House Passes
Medicare and Medicaid Program Integrity Legislation

On May 16, the House Energy and Commerce Committee approved several Medicare and/or Medicaid program integrity bills. The Congressional Budget Office (CBO) determined there would not be much cost savings associated with these provisions. Nonetheless, the bills could be included in an end of the year health care package. The full House of Representatives approved these bills on September 17.

Leveraging Integrity and Verification of Eligibility for Beneficiaries Act (HR 8084)

- Need for Legislation: In recent years, the Department of Health and Human Services (HHS) Office of the Inspector General (OIG) has found over $200 million in payments made by 14 states to Medicaid managed care organizations for beneficiaries who were deceased. The OIG has repeatedly cited the DMF as a tool to help prevent further payments to deceased beneficiaries, and the Centers for Medicare and Medicaid Services (CMS) has identified the DMF as the most com- prehensive, accurate, and up-to-date data source.
- Summary: H.R. 8084 would require States to check the DMF on an at least quarterly basis, in order to identify deceased Medicaid beneficiaries and promptly disenroll them before further payments can be inadvertently made on their behalf. H.R. 8084 includes protections to ensure that, in the rare circumstance an individual is falsely identified as deceased, the state must reinstate the beneficiary's coverage retroactive to disenrollment.

Medicare and Medicaid Fraud Prevention Act of 2024 (HR 8089)

- Need for Legislation: The Government Accountability Office has cited concerns associated with fraud and improper payments associated with implementation of provider screening requirements. One such area of concern is the lack of routine screenings of providers to ensure that they are not deceased.
- Summary: H.R. 8089 would require States to check the DMF upon enrollment (or reenrollment or revalidation or enrollment), and on at least a quarterly basis, in order to identify deceased providers. Existing federal laws, regulations, and guidance dictate the steps states must take in the event the state identifies that the provider is deceased.

Medicaid Program Improvement Act (HR 8111)

- Need for Legislation: The Department of Health and Human Services (HHS) Office of the Inspector General (OIG) has found that nearly every State in advertently paid Medicaid managed care per member per month payments on behalf of beneficiaries who were enrolled in two State programs at the same time, creating waste.

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- Summary: H.R. 8111 would require States to establish processes to regularly obtain address information from reliable data sources, including by requiring state Medicaid agencies to collect address information provided by beneficiaries to managed care entities (where applicable). Receiving such information helps to promote program integrity by ensuring that payments are not made for beneficiaries who do not live in the State, and allowing beneficiaries who remain in the state but have moved to another in-state address to be more readily contacted.
    - "*reliable data sources*" include (section 435.919(f)(1)(iii) of title 42):
        - Mail returned to the agency by the United States Postal Service (USPS) with a forwarding address;
        - The USPS National Change of Address (NCOA) database;
        - The agency's contracted managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), primary care case managers (PCCMs), and PCCM entities provided the MCO, PIHP, PAHP, PCCM, or PCCM entity received the information directly from or verified it with the beneficiary; and
        - Other data sources identified by the agency and approved by the Secretary.

A bill to require certain additional provider screening under the Medicaid program (HR 8112)

- Need for Legislation: The Government Accountability Office (GAO) has raised concerns with the lack of oversight associated with provider screenings and the associated risks of improper payments and fraud from failure to appropriately screen providers. The Data Exchange System (DEX) is a federal database that identifies providers who have been revoked from Medicare and terminated from states' Medicaid programs.
- Summary: H.R. 8112 would require States to conduct monthly screenings of the DEX. Existing federal laws, regulations, and guidance dictate the steps states must take in the event the state identifies that the provider's enrollment has been terminated or revoked ''for cause'' by Medicare.
    - The bill requires the state to "*check of any database or similar system developed pursuant to section 6401(b)(2) of the Patient Protection and Affordable Care Act*"
        - *Section 6401 Provider screening and other enrollment requirements under Medicare, Medicaid, and CHIP* '
            - (B) LEVEL OF SCREENING.
            - '(ii) may, as the Secretary determines appropriate based on the risk of fraud, waste, and abuse described in the preceding sentence, include—
                - ''(I) a criminal background check;
                - ''(II) fingerprinting;
                - ''(III) unscheduled and unannounced site visits, including preenrollment site visits;
                - ''(IV) database checks (including such checks across States); and
                - ''(V) such other screening as the Secretary determines appropriate.