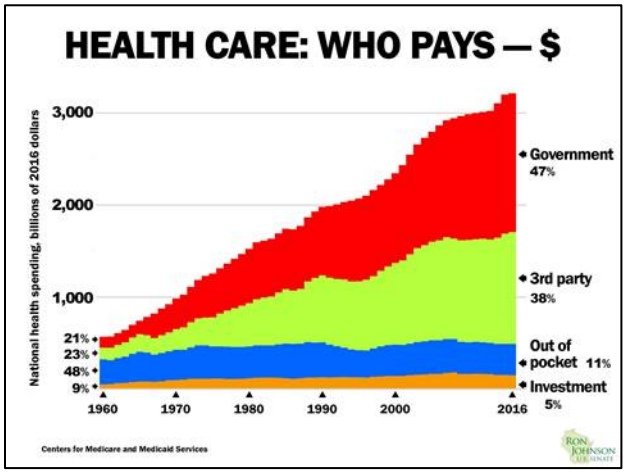
THE CENTERS FOR MEDICARE & MEDICAID SERVICES HAS BEEN A POOR STEWARD OF FEDERAL MEDICAID DOLLARS

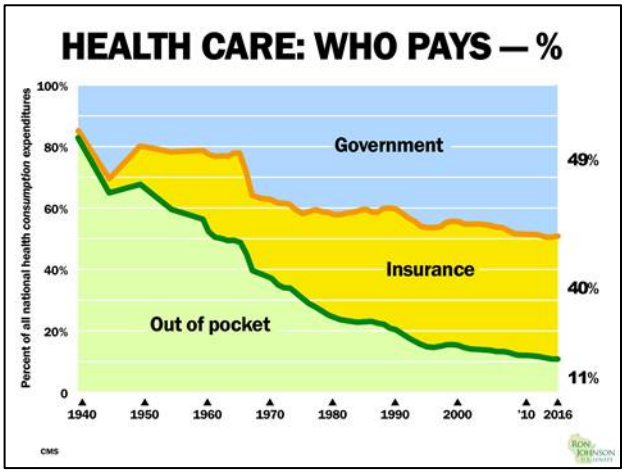
A Majority Staff Report of the
Committee on Homeland Security and Governmental Affairs
United States Senate
Senator Ron Johnson, Chairman

June 20, 2018

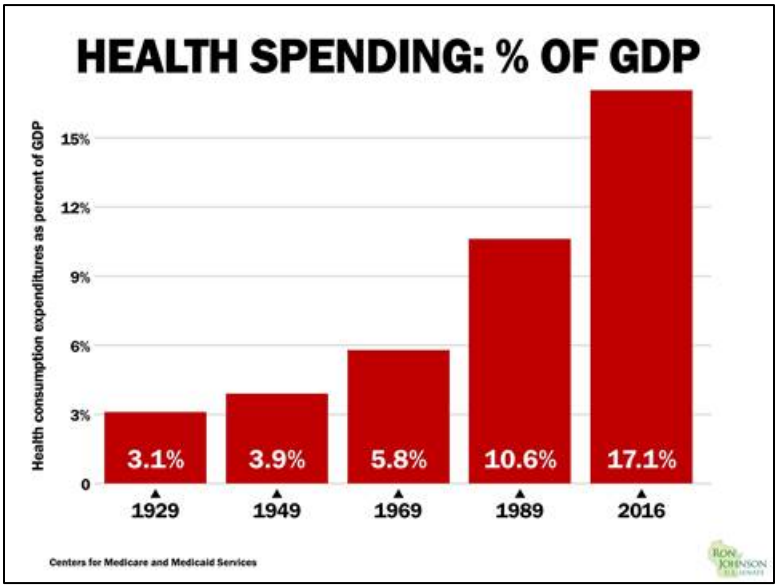
EXECUTIVE SUMMARY

The U.S. health care financing system is broken and increasingly is dominated by the government. By transitioning to a third-party payment system, we have separated the consumer of health care products and services from the direct payment for them. Most consumers do not know what treatments costs, and except for the cost of insurance or copays, they really do not care.





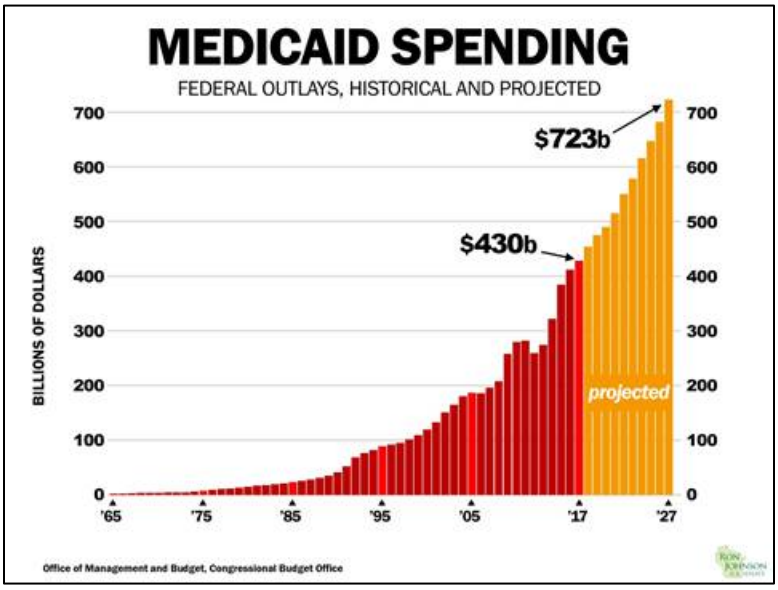
As the benefit of free market competition from health care has been removed, the costs have predictably soared. Since 1960, the share of all health care spending paid by government has more than doubled, from about one-fifth to just under half. The result: Overall health spending now consumes about 17 percent of the nation's gross domestic product.



Central to this unsustainable growth is Medicaid. Medicaid began in 1965 as essentially an afterthought, a program so negligible that President Lyndon Johnson did not even mention it

when it when he signed it into law alongside Medicare.[1] Envisioned as "a small program to cover poor people's medical bills,"[2] Medicaid enrolled just four million people in its first year, at a per-enrollee cost of only $222.

Today, Medicaid has grown to be the nation's largest health insurer, covering about 70 million people, at a cost to taxpayers of $554 billion per year.[3] Per-enrollee costs are now $7,973—a 3,491 percent increase since 1966.[4] This growth is especially dramatic when current Medicaid spending is compared to the $165 billion that Medicaid would have cost in 2015 if it had grown only at the rate of inflation and growth in population since 1990.[5] Federal government projections expect this growth to accelerate in the coming years, primarily due to the Affordable Care Act's (ACA) Medicaid expansion.[6]

