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

May 20, 2016

TO: Members, Subcommittee on Oversight and Investigations

FROM: Committee Majority Staff

RE: Hearing entitled "Medicare and Medicaid Program Integrity: Combatting Improper Payments and Ineligible Providers"

On May 24, 2016, at 10:15 a.m. in 2322 Rayburn House Office Building, the Subcommittee on Oversight and Investigations will hold a hearing entitled "Medicare and Medicaid Program Integrity: Combatting Improper Payments and Ineligible Providers."

Medicare and Medicaid are large and fast-growing federal programs, representing significant financial outlays for both states and the federal government. In 2014, Medicare spending grew 5.5 percent to $618.7 billion, and Medicaid spending grew 11 percent to $495.8 billion.[1] In recent months, the Government Accountability Office (GAO) and the Department of Health and Human Services Office of the Inspector General (OIG) have released several reports that present evidence of substantial fraud and abuse in Medicare and Medicaid programs.

The findings in these reports raise questions about the Centers for Medicare and Medicaid Services' (CMS) effectiveness in rooting out waste, fraud, and abuse in these programs. This hearing will examine two distinct challenges faced by CMS in implementing these programs: (1) preventing improper payments; and (2) ensuring that providers are properly eligible and enrolled. This hearing will also provide an opportunity to discuss the ways in which CMS can operate the Medicare and Medicaid programs more effectively and appropriately by implementing recommendations to address these challenges.

## I. WITNESSES

- Ann Maxwell, Assistant Inspector General, Office of Evaluation and Inspections, Office of Inspector General, U.S. Department of Health and Human Services;
- Seto J. Bagdoyan, Director, Audit Services, Forensic Audits and Investigative Service, U.S. Government Accountability Office; and
- Shantanu Agrawal, M.D., Deputy Administrator and Director, Center for Program Integrity, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services.

[1] Centers for Medicare and Medicaid Services, National Health Expenditure Data, NHE Fact Sheet 2014, available at: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html (last visited May 12, 2016).

## II. BACKGROUND

The purpose of this hearing is to strengthen Medicare and Medicaid program integrity by exploring two major approaches: eliminating improper payments and strengthening provider enrollment.

### a. Improper Payments

This hearing will examine the Department of Health and Human Services (HHS) improper payment error rates impacting both the Medicare and Medicaid programs. In 2015, HHS reported approximately $89 billion in improper payments made through Medicare, Medicaid, and other public health programs.[2] Improper payments occur when federal funds go to the wrong recipient, the recipient receives the incorrect amount of funds (either an underpayment or overpayment), documentation is not available to support a payment, or the recipient uses federal funds in an improper manner.[3] The OIG is required to review and report on agencies' annual improper payment information included in their Agency Financial Reports (AFRs) to determine compliance with the Improper Payments Act of 2002 (IPIA).[4] Every year, the HHS OIG audits HHS's compliance with IPIA as amended, and assesses HHS's performance in reducing and recapturing improper payments. In a report issued May 11, 2016, the HHS OIG found that HHS did not fully comply with the IPIA as amended, for FY 2015.[5] Specifically, HHS did not achieve targets or goals for certain programs, including Medicare fee-for-service, Medicare Advantage, Medicaid, and the Children's Health Insurance Program (CHIP).[6] It was also found that HHS did not meet requirements to implement a plan to reduce improper payments.[7]

#### *1. Medicare Improper Payments*

In its report, the OIG noted that HHS failed to meet improper payment rate reduction targets, and reduce improper payment error rates to below 10 percent for the Medicare Fee-For-Service (FFS) program.[8] While HHS has referenced a number of actions to address improper payments through Corrective Action Plans (CAPs), the reported error rate exceeded IPIA's 10 percent benchmark. For FY 2015, the Medicare Fee-For-Service program's improper payment was 12.09 percent, meaning that 12 percent of payments issued to providers either should not

