U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE

May 29, 2015

TO: Members, Subcommittee on Oversight and Investigations

FROM: Committee Majority Staff

RE: Hearing entitled "Medicaid Program Integrity: Screening Out Errors, Fraud, and Abuse"

On June 2, 2015, at 10:15 a.m. in 2322 Rayburn House Office Building, the Subcommittee on Oversight and Investigations will hold a hearing entitled "Medicaid Program Integrity: Screening Out Errors, Fraud, and Abuse." Medicaid is a significant obligation for the federal government and the states, with total federal outlays of $310 billion in fiscal year (FY) 2014 alone. Given the substantial current and projected federal dollars spent on Medicaid, and evidence of substantial fraud and abuse in the program, the Subcommittee is conducting oversight to ensure that the program operates more effectively and tax dollars are spent appropriately. In particular, this hearing will examine the findings of a recent report of the U.S. Government Accountability Office (GAO), "Medicaid: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls," GAO-15-313, available here: http://www.gao.gov/products/GAO-15-313.[1]

I. WITNESSES

- Seto J. Bagdoyan, Director, Audit Services, Forensic Audits and Investigative Service, U.S. Government Accountability Office
- Shantanu Agrawal, M.D., Deputy Administrator and Director, Center for Program Integrity, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services

II. BACKGROUND

Medicaid Facts and Figures

Medicaid is a joint federal-state program that finances the delivery of primary and acute medical services as well as long-term services and supports for a diverse low-income population. Medicaid was enacted in 1965 as part of the same law that created the Medicare program. State

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[1] U.S. Gov't Accountability Office, *Medicaid: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls*, GAO-15-313 (May 2015).

participation in Medicaid is voluntary, but all states, the District of Columbia, and the territories choose to participate. The Centers for Medicare and Medicaid Services (CMS) within the Department of Health and Human Services (HHS) is responsible for broad program oversight, including disbursement of matching federal funds, while states are responsible for the daily administration of their Medicaid programs. States must follow broad federal rules in order to receive matching federal funds, but have the flexibility to design their own version of Medicaid within the federal statute's framework. In addition to oversight, CMS also provides guidelines, technical assistance, and periodic assessments of state Medicaid programs.

Medicaid enrollment has steadily increased over the past several years. Further, the Patient Protection and Affordable Care Act (ACA) substantially expanded Medicaid eligibility to reduce the number of uninsured citizens. Enrollment—measured by "person-year equivalents," which is the average enrollment over the course of the year—has increased from approximately 34 million in FY 2000 to more than 60 million in FY 2014.[2] Medicaid is projected to have approximately 80 million enrollees by 2021.[3]

Medicaid is a significant expenditure for the federal government and the states, with total federal outlays of $310 billion in fiscal year 2014. According to the Congressional Budget Office (CBO), the federal share of Medicaid outlays is expected to roughly double over the coming decade to more than $576 billion per year in 2025.[4] As a result, over the next ten years, Medicaid is expected to cost federal taxpayers $4.8 trillion dollars.[5]

In February 2015, GAO reported that Medicaid remains at high risk for fraud, waste, and abuse because of concerns about the adequacy of the fiscal oversight of the program, including improper payments.[6] In fact, GAO has designated Medicaid a high-risk program since 2003. CMS reported an estimated improper-payment rate of 6.7 percent, or $17.5 billion for fiscal year 2014 for the Medicaid program. This is an increase over its 2013 estimate of 5.8 percent, or $14.4 billion.

May 14, 2015 GAO Report

In July 2012, Chairman Upton and then-Oversight and Investigations Subcommittee Chairman Cliff Stearns requested that the GAO Forensic Audit and Investigative Service team perform audit and related investigative work focused on provider and beneficiary integrity for selected Medicaid state programs. For this review, GAO (1) identified and analyzed indicators, if any, of improper or potentially fraudulent payments to Medicaid beneficiaries and providers in four selected states (Arizona, Florida, Michigan, and New Jersey); and (2) examined the extent to which federal and state oversight policies, controls, and processes are in place to prevent and

[2] Alison Mitchell, et al., Cong. Research Service, *Medicaid: An Overview*, R43357 (Jan. 2014) *available at* http://www.crs.gov/pages/Reports.aspx?PRODCODE=R43357&Source=search.
[3] *Id*.
[4] Cong. Budget Office, *Details of Spending and Enrollment for Medicaid—CBO's March 2015 Baseline* (March 2015), *available at* http://www.cbo.gov/sites/default/files/cbofiles/attachments/44204-2015-03-Medicaid.pdf.
[5] *Id*.
[6] U.S. Gov't Accountability Office, *High-Risk Series: An Update,* GAO -15-290 (Feb. 2015).

detect fraud and abuse in determining eligibility for Medicaid beneficiaries and enrolling providers. Key findings include:

- The four states examined—Arizona, Florida, Michigan, and New Jersey—had about 9.2 million beneficiaries, which accounted for 13 percent ($3.5 billion) of all fiscal year 2011 Medicaid payments. These four states were selected based on geographic distribution, Medicaid enrollment numbers, and the reliability of their data.

