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

January 27, 2017

TO: Members, Subcommittee on Oversight and Investigations

FROM: Committee Majority Staff

RE: Hearing entitled "Medicaid Oversight: Existing Problems and Ways to Strengthen the Program."

On January 31, 2017, at 10:00 a.m. in 2123 Rayburn House Office Building, the Subcommittee on Oversight and Investigations will hold a hearing entitled "Medicaid Oversight: Existing Problems and Ways to Strengthen the Program." Medicaid is one of the nation's largest health programs and represents a substantial financial obligation for the federal government and the states. Given the sizeable current and projected federal dollars expended through the Medicaid program, the Subcommittee is conducting oversight to ensure that the program operates effectively, tax dollars are spent appropriately, and that patients receive the quality care that they deserve. This hearing will examine the findings of reports issued by the Government Accountability Office (GAO) and the Department of Health and Human Services Office of the Inspector General (HHS OIG) that present evidence of waste, fraud, and abuse in the Medicaid program.

I. WITNESSES

- Carolyn L. Yocom, Director, Health Care, U.S. Government Accountability Office;
- Ann Maxwell, Assistant Inspector General, Office of Evaluation and Inspections, Office of Inspector General, U.S. Department of Health and Human Services;
- Paul Howard, Senior Fellow, Director, Health Policy, The Manhattan Institute;
- Josh Archambault, Senior Fellow, The Foundation for Government Accountability; and
- Timothy M. Westmoreland, Professor from Practice, Senior Scholar in Health Law, Georgetown University Law Center

II. BACKGROUND

Medicaid is a joint federal-state entitlement program that finances the delivery of medical services for a diverse, low-income population. State participation in Medicaid is voluntary, but

all states, the District of Columbia, and the territories choose to participate. States must follow broad federal rules in order to receive matching federal funds, but have programmatic flexibility within the federal statute's framework. A total of 72.8 million Americans received health coverage through state Medicaid programs or the related Children's Health Insurance Program (CHIP) as of June 2016.[1]

Prior to passage of the Patient Protection and Affordable Care Act (PPACA), Medicaid eligibility was generally limited to low-income children, pregnant women, parents of dependent children, the elderly, and individuals with disabilities.[2] The PPACA substantially expanded Medicaid eligibility to include individuals under the age of 65 with incomes up to 133 percent of the federal poverty level.[3] In 2012, the Supreme Court ruled that the enforcement mechanism requiring states to expand Medicaid was unconstitutional, which essentially made Medicaid expansion optional for the states.[4] Currently, 32 states have elected to expand Medicaid under the new parameters set out in the PPACA.[5]

Of the roughly 20 million individuals who enrolled in insurance through the health care insurance exchanges created under the PPACA, about 14.5 million enrolled in Medicaid and CHIP coverage.[6] Of those 14.5 million, about 10.7 million were newly eligible for Medicaid under the PPACA expansion parameters, and 3.4 million were previously eligible for Medicaid but had not enrolled in the program.[7]

Since the passage of the PPACA, all states have seen an increase in Medicaid enrollment. From September 2013, when open enrollment under PPACA began, to September 2016, enrollment in Medicaid or CHIP increased by 15.7 million among 49 states reporting, amounting to a 27.9 percent increase.[8] The 32 states that have expanded Medicaid saw the largest growth in enrollment, of 35.7 percent, or 13.3 million between September 2013 and September 2016.[9] In 22 states, enrollment increased by at least 25 percent.[10] Although most of the growth was a result of newly eligible adults enrolling in states that expanded the program, Medicaid has grown, regardless of expansion, in all but two states.

---

[1] Centers for Medicare and Medicaid Services, *Medicaid & CHIP Monthly Application, Eligibility Determinations, and Enrollment Reports,* June 2016, *available at:* https://www.medicaid.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-enrollment-data/medicaid-and-chip-application-eligibility-determiniation-and-enrollment-data.html.
[2] Alison Mitchell, et al., Congressional Research Service, *Medicaid: An Overview, R43357* (August 2015).
[3] *Id.*
[4] National Federation of Independent Business (NFIB) v. Sebelius, 132 S. Ct. 2566 (2012).
[5] *Status of State Action on the Medicaid Expansion Decision*, Kaiser Family Foundation, http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0 (last updated Jan. 1, 2017).
[6] U.S. Dept. of Health & Human Serv., *Health Insurance Coverage and the Affordable Care Act*, Mar. 3, 2016.
[7] Medicaid Expansion Enrollment, Kaiser Family Foundation, http://kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0 (last visited Jan. 25, 2017).
[8] *Medicaid Enrollment Changes Following the ACA*, Medicaid and CHIP Payment and Access Commission, https://www.macpac.gov/subtopic/medicaid-enrollment-changes-following-the-aca/ (last visited Jan. 25, 2017).
[9] *Id.*
[10] *Id.*

