

STATEMENT OF

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ON

CMS'S EFFORTS TO FIGHT MEDICAID FRAUD AND OVERPAYMENTS

BEFORE THE

**U.S. SENATE COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL
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on
“CMS’s Efforts to Fight Medicaid Fraud and Overpayments”
U.S. Senate Committee on Homeland Security and Governmental Affairs Committee
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Chairman Johnson, Ranking Member McCaskill, and members of the committee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services’ (CMS’s) efforts to improve the integrity of the Medicaid program. I am particularly appreciative of this Committee’s recent work on this issue. As the nation’s largest payer and a steward of taxpayer dollars, our most important role is to strengthen our programs so they continue to well serve the beneficiaries who rely on them. I appreciate the opportunity to update the Committee on our efforts to improve the fiscal accountability of how we manage Federal taxpayer dollars in partnership with States.

Medicaid provides healthcare for an estimated 74.6 million Americans, including many of our most vulnerable citizens, at an annual combined Federal and State cost of over \$600 billion.¹ Medicaid expenditures have grown rapidly and are consuming ever-increasing shares of State budgets. As this Committee knows, Federal spending on the program has ballooned, growing by over \$100 billion between 2013 and 2016,² and it often sits at the number one or two spot in State budgets. We have a responsibility to make sure that taxpayer dollars are spent only on those who are truly eligible.

As the GAO acknowledged in its June 27, 2018 testimony to this Committee, “the size, complexity, and diversity of Medicaid make the program particularly challenging to oversee at the Federal level.”³ The Medicaid program has been on the GAO’s “High Risk List⁴” since 2003, and many of their outstanding recommendations have gone unimplemented for years. In March 2017, when I arrived at the agency, there were 212 outstanding GAO recommendations and 373 OIG recommendations across all CMS programs. Since then, I have placed a renewed focus on

¹ Source: CMS office of Actuary

² 2016 CMS Actuarial Report <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2016.pdf>

³ <https://www.hsgac.senate.gov/imo/media/doc/Testimony-Dodaro-2018-06-27.pdf>

⁴ <https://www.gao.gov/highrisk/overview>

engaging with and utilizing their expertise and implementing their recommendations quickly and in a thoughtful manner. I am happy to report that, since March 2017, we have implemented 92 GAO recommendations and 187 HHS-OIG recommendations, including 65 for the Medicaid program (18 GAO and 47 HHS-OIG). We have more work to do and we will continue to engage with the GAO and OIG. We have submitted 11 additional Medicaid recommendations to the GAO and 8 additional Medicaid recommendations to HHS-OIG for their review and closure. For example, in the spring of 2017 CMS began sharing access to the Social Security Administration's Death Master File (DMF) with States. This important step addresses a 2015 GAO recommendation⁵ and helps States identify deceased individuals who may be improperly enrolled in their Medicaid program. As CMS moves forward with our efforts to strengthen Medicaid, we will continue to rely on input from these same partners to inform our work. For example, the GAO's 2015 Fraud Risk Assessment Framework,⁶ is providing CMS with valuable guidance on how we can ingrain fraud risk assessment principles throughout the Agency to ensure that this critical work is not completed in a silo.

Since the beginning of my tenure here at CMS, my priority has been to partner with GAO, OIG and other oversight entities to deliver better outcomes for patients, and safeguard the integrity of the Medicaid program so resources are available for the vulnerable beneficiaries who rely on the program. Our vision for transforming the Medicaid program is grounded on three principles: greater flexibility, stronger accountability, and enhanced program integrity.

Providing States Flexibility to Design Their Medicaid Programs

CMS has delivered on our commitment to resetting the State-Federal partnership by offering States unprecedented flexibility to design health programs that meet the needs of their residents. We have taken action through a number of changes that make it easier than ever before for States to design innovative approaches to improving quality, lowering costs, and delivering value to our beneficiaries.

⁵ <https://www.gao.gov/products/GAO-15-313>

⁶ <https://www.gao.gov/products/GAO-15-593SP>

Recently, CMS adopted new strategies for more efficient processes for approval of State Plan Amendments (SPAs) and waiver and adjudication under Section 1915 of the Social Security Act, as well as implementing other long term process improvements.⁷ CMS also announced new procedures, effective October 1, 2018, to prevent formation of a backlog of pending SPAs in instances where CMS has not received a State response to a formal request for additional information within 90 days of issuance.

