return, overpayments from Medicare and Medicaid. New provisions also allow the Inspector General to exclude from Medicare and Medicaid any provider that makes false statements on an application to enroll or participate in these programs.[16]

- **Withhold Payments**. The ACA permits the Secretary, in consultation with OIG, to suspend Medicare payments to a provider or supplier pending an investigation of a "credible allegation of fraud," unless the Secretary determines there is good cause not to suspend payments. Likewise, state Medicaid agencies are required to suspend payments to a provider of services or supplier pending an investigation of a credible allegation of fraud, unless good cause exists not to suspend such payments.[17]

- **New funding to fight Medicare and Medicaid fraud.** The ACA significantly increases funding for the Health Care Fraud and Abuse Control (HCFAC) Fund, indexing the program's mandatory baseline and funding to inflation, and providing additional mandatory HCFAC funding of $350 million over 10 years (FY2011-FY2020).[18]

- **Termination of provider participation under Medicare, Medicaid and CHIP if terminated under Medicare or another State Medicaid or CHIP program.** The ACA requires states to terminate a provider or supplier under Medicaid or CHIP when the provider or supplier's billing privileges have been revoked by Medicare or by another State's Medicaid program or CHIP. In addition, CMS is permitted to

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[15] Centers for Medicare & Medicaid Services, *Medicaid/CHIP Provider Screening and Enrollment* (Dec. 23, 2011) (online at www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-12-23-11.pdf).

[16] Congressional Research Services, *Health Care Fraud and Abuse Laws Affecting Medicare and Medicaid: An Overview* (Sept. 8, 2014).

[17] Department of Health and Human Services, *Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers* (Feb. 2, 2011).

[18] P.L. 111-148, Section 6402(i) (2010).

revoke Medicare billing privileges when a provider or supplier's Medicaid billing privileges are terminated or revoked by a State Medicaid agency.[19]

- **Authority to impose a temporary moratorium on the enrollment of new Medicare, Medicaid, or CHIP providers and suppliers.** The ACA provides the Secretary of HHS with new authority to impose a temporary moratorium on newly enrolling providers and suppliers in the Medicare program, if the agency determines that there is a significant potential for fraud, waste, or abuse with respect to a particular provider or supplier type or particular geographic areas, or both.[20] State Medicaid agencies must comply with any moratorium, unless the state determines that it would adversely affect Medicaid beneficiaries' care.[21]

IV. RECENT OIG REPORTS

The HHS OIG has four recent reports pertaining to provider enrollment and screening in Medicare and Medicaid. Three of these reports will be released in conjunction with the hearing. These reports found that some of the ACA anti-fraud tools have not been fully implemented, and that areas for improvement remained regarding provider screening efforts.

HHS OIG reviewed the implementation of the ACA's required enhanced enrollment screening for providers in reports on Medicare and Medicaid. For Medicare, OIG found that enhanced screening may have affected the number of providers applying for enrollment, potentially due to a "deterrent effect" resulting from the implementation of enhanced enrollment screening process, and that revalidation of existing provider enrollments led to substantial revocations and deactivations of providers.[22] However, they found several areas that could use strengthening, such as Medicare Administrative Contractor (MAC) processes for verifying key provider information and using the result of site visits conducted by the National Site Visit Contractor (NSVC) to make enrollment and revalidation decisions. The report makes 5 recommendations to improve the monitoring of both MACs and the NSVC and the collection and use of site visit data.[23]

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[19] Department of Health and Human Services, *Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers* (Feb. 2, 2011).

[20] *Id.*

[21] *Id.*

[22] Department of Health and Human Services Office of Inspector General, *Enhanced Enrollment Screening of Medicare Providers: Early Implementation Results* (April 2016).

[23] *Id.*

With regard to the Medicaid program, OIG found that enhanced provider enrollment screenings have not been fully implemented.[24] For example, most states reported not having implemented fingerprint-based background checks; 11 states had not implemented site visits; and 14 states reported they would not finish revalidating existing providers by the September 2016 deadline.[25] The report makes 6 recommendations to help ensure full implementation of Medicaid enhanced provider screening, including assisting states in overcoming challenges to background checks, site visits, and revalidation of providers in a timely manner.[26]

The OIG also conducted two reviews of provider ownership information for Medicare and Medicaid, and identified inconsistencies and potential vulnerabilities.[27] For States to identify potentially fraudulent providers, as well as those that may be associated with excluded individuals or entities, providers must disclose accurate and timely information about their owners (i.e., individuals or corporations with a 5-percent or more ownership or controlling interest; agents; or managing employees). These reviews compared three sets of owner names: those submitted by a sample of providers to OIG, those on record with CMS for Medicare, and those on record with state Medicaid programs. The reviews found a high rate of discrepancies between ownership information provided to OIG and Medicare or Medicaid data. Further, many providers had names in state Medicaid records that did not match CMS's Medicare records. OIG makes 4 recommendations for Medicare and 7 recommendations to Medicaid to address the discrepancies and to improve the collection and verification of provider ownership information.[28]

V. RECENT GAO REPORTS

GAO reported on the implementation of enrollment screening procedures for Medicare's PECOS database in June 2015 and April 2016.

