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Testimony of

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on

"Improper Payments in State-Administered Programs: Medicaid"

before the

Subcommittee on Government Operations

and

Subcommittee on Intergovernmental Affairs

House Committee on Oversight and Government Reform

2154 Rayburn House Office Building

March 21, 2018

Good morning Chairman Meadows and Chairman Palmer, Ranking Members Connolly and Raskin, and Members of the Subcommittees. I am Andy Schneider, a Research Professor of the Practice at the Center for Children and Families.

The Center for Children and Families is an independent, nonpartisan policy and research center based in the McCourt School of Public Policy at Georgetown University. Our mission is to expand and improve high-quality, affordable health coverage for America's children and families, particularly those with low and moderate incomes.

I want to emphasize that I am here in my individual capacity and that my views do not necessarily represent the views of Georgetown University.

Thank you for the invitation to testify. I am especially honored to be here because I had the privilege of serving as Chief Health Counsel to the full Committee in 2007 and 2008. I know from personal experience how important the oversight efforts of this Committee's Members and staff can be to making government work.

The Committee's institutional role is particularly important for programs like Medicaid, on which over 70 million Americans depend for basic health and long-term care services. The focus of this hearing—federal and state efforts to identify, prevent, and recover improper payments in Medicaid—is in the finest tradition of the Committee's exercise of its oversight responsibilities. I applaud the Committee's interest and diligence.

From 2013 through 2016 I served as a Senior Advisor to the Center for Medicaid and CHIP Services, where my portfolio included program integrity in Medicaid. During that time, I had an opportunity to see dedicated CMS career staff and state Medicaid agency staff work to strengthen the administration of the program. A good deal of progress was made, but there is room for improvement. [1] I hope this hearing will help inform the Committee about the path forward.

I want to stress three points:

- First, Medicaid is the nation's most important health insurance program for low-income children and families. It covers 40 percent of our country's children without regard to pre-existing conditions. The research shows that it works for children and for families, which helps to explain the program's popularity. Central to the program's success is its 50-year-old federal-state financing partnership. Disrupting that partnership by capping federal Medicaid payments to states will put low-income children and families in severe jeopardy for rationing of care.

- Second, despite its success, Medicaid is not perfect. The program's 10.1 percent improper payment rate is too high and needs to come down. There

is a clear path forward for bringing it down: fully implement the provider screening and enrollment requirements that are already on the books. By identifying bad actors and keeping them out of the program, provider screening and enrollment will protect children and families and other Medicaid beneficiaries from substandard care while at the same time preventing the theft or diversion of federal and state funds from their intended use.

- Finally, payments made to fraudulent providers are clearly improper, but improper payments are not the same as fraud. Fraud is a deception or misrepresentation made by a person or entity with the intent of receiving an unauthorized payment. Improper payments, in contrast, are payments that should not have been made or that were made in an incorrect amount. They include unintentional documentation errors as well as noncompliance with the provider screening and enrollment requirements. Capping federal Medicaid payments to states will do nothing to reduce fraud. The way to reduce fraud—as well as improper payments—is to screen providers before allowing them to treat Medicaid beneficiaries and bill the Medicaid program, whether in fee-for-service or in managed care.

Medicaid is the nation's most important health insurance program for low-income children and families.

Medicaid covers over 37 million children and over 9 million parents.[2] (The Children's Health Insurance Program (CHIP) covers roughly 9 million additional children).[3] About four out of every ten children in America are covered through Medicaid or CHIP.[4]

Medicaid guarantees eligible children coverage for preventive services, including periodic screening for physical and mental health problems, developmental delays, and vision, hearing and dental issues. It also covers needed diagnostic and treatment services to address problems identified by the periodic screenings.[5] In short, Medicaid is absolutely essential to the health and well-being of children in low-income families—especially those with disabilities and special health care needs.

