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

September 8, 2015

TO: Members, Subcommittee on Health

FROM: Committee Majority Staff

RE: Hearing: "Strengthening Medicaid Program Integrity and Closing Loopholes."

I. INTRODUCTION

On Friday, September 11, 2015, at 9:15 a.m. in 2322 of the Rayburn House Office Building, the Subcommittee on Health will hold a hearing entitled, "Strengthening Medicaid Program Integrity and Closing Loopholes."

II. WITNESSES

- John Hagg, Director of Medicaid Audits, Office of Inspector General, U.S. Department of Health and Human Services;
- Nico Gomez, Chief Executive Officer, Oklahoma Health Care Authority; and
- Trish Riley, Executive Director, National Academy for State Health Policy; Commissioner, Medicaid and CHIP Payment and Access Commission.

III. BACKGROUND

Created in 1965 to finance health care coverage to serve low-income Americans and the indigent, Medicaid is now the world's largest health insurance program. Medicaid currently covers nearly 72 million Americans — more than Medicare — and up to 83 million may be covered at any one point in a given year.[1] Medicaid is jointly funded by Federal and State governments. According to the Congressional Budget Office, Federal Medicaid outlays are expected to increase dramatically over the coming decade, from $343 billion in 2015 to $576 billion in 2025.[2] At the same time, Medicaid is one of the fastest growing spending items for States, and accounted for more than 25 percent of State spending in fiscal year 2014, according to the National Association of State Budget Officers.[3]

The Federal government establishes specific parameters and minimum requirements for Medicaid, including specifying mandatory and optional benefits and minimum Federal standards

[1] http://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/june-2015-enrollment-report.pdf and http://www.cbo.gov/sites/default/files/cbofiles/attachments/44204-2015-03-Medicaid.pdf
[2] http://www.cbo.gov/sites/default/files/cbofiles/attachments/44204-2015-03-Medicaid.pdf
[3] http://www.nasbo.org/sites/default/files/NASBO%20Spring%202015%20Fiscal%20Survey%20of%20States%20-%20S.pdf

for eligibility. Within those standards, States and territories administer their own Medicaid programs.

Medicaid's size and diversity make the program vulnerable to waste, fraud, and abuse. Given the program's vulnerabilities, the Medicaid program has been on the U.S. Government Accountability Office's (GAO) list of high risk programs for over a decade.[4] GAO designated Medicaid as a high risk program due to "its size, growth, diversity of programs, and concerns about the adequacy of fiscal oversight."

States represent the first line of defense against waste, fraud, and abuse. For example, States must comply with Federal requirements to ensure the qualifications of the providers who bill the program, assess and determine applicants' eligibility for the program, detect improper payments, recover overpayments, and refer suspected cases of fraud and abuse to law enforcement authorities. At the Federal level, the Centers for Medicare and Medicaid Services (CMS) within the Department of Health and Human Services (HHS) is responsible for supporting and overseeing State Medicaid program integrity activities.

IV. LEGISLATION

At this hearing, the Subcommittee will discuss six bills targeted at strengthening Medicaid program integrity and closing eligibility loopholes in the program that have allowed individuals with significant resources to qualify for program benefits. If enacted, these bills would save Federal and State taxpayers hundreds of millions of dollars while making the program more transparent, accountable, and available to future generations.

A. H.R. 2446, to amend title XIX of the Social Security Act to require the use of electronic visit verification for personal care services furnished under the Medicaid program, and for other purposes

Medicaid personal care services (PCS) provide assistance to the elderly, people with disabilities, and individuals with chronic or temporary conditions so that they can remain in their homes and communities. PCS consist of non-medical services supporting activities of daily living, including bathing, dressing, light housework, money management, meal preparation, and transportation. PCS generally are provided by an attendant to vulnerable care-dependent persons, such as the elderly, infirm, or disabled.

