



Testimony

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MEDICAID

CMS Could Take Additional Actions to Help Improve Provider and Beneficiary Fraud Controls

Statement of Seto Bagdoyan,
Director, Forensic Audits and Investigative Service

Chairman Murphy, Ranking Member DeGette, and Members of the Subcommittee:

I am pleased to appear before you today to discuss our May 2015 report on Medicaid provider- and eligibility-fraud controls.¹ Medicaid, a federal-state health-financing program for low-income and medically needy individuals, is a significant expenditure for the federal government and the states, with total federal outlays of \$310 billion in fiscal year 2014. The Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services (HHS), is responsible for broad program oversight, including disbursement of federal matching funds, while states are responsible for the daily administration of their Medicaid programs. CMS also provides guidelines, technical assistance, and periodic assessments of state Medicaid programs. Federal laws require both federal and state entities to protect the Medicaid program from fraud, waste, and abuse. In February 2015, we reported that Medicaid remains at high risk because of concerns about the adequacy of fiscal oversight of the program, including improper payments to Medicaid providers.² In fiscal year 2014, CMS reported an estimated improper-payment rate of 6.7 percent, or \$17.5 billion, for the Medicaid program, which is an increase over its 2013 estimate of 5.8 percent, or \$14.4 billion.³

My remarks today highlight the key findings of our May 2015 report on CMS oversight of Medicaid provider- and beneficiary-eligibility screening and fraud controls.⁴ Accordingly, this testimony discusses (1) the results of our analysis of indicators of improper or potentially fraudulent payments to Medicaid beneficiaries and providers; and (2) the extent to

¹GAO, *Medicaid: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls*, [GAO-15-313](#) (Washington, D.C.: May 14, 2015).

²GAO has designated Medicaid as a high-risk program since 2003. GAO, *High-Risk Series An Update*, [GAO-15-290](#) (Washington, D.C.: Feb. 11, 2015).

³An improper payment is defined by statute as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. Fraud is one type of improper payment and involves an intentional act or representation to deceive with the knowledge that the action or representation could result in gain. Not all improper payments are a result of fraud. Additionally, Office of Management and Budget guidance also instructs agencies to report as improper payments any payments for which insufficient or no documentation was found.

⁴[GAO-15-313](#).

which federal and state oversight policies, controls, and processes are in place to prevent and detect fraud and abuse in determining eligibility for Medicaid beneficiaries and enrolling providers.

To conduct this work, we obtained and analyzed Medicaid claims paid in fiscal year 2011, the most-recent consistently comparable and reliable data, for four states— Arizona, Florida, Michigan, and New Jersey— to identify indicators of potentially improper or fraudulent payments to Medicaid beneficiaries and providers. These states were selected primarily because they had reliable data and were among states with the highest Medicaid enrollment. The results of our analysis of these states cannot be generalized to other states. We performed data matching to identify indicators of potentially improper payments, which includes fraud. These matches sought to identify individuals who may be ineligible to receive Medicaid benefits or providers who should not have received Medicaid payments due to residency, death, or other exclusionary factors.⁵ We also reviewed federal statutes, CMS regulations, and state Medicaid policies pertinent to program-integrity structures, met with agency officials, and visited state Medicaid offices that perform oversight functions. Our May 2015 report includes a detailed explanation of the methods used to conduct our work. The work on which this testimony is based was performed in accordance with generally accepted government auditing standards.

In summary, our analysis of indicators of improper or potentially fraudulent payments revealed thousands of beneficiaries and hundreds of providers involved in potential improper or fraudulent payments during fiscal year 2011 in the four selected states. For example, we found

- Approximately 8,600 beneficiaries received benefits worth about \$18.3 million concurrently in two or more states — even though federal regulations do not permit beneficiaries to have payments made on their behalf by two or more states concurrently.⁶

⁵On the basis of our discussions with agency officials and our own testing, we concluded that the data elements used for this report were sufficiently reliable for our purposes.

⁶A state agency must provide Medicaid services to eligible residents of that state. If a resident of one state subsequently establishes residency in another state, the beneficiary's Medicaid eligibility in the previous state should end, subject to appropriate notice and hearing procedures. 42 C.F.R. §§ 431.200 - 431.246.

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- Identities of about 200 deceased beneficiaries received about \$9.6 million in Medicaid benefits subsequent to the beneficiary's death.
 - About 90 providers had suspended or revoked licenses in the state where they performed Medicaid services yet they received a combined total of at least \$2.8 million from those states.

