MEMORANDUM

To: Members and Staff, Subcommittee on Oversight and Investigations
From: Committee on Energy and Commerce Majority Staff
Re: Oversight Subcommittee Hearing on April 16, 2024

The Subcommittee on Oversight and Investigations will hold a hearing on Tuesday, April 16, 2024, at 10:30 a.m. (ET). The hearing will take place in 2322 Rayburn House Office Building and is entitled, "Examining How Improper Payments Cost Taxpayers Billions and Weaken Medicare and Medicaid."

I. WITNESSES

- The Honorable Gene Dodaro, Comptroller General, Government Accountability Office
- The Honorable Christi Grimm, Inspector General, Health and Human Services
- Timothy Hill, MPA, Medicaid and CHIP Payment and Access Commission Member
- Michael Chernew, PH.D. Medicare Payment Advisory Commission Chair

II. OVERVIEW

The hearing will focus on understanding ways to strengthen programmatic oversight, curtail improper payments, and ensure efficient use of taxpayer dollars in the Medicare and Medicaid programs. The hearing is an opportunity to hear from witnesses regarding strategies to improve the accountability of Medicare and Medicaid and to protect essential health care services seniors have earned and beneficiaries genuinely need.

The United States Comptroller General Gene Dodaro, the head of the Government Accountability Office (GAO), will present a wide-ranging analysis of improper payments' national impact, highlighting fiscal implications and long-term trends. Department of Health and Human Services (HHS) Inspector General (OIG) Christi Grimm will provide insight into fraud detection techniques as well as challenges in maintaining program integrity. Lastly, the Medicaid and CHIP Payment and Access Commission (MACPAC) as well as the Medicare Payment Advisory Commission (MedPAC) will offer testimony on targeted research and will highlight its policy recommendations to address these issues effectively.

III. BACKGROUND

In Fiscal Year 2023, the gross federal debt exceeded 120 percent of gross domestic product (GDP), reaching a ratio last observed during World War II.[1] Given these fiscal conditions, the United States is in a position where it cannot afford significant financial waste. Despite ongoing efforts and recommendations from congressional committees[2], the GAO, and various oversight entities, the issue of improper payments and wasteful spending continues to be a weight on the federal budget, burdening both present and future American taxpayers.

An improper payment is defined as any disbursement of funds that should not have occurred or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements. This includes overpayments, underpayments, payments to ineligible recipients, expenditures on non-eligible services or products, duplicate payments, and payments for undelivered goods or services, with the exception of those explicitly allowed by law.[3] Furthermore, if an executive agency is unable to verify the legitimacy of a payment due to insufficient or missing documentation, this too is classified as an improper payment for the purposes of federal accounting.[4]

The GAO has consistently identified improper payments as a critical concern in its audit reports dating back to fiscal year 1997. These payments have been identified as clear indicators of significant deficiencies or vulnerabilities within the federal government's internal controls. Disturbingly, recent GAO findings suggest that the federal government faces challenges in fully tracking the extent of its improper payments and struggles to establish and enforce measures to address this issue effectively.[5]

The repercussions of disbursing government benefits to ineligible recipients are substantial, negatively impacting the integrity of federal spending. Improper payments often arise within public health programs due to the federal government's system of open-ended reimbursement for state expenditures. Medicare and Medicaid – two of the largest

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[1] U.S. Dep't of Treasury, *What is the National Debt?*, FiscalData (last visited Apr. 10, 2024), https://fiscaldata.treasury.gov/americas-finance-guide/national-debt/. *See also* Bhargavi Sakthivel et al., *A Million Simulations, One Verdict for US Economy: Debt Danger Ahead*, Bloomberg (Apr. 1, 2024), https://www.bloomberg.com/news/articles/2024-04-01/us-government-debt-risk-a-million-simulations-show-danger-ahead.