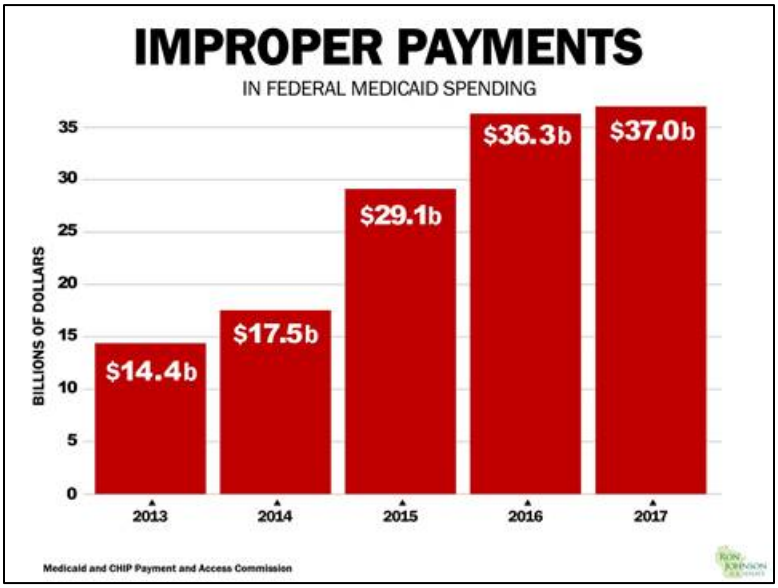


As Medicaid spending consumes even more of the federal budget, it is important that Medicaid dollars are spent properly—***so that the funds flow only to those Americans in need***. However, independent government watchdogs and ongoing oversight by the Committee on

[1] Lyndon B. Johnson, Remarks with President Truman at the Signing in Independence of the Medicare Bill (July 30, 1965), *available at* http://www.presidency.ucsb.edu/ws/?pid=27123.
[2] Kate Zernike, Abby Goodbough & Pam Belluck, *In Health Bill's Defeat, Medicaid Comes of Age*, N.Y. TIMES (Mar. 27, 2017), *available at* https://www.nytimes.com/2017/03/27/health/medicaid-obamacare.html?_r=0.
[3] U.S. Dep't of Health & Human Servs., *2016 Actuarial Report on the Financial Outlook for Medicaid* (2016), *available at* https://www.medicaid.gov/medicaid/finance/downloads/medicaid-actuarial-report-2016.pdf.
[4] Medicaid & CHIP Payment & Access Comm'n, *Medicaid Enrollment and Total Spending Levels and Annual Growth, in* MACStats: Medicaid & CHIP Data Book (Dec. 2017), *available at* https://www.macpac.gov/wp-content/uploads/2015/11/EXHIBIT-10.-Medicaid-Enrollment-and-Total-Spending-Levels-and-Annual-Growth-FYs-1966%E2%80%932016.pdf.
[5] Chairman Johnson's staff calculated this number using Consumer Price Index (CPI-U) data and figures from Bureau of Labor Statistics and the U.S. Census Bureau.
[6] Letter from Sen. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Gov't Affairs, to Seema Verma, Adm'r, Ctrs. for Medicare & Medicaid Servs. (Sept. 27, 2017).

Homeland Security and Governmental Affairs show that the Medicaid program is plagued by waste, fraud, and abuse:

- Medicaid overpayments to providers stand at $37 billion per year, a 157 percent increase since 2013.[7]



- The Department of Health and Human Services Office of Inspector General (HHS OIG) recently estimated that California spent more than $1 billion in federal Medicaid funds for 445,000 ineligible or potentially ineligible beneficiaries.[8]

- The HHS OIG also found that New York made federal Medicaid payments of $26.2 million on behalf of more than 47,000 ineligible people.[9]

- Medicaid fraud convictions by state Medicaid Fraud Control Units nationwide have increased 17 percent since 2013, while criminal recoveries nearly doubled in 2017 compared to the year before.[10] At the end of 2017, state Medicaid Fraud Control Units had nearly 20,000 open fraud investigations.[11]

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[7] U.S. Gov't Accountability Office, GAO-18-444T, *Medicaid: Opportunities for Improving Program Oversight* (Apr. 2018), *available at* https://www.gao.gov/assets/700/691209.pdf.
[8] U.S. Dep't of Health & Human Servs. Off. of Inspector Gen., A-09-16-02023, *California Made Medicaid Payments on Behalf of Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements* (Feb. 2018), *available at* https://oig.hhs.gov/oas/reports/region9/91602023.pdf.
[9] U.S. Dep't of Health & Human Servs. Off. of Inspector Gen., A-02-15-01015, *New York Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries* (Jan. 2018), *available at* https://oig.hhs.gov/oas/reports/region2/21501015.pdf.
[10] U.S. Dep't of Health & Human Servs. Off. of Inspector Gen., Medicaid Fraud Control Units Fiscal Year 2017 Annual Report (March 2018), https://oig.hhs.gov/oei/reports/oei-09-18-00180.pdf.
[11] *Id.*

- The U.S. Government Accountability Office (GAO) has discovered Medicaid benefits for dead people and prisoners; hundreds of thousands of beneficiaries who provided apparently false social security numbers;[12] and an ACA data hub granting coverage to fictitious applicants.[13]

- Private insurers have made "spectacular profits"[14] from Medicaid expansion in California, with one insurer's margins increasing 578 percent in the expansion's first two years, from $71 million to $484 million.[15]

- The Centers for Medicare & Medicaid Services (CMS) has vast authority granted by a 2005 law to police Medicaid fraud,[16] but it has largely failed to do so. GAO and other watchdogs have warned CMS for the past 15 years that Medicaid is uniquely vulnerable to fraud and overpayments.

- CMS has not even attempted to recoup for federal taxpayers the more than one billion in potentially fraudulent Medicaid payments in California, New York and Kentucky,[17] and has not said whether it will go after the excessive payments to insurers in California.

- With the ACA's reimbursement formula giving states an incentive to enroll more beneficiaries to obtain more federal money, CMS has allowed certain states to game the system. California, for example, has received a share of Medicaid expansion dollars vastly disproportionate to other states,[18] even while California officials gave Medicaid money to ineligible people.

Medicaid is a program to assist low-income Americans and others in need. This staff report is not meant to challenge the intentions of such assistance. But for American taxpayers to have confidence that Medicaid funds are only going to those truly in need, CMS must better police waste, fraud, and abuse in the Medicaid program. The depth of Medicaid's fiscal problems shows the need for continued congressional attention on health care reform to slow Medicaid's rate of growth and more equitably fund state Medicaid programs.

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[12] U.S. Gov't Accountability Office, GAO-15-313, *Medicaid: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls* (May 2015), *available at* https://www.gao.gov/products/GAO-15-313.

[13] U.S. Gov't Accountability Office, GAO-16-29, *Patient Protection and Affordable Care Act: CMS Should Act to Strengthen Enrollment Controls and Manage Fraud Risk* (Feb. 2016), *available at* https://www.gao.gov/assets/680/675767.pdf.

[14] Chad Terhune & Anna Gorman, *Insurers make billions off Medicaid in California during Obamacare expansion*, L.A. Times, Nov. 5, 2017.

[15] *Medi-Cal Managed-Care Financial Results, 2012*, KAISER HEALTH NEWS, available at https://kaiserhealthnews.files.wordpress.com/2017/11/medi-cal_financials3.pdf.

[16] Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (2006).

[17] *"Improper Payments in State-Administered Programs: Medicaid": Hearing before the Subcomm. on Gov't Operations & the Subcomm. on Intergovernmental Affairs of the H. Comm. on Oversight & Gov't Reform*, 115h Cong. (2018).

[18] Letter from Sen. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Gov't Affairs, to Edmund Brown Jr., Governor of Cal. (Sept. 27, 2017) (California "represents 34 percent of all Medicaid expansion spending, even though California represents only 12 percent of the total U.S. population" (citations omitted)).

FINDINGS

Senator Ron Johnson, Chairman of the Senate Committee on Homeland Security and Governmental Affairs, has been conducting oversight of Medicaid program integrity and escalating costs since February 2017. This oversight has included several letters to CMS and requests for information from eight states. To date, the Chairman's oversight has found:

- Congress substantially expanded CMS's oversight responsibilities in the Deficit Reduction Act of 2005,[19] requiring CMS to root out Medicaid fraud, waste and abuse. Yet CMS has failed to live up to the requirements of this law by conducting only irregular, highly flawed audits of Medicaid providers and failing to meet annual deadlines for program integrity reporting to Congress.

