MEDICAID PROGRAM INTEGRITY: SCREENING OUT ERRORS, FRAUD, AND ABUSE

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTEENTH CONGRESS

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TUESDAY, JUNE 2, 2015

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:16 a.m., in room 2322 of the Rayburn House Office Building, Hon. Tim Murphy (chairman of the subcommittee) presiding.

Members present: Representatives Murphy, McKinley, Burgess, Blackburn, Bucshon, Brooks, Mullin, Collins, DeGette, Schakowsky, Castor, Yarmuth, Clarke, Kennedy, Green, Welch, and Pallone (ex officio).

Staff present: Noelle Clemente, Press Secretary; Jessica Donlon, Counsel, Oversight and Investigations; Brittany Havens, Oversight Associate, Oversight and Investigations; Charles Ingebretson, Chief Counsel, Oversight and Investigations; Michelle Rosenberg, GAO Detailee, Health; Chris Santini, Policy Coordinator, Oversight and Investigations; Alan Slobodin, Deputy Chief Counsel, Oversight; Jessica Wilkerson, Oversight Associate, Oversight and Investigations; Jeff Carroll, Democratic Staff Director; Ryan Gottschall, Democratic GAO Detailee; Ashley Jones, Democratic Director, Outreach and Member Services; Chris Knauer, Democratic Oversight Staff Director; Una Lee, Democratic Chief Oversight Counsel; Elizabeth Letter, Democratic Professional Staff Member; and Tim Robinson, Democratic Chief Counsel.

OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. MURPHY. Good morning. I convene this hearing of the Subcommittee on Oversight and Investigations. We are here today to discuss a continuing and increasingly expensive problem, waste, fraud, and abuse in the Medicaid program. I guess one way I could put this is, for centuries people have tried to deal with the issue is there life after death, and apparently there is in Medicaid, and we will get to the bottom of that today.

Last year the Medicaid program provided medical services for approximately 60 million people at a cost of $310 billion. But during that same year, the Centers for Medicare and Medicaid Services estimate that the improper payment rate was 6.7 percent, or $17.5 billion. This is an increase of almost one percent, or over three bil-

lion, from the previous year. It is a troubling trend, especially as the program continues to expand.

Unfortunately, the Medicaid program is far too accustomed to fraud. In fact, the Government Accountability Office has designated the Medicaid program as a high risk for fraud and abuse since 2003, and it has been the subject of multiple GAO and Department of Health and Human Services Office of Inspector General Reports over the past several years, including a GAO report being highlighted today.

In 2012 the Committee requested GAO identify and analyze indicators of improper and potentially fraudulent payments to Medicaid beneficiaries and providers. In a trustworthy study, another in a longtime examining Medicaid fraud, GAO has reported that CMS needs to take additional actions to improve provider and beneficiary fraud controls. GAO found that thousands and Medicaid beneficiaries and hundreds of providers in just four states: Arizona, Florida, Michigan, and New Jersey, were involved in possible improper or fraudulent payments during fiscal year 2011. For example, almost 200 deceased beneficiaries received at least $9.6 million in Medicaid benefits. About 8,600 beneficiaries received payments by two or more states, totaling at least $18.3 million.

The Social Security numbers for about 199,000 beneficiaries did not match the Social Security Administration databases. About 90 medical providers had their medical license revoked or suspended in the state in which they received Medicaid payments. At least 47 providers had foreign addresses as their location of services, including Canada, China, India, and Saudi Arabia. About 50 providers who received Medicaid payments were excluded from the Federal program for a variety of reasons, including patient abuse, or neglect, fraud, theft, bribery, and tax evasion.

GAO acknowledged that regulations issued in response to the Affordable Care Act may have addressed some of the improper payment indicators found in GAO's analysis. For example, CMS created a tool called the Data Services Hub to help verify beneficiary application information, but questions remain whether this tool has been properly implemented, and if the states have been able to effectively use this tool to combat waste and fraud. In fact, just a few weeks ago, a Reuters report found that more than one in five of the thousands of doctors and other health care providers in the U.S. prohibited from billing Medicare are still able to bill state Medicaid programs.

The report included disturbing stories, such as a Georgia optometrist who claimed he conducted 177 eye exams in one day, yet remained on South Carolina's Medicaid rolls for almost a year after he pleaded guilty in Georgia. In another instance, an Ohio psychiatrist routinely over-reported the time he spent with patients, and even billed for no-show patients. CMS revoked his billing privileges after he was convicted of felony Workers' Compensation fraud, yet he continued to work in the Illinois Medicaid program, getting paid $560,000 for services or prescriptions he wrote after his Medicare provider revocation. Shockingly, on the day he was being sentenced in Columbus, Ohio, he also claimed that he saw 131 group therapy patients at his Illinois practice.

Now, these stories, we know, are unacceptable. Medicaid fraud undermines the integrity of the program, denies our most vulnerable the services they deserve, and waste taxpayers' hard earned dollars. I hope we will hear today about the steps that can be taken to further combat fraud in the Medicaid program. That is what we want to focus on. And GAO has recommended some common sense steps that would reduce fraud, such as issuing guidance to states, better identifying beneficiaries who are deceased, and the availability of automated information through Medicare's enrollment database.

In light of the history of fraud in the Medicaid program, and its growing size, however, will these steps be enough? Will we be here again in another 2 years discussing the same thing? And with the Medicaid program continuing to expand, the Committee is concerned that the opportunity and motivation to defraud the program will only increase.

So I would like to thank our witnesses who are here today. You have the ability to save the taxpayers a massive amount of money. We hope to hear from you today how you plan to do that, and we are grateful for your presence.

[The prepared statement of Mr. Murphy follows:]

PREPARED STATEMENT OF HON. TIM MURPHY

We are here today to discuss a continuing and increasingly expensive problem: Waste, fraud, and abuse in the Medicaid program.

Last year the Medicaid program provided medical services for approximately 60 million people at a cost of $310 billion. But during that same year, the Centers for Medicare and Medicaid Services estimated that the improper-payment rate was 6.7 percent or $17.5 billion. This is an increase of almost 1 percent or over $3 billion from the previous year. This is a troubling trend, especially as the program continues to expand.

Unfortunately, the Medicaid program is far too accustomed to fraud. In fact, the Government Accountability Office has designated the Medicaid program as a high risk for fraud and abuse since 2003. And it has been the subject of multiple GAO and Department of Health and Human Services Office of Inspector General reports over the past several years, including a GAO report being highlighted today.

In 2012, the Committee requested GAO identify and analyze indicators of improper or potentially fraudulent payments to Medicaid beneficiaries and providers. In a just-released study-another in a long line examining Medicaid fraud-GAO has reported that CMS needs to take additional actions to improve provider and beneficiary fraud controls.

GAO found that thousands of Medicaid beneficiaries and hundreds of providers in just four states—Arizona, Florida, Michigan, and New Jersey-were involved in possible improper or fraudulent payments during Fiscal Year 2011. For example, almost 200 deceased beneficiaries received at least $9.6 million in Medicaid benefits. About 8,600 beneficiaries received payments by two or mate states totaling at least $18.3 million. The Social Security Numbers for about 199,000 beneficiaries did not match the Social Security Administration databases. About 90 medical providers had their medical licenses revoked or suspended in the state in which they received Medicaid payments. At least 47 providers had foreign addresses as their location of service, including in Canada, China, India, and Saudi Arabia. About 50 providers who received Medicaid payments were excluded from the federal program for a variety reasons including patient abuse or neglect, fraud, theft, bribery, and tax evasion.

GAO acknowledged that regulations issued in response to the Affordable Care Act may have addressed some of the improper-payment indicators found in GAO's analysis. For example, CMS created a tool called the Data Services Hub (hub) to help verify beneficiary applicant information. But questions remain whether this tool has been properly implemented and if the states have been able to effectively use this tool to combat waste and fraud.

In fact, just a few weeks ago, a Reuters report found that "more than one in five of the thousands of doctors and other health care providers in the U.S. prohibited

from billing Medicare are still able to bill state Medicaid programs." The report included disturbing stories such as a Georgia optometrist, who claimed he conducted 177 eye exams in one day, yet remained on South Carolina's Medicaid rolls for almost a year after he pleaded guilty in Georgia. In another instance, an Ohio psychiatrist routinely overreported the time he spent with patients and even billed for no-show patients. CMS revoked his billing privileges after he was convicted of felony workers' compensation fraud. Yet, he continued to work in the Illinois Medicaid program, getting paid $560,000 for services or prescriptions he wrote after his Medicare provider revocation. Shockingly, on the day he was being sentenced in Columbus, Ohio, he also claimed that he saw 131 group therapy patients at his Illinois practice.

These stories are unacceptable. Medicaid fraud undermines the integrity of the program, denies our most vulnerable the services they deserve, and wastes American taxpayers' hard-earned dollars.

I hope we will hear today about the steps that can be taken to further combat fraud in the Medicaid program. GAO has recommended some common sense steps that would reduce fraud, such as issuing guidance to state to better identify beneficiaries who are deceased and the availability of automated information through Medicare's enrollment database. In light of the history of fraud in the Medicaid program and its growing size, however, will these steps be enough? Will we be here again in another two years discussing the same thing? With the Medicaid program continuing to expand, the Committee is concerned that the opportunity and motivation to defraud the program will only increase.

I would like to thank our witnesses joining us today-you all have the ability to save the American taxpayer a massive amount of money, and we hope to hear from you today on how you plan to do that.

Mr. MURPHY. And I now recognize the Ranking Member, Ms. DeGette of Colorado, for 5 minutes.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. DEGETTE. Thank you, Mr. Chairman. Good news on a bipartisan basis, we are against waste, fraud, and abuse, as usual, in the Medicaid program, and everyplace else. I have been on this subcommittee now 19 years, and we have had a whole series of hearings over the years. And as you accurately point out, Mr. Chairman, it goes from administration to administration, Medicaid seems to be particularly vulnerable to issues like fraud, and we have to continue our oversight. So when you say will we be here again in 2 years? Probably. We will probably be here in 10 years, because this kind of a problem takes ever vigilance by this Committee.

The GAO report we are talking about today tells us that the Medicaid program, like many other large programs, like Medicare, defense contracts, and private insurance plans, experience thousands of improper, and possibly fraudulent, payments every year. Last year CMS found an estimated improper payment rate of 6.7 percent, which amounted to about $17.5 billion for the Medicaid program in 2014.

Now, as I said, and you said, like many other programs, Medicaid fraud is not unique to this Committee. In our report, which was published in 2003, which was 12 years ago, we said, "Committee hearings last year revealed that the cost of the Medicaid fraud program could exceed $17 billion every year. This year, 2003, the Committee will examine ways in which states could adopt more rigorous enrollment controls to keep unscrupulous providers out of their programs, and improve their program integrity standards." And we had laudable efforts since that time. Truly, $17 billion in

2003, and about $17 billion now, even with the Medicaid expansion, that is not something to be proud about, although I guess we should be glad it doesn't seem to be getting a lot worse. Nonetheless, Congress, and the Administration, and the governors all across the country need to focus on improper payments.

There is something exciting, though, that I think may actually make a major difference going forward. Under the Affordable Care Act, a number of important measures were enacted to prevent or reduce improper payments in the Medicaid and Medicare programs. For example, the ACA provided nearly $350 million in new funds for anti-fraud efforts. It provided new authorities to the Secretary of HHS to help shift from a traditional pay and chase model to a preventative approach, by keeping fraudulent suppliers and providers out of the program before they commit fraud. And now we have in place a host of new and enhanced anti-fraud penalties to deter those attempting to improperly bill Medicaid or Medicare. These are important new tools, and I think they can help safeguard the program. I am looking forward to hearing from CMS and GAO on how these efforts are working, and how they expect to build upon efforts to strengthen Medicaid at both the Federal and State levels.

I think it is important to put this discussion of improper payment rates in context with large scale financing of other public and private sector programs. For example, I can cite endless examples of major defense contractors receiving improper payments from the Pentagon. Last year the Washington Post revealed that one company improperly charged the government more than $100 million for services. DOD alone reported it had made $1.1 billion in improper payments for fiscal year 2011.

Overbilling occurs across all sectors of the government, and we have to figure out why that is happening, and how we can strengthen our financial controls across the government to prevent this kind of overpayment and fraud, and find new ways to protect taxpayers. And so I think the GAO does a really important job, both here, in helping strengthen the Medicaid program, and many other places.

I have a lot of questions about the finding and recommendations, some of which may go beyond the scope of the report. For example, and this is in context of the ACA too, the audit relies on data from fiscal year 2011. As we implement these ACA provisions that have gone into place since that time, I would be interested to know, are they really making a difference on the data in the 3 or 4 years since that time? The other issue we need clarification on is the basis of the four states that were chosen for this audit.

So, as I say, I really want to thank the agencies for coming in and helping us. Anything we can do to strengthen the controls to prevent overpayment and fraud is great with me, because the hard working Americans in all 50 states rely on these Medicaid services, and they also rely on the fact that their tax dollars are going to best serve this country. Thank you, Mr. Chairman.

Mr. MURPHY. Thank you. Now I will recognize Dr. Burgess for 5 minutes.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. Thank you, Mr. Chairman. This is an important hearing we are having today. Medicaid, a program that is entirely under our jurisdiction in the Energy and Commerce Committee, is a vital program that covers and provides care for some of the nation's most vulnerable populations. This Committee does have exclusive legislative jurisdiction over Medicaid, and it is our responsibility to ensure that the long term sustainability of Medicaid is assured through proper oversight.

Inefficient and misdirected payments within the Medicaid program have substantive budgetary, access, and provider impacts that ultimately affect patients. If states do not have the proper tools available for monitoring enforcement, there can be lasting effects on the nation's Medicaid recipients, and the providers of their care. CMS has reported improper payments well over $17 billion for fiscal year 2014 for the Medicaid program, an increase of nearly $3 billion from the prior year. That is a trend that should concern all of us. Each of those dollars that is spent inappropriately is a dollar not spent on a patient, and is, in fact, a wasted taxpayer dollar.

I do want to point out that the recently passed H.R. 2, that this committee had a great hand in getting started, and shepherding through the legislative process, and ultimately it was signed by the President, but it did have a number of anti-fraud provisions contained within. Most of those pertained to the Medicare system, but I do wonder if some of those examples may not also be extrapolated to the Medicaid system. Specifically, Mr. Chairman, Section 502, preventing wrongful Medicare payments for items and services furnished to incarcerated individuals, individuals not lawfully present, and deceased individuals. That may be something worthy of study that the CMS may want to consider for the Medicaid system as well.

I am also concerned about allowing entities engaging in fraud to continue to receive Federal funds. We want to ensure provider participation in Medicaid, and patients should never be faced with a choice of no care or low quality care from those providers. The Office of Inspector General has the authority to exclude entities that employ deceptive business practices within the Medicaid program. In 2014 Ranking Member DeGette and I looked into the practices of certain dental management service companies within the Medicaid program which not only provide managerial services to dental clinics, but also, in fact, actually own these clinics, and have direct control over the operations and finances of the clinics. We became very concerned because this corporate structure was resulting in failure to meet basic quality and compliance standards.

Unfortunately, many of these practices have continued, despite Federal Government intervention. The Office of Inspector General may initiate a corporate integrity agreement, but these deceptive entities may dissolve under bankruptcy, only to re-emerge under new management. The Office of Inspector General has the authority to exclude individuals and entities that have engaged in fraud and abuse related to Federal health programs, including Medicaid. Following our investigation, we sent a letter to the Office of Inspec-

tor General recommending that OIG consider excluding any corporate entity that employs deceptive practices that result in substandard care.

So we are grateful that some action was taken over that, but it is incredibly important that there be a way to exclude someone who is engaged in deceptive practice, and prevent that process of dissolving, and then re-emerging in another corporate form. We must ensure that states have the proper tools available to ensure that tax dollars are never fraudulently wasted in the Medicaid program, and that access for Medicaid beneficiaries is subsequently protected.

