



U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Testimony of:
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Hearing:
“Strengthening Medicaid Program Integrity and Closing Loopholes”

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Good morning, Chairman Pitts, Ranking Member Green, and other distinguished Members of the Committee. Thank you for the opportunity to testify about the efforts to reduce fraud, waste and abuse and to promote quality and safety in the Medicaid program.

Our mission at the Office of Inspector General (OIG) is to protect both the integrity of the Department of Health and Human Services' programs and operations as well as the health and welfare of the people the department serves. Overseeing the Medicaid program is a critical component of that mission. Medicaid spending totals almost \$500 billion, and the program serves more than 72 million individuals. OIG advances our mission through a robust program of audits, evaluations, investigations, enforcement actions, and compliance efforts.

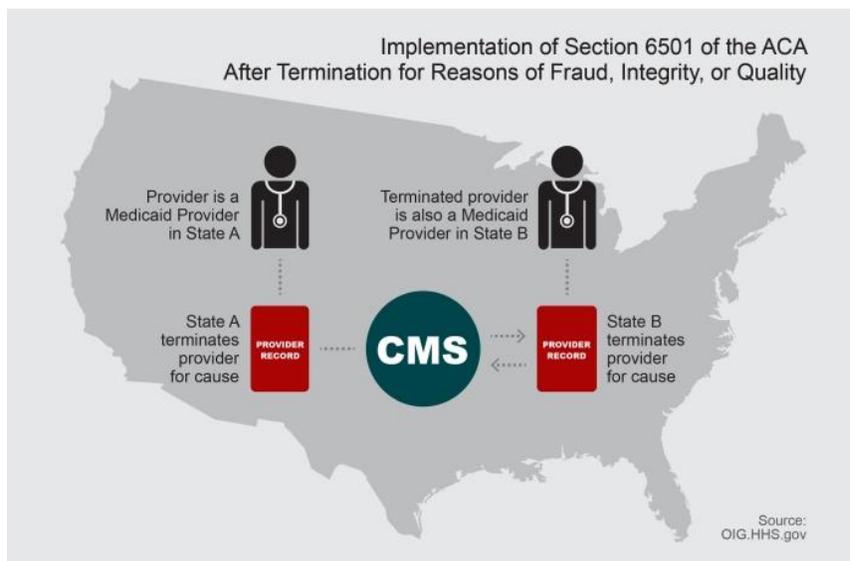
The Medicaid program provides medical assistance to low-income individuals and those with disabilities. The Federal and State governments jointly fund and administer Medicaid. At the Federal level, the Centers for Medicaid & Medicare Services (CMS) administers Medicaid. At the State level, each State administers its Medicaid program in accordance with a CMS-approved State plan. State Medicaid Fraud Control Units (MFCUs) play key roles in protecting the integrity of the Medicaid program. Among their responsibilities, MFCUs investigate and prosecute provider fraud and patient abuse and neglect. MFCUs must be single, identifiable entities of the State government and certified annually by OIG as meeting Federal requirements. Forty-nine States and the District of Columbia have established MFCUs. OIG's federal investigators also work closely with MFCUs on many criminal and civil cases involving Medicaid.

Protecting the integrity of Medicaid takes on a heightened urgency as expenditures and the number of beneficiaries served continue to grow. Many states and the District of Columbia are expanding Medicaid eligibility to include a larger group of qualifying adults pursuant to the Affordable Care Act (ACA) and Medicaid waivers. Further, States that have not expanded eligibility have also seen increases in Medicaid enrollment. OIG has a substantial portfolio of past, ongoing, and planned work addressing the Medicaid program.

As requested by the Committee, my testimony today will focus on three specific areas in need of corrective action within the Medicaid program, including terminated providers continuing to participate in and bill Medicaid, adequate safeguards being implemented to prevent fraud in personal care service and a lack of MFCUs in the U.S. territories.

Terminated Providers Continue to Participate in and Bill Medicaid

Prior to passage of the ACA, if a State terminated a provider's participation in its Medicaid program, the provider could potentially 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, the ACA broadly requires States to terminate a provider's participation in their Medicaid programs if that provider is terminated from another State Medicaid or Medicare program. CMS, in regulations, clarified that this requirement applies only to providers terminated "for cause" (i.e., for reasons of fraud, integrity, or quality).



Note: State A refers to the State that initiates a provider's termination for cause. State B refers to any other State where this provider is providing services or to where the provider could move.

OIG found weaknesses in the CMS process for sharing termination information among the States. The ACA requires 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 can identify those providers who are required to be terminated. To implement this requirement, CMS established a data-sharing process that allows State Medicaid agencies to voluntarily report to a central database providers whom the 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.

OIG also found that providers terminated in one State continued to participate in other States' Medicaid programs. Specifically, we found that 12 percent of providers who were terminated for cause from State Medicaid programs in 2011 continued to participate in other States'

Medicaid programs, 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.

Some of the challenges that States face include: not having a comprehensive data source for identifying all terminations for cause as well as difficulty differentiating such terminations from other administrative actions that a State reports. Of the 41 States that used managed care in 2012 to deliver Medicaid services, 25 did not require providers who participated via managed care to be directly enrolled with the State Medicaid agency. This further complicated said States' ability to terminate providers. If a State has not directly enrolled a provider, it cannot terminate that provider, and it may not even be aware that the provider is participating in its Medicaid program. Of the 295 providers who were reported by States as terminated for cause but who continued to participate in other States, 91 were not directly enrolled with the State Medicaid agencies.

To address these issues identified in our reports, we have recommended that CMS:

- Require each State Medicaid agency to report all providers terminated for cause.
- Ensure that the shared information contains only records that meet CMS's criteria for terminations for cause.
- Work with States to develop uniform terminology to clearly denote terminations for cause.
- Require that State Medicaid programs enroll all providers participating in Medicaid managed care.

