

**Dr. Agrawal’s Hearing
“Medicaid Program Integrity”
Before
E&C O&I Subcommittee
June 2, 2015
Answers as of hearing date**

Attachment 1—Additional Questions for the Record

The Honorable Tim Murphy

- 1. The Public Assistance Report System (PARIS) is supposed to help states check to see if an applicant or enrollee is already enrolled in another state’s Medicaid program. HHS’ Office of Inspector General recommended that CMS issue guidance to help states comply with the requirement for participating in PARIS. CMS indicated that it would do so by March of this year. Was this implemented on time? If not, why not?**

Answer: CMS met with state Medicaid agencies on April 15, 2015, to review the statute and policies regarding the use of PARIS by state Medicaid agencies. During this discussion, CMS reviewed the requirements outlined in the State Medicaid Director Letter issued June 21, 2010, and offered technical assistance to states. State representatives had the opportunity to ask questions and identify challenges related to PARIS participation and reporting. A follow-up meeting is scheduled for June 17, 2015, to provide an opportunity for new questions and feedback.

- a. What are (if any) impediments to states’ participation in PARIS?**

Answer: Based on our recent discussions, no state reported any impediments to participation in PARIS. CMS shares your interest and commitment to ensuring effective, consistent state use of PARIS. One of CMS’ larger priorities is to provide states with the tools to make accurate eligibility determinations. Since 2010, as GAO noted, states have made improvements to their Medicaid eligibility and enrollment systems. In 2013, for the first time, states were required to submit a verification plan to CMS, indicating, among other things, their use of PARIS. CMS met with each state to discuss how electronic data sources, including PARIS, were used, and changes the state would need to make to comply with Medicaid requirements. In 2014, states resubmitted their verification plans, again identifying their use of PARIS. All states with finalized verification plans reported to CMS that they have electronic data matching with PARIS.

- b. What actions has CMS taken or plans to take against states that are not appropriately using PARIS?**

Answer: Under CMS rules, states are required to submit their data and check PARIS. Based on a recent OIG finding about the use of PARIS by states, CMS provided technical assistance to state eligibility experts on the need and requirement for states to use PARIS and recommended that states perform quarterly matches. We will continue to monitor state progress and use of

PARIS and provide technical assistance to states as needed. As states are updating their verification plans, we will use this as an opportunity to ensure that states are appropriately participating in PARIS.

2. Is CMS tapping into all available government databases to cross-check provider and beneficiary information to combat waste, fraud, and abuse in the Medicaid program? For example, is CMS cross-checking against the FDA debarment list?

Answer: In the last five years, CMS has undertaken the most serious effort in the history of the Medicaid program to improve provider enrollment and verify beneficiary eligibility. The Affordable Care Act and accompanying Federal regulations have established a modernized, data-driven approach to verification of financial and non-financial information needed to determine Medicaid and CHIP and Marketplace eligibility. States now rely on available electronic data sources to confirm information included on the application, and promote program integrity, while minimizing the amount of paper documentation that consumers need to provide.

In 2012, CMS issued regulations to require States to use the Data Services Hub (Hub) to verify applicant eligibility upon enrollment and at least annually thereafter. States are able to use this to identify applicants and beneficiaries who may be incarcerated, deceased, or do not meet Medicaid eligibility requirements. States can also validate applicants' Social Security Numbers (SSNs) using the Hub. CMS also required every state to submit a verification plan describing their verification policies and procedures including confirmation that the state verifies SSNs.

States are also required to use PARIS to identify individuals who are enrolled in Medicaid in more than one state. PARIS is a system for matching data from certain public-assistance programs, including State Medicaid programs, with selected Federal and state data for purposes of facilitating appropriate enrollment and retention in public programs. In certain circumstances, PARIS may also be used as a tool to identify individuals who have not applied for Medicaid coverage, but who may be eligible based on their income.

