U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Testimony of:
John Hagg
Director of Medicaid Audits
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U.S. Department of Health and Human Services

Hearing Title:
"Examining the Federal Government's Failure to Curb Wasteful State Medicaid Financing Schemes"

House Committee on Oversight and Government Reform
Subcommittee on Energy Policy, Health Care and Entitlements

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Good morning, Chairman Lankford, Ranking Member Speier, and other distinguished Members of the Committee. Thank you for the opportunity to testify about the Office of Inspector General's (OIG) ongoing efforts to identify improper State claims of Federal Medicaid dollars. Federal and State outlays for Medicaid exceed $450 billion and are increasing as the beneficiary population expands. OIG has conducted a wide range of State- and national-level Medicaid reviews and has identified protecting the integrity of an expanding Medicaid program as a top management challenge for the Department of Health and Human Services (HHS).[1]

Per your request, my testimony summarizes select OIG reports in four areas of the New York Medicaid program — provider types that are susceptible to fraud, waste, and abuse; Medicaid payments to managed care organizations; payment rates for State-operated facilities; and other areas or issues that OIG determined to be vulnerable to inappropriate claims.

The two key takeaways from my testimony are:

- New York must do a better job of monitoring providers to ensure that only allowable services are paid. Improper payments cost taxpayers and beneficiaries billions of dollars a year. For example, in 2013, the Department reported an improper Medicaid payment rate of 5.8 percent, or $14.4 billion (in Federal payments). Greater monitoring of providers by States protects both State and Federal dollars from being misspent.
- The Centers for Medicare & Medicaid Services (CMS) must take more aggressive action to ensure that States do not improperly claim Federal reimbursement for payments to which they are not entitled. In the past, we have seen States inappropriately maximize their payments from the Federal Government. When this happens, CMS must stop these occurrences and correct them.

New York Must Improve Oversight of Its Medicaid Program

The New York Medicaid program is the second largest in the country. In fiscal year 2013, New York received more than $26 billion in Federal reimbursement and had over 5 million

[1] See *Top Management and Performance Challenges*, available at http://oig.hhs.gov/reports-and-publications/top-challenges/2013/challenge04.asp.

beneficiaries enrolled in its Medicaid program. In areas such as home health services, continuing day treatment (CDT) services, orthodontic and dental services, and traumatic brain injury waiver services, OIG has found millions in improper payments, including payments for services that were not provided and duplicative payments. With such significant dollars and a sizeable beneficiary population at risk, it is critical that New York vigorously oversee providers and other components of its Medicaid program.

Home Health Services Did Not Meet State and Federal Requirements

Home health services are services provided to beneficiaries who need additional support to remain safely at home and avoid unnecessary hospitalization. Our audit of home health services in New York identified some claims for services that were not provided in accordance with Federal and State requirements.[2] These requirements include: the beneficiary must have a plan of care that the physician reviews every 60 days, services must be documented, services must be furnished in the beneficiary's place of residence, and aides must meet certain training requirements. These requirements are in place to ensure that patients receive appropriate care in an appropriate setting. Most of the claims we examined met Federal and State requirements, but New York claimed Federal reimbursement of at least $31 million over 3 years for services that did not. Most of the noncompliant claims did not meet the requirement that the physician review the beneficiary's plan of care within the prescribed time frame. New York paid for and billed the Federal Government for noncompliant services because it had not ensured that Certified Home Health Agencies were familiar with requirements related to physician orders and plans of care.