Mr. Chairman, I thank you for the recognition, for the time, and I will yield back.

Mr. MURPHY. Gentleman yields back, and—if there is anybody else on our side who wants the remaining 50 seconds? And, if not, we will move over to the Ranking Member, Mr. Pallone, for 5 minutes.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Mr. Chairman. For decades Medicaid has been a lifeline for tens of millions of hard working Americans across the country. That is why we must make sure that the resources we devote to this program are administered efficiently and effectively. Every dollar lost to misuse or fraud of our Federal health programs is one less dollar available to fund essential lifesaving medical services for Americans. Cutting down on waste, fraud, and abuse is, and must remain, a priority for CMS, state Medicaid programs, and this Committee.

Some of my colleagues on the other side of the aisle have expressed concerns that expansion of Medicaid will put state budgets in an untenable position and increase fraud, and that is simply not true. Beneficiary access and program integrity efforts are not competing goals. Smart, effective regulation reinforces both goals simultaneously.

In the short time since states have had the option to expand Medicaid, those states have already realized significant qualitative and economic benefits, as uncompensated care rates drop, and states are able to collect more revenue. Expansion makes good economic sense, and good moral sense. For instance, in my home state of New Jersey, projects a nearly $150 million decline in charity care in fiscal year 2016, with savings from the Medicare expansion totaling nearly $3 billion through 2020. Let us also not forget that Medicaid coverage lowers financial barriers to access, increases use of preventative care, and improves health outcomes. Making the program available to more vulnerable Americans is a great achievement, and one that I am very proud of having played a part in.

But, of course, it is now more important than ever that we act as good stewards of Medicaid dollars, and ensure that the benefits of this program are available for generations to come. That is why, when we passed the Affordable Care Act in 2010, we included a number of measures to strengthen program integrity and reduce fraud in the Medicaid program. In 2011, for example, CMS estab-

lished procedures to screen providers and suppliers based on their risk levels so we can prevent fraud before it occurs. This has changed the traditional pay and chase model towards a preventative approach by keeping fraudulent suppliers out of the program before they can commit fraud.

There are a number of other ACA anti-fraud measures that have impacted the Medicaid program positively over the past few years. These include new and enhanced penalties for fraudulent providers. These new authorities allow the Inspector General to exclude from Medicaid any provider that makes false statements on an application to enroll or participate in the program. The ACA also requires state Medicaid agencies to withhold payments to a provider or supplier pending investigation of a credible allegation of fraud. The law also significantly increased funding to fight Medicare and Medicaid fraud.

So I want to hear today about how all these measures have worked, and about how CMS is implementing regulations to better protect patients and legitimate providers. Although the ACA made significant steps to reduce fraud and abuse in the Medicaid program, I know there is always room for improvement, and I am glad the GAO is here today to share their findings and provide constructive advice about how can we make the Medicaid program even stronger.

But I want to caution against applying GAO's findings too broadly. First, the analysis focused on four states, Arizona, Florida, Michigan, and New Jersey, and its findings are not generalizable across the country. Second, the report looked at data from fiscal year 2011, before many of the ACA anti-fraud provisions went into effect. GAO acknowledges several times in a report that CMS has since made changes to address improper payment issues. Third, I want to make the point that many of the potentially improper payments listed in this report are likely examples of provider fraud, not beneficiary fraud. The GAO report lists examples such as billing under deceased beneficiaries' identities, or billing on behalf of currently incarcerated beneficiaries. Given that these beneficiaries are hardly in a position to defraud the government, I think it is likely that many of these are examples of provider fraud.

So, Mr. Chairman, good program integrity helps to ensure that beneficiaries receive the care they need, so I look forward to hearing from CMS and GAO how these latest efforts are being implemented by the states. I don't know if anybody wants my 30 seconds—otherwise I will yield back. Thank you.

Mr. MURPHY. Thank you, I appreciate that. We will proceed onward. It is good to see we are all on the same team today, focused on this, and our witnesses are part of this too, so I would like to introduce the witnesses for today's panel, make sure I get the names right. It is Seto Bagdoyan, did I get that right? Good, thank you. The Director of Audit Services in the U.S. Government Accountability Office Forensic Audits and Investigative Services Missions Team. Welcome here.

And Dr. Shantanu Agrawal—you have been here before, welcome back—is the Deputy Administrator and Director of the Center for Program Integrity at the Centers for Medicare and Medicaid Services.

I will now swear in the witnesses. As you are aware, the committees holding investigative hearing and when doing so, has the practice of taking testimony under oath. Do either of you have any objections to testifying under oath? Neither of you do, thank you.

So, as the Chair, I would advise you that under the rules of the House and rules of the Committee you are entitled to be advised by counsels. Do either of you desire to be advised by counsel during your testimony today? And both of you say no to that, so, in that case, if you would please rise, raise your right hand, I will swear you in.

[Witnesses sworn.]

Mr. MURPHY. Thank you. You are now under oath, and subject to the penalties set forth in Title 18, Section 1001 of the United States Code. You may now give a 5 minute summary of your written statement. You know how to watch the red light in front of you. Stick with that, and I guess we will start off with Mr. Bagdoyan.

TESTIMONY OF SETO J. BAGDOYAN, DIRECTOR, AUDIT SERVICES, FORENSIC AUDITS AND INVESTIGATIVE SERVICE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE; AND SHANTANU AGRAWAL, M.D., DEPUTY ADMINISTRATOR AND DIRECTOR, CENTER FOR PROGRAM INTEGRITY, CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

TESTIMONY OF SETO J. BAGDOYAN

Mr. BAGDOYAN. Chairman Murphy, Ranking Member DeGette, and members of the subcommittee, I am pleased to be here today to discuss results of GAO's recent report on Medicaid beneficiary and provider fraud controls. As you know, and as you mentioned, Mr. Chairman, Medicaid is a significant expenditure for the Federal Government and the states, with combined outlays of about $516 billion in fiscal year 2014, involving millions of beneficiaries and providers.

These numbers, as members mentioned, are all expected to grow as a result of the expansion of Medicaid under the Affordable Care Act. A program of this scope and scale is inherently susceptible to error, including improper payments, as well as fraudulent activity. In fact, as mentioned again, CMS reported an estimated improper payment rate of 6.7 percent, or $17.5 billion, for Medicaid in fiscal year 2014, compared to 5.8 percent, or $14.4 billion respectively, in FY 2013. Also, earlier this year we reported that Medicaid remains on GAO's high risk list in part because of concerns about the adequacy of fiscal oversight of the program, including improper payments.

With this backdrop, I will now discuss our report's key findings. Overall we found thousands of Medicaid beneficiaries and hundreds of providers were involved in potentially improper or fraudulent payments during fiscal year 2011, the most recent year for which reliable and comparable data were available in the four selected states we reviewed, namely Arizona, Florida, Michigan, and New Jersey. These states accounted for about 9.2 million beneficiaries, and about 13 percent of all fiscal year 2011 Medicaid payments.

More specifically, examples of potentially improper or fraudulent payments include about 8,600 beneficiaries had payments made on their behalf concurrently by two or more of the selected states, totaling at least $18.3 million. The identities of roughly 200 deceased beneficiaries received about $9.6 million in Medicaid benefits subsequent to the beneficiary's death. Some 3,600 individuals received about $4.2 million worth of Medicaid services while incarcerated in State prison facilities. 90 providers had suspended or revoked licenses in at least one state in which they received payment. Associated Medicaid claims totaled at least $2.8 million.

To its credit, as, again, mentioned in opening statements, CMS has taken some regulatory steps to make the Medicaid enrollment process more rigorous and data-driven. However, gaps in beneficiary eligibility, verification guidance, and data sharing persist. For example, in 2013, CMS required states to use electronic data maintained by the Federal Government in its data services hub to verify beneficiary eligibility. According to CMS, the hub can verify key application information, including state residency, incarceration status, and immigration status.

However, CMS regulations do not require states to review Medicaid beneficiary files for deceased individuals more frequently than annually, nor specify whether states should reconsider using the more comprehensive Social Security Administration's full death master file in conjunction with state reported death data when doing so. As a result, states may not be able to detect individuals that have moved to, and later died, in another state, or prevent the payment of potentially fraudulent benefits to individuals using their identities. Accordingly, additional guidance from CMS to states might further enhance program integrity efforts beyond using the hub.

In closing, our findings underscore that, as Medicaid's numbers grow as expected, both the Federal Government and the states need to maximize their efforts to promote program integrity by preventing and reducing potential for improper payments and fraud. Our recommendations to CMS, which the agency has accepted, are designed to enhance its toolbox to this effect, help narrow the windows of opportunity for improper payments and fraud, and provide reasonable assurance that Medicaid eligibility controls are functioning as intended.

Mr. Chairman, members of the subcommittee, this concludes my statement. I look forward to your questions. Thank you.

[The prepared statement of Mr. Bagdoyan follows:]

United States Government Accountability Office

GAO

Testimony

Before the Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, House of Representatives

For Release on Delivery
Expected at time, 10:15 a.m ET
Tuesday, June 2, 2015

MEDICAID

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

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

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

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

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

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

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

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

[4]GAO-15-313.

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

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

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

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

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

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

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

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

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

[8] 42 C.F.R. § 455.410(c)(1).

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

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

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

[9]GAO-15-313.

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

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

match any United States Postal Service records[12] and Social Security numbers that did not match identity information contained in SSA databases.

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

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

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

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

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

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

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

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

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

[14] 42 C.F.R. §§ 435.940 - 435.960.

[15] 42 C.F.R. § 435.916.

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

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

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

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

[17]42 C.F.R. § 455.410(c)(1).

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

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

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

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

GAO Contact and Staff Acknowledgments

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

Mr. MURPHY. Thank you. Dr. Agrawal, you are recognized for 5 minutes.

TESTIMONY OF SHANTANU AGRAWAL

Dr. AGRAWAL. Thank you. Chairman Murphy, Ranking Member DeGette, and members of the Subcommittee, thank you for the invitation to discuss CMS's efforts to strengthen Medicaid. Enhancing program integrity is a top priority for the Administration, and an agency-wide effort at CMS. We share the Subcommittee's commitment to protecting beneficiaries and ensuring taxpayer dollars are spent on legitimate items and services, both of which are at the forefront of our program integrity mission.

I would like to make three major points in my testimony today. First, Medicaid program integrity is a shared state/Federal responsibility, and I feel strongly that states and the Federal Government share the goal that the Medicaid program be as secure as possible to ensure beneficiaries are protected, and the right payments are being made. Second, we have made important progress in addressing beneficiary eligibility and provider enrollment issues through advanced data systems and improved collaboration. And third, it is clear that more work remains, that we can build on our accomplishments with improved guidance, building more capabilities, and enhanced oversight.

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. This Federal/state partnership is central to the success of the Medicaid program, and it depends on clear lines of responsibility and shared goals. Although the Federal Government establishes general guidelines for the program, states design, implement, and administer their own Medicaid programs. Medicaid is currently undergoing significant changes as CMS and states implement reforms to modernize and strengthen the program and its services.

While focused on implementation of the Affordable Care Act, CMS has been working closely with states to implement new, more modern delivery system and payment reforms. In the last few years CMS and states have made important progress in improving the systems and processes that determine a beneficiary's eligibility for Medicaid, and that ensure only legitimate providers enroll in and build a program. We have made great strides. The error rate in beneficiary eligibility, for example, has been cut in half since 2011. We recognize, however, that more remains to be done, and continue to work collaboratively with states to further improve Medicaid program integrity.

A critical component to preventing waste, abuse, and fraud is ensuring that only legitimate providers have the ability to bill Medicaid in the first place. While states bear the primary responsibility for provider screening and enrollment for Medicaid, CMS is engaging in new efforts to work with states to make sure that only legitimate providers are enrolling in the Medicaid program. The ACA required CMS to implement risk-based screening of providers and suppliers who want to participate in Medicaid. This enhanced

screening requires certain categories of providers and suppliers that have historically posed a higher risk of fraud to undergo greater scrutiny prior to their enrollment or re-validation in Medicare, Medicaid, or CHIP.

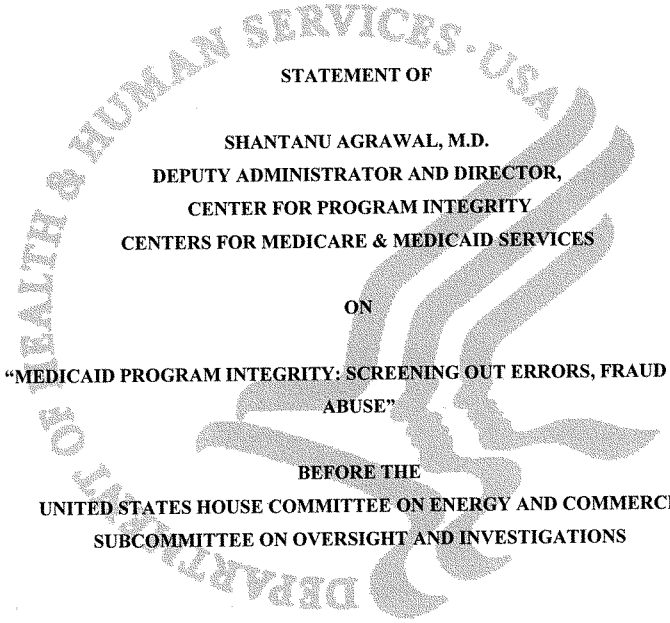
To enroll providers more efficiently, CMS has provided states with direct access to Medicare's enrollment database, the Provider Enrollment Chain and Ownership System, or PECOS, and in response to input from states, began providing access to monthly PECOS data extracts that states could use to systematically compare state enrollment records against available PECOS information.

CMS also provides guidance, education through the Medicaid Integrity Institute, which has reached over 4,200 state employees on enrollment and other topics, and oversight through state program integrity reviews. Additionally, the ACA, and accompanying Federal regulations, have enhanced beneficiary eligibility safeguards by establishing a modernized, data-driven approach to verification of financial and non-financial information needed to determine Medicaid eligibility. States now rely on available electronic data sources, including the Federal data hub and PARIS system, to confirm information included on the application and promote program integrity, while minimizing the amount of paper documentation that consumers need to provide.

CMS has also developed its most recent comprehensive Medicaid integrity plan, in collaboration with our partners, including the National Association of Medicaid Directors, and is working to implement this plan. This work includes providing Medicare data to states for program integrity purposes, expanding support and training of state program integrity staff in vulnerable areas, such as program integrity oversight of managed care and evolving integrated care models, and facilitating development of state capacity and access to cost-effective analytics technology.

The past several years have brought numerous gains in combating fraud, waste, and abuse in the Medicaid program, but more work clearly remains. Today the eligibility determination process for beneficiaries and provider screening efforts are significantly more modern and digital than ever before. We thank the GAO for highlighting critical issues in the Medicaid program, and look forward to continuing to work with states and other stakeholders to establish new initiatives and expand upon our existing programs to fight fraud, reduce improper payments, and improve oversight. Thank you, and I am happy to answer any questions.

[The prepared statement of Dr. Agrawal follows:]



STATEMENT OF

SHANTANU AGRAWAL, M.D.
DEPUTY ADMINISTRATOR AND DIRECTOR,
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CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

"MEDICAID PROGRAM INTEGRITY: SCREENING OUT ERRORS, FRAUD AND ABUSE"

BEFORE THE
UNITED STATES HOUSE COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

JUNE 2, 2015

Statement of Shantanu Agrawal
"Medicaid Program Integrity: Screening Out Errors, Fraud and Abuse"
House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations
June 2, 2015

Chairman Murphy, Ranking Member DeGette, and members of the Subcommittee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) efforts to strengthen Medicaid. Enhancing program integrity is a top priority for the administration and an agency-wide effort at CMS. We share this Subcommittee's commitment to protecting beneficiaries and ensuring taxpayer dollars are spent on legitimate items and services, both of which are at the forefront of our program integrity mission. CMS is coordinating a variety of efforts with Federal and State partners, as well as the private sector to better share information to combat fraud and to verify provider and beneficiary eligibility.