- CMS has not taken basic steps to fight Medicaid fraud, including reviewing federal eligibility determinations for accuracy and even creating an antifraud strategy. Since 2015, GAO has made 11 separate anti-fraud recommendations to CMS. CMS has implemented none.[20]

- HHS programs overall are riddled with fraud. New data show that HHS fraud totals nearly $6 billion, by far the highest of any federal agency and 68 percent of the total fraud reported across the government.[21]

- Although there is no specific breakdown for Medicaid in HHS fraud numbers, evidence indicates that Medicaid fraud is rampant.

    - The Committee identified nearly 1,100 people convicted or charged nationwide since 2010 in fraud or related schemes targeting Medicaid to obtain prescription opioids.[22]

    - GAO and other watchdogs have documented potential improper or fraudulent Medicaid payments totaling more than $1 billion in at least eight states—California, New York, Kentucky, Illinois, Arizona, Florida, Michigan, and New Jersey.[23]

- The ACA worsened the problem of Medicaid fraud and overpayments by giving states incentives to declare people newly eligible to receive 100 percent federal reimbursement during the Medicaid expansion's first three years.

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[19] Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (2006).
[20] *Improper Payments in State-Administered Programs: Medicaid*, *supra* note 17.
[21] *Resources*, PAYMENTACCURACY.GOV, https://paymentaccuracy.gov/resources/.
[22] Maj. Staff of S. Comm. on Homeland Sec. and Gov't Affairs, *Drugs for Dollars: How Medicaid Helps Fuel the Opioid Epidemic* (2018).
[23] GAO-15-313, *Medicaid: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls*, *supra* note 12.

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THE MEDICAID PROGRAM AND CMS'S ROLE IN IT

Medicaid provides free or low-cost health coverage to low-income people, families and children, pregnant women, the elderly, and people with disabilities.[24] The program is run day-to-day by states and overseen by CMS,[25] which is a component entity of HHS.

Federal taxpayers contribute a specified percentage of Medicaid program expenditures to the states.[26] HHS calculates and annually publishes this federal contribution, known as the Federal Medical Assistance Percentage.[27] There is generally no cap on the amount that the federal government contributes to Medicaid in a particular state.[28]

Much of Medicaid's recent growth is due to the ACA, which expanded Medicaid eligibility to include adults under 65 with incomes up to 133 percent of the federal poverty level.[29] CMS significantly understated its projections for per-enrollee spending on adults newly eligible for Medicaid under the ACA.[30] HHS now estimates that federal Medicaid expenditures—which were $299 billion in fiscal year 2014—will rise 96 percent to $588 billion by 2025.[31] CMS recently acknowledged "the heightened potential for waste, fraud and abuse in states that chose to expand their Medicaid program under the [ACA]."[32]

CMS has vast authority to fight this fraud and waste. The ACA provided additional anti-fraud tools, including allowing "CMS to suspend payments to providers on the basis of a credible allegation of fraud."[33] The Improper Payments Information Act of 2002 also directed CMS and other federal agencies to publicly report overpayments to Medicaid providers.[34] CMS's broadest authorities came in the Deficit Reduction Act of 2005, which provided "a serious restoration of fiscal responsibility . . . closing loopholes and preventing the unscrupulous gaming of the Medicaid system."[35] The legislation expanded CMS's role and responsibilities to combat Medicaid waste, fraud and abuse by creating a Medicaid Integrity Program.[36] Among other provisions, the law required that CMS:

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[24] *Medicaid & CHIP Coverage*, HEALTHCARE.GOV, https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/.
[25] *Medicaid 101: Administration*, MACPAC, https://www.macpac.gov/medicaid-101/administration/.
[26] *Financial Management*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/finance/.
[27] Office of the Assistant Sec'y for Planning & Evaluation, *Federal Medical Assistance Percentages or Federal Financial Participation in State Assistance Expenditures*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (Mar. 1, 2015), https://aspe.hhs.gov/federal-medical-assistance-percentages-or-federal-financial-participation-state-assistance-expenditures.
[28] *See* Alison Mitchell, CONG. RESEARCH SERV., R42865, *Medicaid Disproportionate Share Hospital Payments*, at 1 (June 17, 2016), http://www.crs.gov/reports/pdf/R42865.
[29] *Eligibility*, MEDICAID.GOV, https://www.medicaid.gov/affordable-care-act/eligibility/index.html.
[30] Letter from Sen. Ron Johnson, *supra* note 6.
[31] *Id.*
[32] Email from Emily Felder, CMS, to S. Comm. on Homeland Sec. & Gov't Affairs maj. staff (May 18, 2018).
[33] U.S. Gov't Accountability Office, GAO-12-288T, *Medicaid Program Integrity: Expanded Federal Role Presents Challenges to and Opportunities for Assisting States* (Dec. 2011), *available at* https://www.gao.gov/assets/590/586719.pdf.
[34] Improper Payments Information Act of 2002, Pub. L. No. 107-300, 116 Stat. 2350 (2002).
[35] 151 Cong. Rec. S12,149-219 (daily ed. Nov. 2, 2005).
[36] 42 U.S.C.A. § 1396u-6.

- Review Medicaid providers "to determine whether fraud, waste, or abuse has occurred";
- Audit Medicaid claims to identify "overpayments to individuals or entities receiving Federal funds";
- Hire 100 new employees to focus solely on program integrity;
- Provide anti-fraud education and training
- Prepare anti-fraud plans every five years; and
- Report annually to Congress on the use of anti-Medicaid fraud funds.[37]

[37] Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (2006).

CMS'S LAX OVERSIGHT OF MEDICAID PROGRAM INTEGRITY

Medicaid program integrity had been considered primarily a state responsibility during the program's first four decades.[38] In the early 2000s, as independent watchdogs shined a light on Medicaid waste, fraud, and abuse, federal policymakers insisted that CMS do more. By 2005—four decades into Medicaid's existence—CMS had only eight full-time employees working to help states fight Medicaid fraud and abuse. That constituted about 0.2 percent of CMS's entire workforce, at a time when federal taxpayers spent more than $168 billion on Medicaid.[39] Each of CMS's eight employees was responsible for monitoring $21 billion in fraud.

In 2006, CMS established a Medicaid Integrity Group. Nearly a decade later, just after the ACA took effect, CMS subsumed that group under a broader Center for Program Integrity also focusing on Medicare—meaning that the Medicaid Integrity Group "no longer exists as a separate unit."[40]

The change highlights what government watchdogs have repeatedly found: that CMS's oversight of Medicaid program integrity—and its compliance with the 2005 law—has been spotty at best. Despite its vast authority to fight Medicaid waste and fraud, CMS struggles with its oversight of Medicaid program integrity.

Medicaid fraud

Medicaid fraud ranges from billing the government for services not performed to improperly billing for illicit prescriptions such as dangerous opioids. Although health care fraud is difficult to detect and often not prosecuted,[41] evidence indicates that fraud is pervasive in the Medicaid program and that CMS is failing to adequately police Medicaid fraud.

