U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
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Medicaid Fraud and Overpayments: Problems and Solutions

Testimony of:

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Good morning, Chairman Johnson, Ranking Member McCaskill, and distinguished Members of the committee. I am Brian P. Ritchie, Assistant Inspector General for Audit Services, U.S. Department of Health and Human Services. Thank you for your longstanding commitment to ensuring that the Medicaid program's 67 million beneficiaries are well served and the taxpayers' approximately $600 billion investment is well spent. I appreciate the opportunity to discuss the Office of Inspector General's work to combat fraud, waste, and abuse in Medicaid and what more can be done to secure the future of this important program.

Introduction

Medicaid spending represents one-sixth of the national health care economy, and Medicaid serves more people, including some of the Nation's most vulnerable individuals, than any other Federal health care program. Congress created the Office of Inspector General (OIG) for the U.S. Department of Health and Human Services (HHS or the Department) in 1976 as an independent body to oversee HHS programs. A key component of my office's mission is to promote integrity and efficiency in Medicaid and other Federal health care programs. While OIG does not directly operate the Medicaid program, through a nation-wide program of audits, evaluations, inspections, investigations, and enforcement actions, OIG has identified numerous vulnerabilities to program operations and offered specific recommendations to the Centers for Medicare & Medicaid Services (CMS) and its State partners for how to mitigate or eliminate those vulnerabilities and enhance the economy and efficiency of the Medicaid program going forward.

OIG shares the committee's commitment to protecting Medicaid from fraud, waste, and abuse and has an extensive body of oversight work in this area. Persistent challenges include high improper payment rates, inadequate program integrity safeguards, and beneficiary health and safety concerns. In our extensive experience combating various types of vulnerabilities in all regions of the country, across all provider types, regarding all classes of items and services, one program administration shortcoming has emerged as a consistent impediment to effective oversight. That shortcoming is the lack of a robust national Medicaid dataset that is complete, accurate, and timely. A complete, accurate, and timely Medicaid dataset would greatly facilitate Medicaid program operations and promote economy and efficiency.

Much program integrity work seeks to recover improper payments already made and reduce improper payments going forward. In FY 2017, projected improper Medicaid payments totaled about $59 billion. CMS must do more to ensure that Medicaid payments are made to the right provider, for the right amount, for the right service, on behalf of the right beneficiary.

My testimony addresses how to protect Medicaid and its program beneficiaries through the lens of OIG's core program integrity principles of prevention, detection, and enforcement. Enhanced data functionality offers cross-cutting benefits that would enhance prevention, detection, and enforcement to correct problems and prevent future harm.

Oversight of CMS's Efforts To Address Fraud and Overpayments in Medicaid

Complete and reliable national Medicaid data are necessary for effective program oversight and management and to detect bad actors.

The ability to detect problems in real time, or as close to real time as possible, enables effective oversight and can protect patients and help prevent improper payments. CMS, States, Medicaid managed care entities, and providers share the responsibility for detecting and addressing problems in the Medicaid program. The lack of national Medicaid data hampers the ability to quickly detect and address improper payments, fraud, waste, or quality concerns, both within States and across the Nation.

CMS must ensure the completeness and reliability of data in the Transformed Medicaid Statistical Information System.

Congress has recognized the value of enhanced Medicaid data, but more needs to be done to achieve the goal. Through the Balanced Budget Act of 1997, Congress mandated that States submit data to provide for a national Medicaid dataset. The Transformed Medicaid Statistical Information System (T-MSIS) is a joint effort by CMS and the States to address previously identified problems with national Medicaid claims and eligibility data. CMS's goals for T-MSIS are to improve the completeness, accuracy, and timeliness of Medicaid data.

CMS began testing T-MSIS with 12 volunteer States in 2011. T-MSIS builds on and replaces the Medicaid Statistical Information System. CMS initially set a goal for all States to submit T-MSIS data by July 2014. CMS subsequently extended that deadline several times. After multiple missed implementation deadlines, technological problems, competing priorities, and other implementation delays, as of May 2018, 49 States (all States except Wisconsin) and the District of Columbia had begun reporting data to T-MSIS, but concerns remain about the quality and completeness of the data reported.