A key goal of this initiative was to develop a process improvement strategy that enhanced the efficiency of the SPA and 1915 waiver review process, reducing the administrative burden for States and, ultimately, reducing processing times. We collaborated closely with States and the National Association of Medicaid Directors (NAMd) to identify the issues that impact SPA and 1915 waiver processing and jointly developed a number of process improvement strategies, the first of which was implemented in the fourth quarter of 2017. The concerted effort by both States and CMS on process improvement and the implementation of the new strategies are beginning to result in more efficient and timely processing of SPA and 1915 waiver actions:

- Between calendar year 2016 and the first quarter of 2018, there was a 23 percent decrease in the median approval time for Medicaid SPAs.
- Eighty-four percent of Medicaid SPAs were approved within the first 90 day review period in the first quarter of 2018, a 20 percent increase over calendar year 2016.
- Between calendar year 2016 and the first quarter of 2018, median approval times for 1915(b) waivers decreased by 5 percent, 1915(c) renewal approval times decreased by 38 percent, and 1915(c) amendment approval times decreased by 54 percent.

We've approved groundbreaking Medicaid demonstration projects, including reforms to test how Medicaid can be designed to improve health outcomes and lift individuals from poverty by connecting coverage to community engagement. We are also streamlining our internal processes and breaking down regulatory barriers that force States to commit too much of their time and resources to administrative tasks rather than focusing on delivering better care. For example, earlier this year CMS proposed relieving States' from burdensome paperwork requirements

⁷ See: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib081618.pdf>

relating to duplicative monitoring of patients in managed care and fee for service.⁸ States have raised concerns over undue administrative burden associated with meeting potentially duplicative reporting requirements of a final rule CMS published in November 2015.⁹ Specifically, States with few Medicaid members enrolled in their fee-for-service program or with members that are only temporarily enrolled, and States making small reductions to fee-for-service payment rates, have urged CMS to consider whether analyzing data and monitoring access in that program is a beneficial use of State resources.

State Accountability for Outcomes

This new flexibility must be balanced by a system that holds States accountable for producing improvements in program outcomes for the people they serve, as well as appropriate Federal oversight of program integrity to protect the American taxpayers. Ultimately, States and the Federal government share mutual obligations and accountability for the integrity of the Medicaid program and the development, application, and improvement of program safeguards necessary to ensure proper and appropriate use of both Federal and State dollars. CMS is committed to achieving this balance, and that is precisely why, in June, CMS released the first ever CMS Medicaid and Children’s Health Insurance Program (CHIP) Scorecard¹⁰ to increase public transparency about the programs’ administration and outcomes. For too long, we have lacked transparency in the performance and outcomes of this critical program. This first version of the Scorecard includes information on selected health and program indicators such as subsets of measures from the CMS Medicaid and CHIP Child and Adult Core Sets along with Federal and State accountability measures. The Scorecard also sheds light on key questions about the scope of Medicaid and CHIP regarding enrollment, annual expenditures, and the data CMS and States are developing to support program improvement. The Scorecard will be used to track and display progress being made throughout and across the Medicaid and CHIP programs, so others can learn from the successes of high performing States. Future iterations of the Scorecard likely will allow year-to-year comparisons to help identify trends, including on measures such as quality

⁸ <https://www.federalregister.gov/documents/2018/03/23/2018-05898/medicaid-program-methods-for-assuring-access-to-covered-medicaid-services-exemptions-for-states-with>

⁹ <https://www.federalregister.gov/documents/2015/11/02/2015-27697/medicaid-program-methods-for-assuring-access-to-covered-medicaid-services>

¹⁰ <https://www.medicaid.gov/state-overviews/scorecard/index.html>

outcomes, per-person spending, and program integrity performance. CMS envisions that Scorecard will be strengthened by the availability of more timely, accurate, and complete data collected through the Transformed Medicaid Statistical Information System (TMSIS)¹¹ as State reporting continues to improve. By using meaningful data and fostering transparency, we will see the development of best practices that lead to positive health outcomes for our most vulnerable populations.

The first version of the Scorecard includes measures voluntarily reported by States, as well as Federally reported measures in three areas: State health system performance; State administrative accountability; and Federal administrative accountability. The metrics included in the first Scorecard reflect important health issues such as well child visits, mental health conditions, children's preventive dental services, and other chronic health conditions. The Scorecard represents the first time that CMS is publishing State and Federal administrative performance metrics - which include measures like State/Federal timeliness of managed care capitation rate reviews, time from submission to approval for demonstration projects, under the authority of section 1115 of the Social Security Act (section 1115 demonstrations), and State/Federal SPA processing times.