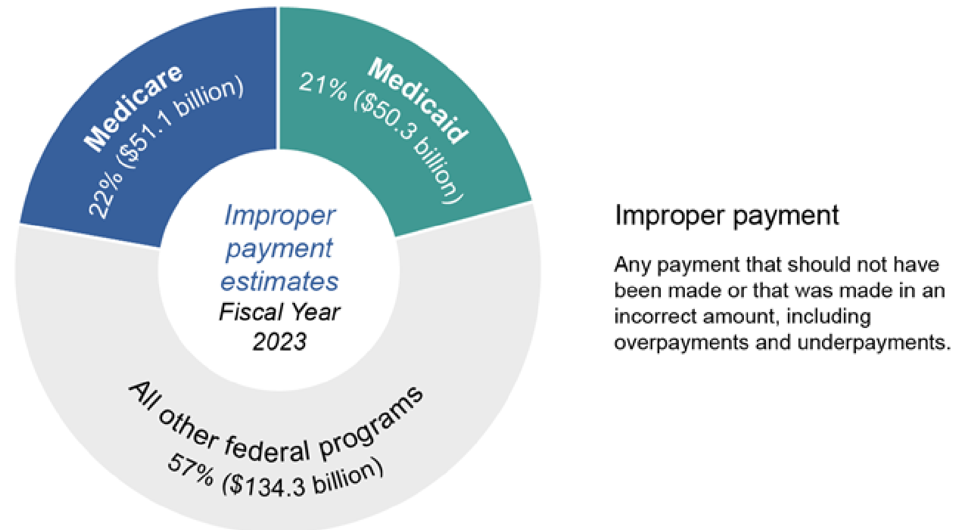
[2] Letter from Cathy McMorris Rodgers, Chairwoman, H. Comm. on Energy and Commerce, to Christi Grimm, Inspector General, U.S. Dep't of Health and Human Serv. (Jun. 5, 2023), https://d1dth6e84htgma.cloudfront.net/Oversight_Request_on_Eligibility_SIGNED_e7a0e832de.pdf?updated_at=2023-06-05T19%3A03%3A41.346Z. *See also* Letter from Ron Johnson, Ranking Member, Permanent Subcomm. on Investigations, S. Comm. on Homeland Security and Gov't Affairs, & James Comer, Chairman, H. Comm. on Oversight & Accountability, to Chiquita Brooks-Lasure, Administrator, Centers for Medicare & Medicaid Serv. (Apr. 27, 2023), https://oversight.house.gov/wp-content/uploads/2023/04/Letter-to-CMS-Brooks-LaSure-on-Medicaid-Improper-Payments-with-Sen-Johnson-42723.pdf.

[3] 31 U.S.C. § 3351(4).

[4] 31 U.S.C. §3352(c)(2).

[5] U.S. Gov't Accountability Office, GAO-24-106927, Improper Payments: Information on Agencies' Fiscal Year 2023 Estimates (2024), https://www.gao.gov/products/gao-24-106927 at 1.

federal health insurance programs – have been plagued by improper payments for years.[6] In Fiscal Year 2023 alone, Medicare reported approximately $51.1 billion in improper payments, while Medicaid reported around $50.3 billion.[7] However, the true magnitude of improper payments could be more significant, exacerbated by the complexity of Medicaid state financing mechanisms.[8] While not all improper payments necessarily imply fraudulent activity, maintaining diligent oversight over government expenditures is essential to minimize these occurrences and safeguard taxpayer resources.



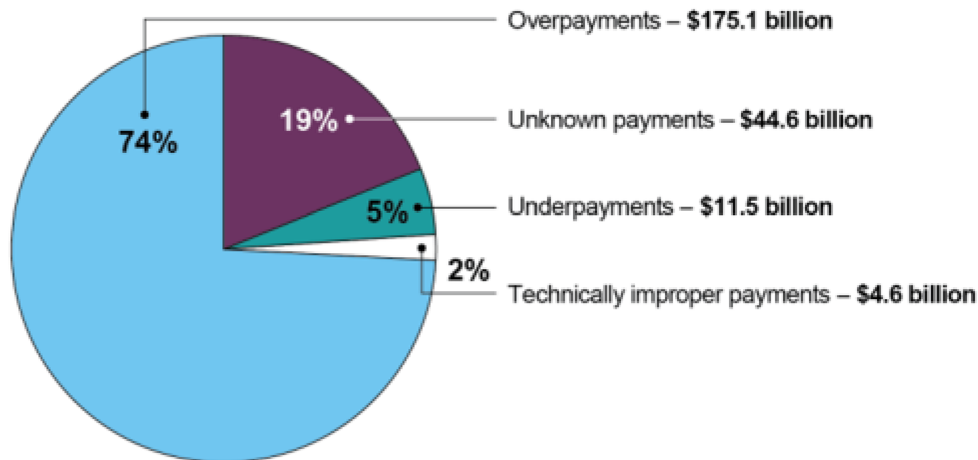
Source: GAO analysis of Office of Management and Budget Payment Accuracy data. | GAO-24-107487

[6] Centers for Medicare & Medicaid Serv., Improper Payment Rates and Additional Data, CMS.gov (last visited Apr. 2, 2024), https://www.cms.gov/data-research/monitoring-programs/improper-payment-measurement-programs/comprehensive-error-rate-testing-cert/improper-payment-rates-and-additional-data; *see also* Payment Error Rate Measurement (PERM) Error Rate Findings and Reports, CMS.gov (last visited Apr. 2, 2024), https://www.cms.gov/data-research/monitoring-programs/improper-payment-measurement-programs/payment-error-rate-measurement-perm/perm-error-rate-findings-and-reports.