OIG is concerned about whether the data will be actionable, as our work has identified numerous issues with the completeness and quality of the data. We found that States are not consistently submitting the same T-MSIS data elements, limiting the ability to make comparisons across all States. Despite CMS's attempts to further standardize meaning through a revised standard data dictionary, T-MSIS data elements may not mean the same thing across States. Different interpretations across States could result in data that is not comparable across different States.

Until CMS and States achieve full implementation, the Department must prioritize obtaining complete and reliable T-MSIS data. CMS must ensure that the same data elements are consistently reported and uniformly interpreted across States to best inform program management and oversight. To accomplish this, OIG recommends that CMS establish a deadline for when national T-MSIS data will be available for multi-State program integrity efforts. Without the prioritization motivated by a fixed deadline, some States and CMS may delay full implementation of T-MSIS to the detriment of Medicaid program integrity.

CMS should ensure that States report encounter data for all managed care entities.

Eighty percent of all Medicaid beneficiaries receive part or all of their services through managed care. For CMS and States to operate Medicaid effectively at both the Federal and State level, it is vital that T-MSIS include complete and accurate managed care encounter data. State Medicaid agencies contract with managed care entities to deliver health care services and perform certain administrative functions such as data collection and reporting. Most importantly, managed care entities are required to report medical claims data, known as encounter data, to States that then report the data to CMS via T-MSIS. Encounter data include detailed information about the services provided to Medicaid beneficiaries enrolled in managed care. Like fee-for-service Medicaid claims, encounter data are the primary record of services provided to Medicaid beneficiaries enrolled in managed care. The Society of Actuaries calls encounter data "the single most important analytical tool for health plans and health programs. Without accurate and timely data, it is not possible to analyze costs, utilization or trends; evaluate benefits; or determine the quality of services being provided."

OIG found that States' Medicaid managed care encounter data were incomplete. Reasons that States cited for their failure to report complete information included the inability to collect encounter data from some managed care entities and limitations in the State's data systems. CMS has made some progress in addressing this problem, including regulatory requirements, guidance, and an ongoing data quality monitoring review of submissions of encounter data through T-MSIS. However, the Department must do more to ensure that the data necessary to support program integrity in Medicaid managed care are complete, accurate, and timely. Thus, OIG continues to recommend that CMS ensure that States report encounter data for all managed care entities.

The lack of quality national Medicaid data hampers enforcement efforts.

States and the Federal Government need a high-quality Medicaid dataset to effectively administer the Medicaid program. National data can be used to identify fraud schemes and other vulnerabilities that cross State lines. Even localized schemes are more easily concealed absent national data. Aberrant utilization or spending patterns may not appear problematic until compared against another State's experience or national averages. Identifying such schemes in one State can alert other States to patterns of fraudulent or abusive practices that

may be occurring in their jurisdiction. This information can generate referrals to State law enforcement agencies like the State Medicaid Fraud Control Units or joint investigations across State lines. Complete and reliable data are critical to identifying improper payments and to enable Federal and State enforcement efforts to keep fraudulent and harmful providers out of Medicaid and hold bad actors accountable. National Medicaid data holds the promise of supporting and amplifying enforcement efforts. We have seen this potential for data to strengthen the effectiveness of enforcement efforts. For example, in July 2017, OIG and its law enforcement partners conducted the largest ever National Health Care Fraud Takedown. Sophisticated data analytics played an indispensable role in enabling the success of this takedown. The end result—charges against more than 400 defendants across 41 Federal districts for their alleged participation in health care fraud schemes involving about $1.3 billion in false billings—protected the programs and sent a strong signal that theft of taxpayer funds will not be tolerated. Notably, 120 defendants, including doctors, were charged for illegally prescribing and distributing opioids and other dangerous drugs, and 295 providers were served with exclusion notices for conduct related to opioid diversion and abuse. A concurrent data brief underscored the magnitude of the opioid problem, identifying concerns about extreme use and questionable prescribing of opioids in Medicare Part D. That is the potential of data— leveraged by skilled auditors, investigators, and analysts—to protect the program, to protect beneficiaries, and to bring bad actors to justice.