The Affordable Care Act required CMS to implement risk-based screening of providers and suppliers who want to participate in Medicare, Medicaid, and CHIP, and CMS put these additional requirements in place for newly enrolling and revalidating relevant providers and suppliers in March 2011. This enhanced screening requires certain categories of providers and suppliers that have historically posed a higher risk of fraud to undergo greater scrutiny prior to their enrollment or revalidation in Medicare, Medicaid, and CHIP. States are also required to conduct reviews and revalidations of their Medicaid and CHIP providers by March 2016. States must repeat this process at least once every five years.

State Medicaid agencies may rely on the screening done by CMS for dually-enrolling providers to assist them in complying with these requirements. CMS has been proactive about assisting States with provider enrollment and revalidation screening. In April 2012, we provided States with direct access to Medicare's enrollment database-the Provider Enrollment, Chain, and Ownership System (PECOS). In October 2013, in response to input from States, CMS began providing access to monthly PECOS data extracts that States could use to systematically

compare state enrollment records against available PECOS information. We have also provided States with training and technical assistance on using PECOS.

As part of the Medicare enrollment screening process, CMS has reviewed the FDA's debarment and disqualification lists, and found that the data does not contain the adequate personal identifiers required for confident systematic data matching and immediate action. When CMS last reviewed the FDA list, it contained only about 100 names. Therefore CMS has focused efforts on expanding the use of greater value sources such as the Federal Government's System for Awards Management website (SAM), which now includes GSA's Excluded Parties List System (EPLS), and OIG's List of Excluded Individuals and Entities (LEIE), which provide clear and definitive data that is immediately actionable. Individual providers, owners, Authorized and Delegated officials, and managing employees are validated upon enrollment to ensure applications from entities identified in SAM, EPLS and the LEIE are not approved.

3. Current CMS regulations require states to screen beneficiaries annually for deceased individuals in Medicaid. Do you think screening more frequently could help prevent deceased beneficiaries receiving benefits?

a. Is this kind of process doable? Are there administrative constraints to screening more often than once per year?

Answer: Current Medicaid regulations require states to redetermine beneficiaries' eligibility on an annual basis. The Affordable Care Act established new requirements for streamlined eligibility and enrollment processes, including the use of electronic data matching. To the extent that information is available through electronic data sources, states must utilize those sources first. The Department of Health and Human Services established the Hub to ensure that states have reliable and consistent access to real-time eligibility data from Federal agencies, including the Social Security Administration (SSA), and in 2012, CMS issued regulations requiring states to utilize the Hub. SSA's death information is included in this access which gives states a readily-available source of information on deceased individuals at the time of an individual's application to the Medicaid benefit.

In addition to data accessed through the Hub, states continue to rely upon their own electronic data sources, which may include direct data matches to SSA. Many states have policies to conduct more frequent checks of beneficiary status against the information in SSA's records and state vital-records systems. As states continue to automate their eligibility and enrollment processes, it becomes less labor-intensive to utilize electronic data sources. For states that want to develop and implement new policies, we are well-positioned to provide them with technical assistance. CMS concurred with the GAO recommendation to provide additional guidance to states in this area. CMS is aware of states that are more frequently checking death information maintained by SSA, and we plan to identify and share best practices from those states.

4. According to the GAO report, CMS has not explored the feasibility of states using the full death master file in the periodic screening of individuals, outside of the initial enrollment or the annual revalidation period. Why not? Are there plans to study this?

Answer: Regarding beneficiary enrollment, CMS provides access, through the Hub, to SSA's composite service, which includes access to death information maintained by SSA. This data match is used by states at application and CMS also provides this service for eligibility redeterminations. States can at any time use their existing data connections with SSA, and many states do use their own data sources to conduct more frequent checks of beneficiary status. CMS continues to work with states to determine additional approaches – such as identifying and sharing best practices from states that more regularly check death information maintained by SSA – to better identify deceased beneficiaries. We will also continue to provide state-specific technical assistance as needed.

Regarding provider enrollment, States may use PECOS to identify individual Medicare providers that may have been deactivated due to death. Based on the Interagency Agreement established between CMS and SSA, CMS cannot directly share the death master file with the States. States are expected to get the data directly from SSA or other data sources they may have available to them.

