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Medicaid Oversight: Existing Problems and Ways to Strengthen the Program

Testimony of:

Ann Maxwell
Assistant Inspector General
Office of Evaluation and Inspections
Office of Inspector General
Department of Health and Human Services

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Ann Maxwell
Assistant Inspector General for Evaluation and Inspections
Office of Inspector General, U.S. Department of Health and Human Services

Good morning, Chairman Murphy, Ranking Member DeGette, and other distinguished Members of the Subcommittee. I am Ann Maxwell, Assistant Inspector General for Evaluation and Inspections in the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS or Department). Thank you for the opportunity to appear before you to discuss existing fraud, waste, and abuse in Medicaid and ways to strengthen the program.

Created by statute in 1976, OIG remains a nonpartisan body of evaluators, auditors and investigators, deployed across the nation, to help assess and protect the integrity of Federal health and human services programs enacted by Congress. We remain committed to working with our stakeholders to achieve our shared goals of protecting patients and the taxpayer-funded programs they rely on from fraud, waste, and abuse, and promoting efficient and effective program operations.

Protecting Medicaid from fraud, waste, and abuse is an urgent priority because of its impact on the health of vulnerable individuals and its fiscal impacts on Federal and State spending. As of September 2016, more than 74 million individuals were enrolled in Medicaid, and total Medicaid spending for fiscal year (FY) 2016 was $574 billion. Thus, achieving this goal is critically important. OIG has consistently identified effective administration and strengthening the program integrity of Medicaid as among the top management challenges facing HHS.

The Office of Inspector General's Strategy for Medicaid Oversight

OIG advances its core mission of protecting the integrity of HHS programs, including Medicaid, and the people they serve by working to prevent and detect fraud, waste, and abuse. OIG offers recommendations to improve program integrity and the efficiency and effectiveness of programs and operations. When misconduct is identified, OIG takes appropriate enforcement action.

We accomplish this by focusing on the core program integrity principles of prevention, detection, and enforcement. On the basis of our experience overseeing Medicaid and other health and human services programs in the Department's $1 trillion portfolio, we know that these programs can and should be designed and operated to minimize fraud, waste, and abuse by following these same principles. Programs, and those who are accountable for their success, need effective tools (i) to prevent fraud, waste, and abuse from occurring in the first instance – such as effective gatekeeping to prevent untrustworthy individuals and entities from accessing Federal funds, risk assessment capabilities, and sound management practices; (ii) to detect fraud, waste, and abuse – through access to and effective use of high-quality data and sharing of information about potential problems; and (iii) to address problems that are detected – such as through enforcement or corrective actions.

Program Integrity Principles
Prevent – Know Who You Are Doing Business With
Detect – Identify Fraud, Waste, and Abuse in a Timely Manner
Enforce – Take Appropriate Action to Correct Problems and Prevent Future Harm

OIG operationalizes our mission by conducting audits, evaluations, and investigations, and using data analytics to identify problems or program risks; recommending improvements to address problems and prevent their recurrence; holding wrongdoers accountable; and providing guidance and tools to help well-intended participants in HHS programs to comply with the rules. OIG has an additional, unique role in Medicaid program integrity. We administer and oversee Federal grants to State Medicaid Fraud Control Units (MFCU) and assess each MFCU's performance and compliance with Federal requirements. MFCUs investigate and prosecute Medicaid provider fraud and patient abuse or neglect under State law and receive referrals of credible allegations of fraud from State Medicaid agencies. OIG investigators often partner with MFCUs on joint investigations of Medicaid fraud.

Medicaid's Existing Program Integrity Challenges and Recommendations for Improvement

For many years, OIG has designated the Medicaid program a Top Management Challenge. Our evaluations, audits, and investigations have consistently found that Medicaid and the patients that rely on it are not as protected as they could be from fraudulent institutions, agencies and providers that intend to defraud the program, and potentially harm patients. Beyond OIG, the Centers for Medicare & Medicaid Services (CMS), State Medicaid agencies, and managed care contractors have an essential responsibility to ensure Medicaid program integrity.