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. This Federal-State partnership is central to the success of the Medicaid program, and it depends on clear lines of responsibility and shared expectations. CMS takes seriously our role in overseeing the financing of States' Medicaid programs, and we continue to look for ways to refine and further improve our processes.

Medicaid Background

Medicaid is the primary source of medical assistance for millions of low-income and disabled Americans, providing health coverage to many of those who would otherwise be unable to obtain health insurance. As of FY 2015, nearly 69 million people were enrolled to receive their health care coverage through Medicaid.

Although the Federal Government establishes general guidelines for the program, States design, implement, and administer their own Medicaid programs. The Federal Government matches State expenditures on medical assistance based on the Federal medical assistance percentage (FMAP), which can be no lower than 50 percent.

Medicaid is currently undergoing significant change as CMS and States implement reforms to modernize and strengthen the program and its services. While focused on implementation of the Affordable Care Act, CMS has been working closely with States to implement delivery system and payment reforms. CMS has encouraged State efforts with new tools and strategies to improve the quality of care and health outcomes for beneficiaries and to promote efficiency and cost effectiveness in Medicaid. And, as always, CMS works to make sure appropriate financial management mechanisms are in place so that dollars are spent appropriately.

Enhancing Provider Eligibility Safeguards

A critical component to preventing waste, fraud and abuse is to ensure that only legitimate providers have the ability to bill Medicaid in the first place. States bear the primary responsibility for provider screening, credentialing, and enrollment for Medicaid. Provider enrollment is the gateway to billing the Medicaid program, and CMS is engaging in new efforts to work with states to make sure that only legitimate providers are enrolling in the Medicaid program.

CMS Oversight of State Medicaid Provider Enrollment

The Affordable Care Act required CMS to implement risk-based screening of providers and suppliers who want to participate in Medicare, Medicaid, and CHIP, and CMS put these additional requirements in place for newly enrolling and revalidating Medicare, Medicaid, and CHIP providers and suppliers in March 2011. This enhanced screening requires certain categories of providers and suppliers that have historically posed a higher risk of fraud to undergo greater scrutiny prior to their enrollment or revalidation in Medicare, Medicaid, and CHIP. States are also required to conduct reviews and revalidations of their Medicaid and CHIP providers by March 2016. States must repeat this process at least once every five years.

Providers in the "limited" risk category undergo verification of licensure, verification of compliance with Federal regulations and state requirements, and various database checks. Providers in the "moderate" and "high" risk categories undergo additional screening, including unannounced site visits. Additionally, as a condition of enrollment, States must require providers in the "high" risk category or persons with five-percent ownership interest in such a provider to consent to criminal background checks including fingerprinting. CMS began conducting fingerprint-based background checks for Medicare providers in August 2014.

State Medicaid agencies may rely on the screening done by CMS for dually-enrolling providers to assist them in complying with these requirements. CMS has been proactive about assisting States with provider enrollment and revalidation screening. In April 2012, we provided States with direct access to Medicare's enrollment database-the Provider Enrollment, Chain, and Ownership System (PECOS). In October 2013, in response to input from States, CMS began providing access to monthly PECOS data extracts that States could use to systematically compare state enrollment records against available PECOS information. We have also provided States with training and technical assistance on using PECOS.

Section 6501 of the Affordable Care Act requires state Medicaid programs to terminate a provider that has been terminated by Medicare, another state Medicaid program, or the Children's Health Insurance Program (CHIP) "for cause" which is defined at 42 CFR 455.101 to include reasons based on fraud, integrity or quality. CMS clarified in May 2011 guidance[1] that termination "for cause" does not include terminations for reasons such as a provider's failure to submit claims due to inactivity. CMS further clarified its interpretation of "for cause" in 2012[2] by specifying examples of conduct that constitutes termination "for cause," and should be reported by the States. Examples of "for cause" termination that require reporting include terminations resulting from adverse licensure actions, fraudulent conduct, abuse of billing privileges, and falsification of billing records.

The Affordable Care Act did not require the Medicare program to revoke the enrollment of a provider terminated by a state Medicaid program, however CMS used its general rulemaking authority to permit CMS to revoke Medicare enrollment where a state has terminated Medicaid enrollment.[3] This cooperation prevents bad actors from jumping from program to program.

On January 1, 2011, CMS launched a shared system that States can access to upload information about providers terminated from other Medicaid and CHIP programs. States are required to report their data on terminations to CMS.[4] States use this information to terminate enrollment

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[1] CPI-CMCS Informational Bulletin, CPI-B 11-05, May 31,2011, and CPI-CMCS Informational Bulletin, CPI-B 12-02, January 20, 2012.

[2] Informational Bulletin (CPI-B 12-02), "Affordable Care Act Program Integrity Provisions- Guidance to States-Section 6501 -Termination of Provider Participation under Medicaid if Terminated under Medicare or other State Plan."

[3] Note: This authority was created by http://www.gpo.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf

[4] The Social Security Act§ 1902(a)(41) Provides that whenever a provider of services or any other person is

from providers terminated by other programs, and CMS uses the state data to revoke providers' Medicare billing privileges if they have been terminated for fraudulent or abusive practices. In December 2013, CMS enhanced the process for Medicaid termination notifications. States have been instructed to report all "for cause" Medicaid terminations, as defined in the 2012 guidance, for which state appeal rights have been exhausted, to CMS by submitting a copy of the original termination letter sent to the provider, along with specific provider identifiers, and the reason for Medicaid termination. CMS reviews each Medicaid termination to determine if a Medicare revocation is appropriate[5].

Enrollment Moratoria

CMS has used the authority provided to the Secretary in the Affordable Care Act to temporarily pause the enrollment of new Medicare, Medicaid, or CHIP providers and suppliers, including categories of providers and suppliers, if the Secretary determines certain geographic areas face a high risk of fraud. In July 2013, CMS announced temporary moratoria on the enrollment of new home health agencies (HHAs) and ambulance companies in Medicare, Medicaid, and CHIP in three "fraud hot spot" metropolitan areas of the country: HHAs in and around Miami and Chicago, and ground-based ambulances in and around Houston.[6] In January 2014, CMS announced new temporary moratoria on the enrollment of HHAs in four metropolitan areas: Fort Lauderdale, Detroit, Dallas, and Houston, and on ground ambulances in the metropolitan Philadelphia area.[7] CMS also extended for six months the existing moratoria for HHAs in and around Chicago and Miami, and ground ambulance suppliers in the Houston area. CMS is required to re-evaluate the need for such moratoria every six months, and, as a result, CMS extended the moratoria in July 2014 and January 2015. CMS has worked closely with each of the affected states to evaluate patient access to care, and these states reported that Medicaid and CHIP beneficiaries will continue to have access to services. During the moratoria period, CMS and the affected states will continue to monitor access to care to ensure that Medicare, Medicaid, and CHIP beneficiaries are receiving the services they need.

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terminated, suspended, or otherwise sanctioned or prohibited from participating under the State plan, the State agency shall promptly notify the Secretary and, in the case of a physician and notwithstanding paragraph (7), the State medical licensing board of such action.

[5] As defined in 42 CFR 424.535

[6] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-07-26.html

[7] http://cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-01-30-2.html

Enhancing Beneficiary Eligibility safeguards

The Affordable Care Act and accompanying Federal regulations have established a modernized, data driven approach to verification of financial and non-financial information needed to determine Medicaid and CHIP and Marketplace eligibility. States now rely on available electronic data sources to confirm information included on the application, and promote program integrity, while minimizing the amount of paper documentation that consumers need to provide.

In 2012, CMS issued regulations to require States to use the Data Services Hub (Hub) to verify applicant eligibility upon enrollment and at least annually thereafter. States are able to use this to identify applicants and beneficiaries who may be incarcerated, deceased, or do not meet Medicaid eligibility requirements. States can also validate applicants' Social Security Numbers (SSNs) using the Hub. CMS also required every state to submit a verification plan describing their verification policies and procedures including confirmation that the state verifies SSNs.

States are also required to use the Public Assistance Reporting Information System (PARIS) to identify individuals who are enrolled in Medicaid in more than one state.

PARIS is a system for matching data from certain public assistance programs, including State Medicaid programs, with selected Federal and State data for purposes of facilitating appropriate enrollment and retention in public programs. In certain circumstances, PARIS may also be used as a tool to identify individuals who have not applied for Medicaid coverage, but who may be eligible based on their income. We plan to provide additional guidance to help States participate in the PARIS match over the coming months.

Revision of the Payment Error Rate Measurement to Align with Program Changes

The Payment Error Rate Measurement (PERM) program measures improper payments in Medicaid and CHIP and produces error rates for each program. The error rates are based on reviews of the FFS, managed care, and eligibility components of Medicaid and CHIP in the FY under review.

In light of the changes to the way States adjudicate eligibility for applicants for Medicaid and CHIP implemented by the Affordable Care Act, the State Health Official Letter 13-005, issued on August 15, 2013, directs States to implement Medicaid and CHIP Eligibility Review Pilots in

place of the PERM and Medicaid Eligibility Quality Control (MEQC) eligibility review requirements for FYs 2014-2016. The Medicaid and CHIP Eligibility Review Pilots will provide more targeted, detailed information on the accuracy of eligibility determinations using the Affordable Care Act's rules, and provide States and CMS with critical feedback during initial implementation.

The eligibility review pilots will provide a testing ground for different approaches and methodologies for producing reliable results and help inform CMS' approach to future rulemaking.

Working with States to Improve Medicaid Program Integrity

Medicaid is a Federal-state partnership, and that partnership is central to the program's success. CMS provides States with interpretive guidance to use in applying statutory and regulatory requirements, technical assistance including tools and data, Federal match for their expenditures, and other resources. The following efforts will expand the capacity of CMS to protect the integrity of the Medicaid program:

Comprehensive Medicaid Integrity Plan

Section 1936(d) of the Social Security Act directs the Secretary of Health and Human Services (HHS) to establish, on a recurring 5-fiscal year basis, a comprehensive plan for ensuring the integrity of the Medicaid program by combatting fraud, waste, and abuse. The current Comprehensive Medicaid Integrity Plan (CMIP) provides a strategy for CMS to improve Medicaid program integrity for the FY 2014-2018 period.[8] The current CMIP was shaped by six broad considerations: (1) the transformation of the Medicaid program over the next five years; (2) the actual harm from fraud, waste and abuse on the entire Medicaid program beyond the risk to State and Federal funds; (3) the importance of the Federal-state partnership in Medicaid program integrity efforts; (4) the shift within program integrity strategies from "pay and chase" to prevention efforts; (5) the coordination across CMS to safeguard the integrity of the Medicaid program; and (6) the coordination of program integrity efforts across the Medicare and Medicaid programs.

[8] http://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/Downloads/cmip2014.pdf

To increase the ability of state Medicaid agencies and CMS to leverage program data to protect Medicaid from fraud, waste, and abuse, CMS will:

- Improve the quality and consistency of Medicaid data reported to CMS;
- Increase state Medicaid agency access to Medicare program integrity data; and
- Improve the analysis of Medicaid program data to identify potential fraud, waste, and abuse.

To build the capacity of state Medicaid agencies to prevent and detect fraud, waste, and abuse against the Medicaid program, CMS will:

- Streamline CMS assessment of state Medicaid program integrity activities;
- Support state oversight of program integrity in Medicaid managed care;
- Provide technical assistance to state Medicaid agencies with respect to data analysis; and
- Expand training of state staff through the Medicaid Integrity Institute.

To expand the capacity of CMS to protect Medicaid program integrity and to manage risk in the administration of Federal grants to States, CMS will:

- Eliminate duplication of efforts by integrating Medicare and Medicaid audits and investigations;
- Improve financial accountability for Medicaid managed care organizations;
- Improve safeguards for Medicaid fee-for-service claims;
- Expand reporting and controls for provider rate setting;
- Enhance beneficiary eligibility safeguards;
- Improve the accuracy of state claiming and grant management;
- Execute safeguard strategies for new forms of payment and new delivery systems; and

- Revise measurement of error rates to align with program changes.

The execution of the strategies in CMIP will improve the ability of state Medicaid agencies and CMS to leverage program data to detect and prevent improper payments, which will strengthen the ability of state Medicaid agencies to safeguard state and Federal Medicaid dollars from diversion into fraud, waste, and abuse. These efforts will expand the capacity of CMS to protect the integrity of the Medicaid program and to manage risk in the administration of Federal grants to States. CMS has already made progress in these areas, as described below.

Improve Financial Accountability for Medicaid Managed Care Organizations

CMS recently proposed the first major update to Medicaid and CHIP managed care regulations in more than a decade that will modernize the programs' rules to strengthen the delivery of quality care in Medicaid or CHIP.[9] These proposals would better align Medicaid and CHIP managed care rules and practices with those of other sources of health insurance coverage, improve consumer communications and access, provide new program integrity tools, and support state efforts to deliver higher quality care in a cost-effective way.

The proposed rule would require States to screen Medicaid and CHIP managed care providers consistent with the requirements for Medicaid and Medicare fee-for-service providers, which includes reviewing Federal databases to determine whether the provider is eligible to participate in public programs. This approach may result in administrative and cost efficiencies by providing the option to eliminate duplicative screening activities as part of the credentialing process for network providers and having that function performed instead by states (or, in the case of dually-participating providers, by Medicare contractors) for all providers. Every provider rendering a service to a Medicaid or CHIP beneficiary, whether in fee- for-service or managed care, would be screened utilizing the same criteria.

The proposed rule would add several components to strengthen Medicaid and CHIP managed care plans' program integrity through administrative and managerial procedures that prevent,

[9] https://www.Federalregister.gov/articles/2015/06/01/2015-12965/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered

monitor, identify, and respond to suspected provider fraud. This would include implementation of procedures for internal monitoring, auditing, and prompt referral of potential compliance issues within the managed care plan; mandatory reporting of potential fraud, waste or abuse to the state; mandatory reporting of any potential changes in an enrollee's circumstances that may impact Medicaid eligibility as well as changes in a provider's circumstances that may impact that provider's participation in the managed care plan's network; and the suspension of payments to a network provider when the state determines a credible allegation of fraud exists.

Data Analytics and Technical Assistance

Programs with the size and scope of Medicaid and CHIP require robust, timely, and accurate data in order to ensure the highest financial and program performance, support policy analysis and ongoing improvement, identify potential fraud or waste, and enable data-driven decision making. Section 4753 of the Balanced Budget Act of 1997 included a statutory requirement for States to submit claims data, enrollee encounter data, and supporting information. Section 6504 of the Affordable Care Act strengthened this provision by requiring States to include data elements the Secretary determines necessary for program integrity, program oversight, and administration.

CMS is working with States to improve Medicaid and CHIP data and data analytic capacity through the Medicaid and CHIP Business Information Solutions (MACBIS) initiative. This initiative includes changes to the Medicaid Statistical Information System (MSIS), which will be known as Transformed-MSIS or T-MSIS. The enhanced data available from T-MSIS will support improved program integrity and financial management and more robust evaluations of demonstration programs. It will also enhance the ability to identify potential fraud and improve program efficiency.

CMS also administers the Medicare-Medicaid Data Match program in partnership with participating States to identify improper billing and utilization patterns that may not be seen in one program alone. CMS is working to make the program more customizable to State-specific needs. Additionally, in September 2014, CMS established a process for State Medicaid agencies to request timely Medicare Parts A, B and D data for Medicare-Medicaid enrollees to support

care coordination and program integrity activities to combat fraud, waste, and abuse in their Medicaid programs.