5. GAO identified 47 providers—in just four states—with foreign addresses as their location of business, including Canada, China, India, and Saudi Arabia. How was it possible that a provider could list a foreign address? Could this happen still today? Why or why not?

Answer: CMS shares your interest in ensuring the effective use of taxpayer resources and ensuring Medicaid providers deliver safe, high-quality care. The Affordable Care Act requires that a State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States. CMS issued guidance related to this policy on December 30, 2010 (see State Medicaid Director Letter # 10-026). Among other things, the guidance clarifies that if it is found that payments have been made to financial institutions or entities outside of the United States, states must recover these payments and must forward any Federal match for such payments to CMS consistent with the guidelines specified in Federal regulations. The guidance also notified states that the prohibition would take effect June 1, 2011, half-way through the time-period studied by the GAO. A disproportionately-smaller percent of the payments GAO identified – 28 percent – occurred after these new rules took effect.

The Honorable David McKinley

- 1. It seems as though the continuously increasing complexity of the Medicaid payment system has to be adding to the error or improper payment rates. Is there any effort being made to standardize pre-certification and billing processes for all providers?**
- 2. Electronic medical records were intended to facilitate the accurate and timely flow and management of patient information. Is there any evidence that the EMRs are contributing to the increased error or improper payment rate?**

Answer to 1 and 2: The Payment Error Rate Measurement (PERM) program measures improper payments in the Medicaid and CHIP programs and produces state and national-level improper payment rates for each. The improper payment rates are based on reviews of the fee-for-service (FFS), managed care, and eligibility components of Medicaid and CHIP in the fiscal year under review. All referring/ordering providers are now required to be enrolled in Medicaid, states must screen providers under a new risk-based screening process prior to enrollment, and the attending provider National Provider Identifier (NPI) must be on all electronically-filed institutional claims. While these requirements will ultimately strengthen the integrity of the program, they require systems changes, and, therefore, many states had not fully implemented these new requirements. We have no evidence suggesting that the rise in the use of electronic medical records negatively impacted the FY 2014 PERM rate.

Although the Federal Government establishes general guidelines for the program, States design, implement, and administer their own Medicaid programs. Medicaid programs have flexibility, under broad Federal rules, to establish administrative requirements. Where possible, CMS provides guidance, technical assistance and shares best practices across states. CMS has provided states with training and direct access to the Medicare enrollment system, PECOS. Through the PECOS system, states can view specific enrollment data for each provider including site visit information, fingerprint status, enrollment status, and other key identifiers. In addition, CMS offers regular custom data extracts of key Medicare enrollment information for use by all states. CMS continues to expand efforts in assisting the states.

The Honorable Michael C. Burgess

- 1. GAO released a report regarding third party liability in January of this year and made recommendations that focused on CMS' need to better support states through facilitation of information sharing and providing guidance to the states. Has CMS taken any steps towards providing additional guidance to the states to allow for increased monitoring and oversight of third party liability efforts?**

Answer: HHS will continue to look at ways to provide guidance to states, to allow for continued sharing of proven effective practices and to increase awareness of initiatives under development among the states. CMS already has taken several actions:

- Developed a work plan to implement GAO's recommendations;
- Briefed the Coordination of Benefits/Third Party Liability (COB/TPL) Technical Advisory Group (TAG) on the report findings and recommendations;
- Reminded the TAG State Representatives (10 state Medicaid program COB/TPL officials, each representing all states in a specific geographic region of the United States) of their responsibilities to solicit COB/TPL issues from all states within their regions for TAG discussion with CMS, and to share resulting CMS guidance with the states;
- Requested and received assistance from the TAG State Representatives to solicit from all states effective state practices and innovative ideas for publication by CMS.