Today, I would like to focus on recent challenges facing Medicaid and ways we believe States, CMS, and providers could address these challenges. I will frame my testimony by the core program integrity principles of prevention, detection, and enforcement.

Prevention: Preventing bad actors from participating in Medicaid is critical, but Medicaid programs sometimes fail to do so effectively

States have not fully enacted enhanced provider screening. The most effective way to prevent fraud is to keep bad actors out of the program to begin with. However, States are not screening high-risk providers with all of the tools at their disposal. We found that in 2015, 4 years after they were required to do so, 37 States reported that they were not conducting fingerprint-based criminal background checks. In addition, 11 States were not conducting site visits, which were also required. This leaves Medicaid vulnerable to providers who may be ineligible or who may defraud the program and harm patients.

OIG has also raised concerns about the varying standards, and in some cases minimal vetting, for Medicaid personal care services providers. This leaves the Medicaid program vulnerable to financial fraud. Even more concerning, it leaves Medicaid patients vulnerable to abuse and neglect and puts patients and the program at risk

Personal Care Services Patient Harm

In Illinois, a concerned neighbor found a Medicaid beneficiary in an incoherent state. The beneficiary was ultimately hospitalized for multiple days as a result of neglect. An investigation revealed that the beneficiary's personal care attendant had not been there in over a week, yet the attendant had been submitting claims to the Illinois Home Services Program.

from individuals who should not be trusted to render care. OIG and the MFCUs have uncovered a disturbingly high number of cases of fraud and abuse by Medicaid personal care services providers. While it is important to give patients the flexibility to receive care in their homes, CMS and States must to do more to balance this goal with the real risks of harm to patients and potential fraud.

States also are not collecting and maintaining accurate ownership information about the providers they are paying. For example, when we compared Medicaid and Medicare ownership data for the same provider, Medicaid had 63 owners listed and Medicare's database had 14 owners listed. This same provider reported to OIG that it had 12 owners (and most of the 12 owners did not match those listed with Medicaid or Medicare). OIG has recommended that CMS work to develop an integrated database with provider information that Medicare and all State Medicaid programs could use. This could provide a "one-stop shop" for Federal and State program officials and for providers – reducing burden and duplication in reporting, verifying, and updating information. This also would provide the opportunity for more efficient and effective oversight to ensure that all programs have accurate and complete data to support fraud prevention and detection.

Program Integrity Principle: Know who you are doing business with and refuse business with bad actors.

OIG Recommendations: CMS should improve provider screening by working with States to implement fingerprint-based criminal background checks for high-risk providers, conduct site visits, and maintain accurate provider ownership information.

Improper payment rates indicate the need to better protect Medicaid. Estimated Medicaid improper payments totaled $29.1 billion in FY 2015. To comply with the Improper Payments Elimination and

Recovery Act of 2010, an agency must report an improper payment error rate that is at or less than the target error rate established for the fiscal year. The Medicaid target improper payment rate for FY 2015 was 6.7 percent. HHS did not meet this requirement and had an estimated improper payment rate of 9.8 percent.

Program Integrity Principle: Implement effective safeguards and sound management to prevent waste.

OIG Recommendation: HHS should work to improve payment accuracy.

Detection: Data is an essential tool for detecting fraud, waste, and abuse; however, national Medicaid data has deficiencies that hinder timely and accurate detection, and CMS and States do not always use data effectively

Proper oversight includes the capacity to detect problems in real time. This can help prevent inappropriate payments, protect patients, and reduce time-consuming and expensive "pay and chase" activities. Detecting problems is a shared responsibility for all actors in the Medicaid program: CMS, States, managed care contractors, and providers.

CMS does not have complete and accurate data needed to effectively oversee the Medicaid program. Without accurate claims data, adequate oversight of the Medicaid program is compromised. OIG has a history of work that points to the incompleteness and inaccuracy of CMS's national Medicaid database, the Transformed Medicaid Statistical Information System (T-MSIS). Without a national dataset, CMS is

unable to identify nationwide trends and vulnerabilities. This hampers program integrity efforts because fraud does not respect State boundaries.