The research shows that Medicaid works for children and families. More specifically, the research shows that access to Medicaid in childhood leads to longer, healthier lives, a better chance to finish high school and college, and more prosperous futures for our children.[6] This research may help to explain why the most recent Kaiser Family Foundation Tracking Poll found that nearly three quarters of Americans have a "very favorable" or "somewhat favorable" opinion of Medicaid.[7]

There are many reasons for Medicaid's success, but the program's bedrock is its federal-state financing partnership. Since the enactment of Medicaid over 50 years

ago, the federal government has committed to matching state spending for health and long-term care services for low-income Americans on an open-ended basis. On average, the federal government pays between 63 and 65 percent of the costs of these services (the federal matching rate ranges from 50 percent to as much as 74 percent, depending on a state's per capita income).[8] This commitment has enabled states to invest in the health of their low-income children and families; to address the long-term care needs of individuals with disabilities and seniors; to respond to epidemics like HIV, Zika, and opioid abuse; and to address the needs of victims of hurricanes and other natural disasters.[9]

The President's FY 2019 Budget proposes to cap federal Medicaid payments to states.[10] If enacted, this proposal would effectively end the federal government's commitment to sharing in the costs of basic health and long-term care services for low-income Americans. A cap on federal Medicaid payments—whether in the form of a block grant or a "per capita cap"—will by definition limit federal Medicaid spending, both proper and improper. In doing so, it will shift the costs of health and long-term care services for low-income Americans to the states and counties. States, in turn, will be forced to choose between raising taxes, transferring state funds from other programs to Medicaid, or cutting back on eligibility, benefits, and payments to providers and managed care plans.[11] Beneficiaries, including children and families, will bear the brunt of these cuts.

Medicaid's 10.1 percent improper payment rate in FY 2017 is too high and needs to come down.

Medicaid is large and complicated, with many moving parts. It pays for health and long-term care services delivered by hundreds of managed care plans and tens of thousands of providers to tens of millions of beneficiaries. Medicaid is administered on a day-to-day basis by states within rules established by the federal government to ensure that federal Medicaid matching funds are spent properly to achieve their intended objective: paying for needed health and long-term care services for low-income Americans. Within these rules, states have broad discretion to determine eligibility, design benefits, choose delivery systems, and innovate. As a result, Medicaid programs vary widely from state to state.[12] Given Medicaid's sheer scale, as well as the state-to-state variation, errors will—and do—happen.

Medicaid had an improper payments rate of 10.1 percent, or $36.7 billion, in FY 2017. Of this amount, over half (54%) is attributable to noncompliance with provider screening and enrollment requirements: 47%, or $17.1 billion, were unknown losses due to noncompliance with provider screening and national provider identifier (NPI) requirements, and 7%, or $2.66 billion, were known monetary losses due to the provider who received the payment not being enrolled. (Of the remaining improper payments, 9% were due to insufficient medical documentation, 31% were a proxy estimate of eligibility errors, and the remaining 6% were classified as "other").[13] These data present a clear path forward for

bringing down the Medicaid improper payments rate: fully implement the provider screening and enrollment requirements that are already on the books.

The Affordable Care Act (ACA) included a large number of program integrity provisions, including a requirement that providers serving program beneficiaries in Medicare, Medicaid, and CHIP enroll in the programs and that they be screened prior to enrollment and that their enrollment be periodically revalidated.[14] The Secretary of HHS was directed to develop and publish regulations to implement this requirement, which she did in February of 2011.[15] Among other things, these regulations require that states screen providers based on their level of risk to the program. In the case of those designated as limited risk, the state must verify licensure and check federal databases to ensure that the provider is not excluded from participation by the Office of Inspector General (OIG). Providers designated as moderate risk are also subject to an on-site visit; those designated as high risk are also required to submit fingerprints and undergo a criminal background check. The ACA also directed the Secretary to establish a national database that state Medicaid agencies can access for information about terminated Medicare providers; in 2016, Congress strengthened the ACA provisions in the 21st Century Cures Act to ensure that fraudulent providers do not move undetected from one state Medicaid program to another.[16]

The program integrity logic of these requirements is indisputable. The easiest way to reduce losses due to fraud is to keep fraudulent providers out of the program (experience teaches that once program funds have been stolen or otherwise diverted it is extremely difficult to recover them). The easiest way to keep fraudulent providers out is to identify them before they enroll. This is not to say that sorting providers into risk categories and screening them based on their risk to the program is easy to do or without administrative cost. (The federal government matches state administrative costs for provider screening and enrollment at 50 percent, 75 percent, or 90 percent depending on the activity).[17] But it is fundamental to protecting program funds and beneficiaries, and to maintaining a level playing field for the many providers who are honest actors delivering quality care to people in need.