- About 8,600 beneficiaries had payments made on their behalf by two or more of GAO's selected states totaling at least $18.3 million. Under federal regulations, beneficiaries are not supposed to have payments made on their behalf by two or more states concurrently.

- About 200 deceased beneficiaries received at least $9.6 million in Medicaid benefits. The individuals were already deceased before apparently receiving medical services covered by Medicaid.

- About 3,600 individuals received Medicaid benefits while incarcerated in a state prison facility. In almost 390 cases totaling nearly $390,000 in payments, the beneficiary supposedly received medical services during the period of incarceration, suggesting identity theft. Medicaid also paid about $3.8 million on behalf of the remaining 3,200 individuals. Federal law prohibits states from obtaining federal Medicaid matching funds for healthcare services provided to inmates except when inmates are patients in medical institutions.

- At least 4,400 beneficiaries may have been using a virtual address as their residence address. Although Medicaid does not require physical addresses for beneficiary enrollment and eligibility determinations, the use of virtual addresses may be a way to conceal total household income and is a potential indicator of fraud. More specifically, these beneficiaries used a Commercial Mail Receiving Agency (CMRA) address—such as a United Parcel Service store—as their residence address. Medicaid paid claims totaling at least $20.5 million for the beneficiaries.

- The Social Security Numbers (SSNs) for about 199,000 beneficiaries did not match identity information contained in the Social Security Administration (SSA) bases, suggesting fraud or improper payments. The benefits paid at least $448 million to these 199,000 beneficiaries. Of these beneficiaries, 12,500 of them used a SSN never issued by SSA.

- About 90 medical providers in the selected states had their medical licenses revoked or suspected in the state in which they received payment from Medicaid during fiscal year 2011. Medicaid approved the associated claims of these cases at a cost of at least $2.8 million.

- At least 220 providers may have inappropriately used a virtual address as their physical service location. At least 47 providers had foreign addresses as their location of service,

including Canada, China, India and Saudi Arabia. Nearly 26,600 providers had addresses that did not match any United States Postal Service records.

- Over 50 deceased providers received Medicaid payments. These providers were deceased before the Medicaid service was provided. The Medicaid benefits totaled at least $240,000 for FY 2011.

- About 50 providers who received Medicaid payments were excluded from federal health-care programs, including Medicaid, for a variety of reasons that include patient abuse or neglect, fraud, theft, bribery, or tax evasion.

- At the conclusion of the report, GAO recommended that CMS:

    1. Issue guidance to states to better identify beneficiaries who are deceased; and

    2. Provide guidance to states on the availability of automated information through Medicare's enrollment database—the Provider Enrollment, Chain and Ownership System (PECOS)—and full access to all pertinent PECOS information, such as ownership information, to help screen Medicaid providers more efficiently and effectively.

HHS has concurred with both recommendations.

April 29, 2015 Reuters Story

According to an April 29, 2015, Reuters story entitled "Banned from Medicare, Still Billing Medicaid," state insurance programs are continuing to pay thousands of Medicaid dollars to healthcare providers who have previously been banned from Medicare or another state's Medicaid system.[7] Reuters found that more than one in five of the thousands of doctors and other healthcare providers in the U.S. prohibited from billing Medicare are still able to bill state Medicaid programs.

III. ISSUES

The following issues may be examined at the hearing:

- What specific actions do HHS or CMS plan to take to address GAO's recommendations in this report?

- What additional sets of data can be made available and shared with the states to prevent fraudulent and/or improper Medicaid payments?

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[7] M.B. Pell and Kristina Cook, *Banned from Medicare, Still Billing Medicaid*, Reuters, Apr. 29, 2015, *available at* http://www.reuters.com/investigates/special-report/usa-medicaid-fraud.

- Is CMS using all the tools at its disposal to mitigate vulnerabilities to the Medicaid program?

IV. STAFF CONTACTS

If you have any questions regarding this hearing, please contact Jessica Donlon or Alan Slobodin of the Committee staff at (202) 225-2927.