Since 2011, CMS has taken regulatory steps to make the Medicaid enrollment process more rigorous and data-driven; however, gaps in beneficiary-eligibility verification guidance and data sharing continue to exist. For example, in October 2013, CMS required states to use electronic data maintained by the federal government to verify beneficiary eligibility.⁷ We found, however, that CMS regulations do not require states to periodically review Medicaid beneficiary files for deceased individuals more frequently than annually, nor specify whether states should consider using the more-comprehensive Social Security Administration (SSA) Death Master File (DMF) in conjunction with state-reported death data when doing so. As a result, states may not be able to detect individuals that have moved to and died in other states, or prevent the payment of potentially fraudulent benefits to individuals using these identities. In 2011, CMS also issued regulations to strengthen Medicaid provider-enrollment screening, such as allowing states to use Medicare's enrollment database—the Provider Enrollment, Chain and Ownership System (PECOS)—to screen Medicaid providers so that duplication of effort is reduced.⁸ However, CMS has not provided full access to all PECOS information, such as ownership information, that states report are needed to effectively and efficiently process Medicaid provider applications. Based on these concerns, we recommended that CMS issue guidance to states to better identify beneficiaries who are deceased and provide states with additional information from PECOS. HHS concurred with both recommendations and stated it would provide state-specific guidance to address them.

⁷ Under 42 C.F.R. § 435.945(k), subject to approval by the Secretary of Health and Human Services, states may request and use information from alternate sources, provided that such alternative source or mechanism will reduce the administrative costs and burdens on individuals and states while maximizing accuracy, minimizing delay, meeting applicable requirements relating to the confidentiality, disclosure, maintenance, or use of information, and promoting coordination with other insurance-affordability programs.

⁸42 C.F.R. § 455.410(c)(1).

Indicators of Potentially Improper Medicaid Payments to Beneficiaries and Providers Highlight Potential Weaknesses in Selected State Controls

In our May 2015 report, we found that, of the approximately 9.2 million beneficiaries in the four states that we examined, thousands of cases from the fiscal year 2011 data analyzed showed indications of potentially improper payments, including fraud, to Medicaid beneficiaries.⁹ Applications may have inaccuracies due to simple errors such as inaccurate data entry, making it difficult to determine whether these cases involve improper payments or fraud through data matching alone. However, our work raises concerns about whether payments made on behalf of certain beneficiaries were appropriate, including the following:

- Approximately 8,600 beneficiaries received benefits worth about \$18.3 million concurrently in two or more states — even though federal regulations do not permit beneficiaries to have payments made on their behalf by two or more states concurrently.¹⁰
- The identities of about 200 beneficiaries received \$9.6 million worth of Medicaid benefits subsequent to the beneficiary's death, based on our matching Medicaid data to SSA's full DMF.
- About 3,600 beneficiaries supposedly received about \$4.2 million worth of Medicaid services while incarcerated in a state prison facility even though federal law prohibits states from obtaining federal Medicaid matching funds for health-care services provided to inmates except when they are patients in medical institutions.¹¹
- Hundreds of thousands of beneficiaries had irregularities in their address and identifying information, such as addresses that did not

⁹[GAO-15-313](#).

¹⁰A state agency must provide Medicaid services to eligible residents of that state. If a resident of one state subsequently establishes residency in another state, the beneficiary's Medicaid eligibility in the previous state should end, subject to appropriate notice and hearing procedures. 42 C.F.R. §§ 431.200 - 431.246.

¹¹In almost 390 cases totaling nearly \$390,000 in payments, the beneficiary supposedly received medical services during the period of incarceration. This suggests possible identity theft since the beneficiary's incarceration would have physically prevented him or her from receiving medical services covered by Medicaid. Medicaid paid about \$3.8 million on behalf of the remaining 3,200 individuals in the form of capitated payments, which are the fixed monthly payments states pay to certain managed-care organizations for delivering care through networks.

match any United States Postal Service records¹² and Social Security numbers that did not match identity information contained in SSA databases.

We also found hundreds of Medicaid providers who were potentially improperly receiving Medicaid payments among the approximately 881,000 Medicaid providers we examined, including the following examples:

- About 90 providers had suspended or revoked licenses in the state where they performed Medicaid services yet they received a combined total of at least \$2.8 million from those states in fiscal year 2011. All physicians applying to participate in state Medicaid programs must hold a current, active license in each state in which they practice and states are required to provide CMS with information and access to certain information respecting sanctions taken against health-care practitioners and providers by their own licensing authorities.¹³
- Over 50 providers were deceased in the four states we examined, but whose identities received Medicaid payments totaling at least \$240,000.
- About 50 providers were excluded from participating in Medicaid at the time that they billed Medicaid for services at a cost of about \$60,000.

¹² Federal law requires states to make Medicaid available to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address. Therefore, there are no requirements related to listing actual physical addresses for beneficiary enrollment and eligibility determinations.

¹³ Matches were identified using data from the Federation of State Medical Boards. We did not independently verify the final suspension and revocation decisions with the state medical licensing boards.

CMS Has Taken Steps to Strengthen Certain Medicaid Enrollment-Screening Controls, but Gaps Remain

Through regulation, CMS has taken steps since 2011 to make the Medicaid enrollment-verification process more data-driven. The steps may address many of the improper-payment indicators that we found in our 2011 analysis of Medicaid claims. However, we reported in May 2015 that gaps in guidance and data sharing continue to exist, and additional opportunities for improvements are available for screening beneficiaries and providers.