Unfortunately, we currently cannot replicate this type of analysis in Medicaid. Development of a national Medicaid dataset would promote economy and efficiency in Medicaid by facilitating timely detection of and rapid response to improper payments and fraud. Quality national Medicaid data provide visibility into payments and offer the transparency necessary to determine whether Medicaid is paying the right amount, to the right provider, for the right service, on behalf of the right beneficiary. OIG can harness the power of accurate, timely, and complete data not only to support enforcement efforts, but also to identify vulnerabilities to avoid, and best practices to replicate with the ultimate goal of promoting value and improving quality of care. While CMS and States have made important strides to improve Medicaid data, more can be done to ensure T-MSIS achieves its full potential. Ultimately, T-MSIS will be only as useful as the data it receives. This is why CMS must ensure the completeness and reliability of T-MSIS data and improve provider enrollment data to prevent unscrupulous providers from enrolling in Medicaid and gaining access to Medicaid funds and beneficiaries. Such data are essential to the efficiency, effectiveness, and integrity of Medicaid. Savings achieved through improved program integrity and reduced improper payments could fund improved services for beneficiaries.

Leveraging Tools To Prevent Fraud

Although OIG has extensive experience conducting investigations and enforcement actions to recoup improper payments and exclude fraudulent providers, the first pillar of our program integrity strategy is prevention. Keeping bad actors and ineligible beneficiaries out of the program on the front end prevents improper payments. Complete and reliable data can help

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States achieve this front-end integrity. By knowing with whom they are doing business, States can enroll trusted providers and avoid paying, or having their beneficiaries endure subpar services from, providers who do not deserve such trust.

States have not fully enacted enhanced provider screening.

To ensure that Medicaid pays the right provider, the program must be able to identify the providers with whom it does business, and keep bad actors out of the program. Preventing bad actors from entering the Medicaid program not only reduces improper payments, but also protects patients from harm.

States must screen providers commensurate with the potential risk for fraud, waste, and abuse that they pose to Medicaid, with high-risk providers requiring more intense scrutiny. However, States often fail to effectively screen high-risk providers, including key safeguards like conducting fingerprint-based criminal background checks and site visits. Previous OIG work found that many States had yet to implement fingerprint-based criminal background checks and site visits. OIG made recommendations to CMS to assist States with implementing these activities. CMS concurred with OIG's recommendations and has provided assistance to States. However, CMS has extended the deadline for implementation of fingerprint-based criminal background checks, indicating that States have not yet resolved the vulnerability inadequate background check procedures pose for provider enrollment. OIG has ongoing work to provide a status update on implementation of fingerprint-based criminal background checks.

CMS must ensure that States timely and fully implement these critical safeguards lest bad actors defraud Medicaid of millions of dollars and endanger beneficiaries. For example, in Virginia two individuals conspired to defraud a special caregiver program covered under Medicaid by submitting timesheets for payment for services that were never rendered. One of the conspirators was actually incarcerated on the days when he falsely claimed to have provided Medicaid services. Better compliance with criminal background check requirements can help prevent similar fraud schemes.

In another example, in North Carolina a mental health facility operator submitted fraudulent Medicaid claims for services for beneficiaries with developmental disabilities. The operator submitted at least $2.5 million in fraudulent claims using stolen beneficiary information from a defunct company that he previously co-owned, and he received more than $2 million in reimbursements from Medicaid. State site visits could have revealed that the beneficiaries never actually received services.

These cases exemplify why OIG recommends that CMS improve provider screening by working with States to implement fingerprint-based criminal background checks and site visits for high-risk providers.

For provider screening to be truly effective, States need timely, complete, and accurate data to identify the providers seeking access to Medicaid monies and patients. OIG has issued several recommendations to reduce duplicate provider enrollment data collection by sharing data across States or creating central repositories. Sharing data across States and with Medicare data systems would streamline the Medicaid enrollment process and reduce the chance for error within any one database. A joint enrollment system would provide a "one-stop shop" for State Medicaid officials and providers—reducing provider burden and duplication in reporting, verifying, and updating information. This could reduce data-collection duplication and burdens on States and providers and improve the completeness and accuracy of the data available to Medicaid. The President's FY 2019 Budget request includes a proposal to consolidate provider enrollment screening for Medicare, Medicaid, and the Children's Health Insurance Program.