Medicaid is a significant expenditure for the federal government and the states, with total spending of $509 billion in Fiscal Year (FY) 2015, of which 62 percent was paid by the federal government and 38 percent was paid by the states.[11] According to the Congressional Budget Office (CBO), the federal share of Medicaid outlays is expected to rise significantly over the coming decade, from $371 billion in 2016 to $624 billion in 2026.[12]

The size of the Medicaid program lends itself to challenges and vulnerabilities related to program integrity resulting in waste, fraud, and abuse of the program. Prior to passage of the PPACA, the program suffered high improper payment rates and reporting errors, eligibility errors, and provider fraud. Medicaid expansion has created new challenges such as improper eligibility determinations, inaccurate federal matching rates, and insufficient data collection.

In an effort to combat these problems, multiple agencies at the federal and state levels are involved in program integrity and oversight of the Medicaid Program. Federal agencies involved in ensuring program integrity include the Centers for Medicare and Medicaid Services (CMS), HHS OIG, and GAO. Program integrity initiatives are designed to combat waste, fraud, and abuse, while oversight efforts focus on preventing fraud and abuse through effective program management and addressing problems after they occur through investigations, recoveries, and enforcement activities.[13]

GAO Reports

The GAO added Medicaid to their list of high-risk programs in 2003 due to the program's size, growth, diversity of programs, and concerns about the adequacy of fiscal oversight.[14] As a result, the GAO has released a large body of work surrounding Medicaid, including but not limited to eligibility determination, enrollment controls, duplication in coverage, and ensuring that state spending is appropriately matched with federal funds. Their program integrity work estimates that more than $29 billion in FY 2015 was wasted on improper payments alone.[15] The GAO remains concerned that CMS has not provided sufficient guidance, or sufficiently coordinated with other federal agencies, to help ensure that only eligible providers participate in the program. The agency also notes that there continue to be gaps in CMS's efforts to ensure that only eligible individuals are enrolled into Medicaid, and that Medicaid expenditures for enrollees are matched appropriately by the federal government.[16]

After the passage of the PPACA, the GAO conducted numerous audits to assess additional risks to the integrity of the Medicaid program due to the new federal matching rate for newly eligible individuals under Medicaid expansion and the new eligibility determination

---

[11] *Medicaid Enrollment & Spending Growth: FY 2016 & 2017,* The Henry K. Kaiser Family Foundation, Commission of Medicaid and the Uninsured, October 2016, *available at:* http://files.kff.org/attachment/Issue-Brief-Medicaid-Enrollment-&-Spending-Growth-FY-2016-&-2017

[12] Congressional Budget Office, *Details of Spending and Enrollment for Medicaid—CBO's March 2016 Baseline* (March 2016), *available at:* https://www.cbo.gov/sites/default/files/recurringdata/51301-2016-03-medicaid.pdf b

[13] Alison Mitchell, et al., Congressional Research Service, *Medicaid: An Overview, R43357* (August 2015).

[14] U.S. Gov't Accountability Office, *High Risk List – Medicaid,* http://www.gao.gov/highrisk/medicaid_program/why_did_study (2015).

[15] *Id.*

[16] *Id.*

process (health care insurance exchanges). In October 2015, the GAO examined state and CMS efforts to properly allocate federal matching funds for the newly eligible Medicaid populations in expansion states. CMS assesses the accuracy of eligibility determinations and examines states' expenditures to ensure they are attributed to the accurate eligibility group, but a GAO report found gaps in these review systems, which could result in inappropriate spending.[17] For example, in the federal facilitated exchange states, CMS will not be able to assess the accuracy of eligibility determinations until 2018, creating the potential for improper payments. Further, CMS does not consider information obtained from its eligibility determination errors when reviewing state expenditures, which prevents CMS from identifying erroneous expenditures due to incorrect eligibility determinations.