[7] *See* Improper Payments: Information on Agencies' Fiscal Year 2023 Estimates *supra* note 5.

[8] U.S. Gov't Accountability Office, GAO-21-98, MEDICAID: CMS Needs More Information on States' Financing and Payment Arrangements to Improve Oversight (2020), https://www.gao.gov/assets/gao-21-98.pdf.; *see also* Brian C. Blase*, The Importance of the Medicaid Fiscal Accountability Rule*, Health Affairs (Apr. 7, 2020), https://www.healthaffairs.org/do/10.1377/forefront.20200331.308494.

Agencies' Fiscal Year 2023 Reported Estimated Improper Payments by Type[9]



Medicare

Within the Medicare program, improper payments not only pose a critical fiscal concern but also test the principles of responsible governance and stewardship of taxpayer dollars. These payments pose a significant challenge, emphasizing the need to maintain the program's integrity and financial sustainability for the benefit of both current and future generations.[10]

Recent audits by the HHS OIG have highlighted the persistent challenge of improper payments. One audit disclosed that Medicare had incorrectly compensated acute-care hospitals for inpatient claims that should have been subject to the post-acute-care transfer policy, leading to $41.4 million in overpayments, because of the misuse of discharge status codes by hospitals.[11] Additionally, there were $17.8 million in potentially improper payments identified for opioid-use-disorder treatment services provided by treatment programs.[12] These examples underscore the need for rigorous oversight and compliance mechanisms to guarantee conformity with Medicare regulations, pointing to broader systemic issues within the compliance and oversight frameworks. These reports underscore the urgent need for the Centers for Medicare and Medicaid Services (CMS) to

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[9] *Id.*
[10] U.S. Gov't Accountability Office, GAO-24-106987, The Nation's Fiscal Health: Road Map Needed to Address Projected Unsustainable Debt Levels (2024), https://www.gao.gov/assets/d24106987.pdf.
[11] Amy Frontz, Dep't of Health & Human Serv. Office of Inspector General, A-09-23-03016, Medicare Improperly Paid Acute-Care Hospitals for Inpatient Claims Subject to the Post-Acute-Care Transfer Policy over a 4-Year Period, but CMS's System Edits Were Effective in Reducing Improper Payments by the End of the Period (2023), https://oig.hhs.gov/documents/audit/9661/A-09-23-03016-Complete%20Report.pdf at 4.
[12] Amy Frontz, Dep't of Health & Human Serv. Office of Inspector General, A-09-22-03005, Medicare Made $17.8 Million in Potentially Improper Payments for Opioid-Use-Disorder Treatment Services Furnished by Opioid Treatment Programs (2023), https://oig.hhs.gov/documents/audit/9653/A-09-22-03005-Complete%20Report.pdf.

refine its auditing processes and strengthen the enforcement of existing policies to address these vulnerabilities.

The adoption of telehealth services during the COVID-19 Public Health Emergency, including the expansion of telehealth-like video consultations, marked a significant shift in patient care delivery. These innovations, while opening new avenues for health care accessibility, necessitated an adaptive oversight approach to avert financial inefficiencies and uphold care quality. Contrary to initial concerns, data from the HHS OIG indicate that telehealth, including services like evaluation and management via remote means, exhibited a lower rate of improper payments compared to traditional in-person care. This finding suggests that, with rigorous oversight, including precise provider education on billing protocols, efficient audit processes, and the deployment of sophisticated analytics for irregularity detection, telehealth can offer a model for reducing improper payments.[13] The effective implementation of these measures during the telehealth expansion highlights the potential for telehealth practices, when subjected to proper oversight, not only to extend care but also to enhance the integrity of health care programs.

Fiscal responsibility extends beyond merely correcting payment inaccuracies; it encompasses proactive measures to protect against waste, fraud, and abuse.[14] Strengthening Medicare's defense against improper payments requires a concerted effort to improve provider education on billing standards, streamline audit processes, and deploy advanced analytics for detecting discrepancies.[15] This proactive stance is essential for maintaining the trust of American taxpayers and ensuring that Medicare funds are devoted to providing quality care for our seniors and disabled populations.

As the Committee examines Medicare's challenges with improper payments, the insights from GAO and investigative findings from the HHS OIG are invaluable. These resources showcase options for a path toward tighter fiscal controls and program accountability, and safeguarding public resources and enhancing the overall quality of service for Medicare beneficiaries. Emphasizing transparency, accountability, and efficiency in Medicare's payment systems reinforces the Committee's commitment to sensible fiscal management and the program's longevity.