Streamline CMS Assessment of State Medicaid Program Integrity Activities

Section 1936 of the Social Security Act requires CMS to provide support and assistance to State Medicaid program integrity efforts. To fulfill this requirement, CMS began conducting comprehensive state program integrity reviews in 2007 on a triennial basis, which play a critical role in how CMS provides assistance to States in their efforts to combat provider fraud and abuse. The reviews assess the operations of each State's program integrity unit, including examinations of provider enrollment and disclosure processes, managed care program integrity operations, and the interaction between the state's Medicaid agency and its Medicaid Fraud Control Unit (MFCU). Through these reviews, CMS also assesses the State's compliance with Federal statutory and regulatory program integrity requirements and identifies effective State program integrity activities that are noteworthy and then shares them with other States.

By the end of FY 2013, CMS had completed comprehensive program integrity reviews of every State, Puerto Rico, and the District of Columbia at least twice. CMS is streamlining its process for conducting these reviews by shifting from an emphasis on regulatory compliance to a more integrative assessment of risk and program vulnerabilities that is tailored to address the distinct challenges of each state Medicaid program. As part of a process of continuous improvement, CMS began work in FY 2012 to redesign the state program integrity review guide to achieve an increased focus on program vulnerabilities and risk, reduce the burden of the reviews on the States, and identify more opportunities for technical assistance to the States.

In FY 2014, CMS conducted reviews of 10 States that have opted to expanded Medicaid, and focused on three priority areas: operations of managed care entities' special investigations units, implementation of provider enrollment and screening provisions, and personal care services. During FY 2015, CMS is conducting reviews in 10 additional States with a focus on Medicaid managed care, non-emergency medical transportation and personal care services in certain States.

As another means of providing assistance to States, CMS develops toolkits to address these findings from these reviews and other issues. Toolkits are designed to help States better

understand the requirements and improve compliance with Federal regulations. The toolkits identify common issues observed and provide practical solutions that States can implement on issues such as disclosures of ownership and control, healthcare-related criminal convictions, notifications to the HHS Office of Inspector General (OIG).

Expand Training of State Staff Through the Medicaid Integrity Institute

Since 2007, the Medicaid Integrity Institute (MII) has provided professional education to more than 4,200 Medicaid employees from every state, the District of Columbia, and Puerto Rico. The first national Medicaid integrity training program, the MII provides a unique opportunity for CMS to offer substantive training, technical assistance, and support to the States in a structured learning environment. The MII focuses on developing a comprehensive program of study addressing aspects of Medicaid program integrity to include: fraud investigation, data mining and analysis, and case development.

CMS and the MII hold an annual advisory group meeting with senior state program integrity officials comprising the Medicaid Fraud and Abuse Technical Advisory Group (TAG). The TAG provides CMS and the MII with critical input and recommendations for training topics and courses for the following year. The TAG provides state agency updates and guidance on what issues the States are facing in order to provide Subject Matter Experts (SMEs) for each course. The TAG is divided into workgroups that are charged with identifying and developing suggestions that can be shared during the monthly TAG call with States, CMS, and the MII. The success of the MII lies largely with the commitment of our state partners. The tailored courses are identified in the yearly meeting with the MII advisory group and developed by working group experts from States, CMS, and MII.

Eliminate Duplication of Efforts by Integrating Medicare and Medicaid Audits and Investigations

CMS currently relies on a network of contractors to carryout program integrity work in Medicare and Medicaid. To improve efficiency and coordination of Federal data analysis and audit and investigation work within each region, CMS is developing a Unified Program Integrity Contractor (UPIC) strategy. Under this strategy, Medicare and Medicaid program integrity audit and investigation work at the Federal level will be consolidated into a single contractor within a

defined multi-state area, which will complement audit and investigation efforts by States. This contractor will conduct Medicare, Medicaid, and joint Medicare-Medicaid investigations and audits within designated geographic jurisdictions. CMS expects to implement the UPIC strategy beginning with initial contract awards in FY 2016 with additional transitions to occur in subsequent fiscal years.

CMS's goals for unifying this work are to achieve enhanced prediction, detection, and prevention of fraud, waste and abuse across the Medicare and Medicaid programs. CMS anticipates that this integrated and data-driven approach will lay the groundwork for fostering further program integrity coordination with other private and governmental payers across the entire health care industry. Ultimately, it is through partnership and increased awareness across a variety of programs that health care fraud, waste, and abuse can be reduced; therefore benefiting all beneficiaries and patients.

Working with Law Enforcement and the Private Sector to Improve Medicaid Program Integrity

CMS is engaging with the private sector in new ways to better share information to combat fraud. The Healthcare Fraud Prevention Partnership (HFPP) is a voluntary public-private partnership between the Federal Government, State officials, law enforcement, private health insurance plans and associations, and healthcare anti-fraud associations. The HFPP aims to foster a proactive approach to detect and prevent healthcare fraud through data and information sharing. The HFPP's purpose is to improve the detection and prevention of healthcare fraud by exchanging data and information between the public and private sectors, leveraging various analytic tools against data sets provided by HFPP partners, and providing a forum for public and private leaders and SMEs to share successful anti-fraud practices and effective methodologies for detecting and preventing healthcare fraud. The HFPP currently has 39 partners including 8 state agencies.[10]

[10] State agencies include: Arizona Medicaid Office of the Inspector General, Arizona Health Care Cost Containment System; Illinois Department of Healthcare and Family Services, Office of the Inspector General; Iowa Insurance Fraud Bureau (National Association of Insurance Commissioner's representative on the Information Sharing Committee); Massachusetts Office of the State Auditor; New York Office of Medicaid Inspector General; Ohio Attorney General's Office (National Association of Medicaid Fraud Control Units (NAMFCU) representative on the

We are continuing to grow strategically by adding new partners and identifying additional overlapping fraud schemes. The HFPP has completed the following four studies to date – Misused Codes and Fraud Schemes, Non-Operational Providers (or "false store fronts"), Revoked and Terminated Providers, and Top-Billing and High Risk Pharmacies – that have enabled partners, including CMS, to take substantive actions to stop payments from being issued The HFPP is now in the process of launching three new studies based on successful identification of continuing challenges faced by current and new members.

Through the fraud, waste, and abuse prevention and enforcement efforts of the Health Care Fraud and Abuse Control (HCFAC) program, in FY 2014 the Federal Government attained legal judgments or negotiated settlement agreements with a total value of more than $2.3 billion in health care fraud cases and additionally, took administrative actions in many other health care fraud cases. As a result of these efforts, as well as those of prior years, in FY 2014, approximately $3.3 billion was returned to the Federal Government or paid to private persons. Of this $3.3 billion, the Medicare Trust Funds received transfers of approximately $1.9 billion during this period, and over $523 million in Federal Medicaid money was similarly transferred separately to the Treasury as a result of these efforts.

Additional Resources to Improve Medicaid Program Integrity

To help build on these successes, the FY 2016 President's Budget proposes to provide an additional $25 million to the inflation-adjusted base in FY 2016 for the Medicaid Integrity Program. The additional investment will grow each year until $100 million is added in FY 2025, and, thereafter, the total will be adjusted annually for inflation. Additionally, the proposal would make statutory changes to expand the authority of the program so that both contractors and Federal employees can engage in the same broad range of program integrity activities available under the authorities of the HCFAC program.

This funding will give CMS the ability to address additional program integrity vulnerabilities, including expansion of Medicaid Financial Management program reviews of state financing practices; critical updates to Medicaid claims and oversight systems needed to enhance auditing,

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Information Sharing Committee); Texas HHS Commission Office of Inspector General; and Vermont Program Integrity unit, Dept. of Vermont Health Access.

and other efforts to assist States to fight fraud, waste and abuse. Over time, the inflation adjusted investment will support initiatives that respond to emerging vulnerabilities.

Conclusion

CMS is committed to ensuring that state Medicaid programs effectively combat fraud, waste, and abuse. The past several years have brought numerous gains in these areas, but more work remains. Strengthening and improving upon programs that provide vital services like Medicaid to millions of Americans is a continuous process, and at CMS we take seriously our responsibilities to taxpayers and beneficiaries. We will continue to work with States and other stakeholders to establish new initiatives and expand upon our existing programs to fight fraud, reduce improper payments, and improve oversight. We look forward to working with this Committee to further improve Medicare and Medicaid.

Mr. MURPHY. Thank you very much. Let me recognize myself for 5 minutes and keep this moving. We appreciate your input on this, and some ideas here.

Dr. Agrawal, the improper payment rate for Medicaid program was 6.7 percent in fiscal year 2014. That was an increase over fiscal year 2013, where it was just 5.8 percent. Now, CMS set the target rate for Medicaid payments at 5.6 percent, so CMS failed to meet the target rate for 2014, is that correct?

Dr. AGRAWAL. That is correct.

Mr. MURPHY. So why was the target rate not met?

Dr. AGRAWAL. Yes, there are three major components of the PERM rate of the Medicaid improper payment rate. There is a fee-for-service component, a Medicaid managed care component, and then a beneficiary eligibility component, and what I think you see in the error rate is a bit of a mixed picture. So on one hand, the beneficiary eligibility rate, which was a central topic in the GAO report, did actually decrease, from 3.3 percent to 3.1. Where we saw the biggest rise was in the provider screening and enrollment standards in the fee-for-service component. What I think the increase shows is that states are in various places of implementing those screening standards, which has led to an increase in the error rate in that part of PERM.

Mr. MURPHY. But for 2015 they have set this improper payment rate target at 6.7 percent, and that is the same rate it was in 2014. It is actually higher than the improper payment rate for 2013 and 2014. So why is CMS actually raising that improper payment rate, that error rate, for Medicaid instead of lowering it, and setting a target for reduction of errors?

Dr. AGRAWAL. Well, I think, you know, we clearly want to make progress on the improper payment rate and Medicaid. The biggest driver right now are those provider enrollments and screening standards. You know, obviously we want to continue to make progress on the beneficiary eligibility requirements as well. You know, what we find is that states are in various different places of implementing their screening and enrollment for providers. It is a major driver.

I think there are a lot of tools that we have to help states make progress, including oversight, education, guidance, giving access to more data systems. But I think we want to set realistic targets and, you know, work on that to make sure states can meet them.

Mr. MURPHY. And we want to help you with this. We just want to make sure that the information that this Subcommittee gets, this Committee gets, can help facilitate that process. But if we raise our tolerance level for errors, and then we say, well, it is all within what we accept, that's not acceptable, so I really want to caution you on that. What I am hoping, that we can not have that goal, but really work towards of a goal of how to lower it, and then identify those outliers. And, I mean, you heard the opening statements. This subcommittee is with you on trying to identify mechanisms for this.

Now, the Office of Management and Budget has designated Medicaid as one of 13 programs as higher, with Medicaid ranking third, with $17.5 billion in improper payment amounts. So does CMS

know why Medicaid has been designated by OMB as a high error agency, Dr. Agrawal?

Dr. AGRAWAL. Yes. There are clearly important factors in the size and scope of the program. The fact that the program is administered in numerous, different state Medicaid agencies, and require a great deal of collaboration. I am sure it does also reflect our historical error rate. So I think the designation of it being a high risk program certainly makes sense.

I would also add, Chairman, to your last question that part of, what we see as the dynamic in program integrity, which is, I think, important to think about, is that as requirements increase, as the stringency of the program increases, oftentimes we also see an increase in the error rate as a result, because providers, or other stakeholders, such as states, need time to catch up to requirements. I think that is a common underlying element to many factors in the error rate, but specifically the provider enrollment standards that the ACA created.

Mr. MURPHY. Well, let me move on to something else here. Director Bagdoyan, the GAO has also designated Medicaid as a high risk program since 2003.

Mr. BAGDOYAN. Right.

Mr. MURPHY. What are the criteria that land the Federal program into that kind of category, and it has been that way for a long time?

Mr. BAGDOYAN. Yes. For Medicaid, Mr. Chairman, the specific factor that we cited in our report is the fact that its fiscal oversight over the years has been not where it should be, and within that, the——

Mr. MURPHY. Fiscal oversight at the Federal level, or state, or both?

Mr. BAGDOYAN. That would be at both levels, since it is——

Mr. MURPHY. OK.

Mr. BAGDOYAN [continuing]. A joint program. And then, further within that context, of course, the risk of improper payments and/or fraudulent activity contributes to that designation.

Mr. MURPHY. And part of this too is—we see that you are collecting data. You couldn't even get data from some of the states because it just isn't there. Is there things we need to do or things that you can recommend as well—what we need to make sure that states have been presenting data so we can analyze it and identify the problem, either one of you?

Mr. BAGDOYAN. I would go first. Obviously data analytics is the growing field, and it would be incumbent upon both the Federal Government and the states to really pay attention to the quality of their data, the collection, the analysis, the reliability to make cross-comparisons and other analyses.

Mr. MURPHY. And what we usually have as our tools in Congress is a carrot or a stick to enhance that, I am out of time here, but I would be looking forward to your comments of what we could do, because without the data, you can't provide an accurate recommendation to us. Ms. DeGette, 5 minutes.

Ms. DEGETTE. Thank you. Dr. Agrawal, in March 2011 CMS put into place new requirements for enrolling and re-validating Medicaid providers and suppliers, is that correct?

Dr. AGRAWAL. Yes, that is correct.

Ms. DEGETTE. And the new process separates providers and suppliers into categories of risk, either high, moderate or limited risk for additional screening before enrollment or re-validation in the Medicaid program, is that correct?

Dr. AGRAWAL. That is correct.

Ms. DEGETTE. And, briefly, how does CMS determine which risk category an individual provider or supplier will be put into?

Dr. AGRAWAL. Sure. So these risk categories are done at the provider sort of group level, or provider type level. So it isn't an individual provider that we would be placing in these various categories, it would be a whole class, such as—newly enrolling home health agencies are considered high risk.

Ms. DEGETTE. I see.

Dr. AGRAWAL. And we designated these risk levels based on input from multiple sources, including the HHS OIG, based on historical levels of fraud or——

Ms. DEGETTE. Fraud.

Dr. AGRAWAL [continuing]. Issues with those specific provider types.

Ms. DEGETTE. OK. And do the states also have to implement screening requirements before they enroll a provider in the Medicaid program?

Dr. AGRAWAL. They do. Those requirements are largely identical to Medicare's.

Ms. DEGETTE. And those go into effect March 2016, 5 years after the regulation first went into effect, is that right?

Dr. AGRAWAL. Many of the requirements have had to be implemented by now already.

Ms. DEGETTE. OK.

Dr. AGRAWAL. There were already deadlines. I think what you are referencing is a re-validation deadline——

Ms. DEGETTE. Right.

Dr. AGRAWAL [continuing]. Yes, March of 2016.

Ms. DEGETTE. OK. And then, after everything is either validated or re-validated, it has to be re-validated again every 5 years, is that right?

Dr. AGRAWAL. That is correct.

Ms. DEGETTE. Now, is CMS working with the states to implement these new requirements?

Dr. AGRAWAL. We are, across the board. So, we have largely the same requirements in Medicare and, therefore, are undertaking the same work in the Medicaid program. Where possible, we have made data assets available to states so that they can utilize the results of our screening. For example, I referenced PECOS, where we have done a site visit, or fingerprint-based background check. States have access to that data so that they don't have to duplicate those——

Ms. DEGETTE. OK.

Dr. AGRAWAL [continuing]. Initiatives.

Ms. DEGETTE. And are the states generally on track with their implementation?

Dr. AGRAWAL. You know, states are in really different places, what we——

Ms. DEGETTE. OK.

Dr. AGRAWAL [continuing]. Find. So, when we do the PERM rate measurement every year, or do state program integrity reviews, there are certain states that are well advanced in their implementation of these requirements, and other states that are lagging quite far behind.

