Testimony Before the United States House of Representatives
Committee on Energy and Commerce:
Subcommittee on Oversight and Investigations

Medicare and Medicaid Program Integrity: Combatting Improper Payments and Ineligible Providers

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May 24, 2016

10:15 a.m.

Location: Rayburn House Office Building, Room 2322

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Good morning, Chairman Murphy, Ranking Member DeGette, and other distinguished Members of the Subcommittee. Thank you for the opportunity to appear before you to discuss improper payments in Medicare and Medicaid and the role that improved provider enrollment safeguards can play in protecting these programs.

OIG's mission is to protect the integrity of Department of Health and Human Services (HHS) programs and operations as well as the health and welfare of the people HHS serves. The 2014 combined expenditures for Medicare and Medicaid amounted to over one trillion dollars, and the programs served 120 million beneficiaries. OIG protects the integrity of these programs and others through robust audits, evaluations, investigations, enforcement actions, and compliance efforts.

To ensure that these essential programs can continue to serve our nation's most vulnerable populations well into the future, we must foster their sound financial stewardship. Reducing improper payments to providers is a critical element in protecting the financial integrity of the Medicare and Medicaid programs. Although not all improper payments are fraud, nor even overpayments, all improper payments pose a risk to the financial security of these programs. The estimated levels of improper payments in these programs indicate that HHS must remain vigilant in its efforts to pay the right provider the right amount for the right service. In its Fiscal Year (FY) 2015 Agency Financial Report (AFR), HHS reported the estimated improper payments for Medicare and Medicaid to be approximately $88.8 billion.

One way to protect Medicare and Medicaid from improper payments is to have strong enrollment safeguards to prevent ineligible providers from ever entering the program and to identify those with whom HHS does business. The Centers for Medicare & Medicaid Services (CMS) and States can prevent inappropriate payments, protect beneficiaries, and reduce time-consuming and expensive "pay and chase" activities by ensuring that providers engaging in fraudulent or abusive activities are not allowed to enroll in Medicare and Medicaid. Of course, this vigilance must be balanced with the need to maintain a relatively burden-free system for eligible providers.

My testimony today focuses on how HHS's improper payment rates did not meet targets as well as insights into the implementation of the new provider enrollment safeguards authorized by the Patient Protection and Affordable Care Act (ACA) to better screen providers in an effort to protect Medicare and Medicaid from paying fraudulent and abusive providers.

IMPROPER PAYMENT RATES INDICATE NEED TO BETTER PROTECT MEDICARE AND MEDICAID

Medicare and Medicaid accounted for $88.8 billion, or almost 99 percent, of the $89.8 billion in improper payments that HHS reported in its FY 2015 AFR. Traditional Medicare fee-for-service alone accounted for $43.3 billion, or almost one-half, of the improper payments that HHS reported. Medicaid improper payments totaled an additional $29.1 billion. OIG has identified reducing improper payments as an organizational priority necessary to ensuring the long-term health of HHS programs, especially Medicare and Medicaid.

To improve accountability for the administration of funds, Federal agencies are required to annually report information on the agencies' improper payments to the President and Congress. For FY 2015, HHS did not fully comply with these reporting requirements. OIG has looked into HHS's noncompliance with these requirements for the Medicare and Medicaid programs and has issued annual reports on the topic since 2012. Two findings from the most recent report are described below.

HHS's Error Rate Percentage for Medicare Fee-for-Service Exceeded 10 Percent

To comply with the Improper Payments Elimination and Recovery Act of 2010, an agency must report an improper payment rate of less than 10 percent (a statutorily required target level) for each program determined susceptible to significant improper payments. HHS did not meet this requirement as it reported an estimated improper payment rate for the Medicare Fee-for-Service program of 12.1 percent in FY 2015. Although Medicare Fee-for-Service improper payments exceeded the 10 percent threshold, the error rate decreased 0.6 percentage points from its estimated FY 2014 level of 12.7 percent.