PCS, which are currently offered as either a State plan optional benefit or through various demonstrations and waivers in all 50 States, have grown rapidly. For example, in 2011, Medicaid costs for PCS totaled approximately $12.7 billion, a 35 percent increase since 2005. Additionally, the Bureau of Labor Statistics projected that personal care aides are the second fastest growing occupation, growing 49 percent between 2012 and 2022, compared to an average growth of 11 percent for all occupations.[5]

[4] http://www.gao.gov/products/GAO-03-101
[5] http://www.bls.gov/ooh/fastest-growing.htm

Between 2006 and August 2012, the Office of Inspector General at the U.S. Department of Health and Human Services (OIG) produced 23 audit and evaluation reports on PCS.[6] OIG's audit and evaluation work revealed a pattern of improper PCS payments linked to lack of compliance with State policies and requirements. Additionally, the work demonstrated that existing program safeguards intended to ensure medical necessity, patient safety, and quality and prevent improper payments were often ineffective. Furthermore, according to the OIG, PCS fraud — including many cases in which the care attendants and the beneficiaries acted as co-conspirators to scam the Medicaid system — is on the rise, representing more cases investigated by State Medicaid Fraud Control Units than any other type of Medicaid fraud.

Electronic visit verification (EVV) systems offer a way to reduce the level of fraud and improper payments, while protecting some of the most vulnerable Medicaid beneficiaries and ensuring that they receive the care they need. EVV systems are telephonic or computer-based systems that verify that service visits occur and documents the precise times that a personal care attendant is with the patient, thereby improving patients' quality of care and ensuring that payments are only made for services rendered.

At the hearing, the Subcommittee will discuss an updated version of H.R. 2446, introduced by Mr. Guthrie, which would incentivize State Medicaid programs to adopt EVV for personal care services. Specifically, effective 2018, States that do not require the use of an EVV system for personal care services would face a modest reduction in the Federal matching rate for home and community based services.

B. H.R. ____, Medicaid and CHIP Territory Fraud Prevention Act

Medicaid Fraud Control Units (MFCU) serve as a leading source of health care fraud control. MFCUs are a single, identifiable entity of State government responsible for investigating and prosecuting Medicaid provider fraud and patient abuse and neglect in health care facilities. According to the OIG, the Federal agency that oversees MFCUs, in fiscal year 2014, MFCUs reported 1,318 criminal convictions involving various types of providers who provide services to Medicaid beneficiaries. Three-quarters of these criminal convictions were for fraud, including convictions for billing for services not rendered and falsifying timesheets. Recoveries from criminal cases in 2014 reached nearly $300 million. Additionally, MFCU convictions led to the exclusion of 1,337 providers from Federal health care programs. MFCUs also reported 874 civil settlements and judgments, resulting in $1.7 billion in recoveries.[7]

MFCUs are jointly funded by the Federal and State governments; with the Federal government paying 75 percent of the costs for operating a unit. As part of their Medicaid plans, all Medicaid programs are required to operate a MFCU unless they demonstrate to the Secretary of HHS that operation of a MFCU would not be cost effective and that other program integrity provisions are in place. Currently, 49 States and the District of Columbia operate a MFCU; one State has received a waiver from the Secretary because operating a MFCU would not be cost effective.

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[6] http://oig.hhs.gov/reports-and-publications/portfolio/portfolio-12-12-01.pdf
[7] www.oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu

None of the U.S. territories that participate in the Medicaid program currently operate a MFCU. The absence of rigorous auditing and independent reviews from MFCUs in the territories could allow Federal taxpayer dollars to be lost to waste, fraud, or abuse.

Unlike the 50 States and the District of Columbia, Federal Medicaid funding for the territories is subject to an annual limit or cap. Thus, under current law, any funds used for the operation of a MFCU would count against a territory's cap, reducing the amount that could be spent on health care services for beneficiaries.

The Medicaid and CHIP Territory Fraud Prevention Act, which will be introduced by Mr. Pitts and Ms. Brooks, builds on the president's fiscal year 2016 budget request, would encourage territories to create MFCUs by exempting Federal funding for the fraud control units from territories' cap on Medicaid funding and by exempting territories from the statutory ceiling on quarterly Federal payments for the units.

C. H.R. 1570, Medicaid and CHIP Territory Transparency and Information Act

U.S. territories American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands all operate Medicaid and CHIP programs that are funded with a majority of Federal dollars. The amount of Federal funding for these territories Medicaid and CHIP programs has increased in recent years as the Patient Protection and Affordable Care Act (PPACA) increased the Federal matching rate for the territories, as well as their Federal spending cap. However, little is known about how these programs operate and their use of Federal funds.