Ms. DEGETTE. And so I assume those are the states you are focusing on, trying to get them——

Dr. AGRAWAL. Correct. We can increase the amount of oversight, we can offer more technical assistance, education efforts, things like that.

Ms. DEGETTE. Now, these efforts were not included in the data of the GAO report, which went for 2011 data, is that right?

Dr. AGRAWAL. That is right.

Ms. DEGETTE. Yes or no will work.

Dr. AGRAWAL. Yes.

Ms. DEGETTE. Thank you. Now, Mr. Bagdoyan, in your written testimony, which you confirmed in your testimony today in the Committee, you said CMS has taken steps since 2011 to make the Medicaid enrollment verification process more data-driven. I am assuming you are talking about some of these implementations that——

Mr. BAGDOYAN. Right.

Ms. DEGETTE [continuing]. Dr. Agrawal is——

Mr. BAGDOYAN. Yes.

Ms. DEGETTE [continuing]. Talking about.

Mr. BAGDOYAN. That is correct.

Ms. DEGETTE. Do you think that these steps will help close some of the gaps GAO identified in the report with regard to potentially improper fraudulent payments?

Mr. BAGDOYAN. Sure. As I mentioned in my closing, those steps will definitely add to the toolbox that CMS and the states have, and narrow the opportunities for potential improper payments and fraudulent activity. They will probably play out over time. As Dr. Agrawal said, some states are in different places than others, so——

Ms. DEGETTE. And we have to focus on the ones who are——

Mr. BAGDOYAN. That is correct.

Ms. DEGETTE. Yes.

Mr. BAGDOYAN. Long term implementation success and sustainability will be key in these areas.

Ms. DEGETTE. Now, since 2011, do you agree that CMS has taken measures to address some of these real concerns that you raise in your report, like the deceased providers billing Medicaid, providers with suspended or revoked licenses, and people inappropriately using virtual addresses? Are they working on that now?

Mr. BAGDOYAN. I think they are taking steps. They are in the right direction, we believe, but execution and sustainability will be, again, key for both——

Ms. DEGETTE. I agree.

Mr. BAGDOYAN [continuing]. Federal Government and the states.

Ms. DEGETTE. Yes. I appreciate GAO's sustained work on this issue. Excuse me, that is my child. She programmed my phone to bark when——

Mr. BAGDOYAN. Distinct voice that your child has.

Ms. DEGETTE. Yes. That is my other one. But I am glad that you both agree that the Affordable Care Act has changed the way we prevent and address Medicaid fraud, and I look forward to it. As we said, Mr. Chairman, we are going to be back here in a couple of years, making sure that these ACA requirements have been implemented. Thank you.

Mr. MURPHY. Thank you. I now recognize Mr. McKinley for 5 minutes.

Mr. MCKINLEY. Two quick questions. One, the CMS has raised its proper payment rate target from fiscal year 2015 to 6.7 percent, from the 5.6 target rate in 2014. Is that a good internal control practice, to raise the target rate?

Dr. AGRAWAL. Sir, are you asking me?

Mr. MCKINLEY. Yes.

Dr. AGRAWAL. No. I do appreciate the question, and, again, I think it is important to set realistic targets and goals that do push us to improvement, but at the same time recognize that Medicaid is a state and Federal program that states are in various places of implementing things like the provider enrollment standards, which are the major driver of the improper payment rate at this point.

Mr. MCKINLEY. OK. Let me get to the question I had from West Virginia, and it is more of a question, I think, of—perhaps abuse and errors. Let me frame the argument. In West Virginia, ⅓ of the hospitals we have in West Virginia are critical access hospitals. We are a very rural state. And for nearly 30 years, since the early '80s, West Virginia's critical access hospitals have been using a provider tax to supplement and provide resources for them.

In 2012 CMS hired a different auditor from all of these past 30 years, and this new auditor stepped in and said that process isn't approved anymore, and we are going to go back and—we are auditing you back until 2009, and—trying to recover the money that you previously were working under the idea that this was the appropriate way to go about getting the provider tax revenue coming in. This is going to be an incredible hindrance for these hospitals to provide medical care in rural areas of West Virginia, when we go backwards on them after they were working under the idea that they thought they were working properly.

So we have talked about—can we go forward from here, not go back and try to penalize them for following someone else's advice, that was also with CMS? Now we go forward. We have written letters. We have had conversations with CMS—until recently, but CMS really was disengaged with us. Now these hospitals are all getting invoices 3 years after 2012, when they were told, we are not going to allow that anymore, now in 2015 they are getting invoices that they say they have to pay them within 15 days, or they are going to have the funds withheld.

First, I don't know of any private sector—coming from the private sector—I have got 50 years in the private sector. I have never heard of someone saying, if you don't pay within 15 days, we are taking it out of your hide. That just doesn't work. There are no details on these invoices. And when they have asked, can we get the details of what this invoice includes, and they say that they can't have it. They are being denied access to what the invoice reflects.

I hope you understand, this kind of smacks of bullying on the part of CMS to rural hospitals. Especially given the fact that they were told to use this, this was OK. And now a new auditor has a different opinion. So do you think CMS is handling this crisis in West Virginia, and probably in other rural areas of this country? Do you think CMS is handling this sensitively and appropriately?

Dr. AGRAWAL. Congressman, I appreciate the question. I can tell you that CMS has definitely been focused on critical access hospitals and rural hospitals, and the various policies we promulgate, including payments and other policies. I will tell you, I am not aware of the specifics of this particular situation. I understand some of the details now from what you have explained. However, I think I would have to connect you to the other folks in the agency that are directly working on this issue, but I would be happy to take it back.

Mr. MCKINLEY. If you would, please. We have been given the runaround. I have never seen so many fingers pointing in different directions. It is not my problem, it is someone else, and we have been trying to pursue that. So if you can help us on that, we will put you on record. OK. You are under oath that you said you were going to help, so——

Dr. AGRAWAL. Thank you, Congressman, I appreciate that. I will——

Mr. MCKINLEY. I will remind you——

Dr. AGRAWAL. I will think of that.

Mr. MCKINLEY [continuing]. Of that in the future. But thank you, because we need to get this resolved. Remember, a third of the hospitals could very well go under if they have to make these payments. Thank you.

Dr. AGRAWAL. Thank you.

Mr. MCKINLEY. Yield back.

Mr. MURPHY. Gentleman yields back. Now recognize the Ranking Member, Mr. Pallone, for 5 minutes.

Mr. PALLONE. Thank you. GAO reports that CMS has made several changes since 2011 to help limit improper payments, and these steps may address many of the potential improper payments GAO found in their analysis of 2011 claims. In addition, to noting in their progress already made, GAO made two recommendations to further improve efforts to limit improper payments by increasing information and data sharing efforts between the Federal Government and the state Medicaid programs, and GAO first recommended that CMS help states better identify deceased beneficiaries.

I want to ask a question of each of you, but I have got three sets here, so we have got to go fairly quickly. Mr. Bagdoyan, can you comment on GAO's findings that led to this recommendation?

Mr. BAGDOYAN. Well, we did matching of deceased roles from the death master file. That is the complete file that has about 98 million records, and we matched those against claims data, and we discovered those beneficiaries who had been deceased before their services were billed for, so——

Mr. PALLONE. OK. And, Dr. Agrawal, what steps is CMS taking to implement this recommendation?

Dr. AGRAWAL. Yes. We take the recommendations very seriously, and, as I mentioned, we do appreciate the report. Specifically for the dead beneficiaries issue, there are clearly things that we have done, like implement the Federal data hub that allows states to check for death and other issues on the front end. We are also looking to work with our technical advisory groups with the states and recommend more guidelines for the states to both access the right data, and then access it frequently enough.

Mr. PALLONE. OK. The GAO next recommended that CMS apply more complete data for screening Medicaid providers by providing states with full access to the Provider Enrollment Chain and Ownership System, or PECOS, database. So, again, Mr. Bagdoyan, can you describe the PECOS system? Can you comment on how states are using PECOS, and why GAO issued a recommendation for CMS to provide additional guidance to states?

Mr. BAGDOYAN. Sure. Thank you for your question. With PECOS it is a situation where states would need access to the system electronically so they can be able to run batch searches, if you will. I know it is a little technical term, but right now they have to do a manual search on a case by case basis each name, each time in order to get a result, whether there is an issue or not. So that is the essence of our recommendation, is to get them the automated access that would allow them to do bigger and wider searches at once.

Mr. PALLONE. Thanks. Dr. Agrawal, what training and guidance has been provided to states on using the PECOS system, and what additional efforts will you be undertaking?

Dr. AGRAWAL. Sure. So we have two different kinds of access to PECOS, one that is the sort of provider-by-provider real time access to the system, but since this analysis was done, we have also been making data extracts available to states so that they can use those extracts and compare them against their entire enrollment file. We have already made changes to those extracts based on state input, and are looking to expand them as we go on.

With respect to guidance, we do offer education in using CMS data assets to states through things like the Medicaid Integrity Institute. We also offer other technical guidance, and sort of case-by-case help as needed, and states can contact us for that.

Mr. PALLONE. All right. Let me see if I get my third question in. Given that Medicaid is a joint state/Federal program, states have a very important role to play in preventing improper payments. It sounds like there is a fair amount of Federal information available to states, but that not all states are taking full advantage of what is available. So I will start with Dr. Agrawal. How can states be encouraged to use the data available to them?

Dr. AGRAWAL. Yes, I think that is a great question. So, there are data assets like PECOS and PARIS, where we know that all states have access. And I think part of getting them to use it offering the guidance, offering the technical input to make sure that they are using the data in the right way, and using it as frequently as they can. With something like PARIS, for example, we were able to release guidance, and ask all states to not only input their data every quarter, but also to use that data in their enrollment efforts every quarter.

Mr. PALLONE. OK. And, Mr. Bagdoyan, based on GAO's findings, how can the states more effectively use the data available to them?

Mr. BAGDOYAN. I think I would echo Dr. Agrawal's comments. I think, if they are available, once they are available, they would be encouraged through guidance, they would be held to account to make sure that this works as intended. I mean, again, it is a partnership. It is a common model, if you will, to make this work.

Mr. PALLONE. All right. Just want to thank both of you. In addition to the important tools already added by the Affordable Care Act, I am encouraged that CMS implementation of GAO's recommendations will further help state Medicaid programs in their efforts to address this persistent issue. So thanks again. Thanks, Mr. Chairman.

Mr. MURPHY. Thank you. Now recognize Dr. Burgess for 5 minutes.

Mr. BURGESS. Thank you, Mr. Chairman. One of the hazards of having been on this committee for a number of years is you see themes repeating themselves. And, Chairman Murphy, I remember very well a morning in late September 2008, when we held a Health Subcommittee hearing downstairs, and we had some, I don't know, 8, 10, 12 witnesses. It was a pretty varied panel. Karen Davis from Commonwealth, Steve Parenti from the McCain campaign, the late Elizabeth Edwards was one of the panel members, and it was all a panel to discuss what is it going to cost to provide health care to everyone who lacks health insurance in this country. And the estimates were quite varied, and they ran from $60 billion a year to $800 billion a year.

Chairman Murphy, I remember you asking the question, how could there be so much variation? And Steve Parenti, on the panel, was the only one willing to take it on, and said, well, if you provide Medicaid to everyone, and that is how you expand your coverage, that is the lower number. If you provide Federal employee health benefit plan to everyone, which was being talked about by some of the candidates at the time, that is the higher number.

So I guess my point is, everyone knew going into everything that became the Affordable Care Act that the way to expand coverage without blowing up the cost was Medicaid expansion. Why wouldn't you fix some of these problems before you undertook to expand a program that, if I understand correctly, Mr. Bagdoyan, it was already on a watch list in 2008, and certainly on a watch list in 2009, when the law was written in 2010, when the law was signed. But really, why not put the effort on the front end? The way we are going to expand coverage is through Medicaid, maybe we could deal with some of these problems. What about the fact we have got dead people that we are paying money for? What about the fact we have got people who are receiving benefits in two states simultaneously? That is not supposed to happen, is it, Dr. Agrawal?

Dr. AGRAWAL. That is correct.

Mr. BURGESS. Then the whole issue—GAO in 2005 or 2006 put out a report about the third party liability—Medicaid will pay a claim when a person has private health insurance. And, really, Medicaid is supposed to be the payer of last resort, not the payer of first resort. And we have never really satisfactorily dealt with that problem, have we?

Mr. BAGDOYAN. I am not familiar with the report.

Mr. BURGESS. Well, I will tell you, no, we have not. So here we have it here, three very basic steps, don't pay the dead people, don't pay people twice, and, hey, if Aetna, United, Cigna is supposed to be paying the bill, you get them to pay first, before the state reimburses on their Medicaid system. Relatively simple steps that could have been done before expanding a program massively. And now we are in a situation where not every state has expanded their Medicaid.

And Dr. Agrawal, let me just ask you, when states come in with their proposals, if a state is considering expanding Medicaid in their state, and some states are, whether I think that is correct or not, some states are, when they come in with those proposals, are you talking to them about the fact that there are some inherent problems in the Medicaid system, and we would like to see those fixed before you double your number?

Dr. AGRAWAL. Yes, thank you for the question, Dr. Burgess. So I think our relationship with the states is such that we are talking to them regardless of whether or not they are seeking to expand their Medicaid programs. There are current program integrity challenges and vulnerabilities, as the GAO has pointed out. They exist in the current Medicaid program. Our state oversight efforts, whether it is the PERM rate, or state program integrity reviews, include all states, not just those that are expanding.

I think, to your larger point, what we are trying to do is balance real program integrity interests and needs against the needs of socioeconomically disadvantage population that needs access to health care and health——

Mr. BURGESS. Let me stop you there, because time is going to become critical. In my opening statement I referenced a problem that was related to dental care in the State of Texas. You have got a real problem. People who should be barred from ever participating in the program again simply dissolve into bankruptcy, and reemerge someplace else. What are you doing to keep that from happening?

Dr. AGRAWAL. There are clearly efforts that we—we do conduct collaborative audits and investigations with states and, where appropriate, encourage states to take termination actions in their programs. I think you referenced the exclusion authority by the HHS OIG. We obviously agree that that is a very powerful authority. We encourage OIG to implement it where appropriate. And where they do, we can take revocation action quickly behind it.

Mr. BURGESS. Let me just, before time expires, Dallas Morning News over the weekend, an article that I think is part of a series of articles about how private nursing homes are drawing down dollars by combining with a public entity, and some of these are fairly low ratings on the star rating on the nursing homes. Are you working with the states to address this problem?

Dr. AGRAWAL. Yes. I am not aware of the specific nursing homes, but we do have survey and certification, and other rating functions CMS uses to work with states on these issues.

Mr. BURGESS. Well, $69 million just to these nursing homes identified last year, so it is a place where we need to put some effort. Thank you, Mr. Chairman, I will yield back.

Mr. MURPHY. Gentleman yields back. Now recognize Mr. Kennedy for 5 minutes.

Mr. KENNEDY. Thank you very much, Mr. Chairman. Thank you to our witnesses for coming today, and for your testimony at an important hearing. I want to touch base a little bit on the improper payment rate, and put that in context. Medicaid program provides about 70 million low income and disabled Americans with vital health care services, and we must do everything we can to strengthen it and protect it. As you have heard from my colleagues here this morning, no one, Democrat or Republican, is in favor of fraud. We clearly want to make sure this program is as lean as it possibly can be, and that the people that need help and need the services are getting them.

So, to that end, Mr. Bagdoyan, I would like to begin with you. Since its peak of 9.4 percent in 2010, the improper payments rate for the Medicaid program has steadily decreased, reaching a low of 5.8 percent in 2013, or $14.4 billion. That number rose to 6.7 percent in 2014, or $17.5 billion. Is that right?

Mr. BAGDOYAN. That is correct, sir.