HHS Did Not Meet All Goals for Reducing Improper Payments

In FY 2015, HHS did not meet its established improper payment targets for four programs – Medicare Advantage; Medicaid; Children's Health Insurance Program (CHIP); and Child Care Development Fund. In FY 2014, HHS set FY 2015 targets of 8.5 percent for the Medicare Advantage program and 6.7 percent for Medicaid. However, the actual improper payment rates for FY 2015 were 9.5 percent for Medicare Advantage (1 percentage point over the goal) and 9.8 percent for Medicaid (3 percentage points over the goal).

Primary Causes of Improper Payments and Plans for Reducing Them

In its FY 2015 AFR, HHS attributed about 69 percent of Medicare Fee-for-Service improper payments to errors associated with insufficient documentation and the remaining improper payments to medical necessity errors (about 17 percent) and administrative or process errors (about 14 percent). HHS said that the primary reason for Medicaid improper payments relates to States' difficulties bringing their systems into compliance with new requirements, including requiring screening of providers under a risk-based process prior to enrollment.

HHS described a variety of corrective actions it is taking to address improper payments in both the Medicare and Medicaid programs. For example, in the Medicaid program, HHS has engaged with States to proactively address issues identified in their Corrective Action Plans, facilitated national best practice calls to share ideas across States, offered ongoing technical assistance, and provided additional guidance, as needed.

For our part, OIG has long been at the forefront of measuring, monitoring, and recommending actions to prevent improper payments, including developing the first Medicare payment error rate in 1996, a time when there were few error rate models in Government. In addition to reviewing and reporting on HHS's annual improper payment information, OIG audits, evaluations, and investigations identify improper payments for specific services and items, assess internal control and payment vulnerabilities, and make recommendations to prevent future improper payments. For example, we found that hospices inappropriately billed Medicare over $250 million for general inpatient care and made recommendations to CMS, such as conducting prepayment reviews, that may help prevent improper payments. In the FY 2015 AFR, HHS reported that the improper payment rate for home health care claims increased to 59 percent, up by 7.57 percentage points since the last reporting period. Considering this statistic, and the results of prior OIG work, home health care is an area ripe for corrective action and reducing improper payments. In fact, we have audits underway to determine whether home health agencies across the country complied with Medicare requirements.

One key component of a strategy for minimizing improper payments is to take steps to ensure that only eligible providers are allowed to enroll in the Medicare and Medicaid programs. Provider enrollment safeguards are important tools in helping prevent improper payments. My comments on provider enrollment safeguards will highlight four OIG reports, three of which are being released to this Subcommittee today. As mentioned, the ACA strengthened provider enrollment by expanding who gets screened and how they get screened. These reports will inform today's conversation and enhance our combined efforts to ensure that the Medicare and Medicaid programs maximize the valuable tools the ACA provided.

PROVIDER ENROLLMENT IS A CRITICAL SAFEGUARD

Preventing ineligible providers from entering the Medicare and Medicaid programs not only reduces improper payments, but also prevents patient harm. Unfortunately, there are numerous examples of Medicare and Medicaid providers causing significant harm to patients. One such example includes an oncologist with multiple facilities who administered aggressive cancer treatments and other therapies to patients who did not need them to increase the provider's billings to Medicare. The unnecessary therapy and excessive medications led to significant health problems for a number of patients. Another example includes a number of dentists in a pediatric dentistry company. These pediatric dentists performed medically unnecessary dental services, including baby root canals, on young children covered by Medicaid. These dental facilities did not let parents accompany their children, placed children in unreasonable confinement, and caused significant physical pain to this vulnerable population of children.

Strong provider safeguards at the beginning of the enrollment process and ongoing verification to ensure that enrolled providers continue to meet Medicare and Medicaid requirements allow CMS to better protect beneficiaries from harm and reduce improper payments. Through the ACA, Congress provided CMS and States the authority for enhancements to the enrollment screening process.