Program Integrity Principle: Complete, accurate, and relevant data are essential to program integrity.

OIG Recommendations: CMS should establish a deadline for when national T-MSIS data will be available for multi-State program integrity efforts, and CMS and States should improve the accuracy of information about which providers are participating in Medicaid managed care.

Inaccurate information about providers in Medicaid managed care plans inhibits fraud detection and patient care. Accurate rosters of providers participating in managed care plans are essential for State and Federal oversight to detect potential fraud, waste, and abuse, as well as for patients to obtain health care. However, we found vulnerabilities in managed care organizations' data regarding their providers. Specifically, when we asked managed care organizations for a list of their providers, we found that 38 percent of them were not participating in the plan at the location listed in the State's Medicaid provider directory.

Program Integrity Principle: Complete and accurate information about providers is essential to program integrity.

OIG Recommendation: CMS should work with States to improve the accuracy of plan information and assess the number of providers offering care.

States are not ensuring that providers detect and repay overpayments in patient accounts. States must rely on providers to review credit balances in patients' accounts to detect overpayments and return them to the State. Medicaid credit balances occur when the reimbursement a provider receives

for services rendered to a Medicaid beneficiary exceeds the charges billed. We found providers sometimes failed to reconcile patient records with credit balances and report and return the associated Medicaid overpayments to State Medicaid agencies.

Program Integrity Principle: Detection of fraud, waste, and abuse is a shared responsibility.

OIG Recommendation: CMS should clarify that providers are expected to exercise reasonable diligence to identify, report, and return overpayments.

CMS and States could better use data analytics to detect providers with questionable billing patterns that may indicate fraud or harm. OIG has a history of work identifying providers who are outliers when compared to their peers either in terms of the number of patients or the amount billed. We refer to them as "questionable billers." While there is no clear evidence of fraud or abuse, patterns in the providers' behavior suggest a strong suspicion of fraud, waste, or abuse. One example of OIG's questionable-billing work is our evaluation of pediatric dentists in California. We found that 335 dental providers – representing 8 percent of California's general dentists and orthodontists – either billed for an extremely large number of services or provided certain services to an extremely large number of children. These services included pulpotomies – often referred to as "baby root canals" – and extractions. We referred those providers to the State and CMS for followup. CMS and States could do more to conduct similar analyses to OIG's to detect and followup on questionable billing that may signal fraud or abuse, especially where there is a risk of patient harm.

Program Integrity Principle: Use data analytics to detect potential fraud and patient harm and target oversight.

OIG Recommendation: CMS and States should increase monitoring of dental providers to address the questionable billing detected and to safeguard against future fraud.

Enforcement: Federal and State enforcement efforts have yielded billions of dollars in recovered funds and held thousands of wrongdoers accountable; however, CMS and States are not taking full advantage of their administrative enforcement authorities; and MFCUs lack a key authority

OIG works closely with our Federal and State partners to investigate and remediate fraud and abuse. In FY 2016, OIG investigative actions related to Medicaid resulted in 312 indictments, 348 criminal actions, and 308 civil actions. These Medicaid cases, some of which also involved Medicare, resulted in almost $3 billion in expected recoveries. We worked most of these cases jointly with MFCUs. OIG also excluded 3,635 providers and entities from Federal health programs in FY 2016.

Home Health Fraud

In a joint investigation with the District of Columbia MFCU, two owners of a home care agency were sentenced to 10 years in prison for health care fraud, money laundering, and other charges stemming from a scheme in which they and others defrauded the District of Columbia Medicaid program of over $80 million.

State MFCU investigations have a significant impact on Medicaid. In FY 2015, MFCUs collectively obtained 1,889 indictments, 1,553 convictions, and monetary recoveries of nearly $744 million. They also make program recommendations to their State Medicaid agencies on the basis of the vulnerabilities they uncover, thus also helping to prevent future fraud. However, more could be done by expanding a key authority for MFCUs to investigate patient abuse.