In response to the Patient Protection and Affordable Care Act (PPACA), which was enacted in 2010, CMS issued federal regulations in 2013 to establish a more-rigorous approach to verify financial and nonfinancial information needed to determine Medicaid beneficiary eligibility.¹⁴ As part of this effort, CMS created a tool called the Data Services Hub (hub) that was implemented in fiscal year 2014 to help verify beneficiary applicant information used to determine eligibility for enrollment in qualified health plans and insurance-affordability programs, including Medicaid. The hub routes to and verifies application information in various external data sources, such as SSA and the Department of Homeland Security. According to CMS, the hub can verify key application information, including household income and size, citizenship, state residency, incarceration status, and immigration status.

CMS regulations also say that state Medicaid offices generally must perform checks to verify continued beneficiary eligibility at least once every 12 months unless the individual reports a change or the agency has information to prompt a reassessment of eligibility.¹⁵

Under CMS regulations, states are to screen beneficiaries through the hub, which includes a check using the full DMF to determine whether the beneficiaries are deceased at the time of initial enrollment as well as on at least an annual basis thereafter.¹⁶ Hence, the extent to which the hub

¹⁴ 42 C.F.R. §§ 435.940 - 435.960.

¹⁵ 42 C.F.R. § 435.916.

¹⁶ Under 42 C.F.R. § 435.945(k), subject to approval by the Secretary of Health and Human Services, states may request and use information from alternate sources, provided that such alternative source or mechanism will reduce the administrative costs and burdens on individuals and states while maximizing accuracy, minimizing delay, meeting applicable requirements relating to the confidentiality, disclosure, maintenance, or use of information, and promoting coordination with other insurance-affordability programs. The data used for our study are from fiscal year 2011, approximately 3 years prior to implementation of the CMS hub requirement.

identifies deceased individuals in Medicaid is generally limited to about once every year. While officials at the four states we examined for our May 2015 report said that they periodically check state vital records to determine whether a potential Medicaid beneficiary has died, officials in these four states did not use the more-comprehensive full DMF to perform this check outside of the initial enrollment or annual revalidation period. CMS officials noted that the federal regulation does not specify how deceased individuals should be identified nor has CMS explored the feasibility of states using the full DMF in their periodic screening for deceased individuals. As a result, states may not be able to detect individuals who have moved to and died in other states and prevent payment of potentially fraudulent benefits.

PPACA also authorized CMS to implement several actions to strengthen provider-enrollment screening. While PPACA requires that all providers and suppliers be subject to licensure checks, it gave CMS discretion to establish a risk-based application of other screening procedures. According to CMS's risk-based screening, moderate- and high-risk providers and suppliers additionally must undergo unscheduled or unannounced site visits, while high-risk providers and suppliers also will be subject to fingerprint-based criminal-background checks. This requirement may address some of the potentially fraudulent or improper payments I mentioned earlier in my statement.

Although CMS has taken steps through its program regulations in providing guidance to states for screening providers, we reported in May 2015 that the states we examined indicated difficulties in implementing the regulations. One provision in the 2011 CMS regulation allowed states to rely on the results of provider screening by Medicare contractors to determine provider eligibility for Medicaid.¹⁷ According to CMS, in April 2012, CMS established a process by which states would have direct access to Medicare's enrollment database—PECOS. However, according to our discussions with officials in the four selected states, these states were using PECOS to screen a segment of their provider population but none currently utilize PECOS for their entire provider population. State officials told us that PECOS required manual lookups of individual providers, a task that one state characterized as inefficient and

¹⁷42 C.F.R. § 455.410(c)(1).

administratively burdensome.¹⁸ Additionally, state officials said that they use a limited amount of pertinent information, specifically site-visit information, from PECOS to perform the necessary provider screening. According to CMS officials, ownership information on providers can be obtained through a detailed-level view of PECOS. However, as of May 2015, CMS had not made ownership information of the providers available to the states through the monthly PECOS data-extract file. Some state officials noted that full electronic access to all information in the PECOS system would streamline provider-screening efforts, resulting in a more-efficient and more-effective process. Additional CMS guidance to the states on requesting automated information through PECOS and ensuring that such information includes key ownership information could help states improve efficiency of provider screening.

To help further improve efforts to limit improper payments, including potential fraud, in the Medicaid program, we made two recommendations to the Acting Administrator of CMS in our May 2015 report. First, we recommended that CMS issue guidance to states to better identify beneficiaries who are deceased. We also recommended that CMS provide guidance to states on the availability of automated information through Medicare's enrollment database—PECOS—and full access to all pertinent PECOS information, such as ownership information, to help screen Medicaid providers more efficiently and effectively. HHS concurred with our recommendations and stated it would provide state-specific guidance to address them.

Chairman Murphy, Ranking Member DeGette, and members of the Subcommittee, this concludes my prepared remarks. I look forward to answering any questions that you may have at this time.

¹⁸Officials stated that large-scale batch matching is not possible, so they must check each provider in PECOS individually.

GAO Contact and Staff Acknowledgments

For questions about this statement, please contact me at (202) 512-6722 or bagdoyans@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Individuals making key contributions to this testimony were Matthew Valenta, Assistant Director; John Ahern; Mariana Calderón; Marcus Corbin; Julia DiPonio; and Colin Fallon.

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