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MEDICAID MAINTENANCE-OF-EFFORT PROVISIONS DO NOT STOP STATES FROM FIGHTING FRAUD

by Sarah Lueck

Affordable Care Act provisions requiring states to maintain their eligibility standards and procedures for Medicaid and the Children's Health Insurance Program do not impede states' efforts to ensure program integrity and reduce fraud, waste, and abuse, contrary to claims of House members who seek their repeal. Moreover, repeal of the provisions, which the House Energy and Commerce Committee will consider this week, would raise the risk that many low-income children, seniors, people with disabilities, and others would lose their Medicaid coverage and end up uninsured.

The requirements, known as a maintenance of effort (or MOE) provisions, were included in the health reform law and generally require that states maintain their current eligibility standards and procedures for Medicaid and CHIP until 2014, when new, nationwide eligibility standards for Medicaid (established under the Affordable Care Act) will take effect. For children, the MOE provision maintains current eligibility standards and procedures through 2019.

But the MOE provisions do *not* affect any of the tools and initiatives that states (and the federal government, which jointly administers Medicaid) use to combat fraud and abuse. Moreover, fraud and abuse in Medicaid are overwhelmingly due to actions by health care providers (or individuals posing as health care providers) — not low-income individuals and families that receive health care and long-term care services. Nor do the MOE provisions affect another critical aspect of program integrity — efforts to identify and remedy Medicaid payment errors that do not involve fraud or abuse.

Misleading claims about the MOE provisions distract from the likely impact of their repeal. Repeal would mean that states could sharply cut eligibility in their Medicaid programs and raise procedural barriers that make it more difficult for eligible individuals and families to apply for and remain enrolled in Medicaid. As a result, many children, seniors, people with disabilities, and others could lose their Medicaid coverage and end up uninsured.[1]

[1] Judith Solomon, "Repealing Health Reform's Maintenance of Effort Provision Could Cause Millions of Children, Parents, Seniors, and People With Disabilities to Lose Coverage," Center on Budget and Policy Priorities, February 24, 2011.

Medicaid Anti-Fraud and Program Integrity Efforts Have Increased in Recent Years

States and the federal government currently use numerous tools and initiatives to prevent and investigate fraud in Medicaid and to recover misspent funds. There is no credible claim or evidence that the MOE provisions affect these efforts, a number of which are described below. In fact, anti-fraud activities have increased since the MOE provisions were enacted as part of the Affordable Care Act (ACA).

- Under the existing Health Care Fraud and Abuse Control program (HCFAC), a 14-year-old effort to combat fraud and abuse in the public and private health sectors, the federal government won or negotiated approximately $2.4 billion in judgments and settlements in fiscal year 2011 and received additional funds through administrative impositions in health care fraud cases and proceedings. As a result, the Medicare Trust Fund received approximately $2.5 billion, and another $600 million in federal Medicaid recoveries was transferred to the Treasury. Since 1997, for every $1 expended under the HCFAC program, $5.10 has been returned to the Treasury. From 2009 to 2011, the three-year rolling average showed a $7.20 return-on-investment — $2.10 higher than the historical average.[2]

- A recent initiative called Project HEAT (for Health Care Fraud Prevention and Enforcement Action Team) focuses on identifying the geographic hot spots for Medicaid and Medicare fraud, using real-time claims data to detect patterns of fraud, and strengthening partnerships and information-sharing between the Department of Justice and HHS, among other efforts.[3]

- HHS and the DOJ have expanded the Medicare Strike Force, which is made up of multi-agency teams dedicated to fighting fraud. In fiscal year 2011, Strike Force operations charged a "record number" of 323 defendants who allegedly billed the Medicare program a collective $1 billion, HHS and DOJ reported. Strike Force teams secured 172 guilty pleas, convicted 26 defendants at trial, and sentenced 175 defendants to prison.[4]

- Under the Medicaid Integrity Program, established by Congress in 2006, the Centers for Medicare and Medicaid Services is reviewing and auditing health care provider claims, supporting state efforts to improve program integrity and conduct investigations in Medicaid, and using expanded data analysis capabilities to identify anomalies in Medicaid provider payments.[5]

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[2] U.S. Department of Health and Human Services and U.S. Department of Justice, "Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2011," February 2012. Some of the transfers reported in fiscal year 2010 are the result of judgments, settlements and actions that occurred in prior years, and some actions in 2010 will result in future transfers.