Fraudulent providers pose risks to program beneficiaries. One notorious example of this is the dental management company for Small Smiles Centers, a nationwide chain of pediatric dental clinics. In 2010, the management company agreed to pay $24 million plus interest and enter into a 5-year quality-of-care corporate integrity agreement to settle allegations that it performed procedures on children that "were either medically unnecessary or performed in a manner that failed to meet professionally-recognized standards of care," including pulpectomies (baby root canals), placing crowns, administering anesthesia, and performing extractions, in order to maximize Medicaid reimbursement.[18] In 2014, the company was excluded from Medicaid and other health care programs for 5 years for "repeated and flagrant violations of its obligations under the corporate integrity agreement—violations that put quality of care and young patients' health and safety at risk."[19]

Medicaid's improper payments rate reflects the extent to which state Medicaid agencies have implemented the provider screening and enrollment provisions, at least in the fee-for-service portion of their programs. Under the Medicaid statistical sampling process, Payment Error Rate Measure (PERM), if a claim has been submitted by a provider who has not been screened and enrolled as required, the payment for that claim is considered improper. If a claim in the sample is for a service that has been ordered by a physician, and the physician's National Provider Identifier (NPI) is not on the claim as required, the payment for that claim is also considered improper, even if the physician has been screened and enrolled. (Without the NPI, it impossible for the state Medicaid agency or CMS to know who the ordering or referring provider is, much less whether he or she has been screened and enrolled). By measuring these payment errors, PERM helps promote state agency implementation of the provider screening and enrollment requirements to the benefit of those eligible for the program and taxpayers alike.

Unlike the fee-for-service component of the Medicaid improper payments rate, the managed care component does not currently measure whether providers in Medicaid managed care organization (MCO) networks have been screened and enrolled. It looks only at capitation payments from states to MCOs, not at payments from MCOs to network providers.[20] Currently two-thirds of Medicaid beneficiaries, largely children and parents, are enrolled in Medicaid MCOs.[21] These beneficiaries—and federal Medicaid dollars—deserve the same screening and enrollment protections from bad actors as those in fee-for-service. CMS managed care regulations issued in May of 2016 require that all MCO network providers be screened and enrolled, effective beginning with capitation rate period for contracts starting on or after July 1, 2018.[22] In the 21st Century Cures Act, Congress reaffirmed this policy and accelerated the effective date to January 1, 2018.[23] CMS should revise the PERM methodology for reviewing improper payments in Medicaid managed care to measure compliance with this requirement.

Medicaid payments made to fraudulent providers are clearly improper, but Medicaid improper payments are not the same as fraud.

Medicaid regulations define fraud as "an intentional deception or misrepresentation made by a person with knowledge that the deception or misrepresentation could result in some unauthorized benefit to himself or some other person."[24] An improper payment, in contrast, is "any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements and includes…any payment for services not received."[25] In short, payments due to fraud are improper—they should not have been made because the services were fraudulently billed—but not all improper payments are due to fraud.

In fact, as the Department of Health and Human Services explains in its FY 2017 Agency Financial Report, the majority of Medicaid improper payments "were due to instances where information required for payment was missing from the claim and/or states did not follow the appropriate process for enrolling providers. However, these improper payments do not necessarily represent payments to illegitimate providers and, if the missing information had been on the claim and/or had the state complied with the enrollment requirements, then the claims may have been payable."[26]

Medicaid fraud can—and has been—committed by beneficiaries, by providers, by managed care plans, and by pharmaceutical manufacturers.[27] CMS has issued regulations to address each type of fraud, most recently the Medicaid managed care rule issued in May 2016 that is now being phased in.[28] This rule contains important program integrity provisions that address both fraud by providers in Medicaid MCO networks29 and fraud by MCOs and/or their subcontractors.[30] As noted, two thirds of Medicaid beneficiaries are already enrolled in MCOs and the projections are for further increases, notably among individuals with disabilities and seniors.[31] CBO projects that an increasing amount of federal Medicaid dollars will flow to providers through MCOs over the next 10 years.[32]

Regrettably, the CMS Administrator has pledged to "rollback" the managed care rule because it is, in her view, "administratively burdensome."[33] It is not clear what changes she will instruct her agency to make and when she will make them. What is clear is this: if the program integrity provisions in the rule are weakened, then Medicaid improper payments—i.e., payments that should not be made either to network providers or to MCOs—will in all likelihood increase. I hope the Committee will engage its oversight resources to prevent this outcome.