- 2. On May 30, 2015, the Dallas Morning News published an article discussing lowly rated private nursing home facilities receiving Medicaid funds. Available at <http://www.dallasnews.com/news/metro/20150530-public-hospitals-help-nursing-home-operators-get-federal-funds.ece>.**

- a. Recognizing that most fraud controls are state-based, are there any federal Medicaid policies that prevent states from looking at lowly rated facilities and preventing these facilities from receiving federal funds?**

Answer: There are no Federal requirements that prohibit a state from investigating a provider for suspicious billing practices or poor quality of care. Federal regulations require states to conduct pre-payment and post-payment claims review for utilization review and fraud. States operate agencies that survey providers such as nursing homes to determine that they meet all requirements, and to investigate complaints about the quality of care. If a state determines a provider is not in compliance with the Medicaid program requirements, CMS would expect the state to take appropriate action.

- b. Can you comment on what was identified in the Dallas Morning News article as a loophole for private low performing facilities drawing down CMS funding designed for public facilities to provide better quality or better coordinated care?**

Answer: CMS is aware of the news article and is working with the state to obtain a better understanding of this particular payment arrangement. States develop the payment methodologies that are used to pay their Medicaid providers, and, through the state plan review

process, CMS reviews and approves these methodologies. The methodologies that states use to set Medicaid rates must be consistent with efficiency, economy, and quality of care; however, states have the flexibility to base Medicaid payment on particular performance or quality of care measures. CMS has taken strides to generally encourage states to establish payment methodologies that reward providers on the basis of quality achievement or improvement. Such methodologies strengthen the health care delivery system and can result in significant savings to the states. CMS would welcome the opportunity to assist Texas in developing a performance based payment methodology for Texas nursing facilities.

- c. The state seems to identify that this is an issue. The state plans to take regulatory steps. Is there anything that CMS could do in the interim to help Texas in these efforts?**

Answer: CMS fully supports Texas in taking steps to address this issue. Ultimately, the state must amend its Medicaid state plan payment methodology to update the criteria that providers must meet to receive these payments. We are committed to working with Texas to address the issue as expeditiously as possible and will assist the state in developing state plan payment methodologies that are consistent with efficiency, economy, and quality of care while incorporating an appropriate source of the non-Federal share.

- d. CMS recently released comprehensive payment information. We know who the high utilizers are. We know who the low quality star providers are in certain sectors. Is there anything in federal regulations that prevents states from implementing safeguards against excessive utilization or simply processing payments to suspicious low quality facilities?**

Answer: No, there is nothing in Federal regulations that would prevent a state from implementing safeguards against excessive utilization or taking appropriate action to address poor performing facilities. In fact, states are required to implement a state-wide surveillance and utilization review program that safeguards against unnecessary or inappropriate use of Medicaid services and excess payments. States are also required to conduct pre-payment and post-payment claims review for utilization review and fraud. As Medicaid is a Federal-state partnership that is funded with both Federal and state funds, states have an incentive to ensure that appropriate program safeguards, including utilization review programs, are in place.

The Honorable Richard Hudson

- 1. North Carolina is currently considering using managed-care to help control Medicaid costs. Managed-care (versus fee-for-service) can be a cost-effective delivery system of Medicaid benefits. What steps is CMS taking to ensure that there is program integrity and it doesn't become a program that is more susceptible to fraud?**

Answer: CMS recently proposed the first major update to Medicaid and CHIP managed care regulations in more than a decade that will modernize the programs' rules to strengthen the delivery of quality care in Medicaid or CHIP. The proposed rule would require states to screen Medicaid and CHIP managed care providers consistent with the requirements for Medicaid and Medicare fee-for-service providers, which includes reviewing Federal databases to determine whether the provider is ineligible to participate in public programs. Assuming it is finalized, this proposed approach may result in administrative and cost efficiencies by providing the option to eliminate duplicative screening activities as part of the credentialing process for network providers and having that function performed instead by states (or, in the case of dually-participating providers, by Medicare contractors) for all providers. Under the proposed rule, every provider rendering a service to a Medicaid or CHIP beneficiary, whether in fee-for-service or managed care, would be screened utilizing the same criteria.