Mr. KENNEDY. So I want to dig into that number a little bit deeper and see if I can better understand the dynamics that are, in fact, driving that improper payment rate. The ACA provided CMS with a number of new tools to strengthen program integrity in the Medicaid program. In 2011 CMS established a new risk-based screening procedure for Medicare, Medicaid, and CHIP providers. CMS also promulgated new regulations, requiring the states to use electronic data maintained by the Federal Government to verity and revalidate beneficiary eligibility through the data services hub.

So, Dr. Agrawal, let us break down that payment rate into its relevant components. I know you touched on this a little bit earlier. If I understand this correctly, Payment Rate Measurement Program, or PRM, measures error rates both overall for the Medicaid program, as well as for certain subcategories, fee-for-service, managed care, and beneficiary eligibility. Is that right?

Dr. AGRAWAL. That is correct.

Mr. KENNEDY. So what has happened to that beneficiary eligibility error rate since 2011?

Dr. AGRAWAL. I think that is an important point, and it does highlight some of the intricacy in the rate. The beneficiary eligibility error rate has actually been cut in half since 2011.

Mr. KENNEDY. So the error rate for—beneficiary eligibility rate cut in half, declined by three percent. Is that a substantial improvement, major improvement, small improvement? How do you characterize it?

Dr. AGRAWAL. I think, given the issues that GAO has highlighted, that is obviously a substantial improvement. More work remains to be done, which we are focusing on, but it does indicate good progress.

Mr. KENNEDY. And so what is driving that improvement, then? Is it the result of, in your opinion, the work CMS has been doing to implement the new program integrity tools in the ACA? Is it something else? What is behind the success?

Dr. AGRAWAL. I think it is work being done at both the Federal and state levels between increased collaboration, more education

and technical guidance going to states, better data assets that have been highlighted by Mr. Bagdoyan.

Mr. KENNEDY. Given that large drop in the error rate for beneficiary eligibility, what factors are driving the increase in the overall PERM rate? And I realize you touched on this a little while ago, but if you could flesh that out a little bit for me?

Dr. AGRAWAL. Sure, no problem. The biggest driver of the increase in the rate are provider enrollment and screening standards. And, again, as with other PI aspects of program integrity, whenever there is a new requirement, certain stakeholders, in this case states can experience some difficulty in keeping up. So what we have found, that, while some states are quite far along, other states are lagging behind, and generally that is causing the error rate to rise.

Mr. KENNEDY. And how do we get those other states to pick up the pace?

Dr. AGRAWAL. Well, we exercise oversight in a variety of ways, so I think it is both what can we offer them in terms of collaboration that will help, like technical assistance, data assets like PECOS, and then where can we exercise real oversight? We do that through the PERM rate. We require states to submit corrective actions to improve the error rate going forward, and also conduct state program integrity reviews, with associated corrective action plans where states fail to meet requirements. So I think it is a mix of both of those things.

I think the error rate increase in that particular aspect is the reflection of more stringent policy, which in and of itself is a good thing. We need that policy.

Mr. KENNEDY. What, if anything, can this committee do to help you with that?

Dr. AGRAWAL. I appreciate the question. I think holding our feet to the fire is appropriate.

Mr. KENNEDY. You are welcome.

Dr. AGRAWAL. Thank you very much. I also think encouraging states to stay on the right path, take advantage of the various resources that we offer, identify improvements that we need to make so that they can make progress, would be extremely helpful.

Mr. KENNEDY. And, again, just putting this in context, if I understand Mr. Bagdoyan, the GAO report, it was four states, yes?

Mr. BAGDOYAN. Yes.

Mr. KENNEDY. And it covered 9.2 million Medicaid beneficiaries, right?

Mr. BAGDOYAN. That is correct.

Mr. KENNEDY. And I know we talked a little bit about the 200 or so deceased beneficiaries that received payment. If we were to put that—just so I understand it, that is 200 out of 9.2 million, right?

Mr. BAGDOYAN. My math is not that good.

Mr. KENNEDY. Right. If we wanted to put that in that percentage, though, if you take my word for it that my iPhone calculator ain't so bad, that is .00002, four zeros and then a two—as far as error rates go, nothing is acceptable, but we are doing OK if it is 200 out of 9.2 million, right? You guys are doing your jobs?

Mr. BAGDOYAN. Well, that is we found is 200 out of the 9.2 million. That is all I am prepared to say.

Mr. KENNEDY. Well, thank you for your work on this. Thank you for your research, and being here today, and highlighting an important issue for the hearing.

Mr. BAGDOYAN. Thank you.

Mr. MURPHY. I guess this can go in the category of lies, damn lies, and statistics. We appreciate it no matter what it is, and we are all in agreement that we want to make sure we rid that—Dr. Bucshon, you are next for 5 minutes.

Mr. BUCSHON. Thank you, Mr. Chairman. First of all, I was a practicing physician for 15 years, as I had mentioned to our witnesses beforehand. I have taken care of all patients, regardless of their ability to pay, which is what we do in health care. But I just want to highlight that all is not rosy with Medicaid. And I know this hearing is about waste, and fraud, and abuse, but I am from Indiana, and our medical practice routinely wrote off hundreds of thousands of dollars from a neighboring state's Medicaid program in billings every year because they ran out of money before the end of the year, and this pre-dates the ACA.

The other thing is that the program within our own state has been financially challenged historically with a significant Medicare provider cut within the last 10 years just to stay afloat. That said, Medicaid is a critical program that we have to have for our citizens. What can we do? Well, Indiana has expanded our Medicaid program using an innovate plan called Healthy Indiana Plan 2.0, and I am hopeful that this state-based plan, as well as state-based plans around the country, can be used as a proving ground how to move forward on our Medicaid program.

Some facts about the Medicaid expansion that are not surprising to me, but seem to be surprising to those who wanted to expand traditional Medicaid, is that ER visits are up, in some cases dramatically up, in multiple studies across the country. And the hospitals are very happy, but we have made no progress because this is the highest cost form of medical care available in the country. And so, having a card in your pocket, but having no access to primary care physicians or others outside of the emergency room is not progress. And the encouragement to seek preventative care, as was mentioned earlier, may be technically true, but functionally not accurate because you can't get preventative care if no one takes your coverage.

States that have expanded Medicaid are already starting to look for ways to pay for the program once the Federal money for the expansion goes down to 90 percent, and my concern is reimbursement cuts will be the way that will happen. And what does that do? Further limits access to the citizens in their states. And if anyone doesn't think that sometime in the future that the Federal Government will look for a way to pay for other things by further cutting that expansion money to the states on their Medicaid program, then you are not following the government very well.

That said, I do have a couple of questions. And, again this is a very important hearing. I saw that we limited the study, Mr. Bagdoyan, to the four states. Why did we pick these states, and did the GAO try to include other states in your study?

Mr. BAGDOYAN. Thank you for your question, Dr. Bucshon. The way we picked our states is we began with the universe of beneficiaries per state, and then we also looked at data reliability, as well as geographic dispersion. So those were the three key factors that we used to pick these states. Now, data reliability being a very important factor, we don't have reliable data, we can't do our analysis.

Mr. BUCSHON. And that segues into Dr. Agrawal. The data we were just talking about, not accurate from states, how do you envision the progress we are making in information sharing on Medicaid between the states and the Federal Government? How can we improve on that situation so if, in the future, we want to study this situation, we can pick any one of the 50 states? How are we doing?

Dr. AGRAWAL. Yes, thank you. I think that is a really important question. Data is really central to program integrity work. What we have found is access to the right data set can really increase the sensitivity and specificity of our leads. The agency has made some of the biggest investments we have ever made in improving Medicaid data assets in programs like T–MSIS, which is seeking to dramatically increase the amount of data and the kind of breadth of that data that we get from state programs.

In addition, Congress has funded previous programs like the Medi-Medi, which encourages Medicare and Medicaid data sharing and integration specifically for program integrity purposes, and we have been engaged in that process for years now.

Mr. BUCSHON. Is proprietariness among different systems a problem? What are the barriers to, it seems like it would be simple, right, but there are barriers.

Dr. AGRAWAL. There are, and I am not a technologist, but there are clearly differences between systems, and getting data integration to occur, that is not a trivial task at all, especially, you know, amongst 50 different states. So, yes, there are some real technical barriers to getting the right data formatted in the right way so that it is readily accessible.

Mr. BUCSHON. But some of it is not just about money, right, where the systems don't want to communicate because of proprietary control over data?

Dr. AGRAWAL. I am not sure how much proprietary issues stand in the way. I think it is more technical implementation. And then, yes, resourcing is important to make sure that we can adequately make this all work together.

Mr. BUCSHON. Thank you. Mr. Chairman, I yield back.

Mr. MURPHY. Ms. Clarke, you are recognized for 5 minutes.

Ms. CLARKE. Thank you, Mr. Chairman, and I thank the Ranking Member, thank our witnesses for their testimony here today. I am glad we have had the opportunity today to talk about the Medicaid program, and how many people it helps across the country. As of February 2015, over 70 million people were enrolled in Medicaid. The number of enrollees will continue to rise, as 30 states have expanded Medicaid, and even more states are considering doing so. We know that fraud and improper payments have long been a reality of the Medicaid system, but with the passage of the Affordable Care Act in 2010, we have made significant steps

to strengthen the Medicare, Medicaid, and CHIP programs by reducing waste, fraud, and abuse.

Dr. Agrawal, I would like to ask you about the Affordable Care Act anti-fraud measures, and how they have strengthened the Medicaid program. In your testimony you noted that the Secretary of HHS can temporarily pause enrollment for new Medicaid providers and suppliers if she determines certain geographic areas face a high risk of fraud. Dr. Agrawal, how does the Secretary make that determination?

Dr. AGRAWAL. Yes, thank you. So, you are right, the moratorium authority is one of many tools granted to CMS for its program integrity efforts. We currently have moratoriums in place in seven different metropolitan areas in two main service categories, ambulance services and home health agencies. And, we arrived at those areas, both the service types and the geographies, by doing data analysis to look at where there were clear areas of market saturation of these provider types, and in all of these metropolitan areas we see somewhere between three to five times higher the number of providers of these categories than, you know, comparative metropolitan areas.

We also conferred with our law enforcement colleagues in DOJ and OIG to assess where hot spots really are, and where billing is really concerning for fraud, and it was really a multitude of things that led us ultimately to implement these moratoria.

Ms. CLARKE. How have they been effective in preventing and reducing fraud in those affected areas?

Dr. AGRAWAL. So, what the moratoria really do is, essentially, pause enrollment. It stops new providers from coming into those areas in these specific provider categories. That affords both us and law enforcement the opportunity to step up our activities in those areas and remove bad actors that are already in those areas prior to lowering the moratorium, and allowing new providers to enroll again.

Ms. CLARKE. And has that been effective, in your estimation?

Dr. AGRAWAL. I think we are still doing data analysis to look at how effective the moratorium as a singular tool is, but what we are finding is that, in those area, which clearly are hotspot areas anyway, we have been able to effectuate literally hundreds of revocations of both home health agencies and ambulance companies. So, we continue to assess the moratorium. We are obviously very concerned about access to care, want to make sure that the moratoria don't interfere with access. And, so, there are a lot of analytics that go on, as well as collaborating with the states.

Ms. CLARKE. And how does the affected states, during the moratorium period, how does CMS work with them?

Dr. AGRAWAL. So, just as we do more broadly, we engage in data exchanges, we work with them on collaborative audits and investigations, and then we do those access to care analyses to make sure that the moratorium is not having an adverse consequence.

Ms. CLARKE. Yes, and on that point, how do you make sure that Medicaid beneficiaries are continuing to receive the services they need?

Dr. AGRAWAL. Right, that is of primary importance. Again, these areas in service categories were chosen in the first place because

of really significant market saturation, making access not such a huge problem right at the outset. But, as the moratoria have gone on, we have worked, through our regional offices at CMS, with the relevant states. We have stayed in contact with them, exchanged data to make sure that that picture has not changed, and thus far it hasn't. Access to care continues not to be a major issue.

Ms. CLARKE. And then, finally, ACA significantly increased funding to fight Medicare and Medicaid fraud. How will additional funding help CMS address program integrity vulnerabilities?

Dr. AGRAWAL. Yes. We do appreciate the work of Congress, and the leadership of this Committee, in providing more resources for us. Those additional resources will allow us to continue to invest in existing programs, to encourage, again, more data collaboration with Medicaid agencies, provide more technical guidance and education. And then, where necessary, especially to respond to recommendations like this, we will be implementing new initiatives and programs to continue the Medicaid and Medicare programs.

Ms. CLARKE. Very well. And just out of curiosity, the implementation of the data hub, have you used that collaboratively in those high concentrated metropolitan areas as you also employ the moratoria?

Dr. AGRAWAL. Well, the data hub is really more of a general Federal asset for states to utilize at the time of beneficiary enrollment and eligibility determinations. It is not really specifically focused on moratoria area. Rather, we see it as a tool that should be utilized across the Medicaid program, to ensure eligibility is done correctly the first time.

Ms. CLARKE. Very well. I yield back. Thank you, Mr. Chairman.

Mr. MURPHY. Now recognize Mr. Brooks for 5 minutes.

Mrs. BROOKS. Thank you, Mr. Chairman, and thanks to our witnesses for being here. I am a former United States Attorney, and so have worked with Medicaid fraud control units run by our states' Attorney General, and also with HHS OIG agents, and my question is really to both of you about the staffing, and the number of people that we dedicate—so while you are very focused on prevention, I understand, but deterrence is also a wonderful tool, and I am curious about the effectiveness of our deterrence. Because if we don't prosecute those, and—while certainly I know U.S. Attorneys' offices and Attorney Generals are prosecuting all across the country, I don't believe they have the resources that they need. These are very complex investigations. The last thing they want to do is prosecute someone wrongfully, and these are very complicated cases.

So my question is to both of you about whether it is our health care providers, or the beneficiaries who are receiving improper payments, what is your thoughts on how we are doing with respect to prosecutions?

Dr. AGRAWAL. So I appreciate the question. Prosecution is obviously an important aspect of health care fraud control generally. What we have been doing over the last 5 years, since the creation of the Center for Program Integrity, is really investing resources in preventing these issues from arising in the first place. That includes, you know, payment edits, audits, investigations, and ulti-

mately removing a provider from the program, if necessary, to stop inappropriate billing.

As part of that work, we are also collaborating closely with OIG and DOJ, making sure that they have data that is adequate for their cases, providing them whatever additional services or resources they need, even using administrative authorities that CMS has, as long as, you know, we are obviously following those authorities and implementing them in the proper way. So I think it is a balance. I think deterrence is obviously very important, and we continue to collaborate with law enforcement as needed.

Mrs. BROOKS. Mr. Bagdoyan?

Mr. BAGDOYAN. Yes, thank you, Ms. Brooks. The issue of prosecution was not within the scope of our audit, certainly, but I would see it certainly as part of the toolbox that I alluded to in my opening remarks. So, in its totality, it would have to have preventative controls, and the ability to investigate, and, if appropriate, prosecute.

Mrs. BROOKS. Let me dig a bit further on the investigation, though, and I have seen the reports done by those units, and the analysis they do, and it is very complex. And I know that in your written testimony you talked about the Medicaid Integrity Institute, Dr. Agrawal. How many employees do you know across the country deal with Medicaid, state and Federal? Any idea? Because I saw in a Reuters report that more than 4,200 employees have been trained, but there are thousands more, I would suspect, but I have no idea.

Dr. AGRAWAL. Right. So I am not sure exactly what the total number of Medicaid employees is. I think the 4,200 number, what that really sort of refers to are state employees that we have been able to bring over to the Medicaid Integrity Institute to engage in an educational experience on some aspect of program integrity, whether it is working with law enforcement, or provider enrollment in screening standards, beneficiary eligibility, whatever the case may be.