The data offered within the Scorecard begins to offer taxpayers insights into how their dollars are being spent and the impact those dollars have on health outcomes. In future years, the Scorecard will be updated annually with new functionality and new metrics, including opioid-related and home and community based services-related quality metrics, as well as the ability to compare spending patterns. CMS will continue to work with States to encourage greater reporting across a broader set of metrics to improve consistency across States.

Enhanced Program Integrity

Oversight of the Medicaid program requires a partnership between CMS and the States. CMS plays a significant role in supporting State efforts to meet high program standards, and we have developed a strategy that prioritizes accountability and integrity protections. In June, we

¹¹ The T-MSIS data set contains: Enhanced information about beneficiary eligibility; Beneficiary and provider enrollment; Service utilization; Claims and managed care data; and Expenditure data for Medicaid and CHIP

announced a new Medicaid program integrity strategy that will bring CMS into a new era of enhancing the accountability of how we manage Federal taxpayer dollars in partnership with States.

These efforts include several new and enhanced Medicaid program integrity initiatives that this Administration believes are essential to help strengthen and preserve the foundation of the program for the millions of Americans who depend on Medicaid's safety net. These initiatives build upon our existing program integrity efforts to include stronger audits, increased beneficiary eligibility oversight, and enhanced oversight of State compliance with Federal rules.

This enhanced Medicaid program integrity strategy was developed with input from stakeholders, including clinicians, Congress, and patients. Insight and recommendations from GAO and HHS-OIG have also contributed to these efforts.

New Audits of State Beneficiary Eligibility Determinations

As part of CMS's strategy to increase program integrity, CMS has initiated new, targeted eligibility review audits and is implementing new requirements for Payment Error Rate Measurement (PERM) audits. Medicaid was created to care for the nation's most vulnerable populations – low income seniors in need, pregnant women, children, and people with disabilities. For these individuals, Medicaid is more than a safety net, it is a lifeline – one that needs to be preserved and protected for those most in need. The Patient Protection and Affordable Care Act (PPACA), however, significantly expanded Medicaid eligibility, allowing States to enroll childless, non-disabled adults with incomes below 138 percent of the poverty level. It also provided States with an enhanced Federal contribution toward this newly eligible expansion population, covering 100 percent of these costs from 2014 through 2016, 95 percent of costs in 2017, and 94 percent this year. This match rate will decline until 2020, at which point States will receive an ongoing 90 percent match for this newly eligible expansion population. This enhanced Federal match increases the need for robust Federal oversight since States receive a higher percentage match for someone who is determined to be newly eligible for Medicaid under the PPACA. In 2016, an estimated 11.2 million newly eligible adult enrollees were covered under the expanded Medicaid eligibility, and, from 2016 through 2025, Medicaid

expenditures for adults newly eligible under the PPACA are projected to amount to \$806 billion (\$741 billion paid by the Federal government).¹²

While CMS has existing controls in these areas, we are particularly concerned by findings from the OIG about State implementation of eligibility systems for the expansion group. In 2017 and 2018, the OIG raised concerns with the accuracy of three States' determinations of Medicaid eligibility for "some newly enrolled beneficiaries."¹³

CMS is taking two key actions to address these concerns. First, CMS has begun our own review of States previously found to be high risk by the OIG to examine how they are determining which groups are eligible for Medicaid benefits. These audits will include assessing the effect of Medicaid expansion and ensuring that States are appropriately claiming the enhanced match for beneficiaries. .

Second, under a CMS regulation¹⁴ published in June 2017, CMS will once again measure the current improper payment rate for the eligibility component of PERM, beginning with the FY 2019 reporting period. This measurement and reporting process is one of many tools CMS uses to identify and address areas at risk for – and factors contributing to – improper payments. It is important to remember that not all improper payments constitute fraud or result in monetary loss to the government. An improper payment is 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. For example, if a physician provides a legitimate service to a legitimate beneficiary but accidentally fills out the paperwork incorrectly or is missing documentation, this would be considered an improper payment.

¹² <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2016.pdf>

¹³ See: <https://oig.hhs.gov/oas/reports/region9/91602023.asp> (California); <https://oig.hhs.gov/oas/reports/region2/21501015.asp> (New York); and <https://oig.hhs.gov/oas/reports/region4/41608047.asp> (Kentucky)

¹⁴ <https://www.federalregister.gov/documents/2017/07/05/2017-13710/medicaidchip-program-medicare-program-and-childrens-health-insurance-program-chip-changes-to-the>

To reduce State burden and improve review accuracy and consistency, these PERM reviews will be conducted by a Federal contractor with support from each State. Through the improper payment rate measurement, CMS identifies and classifies types of errors and shares this information with each State. States then analyze the findings to determine the root causes for improper payments and work with CMS to develop and implement effective corrective actions to safeguard taxpayer dollars.