ACA authorized additional screening tools designed to strengthen provider enrollment

The ACA strengthened provider enrollment processes for Medicaid and Medicare by expanding who gets screened and how they get screened. The ACA screening requirements, as implemented in regulation, apply not only to the provider, but also to all those who have an ownership or controlling interest in the provider. Additionally, the ACA authorized enhanced screening tools, including verifying provider information, placing providers in risk categories, increasing site visits, and requiring fingerprinting. In 2011, CMS began assigning providers to one of three risk categories: limited, moderate, or high risk. The extensiveness of provider screenings depends on provider risk categories. Providers assigned to the high-risk category are subject to a more extensive review than those in the lower-risk categories. Chart 1 provides a description of what screening is required for each risk category.

Chart 1: ACA screening requirements for each risk category

Type Of Screening Required	Limited	Moderate	High
Verify any provider/supplier-specific requirements established by Medicare and Medicaid	X	X	X
Conduct license verifications	X	X	X
Check databases (to verify Social Security Number; the National Provider Identifier; the National Practitioner Data Bank licensure; an OIG exclusion; taxpayer identification number; death of individual practitioner, owner, authorized official, delegated official, or supervising physician)	X	X	X
Conduct unscheduled or unannounced site visits		X	X
Check fingerprint-based criminal history records			X

Implementation by States and CMS of this stronger, risk-based approach needs improvement to truly strengthen provider enrollment in Medicaid and Medicare. OIG has identified a number of opportunities for States' Medicaid programs and CMS to prevent ineligible providers from enrolling in Medicaid and Medicare, as described below. CMS concurred with all of our recommendations related to working with State Medicaid Agencies to strengthen provider enrollment, as well as our provider enrollment recommendations for Medicare.

State Medicaid Agencies should fully implement ACA screening tools

Implementing the ACA required screening activities is critical to safeguarding the Medicaid program as it is expanded to serve more beneficiaries. The ACA requires States to more uniformly screen providers according to the risk for fraud, waste, and abuse that they pose to Medicaid. In addition, to help ensure that CMS and State Medicaid agencies identify potentially fraudulent providers prior to their initial enrollment in Medicaid, providers must disclose the identity of any person or entity who has ownership or controlling interest.

However, when reviewing moderate- and high-risk providers, OIG found that State implementation of ACA screening procedures is incomplete. States with incomplete screening activities enrolled thousands of providers categorized as posing a high or moderate risk to Medicaid without conducting fingerprint-based criminal background checks. This leaves the Medicaid program vulnerable to providers who may be ineligible or who may defraud the program and harm patients in the process.

Some States recently reported incomplete implementation of fingerprint-based criminal background checks and site visits. Specifically, 37 States reported not having fingerprint-based criminal background checks while waiting for CMS to require them. CMS did not require fingerprint-based criminal background checks until June 2015, more than 4 years after the other Medicaid enhanced provider screening activities went into effect. In addition, 11 States reported that they had not implemented site visits, which were required during the period reviewed.

OIG also uncovered problems with provider ownership disclosure. For States to identify potentially fraudulent providers, as well as those that may be associated with excluded individuals or entities, State Medicaid agencies must be aware of those with whom they are doing business. Yet, OIG found that few State Medicaid agencies requested that providers disclose all Federally required ownership information. In addition, 14 State Medicaid agencies reported not verifying the completeness or accuracy of required provider ownership information. Additionally, OIG found that 14 State Medicaid agencies reported not confirming that individuals or entities that providers disclosed as owners were not excluded from other State Medicaid agencies.

OIG Recommends

- CMS assist States in fully implementing the tools provided to them through the ACA. Specifically, States should implement fingerprint-based criminal background checks for high-risk providers and conduct site visits.
- CMS work with State Medicaid agencies to improve the collection and verification of provider ownership information to ensure completeness and accuracy.