Continuing Day Treatment Services Did Not Meet State and Federal Requirements

CDT services are individually tailored treatment services for individuals with mental illness that address substantial skill deficits in specific life areas that interfere with an individual's ability to maintain community living. CDT services include assessment and treatment planning, discharge planning, medication therapy, case management, psychiatric rehabilitation, and activity therapy, among others. Our audits of CDT services in New York found that the State claimed reimbursement of at least $26.1 million over a 2.5-year period for services (provided by hospital-based and non-hospital-based providers) that did not meet certain Federal and State requirements.[3] These requirements include: progress notes for each beneficiary must be recorded at least every 2 weeks by the clinical staff members who provided the CDT services, the provider must document a minimum visit of at least 2 hours, the treatment plan should include specified elements, and the treatment plan must be reviewed periodically and should be signed by the physician involved in the treatment and the beneficiary (if appropriate). Most of

[2] *New York State Improperly Claimed Medicaid Reimbursement for Some Home Health Services Claims Submitted by Certified Home Health Agencies*, A-02-11-01008, September 2013, available at http://oig.hhs.gov/oas/reports/region2/21101008.asp.

[3] *New York Claimed Hospital-Based Continuing Day Treatment Services That Were Not in Compliance With Federal and State Requirements*, A-02-11-01038, September 2013, available at http://oig.hhs.gov/oas/reports/region2/21101038.asp, and *New York Claimed Nonhospital Continuing Day Treatment Services That Were Not in Accordance With Federal and State Requirements*, A-02-12-01011, July 2014, available at http://oig.hhs.gov/oas/reports/region2/21201011.asp.

the noncompliant claims we identified fell into one or more of the following four categories: (1) progress notes associated with the services were not recorded as required, (2) minimum visit requirements for reimbursement were not met, (3) the beneficiary's treatment plan was not complete, and/or (4) the beneficiary's treatment plan was not signed by either the beneficiary or physician. New York paid and claimed Federal reimbursement for noncompliant services because: (1) certain hospital-based CDT providers did not comply with Federal and State requirements and (2) the State agency did not ensure that the New York State Office of Mental Health adequately monitored the CDT program for compliance with certain Federal and State requirements.

Questionable Billing for Orthodontic and Dental Services

The New York State Medicaid Orthodontic Program provides orthodontic services to beneficiaries with "severe handicapping malocclusions." This type of malocclusion occurs when a child's teeth are so far out of position that he or she cannot engage in normal activities — such as eating and talking — without difficulty.

Our audit of orthodontic services in New York City found that the State claimed reimbursement of at least $7.7 million over 3 years for services that did not meet certain Federal and State requirements.[4] These requirements include: eligibility for orthodontic care must be reevaluated annually, services must be documented, and services must be provided to eligible beneficiaries by certified providers. The unallowable services all fell into one or more of the following categories: (1) services were not authorized, (2) providers could not document that services had been provided, or (3) services were not provided. New York paid for and claimed Federal reimbursement for noncompliant services because providers did not follow requirements.

In a separate evaluation of orthodontic and dental services in New York, we examined the billing patterns of general dentists and orthodontists who provided services to 50 or more Medicaid children during 2012.[5] We identified 23 general dentists and 6 orthodontists whose billing patterns, when compared with those of their peers, were questionable. Questionable billing patterns included extremely high payments per child, an extremely large number of services per child, a large number of services per day, and extractions and pulpotomies—often referred to as "baby root canals"—on an extremely high proportion of children.

Traumatic Brain Injury Waiver Services Did Not Meet State and Federal Requirements

Traumatic brain injury waiver services are a set of services provided to help beneficiaries with traumatic brain injuries to live in community-based settings and achieve maximum independence. New York's Traumatic Brain Injury Program is part of its larger strategy to prevent unnecessary entrances into nursing homes and to help individuals leave nursing homes.

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[4] *New York Improperly Claimed Medicaid Reimbursement for Orthodontic Services to Beneficiaries in New York City*, A-02-11-01003, October 2013, available at http://oig.hhs.gov/oas/reports/region2/21101003.asp.
[5] *Questionable Billing for Medicaid Pediatric Dental Services in New York*, OEI-02-12-00330, March 2014, available at https://oig.hhs.gov/oei/reports/oei-02-12-00330.asp.