- In 2015, GAO found "thousands of Medicaid beneficiaries and hundreds of providers involved in potential improper or fraudulent payments" in four states—Arizona, Florida, Michigan, and New Jersey.[42]

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[38] U.S. Gov't Accountability Office, GAO-12-627, *National Medicaid Audit Program: CMS Should Improve Reporting and Focus on Audit Collaboration with States* (June 2012), *available at* https://www.gao.gov/assets/600/591601.pdf.

[39] U.S. Gov't Accountability Office, GAO-06-578T, *Medicaid Integrity: Implementation of New Program Provides Opportunities for Federal Leadership to Combat Fraud, Waste, And Abuse* (Mar. 2006), *available at* https://www.gao.gov/assets/120/113123.pdf.

[40] U.S. Gov't Accountability Office, GAO-15-207T, *Medicaid Information Technology: CMS Supports Use of Program Integrity Systems but Should Require States to Determine Effectiveness* (Jan. 2015), *available at* https://www.gao.gov/assets/670/668233.pdf.

[41] Paul Jesilow & Bryan Burton, *Detecting Healthcare Fraud and Abuse in the United States*, OXFORD RESEARCH ENCYCLOPEDIAS: CRIMINOLOGY & CRIMINAL JUSTICE, *available at* http://criminology.oxfordre.com/view/10.1093/acrefore/9780190264079.001.0001/acrefore-9780190264079-e-275; U.S. Gov't Accountability Office, GAO-16-216, *Health Care Fraud: Information on Most Common Schemes and the Likely Effect of Smart Cards* (Jan. 2016), *available at* https://www.gao.gov/assets/680/674771.pdf.

[42] GAO-15-313, *Medicaid: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls*, *supra* note 12.

- The Committee also found evidence of Medicaid fraud in its examination of Medicaid's role in helping to fuel the opioid epidemic.[43] In January 2018, Chairman Johnson released a staff report highlighting nearly 300 criminal cases involving at least 1,072 defendants in which people were convicted or charged with abusing Medicaid to obtain or sell opioids.[44] The criminal schemes identified by the Committee ranged from large drug rings that employ beneficiaries as "runners" to fill oxycodone prescriptions to nurses who steal hydrocodone pills from patients.[45] The Committee held a hearing in conjunction with the report to hear from local law enforcement and a former state Medicaid official about how Medicaid fraud helps to fuel the opioid crisis.[46]

- In a series of undercover operations between 2014 and 2016, GAO submitted applications to the federal ACA marketplace with names of fictitious enrollees and with fake or no documentation.[47] In nearly every instance, the marketplace granted Medicaid coverage to the non-existent enrollees—complete with premium tax credits—including in a number of stings that occurred three years after the ACA took effect.[48] The marketplace verified the fraudulent eligibility through a CMS-created "data hub." GAO warned in 2016 that the hub, which "plays a key role in the eligibility and enrollment process," was vulnerable to fraud.[49]

- In April 2018, GAO testified that CMS had failed to implement 11 separate GAO recommendation to fight Medicaid fraud, including providing regular fraud-awareness training to employees and requiring new hires to undergo such training, conducting Medicaid fraud risk assessments, and creating and implementing "an anti-fraud strategy."[50]

Medicaid overpayments

Federal law defines improper payments as those that should not have been made or were made in incorrect amounts.[51] Although improper payments include overpayments and underpayments, only 0.8 percent of the $36.7 billion in Medicaid improper payments in fiscal year 2017 were underpayments.[52] Although the exact percentage of overpayments that

[43] *Drugs for Dollars: How Medicaid Helps Fuel the Opioid Epidemic*, *supra* note 22.
[44] *Id.*
[45] *Id.*
[46] *"Unintended Consequences: Medicaid and the Opioid Epidemic": Hearing before the S. Comm. on Homeland Sec. and Gov't Affairs*, 115th Cong. (2018).
[47] GAO-16-29, *Patient Protection and Affordable Care Act: CMS Should Act to Strengthen Enrollment Controls and Manage Fraud Risk*, *supra* note 13.
[48] *Id.*
[49] *Id.*
[50] *Improper Payments in State-Administered Programs: Medicaid*, *supra* note 17.
[51] PAYMENTACCURACY.GOV, https://paymentaccuracy.gov/.
[52] U.S. Dep't of Health & Human Servs., *Agency Financial Report* (2017), *available at* https://www.hhs.gov/sites/default/files/fy-2017-hhs-agency-financial-report.pdf. Because Medicaid improper payments are overwhelmingly overpayments, this report is using the term overpayments where appropriate.

constitute fraud is unclear, there is no doubt that all overpayments waste federal tax dollars. Evidence suggests that CMS could do more to police Medicaid overpayments.

- Federal law required every federal agency to estimate improper payments and report the estimates annually to Congress beginning in FY 2004.[53] HHS, however, did not start reporting improper Medicaid payments until 2007.

- In 2008, the first full year in which HHS disclosed improper Medicaid payments, they were already the highest of any federal program at $18.6 billion.[54] This figure prompted a stern warning from GAO, which linked improper payments to fraud and warned that CMS needed "a culture of accountability over improper payments" to "reduce fraud and address the wasteful spending that results from lapses in controls."[55] GAO added that the magnitude of Medicaid payment errors "indicates that CMS and the states face significant challenges to address the program's vulnerabilities."[56]

- In 2015, GAO reported that while CMS had helped state Medicaid programs implement systems to detect overpayments, it had failed to require states to measure whether those systems worked.[57] With no requirement, most states did not implement metrics to measure success.[58] Around that time, Medicaid improper payments began rising, going from $14.4 billion in 2013[59]—the year before Obamacare took effect—to $37 billion in 2017—a 157 percent increase.[60] During the same period, the Medicaid improper payment rate, the percentage of total federal Medicaid expenditures estimated to be improper, rose 74 percent.[61] Medicaid alone now constitutes 26 percent of improper payments across the entire federal government.[62]

- As recently as 2017, GAO warned in its most recent High Risk report that "CMS's improper payment rate estimates may be inaccurate."[63] According to GAO, 13 years after Congress required CMS to better police Medicaid fraud, CMS must still "take

[53] Improper Payments Information Act of 2002, Pub. L. No. 107-300, 116 Stat. 2350 (2002).
[54] U.S. Gov't Accountability Office, GAO-09-628T, *Improper Payments: Progress Made but Challenges Remain in Estimating and Reducing Improper Payments* (Apr. 2009), *available at* https://www.gao.gov/products/GAO-09-628T.
[55] *Id.*
[56] *Id.*
[57] GAO-15-207T, *Medicaid Information Technology: CMS Supports Use of Program Integrity Systems but Should Require States to Determine Effectiveness*, *supra* note 40.
[58] *Id.*
[59] Letter from Beryl Davis, Dir., Fin. Mgmt. & Assurance, U.S. Gov't Accountability Office, to Sen. Thomas Carper, Chairman, S. Comm. on Homeland Sec. & Gov't Affairs, et al. (Dec. 9, 2014), *available at* https://www.gao.gov/assets/670/667332.pdf.
[60] GAO-18-444T, *Medicaid: Opportunities for Improving Program Oversight*, *supra* note 7.
[61] U.S. Dep't of Health & Human Servs., *Agency Financial Report* (2016), *available at* https://www.hhs.gov/sites/default/files/fy-2016-hhs-agency-financial-report.pdf.
[62] GAO-18-444T, *Medicaid: Opportunities for Improving Program Oversight*, *supra* note 7.
[63] U.S. Gov't Accountability Office, GAO-17-317, *High-Risk Series: Progress on Many High-Risk Areas, While Substantial Efforts Needed on Others* (Feb. 2017), *available at* https://www.gao.gov/products/GAO-17-317.

appropriate measures to reduce improper payments, as dollars wasted detract from our ability to ensure that the individuals who rely on the Medicaid program—including children, and individuals who are elderly or disabled—are provided adequate care."[64]

Medicaid audits and eligibility

CMS's lax oversight has extended into the most vital area of Medicaid program integrity: ensuring only those eligible for Medicaid receive the program's benefits.