Medicaid

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[13] *Id.*

[14] Press Release, U.S, Gov't Accountability Office, *Federal Government Made $236 billion "Improper Payments" Last Fiscal Year* (Mar. 26, 2024), https://www.gao.gov/blog/federal-government-made-236-billion-improper-payments-last-fiscal-year. *See also* Joe Albanese & Brian Blase, Paragon Health Inst., America's Largest Health Care Programs Are Full of Improper Payments (2022), https://paragoninstitute.org/wp-content/uploads/2023/12/2022-Improper-Payment-Brief.pdf.

[15] U.S. Gov't Accountability Office, GAO-23-106203, High-Risk Series: Efforts Made to Achieve Progress Need to Be Maintained and Expanded to Fully Address All Areas (2023), https://www.gao.gov/assets/gao-23-106203.pdf at 236.

Medicaid serves as an important safety net, administered by states under federal guidelines, offering health coverage to America's most vulnerable groups, including low-income adults, children, pregnant women, elderly adults, and individuals with disabilities. Since being placed on the GAO's High-Risk List in 2003, due to concerns about its fiscal oversight, Medicaid has faced significant challenges.[16] The landscape of Medicaid financing has undergone substantial evolution, becoming increasingly complex as states have diversified the sources of their nonfederal share obligations.[17]

The introduction of the Patient Protect and Affordable Care Act (ACA) marked a significant milestone in the evolution of Medicaid, broadening eligibility to include working-aged adults and providing states with financial incentives through an enhanced Federal Medical Assistance Percentage (FMAP) match rate.[18] This expansion has intensified issues related to improper payments.[19] In pursuit of incentives, some states have given preference to enrolling participants under the new eligibility criteria, which detracts from the focus on individuals qualifying under the standard FMAP.[20] Furthermore, the utilization of provider taxes[21] and local government funds,[22] although aligning with federal guidelines, has contributed to an increased federal financial obligation and introduced layers of complexity to Medicaid's fiscal administration.[23]

This transformation in Medicaid's scope and scale has led to concrete, measurable impacts. Notably, post-ACA expansion, there was a marked increase in Medicaid's

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[16] U.S. Gov't Accountability Office, GAO-21-196, MEDICAID: Data Completeness and Accuracy Have Improved, though Not All Standards Have Been Met (2021), https://www.gao.gov/assets/gao-21-196.pdf at 2.
[17] *See* America's Largest Health Care Programs Are Full of Improper Payments, *supra* note 15.
[18] Robin Rudowitz*, Understanding How States Access the ACA Enhanced Medicaid Match Rates*, Kaiser Family Foundation (Sept. 29, 2014), https://www kff.org/medicaid/issue-brief/understanding-how-states-access-the-aca-enhanced-medicaid-match-rates/.
[19] *See* Improper Payments: Information on Agencies' Fiscal Year 2023 Estimates *supra* note 5.
[20] Kaiser Comm'n on Medicaid & the Uninsured, Kaiser Family Found., Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP) (2012), https://www kff.org/wp-content/uploads/2013/01/8352.pdf.
[21] **Provider Taxes** in Medicaid are mechanisms by which states levy taxes on health care providers, seemingly to increase Medicaid funding from the federal government. States then return a portion of these funds to the providers, effectively using the federal reimbursement to subsidize the state's share of Medicaid expenses. This practice, though legal, has raised concerns about its impact on federal spending and the transparency of Medicaid financing. For example, a state might tax a health care provider $1,000,000, which is then matched with $650,000 in federal funds based on the state's Medicaid reimbursement rate. The state has thus engineered a scenario where it gains additional federal dollars without true expenditure, raising questions about the fiscal stewardship of Medicaid funds.
[22] **Intergovernmental Transfers (IGT)** in Medicaid refer to the practice of states receiving funds from local governments or government health care providers, using those funds to increase the amount of Medicaid funding received from the federal government, and then taking a portion of the federal funds to return to the local governments or government providers to make them whole. This practice has been criticized for allowing states to artificially inflate their Medicaid spending and shift the financial burden onto the federal government, leading to unnecessary spending and waste of taxpayer dollars. For example, a state could transfer $1 billion to a local government, which then transfers $1.5 billion back to the state, allowing the state to claim an additional $500 million in federal Medicaid funding. This practice has been criticized for allowing states to artificially inflate their Medicaid spending and shift the financial burden onto the federal government, leading to unnecessary spending and waste of taxpayer dollars.
[23] U.S. Gov't Accountability Office, GAO-21-98, MEDICAID: CMS Needs More Information on States' Financial and Payment Arrangements to Improve Oversight (2020), https://www.gao.gov/assets/d231476.pdf.