The proposed rule also would add several components to strengthen Medicaid and CHIP managed care plans' program integrity through administrative and managerial procedures that prevent, monitor, identify, and respond to suspected provider fraud. This would include implementation of procedures for internal monitoring, auditing, and prompt referral of potential compliance issues within the managed care plan; mandatory reporting of potential fraud, waste or abuse to the state; mandatory reporting of any potential changes in an enrollee's circumstances that may impact Medicaid eligibility as well as changes in a provider's circumstances that may impact that provider's participation in the managed care plan's network; and the suspension of payments to a network provider when the state determines a credible allegation of fraud exists.

Attachment 2—Member Requests for the Record

During the hearing, Members asked you to provide additional information for the record, and you indicated that you would provide that information. For your convenience, descriptions of the requested information are provided below.

The Honorable Michael C. Burgess

- 1. CMS uses the payment error rate measurement (PERM) program to determine the national payment error rate for Medicaid. The program is measured using a 17-state, 3-year rotation to produce and report national program error rates. Why was this method chosen? How long has CMS been using this method to determine the improper payment rate? Is it possible for CMS to assess each state's error rate on a yearly basis? If not, why not?**

Answer: The PERM program measures improper payments in the Medicaid and CHIP programs and produces state- and national-level improper-payment rates for each. The improper-payment rates are based on reviews of the fee-for-service (FFS), managed care, and eligibility components of Medicaid and CHIP in the fiscal year under review.

PERM uses a 17-state rotational approach to measure improper payments in Medicaid and CHIP for the 50 states and the District of Columbia over a three year period. As a result, each state is measured once every three years.

FY 2014 represents the seventh year that CMS calculated improper-payment rates for all components of the Medicaid program (FFS, managed care, and eligibility), meaning that all 50 states and the District of Columbia have been measured at least twice. The improper payment rate reported in the Department of Health and Human Services' Agency Financial Report is a rolling rate that includes findings from the most recent three measurements. Thus, each time a group of 17 states is measured under PERM, the previous findings for that group of states are dropped from the calculation and the newest findings added in.

This method was chosen because it was determined to be statistically valid and to ensure the effective stewardship of both Federal and state resources. Assessing each state's error rate on a yearly basis would be costly and burdensome to both states and CMS. Further, there would not be sufficient time between measures for states to implement corrective actions.

The Honorable Susan Brooks

- 1. How many federal and state employees are responsible for the administration of Medicaid?**

Answer: Staff throughout CMS and our regional offices perform work related to the administration of the Medicaid program. CMS tracks full-time employees (FTEs) by component and funding source and not by the program on which they work. There are approximately 375

FTE in CMS' Center for Medicaid and CHIP Services (CMCS), the Center responsible for Medicaid, as well as other activities, including CHIP and State Grants and Demonstrations. CMS does not generally collect comprehensive data on state employees performing work related to the administration of Medicaid.

The Honorable Markwayne Mullin

1. How many criminal referrals has CMS made to federal or state law enforcement over the past five years?

Answer: From calendar year 2010-2015, CMS's Center for Program Integrity made 2,989 referrals to law enforcement for matters involving Medicare Fee-For-Service, and 2,275 referrals to law enforcement for matters involving Medicare Advantage and Part D.¹ State agencies have primary responsibility for state-level law-enforcement referrals; therefore, CMS does not have complete data on the number of such referrals for Medicaid. When a state determines that a credible allegation of fraud exists regarding a Medicaid provider, the state is required to suspend payments to that provider unless the state, following required analysis and documentation procedures, determines that it has good cause not to suspend payments. A state is required to refer all credible allegations of fraud to its Medicaid Fraud Control Unit or other law-enforcement agency for further investigation in accordance with Federal regulations and CMS's performance standards for suspected fraud referrals.²

¹ The 2015 data reflects only a partial year of reporting. The HHS Office of Inspector General (OIG) is the primary recipient of CPI fraud referrals. However, if OIG does not accept a case, it may be referred to DOJ, (including referrals specifically to the Federal Bureau of Investigation), or state agencies.

² <https://www.cms.gov/FraudAbuseforProfs/Downloads/fraudreferralperformancestandardsstateagencytomfuc.pdf>