Targeted Audits of State Managed Care Claims for Federal Match Funds and Rate Setting

Audits are central to CMS's partnership with States—not only encouraging compliance but also revealing how to improve integrity at all levels. CMS will begin auditing some States' managed care organization financial reporting based on the amount spent on clinical services and quality improvement versus administration and profit.

Most States covered newly eligible adults through managed care programs. Due to the limited historical data and experience for the newly-eligible adult Medicaid expansion population prior to 2014, developing and reviewing managed care capitation rates was more challenging than for populations of individuals traditionally eligible for Medicaid. In particular, there was uncertainty regarding assumptions for pent-up demand and the health status of new enrollees, leading to the possibility of greater utilization of services than that of other adult enrollees already covered by Medicaid.

To address the uncertainty regarding this population, some States employed risk mitigation strategies in setting their managed care rates. Under this approach, the State requires managed care plans to pay at least 85 percent of their capitation rates on health care expenditures for their enrollees. If the plan ultimately spends under 85 percent, they are required to remit the difference to the State. The State is then required to pay back the Federal portion of those costs to the Federal government. Because of the enhanced match prescribed by the ACA, 100 percent of the costs for this population was covered by the Federal government for the first three years. The Administration is aware of concerns that managed care rates resulted in significant profits for insurance companies, and is committed to reviewing these rates and is taking action when appropriate. For example, CMS initiated oversight action to ensure that the State of California

resolves a collection issue and returns a significant amount of funding owed to the Federal government related to the State's Medicaid expansion. CMS is closely monitoring the collection and verification of managed care plans' financial data. By the end of this year, we expect to have recouped roughly \$9.5 billion in rate adjustments for the period January 2014-December 2016.

As part of this new strategy, CMS will make sure claims experience used to set capitation rates actually match what plans have been reporting. Audit activities will include review of high-risk vulnerabilities identified by the GAO and OIG, as well as other behavior previously found detrimental to the Medicaid program.

Addressing the Inherited Backlog of Disallowances

With all of our program integrity efforts, our first goal is to work in partnership with States to prevent the misuse of taxpayer dollars. But from time to time, it is necessary for us to use our enforcement mechanisms to seek the return of Federal funding that has not been claimed appropriately. When the State does not voluntarily return Federal funds associated with unallowable claims, CMS can recover them by issuing a disallowance. The disallowance process consists of significant legal, financial, and policy analyses to ensure our final determination is consistent with Medicaid statute and regulations.

This Administration inherited a backlog of potential disallowances where CMS, OIG, or State oversight activities identified potentially unallowable State claims, but CMS had not yet made a formal determination to disallow. We are taking action to clear out a number of these potential disallowances that were not issued in the past. As part of these efforts, in June we issued over \$321 million in backlogged disallowances. This year, CMS has issued disallowances for such unallowable expenses as improperly claimed school based services administrative costs, improper claims made for school-based transportation services that did not meet State and Federal requirements, improper expenditures for residential habitual services, and unallowable orthodontic services. Since March 2017, we have issued over \$590 million in total disallowances. We are committed to achieving more expeditious resolution of these types of issues, as they arise, to prevent new backlogs from developing in the future, thereby ensuring Federal funds are repaid in a timely manner.

Designated State Health Programs (DSHP) Funding Phase-Out

CMS has closed off financing loopholes that some States have used to generate Federal dollars to support State programs that are historically supported with State-only dollars. Since 2005, CMS has approved a number section 1115 demonstrations that included providing Federal funding for State expenditures for designated State health programs (DSHP) that were previously funded entirely by the State, without Federal funds.

One stated purpose of Federal DSHP funding was to ensure the continuation of these beneficial State programs while the State was incurring additional expenditures for health service delivery reform or expansion of health services under the demonstration project. However, the result has been that many States are not contributing State funds toward these delivery system reform efforts. Instead, these States are primarily relying on dollars freed up by the Federal Medicaid contribution to DSHP to draw down additional Federal Medicaid matching expenditures to support delivery system reforms. For example, one State's approved DSHP includes an immunization program and tobacco use prevention that previously were funded entirely by the State, without Federal Medicaid matching funds, and do not appear integral to the State's section 1115 demonstration supporting delivery system reform.

