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ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115

Majority (202) 225-2927
Minority (202) 225-3641

MEMORANDUM

May 31, 2015

To: Subcommittee on Oversight and Investigations Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Hearing on "Medicaid Program Integrity: Screening Out Errors, Fraud, and Abuse"

On Tuesday, June 2, 2015, 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 "Medicaid Program Integrity: Screening Out Errors, Fraud, and Abuse." The hearing will focus on a Government Accountability Office (GAO) report entitled "Medicaid: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls," as well as recent efforts by the Centers for Medicare & Medicaid Services (CMS) to work with state Medicaid agencies to address waste, fraud, and abuse.

I. BACKGROUND

Medicaid is a joint federal and state program. As of February 2015, the program provided health coverage for 70.5 million low-income beneficiaries.[1] In FY 2013, total Medicaid spending was approximately $440 billion.[2] The federal share of Medicaid spending was about 57% in 2012, the most recent year for which data is available. Medicaid consists of 56 distinct state-based programs. As a result of flexibility in the program's design, each state establishes its own eligibility standards, benefits package, 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

[1] Centers for Medicare & Medicaid Services, *Medicaid & CHIP: February 2015 Monthly Applications, Eligibility Determinations and Enrollment Report* (May 1, 2015).

[2] Kaiser Family Foundation, *Medicaid Moving Forward* (Mar. 9, 2015).

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.[3]

In 2005, the Deficit Reduction Act expanded the oversight role of CMS for Medicaid, which prior to that time had been primarily a state responsibility. To implement the law, CMS created the Medicaid Integrity Group (MIG), which is within the agency's Center for Program Integrity. MIG responsibilities include educating providers on issues such as inappropriate billing practices, providing technical assistance to states, providing training to state Medicaid program integrity staff, and periodically reviewing each state's Medicaid program integrity procedures and processes to ensure that they comply with federal requirements.

On the law enforcement side, State Medicaid Fraud Control Units located in State Attorneys General offices investigate and prosecute Medicaid fraud, working in conjunction with the Department of Health and Human Services Office of Inspector General (HHS-OIG) and the Department of Justice. The Health Care Fraud and Abuse Control Program (HCFAC), under the joint direction of the Attorney General and HHS-OIG, coordinates federal, state, and local law enforcement activities with respect to health care fraud and abuse.

II. IMPROPER PAYMENTS RATE

In 2002, Congress passed the Improper Payments Information Act (IPIA), and CMS subsequently implemented the Payment Error Rate Measurement (PERM) to monitor improper payments in Medicaid and CHIP. The error rate is a measurement of payments that do not meet statutory, regulatory, or administrative requirements; it is not considered a "fraud rate."[4] PERM reviews fee-for-service (FFS) claims, managed care payments, and beneficiary eligibility on a 17-state rotation cycle, so each individual state is reviewed every three years. PERM reviews are conducted on a random sample of Medicaid claims, and thus yield nationally representative results.[5] FY2008 was the first year CMS reported error rates under the PERM program.

Since its peak of 9.4% in 2010, the national Medicaid error rate had been steadily decreasing, reaching a low of 5.8% in 2013, or $14.4 billion.[6] However, in 2014 it rose to 6.7%,

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

[4] Center for Medicare and Medicaid Studies, *Payment Error Rate Measurement (PERM) Overview* (Jan. 2014).

[5] *Id.*

[6] Center for Medicare and Medicaid Studies, *Medicaid and CHIP 2013 Improper Payments Report*.

or $17.5 billion.[7] GAO considers Medicaid a high-risk program due to its size, growth, diversity of programs, and concerns about the adequacy of federal oversight.[8]

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 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.[9]

The final regulations require that all participating providers in the Medicaid and CHIP programs be screened upon enrollment and revalidated at least every five years. Based upon this requirement, state Medicaid agencies must complete the revalidation process of all providers by March 24, 2016. States can rely on the results of Medicare program provider screening by accessing the Medicare Provider Enrollment, Chain, and Ownership System (PECOS).[10]

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

[7] Center for Medicare and Medicaid Studies, *Payment Error Rate Measurement Program (PERM) Medicaid Error Rates* (Nov. 2014).

[8] U.S. Government Accountability Office, *High-Risk Series: An Update* (Feb. 11, 2015) (GAO-15-290).

[9] 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).

[10] 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).

an on-site visit to verify that the information submitted to the state Medicaid agency is accurate and to determine compliance with federal and state enrollment requirements.[11]

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.[12]

- **Withholding payments.** The ACA requires state Medicaid agencies 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.[13]

- **New funding to fight Medicare and Medicaid fraud.** The ACA significantly increases funding for the HCFAC Fund, indexing the program's mandatory baseline and funding to inflation, and providing additional mandatory HCFAC funding of $105 million in FY 2011, $65 million in FY 2012, $40 million in FY 2013 and 2014, $20 million in FY 2015 and 2016, and $10 million in FY 2017-2020.[14]

- **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.[15] State

[11] 45 C.F.R. §§ 455.400 - 455.470.