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[2] Department of Health and Human Services, Fiscal Year 2015 Annual Financial Report for 2015, *available at* http://www.hhs.gov/sites/default/files/afr/fy-2015-hhs-agency-financial-report.pdf.
[3] Definition of Improper Payment, PAYMENTACCURACY.GOV, *available at:* https://paymentaccuracy.gov/content/faq#1 (last visited May 19, 2016).
[4] The Improper Payments Information Act of 2002 (IPIA) requires OIGs to annually report to the President and Congress on the agencies' improper payments, as amended by The Improper Payments Elimination and Recovery Act of 2010, and the Improper Payments Eliminations and Recovery Improvement Act of 2012 (IPERIA), hereinafter as IPIA, as amended.
[5] Department of Health and Human Services, Office of the Inspector General, *U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 But Did Not Fully Comply for Fiscal Year 2015*, (May 2016).
[6] *Id.*
[7] *Id.*
[8] *Id.*

have been made, or were reimbursed for an incorrect amount.[9] In response to this finding, HHS cited insufficient documentation and medical necessity errors as the causes for the high error rate.[10]

Improper payments resulting from insufficient documentation and medical necessity errors could be resolved through the use of claims processing codes. For example, prior OIG work on Medicare improper payments found that over $33 million was erroneously paid to providers rendering services to incarcerated beneficiaries.[11] Medicare generally does not pay for services rendered to individuals who are incarcerated in correctional facilities. However, federal requirements allow Medicare payment if state or local law requires incarcerated beneficiaries to repay the cost of medical services.[12] Health care providers indicate this exception by placing a specific code, or exception code, on the claims submitted for payment. Yet, CMS did not have policies and procedures to review information after the improper payment had been made, resulting in a system that could not recover improper payments. Consequently, CMS did not notify the contractors to recoup any of the $33,587,634 in improper payments. To date, OIG's recommendation to ensure that all claims with exception codes are processed consistently and pursuant to Federal requirements remains unimplemented with CMS.[13]

### *2. Medicaid Improper Payments*

Additionally, the OIG found the overall error rate for Medicaid was 9.78 percent, far off from HHS's goal error rate of 6.7 percent, and the error rate for Medicaid's CHIP increased from 6.50 percent in FY 2014 to 6.80 percent for FY 2015.[14] The OIG noted that the Medicaid program did not achieve its target due to administrative errors made by the state or local agencies, and recommended that HHS work with the states to bring their respective systems into compliance.

As state Medicaid programs continue to explore home care options like Personal Care Services (PCS), it is critical that ample safeguards are in place to prevent improper payments contributing to fraud, waste, and abuse in PCS. Several OIG audits and evaluation reports have found that PCS payments were improper because the services: (1) were not provided in compliance with state requirements, (2) were unsupported by documentation indicating the services had been rendered, (3) were provided during periods in which the beneficiaries were in a hospital or nursing home reimbursed by Medicare or Medicaid, and/or were provided by PCS attendants who did not meet state qualification requirements.[15] Moreover, OIG work has indicated that existing program safeguards intended to ensure medical necessity, patient safety,

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[9] *Id.*
[10] *Id.*
[11] Department of Health and Human Services, Office of the Inspector General, *Medicare Improperly Paid Providers Millions of Dollars for Incarcerated Beneficiaries who Received Services During 2009 through 2011* (Jan. 2013).
[12] *Id.*
[13] Department of Health and Human Services, Office of Inspector General, *Compendium of Unimplemented Recommendations,* (April 2016).
[14] *Id.* at 5.
[15] See, Department of Health and Human Services, Office of Inspector General, *Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement,* (November 2012).

quality, and prevent improper payments were often ineffective.[16] The OIG recommended that CMS should promulgate regulations to reduce significant variation in states' PCS laws and regulations by creating or expanding federal requirements, and issuing operational guidance for claims documentation and beneficiary assessments.

Moreover, the OIG has identified several areas for improvement with CMS's database on terminated providers. Pursuant to the Patient Protection and Affordable Care Act (PPACA), CMS established a web-based portal, the Medicaid and Children's Health Insurance Program State Information Sharing System (MCSIS), to share information on terminated providers. The OIG found that as of June 1, 2013, MCSIS contained records on terminated providers submitted by CMS and thirty three state Medicaid agencies, and did not contain records from the remaining state Medicaid agencies.[17] The OIG also found that over half of MCSIS records did not contain National Provider Identifiers (NPIs), a critical data element for accurately identifying providers.[18] The OIG recommended that CMS require reporting of all terminations "for cause."[19] While CMS agreed with the OIG's recommendation, CMS has yet to indicate whether it planned to require state reporting of terminations "for cause."[20]

Last year, the GAO also released a report highlighting the frequency of improper payments and fraud within the Medicaid program,[21] and it was the subject of a hearing before the Oversight and Investigations Subcommittee in June 2015. After auditing four states with just over 9 million Medicaid beneficiaries, GAO found:

- About 200 deceased beneficiaries received at least $9.6 million in Medicaid benefits. The individuals were already deceased before apparently receiving medical services covered by Medicaid.