- In 2011, CMS was forced to redesign its required audits of Medicaid providers, which were then the largest part of the CMS Medicaid integrity program.[65] Due to poor CMS data that were missing basic provider information, the audits identified less than $20 million in potential overpayments, at a cost of at least $102 million for contractors to conduct the audits.[66]

- Upon the ACA's implementation in 2014, evidence emerged that CMS was not paying enough attention to its fraud-related responsibilities for the fastest-growing part of Medicaid: managed care. GAO found that CMS and other federal entities had "taken few steps to address Medicaid managed care program integrity" and that CMS had failed to update its managed care program integrity guidance to states since 2000.[67] Unless CMS took "a larger role in holding states accountable," GAO warned, "a growing portion of federal Medicaid dollars [would be] vulnerable to improper payments."[68] Although HHS concurred with several GAO recommendations, it contended that a key anti-fraud recommendation—that CMS hold states accountable by requiring them to audit payments to Medicaid managed care providers—was "unclear."[69]

- By 2015, CMS had started interim reviews of Medicaid expansion eligibility determinations. However, CMS officials excluded from review Medicaid eligibility determinations in states where the federal government made such determinations, meaning that 67 percent of the country escaped such scrutiny.[70] In the 17 states that then had their own exchanges, CMS suspended until fiscal year 2018—the first four years of the ACA—its requirement that states review their own eligibility

[64] GAO-18-444T, *Medicaid: Opportunities for Improving Program Oversight*, *supra* note 7.
[65] U.S. Gov't Accountability Office, GAO-12-674T, *Medicaid: Federal Oversight of Payments and Program Integrity Needs Improvement* (Apr. 2012), *available at* https://www.gao.gov/assets/600/590392.pdf.
[66] *Id.*; GAO-12-288T, *Medicaid Program Integrity: Expanded Federal Role Presents Challenges to and Opportunities for Assisting States*, *supra* note 33.
[67] U.S. Gov't Accountability Office, GAO-14-341, *Medicaid Program Integrity: Increased Oversight Needed to Ensure Integrity of Growing Managed Care Expenditures* (May 2014), *available at* https://www.gao.gov/assets/670/663306.pdf.
[68] *Id.*
[69] *Id.*
[70] U.S. Gov't Accountability Office, GAO-16-53, *Medicaid: Additional Efforts Needed to Ensure that State Spending is Appropriately Matched with Federal Funds* (Oct. 2015), *available at* https://www.gao.gov/assets/680/673159.pdf.

determination.[71] Citing ACA-related changes to Medicaid eligibility standards and state eligibility systems, CMS required states that operate their own exchanges to conduct temporary "pilot eligibility reviews."[72] Those reviews did find Medicaid expansion eligibility errors in eight of nine states—including enrollment of people whose incomes were too high to be eligible.[73]

- CMS is still not reviewing eligibility determinations in states using the ACA's federally-facilitated exchanges as GAO has been recommending since 2015,[74] or filing annual reports on its Medicaid integrity program to Congress as required by the 2005 law.[75] According to GAO's latest High Risk report, CMS filed the 2013 and 2014 reports in 2016—and was more than a year late with the 2015 report. As a result, CMS is still unable to discharge its most fundamental duty to American taxpayers: "to ensure the fiscal integrity of the [Medicaid] program."[76]

[71] *Id*.
[72] *Id.*
[73] *Id.*
[74] GAO-18-444T, *Medicaid: Opportunities for Improving Program Oversight*, *supra* note 7.
[75] GAO-17-317, *High-Risk Series: Progress on Many High-Risk Areas, While Substantial Efforts Needed on Others*, *supra* note 63.
[76] *Id.*

CMS's LAX ATTENTION TO STATE MEDICAID PROGRAMS

As a joint federal-state program, Medicaid varies state-to-state. CMS claims it "works closely with [its] state partners to provide them with the tools and knowledge to effectively operate their programs."[77] While CMS has taken some steps to improve state-based integrity programs—including the establishment of the Medicaid Integrity Institute with the Justice Department in 2007—evidence suggests that CMS can do much more to root out waste, fraud, and abuse in state Medicaid programs.

GAO has identified several problems with CMS's oversight of and communication with state Medicaid programs.

- As late as 2014, CMS program integrity guidance issued in 2000 to states for Medicaid managed care was still not available on the CMS website, and state officials reported they did not use the guidance to fight fraud or overpayments. CMS told GAO at the time that the 14-year-old guidance was being "updated" but could not provide "a timeline for its completion."[78]

- CMS has still not provided guidance to states on the availability of automated information through Medicare's enrollment database, which would help states screen Medicaid providers. GAO has been urging this step since 2015.[79]

- CMS has not sought "to identify opportunities to address barriers that limit states' participation in collaborative audits,'' as GAO has also recommended.[80] Federal officials say CMS has sometimes allowed state officials to refuse to participate in these audits, which limited CMS's oversight of fraud and other program integrity issues.[81]

Fraud in state Medicaid programs

CMS's lax oversight of states is leading, in part, to Medicaid fraud and wasted taxpayer money.

- In March 2018, the Illinois auditor revealed that the state paid $71 million for Medicaid services for more than 8,000 people without checking whether they were still eligible within the 12-month period required by federal law.[82] Auditors also

[77] Email from Emily Felder, *supra* note 32.
[78] GAO-14-341, *Medicaid Program Integrity: Increased Oversight Needed to Ensure Integrity of Growing Managed Care Expenditures*, *supra* note 67.
[79] GAO-18-444T, *Medicaid: Opportunities for Improving Program Oversight*, *supra* note 7.
[80] *Id.*
[81] Interview with Gov't Accountability Office officials and S. Comm. on Homeland Sec. & Gov't Affairs maj. staff (Apr. 23, 2018).
[82] Financial Audit for the Year Ended June 30, 2017, STATE OF ILLINOIS DEP'T OF HEALTHCARE & FAMILY SERVS. (Mar. 6, 2018), *available at* https://www.auditor.illinois.gov/Audit-Reports/Compliance-Agency-List/DHFS/FY17-DHFS-Fin-Full.pdf.

determined that Illinois paid Medicaid costs for people who were never Medicaid eligible because their immigration status was not verified or they lacked a valid social security number, and that Illinois failed to recoup $76 million in overpayments to private Medicaid-program insurers.[83]

- In New York, the HHS OIG reported in January 2018 that state officials calculated Medicaid eligibility incorrectly for more than 30 percent of beneficiaries sampled by auditors.[84] The errors resulted in federal Medicaid payments of an estimated $26.2 million for more than 47,000 ineligible people.[85]

- In August 2017, HHS OIG identified an estimated $73 million in federal Medicaid payments for nearly 70,000 potentially ineligible beneficiaries in Kentucky.[86]

California: More than $1 billion in potentially fraudulent Medicaid payments

In California, the HHS OIG identified an estimated than $1 billion in federal Medicaid payments on behalf of 445,000 ineligible or potentially ineligible people.[87] Of that total, the OIG found $629 million in federal taxpayer funds to have been paid for 366,000 ineligible people.[88]

- CMS appears unwilling to recoup taxpayer dollars wrongly paid out from California's Medicaid program. During a hearing of the House Committee on Oversight and Government Reform in April 2018, CMS's deputy director for Medicaid, Timothy Hill, testified that CMS did not intend to collect the more than $1 billion in fraudulent payments from California.[89] Hill testified:

  Rep. Meadows: So, Mr. Hill, are you going after the $1.2 billion?