Reducing Improper and Wasteful Payments and Ensuring Compliance With Fiscal Controls

Ensuring Compliance with Fiscal Controls

Reducing improper payments to providers is a critical element in protecting the financial integrity of Medicaid. In FY 2017, HHS reported a Medicaid improper payment rate of 10.1 percent. CMS has engaged with State Medicaid agencies to develop corrective action plans that address State-specific reasons for improper payments as a part of CMS's Payment Error Rate Measurement program, which measures Medicaid improper payments. CMS has facilitated national best practices calls to share ideas across States, provided State education through the Medicaid Integrity Institute, offered ongoing technical assistance, and provided additional guidance as needed to address the root causes of improper payments. CMS has indicated that it continues to provide guidance to States on their procedures for calculating and claiming costs under waiver programs for home and community-based services.

OIG audits have identified substantial improper payments to providers across a variety of Medicaid services, including school-based services, nonemergency medical transportation, targeted case management services, and personal care services. OIG has also identified several States that made improper payments to Medicaid managed care entities. More specifically, we found that several States made monthly capitated payments on behalf of deceased Medicaid beneficiaries, and we identified several States that made duplicate monthly capitated payments for the same beneficiary. CMS should continue to engage with State Medicaid agencies to develop corrective action plans and provide specific guidance to States regarding services and benefits most vulnerable to improper payments.

OIG audits have identified billions of dollars in Medicaid overpayments that States should pay back. OIG has conducted extensive work looking at how much of this money CMS has collected. One OIG study found that CMS had collected about 80 percent of $1.2 billion in Medicaid overpayments identified in certain audits. OIG plans continued work in this area to ensure the program effectively reclaims overpayments.

At times, States may exploit the Federal-State partnership for Medicaid financing to improperly shift costs to the Federal Government. OIG has identified a number of State policies that may inflate the Federal share of Medicaid expenditures. States have misused provider taxes, intergovernmental transfers, supplemental payments, and inflated payment rates to increase the Federal Medicaid funding that States receive. Such practices may distort the statutorily defined Federal share of Medicaid expenditures and undermine the Federal-State partnership.

CMS has tried to curtail inappropriate State financing mechanisms that inflate the Federal share of Medicaid costs. For example, CMS issued guidance to State Medicaid directors and State health officials to clarify the rules for health care provider taxes.

But more needs to be done. CMS should closely review State Medicaid plans and plan amendments to identify any potentially inappropriate cost-shifting from States to the Federal Government.

Oversight of Eligibility Determinations

States are not always correctly determining Medicaid eligibility for beneficiaries.

Correctly determining beneficiary eligibility is vital to the accuracy of Medicaid payments. To ensure that Medicaid makes payments on behalf of the right beneficiary, it is critical to determine whether the beneficiary receiving services is actually eligible for Medicaid. Recent OIG audits of three States estimated that more than $1.2 billion in Federal Medicaid payments has been made on behalf of potentially ineligible and ineligible beneficiaries. Lack of enrollment data systems functionality was a key contributor to these payments.

OIG recently reviewed whether certain States were correctly determining eligibility, following changes made by the Affordable Care Act (ACA) to Medicaid eligibility rules. ACA allowed States to expand Medicaid eligibility for certain low-income adults and claim a higher Federal Medical Assistance Percentage for those who are newly eligible under the expansion. As a result of States incorrectly determining beneficiaries' eligibility, payments made on behalf of those beneficiaries could be incorrect, resulting in the improper shift of costs from the State to the Federal Government. OIG reviews of Medicaid eligibility determinations by California, New York, and Kentucky reveal that these States did not always comply with Federal and State requirements to verify applicants' income, citizenship, identity, and other eligibility criteria. In total, across these three States, OIG estimated that more than $580 million in Federal Medicaid payments were made on behalf of 183,579 potentially ineligible beneficiaries, and about $655 million in payments made on behalf of 413,349 ineligible beneficiaries—over $1.2 billion in total for more than 596,000 beneficiaries. Both human and system errors contributed to these payments, with some enrollment data systems lacking the ability to (1) deny or terminate ineligible beneficiaries; (2) properly redetermine eligibility when a beneficiary aged out of an eligibility group; (3) maintain records, per Federal requirements, relating to eligibility determinations and verifications; and (4) retrieve and use information from other Government

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databases, such as those managed by the Social Security Administration and Department of Homeland Security.