- At least 4,400 beneficiaries may have been using a virtual address as their residence address. Although Medicaid does not require physical addresses for beneficiary enrollment and eligibility determinations, the use of virtual addresses may be a way to conceal total household income and is a potential indicator of fraud. More specifically, these beneficiaries used a Commercial Mail Receiving Agency (CMRA) address—such as a United Parcel Service store—as their residence address. Medicaid paid claims totaling at least $20.5 million for the beneficiaries.

- The Social Security Numbers (SSNs) for about 199,000 beneficiaries did not match identity information contained in the Social Security Administration (SSA) bases, suggesting fraud or improper payments. The benefits paid at least $448 million to these

[16] *Id.*
[17] See, Department of Health and Human Services, Office of Inspector General, *CMS'S Process for Sharing Information About Terminated Providers Needs Improvement,* (March 2014).
[18] *Id.*
[19] *Id.* at 12.
[20] *Id.*
[21] U.S. Gov't Accountability Office, *Medicaid: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls*, GAO-15-313 (May 2015).

199,000 beneficiaries. Of these beneficiaries, 12,500 of them used a SSN never issued by SSA.

To better protect against fraud and improper payments, GAO recommended that CMS provide better guidance to states on how to identify deceased beneficiaries. This recommendation is still "open," indicating that GAO does not believe CMS has taken necessary actions pursuant to the report.[22]

### b. Provider Eligibility

The Subcommittee will also look into provider enrollment weaknesses with both the Medicare and Medicaid programs. Vulnerabilities within provider enrollment not only contribute to the problem of improper payments and fraudulent billing, but also raise questions on potential patient harm and quality of care issues.

#### *1. Reports from the Government Accountability Office*

Of the $554 billion paid to providers through Medicare in FY 2014, CMS estimates that about 10 percent, or $60 billion was paid improperly.[23] According to GAO, flaws in the eligibility verification process for Medicare providers and suppliers contribute to those improper payments. There are approximately 1.8 million different providers and suppliers that bill Medicare. These providers enroll through the Provider Enrollment, Chain and Ownership System (PECOS), a centralized databased designed to contain providers' and suppliers' enrollment information. CMS largely relies upon contractors to verify the provider's eligibility and root out fraud and abuse.[24] However, CMS guidance in March 2014 reduced the amount of independent verification conducted by contractors, which GAO says "increase[es] the program's vulnerability to potential fraud."[25]

In a June 2015 report entitled "Additional Actions Needed to Improve Eligibility Verification of Providers and Suppliers," GAO identified two main "weaknesses" in CMS's procedures to detect ineligible or fraudulent providers and suppliers: (1) verification of provider practice locations and (2) physician licensure status.[26]

With regard to the verification of provider practice locations, GAO found that CMS' method to validate addresses does not flag potentially ineligible addresses, such as a UPS store mailbox, or vacant, or invalid addresses.[27] Of the 105,234 addresses GAO initially identified as

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[22] U.S. Gov't Accountability Office, *Medicaid: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls*: *Recommendations*, *available at:* http://www.gao.gov/products/GAO-15-313, (last visited May 17, 2016).
[23] Government Accountability Office, *Additional Actions Needed to Improve Eligibility Verification of Providers and Suppliers*, (June 2015).
[24] *Id.*
[25] *Id.*
[26] *Id.*
[27] *Id.*

invalid, 23,400 or 22 percent are potentially ineligible for Medicare providers and suppliers.[28] For example, one provider listed an address that currently houses a fast food restaurant.[29] Another provider listed a UPS store as its address.[30]