  Mr. Hill: The $1.2 [billion] is identified as potential overpayment. There was not a recommendation to collect it because . . .

  Rep. Meadows: Well, let me give you a recommendation. Collect it. I mean, it is the American taxpayers' dollars. Is it your sworn testimony here today…because you did not get a recommendation to collect $1.2 billion in improper payments, you are not going after it?

[83] John O'Connor, *Illinois Fails to Recoup $76 Million in Medicaid Overpayment*, U.S. NEWS (March 24, 2018), https://www.usnews.com/news/best-states/illinois/articles/2018-03-24/illinois-fails-to-recoup-76-million-in-medicaid-overpayment.
[84] U.S. Dep't of Health & Human Servs., A-02-15-01015, *supra* note 9.
[85] *Id.*
[86] U.S. Dep't of Health & Human Servs., A-04-16-08047, *Kentucky Did Not Always Perform Medicaid Eligibility Determinations for Non-Newly Eligible Beneficiaries in Accordance with Federal and State Requirements* (Aug. 2017), *available at* https://oig.hhs.gov/oas/reports/region4/41608047.pdf.
[87] U.S. Dep't of Health & Human Servs. Off. of Inspector Gen., A-09-16-02023, *supra* note 8.
[88] *Id.*
[89] *Improper Payments in State-Administered Programs: Medicaid*, *supra* note 17.

Mr. Hill: No, the recommendations were to fix the systems in California. . .

Rep. Meadows: So are you going after it or not?

Mr. Hill: We are not issuing a disallowance to California . . . .[90]

- CMS's reluctance to police California is all the more glaring in light of the size of California's Medicaid program. California received $20.3 billion for Medicaid expansion from the federal government in 2015—34 percent of all Medicaid expansion spending, even though California represented only 12 percent of the U.S. population.[91] As Chairman Johnson wrote to CMS administrator Verma in September 2017, enrollment under Medicaid expansion has substantially exceeded projections in California and many other expansion states.[92]

- California exemplifies how the ACA's Medicaid expansion reimbursement formula has allowed some states to game the system. Although the traditional federal matching rate ranges from 50 percent to as high as 73 percent, there is a far higher matching rate for people made newly eligible for Medicaid under the ACA—100 percent through 2016, before phasing down to 90 percent in 2020 and beyond.[93] This higher matching rate provides states a tremendous financial incentive to categorize more people as newly eligible to obtain more federal money.

- CMS's lax oversight extends to its review of California's state Medicaid plan. Because CMS allowed California to pay higher Medicaid rates to managed care companies during the ACA's first few years, insurance companies profited handsomely.[94] According to managed care financial results from California's Medicaid program, Health Net, the largest Medicaid insurer nationwide, reported a profit of $71 million in California in 2013.[95] In 2014, the first year of the ACA's Medicaid expansion, Health Net's profits rose to $170 million, and reached $484 million in 2015[96]—a 578 percent increase during the ACA's first two years. CMS has not stated publicly whether it will seek to recoup any of this funding from California.

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[90] *Id.*
[91] Letter from Sen. Ron Johnson, *supra* note 6.
[92] *Id.*
[93] Robin Rudowitz, *Understanding How States Access the ACA Enhanced Medicaid Match Rates*, KAISER FAMILY FOUNDATION (Sept. 29, 2014), https://www.kff.org/medicaid/issue-brief/understanding-how-states-access-the-aca-enhanced-medicaid-match-rates/.
[94] Terhune & Gorman, *supra* note14.
[95] *Medi-Cal Managed-Care Financial Results, 2012*, *supra* note 15.
[96] *Id.*

Medicaid maximization schemes

Because the federal contribution to Medicaid is generally unlimited, some states choose funding sources for their share of Medicaid's cost in a manner designed to maximize the federal government's contribution.[97] Under these so-called "Medicaid maximization schemes," the states artificially inflate what the federal government contributes while reducing the state contribution.[98] Both GAO and the HHS OIG have repeatedly warned that these Medicaid maximization schemes undermine the federal-state Medicaid partnership.[99]

- Intergovernmental transfers (IGTs) include "transfers of . . . funds between State and/or local public Medicaid providers and the State Medicaid agency."[100] IGTs "often do not represent a true expenditure for health care services," which means "states are not fully financing their share of Medicaid costs as was intended."[101] In one instance, Michigan "paid" $122 million of its own funds to county health facilities, along with a federal match—and the same day, the county facilities transferred all but $6 million of the state funds, and the federal match, back to the state.[102] States have used federal matching funds received "for a range of purposes with no direct link to improving quality of care or increasing Medicaid services."[103] According to GAO, CMS "generally does not require (or otherwise collect) information from states on the funds they use to finance Medicaid, nor ensure that the data that it does collect are accurate and complete."[104]

- States tax healthcare providers, then return the funds to the providers and trigger a

[97] *See generally Non-Federal Financing*, MACPAC, https://www.macpac.gov/subtopic/non-federal-financing/ (detailing various sources of funding) (last visited May 22, 2018).
[98] *See* U.S. Gov't Accountability Office, GAO-14-627, *Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection*, at 2-3 (July 2014), *available at* https://www.gao.gov/assets/670/665077.pdf.
[99] U.S. Gov't Accountability Office, GAO-16-195T, *Medicaid: Improving Transparency and Accountability of Supplemental Payments and State Financing Methods*, at 6 (Nov. 2015), *available at* https://www.gao.gov/assets/680/673493.pdf; *Spotlight on Medicaid: State Policies That Result in Inflated Federal Costs*, U.S. DEP'T OF HEALTH AND HUMAN SERVS., OFFICE OF INSPECTOR GEN., https://oig.hhs.gov/newsroom/spotlight/2014/inflated-federal-costs.asp (last visited May 22, 2018).
[100] *"Examining Medicaid and CHIP's Federal Medical Assistance Percentage": Hearing before the Subcomm. on Health of the House Comm. on Energy and Commerce*, 114th Cong. (2016) (statement of John Hagg, Dir. of Medicaid Audits, Off. of Inspector Gen., Dep't of Health and Human Servs.).
[101] Teresa Coughlin & Stephen Zuckerman, *States' Use of Medicaid Maximization Strategies to Tap Federal Revenues: Program Implications and Consequences*, URBAN INSTITUTE, at 11 (June 1, 2002), https://www.urban.org/sites/default/files/publication/60176/310525-States-Use-of-Medicaid-Maximization-Strategies-to-Tap-Federal-Revenues.PDF.
[102] U.S. Gov't Accountability Office, GAO-04-574T, *Medicaid: Intergovernmental Transfers Have Facilitated State Financing Schemes*, at 5-6 (Mar. 2004), *available at* https://www.gao.gov/assets/120/110702.pdf.
[103] *Spotlight on Medicaid: State Policies That Result in Inflated Federal Costs*, U.S. DEP'T OF HEALTH AND HUMAN SERVS., OFFICE OF INSPECTOR GEN., https://oig.hhs.gov/newsroom/spotlight/2014/inflated-federal-costs.asp (last visited May 22, 2018).
[104] GAO-16-195T, *Medicaid: Improving Transparency and Accountability of Supplemental Payments and State Financing Methods*, *supra* note 99, at 13; *see also* GAO-14-627, *Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection*, *supra* note 98, at 39 ("CMS does not collect accurate and complete data from all states on the various sources of funds to finance the nonfederal share . . . .").