Most reports on Medicaid and CHIP do not include the territories, even though the population of Puerto Rico is larger than the entire populations of Wyoming, Vermont, North Dakota, Alaska and South Dakota, combined. Additionally, while CMS includes profiles of the 50 States' Medicaid and CHIP programs on its website, as well as information on their eligibility and enrollment levels and waivers, until recently, similar information was not available for any of the territories. CMS recently added information about Puerto Rico's program to its website, but still does not include information on the other territories. Congress and the public need additional information about the programs in the territories to ensure the appropriate use of Federal funds and inform future policy-making.

H.R. 1570, introduced by Mr. Bilirakis, would address this lack of information by requiring CMS to include on its website similar Medicaid and CHIP Program information about the territories as is provided about the States.

D. H.R. ____, Ensuring Terminated Providers are Removed from Medicaid and CHIP Act

Prior to passage of the PPACA, a provider terminated from participation in one State's Medicaid program, potentially could participate in another State's Medicaid program, leaving the

second State's program vulnerable to fraud, waste, or abuse committed by that provider. To prevent this from happening, section 6501 of PPACA required that, as of January 1, 2011, each State must terminate the participation of a provider from its Medicaid program if that provider's participation was terminated for cause (i.e., for reasons of fraud, integrity, or quality) from Medicare or from another State Medicaid program. This requirement was intended to strengthen Medicaid program integrity across States, so that providers found to warrant termination in one State may not continue to provide services for Medicaid beneficiaries in another State and receive Medicaid payments for doing so.

Despite the PPACA requirement, the OIG found continued participation from providers terminated for cause by one State Medicaid program in other States' programs.[8] Specifically, the OIG found that 12 percent of providers terminated from a State Medicaid program during 2011 (295 of the 2,539 providers) were participating in another State's Medicaid programs as of January 1, 2012. Further, 172 of the 295 providers continued their participation in Medicaid as late as January 2014, more than two years after they were terminated for cause from another State program. These Medicaid programs paid $7.4 million to 94 providers for services performed after each provider's termination for cause by the initial State. Furthermore, a review of public records conducted by Reuters found that more than one in five providers excluded from Medicare were still able to bill State Medicaid programs.[9]

The OIG report noted several challenges faced by States in implementing the PPACA requirement, including the lack of a comprehensive centralized data source that identifies providers terminated for cause; the lack of uniform terminology in existing data sources regarding the reasons for provider terminations; and challenges related to excluding providers that participate in managed care, but are not enrolled with the State Medicaid agency.

The Ensuring Terminated Providers are Removed from Medicaid and CHIP Act, which will be introduced by Dr. Bucshon, addresses the challenges and concerns raised in the OIG's report by requiring State Medicaid and CHIP programs to report providers terminated for cause to CMS; requiring providers participating in Medicaid or CHIP managed care to be enrolled with the State; requiring CMS to include State reported provider terminations and Medicare provider terminations in its Termination Notification Database or equivalent system; and requiring States to pay back the Federal portion of Medicaid and CHIP payments made to providers for services performed more than two months after a provider's termination is included in the CMS Termination Notification Database.

E. H.R. 2339, to amend title XIX of the Social Security Act to clarify the treatment of lottery winnings and other lump sum income for purposes of income eligibility under the Medicaid program, and for other purposes.

Since Medicaid is intended to cover individuals with limited means who cannot afford to pay for their own health insurance or care, Medicaid eligibility is dependent on individuals'

[8] http://oig.hhs.gov/oei/reports/oei-06-12-00030.pdf
[9] http://www.reuters.com/investigates/special-report/usa-medicaid-fraud/

income levels. Under PPACA, States were required to transition to a new income counting rule, referred to as Modified Adjusted Gross Income (MAGI), for determining what income to include or disregard in determining Medicaid eligibility for most nonelderly and non-disabled individuals, children under the age of 18, and adults and pregnant women under the age of 65. Under the Medicaid MAGI income-counting rules, a State will look at an individual's MAGI, deduct an amount equal to 5% of the Federal poverty level (which the law provides as a standard disregard), and compare that income to the income standard set by the State to determine whether the individual meets the program's eligibility requirements.