Concerning physician licensure status, Medicare program requirements state that physicians must hold an active license in the state in which they plan to practice, and must self-report final adverse actions, such as suspensions or revocations of licensure. However, CMS does not provide contractors charged with verifying physician eligibility with information regarding adverse-actions against that physician, or if the physician has medical licenses in other states. GAO found that, as of March 2013, 147 out of 1.3 million physicians listed as eligible had received a final adverse action for crimes against persons, financial crimes, and other types of felonies, such as substance abuse, health-care, fraud or patient abuse.[31] These 147 physicians had not been revoked from the Medicare program until months after the adverse action, or were never removed.[32]

Often, adverse events slip through the cracks because CMS contractors rely upon physicians to self-report these adverse events. For example, GAO identified a physician whose California license was suspended in 2008 due to sexual misconduct.[33] The physician then applied for a Missouri state medical license and was granted a license and enrolled into the Medicare program in 2010. During this physician's first year in the program, he billed Medicare approximately $113,000.[34]

In April 2016, the GAO released an update to its June 2015 report, which considers a new background check process CMS implemented after GAO had conducted its audit. This report explains that CMS could recover about $1.3 million in potential overpayments to 16 potentially ineligible providers with criminal backgrounds, due to new processes in place.[35] In April 2014, CMS implemented more extensive background check processes, and GAO's report had not captured data after 2013. Before April 2014, CMS did not initially have, and therefore did not use, the original felony conviction date that ultimately made the provider ineligible to participate in Medicare. However, GAO did not evaluate the effectiveness of the new process because the most recent data available to GAO were based on procedures in place in 2013.

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[28] About 300 of the addresses were Commercial Mail Receiving Agencies, such as UPS; 3,200 were vacant properties; and 19,900 were invalid, or did not exist. Of the 23,400 potentially ineligible addresses, 2,900 were associated with providers that had claims that were less than $500,000, and 2,600 were associated with providers that had claims that were $500,000 or more per address.
[29] Government Accountability Office, *Additional Actions Needed to Improve Eligibility Verification of Providers and Suppliers*, June 2015.
[30] *Id*.
[31] *Id*.
[32] *Id*.
[33] *Id*.
[34] *Id*.
[35] Government Accountability Office, *Medicare: Opportunities Exist to Recover Potential Overpayments to Providers with Criminal Backgrounds*, (April 13, 2016).

Last year, the GAO also released a report highlighting concerns about CMS' screening of ineligible providers.[36] This report found that, out of the four states audited, about 90 medical providers had their medical licenses revoked or suspended in the state in which they received payment from Medicaid during fiscal year 2011. Medicaid approved the associated claims of these cases at a cost of at least $2.8 million. GAO also found that at least 47 providers had foreign addresses as their location of service, including Canada, China, India, and Saudi Arabia. Nearly 26,600 providers had addresses that did not match any United States Postal Service records.

To mitigate these problems, GAO recommended that CMS provide guidance to states on the availability of automated information through Medicare's enrollment database—PECOS—and full access to all pertinent PECOS information, to help screen Medicaid providers more efficiently and effectively. This recommendation is still "open," indicating that GAO does not believe CMS has taken necessary actions pursuant to the report.[37]

*2. Report from the HHS Inspector General Office*

The HHS OIG also recently examined the issue of provider enrollment and eligibility screening, and released its report in April 2016, entitled "Enhanced Enrollment Screening of Medicare Providers: Early Implementation Results."[38] This report chronicled CMS's new enrollment screening process, which aims to prevent illegitimate providers from enrolling in Medicare. This new screening placed providers in risk categories, increased site visits, required fingerprinting, and denied enrollment to providers who have unresolved overpayments. Despite some positive strides, the HHS OIG expressed concerns that the new process did not solve all the existing problems.

According to the report, CMS's implementation of enhanced enrollment screening needs "strengthening."[39] CMS relies on an enrollment data system, PECOS, as its centralized repository for all provider enrollment information; however, PECOS lacks data needed to evaluate the outcomes of enrollment screening enhancements.[40] Data such as (1) denials and returns of enrollment applications, (2) risk category designations for each enrolling provider, and (3) reasons providers submitted enrollment applications, were not consistently maintained in PECOS. In addition, results from a provider's site visit and the Medicare contractors' decision to enroll a provider cannot be directly linked, making it difficult to evaluate provider enrollment outcomes.[41]