I think there are definitely more than 4,200 out there. Right now, our only constraint is the resourcing and the time to get as many employees in as possible. But the program is a strong one, I think, because it really allows us to spend Federal resources. States have to pay very little to nothing for an individual employee to be educated and have access to those courses.

Mrs. BROOKS. And are all the courses required to be done in person, or could you move to an online training program to help states who have constrained budgets have more of their Medicaid employees trained?

Dr. AGRAWAL. Yes, that is a——

Mrs. BROOKS. I think that is a challenge for a lot of states.

Dr. AGRAWAL. Agreed, that is a great question. We have, up until now, done the vast majority of this educational work in person because there is a value to that in-person education, being able to conduct seminars, real sort of small group trainings. However, I think your point is a good one, and we are currently looking at ways of using more virtual training, as well as potentially putting MII on the road, so that states that can't travel, or for their own policies or whatever, still have access to the education.

Mrs. BROOKS. Do you have any sense as to the success of this institute? I mean, how many folks have gone back and have actually prevented fraud?

Dr. AGRAWAL. Yes. So, measuring the impact of education, as you are probably aware, is really challenging to connect it to specific dollars and cents that are saved. What we find, in certainly post-course assessments, is a very high rating by state officials that indicate that they really did value the education that was given. We do also ask them to self-report where they feel the education contributed to recoveries or savings. We can give that number to you. But, again, I think it is hard to connect education to a specific dollar that is saved. I think it is often important to do these activities merely because that greater awareness at the state level is valuable onto itself.

Mrs. BROOKS. Thank you. I yield back.

Mr. MURPHY. The gentlelady yields back. Now recognize Ms. Castor for 5 minutes.

Ms. CASTOR. Well, thank you, Mr. Chairman, for calling this hearing, and thank you to the witnesses. Thank you for your attention to program integrity, and rooting out fraud in Medicaid. In Medicaid, every dollar counts, because these are dollars that go, in large part, to children and their health care needs, and our older neighbors in nursing homes, and other hard working Americans.

Now, CMS has issued several new regulations and guidance just in the past month, and I would like to ask you about them today. Dr. Agrawal, as I understand it, under the proposed regulation for Medicaid managed care organizations, managed care providers would be subject to the same screening requirements as providers for the fee-for-service program, is that correct?

Dr. AGRAWAL. That is correct.

Ms. CASTOR. And that is especially important because many states are moving their Medicaid programs to managed care models, is that right?

Dr. AGRAWAL. That is correct.

Ms. CASTOR. In fact, do you know how many states have already shifted, and have instituted Medicaid managed care?

Dr. AGRAWAL. I think the majority have. They are at various levels. States like Arizona, where it is essentially all managed care at this point, and other states that have a hybrid population between fee-for-service and managed care. But, that kind of enrollment requirement is a vulnerability or an issue that has been flagged by both OIG and GAO——

Ms. CASTOR. Yes.

Dr. AGRAWAL [continuing]. And so we are happy to get into a proposed rule.

Ms. CASTOR. OK. Elaborate on that. Why did CMS make that decision?

Dr. AGRAWAL. Yes. So, as you mentioned the rise of managed care is definitely occurring in all states, with some at various levels of integrating managed care. Previous OIG and GAO reports have highlighted that as an issue because, up until now, providers that provide services in managed care programs, through MCOs, aren't necessarily known to the states. They don't necessarily have to go

through the same enrollment standards. Some states require that. Most don't.

We felt that this was an important vulnerability or an issue to address. Hence, that was one piece of the program integrity provisions in that NPRM, and we think that requiring the same screening standards will ensure beneficiary safety, regardless of whether they choose to stay in fee-for-service or managed care.

Ms. CASTOR. Good. And, Mr. Bagdoyan, is this a policy change that the GAO supports?

Mr. BAGDOYAN. I am aware of the rule coming out, but I am not familiar with its details. I would go back to my original point that steps like this one would, over time, if executed and sustained, help narrow that window of opportunity for fraud and improper payments. So that would be my assessment at this point.

Ms. CASTOR. OK. Dr. Agrawal, my understanding is that the proposed rule also imposes new internal compliance and program integrity requirements on Medicaid and CHIP managed care plans. Can you walk us through those requirements?

Dr. AGRAWAL. Sure. There are other requirements of managed care plans that include elevating issues, or informing the state about audit issues, other vulnerabilities that they have identified. It is making sure that they have compliance programs in place to ensure the integrity of payments, program integrity generally. Those are all new elements that the majority of states don't have.

In addition, there is a data sharing element, which requires language in managed care contracts to ensure states can still get access to managed care data as needed for obviously, we are in sort of the rulemaking process. But, if finalized in its current form, would make really important progress in program integrity.

Ms. CASTOR. And your goal is to complement what is already in place at some states? Some don't have similar safeguards, is that right?

Dr. AGRAWAL. Correct. You can think of this as trying to build the safeguards in place that have been started in fee-for-service. So, the same screening and enrollment standards, the same kind of access to data, and making sure that those go through to managed care plans. So, again, beneficiaries have the choice for which to engage in in states that have both, or states can make the transition to managed care without necessarily feeling that they have to give up program integrity along the way.

Ms. CASTOR. OK. I would also like to ask you about the guidance CMS issued earlier this week on criminal background checks and fingerprinting of certain providers in the Medicaid program. First of all, who will be subject to the full background check and fingerprinting requirement, and how will CMS and state agencies determine if a provider represents a high risk?

Dr. AGRAWAL. Sure. So you are referring to fingerprint-based criminal background checks that were one of the ACA requirements in enrollment and screening for providers. Generally fingerprint checks are utilized for provider types that are designated high risk. That would be, for example, a newly enrolling home health agency or DME company where there has been a history of kind of endemic fraud issues. If you are newly enrolling in the state in one of those categories, you would be subject to a finger-

print-based criminal background check. If CMS has already done it, states can utilize our results as their own.

The only other provider types are those that have already been issues in the program, and therefore are on an individual basis designated high risk if they try to re-enroll.

Ms. CASTOR. Thank you very much.

Mr. MURPHY. Mr. Mullin, you are recognized for 5 minutes.

Mr. MULLIN. Thank you, Mr. Chairman. Doctor, can you walk me through the process of what happens when a state medical fraud unit identifies a provider that is committing fraud within the system?

Dr. AGRAWAL. Broadly speaking I can. I will sort of tell you the steps that I know, but I will just make the point that MFCUs, or the Medicaid Fraud Control Units, actually respond to the Office of Inspector General, and they work with program integrity units at the state Medicaid agency.

But I, surmising that the relationship is really similar to what we have with our Office of Inspector General, we will often initiate investigations based on data assets, beneficiary complaints, a host of other inputs. And then, if there is any indication of fraud, or patient safety issues, we will send that over to the OIG, and oftentimes state Medicaid agencies with similar policies, engaging their fraud control unit.

Mr. MULLIN. Can the state Medicaid fraud units indict providers?

Dr. AGRAWAL. I believe they can, working with regional DOJ offices.

Mr. MULLIN. Communication with our Oklahoma fraud unit for Medicaid, they indicated that they couldn't. They had to basically turn it over to you all.

Dr. AGRAWAL. Again, they might be referring to Federal law enforcement, either, again, OIG or DOJ. As an administrative agency, we don't indict providers. We have various administrative authorities and actions, but the most severe is kicking somebody out of the program.

Mr. MULLIN. So they can go in and be fraudulent, billing Medicaid for millions of dollars, and the worst thing that happens to them, they get kicked out of the program?

Dr. AGRAWAL. Well, again, we have the administrative authorities that we have. We are able to suspend payments, terminate the enrollment of providers. And then I think, to the point that was made earlier, we do work with law enforcement to bring other, more criminal justice activities.

Mr. MULLIN. But we hear reports over and over again about providers that were kicked out of the program for having fraudulent claims, and then they turn back around, change their name, and are back in business the following week.

Dr. AGRAWAL. So——

Mr. MULLIN. What is the indicator that you communicate with the Federal prosecutors and say, look, we want this guy to go to jail——

Dr. AGRAWAL. Right.

Mr. MULLIN [continuing]. Or do you guys just don't do that? You say, well, whatever, she defrauded the taxpayers millions of dollars, but it is up to you?

Dr. AGRAWAL. Well, specifically with working with law enforcement, we make referrals—I think hundreds, if not thousands of referrals, and we can actually get you some numbers for the last couple of years to show you how many, to law enforcement for those cases that are most concerning for fraud, and where we believe a law enforcement action would be appropriate, at least from our determination.

But I think, to your larger question about providers reinventing themselves, we too have noted that as a vulnerability, and, in fact, have promulgated rules that have allowed us to close it by, for example, tracking administrative actions, and actually applying them to owners who would try to reinvent companies.

Mr. MULLIN. Well, it seems like, to me, if more of them went to jail, that might prohibit them from going through. So do we know how many actually end up doing jail time?

Dr. AGRAWAL. I think that is a question for at least the OIG, or the state law enforcement officials.

Mr. MULLIN. Is that a number that you guys can provide?

Dr. AGRAWAL. Remember, our authorities don't involve——

Mr. MULLIN. So there is a breakdown in communication is what I am saying.

Dr. AGRAWAL. No, I wouldn't say that——

Mr. MULLIN. I am asking you, because you kick them out of the program, then turn it over, then no one pays attention to them anymore. And if the Federal prosecutors aren't willing to prosecute, then they come right back into your system, no one is paying attention to them, and they end up doing the same thing over again. Because if the worst thing that happens to them is they get kicked out, then it is not there.

It might be something that we might want to look at. Maybe we ought to let the states do this. If they have a unit that specifically identifies claims to Medicaid that the state is issuing, and they see fraudulent activities, and they turn it over to you, you all kick them out, you all turn it to the Federal prosecutors, if they end up getting lost in the chain, why don't we simplify the process and just let the state prosecute them?

Dr. AGRAWAL. Just to be clear, states don't have to go through CMS in order to get to prosecutors or law enforcement. They do have Medicaid fraud control units that they can go to directly.

Mr. MULLIN. But they——

Dr. AGRAWAL. They have other——

Mr. MULLIN [continuing]. Can't prosecute them, though.

Dr. AGRAWAL. Right. As administrative agencies, the state Medicaid agency, CMS, we don't prosecute directly, but we don't work with law enforcement to do that. I wouldn't characterize it as a communication breakdown. I would characterize it as different lines of authority. We are happy to work with law enforcement. We provide law enforcement with data on a routine basis, work with them sometimes for years as they develop, investigate, and take action on cases.

Mr. MULLIN. So do you think there is a better way—quickly, because I am running out of time, is there a better way to handle this, then?

Dr. AGRAWAL. I think it depends on what this is that you are trying to improve.

Mr. MULLIN. Well, to prosecute the individuals, rather than just kicking them out of the program, and not actually sending them to prison.

Dr. AGRAWAL. Yes. So it is really important, I think, to engage in prevention, because prosecution takes, understandably, time, and what we don't want is folks billing programs that shouldn't be billing programs. And, so it is useful to actually kick them out of the program and stop dollars from going out the door. At the same time, if we can work with our law enforcement colleagues to get the prosecution, we can have the deterrence effect, and other impact that we want.

Mr. MULLIN. Appreciate it. Thank you.

Mr. MURPHY. Thank you. Mr. Green, you are recognized for 5 minutes.

Mr. GREEN. Thank you, Mr. Chairman. Mr. Bagdoyan, Medicaid is a large program, as is Medicare. Would it be fair to say that as long as these programs existed, there have always been at least some improper payments, some people gaming the system?

Mr. BAGDOYAN. That seems to be the historical record, sir, yes.

Mr. GREEN. I know it wasn't part of your audit specifically, but improper payments were not only associated with Medicare and Medicaid, but they are a challenge government-wide, I assume.

Mr. BAGDOYAN. That is correct. OMB measures that. I think maybe the Chairman or the Ranking Member earlier referred to the higher error programs that OMB tracks, so yes.

Mr. GREEN. OK. Clearly we want to lower the rate of improper payments in programs such as Medicare and Medicaid, but it is important to put it in context. This Committee examined this issue more than a decade ago. Then, as we are discussing today, there were improper payments associated with Medicaid and Medicare. But do we want to constantly try to eliminate improper payments—and we do want to try and eliminate improper payments and better controls.

On page 14 of your report, your audit mentions that CMS, as part of the passage of the Affordable Care Act has put in place some new tools that may help bring down improper payments. I realize that gaps remain, but do you see this as an important step in the right direction?

Mr. BAGDOYAN. I would say they are, and they add to their toolbox that I referred to in my opening statement.

Mr. GREEN. OK. Do you see any new tools as a step in the right direction? If so, can you explain how you think they will help us reduce improper payments moving forward?

Mr. BAGDOYAN. Well, the two recommendations we make available to states, where the action happens, so to speak, with the data they need to better screen both beneficiaries and providers.

Mr. GREEN. OK. I understand more specifically that CMS regulations established a more rigorous approach to verifying financial and non-financial information that could help determine Medicaid

beneficiary eligibility. It has created a tool called the data services hub. I know that gaps will remain, and bad actors constantly try to find ways to game the system, however, does the implementation of this new tool, the data service hub, give you some encouragement that we can reduce the rate of improper payments?

Mr. BAGDOYAN. Again, by all means it is a step in the right direction. Getting the data right and reliable is a key step there, as well as having states regular and electronic access would be also useful.

Mr. GREEN. I am guessing some of these new tools are already having some positive effect. I understand the GAO's audit has some limitation—mainly due to using data that is now almost 5 years old. While I applaud GAO's efforts to help strengthen Medicaid through its work, it is unfortunate that we cannot see how these new and encouraging tools are working until we can examine more recent billing data.

Mr. Chairman, I hope that we continue to work with GAO and CMS to see how these new tools CMS is working on can help us in taking out the fraud and abuse. Again, I want to thank GAO for the excellent work you are doing, and also CMS for responding to what we did in the Affordable Care Act to give you those tools. I yield back my time.

Mr. MURPHY. Gentleman yields back. Now recognize Mr. Collins for 5 minutes.

Mr. COLLINS. I come from the private sector. I am a Lean Six Sigma guy. I have brought Lean Six Sigma into a large municipal government. I think you both know where I am going. It is not a good place. This is the most disturbing hearing I have attended in 2 ½ years. I hear you saying that making 67,000 errors per million opportunities is worth a gold star. Six Sigma says you make 3.4 errors per million. 3.4, not 67,000.

I will be using today's hearing in my stump speeches, in my town halls for a very long time. It is everything wrong with government. That you are setting a standard of making 67,000 mistakes for every million times you try to do something, and you are going to reward and congratulate yourselves, this is disbelief, absolute, utter disbelief of what is wrong with government, to have you two individuals, with smiles on your face, and congratulating each other over trying to achieve 67,000 errors per million opportunities. My mind is blown. I know if 1,000 airplanes take off, and 67 of them crash, that is a 6.7 percent error rate. I don't think we are going to be flying on our airplanes if 67 airplanes crash for every thousand that take off.

In the manufacturing world today, whether it was Toyota many years ago, whether it was General Electric, or some things I have done, we set a goal of Six Sigma, 3.4 errors per million. It is achieved every single day in the private sector. And here we are in government, talking about 67,000 errors per million opportunities, and how this is progress? This is disgusting. It is a waste of taxpayer dollars. It is setting the bar so low that, yes, I guess, we had a goal of 5.6, we hit 6.7, so next year let us make it 6.7. Well, if it is 7.2, then the next year it is going to be 7.2, and we are going to have a hearing, and you guys are going to self-congratulate each

other on achieving something like that? I don't even know that you can't defend the indefensible.