Income eligibility for Medicaid applicants and new enrollees is based on current monthly household income.[10] MAGI-based income under Medicaid refers to income calculated using the same methodology used to determine MAGI in section 36B(d)(2)(B) of the Internal Revenue Code (i.e., it includes tax-exempt interest income earned or accrued, interest from U.S. savings bonds used to pay higher education tuition and fees, earned income of U.S. citizens living abroad that was excluded from gross income, and non-taxable portion of Social Security benefits), with some exceptions. In particular, under Medicaid regulations, irregular income received as a lump sum, such as lottery or gambling winnings, one-time gifts, or inheritances, is counted as income *only in the month received*.[11]

As a result of these CMS regulations, lottery winners, including multi-million dollar winners, have been allowed to retain tax-payer financed Medicaid coverage. For example, in 2014, one State reported to the Committee they had more than 6,000 lottery winners who were receiving, or were part of a household receiving, Medicaid. Of this group of individuals, about 200 of these individuals had winnings of $20,000 or more.

H.R. 2339, introduced by Chairman Pitts would close the loophole in the current statute and regulations by allowing States, for purposes of determining MAGI for Medicaid and CHIP eligibility, to consider monetary winnings from lotteries (and other lump sum payments) as if they were obtained over multiple months, even if obtained in a single month.

F. H.R. 1771, to amend title XIX of the Social Security Act to count portions of income from annuities of a community spouse as income available to institutionalized spouses for purposes of eligibility for medical assistance, and for other purposes.

Individuals seeking Medicaid coverage for long-term care, including nursing home care, must have assets — income and resources — that are below established standards. The financial eligibility standards differ based on whether an individual is married or single. Federal law requires States to use specific minimum and maximum income and resource standards in

[10] When redetermining eligibility for current Medicaid enrollees, States are permitted to use current monthly income and family size, or projected annual income and family size for the remaining months of the calendar year. For States that choose the latter measure, the rules for projected household income and family size under Medicaid differ as compared to the rules under the exchanges. Specifically, Medicaid requires the applicant to predict income and household size for the remaining months of the calendar year, whereas applicants seeking eligibility for premium tax credits must predict income and household size based on the tax year. See 42 C.F. R. §435.603(h)(2). States are required to use "reasonable methods" to account for changes in income such as, increases or decreases in income due to seasonal work. See 42 C.F.R. §435.603(h)(3).
[11] 42 C.F. R. §435.603(e).

determining Medicaid eligibility for married applicants when one spouse is in an institution, such as a nursing home, (referred to as the institutionalized spouse) and the other remains in the community (referred to as the community spouse).

For example, the resources of both the institutionalized and community spouse are considered when determining initial eligibility for Medicaid coverage for nursing home care. The community spouse is able to retain an amount equal to one-half of the couple's combined resources, up to a State-specified maximum level. A community spouse's resources generally are not assessed again after his or her spouse is initially deemed eligible. Additionally, while the institutionalized spouse's income is considered when determining Medicaid eligibility, the income of the community spouse is not considered. The community spouse is allowed to retain all of his or her income.

Medicaid's treatment of married couples' income and resources has resulted in a loophole in Medicaid eligibility that allows married individuals to increase the amount of assets the community spouse is able to retain above State and Federal maximums. Specifically, GAO found that married applicants can increase the amount of assets the community spouse retains by using the couples' resources, which would be counted towards the institutionalized spouse's Medicaid eligibility, to purchase an irrevocable and nonassignable annuity that pays out income to the community spouse.[12] Although annuities for the community spouse must be actuarially sound — they must pay out during the community spouse's life expectancy — and must name the State as a remainder beneficiary, there are no other limitations on the time period in which annuities pay out. Additionally, there is no limit on the amount of income from the annuity, as the community spouse's income is not countable as part of the institutionalized spouse's eligibility.

GAO has noted that married applicants may use the couple's resources to purchase an irrevocable annuity that pays potentially large amounts of income for the community spouse over a short period of time, thereby effectively returning the resources to the community spouse without affecting the institutionalized spouse's Medicaid eligibility. For example, officials from one State told GAO that they have seen annuities for the community spouse worth more than $1 million, while representatives from a law office that GAO spoke with suggested that annuities can be created quickly and used as a last-minute tool for Medicaid planning.

H.R. 1771, introduced by Mr. Mullin, would address this loophole in Medicaid policy by making half of the income generated from an annuity purchased by a community spouse within the 60-month Medicaid look back period — the period of time before applying for Medicaid in which an individual's or couple's assets are reviewed — countable for purposes of determining the institutionalized spouse's Medicaid eligibility for long term care.

V. STAFF CONTACTS

If you have any questions regarding this hearing, please contact Josh Trent or Michelle Rosenberg of the Committee staff at (202) 225-2927.

[12] http://www.gao.gov/assets/670/663417.pdf