After reviewing the practice of DSHP funding, CMS has put out guidance to States that we will no longer approve their proposals for new or renewing section 1115 demonstrations that rely on Federal matching funds for DSHP and we will work with States to phase out this financing mechanism, by the end of their existing demonstrations. Federal DSHP funding has raised oversight concerns about its consistency with the Federal-State financial partnership established under the Medicaid statute. Moreover, current demonstrations have not made a compelling case that Federal DSHP funding is a prudent Federal investment. Authority for DSHP in current demonstrations will continue until the end of the State's current demonstration period but will not be extended or renewed.

Intergovernmental Transfers

CMS has always been concerned about ensuring that States finance their share of Medicaid payments within statutory and regulatory requirements. This can be a challenging endeavor. This Administration has been studying these approaches and where necessary has denied State proposals. We are committed to continuing this effort and holding States and providers accountable. We are exploring options to make requirements more clear as well as options for the necessary review and action that should be taken against improper financing mechanisms. One major concern has been about private/public arrangements that allow transfers of ownership between such entities to allow the use of IGTs. For example, CMS has received State requests to allow supplemental payments to private nursing facilities that lease their facility license to a local government entity that then contract back with the private owner to manage and operate the facility. This happens only on paper, and day to day operations of the facility continue unchanged. Federal rules would ordinarily prohibit a private nursing facility from providing the State match responsibility through a donation to the State. But under this arrangement, States would declare that the non-Federal share of Medicaid funding would be derived from an intergovernmental transfer (IGT) from the local government entity that leased the facility's license, when in reality it originates from the private provider. Since 2017, CMS has issued 2 formal denials of such requests as we concluded there was not a permissible source of non-Federal funding. CMS also works actively with States to provide necessary guidance to States to avoid improper financing. We are also exploring avenues to examine this issue in States where this practice has been going on for a number of years dating back to before this administration.

Budget Neutrality Policies for 1115 Medicaid Demonstration Projects

In response to longstanding concerns raised by our colleagues at the GAO¹⁵, CMS expects to issue guidance to States that formalizes recent changes that CMS made to budget neutrality for demonstration project extensions, in order to strengthen fiscal accountability and prevent the Federal government's exposure to excessive expenditures under section 1115 demonstrations. CMS will provide States with a brand new monitoring tool intended to support a more standardized and timely approach for States' demonstration expenditure reporting

¹⁵ Most recently in GAO-17-312: <https://www.gao.gov/assets/690/683888.pdf>

We will also announce changes to how we expect States to calculate their baseline expenditures to more accurately reflect State spending trends, beginning January 1, 2021. CMS will not approve section 1115 demonstrations unless the project is expected to be budget neutral to the Federal government. A budget neutral demonstration project does not result in Medicaid costs to the Federal government that are greater than what the Federal government's Medicaid costs would likely have been absent the demonstration.¹⁶ The overarching goal of CMS's approach to budget neutrality is, therefore, to limit Federal fiscal exposure resulting from the use of section 1115 authority in Medicaid.

Optimizing Data

As technology advances across the health care industry, data will continue to play an increasing role in our program integrity efforts. That's why improving Medicaid and CHIP data and systems is a high priority for CMS. Through strong data and systems, CMS and States can drive toward better health outcomes and improve program integrity, performance, and financial management in Medicaid and CHIP. CMS has been working with States to implement changes to the way in which data on health services is collected by moving from the Medicaid Statistical Information System (MSIS) to the Transformed-MSIS (T-MSIS).

As of this June, all 50 States, D.C. and Puerto Rico are now for the first time submitting data on their programs to T-MSIS, and over the course of the coming months CMS will be validating the quality and completeness of the data. CMS's ongoing goal is to use advanced analytics and other innovative solutions to both improve T-MSIS data and maximize its potential for program integrity. This will allow CMS to identify instances like a beneficiary receiving more hours of treatment than hours in a day or other flags that necessitate further investigation.

¹⁶ What the federal government's Medicaid costs would likely have been absent the demonstration may also include costs that could be federally matched if the state were to amend its Medicaid state plan or obtain waivers under certain title XIX authorities. These costs may be deemed "hypothetical" if the state could otherwise have covered these costs under a state plan amendment or a waiver under section 1915 of the Act.

Conclusion

We share the Committee's commitment to protecting beneficiaries and ensuring that taxpayer dollars are spent on legitimate items and services, both of which are at the forefront of our program integrity mission. By making sure taxpayer dollars are used responsibly, Medicaid program integrity plays an important role in our shared goal of refocusing Medicaid on the nation's most vulnerable populations in order to provide a more robust level of care and a strengthened program overall.