Our audit of traumatic brain injury waiver services in New York found that the State claimed reimbursement of at least $54 million over 3 years for services that did not meet certain Federal and State requirements.[6] These requirements include: beneficiaries must be assessed to need nursing facility level of care, services must be documented, and services must be provided in accordance with an approved plan of care. Most of the noncompliant claims we identified were for services provided to individuals who did not qualify to receive waiver services. In addition, many of the noncompliant services were not adequately documented or were not provided in accordance with the beneficiaries' required plans of care.

We found that New York paid for and claimed Federal reimbursement for noncompliant services because it did not ensure that: (1) centers responsible for administering the program properly determined and documented that beneficiaries approved for the program were eligible, (2) assessors and screeners responsible for determining eligibility properly evaluated beneficiaries, and/or (3) providers billed the State only for allowable program services.

Fee-for-Service Payments for Services to Beneficiaries Enrolled in Medicaid Managed Care

Our audit of fee-for-service payments on behalf of beneficiaries enrolled in Medicaid managed care plans found that New York claimed Federal reimbursement of $23.4 million for unallowable fee-for-service payments over approximately 5 years.[7] Although the services may have otherwise met Federal and State requirements, these services should have been paid for by the beneficiaries' Medicaid managed care plans; therefore, the fee-for-service payments were duplicate payments. New York paid and claimed reimbursement for unallowable fee-for-service claims because it operated two eligibility systems; as a result, some beneficiaries received multiple Medicaid numbers.

CMS Should Exercise Greater Oversight of States' Activities To Obtain Inappropriate Federal Reimbursement

The Federal Government and States share the cost of Medicaid. From time to time, States have adopted practices that have artificially inflated the Federal Government's share of Medicaid expenditures. Such practices limit Congress's ability to assess the public benefits of Medicaid dollars. OIG addressed this issue broadly in an audit in 2001, and since then, we have continued to identify similar problems in selected States.

Excessive Rates for Services Provided by State-Run Facilities

OIG's September 2012 testimony before this Committee focused on an OIG report that identified payments to New York State-run developmental centers that far exceeded the cost of providing

[6] *New York's Claims for Medicaid Services Provided Under Its Traumatic Brain Injury Waiver Program Did Not Comply With Certain Federal and State Requirements*, A-02-10-0143, May 2013, available at http://oig.hhs.gov/oas/reports/region2/21001043.asp.
[7] *New York State Made Unallowable Medicaid Fee-for-Service Payments for Beneficiaries Also Enrolled in Medicaid Managed Care*, A-02-12-01007, January 2014, available at http://oig.hhs.gov/oas/reports/region2/21201007.asp.

services.[8] In that report, we noted that if New York had used actual costs in its rate-setting methodology, it would have paid $1.4 billion less for services in 2009, which would have saved the Federal Government as much as $701 million in that year alone.[9] In March 2014, we issued a report that identified similarly inflated payments to State-run residential facilities that provide habilitation services.[10] In that report, we determined that if the State agency had used the prior year's actual costs to calculate payment rates for residential habilitation services, its State fiscal year 2011 total reimbursement would have been approximately $692 million less than what it claimed, which would have saved the Federal Government as much as $346 million in that year.

In both instances, we found that the methodologies New York used to develop the rates charged by the State-run facilities resulted in payments that greatly exceeded the costs of the programs. In both instances, the gap between the rates used to reimburse facilities and the actual costs of providing those services increased over many years. CMS, however, did not take action to prevent the gap between reimbursement and costs from growing to the extent that it did until early last year. Last year, CMS and New York agreed on a new methodology for determining the rates paid to State-run developmental centers that will better align rates and costs. This methodology became effective in April 2013.