To ensure compliance with Federal and State requirements for determining Medicaid eligibility, we recommended that States ensure that enrollment data systems are able to verify eligibility criteria, develop and implement written policies and procedures to address vulnerabilities, and undertake redeterminations as appropriate.

Medicaid is overpaying for prescription drugs due to underpaid rebates

To help contain the costs of prescription drugs in Medicaid, manufacturers are generally required to pay rebates to the States for covered outpatient drugs under the Medicaid Drug Rebate Program. As part of the rebate agreements, manufacturers must report product and pricing information to CMS that is used to calculate the rebates owed. CMS and States share responsibility for ensuring that manufacturers pay all rebates to which the States and Federal Government are entitled.

Ensuring that manufacturers report product and pricing information correctly is a challenge for HHS. Manufacturer misreporting can result in manufacturers' underpaying rebates, which inappropriately increases Federal and State Medicaid costs. We found that from 2012 to 2016, Medicaid may have lost $1.3 billion in base and inflation-adjusted rebates for 10 potentially misclassified drugs.

Overseeing States' collection of manufacturer rebates is also a challenge for HHS. OIG has identified instances in which States failed to bill for or collect Medicaid rebates for physician-administered drugs, forgoing money owed to those States and the Federal Government. OIG has ongoing work assessing CMS's oversight of the Medicaid Drug Rebate Program to identify opportunities for improvement.

Quality of Care

Medicaid must know with whom it is doing business, not only to prevent improper payments to ineligible providers, but also to protect beneficiaries from low-quality care. OIG has raised concerns about the varying standards, and in some cases, minimal vetting, for Medicaid personal care services (PCS) providers, potentially exposing the Medicaid program to financial fraud and Medicaid beneficiaries to abuse and neglect. For example, an elderly woman in Idaho was found dangerously malnourished and dehydrated after her Medicaid-funded caregiver failed to provide her with water and food. Investigators found the woman living in filth, when Medicaid was paying a PCS attendant to care for her everyday needs. OIG continues to recommend that CMS improve States' ability to monitor billing and care quality by requiring States to either enroll PCS attendants as providers, or require them to register with their State Medicaid agencies, and assign each attendant a unique identifier.

Group Homes

In response to reports of abuse and neglect of developmentally disabled residents in group homes, OIG launched a series of audits examining how States responded to critical incidents in group homes. OIG found that up to 99 percent of these critical incidents were not reported to the appropriate law enforcement or State agencies as required. To address these troubling findings, we worked with experts from HHS Administration for Community Living, HHS Office for Civil Rights, CMS, the Department of Justice, and State stakeholders to create a joint report entitled *Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight*. This report contains workable, holistic solutions that States can use to protect the health and safety of their residents living in group homes. Building on State efforts to protect people with disabilities in group homes, the report features suggested Model Practices for States and offers suggestions on the Federal level for CMS. These Model Practices focus on four main aspects of handling critical incidents: investigation, reporting, correction, and transparency and accountability. The joint report contains detailed suggestions, including what actions States should take when group homes repeatedly fail to report incidents.

Partnerships With MFCUs and Law Enforcement and Using Data To Protect Programs

Medicaid Fraud Control Units (MFCUs), the State agencies authorized to fight fraud and prevent patient abuse and neglect, are key partners in battling fraud and abuse in Medicaid. In FY 2017, MFCUs reported more than 1,500 convictions, nearly 1,000 civil settlements and judgements, and more than $1.8 billion in criminal and civil recoveries. OIG partners with MFCUs in joint investigations to hold wrongdoers accountable, recover stolen taxpayer dollars, and send a strong message to deter would-be fraudsters.