improper payment rate, soaring from an estimated 6 percent to over 20 percent in Fiscal Year 2020 and 2021.[24] This rise was further complicated by the Maintenance of Effort requirements during the COVID-19 Public Health Emergency, which temporarily suspended states' abilities to reassess Medicaid eligibility.[25] Audits from the HHS OIG highlight the magnitude of these challenges, revealing, for instance, that California and New York alone made $1.7 billion in payments to approximately 1.6 million ineligible recipients in 2014 and 2015.[26] An estimated $4.3 billion was directed towards nearly 4 million potentially-ineligible enrollees, highlighting critical areas where oversight and allocation measures must be strengthened to ensure Medicaid's fiscal integrity.[27]

The Committee has identified additional challenges related to improper payments within Medicaid that require attention.[28] Instances of beneficiaries enrolled in multiple states, continued payments to deceased beneficiaries, and payments made without proper eligibility verification illustrate systemic vulnerabilities that compromise Medicaid's integrity and fiscal responsibility. Such inefficiencies emphasize the urgency for CMS and state agencies to enhance oversight mechanisms and eligibility verification processes, ensuring Medicaid funds serve their intended purpose.

The GAO's insights into CMS's oversight and data management deficiencies reveal critical gaps that hinder effective program administration.[29] The lack of precise data on state Medicaid financing and payment arrangements significantly impairs the enforcement of federal guidelines and the assessment of fiscal health and efficiency.[30]

Effective oversight of Medicaid, therefore, hinges on the strength of federal and state collaboration.[31] Improved communication and data sharing are essential for ensuring the reliability and timeliness of information that underpins program integrity. Systematic enhancements to data collection frameworks and oversight protocols are important for maintaining Medicaid's commitment to its beneficiaries and the appropriate use of taxpayer dollars.[32]

Both Medicare and Medicaid have faced decades-long challenges regarding improper payments, and there is a critical need for systemic reforms and enhanced

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[24] *See* Improper Payment Rates and Additional Data s*upra* note 6.
[25] Jennifer Wagner & Judith Solomon, Ctr. on Budget and Policy Priorities, Medicaid Coverage Protections in Families First Act: What They Require and How to Implement Them (2020), https://www.cbpp.org/sites/default/files/atoms/files/5-27-20health.pdf.
[26] Christi Grimm, Dep't of Health & Human Serv. Office of Inspector General, A-02-20-01018, Prior Audits of Medicaid Eligibility Determinations in Four States Identified Millions of Beneficiaries Who Did Not or May Not Have Met Eligibility Requirements (2022), https://oig hhs.gov/oas/reports/region2/22001018.pdf at 24.
[27] *Id.*
[28] *See* Letter from Cathy McMorris Rodgers *supra* note 2.
[29] U.S. Gov't Accountability Office, GAO-23-106203, High- Risk: Series Efforts Made to Achieve Progress Need to Be Maintained and Expanded to Fully Address All Areas (2023), https://www.gao.gov/assets/gao-23-106203.pdf.
[30] *Id.*
[31] Medicaid & CHIP Payment & Access Comm'n (MACPAC), Program Integrity, https://www.macpac.gov/subtopic/program-integrity/ (last visited Apr. 10, 2024).
[32] *Id*.

oversight. These issues not only strain our nation's fiscal health but also compromise the integrity of vital programs meant to serve millions of Americans. By fostering a culture of accountability, transparency, and innovation, we can ensure that Medicare and Medicaid are sustainable and effective for future generations.

IV. KEY QUESTIONS

1. What steps are being taken to reduce the rate of improper payments in Medicare and Medicaid, and how can the federal government improve oversight of these programs to reduce these improper payments further?

2. How are states using financing and payment arrangements, such as provider taxes, upper payment limits, and supplemental payments, to inflate their FMAP and secure additional federal funding, and what can be done to address this issue?

3. How did the COVID-19 Public Health Emergency impact improper payments in both Medicaid and Medicare?

4. How can the federal government ensure that Medicare and Medicaid funds are being used to provide essential health care services to those in need, rather than being lost to improper payments or fraud?

5. How can advancements in technology and data analytics be used to enhance the detection and prevention of improper payments in Medicare and Medicaid, and what steps are necessary to implement these tools effectively across state and federal levels?

V. STAFF CONTACTS

If you have any questions regarding the hearing, please contact the Subcommittee on Oversight and Investigations Majority staff at (202) 225-3641.