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

[13] 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).

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

[15] 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).

Medicaid agencies must comply with any moratorium, unless the state determines that it would adversely affect Medicaid beneficiaries' care.

IV. GAO REPORT

GAO conducted a study entitled, "Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls." Through its study, GAO identified potentially improper or fraudulent payments during FY2011 in four selected states: Arizona, Florida, Michigan, and New Jersey. The four states were selected based on two criteria: 1) the size of their Medicaid programs, measured by enrollment, and 2) the reliability of state Medicaid data. GAO indicates that the results from these states are not generalizable to all states.[16] Many of the program integrity measures described above were implemented after FY2011. Accordingly, the impact of those measures was not captured in the FY2011 data used in the study.

GAO examined claims totaling $3.5 billion, covering 9.2 million Medicaid beneficiaries and 881,000 providers. It identified the following number of potentially improper claims:

Potential Improper-Payment Indicators For Four Selected States in FY2011		
Potential improper payment indicator	**Approximate number receiving benefits/providing services**	**Estimate of total Medicaid benefits paid (millions)**
Beneficiaries concurrently receiving benefits paid by two or more states	8,600	$18.3
Deceased beneficiaries	200	9.6
Incarcerated beneficiaries	3,600	4.2
Providers with suspended or revoked licenses in at least one state	90	2.8
Providers with Commercial Mail Receiving Agency as mailing addresses	220	0.3
Deceased providers	50	0.2
Excluded providers	50	0.1

The report acknowledges that CMS has taken important steps to strengthen Medicaid beneficiary and provider enrollment processes. Many of these measures went into effect after FY2011, and thus their impacts were not captured in the FY2011 data used in the study. In particular, the February 2011 provider enrollment regulation requires state Medicaid agencies to implement new screening procedures for enrolling and revalidating all Medicaid providers. GAO acknowledges that this rule, if properly implemented would address some of the issues it found in its analysis of fiscal year 2011 data, such as screening of excluded providers.

[16] U.S. Government Accountability Office, *Medicaid: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls* (May 2015) (GAO-15-313).

Additionally, the report observes that new CMS regulations require state Medicaid agencies to perform checks to verify continued beneficiary eligibility. States are required to check beneficiary death status against the Social Security Agency's DMF on an annual basis, as well as conduct quarterly checks of beneficiary residence using the Public Assistance Reporting Information System (PARIS). By using PARIS, states can identify whether beneficiaries are enrolled in another state and appropriately terminate Medicaid benefits so that payments are not concurrently paid for in multiple states.[17] In July 2014, HHS-OIG reported that states' participation in PARIS was limited, and recommended that CMS issue guidance to help states comply with the requirement for participating.[18] CMS is implementing the recommendation.

GAO raises the concern that the February 2011 provider enrollment regulation did not require providers participating in Medicaid managed care organizations (MCOs) to enroll with Medicaid. CMS's recent proposed regulation on Medicaid MCOs reverses this position and requires all state Medicaid agencies to conduct risk-based screening of all network providers of MCOs in the same manner as they do for providers in the fee-for-service program.[19] The proposed regulation also implements a previous GAO recommendation to hold states better accountable for Medicaid managed care program integrity by requiring them to conduct periodic independent audits of encounter and financial data submitted by plans.[20]

Additionally, CMS issued regulations in 2013 requiring states to use the Data Services Hub to determine beneficiary eligibility for enrollment in qualified health plans as well as Medicaid. The hub verifies key application information, including household income and size, citizenship, state residency, incarceration status, social security number, and immigration status. GAO states: "[i]f properly implemented by CMS, the hub can help mitigate some of the potential improper payment issues that we identified earlier in our analysis of fiscal year 2011 Medicaid claims including state residencies, deceased beneficiaries and incarcerated beneficiaries."

Although GAO acknowledges that the steps CMS has already taken "may address many of the improper payment indicators that were found in our 2011 analysis of Medicaid claims," GAO identified additional opportunities for improvement and issued two recommendations: 1) issue guidance to states to better identify beneficiaries who are deceased; and 2) provide

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[17] *Id.*

[18] Department of Health and Human Services, Office of Inspector General, *Public Assistance Reporting Information System: State Participation in the Medicaid Interstate Match is Limited* (July 2014) (OE-09-11-00780).

[19] Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions to Related Third Party Liability* (May 25, 2015) (online at https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-12965.pdf).

[20] *Id.*; U.S. Government Accountability Office, *Medicaid Program Integrity: Increased Oversight Needed to Ensure Integrity of Growing Managed Care Expenditures* (July 2014) (GAO-14-341).

guidance to states on the availability of automated information through PECOS and provide full access to all PECOS information. HHS concurred with both recommendations.

IV. 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

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