"Rolling back" the managed care rule will not reduce the Medicaid improper payments rate. Neither will capping federal Medicaid payments to states. Shifting the costs of health and long-term care from the federal government to the states will harm program beneficiaries and the legitimate providers that serve them; it will not reduce the improper payments rate. States simply can't protect themselves against a federal cost-shift by reducing improper payments. That's because Medicaid costs are not driven by improper payments; they are driven by program enrollment—Medicaid does not exclude based on pre-existing conditions—the use of the services that the program covers, and the prices it pays for those services.[34] Even if states were somehow able to eliminate every last improper payment, they will not be able to avoid the demographic wave of aging Baby Boomers or stop general inflation in health care prices or avoid epidemics or prevent natural disasters. [35] Their only effective response to a cap on federal Medicaid payments will be to cut eligibility, cut benefits, and/or cut payment rates to MCOs and to providers.

CMS and states need to continue to work together to reduce fraud and other improper payments in Medicaid. And this Committee needs to continue to oversee that work and insist on results. But capping federal Medicaid payments to states to

reduce improper payments is not the solution; it will only shift costs to states, throwing out the Medicaid baby with the improper payments bathwater.

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[1] One example of progress is the development of the Medicaid Provider Enrollment Compendium (MPEC), last updated 6/23/2017, https://www.medicaid.gov/affordable-care-act/downloads/program-integrity/mpec-6232017.pdf

[2] For more information on children's enrollment, see: https://www.medicaid.gov/chip/downloads/fy-2016-childrens-enrollment-report.pdf. For more information on parents' enrollment, see: https://www.urban.org/sites/default/files/publication/83976/2000915-A-Look-at-Early-ACA-Implementation-State-and-National-Medicaid-Patterns-for-Adults-in-2014.pdf.

[3] https://www.medicaid.gov/chip/downloads/fy-2016-childrens-enrollment-report.pdf

[4] https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_16_1YR_S2704&prodType=table

[5] Brooks and Whitener, "At Risk: Medicaid's Child-Focused Benefit Structure Known as EPSDT," Center for Children and Families (June 2017), https://ccf.georgetown.edu/wp-content/uploads/2017/06/EPSDT-At-Risk-Final.pdf

[6] Wagnerman, Alker, and Chester, "Medicaid is a Smart Investment in Children," Center for Children and Families (March 2017), https://ccf.georgetown.edu/wp-content/uploads/2017/03/MedicaidSmartInvestment.pdf

[7] Kirzinger, Wu, and Brody, "Kaiser Health Tracking Poll: February 2018," Figure 5, https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-february-2018-health-care-2018-midterms-proposed-changes-to-medicaid/

[8] Congressional Budget Office, "Detail of Spending and Enrollment for Medicaid for CBO's January 2017 Baseline," footnote a, https://www.cbo.gov/sites/default/files/recurringdata/51301-2017-01-medicaid.pdf

[9] Centers for Medicare & Medicaid Services, "Medicaid & CHIP: Strengthening Coverage, Improving Health," (January 2017), https://www.medicaid.gov/medicaid/program-information/downloads/accomplishments-report.pdf

[10] "HHS FY 2019 Budget in Brief," pp. 52-53, https://www.hhs.gov/sites/default/files/fy-2019-budget-in-brief.pdf

[11] "Under [cap] proposals that led to significant reductions in federal funding, many states would find it difficult to offset the reduced federal payments solely through improvements in program efficiency. Those states would have three potential approaches available to them: Raise additional revenues; cut other state programs to transfer resources to Medicaid; or change the program through some combination of reducing payments to providers and health plans, curtailing covered services, and decreasing enrollment. If reductions in federal revenues were large enough, states would probably resort to a combination of all such approaches." Congressional Budget Office, "Options for Reducing the Deficit: 2017 to 2026," p. 225 https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/52142-budgetoptions2.pdf

[12] Medicaid and CHIP Payment and Access Commission (MACPAC), "Medicaid 101," https://www.macpac.gov/medicaid-101/

[13] https://paymentaccuracy.gov/program/medicaid/

[14] Section 6401 of the Patient Protection and Affordable Care Act, P.L. 111-148.

