Statement for the Record for the

United States House of Representatives

Committee on Energy and Commerce

Subcommittee on Health

"Medicaid at 50: Recommendations to Improve the Efficiency and Effectiveness of the Program"

Statement from:

Office of Inspector General
Department of Health and Human Services

July 8, 2015

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In 1975, the Medicaid program provided coverage to approximately 20 million beneficiaries at a cost of $12.6 billion.[1] One year later, the Department of Health and Human Services (HHS or the Department) Office of Inspector General (OIG) was established. Now, thirty-nine years later, Medicaid covers approximately 70 million beneficiaries[2] at a cost of $438 billion and makes up a significant portion of OIG's oversight and enforcement work.[3] Over that time, the Medicaid program has expanded from covering the medical expenses for specific categories of individuals, e.g., individuals with disabilities and dependent children receiving public assistance, to a program that now serves as the nation's largest source for public health coverage for a wide range of beneficiaries.

Considering the vital and growing role that Medicaid plays in the nation's health care system, OIG understands how important it is to ensure that both the Centers for Medicare & Medicaid Services (CMS) and the States jointly operate a Medicaid program that is effective and efficient and delivers high-quality health care to its beneficiaries. To that end, OIG continues to make oversight of the Medicaid program a critically important piece of our mission to protect the integrity of HHS programs and the health and welfare of program beneficiaries. We have identified protecting an expanding Medicaid program from fraud, waste, and abuse as one of the Department's top management and performance challenges.[4]

This statement summarizes significant unimplemented recommendations to improve the efficiency and effectiveness of the Medicaid program. HHS OIG believes that implementation of these recommendations will result in cost savings and/or improvements in the Medicaid program's efficiency and effectiveness.

The recommendations come from OIG audits and evaluations, performed pursuant to the Inspector General Act of 1978, as amended. These recommendations were recently released in OIG's March 2015 *Compendium of Unimplemented Recommendations* (Compendium). For more information about these and other unimplemented recommendations please see the full 2015 Compendium available at: http://oig.hhs.gov/reports-and-publications/compendium/index.asp

OIG is committed to working with CMS, the States, Congress, and other stakeholders to ensure that the Medicaid program operates as efficiently and effectively as possible so that Medicaid beneficiaries receive high quality health care services.

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[1] CMS, *2013 Actuarial Report on the Financial Outlook for Medicaid*, available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/MedicaidReport2010.pdf

[2] CMS, *Medicaid & CHIP, April 2015 Monthly Applications, Eligibility Determinations and Enrollment Report*, available at http://medicaid.gov/medicaid-chip-program-information/program-information/downloads/april-2015-enrollment-report.pdf

[3] Kaiser Family Foundation, *Medicaid & CHIP*, available at http://kff.org/state-category/medicaid-chip/

[4] OIG, *Top Management and Performance Challenges*, available at http://oig.hhs.gov/reports-and-publications/top-challenges/2014/challenge03.asp

OIG Unimplemented Recommendations

High quality, patient-centered care

- ***Ensure that Medicaid children receive all required preventive screening services*** **(Top 25)**[5]
  OIG's review focused on medical, vision, and hearing screenings provided to children under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. We found that very few children received the correct number of vision, hearing, and/or complete medical screenings. Further, we found that children's participation in EPSDT medical screenings remained lower than established goals.

  - CMS should require States to report on vision and hearing screening data for eligible children.

  - CMS should collaborate with States and providers to develop effective strategies to encourage beneficiary participation in screenings.

  CMS concurred with the recommendation and had made efforts to explore adding a requirement and creating a vision quality measure. We continue to monitor CMS's progress in implementing our recommendations. Expected impact is improved quality and safety. OEI-05-08-00520 http://oig.hhs.gov/oei/reports/oei-05-08-00520.pdf

Home and community-based care

- ***Improve oversight of management of Medicaid personal care services*** **(Top 25)**
  OIG's body of work examining personal care services (PCS) has found significant and persistent compliance, payment, and fraud vulnerabilities that demonstrate the need for CMS to take a more active role with States to address these issues. As more and more State Medicaid programs explore home care options like PCS, it is critical that adequate safeguards exist to prevent fraud, waste, and abuse in PCS and other important home care benefits.

  OIG made several recommendations to improve CMS's oversight of PCS:

  - Promulgate regulations to reduce significant variation in States' personal care services laws and regulations by creating or expanding Federal requirements and issuing operational guidance for claims documentation, beneficiary assessments, plans of care, and supervision of attendants.