[3] William Corr, Department of Health and Human Services, Testimony before the House Committee on Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies, March 4, 2010.

[4] "Health Care Fraud Prevention and Enforcement Efforts Result in Record-Breaking Recoveries Totaling Nearly $4.1 Billion," HHS and DOJ news release, February 14, 2012.

[5] Center for Program Integrity, Centers for Medicare and Medicaid Services, "Annual Report to Congress on the Medicaid Integrity Program for Fiscal Year 2010," 2011.

- Under the health reform law, anti-fraud activities have increased. The types of Medicaid providers and suppliers that have historically posed a high risk of fraud or abuse must now be screened before they are allowed to participate in the Medicaid program. The ACA also requires states to withhold Medicaid payments from providers when there is a credible allegation of fraud, has strengthened the civil and monetary penalties for Medicaid fraud and added a requirement that states establish Medicaid Recovery Audit Contractors (RACs) to identify and recover overpayments, among other changes.[6] An anti-fraud expert has called the new tools in the ACA "very good news for patients and taxpayers alike."[7]

Nor do the MOE provisions interfere with ongoing state efforts to prevent and identify erroneous or improper payments (which do not necessarily constitute fraud or abuse) in Medicaid. For example:

- Under the Payment Error Rate Measurement (PERM) program for Medicaid, states and the federal government collect data to detect and remedy errors in provider payments, data processing, and state eligibility decisions and to estimate an annual national error rate for the program. Under an executive order President Obama issued in November 2009, which focused on reducing improper payments and waste across government programs, Medicaid must make reports on a Treasury website and report on their comprehensive error-reduction activities to HHS and the HHS Office of Inspector General.[8]

- Under the Medicaid Eligibility Quality Control (MEQC) system, states sample cases from their eligibility files to monitor Medicaid administration and recover misspent funds. Under MEQC, states can examine Medicaid overall or choose to study particular areas of eligibility or program administration that are error-prone or have a high potential to prevent or reduce errors.

Providers, Not Individuals, Are the Main Source of Medicaid Fraud

Claims that the MOE provisions are hampering states' anti-fraud efforts imply that a major element of Medicaid fraud and abuse is inappropriate enrollment of individuals and that states need greater leeway to tighten their eligibility procedures to fix the problem. There is no evidence, however, of serious eligibility fraud.

An estimated 80 percent of health care fraud — in both public programs like Medicaid and Medicare and in private insurance — is committed by health care providers, not individuals, according to the National Health Care Fraud Association. The most common types of provider fraud include billing for services that were not provided or for more expensive procedures than were actually performed, performing medically unnecessary services to generate insurance payments, and falsifying a patient's diagnosis to justify services or procedures that are not medically necessary.

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[6] U.S. Department of Health and Human Services, "New Tools to Fight Fraud, Strengthen Medicare, and Protect Taxpayer Dollars," March 15, 2011.

[7] Louis Saccoccio, Testimony before the House Committee on Ways and Means, Subcommittee on Oversight, National Health Care Anti-Fraud Association, March 2, 2011.

[8] "Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2010," *op cit.*

When individuals are involved in health care fraud, they frequently are unwitting participants — or even victims. Perpetrators may steal Medicaid beneficiaries' personal information, tamper with their medical records, or perform medically unnecessary and risky procedures as part of fraudulent schemes.[9]

Past Measurement of Eligibility Errors Was Flawed

Tracking eligibility errors is another important component of assuring program integrity in Medicaid, through PERM and other efforts. Eligibility errors found through PERM typically arise from a lack of documentation in reviewed case files or caseworker errors, rather than from individuals providing false information to get benefits for which they are not eligible.[10]

When PERM reviews were first implemented, some states that had eased Medicaid documentation requirements for eligibility purposes had more errors. This, however, was the result of a flaw in the PERM process itself, which initially required states to obtain extra documentation such as pay stubs for PERM eligibility reviews, even though some states did not require Medicaid beneficiaries to provide this type of documentation and the federal government does not require states to collect it. Without the extra documentation, cases were counted as eligibility errors even when the individuals were eligible. Legislative and regulatory corrections have addressed this issue. Now states undergoing PERM reviews are measured on whether they made the correct policy decisions based on their own policies, procedures, and requirements for documentation, which must be consistent with federal law.