Unallowable Costs Used To Calculate Payment Rates

Medicaid does not generally pay for room-and-board costs incurred by community residential facilities under a State's home and community-based services Medicaid waiver program. Our audit of the rates paid to State-operated community residential facilities for habilitation services provided to individuals with developmental disabilities found that that New York claimed excessive Federal reimbursement of $60.8 million over 3 years because some room-and-board costs were included in the indirect costs used to calculate the rates.[11] The unallowable room-and-board costs included repairs, maintenance, utilities, and property-related costs.

The rates were inflated because the New York Medicaid agency determined that it could include the portion of certain room-and-board costs (repairs, maintenance, utilities, and property-related costs) related to what it characterized as the non-residence-related square footage in the indirect cost rate used to calculate payment rates. However, New York characterized these costs as "additional residential habilitation costs" and they were not readily identifiable as room-and-board costs.

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[8] Available at http://oig.hhs.gov/testimony/docs/2012/Hagg_testimony_09202012.pdf.
[9] *Medicaid Rates for New York State-Operated Developmental Centers May Be Excessive*, A-02-11-01029, May 2012, available at http://oig.hhs.gov/oas/reports/region2/21101029.asp.
[10] *Medicaid Rates for Residential Habilitation Services Provided at New York State-Operated Residences Are Excessive*, A-02-13-01008, March 2014, available at http://oig.hhs.gov/oas/reports/region2/21301008.asp.
[11] *New York Claimed Unallowable Room-and-Board Costs Under Its Developmental Disabilities Waiver Program*, A-02-12-01031, May 2014, available at http://oig.hhs.gov/oas/reports/region2/21201031.asp.

Key Recommendations

Key recommendations from the reports I have discussed today include recommendations to both the New York Medicaid State agency and to CMS.

The State agency should:

- Refund the Federal share of the overpayments to the Federal Government. Overpayments in these reports amounted to more than $200 million.
- Issue guidance to the provider community regarding Federal and State requirements for claiming Medicaid reimbursement.
- Improve monitoring to help ensure that providers are in compliance with applicable Federal and State rules.

CMS should:

- Work with New York to help ensure that the methodology used to set payment rates for State-operated facilities meet the Federal requirements that payments for services be consistent with efficiency and economy.

These recommendations address two important needs: for States to improve their oversight of Medicaid providers and for CMS to improve its oversight of States to detect and prevent efforts to inappropriately shift costs to the Federal Government. These needs are not specific to New York. While my testimony today focuses on select issues in the New York Medicaid program, OIG's reviews of Medicaid in other States reveal similar problems with both State and CMS oversight.

Conclusion

New and changing HHS programs, such as Medicaid and others, offer opportunities to improve health and welfare, prevent waste and fraud, and increase the value realized from Federal investments. They also raise challenges for efficient and effective implementation; therefore, close oversight is essential. With respect to oversight of Medicaid, OIG has a substantial body of work both underway and planned to ensure that taxpayer dollars are spent for their intended purposes in a system that operates efficiently and is secure. This work will examine critical issues, such as Medicaid provisions included in the Affordable Care Act, Medicaid payments for medical equipment and supplies, health care provider taxes, and Medicaid payments to managed care organizations.

Funding of OIG's fiscal year 2015 budget request would enable us to continue and enhance our focus on core risk areas associated with Medicaid, as well as HHS public health and human

service programs, the marketplaces, and Medicare.[12] Given the projected growth in Medicaid by CMS, the Congressional Budget Office, and others, we have a responsibility to promote integrity, accountability, and potential cost savings in Medicaid through reports that recommend recoupment of overpayments, changes to policies to better protect Medicaid resources, and improvements that lead to better quality of care for Medicaid beneficiaries.

Thank you for your interest in and support of OIG's mission and for the opportunity to discuss our work. I am happy to answer any questions you may have.

[12] For more details on OIG's impact, the essential work we have planned, and the resources needed to fulfill these mission-critical activities, see OIG's fiscal year 2015 Congressional budget justification, available at http://oig.hhs.gov/reports-and-publications/budget/index.asp.