To determine the accuracy of eligibility determinations, the GAO has conducted undercover testing by applying for Medicaid and private coverage in federal and state marketplaces with fictitious identities. Federal and state marketplaces are required to verify application information to determine eligibility for Medicaid benefits, such as a social security number, citizenship status, and household income. To conduct its audit, the GAO made eight fictitious applications for Medicaid coverage, and those fictitious applicants were approved for coverage in all but one case.[18] In three of the cases, the applicants were approved for Medicaid coverage, even though they provided invalid social security numbers. In the other four cases, the fake applicants received subsidized private coverage in lieu of Medicaid, although the applicants either did not provide a social security number, or provided an invalid immigration document number.

HHS OIG Reports

The HHS OIG has also conducted a substantial body of work related to Medicaid. Their work has covered topics from provider fraud, beneficiary fraud, and overpayments to states. In particular, the OIG has conducted numerous audits to evaluate measures passed as part of the PPACA that were intended to increase program integrity in the Medicaid program.

Section 6402(a) of the PPACA amended the Social Security Act to require that providers report and return overpayments within 60 days of identifying the overpayment or the date any corresponding cost report is due. In August 2015, the OIG found that providers did not always reconcile patient records with credit balances and report and return the Medicaid overpayments to state agencies.[19] Credit balances occur when a provider receives a duplicate payment for the same services from multiple sources–the Medicaid program or a third-party. The audit found that providers did not identify overpayments because states generally did not require that providers exercise reasonable diligence to find overpayments. The report notes that some providers did not

[17] Gov't Accountability Office, GAO-16-53, Additional Efforts Needed to Ensure That State Spending Is Appropriately Matched With Federal Funds (2015).
[18] Gov't Accountable Office, GAO-16-784, Results of Undercover Enrollment Testing for the Federal Marketplace and a Selected State Marketplace for the 2016 Coverage Year (2015); Gov't Accountable Office, GAO-16-792, Final Results of Undercover Testing of the Federal Marketplace and Selected State Marketplaces for Coverage Year 2015 (2016).
[19] Inspector Gen., Dep't. of Health & Human Serv., Providers Did Not Always Reconcile Patient Records with Credit Balances and Report and Return the Associated Medicaid Overpayments to State Agencies (2015).

reconcile patient records for more than six years. The OIG estimated that the states could recover federal Medicaid overpayments of nearly $17 million.[20]

The PPACA also requires the states terminate any providers already terminated for cause in another state. Despite this requirement, the OIG found that twelve percent (295 of 2,539) of providers terminated for cause in 2011 continued participating in other states' Medicaid programs as of January 2014.[21] This amounted to $7.4 million paid to 94 providers for services performed after each provider was terminated for cause by another state. The OIG recommended that CMS require each state Medicaid agency report all terminated providers. While CMS concurred with this recommendation, CMS has not yet required states to report terminations for cause.

In May 2016, the OIG released a report which evaluated the states' compliance with a PPACA requirement that all states screen Medicaid providers using enhanced screening procedures such as fingerprint-based criminal background checks and site visits.[22] The OIG found that most states reported not having fingerprint-based criminal background checks, and some states reported that they have not implemented site visits. Failing to implement these required program integrity measures allows unscrupulous providers to continue to defraud the Medicaid program.

III. ISSUES

The following issues may be examined at the hearing:

- The federal controls that aim to minimize waste, fraud, and abuse within the Medicaid Program;
- Federal agencies' compliance with new program integrity requirements in the PPACA; and
- The effect that Medicaid expansion has had on beneficiaries and the value of the coverage that they receive.

IV. STAFF CONTACTS

If you have any questions regarding this hearing, please contact Emily Felder or Brittany Havens of the Committee staff at (202) 225-2927.

---

[20] *Id.*
[21] Inspector Gen., Dep't. of Health & Human Serv., Providers Terminated from One State Medicaid Program Continued Participating in Other States (2015)
[22] Inspector Gen., Dep't. of Health & Human Serv., Medicaid Enhanced Provider Enrollment Has Not Been Fully Implemented (2016).