[15] 42 CFR Part 455, Subpart E—Provider Screening and Enrollment, 455.400-455.470.

[16] Section 5005 of the 21st Century Cures Act, P.L. 114-255.

[17] 42 CFR 433.15(b)(3), (4), and (7).

[18] Department of Justice, "National Dental Management Company Pays $24 Million to Resolve Fraud Allegations," (January 20, 2010) https://www.justice.gov/opa/pr/national-dental-management-company-pays-24-million-resolve-fraud-allegations

[19] Office of Inspector General, "OIFG Excludes Pediatric Dental Management Chain from Participation in Federal Health Care Programs," (April 3. 2014),

https://oig.hhs.gov/newsroom/news-releases/2014/cshm.asp
[20] Centers for Medicare & Medicaid Services, "Payment Error Rate Measurement Manual," Version 1.7, p. 26 (January 2018) https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Downloads/FY17PERMManual.pdf
[21] Rudowitz and Garfield, "Ten Things to Know About Medicaid: Setting the Facts Straight," Figure 6, Kaiser Family Foundation (March 12, 2018), https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/
[22] 42 CFR 438.608(b); Center for Medicaid and CHIP Services, "Medicaid and CHIP Managed Care Final Rule (CMS 2390-F) Implementation Dates," (April 25, 2016) https://www.medicaid.gov/medicaid/managed-care/downloads/implementation-dates.pdf
[23] Section 1932(d)(6) of the Social Security Act, as enacted in section 5005 of the 21st Century Cures Act, P.L. 114-255.
[24] 42 CFR 455.3
[25] 42 CFR 431.958
[26] Department of Health and Human Services, "Agency Financial Report FY 2017," p. 202, https://www.hhs.gov/sites/default/files/fy-2017-hhs-agency-financial-report.pdf
[27] See Department of Health and Human Services and the Department of Justice, "Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2016," pp. 12-29 (January 2017), for examples of Medicaid fraud by a mental and behavioral health clinic (p. 12), a home care agency (p. 20), a nurse (pp. 22-23), a hospital (p. 23), a managed care plan (p. 18), and drug manufacturers (pp. 15-16). https://www.oig.hhs.gov/publications/docs/hcfac/FY2016-hcfac.pdf
[28] Regulations addressing beneficiary and provider fraud are found at 42 CFR 455.13 – 455.23. Regulations addressing fraud in Medicaid managed care were published at 81 Fed. Reg. 27498 (May 6, 2016), https://www.medicaid.gov/medicaid/managed-care/guidance/final-rule/index.html
[29] 42 CFR 438.608(a)(5), (a)(8), (b).
[30] 42 CFR 438.608(c), 438.610.
[31] Kaiser Family Foundation and National Association of Medicaid Directors, "Medicaid Moving Ahead in Uncertain Times: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018," pp. 17-18 (October 2017), https://www.kff.org/medicaid/report/medicaid-moving-ahead-in-uncertain-times-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2017-and-2018/
[32] Congressional Budget Office, "Detail of Spending and Enrollment for Medicaid for CBO's January 2017 Baseline," https://www.cbo.gov/sites/default/files/recurringdata/51301-2017-01-medicaid.pdf
[33] "Remarks by Administrator Seema Verma at the National Association of Medicaid Directors (NAMD) 2017 Fall Conference (November 7, 2017) https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-07.html
[34] Medicaid and CHIP Payment and Access Commission (MACPAC), "Addressing Growth in Medicaid Spending: State Options," (June 2016) https://www.macpac.gov/wp-content/uploads/2016/06/Addressing-Growth-in-Medicaid-Spending-State-Options.pdf
[35] Park, "New National Health Expenditure Projections Contain Several Key Findings Relevant to Medicaid," (March 13, 2018) https://ccf.georgetown.edu/2018/03/13/new-national-health-expenditure-projections-contain-several-key-findings-relevant-to-medicaid/