The 2015 report found that CMS procedures appeared to be working to screen for providers and suppliers listed as deceased or excluded from participating in federal programs or health care–related programs.[29] However, GAO found weaknesses in CMS's verification of provider practice location and physician licensure status. Looking at 2013 data, GAO initially identified 105,234 (11 percent) out of 980,974 addresses in PECOS as questionable and upon

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[24] Department of Health and Human Services Office of Inspector General, *Medicaid Enhanced Provider Enrollment Screenings Have Not Been Fully Implemented* (May 2016).

[25] *Id.*

[26] *Id.*

[27] Department of Health and Human Services Office of Inspector General, *Medicaid: Vulnerabilities Related to Provider Enrollment And Ownership Disclosure* (May 2016); U.S. Department of Health and Human Services Office of Inspector General, *Medicare: Vulnerabilities Related to Provider Enrollment and Ownership Disclosure* (May 2016).

[28] *Id.*

[29] Government Accountability Office, *Medicare Program: Additional Actions Needed to Improve Eligibility Verification of Providers and Suppliers* (June 25, 2015) (GAO-15-448).

further analysis found that about 23,400 of those practice location addresses were potentially ineligible--- about 2.3 percent of the total 980,974 addresses in PECOS.[30] In addition, they noted that March 2014 guidance from CMS reduced the amount of independent verification of addresses conducted by contractors.

With regard to physician licensure status, GAO found 147 (0.01%) out of about 1.3 million physicians listed as eligible to bill Medicare who, as of March 2013, had received a final adverse action from a state medical board for crimes against persons, financial crimes, and other types of felonies but were either not revoked from the Medicare program until months after the adverse action or never removed.[31] GAO recommended that CMS incorporate flags into its software to help identify potentially questionable addresses, revise its 2014 guidance for verifying practice locations, and collect additional license information.[32]

The 2016 report looked at a fifth enrollment screening procedure: verifying criminal background information.[33] GAO found 66 potentially ineligible providers with criminal backgrounds, using 2013 data. CMS implemented new procedures in April 2014 to update the criminal background check process. GAO determined that if these new procedures are implemented as designed, they should help to address the limitation identified in the report, thus they make no recommendations.[34]

VI. RECENT LEGISLATIVE ACTION

On March 2, 2016 the House passed H.R. 3716, the Ensuring Access to Quality Medicaid Providers Act, sponsored by Rep. Buschon (R-IN) and Rep. Welch (D-VT), by a vote of 406-0.[35] This legislation implements OIG recommendations from two reports to strengthen authorities originally provided under the ACA for terminating providers.[36]

The ACA required CMS to establish a process for sharing information about terminated providers. To meet this requirement, CMS established a Web-based portal accessible to states and the federal government. In its reviews, HHS-OIG found that not all State Medicaid agencies reported all terminated providers to the database, and identified issues pertaining to the accurateness and completeness of records reported to the database.[37] Additionally, contrary to

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[30] *Id.*

[31] *Id.*

[32] *Id.*

[33] Government Accountability Office, *Medicare: Opportunities Exist to Recover Potential Overpayments to Providers with Criminal Backgrounds* (April 13, 2016) (GAO-16-365R).

[34] *Id.*

[35] H.R. 3716 (114th Cong).

[36] P.L. 111-148, § 6501 (2010), 42 U.S.C. § 1396a(a).

[37] Department of Health and Human Services Office of Inspector General, *CMS System for Sharing Information About Terminated Providers Needs Improvement* (March 2014) (OEI-06-

CMS guidance, about one-third of the 6,439 records did not relate to providers terminated "for cause." The OIG recommended that CMS implement mandatory reporting on provider terminations, take actions to improve the completeness of records, and work with states to develop a uniform terminology to denote "for cause" terminations.[38]

H.R. 3716 requires states to report the termination of any individual or entity from the state's Medicaid/CHIP program to the Secretary within 21 business days from the date that all provider appeals of a termination decision have expired. The legislation sets forward specific criteria for inclusion in the report, and would apply such requirements in both the managed care and fee-for-service space. The legislation also requires the Secretary to develop uniform technology for states to use with respects to specifying reasons for termination. The Secretary would be required to ensure that information received from states regarding terminated providers was included in the Termination Notification Database within 14 business days of receipt.

VII. WITNESSES

The following witnesses have been invited to testify:

Shantanu Agrawal, M.D.
Deputy Administrator and Director
Center for Program Integrity
Centers for Medicare & Medicaid Services

Ann Maxwell
Assistant Inspector General
Evaluation and Inspections
U.S. Department of Health and Human Services Office of Inspector General

Seto Bagdoyan
Director
Audit Services
U.S. Government Accountability Office

12-00031); Department of Health and Human Services Office of Inspector General, *Providers Terminated from One State Medicaid Program Continued Participating in Other States* (August 2015) (OEI-06-12-00030).

[38] *Id.*