CMS concurred with our recommendations and has stated that it is committed to improving Medicaid program integrity efforts.

Adequate safeguards to prevent fraud in Personal Care Services

Personal care services such as bathing, light housework, or meal preparation, allow many elderly people and those with disabilities or chronic or temporary conditions to remain in their homes rather than be placed in a nursing facility or other institutionalized care setting. Eligible beneficiaries can receive these services under Medicaid State plan options or waivers. The services must be provided at home or another approved location and follow a specific plan of care. These services are typically performed by care attendants.

OIG is committed to ensuring that personal care services provided under Medicaid have adequate safeguards to prevent fraud, waste, and abuse. Over the last decade, OIG has issued

numerous reports on the topic of personal care services and conducted numerous investigations involving personal care services fraud. A 2012 report entitled personal care services: *Trends, Vulnerabilities, and Recommendations for Improvement* synthesized our body of work and offered new and comprehensive recommendations to address vulnerabilities that we have identified. Our work in this area continues to demonstrate that significant problems remain.

OIG also found that payments for personal care services were improper because the services were not provided in compliance with State requirements, were unsupported by documentation, were provided during periods in which the beneficiaries were institutionalized and were provided by attendants who did not meet State qualifications. We have also found that existing program safeguards intended to prevent improper payments and ensure medical necessity, patient safety and quality have often been ineffective.

Through our reports, we made a number of recommendations to CMS to address the deficiencies we identified, including:

- Making qualification standards for care attendants more consistent.
- Requiring care attendants to be enrolled or registered with the State and requiring dates, times, and attendants' identities to be listed on claims to Medicaid.
- Expanding Federal requirements and guidance to reduce variation of requirements for claims documentation, beneficiary assessments, plans of care, and supervision of attendants across States.
- Issuing guidance to States regarding adequate prepayment controls.
- Assessing whether additional controls are needed to ensure that personal care services are allowed under program rules and are provided.
- Providing States with the data to identify overpayments when beneficiaries are receiving institutionalized care.

In response, CMS agreed that more needs to be done at the Federal and State levels to ensure appropriate billing for personal care services and has agreed to take a number of steps to address the recommendations made by OIG.

Medicaid Fraud Control Units

Another way that OIG helps protect Medicaid from fraud and abuse and Medicaid beneficiaries from harm is by overseeing State Medicaid Fraud Control Units (MFCUs). OIG evaluates MFCU operations, ensures that the MFCUs comply with grant requirements, compiles statistics on performance, and manages the awarding of Federal funds to them.

State MFCUs play the primary role for Medicaid in the investigation and prosecution of provider fraud and patient abuse or neglect in health care facilities. MFCUs, usually part of the State Attorney General's office, operate under an interdisciplinary model, employing attorneys,

auditors, and investigators, and are typically responsible for both the investigation and the criminal and or civil prosecution of cases. Each MFCU receives a 75 percent Federal match under the program; new MFCUs receive a 90 percent Federal match for an initial 3-year period. In fiscal year 2014, MFCUs employed 1,957 staff and spent over \$235 million in both Federal and State funds.

MFCUs reported a total of 1,318 criminal convictions for fiscal year 2014, including 956 for provider fraud and 362 for patient abuse or neglect. MFCU criminal and civil cases contributed to reported monetary recoveries of over \$2 billion for the fiscal year. This translates to a return on investment of \$8.53 in recoveries for each dollar expended in Federal and State funds.

MFCUs operate in 49 States and the District of Columbia. Under the Medicaid statute, all States – defined to include the District of Columbia and the five U.S. territories – are required to have a MFCU as a feature of their Medicaid State plan, unless the State receives a waiver from the Secretary. All five U.S. territories and the State of North Dakota do not maintain a MFCU.

The major barrier to establishing a MFCU in Puerto Rico and the other territories is the nature of Medicaid funding for the territories. Unlike Medicaid funding for the 50 States and the District of Columbia, the territories receive a capped appropriation to provide both Medicaid services and most administrative costs, which would include operation of a MFCU. Although the ACA provided a temporary increase in the amount of Medicaid funding to the territories, they routinely use the full amount of their capped appropriation for Medicaid services and essential administrative costs. This becomes a significant obstacle to the allocation of scarce Medicaid dollars to the establishment and operation of a MFCU.

The lack of a MFCU in Puerto Rico, the territory with the largest Medicaid program by far, is a particular concern. OIG believes that the addition of a MFCU in this jurisdiction is important to protect the program and its beneficiaries from fraud, and to protect residents of health care facilities from abuse or neglect. Puerto Rico has a total Medicaid enrollment of more than 1 million people, comparable to the Medicaid enrollment in many medium-size States. OIG has a significant investigative workload in Puerto Rico that includes over 117 criminal convictions and \$12 million in civil settlements from calendar year 2012 to date.

Legislation could remove the disincentive to establish MFCUs in the territories. This could be accomplished by exempting MFCU funding from the capped Medicaid appropriation. OIG believes that such a change would also be cost-efficient, especially in Puerto Rico. Current data demonstrate that MFCUs generate positive returns on investment. Puerto Rico officials have expressed interest to OIG in establishing a MFCU but have not been able to get approval for it.

Conclusion

We have a substantial body of Medicaid-related work, both underway and planned, to ensure that taxpayer dollars are spent for their intended purposes. This work will examine additional critical issues that were not discussed in my testimony today, such as eligibility determinations for the Medicaid expansion population, Medicaid payments for medical equipment and supplies, health care provider taxes, and Medicaid payments to managed care organizations

Given the growth of the Medicaid program, 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 Medicaid beneficiaries.

Thank you for the opportunity to testify about the Office of Inspector General's work in the Medicaid program.