[5] Top 25 indicates that the unimplemented recommendation is included in OIG's Top 25 unimplemented recommendations that, on the basis of the professional opinion of OIG, would best protect the integrity of HHS programs if implemented. OIG is required by law to report the Top 25 unimplemented recommendations in the Compendium. For more information on the Top 25 unimplemented recommendations, see our 2015 Compendium at http://oig.hhs.gov/reports-and-publications/compendium/files/compendium2015.pdf

- Promulgate regulations to reduce significant variation in State PCS attendant qualification standards and the potential for beneficiary exposure to unqualified PCS attendants by establishing minimum Federal qualification standards applicable to all PCS reimbursed by Medicaid.

- Promulgate regulations to improve CMS's and States' ability to monitor billing and care quality by requiring States to (1) either enroll all PCS attendants as providers or require all PCS attendants to register with the State Medicaid agencies and assign each attendant a unique identifier and (2) require that PCS claims include the specific date(s) when services were performed and the identities of the rendering PCS attendants.

- Issue guidance to States regarding adequate prepayment controls. Consider whether additional controls are needed to ensure that PCS are allowed under program rules and are provided.

- Take action to provide States with data suitable for identifying overpayments for PCS claims during periods when beneficiaries are receiving institutional care paid for by Medicare or Medicaid.

CMS concurred with the recommendation. In June 2014, CMS indicated that it promulgated final rules for the new Community First Choice benefit, under section 1915(k) and for home- and community-based services (HCBS) provided under sections 1915(c) and 1915(i) of the Social Security Act. OIG believes CMS's actions do not fully implement the recommendation. We recommended that CMS promulgate regulations to reduce variation in State rules regarding PCS by creating Federal requirements for claims documentation, beneficiary assessments, plans of care, and supervision of attendants. The final rules address beneficiary assessments and plan-of-care provisions. However, they do not address provisions related to consistent claims documentation and supervision of attendants. We continue to monitor CMS's progress in implementing our recommendations. Expected impact is an estimated savings of $1.3 billion and improved program management. OIG-12-12-01 http://oig.hhs.gov/reports-and-publications/portfolio/portfolio-12-12-01.pdf

Other OIG significant unimplemented recommendations:

- Require at least one onsite visit before a home and community-based services waiver program is renewed and develop detailed protocols for such visit. CMS concurred with this recommendation in part. OEI-02-08-00170 http://oig.hhs.gov/oei/reports/oei-02-08-00170.pdf

- Make information available to the public about State compliance with the home and community-based services waiver assurances available to the public. CMS concurred with this recommendation. OEI-02-08-00170 http://oig.hhs.gov/oei/reports/oei-02-08-00170.pdf

Medicaid managed care

- ***Strengthen Oversight of State access standards for Medicaid Managed Care*** **(Top 25)**

  OIG reviewed State standards and oversight related to Medicaid managed care organizations' (MCO) maintenance of a sufficient network of providers to provide adequate access to care for enrollees. We found that State standards for access to care vary widely and that CMS provides limited oversight of these standards. Additionally, standards are often not specific to certain types of providers or to areas of the State.

  - CMS should strengthen its oversight of State standards and ensure that States develop standards for key providers.

  - CMS should strengthen its oversight of State's methods to assess plan compliance and ensure that States conduct direct tests of access standards.

  - CMS should improve States' efforts to identify and address violations of access standards and provide technical assistance and share effective practices.

  CMS concurred with the recommendation. In a recent notice of proposed rulemaking,[6] CMS proposed new regulatory requirements to improve and monitor beneficiary access to care in the Medicaid MCO setting. We continue to monitor CMS's progress in implementing our recommendations. Expected impact is improved quality and safety. OEI-02-11-00320 http://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf

  Other OIG significant unimplemented recommendations:

- Work with States to assess the number of providers offering appointments and improve the accuracy of plan information. CMS concurred with this recommendation. OEI-02-13-00670 http://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf

- Work with States to ensure that plans' networks are adequate and meet the needs of their Medicaid managed care enrollees. CMS concurred with this recommendation. OEI-02-13-00670 http://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf

- Require that State contracts with managed care entities include methods to verify with beneficiaries whether services billed by providers were received. CMS concurred with this recommendation. OEI-01-09-00550 http://oig.hhs.gov/oei/reports/oei-01-09-00550.pdf

Data systems

- ***Improve the Transformed Medicaid Statistical Information System*** **(Top 25)**

[6] 80 Fed. Reg. 31098 (Jun. 1, 2015), available at http://www.gpo.gov/fdsys/pkg/FR-2015-06-01/pdf/2015-12965.pdf

OIG reviewed CMS's implementation of the Transformed Medicaid Statistical Information System (T-MSIS) that is designed to operate as a national database of Medicaid and Children's Health Insurance Program (CHIP) information to cover a broad range of user needs, including program integrity. We found that some progress had been made in 12 volunteer States; however, most other States had not started implementing T-MSIS, and they reported varied timeframes for when they planned to begin. Furthermore, early T-MSIS implementation outcomes raised questions about the completeness and accuracy of T-MSIS data upon national implementation.