federal match.[105] This shell game artificially inflates what the federal government contributes.[106] These taxes are "increasingly popular and [have] resulted in billions of dollars in additional Medicaid spending."[107] An Oregon official described the state's provider tax as a "dream tax," where "we [Oregon] collect the tax from hospitals, we put it up as a match for federal money, and then we give it back to the hospitals."[108] Connecticut has a similar scheme that, if approved by CMS, would enable it to pocket funds from federal taxpayers to bolster the state's bottom line.[109]

- Supplemental payments are "payments that are separate from the regular payments states make based on claims submitted for services rendered."[110] One type of supplemental payments, disproportionate share hospital (DSH) payments, helps offset costs that hospitals accrue when serving Medicaid beneficiaries and other low-income patients.[111] Such payments are "capped at a facility-specific level and state level."[112] But states also make non-DSH supplemental payments to hospitals and other providers that "are not subject to firm dollar limits at the facility or state level."[113] In fact, these payments "are not necessarily made on the basis of claims for specific services to particular patients and can amount to tens or hundreds of millions of dollars to a single provider, annually."[114] They can also exceed the costs of services provided.[115] According to GAO, "CMS lacks data at the federal level on [these] non-DSH supplemental payments," and "the payments are not subject to audit."[116] Similarly, according to GAO, CMS should require more "reliable[] and timely information" concerning supplemental payments states make to providers.[117]

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[105] *See* GAO-14-627, *Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection*, *supra* note 98, at 2.
[106] *Id*.
[107] Alex Brill, *Medicaid Provider Taxes: Closing a Loophole*, TAX NOTES, at 5 (June 29, 2015), *available at* http://www.aei.org/wp-content/uploads/2015/06/Brill-Medicaid-Provider-Taxes.pdf.
[108] Peter Wong, *Oregon House Extends Hospital Tax*, PORTLAND TRIBUNE, Mar. 11, 2015, *available at* http://portlandtribune.com/pt/9-news/253422-123198-oregon-house-extends-hospital-tax.
[109] Red Jahncke, *Why Tax Hospitals? It's a Medicaid Shell Game*, WALL ST. J., Dec. 29, 2017, *available at* https://www.wsj.com/articles/why-tax-hospitals-its-a-medicaid-shell-game-1514586150.
[110] GAO-14-627, *Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection*, *supra* note 98, at 2.
[111] GAO-16-195T, *Medicaid: Improving Transparency and Accountability of Supplemental Payments and State Financing Methods*, *supra* note 99, at 5.
[112] *Id*.; *see also* Alison Mitchell, CONG. RESEARCH SERV., R42865, *Medicaid Disproportionate Share Hospital Payments*, at 1 (June 17, 2016), http://www.crs.gov/reports/pdf/R42865.
[113] GAO-16-195T, *Medicaid: Improving Transparency and Accountability of Supplemental Payments and State Financing Methods*, *supra* note 99, at 5.
[114] *Id*.
[115] In 2012, GAO reported that "39 states made non-DSH supplemental payments" that exceeded "total costs of providing Medicaid care by about $2.7 billion." *Id.* at 7.
[116] *Id*. at 8.
[117] *See id.* at 6-7; *see also id.* at 8-9 (describing need for "complete and reliable provider-specific data" on non-DSH supplemental payments because such data is needed to identify payments that may be "excessive" and inappropriate).

THE COMMITTEE'S OVERSIGHT OF CMS AND MEDICAID

As the Chairman of the Senate's chief oversight committee, Senator Johnson has a duty to conduct oversight of federal agencies, including CMS, to ensure the government spends federal tax dollars efficiently and effectively.

Medicaid's escalating costs and enrollment figures

In the early days of the Trump Administration, Chairman Johnson became concerned about growing evidence that Medicaid expansion costs and enrollment were spiraling far beyond initial projections. Committee majority staff sought CMS's help in exploring this problem and understanding CMS's actions to address it.[118]

- On September 27, 2017, Chairman Johnson sent a letter to Administrator Verma formally requesting information about the escalating costs of Medicaid expansion and CMS's efforts to address the rising costs.[119] Chairman Johnson raised concerns that the cost surge could stem "from the Medicaid expansion's reimbursement formula, which gives states a financial incentive to categorize people as newly eligible to obtain more federal money."[120] Chairman Johnson also sent letters to eight states with particularly alarming rates of growth in Medicaid costs or enrollment.[121]

- In October 2017, Administrator Verma responded. She wrote that CMS "takes very seriously [its] responsibility to see that only eligible individuals are enrolled in entitlement programs."[122]

    - Administrator Verma wrote that CMS had provided enhanced funding for modernized or new state Medicaid eligibility systems and taken other steps, such as holding "multiple all-state calls and in-person trainings," to provide guidance to states on how to "implement the federal [Medicaid] match rate methodology appropriately."[123]

    - Administrator Verma's response did not address the repeated warnings from government watchdogs that CMS's actions to police Medicaid program integrity have been insufficient.[124] She wrote that CMS conducts quarterly reviews of state Medicaid expenditure reports and had disallowed only "over $15 million" in claims for services for newly eligible beneficiaries.[125] In

[118] *See e.g.* meeting with Cntrs. for Medicare & Medicaid Servs. and S. Comm. on Homeland Sec. & Gov't Affairs maj. staff (May 4, 2017); meeting with Brian Neale, Cntrs. for Medicare & Medicaid Servs. and S. Comm. on Homeland Sec. & Gov't Affairs maj. staff (Mar. 31, 2017).
[119] Letter from Sen. Ron Johnson, *supra* note 6.
[120] *Id.*
[121] *E.g.* Letter from Sen. Ron Johnson, *supra* note 18.
[122] Letter from Seema Verma, Adm'r, Ctrs. For Medicare & Medicaid Servs., to Sen. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Gov't Affairs (Oct. 27, 2017).
[123] *Id.*
[124] *Id.*
[125] *Id.*

comparison to the estimated $37 billion in annual Medicaid overpayments,[126] CMS's disallowance data shows that it could be doing more to police Medicaid program integrity.

Medicaid fraud and the opioid crisis

Chairman Johnson also uncovered evidence suggesting a correlation between the Medicaid program and the nation's opioid crisis.

- On January 17, 2018, Chairman Johnson convened a hearing of the Committee and released a staff report detailing how the structure of the Medicaid program creates a series of incentives for opioid abuse.[127] The report detailed hundreds of examples of opioid-related fraud in the Medicaid program and explained how Medicaid is serving as a funding source for obtaining and illicitly distributing opioids.[128] Chairman Johnson sent a copy of the report to Administrator Verma, along with specific questions about CMS's efforts to eliminate Medicaid's role in the opioid epidemic.[129]

- Administrator Verma responded on February 9, focusing instead on Medicaid's role in ensuring beneficiaries have treatment for substance abuse disorders.[130] While treatment is certainly an important element of Medicaid, Administrator Verma's response failed to address the key questions Chairman Johnson asked, specifically his request that she explain CMS's "work to improve the structure of the Medicaid program to limit the perverse incentives that lead to opioid abuse."[131] The Committee sought supplementary materials from CMS, which has provided only limited information to date about its work to address Medicaid's role in the opioid crisis.