In the past, critics of the MOE provisions have cited a statistic that 20 percent of the people in Oregon's Medicaid program were ineligible. This figure recently appeared, for example, in a paper issued by House Energy and Commerce Committee Republicans in support of past legislation repealing the MOE provisions. But this percentage is incorrect; it was based on miscalculations made during an FY 2008 PERM review of Oregon's Medicaid program. The state's eligibility error rate was officially corrected to be 6.8 percent after the technical calculation errors were discovered. Moreover, this lower figure does not mean that 6.8 percent of Medicaid beneficiaries in Oregon are not eligible. It is an estimate of improper payments for Medicaid services in cases where issues were identified during the eligibility review.[11]

Repealing MOE Would Likely Prevent Many Eligible Individuals from Enrolling in Medicaid

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[9] Sara Rosenbaum, Testimony before the House Committee on Energy and Commerce Subcommittee on Oversight and Investigation, March 2, 2011. See also, National Health Care Anti-Fraud Association, "The Problem of Health Care Fraud," accessed at www.nhcaa.org on May 20, 2011.

[10] See for example, "Medicaid Payment Error Rate Measurement Final Report, Fiscal Year 2008," Department of Health and Human Services, October 21, 2009, pp. 27-28.

[11] PERM error rates include both underpayments and overpayments, people being placed in the incorrect program, and (as noted previously) documentation problems even if no improper payment was made. The main purpose of state error rates is to calculate a national error rate, and state rates may not be meaningful on their own.

The health care reform law maintains existing eligibility levels in Medicaid until new, nationwide Medicaid eligibility standards take effect and health insurance exchanges begin operating in 2014. It prohibits states from making changes to eligibility standards as well as to enrollment procedures. If the MOE is repealed, states would be able to tighten their enrollment procedures by requiring extra paperwork and adopting other procedural barriers. Experience shows that such changes would lead many individuals and families to lose coverage. For example:

- In 2005, Mississippi began requiring low-income adults, including parents trying to secure health coverage for their children, to travel to a state office for a face-to-face meeting in order to receive or renew benefits in Medicaid and CHIP. If another state wanted to adopt a Mississippi-style interview requirement it would represent a violation of the MOE, and with good reason. Not only is Mississippi's requirement far stricter than those of other states[12] — which have been moving away from in-person interviews and instead modernizing their eligibility systems and using electronic submissions and computerized databases to verify applications — but it has been a significant barrier to enrollment and apparently has resulted in breaks in coverage among significant numbers of people who remained eligible. At least 62,000 fewer children and adults in Mississippi were enrolled in Medicaid and the Children's Health Insurance Program in 2006 (after the requirement took effect in these programs) than in 2004, even though the number of uninsured children in the state rose during this period, according to a 2007 report.[13] Mississippi Governor Haley Barbour, a supporter of MOE repeal, has said that his state's interview requirement has kept ineligible people off Medicaid.[14] However, nearly 90 percent of the "new" Medicaid applications Mississippi approved for families and children in 2006 were for people whose Medicaid coverage had temporarily lapsed,[15] in part due to the new requirement.

- In 2003, Washington State began requiring families to reapply every six months to maintain their children's Medicaid eligibility, rather than every 12 months. The state also began requiring families to provide pay stubs to verify family income, instead of verifying the information without extra paperwork by utilizing state databases on earnings. More than 30,000 children lost coverage over the next two years. In January 2005, the state restored its previous 12-month eligibility period; 30,000 children gained coverage by the end of the year.[16]

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[12] Only one other state, Tennessee, has retained any face-to-face interview requirement for children, and this is only for Medicaid enrollment (not for renewal, and not for CHIP). See "Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and CHIP, 2010-2011," Georgetown Center for Women and Families and the Kaiser Family Foundation, January 2011.

[13] "Losing Ground: Declines in Health Coverage for Children and Families in Mississippi," the Mississippi Center for Justice and the Mississippi Health Advocacy Program, Fall 2007.

[14] Christopher Rowland, "Amid strained clinics, foe assails 'Obamacare,'" *The Boston Globe*, April 20, 2011.

[15] "Losing Ground," op cit. See also, Sarah Lueck, "Mississippi's 'Face-To-Face' Rule Blocks Coverage of Eligible People, Not Fraud," Center on Budget and Policy Priorities, March 25, 2009.

[16] Washington State Department of Social and Health Services, 2006.