OIG provides oversight and administers the grants that fund the MFCUs. In this role, OIG continually strives to maximize the effectiveness of State MFCUs, thereby empowering States to better serve their populations. OIG actions to drive the effectiveness of MFCUs include enhancing OIG oversight using a data-driven risk assessment to target engagement, improving MFCUs' capabilities through training, increasing law enforcement collaboration between MCFUs and OIG, and working to help the MFCU program obtain resources consistent with an evolving Medicaid program.

Although Medicaid has grown substantially since 2010, the fraud-fighting resources of the State MFCUs have not kept pace. The 50 existing MFCUs receive 75 percent of their funding on a matching basis from the Federal Government but often they encounter severe restrictions on their ability to maintain or expand staff. In addition to the challenges of securing State-appropriated dollars for the MFCU match, some Units have difficulty in recruiting and retaining staff because of salary limitations.

Number of MFCU Staff and Medicaid Expenditures FY 2010-2017
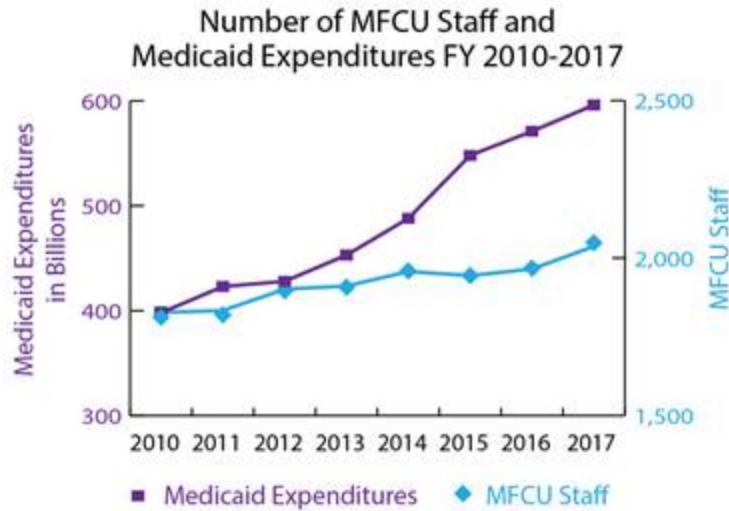
Between FY 2010 and 2017, while total MFCU staff resources increased 11.5 percent, total Medicaid expenditures for both Federal and State Governments increased 50 percent. In 2010, each MFCU employee had oversight responsibility for nearly $218 million in program expenditures, but by FY 2017 that ratio increased, and each MFCU employee was responsible for overseeing nearly $293 million. MFCUs are a wise investment, offering an estimated return of $6.52 for every $1 invested.

Conclusion

Effectively overseeing Medicaid remains a top management challenge for HHS. OIG has offered several suggestions to improve Medicaid program operations, including the following unimplemented recommendations:

- *CMS should ensure that national Medicaid data are complete, accurate, and timely.*

- *CMS should facilitate State Medicaid agencies' efforts to screen new and existing providers by ensuring the accessibility and quality of Medicare's enrollment data.*

- *CMS should pursue a means to compel manufacturers to correct inaccurate classification data reported to the Medicaid Drug Rebate Program.*

- *CMS should require States to either enroll PCS attendants as providers or require PCS attendants to register with their State Medicaid agencies and assign each attendant a unique identifier.*

OIG plans to continue prioritizing Medicaid oversight to prevent and detect fraud, waste, and abuse, and take appropriate action when fraud, waste, or abuse occur.

OIG has the capacity to leverage advanced data analytic techniques to detect potential vulnerabilities and fraud and better target our resources to those areas and individuals most in need of oversight. However, to date, this innovative way to enhance and strategically target our oversight efforts cannot be accomplished in Medicaid without better quality, national Medicaid data. This is the consistent cross-cutting impediment to effective prevention, detection, and enforcement within the Medicaid program. While neither CMS nor State Medicaid agencies presently command the data necessary to optimally support a 21st century Medicaid program, we believe this committee's continued oversight will help achieve this goal. Thank you for your ongoing leadership and for affording me the opportunity to testify on this important topic.