Union dues skimming from Medicaid funds

On April 30, 2018, Chairman Johnson wrote to Administrator Verma urging CMS to review the practice of "dues skimming," in which states allow unions to classify home health care workers as government employees for purposes of collecting union dues from Medicaid payments.[132] Dues skimming allows states to take an estimated $200 million each year in union dues—money that would otherwise help for the care of Medicaid beneficiaries.[133]

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[126] GAO-18-444T, *Medicaid: Opportunities for Improving Program Oversight*, *supra* note 7.
[127] *Unintended Consequences: Medicaid and the Opioid Epidemic*, *supra* note 17; *Drugs for Dollars: How Medicaid Helps Fuel the Opioid Epidemic*, *supra* note 22.
[128] *Drugs for Dollars: How Medicaid Helps Fuel the Opioid Epidemic*, *supra* note 22.
[129] Letter from Sen. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Gov't Affairs, to Seema Verma, Adm'r, Ctrs. For Medicare & Medicaid Servs., & Eric D. Hargan, Acting Secretary, Dep't of Health & Human Servs. (Jan. 17, 2018).
[130] Letter from Seema Verma, Adm'r, Ctrs. For Medicare & Medicaid Servs., to Sen. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Gov't Affairs (Feb. 9, 2018).
[131] Letter from Sen. Ron Johnson, Chairman, *supra* note 6.
[132] Letter from Sen. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Gov't Affairs, to Seema Verma, Adm'r, Ctrs. For Medicare & Medicaid Servs. (Apr. 30, 2018).
[133] *Id.*

Administrator Verma responded on June 13, 2018.[134] She informed the Chairman that CMS "does not possess" information about the amount of Medicaid funds diverted for union dues, but that CMS was reviewing whether to implement changes to "ensure Medicaid fund are legally spent."[135] The response enclosed correspondence with the Illinois Governor about Medicaid dues skimming, but otherwise provided no responsive documents.[136]

[134] Letter from Seema Verma, Adm'r, Ctrs. For Medicare & Medicaid Servs., to Sen. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Gov't Affairs (June 13, 2018).
[135] *Id.*
[136] *Id.*

STEPS TOWARD REFORM

Medicaid is an important program that helps millions of Americans in need. But as the program has grown over the past half-century, it has expanded at a pace that is now threatening to overwhelm federal and state budgets.[137] The ACA is putting new strains on CMS and Medicaid,[138] making it vitally important that the federal government ensure that no tax dollars go to waste.[139]

Yet as this staff report shows, CMS is failing to safeguard the hundreds of billions of dollars that fund Medicaid each year.[140] A series of government watchdog reports, dating back more than a decade, show that CMS is not effectively policing Medicaid fraud. A succession of CMS administrators have not provided the effective oversight that Congress required in 2005.[141] The Committee's oversight of soaring expansion costs,[142] the pernicious role of opioids,[143] and the plague of Medicaid fraud[144] further demonstrates that CMS has not proven an effective steward of Medicaid taxpayer dollars. This unfortunate trend has continued, despite the Trump Administration's stated goal to reign in Medicaid fraud.[145]

The time is ripe for CMS to take proactive steps to reduce Medicaid fraud and improve program integrity. It must make a more serious commitment to Medicaid program integrity and sustain that effort through smart and effective oversight of state Medicaid programs. That commitment must extend through every part of the agency.

There are several steps that CMS could take toward improving Medicaid's program integrity.

- CMS should enact the 11 open GAO anti-fraud recommendations dating to 2015, especially those urging CMS to review federal Medicaid eligibility determinations for accuracy and to provide fraud-awareness training for all CMS employees.[146]

- CMS should take perhaps the most basic step of all: create, document and implement a Medicaid anti-fraud strategy.[147]

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[137] Letter from Sen. Ron Johnson, *supra* note 6.
[138] *Id.*
[139] *"Nomination of Seema Verma to be Administrator of the Centers for Medicare and Medicaid Services": Hearing before the S. Comm. on Finance*, 115th Cong. (2017).
[140] Robin Rudowitz & Allison Valentine, *Medicaid Enrollment & Spending Growth: FY 2017 & 2018*, KAISER FAMILY FOUNDATION (Oct. 19, 2014), https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2017-2018/.
[141] Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (2006).
[142] Letter from Sen. Ron Johnson, *supra* note 6.
[143] *Drugs for Dollars: How Medicaid Helps Fuel the Opioid Epidemic*, *supra* note 22.
[144] Letter from Sen. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Gov't Affairs, & Claire McCaskill, Ranking Member, S. Comm. on Homeland Sec. & Gov't Affairs, to Seema Verma, Adm'r, Ctrs. for Medicare & Medicaid Servs. (May 15, 2018).
[145] James Swann, *Trump Budget Would Boost Spending to Fight Medicare, Medicaid Fraud*, BLOOMBERG (Mar. 20, 2017), https://www.bna.com/trump-budget-boost-n57982085442/.
[146] GAO-18-444T, *Medicaid: Opportunities for Improving Program Oversight*, *supra* note 7.
[147] *Id.*

- CMS ought to crack down on states that allow fraud or otherwise abuse Medicaid funding, starting with recouping the more than $1 billion California spent on behalf of ineligible or potentially ineligible beneficiaries.[148]

- CMS should make a sustained effort to slow and then eliminate the $37 billion in overpayments plaguing the Medicaid program each year.[149]

- CMS should take seriously Medicaid's role in the opioid epidemic and make structural changes to the program that eliminate incentives leading to opioid abuse and illicit fraud.[150]

- CMS must work with government watchdogs, especially the non-partisan GAO and HHS OIG, to better police Medicaid fraud.

- CMS must become more responsive to and cooperative with Congressional oversight seeking to identify and eliminate Medicaid fraud.

In addition, Congress could take steps to address fundamental incentives that currently present challenges to Medicaid program integrity.

- Congress should reduce the "safe harbor" for states' taxes on health care providers to limit Medicaid maximization schemes that have inflated federal payments to states.[151]

- Congress should transition Medicaid to a block grant funding mechanism for existing Medicaid expansion populations,[152] instead of the current open-ended federal entitlement. This mechanism would help reduce incentives for states that seek to maximize federal funds and potentially enroll ineligible people. A block grant system would also provide a more equitable distribution of federal funding to states that have been good stewards of taxpayer dollars.[153]

[148] U.S. Dep't of Health & Human Servs. Off. of Inspector Gen., A-09-16-02023, *supra* note 8.
[149] GAO-18-444T, *Medicaid: Opportunities for Improving Program Oversight*, *supra* note 7.
[150] *Drugs for Dollars: How Medicaid Helps Fuel the Opioid Epidemic*, *supra* note 22.
[151] *Limit States' Taxes on Health Care Providers*, CONG. BUDGET OFFICE (Dec. 8, 2016), https://www.cbo.gov/budget-options/2016/52230.
[152] *Graham-Cassidy-Heller-Johnson Plan to Replace ACA Funding With a New Block Grant and Cap Medicaid Would Decrease Federal Funding for States by $160 Billion from 2020-2026; Then a $240 Billion Loss in 2027 if the Law is Not Reauthorized*, KAISER FAMILY FOUNDATION (Sept. 21, 2017), https://www.kff.org/health-reform/press-release/graham-cassidy-heller-johnson-plan-to-replace-aca-funding-with-a-new-block-grant-and-cap-medicaid-would-decrease-federal-funding-for-states-by-160-billion-from-2020-2026-then-a-240-billion-loss-in/.
[153] *Id.*