**Summary of House Energy and Commerce Subcommittee on Oversight and Investigations Hearing**
*"Medicaid Program Integrity: Screening Out Errors, Fraud, and Abuse"*
Washington, DC – June 2, 2015

***Overview***

The Energy and Commerce Committee's Subcommittee on Oversight and Investigations held a hearing to discuss the findings of a recently-published Government Accountability Office (GAO) report on Medicaid program integrity. The Subcommittee's hearing focused on improper or potentially fraudulent payments and also on federal and state oversight programs and processes to prevent fraud, waste, and abuse in Medicaid. The Subcommittee is chaired by Rep. Tim Murphy of Pennsylvania and the ranking member is Rep. Diana DeGette of Colorado.

The GAO report, titled Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls, examined Fiscal Year (FY) 2011 data from four predominantly managed care states – Arizona, Florida, Michigan, and New Jersey – all of which included 9.2 million Medicaid beneficiaries and accounted for 13% of all FY 2011 Medicaid payments. GAO found:

- About 8,600 beneficiaries had payments made on their behalf concurrently by two or more of GAO's selected states totaling at least $18.3 million.
- The identities of about 200 deceased beneficiaries received about $9.6 million in Medicaid benefits subsequent to the beneficiary's death.
- Hundreds of providers were potentially improperly receiving Medicaid payments, including 50 providers who were excluded from federal health care programs, including Medicaid, for either patient abuse or neglect and/or fraud, theft, bribery, and tax evasion.

***Member Opening Statements***

In his opening statement, **Chairman Murphy** said "Medicaid fraud undermines the integrity of the program, denies our most vulnerable the services they deserve, and wastes American taxpayers' hard-earned dollars." Chairman Murphy noted that GAO has designated Medicaid as a high-risk program for fraud and abuse every year since 2003. He said the Subcommittee would like to work with GAO and the Centers for Medicare and Medicaid Services (CMS) to decrease the opportunity and motivation to defraud Medicaid, especially given the expansion of the program under the Affordable Care Act. (ACA). **Ranking Member DeGette**, in her opening statement, urged her colleagues in Congress, in the Obama administration, and also Governors to be vigilant in their pursuit of fraud and improper payments. She also highlighted certain ACA anti-fraud provisions for Medicaid and Medicare, including prevention programs designed to keep fraudulent suppliers and providers out of the program and also anti-fraud penalties.

**Rep. Michael Burgess**, MD, of Texas said "inefficient and misdirected payments within the Medicaid program have substantive budgetary, access, and provider impacts that ultimately affect patients" in his opening statement Dr. Burgess noted that states and the federal government need to have appropriate tools to monitor Medicaid program integrity. He also questioned whether certain anti-fraud measures in Medicare should be applied to the Medicaid system. **Rep. Frank Pallone** of New Jersey, the ranking member of the full committee, in his opening statement, cautioned his colleagues against "applying GAO's findings too broadly," noting that they "are not generalizable across the country." He also noted that much of the potentially improper payments GAO found are more likely to be examples of provider rather than beneficiary fraud. Similarly to Ranking Member DeGette, Rep. Pallone showcased several ACA anti-fraud measures designed to improve Medicaid program integrity, including requiring state Medicaid agencies to withhold payments to a provider or supplier pending investigation of a credible allegation fraud.

***Witness Testimony***

In his subcommittee testimony, which principally focused on the aforementioned GAO findings, **Mr. Seto Bagdoyan**, Director, Forensic Audits and Investigative Service, GAO, said Medicaid is a significant expenditure for the federal government and the states, including outlays of approximately $516 billion in FY 2014. He noted that CMS reported an estimated payment error rate of 6.7% or $17.5 billion for FY 2014, a .9% increase from FY 2013 for which CMS reported a 5.8% payment error rate or $14.4 billion. Mr. Bagdoyan, however, stated that CMS has taken appropriate

"regulatory steps to make the Medicaid enrollment process more rigorous and data-driven," including requiring states to use data maintained in the CMS Data Services Hub to verify beneficiary eligibility. Mr. Bagdoyan also discussed the following GAO recommendations, with which CMS concurred, to improve Medicaid program integrity. CMS noted it will provide state-specific guidance in the near future.

- CMS should issue guidance to states to better identify beneficiaries who are deceased.
- CMS should provide guidance to states on the availability of automated information through Medicare's enrollment database – the Provider Enrollment, Chain and Ownership System (PECOS) – and full access to all pertinent PECOS information, such as ownership information, to help screen Medicaid providers more efficiently and effectively.

**Dr. Shantanu Agrawal**, who serves as the Deputy Administrator and Director of the Center for Program Integrity at CMS, discussed how enhancing Medicaid program integrity is a "top priority for the (Obama) administration and an agency wide-effort at CMS." He noted that CMS, thanks to the ACA, has taken steps to require risk-based (based on historical information) screening of providers and suppliers who wish to participate in federal health care programs and for states to conduct reviews and revalidations of their Medicaid and CHIP providers by March 2016, a process which must be repeated at least once every five years. Dr. Agrawal said CMS and states are working together to better share information, especially as it relates to certain providers, but he made no mention of the role managed care organizations (MCOs) could play in such collaborative work. Dr. Agrawal also discussed the Payment Error Rate Measurement program, which measures improper payments in Medicaid and CHIP and produces error rates for each program. The error rates are based on reviews of the fee-for-service (FFS), managed care, and eligibility components of Medicaid and CHIP in a given FY under review.

***Questions, Answers, and Comments***

**Chairman Murphy**, along with several other subcommittee members, asked why the FY 2014 payment error rate increased from FY 2013. Dr. Agrawal said CMS would like to make progress on the payment error rate, noting that while the managed care and eligibility components of the rate decreased, the "biggest rise was in the provider screening and enrollment standards in the FFS component" of the payment error rate. (Note: In FY 2013, the error rates by component were 3.6% FFS, 0.3% managed care, and 3.3% eligibility, with an overall weighted average of 5.8%. While stating the overall weighted average had increased to 6.7% in FY 2014, Dr. Agrawal did not provide a breakdown by component. However, the FY 2014 error rates by component are as follows: 5.1% FFS, 0.2% managed care, and 3.1% eligibility.)[i]

**Ranking Member DeGette** asked Mr. Bagdoyan if CMS is taking appropriate steps to decrease the payment error rate and to stop fraudulent and improper payments. Mr. Bagdoyan answered affirmatively. Ranking Member DeGette and **Rep. Pallone** inquired about the PECOS enrollment database, how states are currently accessing information, and also what type of training is provided to states regarding PECOS. Mr. Bagdoyan said states, and by extension the federal government, would benefit by having greater and automated access to the PECOS database. Dr. Agrawal said CMS will release guidance to incentivize states to use already existing tools to protect and improve Medicaid program integrity.

**Rep. Kathy Castor** of Florida focused on the recently-released proposed regulations for Medicaid and CHIP managed care. Rep. Castor said the proposed rule requires managed care providers to be subject to the same screening requirements as FFS providers, a proposal Rep. Castor views favorably. Dr. Agrawal noted the proposed rule requires managed care contract language that ensures states have access to MCO data for program integrity purposes. Dr. Agrawal also said the proposed rule allows states to make "the transition to managed care without necessarily feeling that they have to give up program integrity along the way."

[i] "Payment Error Rate Measurement Program (PERM) Medicaid Error Rates." Center for Medicare and Medicaid Services, November 2014. http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Downloads/PERMMedicaidErrorRates2014.pdf.