CMS should do more to strengthen ACA enhanced enrollment safeguards in Medicare

To fully benefit from the new authorities that the ACA provided, CMS needs to strengthen implementation of enhanced enrollment screening in Medicare. For instance, OIG found gaps in CMS contractors' verification of key information on enrollment applications that could leave Medicare vulnerable to ineligible providers. OIG also found that CMS contractors were inconsistent in applying site visit procedures and using site visit results for enrollment decisions. The purpose of site visits is to determine whether a provider is operational and meets all applicable Medicare standards. However, OIG found that contractors approved hundreds of applications where site visit inspectors found providers to be nonoperational. We followed up with one contractor to determine under what circumstances it would approve enrollment with an

unfavorable site visit result. The contractor reported that it had not reviewed the site visit results in some cases, should have conducted more research on the provider location in others, or may have provided an incorrect location for the site visit. OIG also found that, site visit inspectors were sometimes inconsistent in their determination of whether a site was operational and sometimes provided contradictory information on site visit forms.

Despite these gaps, CMS achieved some positive outcomes as a result of the new screening tools. For example, when CMS revalidated current providers' enrollment using the new screening tools, OIG found that the number of revocations and deactivations substantially increased.

While there are some positive results from the new screening tools, OIG has identified several potential vulnerabilities in the enhanced enrollment process. To address these vulnerabilities and prevent ineligible providers from enrolling in Medicare, OIG recommends that CMS take practical steps to ensure effective oversight of enrollment data to ensure that contractors are performing their activities appropriately and that enhancements are producing intended results.

OIG Recommends

- CMS monitor contractors to ensure they are verifying information on enrollment applications.
- CMS improve the execution and use of site visits by:
    - revising site visit forms so that they can be more easily used by inspectors,
    - improving quality assurance oversight and training of site visit inspectors, and
    - ensuring that contractors are appropriately considering site visit results when making enrollment decisions.

CMS must improve Medicare and Medicaid provider data systems

OIG has a history of work pointing to problems in CMS's Medicare enrollment data system, the Provider Enrollment, Chain and Ownership System (PECOS). The information in PECOS should aid CMS in tracking enrollment and revalidation trends as well as to help determine whether CMS contractors are abiding by program requirements. However, OIG has found PECOS to be incomplete and inaccurate. Additionally, OIG has found inaccuracies in a separate database that CMS established for storing information about providers terminated from the Medicare and Medicaid programs. The database is meant to assist State Medicaid agencies in denying enrollment to providers who have been terminated from Medicare or by another State Medicaid agency.

OIG has historically found PECOS data to be incomplete, inconsistent and inadequate. In 2013, OIG found that provider data were inconsistent between the National Plan and Provider Enumeration System and PECOS for 97 percent of records. Addresses, which are essential for contacting providers and identifying trends in fraud, waste, and abuse, were the source of most inaccuracies and inconsistencies. Also, OIG recently found that PECOS did not contain all the information needed for CMS to effectively oversee whether its contractors are performing their activities appropriately and that enhancements are producing intended results. OIG found that shortcomings in PECOS rendered CMS unable to leverage data to determine whether enhancements were strengthening provider enrollment.

More recently, OIG has also found vulnerabilities in the accuracy of provider ownership information within PECOS. Specifically, we compared provider ownership names in PECOS with names that State Medicaid agencies had on file for the same providers. We found that for nearly all providers in our review, owner names in PECOS did not match those on record with the State Medicaid agencies. This means that Medicare and Medicaid information for the same providers does not match. Further, when we compared PECOS data with provider ownership names that we collected directly from providers, we found that over three-quarters of them did not match.

An example helps illustrate the issues we found with provider enrollment information. When we asked for ownership names from a provider enrolled in both Medicare and Medicaid, the provider reported having 12 owners. In the State Medicaid agency's database, this same provider was listed as having 63 owners. And finally, Medicare's PECOS database listed the provider with 14 owners. Most of the 12 owners reported to OIG did not even match those listed with Medicaid or Medicare.