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[36] U.S. Gov't Accountability Office, *Medicaid: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls*, GAO-15-313 (May 2015).
[37] U.S. Gov't Accountability Office, *Medicaid: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls*: *Recommendations*, *available at:* http://www.gao.gov/products/GAO-15-313, (last visited May 17, 2016).
[38] Department of Health and Human Services, Office of the Inspector General, *Enhanced Enrollment Screening of Medicare Providers: Early Implementation Results*, April 2016.
[39] *Id.*
[40] *Id.*
[41] *Id.*

Finally, OIG expressed concerns about CMS' ability to conduct oversight over the new screening process. The OIG found that "gaps in contractors' verification of key information on enrollment applications that could leave Medicare vulnerable to illegitimate providers."[42] The OIG also noted that contractors were "inconsistent" when conducting site visits and how results were utilized in making enrollment decisions.[43] OIG found that CMS could address both issues through implementation of enhancements such as site visits and PECOS improvement, to ensure that providers are being effectively screened for entry into Medicare.

*3. Forthcoming OIG Reports*

The OIG has recently notified the Committee that three additional reports will be released in conjunction with the upcoming hearing. These reports continue the examination of vulnerabilities within Medicare and Medicaid provider screening, and provide CMS with additional recommendations to enhance program integrity within both programs.

In the forthcoming report entitled, "*Medicaid Enhance Provider Enrollment Has Not Been Fully Implemented"* (OEI-05-13-00520), the OIG surveyed states and requested data about their use of risk-based screening. The ACA requires states to screen Medicaid providers according to their risk for fraud, waste, and abuse using enhanced screening procedures such as fingerprint-based criminal background checks and site visits. 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. As a result, the OIG has recommended that CMS assist states in implementing fingerprint-based criminal background checks for all high-risk providers, and overcoming challenges in conducting site visits.

The OIG plans on releasing another Medicaid report entitled, "*Medicaid: Vulnerabilities Related to Provider Enrollment and Ownership Disclosure"* (OEI-04-11-00590), which determined the extent to which states requested and verified provider ownership information and checked exclusions databases. By verifying ownership, states can prevent inappropriate payments and protect the integrity of services being rendered to beneficiaries. The OIG found that fourteen state Medicaid programs reported they did not verify the completeness or accuracy of provider ownership, nor did they check all required exclusions databases. Moreover, nearly all providers reviewed by the OIG had names on record with state Medicaid programs that did not match those on record with CMS. The OIG has recommended that CMS require state Medicaid programs to verify the completeness and accuracy of provider ownership, and ensure that state Medicaid programs check exclusions databases as required.

In April 2016, the OIG released a report assessing enrollment screenings of Medicare providers.[44] The OIG also plans on releasing another report evaluating Medicare enrollment screenings, specifically looking at how inconsistencies with provider ownership disclosure, could allow potentially fraudulent providers to enroll in the Medicare system. Findings from this study are discussed in the forthcoming report, "*Medicare: Vulnerabilities Related to Provider Enrollment and Ownership Disclosure"* (OEI-04-11-00591). The OIG compared three sets of

[42] *Id.*
[43] *Id.*
[44] *Id.* at 38.

owner names for selected providers. Specifically, they compared: (1) the names listed on Medicare enrollment records, (2) names submitted by providers directly to the OIG for their evaluation, and (3) names listed on state Medicaid enrollment records. Also, the OIG surveyed CMS's Medicare Administrative Contractors to learn how they verify provider exclusions when processing Medicare enrollment applications. The OIG found that two of the eleven CMS contractors did not check all required exclusions databases, and that nearly all providers in the OIG's review had different names on record with other state Medicaid programs. To warrant effective provider enrollment screening, the OIG has recommended that CMS ensure its contractors check exclusions databases, and review providers that submitted nonmatching owner names on enrollment records.

## III. ISSUES

The following issues may be examined at the hearing:

- What is CMS doing to reduce improper payments and payment error rates with the Medicare and Medicaid programs?

- What steps has CMS taken to enhance program integrity when enrolling providers into Medicare and Medicaid?

- How is CMS ensuring that terminated providers are no longer enrolled in one Medicaid program and other state programs?

- What progress has CMS made on the numerous unimplemented recommendations made by HHS OIG and GAO?

## IV. STAFF CONTACTS

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