State Medicaid Fraud Control Units lack the authority to investigate and prosecute patient abuse or neglect in noninstitutional settings. While MFCUs can investigate and prosecute patient abuse or neglect in Medicaid-funded health care facilities and in board-and-care facilities, they do not have authority to pursue similar cases that occur in a home- or community-based setting, such as abuse or neglect by a personal care services attendant or in a clinician's office. MFCUs must instead refer any such complaints to local law enforcement, which may have less expertise in investigating patient abuse and neglect than MFCU staff. The current limitation on MFCU authority was logical when the program was established in 1978, at a time when Medicaid services were typically provided in an institutional setting. But the limitation has become outmoded as the delivery and payment for health services has increasingly shifted to in-home and community-based settings.

Program Integrity Principle: Ensure that enforcement bodies have sufficient authority to protect patients and the program. **OIG Recommendation:** MFCUs should be granted the authority to investigate and prosecute patient abuse or neglect in home- and community-based settings.

Federal and State enforcement efforts are necessary to keep fraudulent and harmful providers out of the program and to hold wrong-doers accountable. OIG has identified areas in which CMS and State Medicaid agencies are not taking full advantage of their administrative enforcement authorities.

Medicaid providers terminated from one State continued participating in other States. Failure to share data on terminated providers across States is inefficient, and worse, it puts programs and patients at unnecessary risk of fraud or harm. CMS established a database meant to assist State Medicaid agencies

in denying enrollment to providers who have been terminated for cause from Medicare or by another State Medicaid agency. Yet we found that 12 percent of providers who were terminated for cause from State Medicaid agencies in 2011 continued to participate in other State Medicaid agencies as of January 2012, many continued to participate as late as January 2014. Thanks to the support of your Subcommittee, and the Committee at large, beginning in 2018, State Medicaid agencies will be required to report to the terminated-provider database so we hope to see improvements in this area.

States did not always suspend Medicaid payments to providers suspected of fraud. When program officials have credible allegations of fraud, swift response is imperative. When we reviewed use of payment suspensions by several State Medicaid agencies, we found that some did not suspend Medicaid payments to all providers with credible allegations of fraud. For example, of the 81 providers with a credible allegation of fraud in Washington, the State Medicaid agency suspended Medicaid payments to only 33 of them.

Program Integrity Principle: All appropriate steps should be taken to protect the program.

OIG Recommendation: States should suspend Medicaid payments to providers when there are credible allegations of fraud.

Conclusion: Strong Program Integrity Will Always Be Critical

OIG has documented significant challenges in protecting Federal and State Medicaid dollars from fraud, waste, and abuse, and vulnerable populations from harm. In response, OIG and its State and Federal partners have focused their resources on Medicaid fraud, and OIG has made numerous

recommendations for strengthening Medicaid program integrity. Recognizing that Medicaid program integrity is a shared responsibility, OIG has made recommendations that offer suggestions for improvements to CMS and States, as well as the down-stream managed care entities that are often the first line of defense.

Regardless of the financial arrangements between the Federal and State governments, the Medicaid program can and should be designed and operated to minimize fraud, waste, and abuse by following core program integrity principles. Better protection of Medicaid now and in the future requires strengthening the ability to prevent fraud, waste, and abuse; detecting it quickly when it does occur; and swiftly holding wrongdoers accountable. It also requires continuous vigilance to keep up with changes in the environment and constantly evolving fraud schemes.

Thank you, again, for inviting OIG to speak with you on strengthening Medicaid program integrity. We appreciate the Subcommittee's interest. Continued emphasis on program integrity will help to protect Medicaid patients from patient harm and ensure that taxpayer money is appropriately spent.

We hope that our work and this testimony will assist you in your oversight efforts to protect Medicaid patients and all taxpayers from fraud, waste, and abuse.