The prevalence of nonmatching owner names raises concern about the completeness and accuracy of information about Medicare providers' ownership in PECOS, and in State databases. If PECOS does not accurately and completely capture provider ownership information for Medicare providers, CMS does not know exactly with whom it is doing business, and its ability to provide adequate oversight of the Medicare program is compromised. High-quality PECOS data are equally important to State Medicaid agencies. To streamline the enrollment process and save resources, States are allowed to use Medicare screening results – assuming the provider is also enrolled in Medicare – rather than screening a provider again for Medicaid. However, many States reported that they did not take advantage of this option because of concerns about the completeness and accuracy of the PECOS data.

OIG also found weaknesses in the CMS process for collecting and sharing data on providers terminated from Medicaid for reasons of quality, integrity, or fraud. Specifically, there is not a comprehensive CMS data source for identifying all provider terminations for cause. The ACA required CMS to establish a process to make available to State agencies information about

providers terminated from the Medicare, Medicaid, and CHIP programs so that States do not enroll providers who have been terminated in other States and can identify those enrolled providers who are required to be terminated. To implement this requirement, CMS established a central database that allows State Medicaid agencies to voluntarily report providers whom the State agencies terminated for cause from their programs and to retrieve information about providers who were terminated for cause by Medicaid programs in other States. We found that not all State Medicaid agencies were reporting to the database and that not all of the submitted records met the CMS definition of a for-cause termination.

The lack of this comprehensive database allows providers terminated in one State to continue participating in other States' Medicaid programs. OIG found that 12 percent of providers who were terminated for cause by State Medicaid agencies in 2011 continued to participate in other State Medicaid programs as of January 2012, notwithstanding the requirement that such providers be terminated in all States. About half of these providers remained listed as participating in Medicaid in other States until as late as January 2014, and about one-third of these participating providers received payments for services rendered to Medicaid beneficiaries after the providers' terminations for cause.

OIG Recommends

- CMS ensure that PECOS includes data that relate to the enhancements implemented for the provider enrollment process and that contractors enter all required data.
- CMS enable States to substitute Medicare screening data by ensuring the accessibility and quality of PECOS data.
- CMS require each State Medicaid agency to report all terminated providers.

To promote further efficiencies, we recommend that CMS develop a central system for States to submit and access results from other States. CMS could eventually consider creating a consolidated enrollment system that covers both Medicare and Medicaid. A joint enrollment system would reduce duplication and inconsistency across government programs and would also reduce the burden on providers. Providers would no longer have to separately provide enrollment information, including ownership information, to CMS and to their respective States' Medicaid programs.

CONCLUSION

We appreciate the Subcommittee's interest in these important issues. Increased attention to CMS improper payments and provider enrollment safeguards will help keep our Medicare and Medicaid programs safe and secure, while protecting beneficiaries from patient harm and ensuring that taxpayer money is appropriately spent. To that end, we continue to urge CMS to fully address OIG's recommendations related to improving provider enrollment safeguards. While we are encouraged by CMS's commitment to strong provider enrollment safeguards, our work has demonstrated that more could be done to strengthen the implementation of enhanced provider screening in Medicare and to fully implement enhanced provider screening in all State Medicaid agencies. Until such time, these programs are not as protected as they could be from ineligible providers who intend to defraud the program and potentially harm beneficiaries in the process.

OIG is encouraged that CMS concurred with all of our recommendations referenced in this testimony and stated that it is strongly committed to program integrity efforts in Medicare and Medicaid. We look forward to continuing to work with CMS to implement all of the recommendations expeditiously so that CMS can take maximum advantage of the array of tools afforded to it by the ACA to protect Medicare and Medicaid resources and the beneficiaries these programs serve.

OIG believes it is critical that we continue to conduct effective oversight to ensure that funds are spent appropriately and that steps are taken to improve the quality of care for Medicare and Medicaid beneficiaries. We have a substantial body of Medicare- and Medicaid-related work, both underway and planned, to ensure that beneficiaries are protected from harm and taxpayer dollars are spent for their intended purposes.

Thank you again for inviting OIG to speak with the Subcommittee today on improper payments in Medicare and Medicaid and the role that improved provider enrollment safeguards can play in reducing them. We hope that our work and this testimony will assist you in your oversight efforts to protect these programs.