- CMS should ensure that the national T-MSIS is complete, accurate, and timely.

- CMS should ensure that States submit required T-MSIS data and establish a deadline for when national T-MSIS data will be available.

CMS concurred with the recommendation. In March 2014, CMS indicated that it is working to create a set of rules to govern the submission of T-MSIS data. CMS also indicated that it reviewed States' source-to-target mapping documents and distributed State technical requirements. In addition, CMS plans to define State file processing procedures, delineate a data quality oversight strategy, and provide stakeholders with information on data quality issues. OIG has ongoing work[7] that will assess the completeness of States' submission of T-MSIS data. We continue to monitor CMS's progress in implementing our recommendations. Expected impact is improved program management. OEI-05-12-00610 http://oig.hhs.gov/oei/reports/oei-05-12-00610.pdf

Other OIG significant unimplemented recommendations:

- Require each State Medicaid agency to report all terminated providers. CMS concurred with this recommendation. OEI-06-12-00031 http://oig.hhs.gov/oei/reports/oei-06-12-00031.pdf

- Ensure that the shared information contains only records that meet CMS's criteria for inclusion. CMS concurred with this recommendation. OEI-06-12-00031 http://oig.hhs.gov/oei/reports/oei-06-12-00031.pdf

- Work with States to improve the quality of claims data for drugs submitted by providers and pharmacies. CMS concurred with this recommendation. OEI-05-11-00580 http://oig.hhs.gov/oei/reports/oei-05-11-00580.pdf

- Help States obtain better data on ineligible drugs. CMS concurred with this recommendation. OEI-05-11-00580 http://oig.hhs.gov/oei/reports/oei-05-11-00580.pdf

- Facilitate States' submission of standardized claims data. CMS concurred with this recommendation. OEI-05-11-00580 http://oig.hhs.gov/oei/reports/oei-05-11-00580.pdf

[7] OEI-05-15-00050; expected issue date: fiscal year 2016

- CMS should be more engaged in dispute resolution between States and drug manufactures. CMS concurred in part with this recommendation. OEI-05-11-00580 http://oig.hhs.gov/oei/reports/oei-05-11-00580.pdf

Program integrity and financial management

- ***Ensure that States calculate accurate costs for Medicaid services provided by local public providers***. **(Top 25)**
  OIG's review focused State practices that utilize the Federal Upper Payment Limit (UPL) to obtain Federal Medicaid funds without committing the States' shares of required matching funds or by other means artificially inflate the Federal share. We found that some States utilized the UPL rules to their advantage by requiring certain classes of facilities to transfer the UPL funds to the States to be put to other uses, leaving the facilities underfunded.

  - CMS should provide States with definitive guidance for calculating the UPL, which should include using facility-specific UPLs that are based on actual cost report data.

  - CMS should require that the return of Medicaid payments by a county or local government to the State be declared a refund of those payments and thus be used to offset the Federal share generated by the original payment.

  In 2008, CMS issued a final rule that, among other things, would limit Medicaid payments to public providers to their costs of providing care, but the rule was ultimately vacated by Federal District Court. We continue to monitor CMS's progress in implementing our recommendations. Expected impact is estimated savings of $3.87 billion over 5 years and improved payment efficiency. A-03-00-00216 http://oig.hhs.gov/oas/reports/region3/30000216.pdf

  Other OIG significant unimplemented recommendations:

- Ensure that all States appropriately report offset drug rebate amounts. CMS concurred with this recommendation. OEI-03-12-00520 https://oig.hhs.gov/oei/reports/oei-03-12-00520.pdf

- Seek legislative authority to extend the additional rebate provisions for brand-name drugs to generic drugs. CMS agreed to consider this recommendation. A-06-07-00042 http://oig.hhs.gov/oas/reports/region6/60700042.pdf

- Work with State Medicaid agencies to determine whether the use of manufacturer rebates and lower provider reimbursement rates could achieve net savings for the purchase of diabetes test strips. CMS concurred with this recommendation. A-05-13-00033 http://oig.hhs.gov/oas/reports/region5/51300033.pdf

- Encourage States to adopt a multitiered payment system to bring pharmacy reimbursement more in line with the actual acquisition cost of drug products. CMS

concurred in part with this recommendation. A-06-02-00041 http://oig.hhs.gov/oas/reports/region6/60200041.pdf

- Take action to provide States with data suitable for identifying overpayments for PCS claims during periods when beneficiaries are receiving institutional care paid for by Medicare or Medicaid. OIG 12-12-01. CMS concurred with this recommendation. http://oig.hhs.gov/reports-and-publications/portfolio/portfolio-12-12-01.pdf