So, while I am carrying on here a little bit, I know you can't defend the indefensible, but maybe I will let you try. And I will also say there is a sign in my office, in God we trust, all others bring data. I am a data guy, if you can't already tell. That means you need good data. And now I am reading that the PERM program, the Payment Error Rate Measurement Program, at best, it is using a rolling sampling of 17 states, the data is not consistent, it is not gathered in a consistent way. I have one word for that data, and that is garbage. Garbage, complete garbage.

So, I don't know, Mr. Bagdoyan, do you have anything to say?

Mr. BAGDOYAN. Well, Mr. Collins, I thank you for your comments. I think our audit was thorough, by our audit standards, and our findings speak for themselves.

Mr. COLLINS. You are familiar with Six Sigma, right?

Mr. BAGDOYAN. I am indeed, yes.

Mr. COLLINS. All right. So, what would you think if you are in my world, and I am used to 3.4 errors per million, and you are at 67,000? How long do you think you would work for me?

Mr. BAGDOYAN. I take your point.

Mr. COLLINS. Yes, not very long. And, Dr. Agrawal, again, you are—you seem OK with taking the 5.6 to 6.7. Can you defend that? I am going to stand up in front of my residents, and I am going to talk about this hearing, and they are going to be shaking their heads in total disbelief. You are going to be an example of everything wrong with government from this day forward in western New York when I tell them at 5.6 percent—you hit 6.7, so the next year you just changed it to 6.7. If that is not oh, my God, I am just—again, this is the most disturbing hearing I have ever taken place in. So what do you say to the third graders when I tell them that?

Dr. AGRAWAL. I think I have made it pretty clear from my opening remarks, Congressman, that we do view these findings as important, and, while we have made progress, there is more progress to be made. I don't view it as any other way. I don't view it as just sort of being happy with the results and where we are.

Mr. COLLINS. Well, my time has expired, but I would suggest you set different standards for yourselves, ones that respect the B in billions. We talk in government about dollars like billions don't even matter anymore because we are trillions in debt, and I would suggest that, as somebody who has got something to do with this, next year, when they try to raise the error rate to 7.2 percent, you actually stand up and make a name for yourself and say, I am not going to stand by and let that happen. With that, I yield back.

Mr. MURPHY. Gentleman yields back. Just to clarify, Dr. Agrawal, did you set the standard at 6.7 percent?

Dr. AGRAWAL. No. That is a process that involves a different part of the, it is obviously kept separate from folks that are trying to make the interventions, right, so that there is some objectivity to it.

Mr. MURPHY. And, Mr. Bagdoyan, you more or less audited this information and provided it for us, correct?

Mr. BAGDOYAN. Yes. We use it as a point of reference, sir. We don't set the number.

Mr. MURPHY. So the follow up to Mr. Collins's question that is important for us to know, the process of how that is done? Because I think you heard unanimity of opinion, none of us want to tolerate that, but we need to know how that is happening so we can make changes on this very thing. But I thank you. I now recognize Mr. Yarmuth for 5 minutes.

Mr. YARMUTH. Thank you, Mr. Chairman, and thanks to the witnesses. I want to get some clarification on this PERM rate, because I am not sure I understand it. If you characterize these as errors, are these errors that CMS made, or are they errors that—just some kind of incorrect payment was made? So you would have had, for instance, a bill come in that was coded incorrectly, wrong procedure, whatever it is, and—would that have been counted as an error?

Dr. AGRAWAL. Yes, it would be.

Mr. YARMUTH. So it wasn't a mistake that you made, it was a mistake that somebody who was sending the bill in made, is that correct?

Dr. AGRAWAL. Yes. I mean, I think it could be argued, and in fairness, that we need to have preventative programs in place to catch that.

Mr. YARMUTH. I understand, but this is not necessarily an——

Dr. AGRAWAL. Correct.

Mr. YARMUTH [continuing]. Indication of negligence on the part of CMS.

Dr. AGRAWAL. Correct.

Mr. YARMUTH. And I have got my problems, as everybody does, with CMS, but if somebody sent in a bill on a fee-for-service basis for $100, and they were actually only entitled to $90, that would be an error under this——

Dr. AGRAWAL. That would be——

Mr. YARMUTH [continuing]. Report? Now, would that total $100 be counted in the 14 billion? My point being that——

Dr. AGRAWAL. Yes.

Mr. YARMUTH [continuing]. I think there is the danger here—and I am a former journalist. There is a danger here that somebody would look at this report and say the mistakes cost taxpayers $14 billion in 2013, when, in fact, they didn't cost taxpayers $14 billion, they cost them some—could be a very small fraction of $14 billion. Am I analyzing that correctly?

Dr. AGRAWAL. Right. I think what is really important is the measured tone that GAO and Mr. Bagdoyan have taken today, that these are all potentially improper payments, and not the data inconsistency alone doesn't absolutely establish that. In many of the specific claims where these improper payments have been noted, states or CMS are able to actually recover those dollars, or Federal portions are withheld. So, yes, there is obviously complexity underlying this that you are correct to point out.

Mr. YARMUTH. Right. I just want to make that clear, because, again, I think there is a danger in taking these numbers and blowing them out, at least not with a full understanding of what they represent.

And, Mr. Bagdoyan, looking at the numbers there, I did the same calculations that Mr. Kennedy did, and on the deceased question, looking at it another way, it was one out of every 46,000 beneficiaries. Just on the total beneficiary problems, it was one out of every 742, and on the provider problems it was one out of every 2,753. Now, I think, again, there is a danger in looking at it and saying, 8,600 beneficiaries got benefits in two states, but——

Mr. BAGDOYAN. Yes.

Mr. YARMUTH [continuing]. It is a relatively small number. I would be negligent if I didn't spend time talking about the Kentucky experience, because I know my colleague from Indiana talked about how states are worried about paying for the Medicaid expansion. I think everybody has some concern over what the impact will be, but—in Kentucky—and I need to congratulate Governor Beshear and his team. Under the expansion of Medicaid, more than 520,000 Kentuckians now have insurance who didn't have it before. The ACA, the uninsured rate across the state has been reduced by almost half. In my district alone, the uninsured rate has been reduced by 81 percent, which is a phenomenal occurrence—I think a very humane one.

But more importantly, the governor just had the Deloitte Firm, highly respected accounting and business consulting firm, do an analysis and a project as to what the ACA would mean to Kentucky over the next 6 years. And, again, most of this is because of Medicaid expansion, but the vast majority of the newly insured are part of the Medicaid expansion. The Deloitte Firm concluded that over the next 6 years the ACA, in Kentucky, would create 40,000 new jobs, it would have a positive impact on the economy—additional impact on the economy positive of $30 billion, and would have a positive impact on Kentucky's budget over the next 6 years of $819 million.

So, I think that it is easy to sit here and say, gosh, what are states going to do when they have to pay 90 percent in 2021, or 95 percent in 2017 or '18? But, in fact, an analysis of our situation shows that it is going to have a positive impact well into the 2020s. So I wanted to get that on the record as part of this discussion, and with that, Mr. Chairman, I yield back.

Mr. MURPHY. Gentleman yields back, and I will recognize Ms. Blackburn for 5 minutes.

Ms. BLACKBURN. Thank you, Mr. Chairman, and I thank you all for being here. And, as Mr. Collins just said, this is really a frustrating hearing in so many ways for us. In 2003, shortly after, we did a field hearing in Tennessee, looking at the TennCare program, which was the test case for Hillary Clinton's health care, and implemented in Tennessee, and a lot of Obamacare has been built on it. And one of the focuses of that hearing was the waste, fraud, and abuse, and the fact that CMS just couldn't seem to get its act together when it came to dealing with waste, fraud, and abuse.

And when you isolated our state and looked at it, the payment error rate, and the eligibility issues with verification of who was and was not eligible, and then the providers, so to see this continue on, and your willingness to accept a failing grade in addressing this is just beyond us. Because you are not getting better, you are get-

ting worse, and then you change the grading system to accommodate that you are not improving.

And, Dr. Agrawal, if I am understanding this right, you moved from 5.6 to 6.7 in that rate, and this was done by committee, so there is no one person in charge of this debacle, is that correct?

Dr. AGRAWAL. I am sorry, ma'am, I don't understand what you are asking about.

Ms. BLACKBURN. You changed your grading rate. You went from a target for—5.6, a target rate, to 6.7 in your improper payment rate. And, if I am understanding your answer to Mr. Collins, there is no one person that decided that, it was a committee, or a group, that decided that. Is that correct? Who do we hold responsible for accepting a failing grade?

Dr. AGRAWAL. Well, Congresswoman, clearly the target is set, but I think what is important is we actually measure our——

Ms. BLACKBURN. Who sets the target? Who set it?

Dr. AGRAWAL. I don't know. We would have to——

Ms. BLACKBURN. Who accepts this?

Dr. AGRAWAL [continuing]. Go back and identify that person.

Ms. BLACKBURN. Who accepts the wasting of taxpayer money? You have got an issue that gets worse every year. Let me ask you this, we are going to get in behind this. Was it 90 providers in one state that were found to be receiving erroneous payments? Did I understand that right, sir?

Mr. BAGDOYAN. Sorry, it was 90 in the four states we looked at.

Ms. BLACKBURN. Ninety in four states?

Mr. BAGDOYAN. That is correct.

Ms. BLACKBURN. OK. What would happen if we were to say there were a zero tolerance policy for improper payments, and for waste, fraud, and abuse that is taking place in CMS? What would happen? How would you all react? Because Federal agencies that deal with taxpayers, they pretty much have a zero tolerance policy.

Or what if we did this, what if we were to look at these numbers—according to CMS, improper payments in the Medicaid program rose from 14.4 billion in 2013 to 17.5 in 2014. What if we were to say, CMS, we are going to charge you back with this $17.5 billion until you can get your act together? And you have got to take that out of your budget, and you have got to find a way to deliver the services and avail yourselves of technology.

Let me ask you a question too. When it comes to the data, and transferring that into information that can be used, have you looked? You say you offer guidance and support to the states. Have you told the states, we are going to hold you accountable for giving us data that can be turned into information, and we are going to cut your payments if you don't give us the data that can be used? Garbage in, garbage out. It is not going to change.

And the fact that you have a secure job, and a paycheck, and think you can't be fired, and then you come in here, and what we hear is, going back to my first hearing on this in 2003, the problem gets worse, the problem doesn't get better, and when it does get worse, you just change the metrics and say, well, that is OK, we are going to do better next year. No, it is not OK. The error rate is not OK. And it is something we are going to push forward, and

holding you all accountable, and look for new ways of doing that. And I yield back my time.

Mr. MURPHY. Gentlelady yields back. I am going to let Ms. DeGette take 2 minutes, and Mr.——

Ms. DEGETTE. Yes.

Mr. MURPHY [continuing]. Dr. Burgess, and we will proceed from there. Thank you.

Ms. DEGETTE. Now, in fairness, Dr. Agrawal, were you in your job in 2003, in this job?

Dr. AGRAWAL. No.

Ms. DEGETTE. Mr. Bagdoyan, were you in this job in 2003?

Mr. BAGDOYAN. I was not, ma'am.

Ms. DEGETTE. I am going to ask you, because you are with the GAO, has the agency tried to institute new metrics to try to prevent fraud since 2003?

Mr. BAGDOYAN. I think, as we reflect in our report, and in my statement, they have. Those will have to play out over the long term——

Ms. DEGETTE. Right, and as——

Mr. BAGDOYAN [continuing]. At all.

Ms. DEGETTE. And as we discussed when I was asking questions, unfortunately, the data that you had for those four states was from 2011, so it didn't reflect some of the preventative efforts that have happened since——

Mr. BAGDOYAN. That is correct. That was part of the necessity of our methodology.

Ms. DEGETTE. Right, exactly, because you just didn't have the data, right?

Mr. BAGDOYAN. That is correct.

Ms. DEGETTE. And, Dr. Agrawal, do you think that it is a good idea to have fraud? Do you support that? Because I have been listening to these other questioners, they seem to somehow imply that either you personally, or the agency, think that it is acceptable to have fraud.

Dr. AGRAWAL. Obviously, I do not.

Ms. DEGETTE. Why?

Dr. AGRAWAL. Well, I come at it from the perspective of an ER physician. I have taken care of Medicaid and Medicare beneficiaries, and other beneficiaries, the uninsured. I do this work so that we can preserve resources for the folks who need it.

Ms. DEGETTE. Thank you. I yield back.

Mr. MURPHY. Dr. Burgess?

Mr. BURGESS. Thank you, Mr. Chairman. I do thank our panel for being here, and I know it has been a long morning. Let me just ask a question, because I am trying to get a better understanding of what is referred to as the PERM program. That is a 3 year rolling average of 17 states examined on a yearly basis, is that correct?

Dr. AGRAWAL. That is correct.

Mr. BURGESS. And, now, what kind of statistical modeling was involved in coming up with that formula?

Dr. AGRAWAL. So there is a statistical sample done in each of these states along the three major categories of the PERM program. And, again, we conduct the cycle so that every state is measured at least once in the 3 year period. And there is statistical

analysis behind it to make sure that the results are generalizable, and can actually arrive at a national rate.

Mr. BURGESS. How do you select the 17 states to be in the particular cohort?

Dr. AGRAWAL. They are——

Mr. BURGESS [continuing]. Alphabetical, and then you cut it off at 17, and——

Dr. AGRAWAL. That is a good question. Actually, I am not sure. I don't think it is alphabetical, but there are 17 in every cohort, and we make sure that every state is represented once in a 3 year period.

Mr. BURGESS. So the four states that Mr.——

Mr. BAGDOYAN. Bagdoyan.

Mr. BURGESS [continuing]. Bagdoyan was concerned about, are those four states all in one cohort, or are they evenly distributed between the three rolling averages?

Dr. AGRAWAL. They are distributed between them.

Mr. BURGESS. Well, I guess, it seems like that is a difficult one. I don't understand why that model was selected. Is it just simply too difficult to assess every state on a yearly basis?

Dr. AGRAWAL. I think it would be a real resource constraint to try to assess every single state every single year, and it does also pose burden issues for the states.

Mr. BURGESS. Everybody knows HHS has the best computers in the world, right? So why can't you?

Dr. AGRAWAL. I can take that back as a specific question if we are going to alter the methodology, but I think the methodology itself has been—it is not the—sort of under——

Mr. BURGESS. Yes.

Dr. AGRAWAL [continuing]. Your question here. It——

Mr. BURGESS. It just struck me as unusual to do it in this fashion. So, again, that is why I was wondering, is there a particular statistical methodology that has been followed, as far as the sampling, on a rotating basis, 17, 17, 17 year in and year out, and how long have you been doing it this way?

Dr. AGRAWAL. Since the PERM program started.

Mr. BURGESS. Which was?

Dr. AGRAWAL. I believe we had the first rates in '07, but I would have to get back to you about that.

Mr. BURGESS. And do you see consistency in those numbers over those years that you go back and look at this?

Dr. AGRAWAL. What we do is we report a national average rate every single year so you can actually follow the rates, as people have done in this hearing, sort of talk about the rates over time. What we don't report are rates by state, because it is very difficult to compare two different Medicaid programs that might have two very different approaches to eligibility and other things.

Mr. BURGESS. All right, thank you. Mr. Chairman, I am going to submit a question in writing about the Dallas Morning News article that I referenced earlier in the hearing, and I would appreciate a response on that.

Dr. AGRAWAL. Sure. Thank you.

Mr. BURGESS. Thank you.

Mr. MURPHY. Thank you. Let me just say this, first of all, we are grateful you came to us in a candid way. But I think you hear among us, we want to facilitate this. None of us are going to tolerate any kind of acceptance of this. And there was a concern about whoever made the decision to just raise the level, it is not really acceptable. What we want to know is the methodology, and work with you, and see what next steps we need to take to deal with fraud and abuse.

Granted, this data is from 2011. Some changes, as Ms. DeGette pointed out, may have already been put in place, to whatever extent you can tell us about that. We want to move a trajectory towards this, because, goodness knows, federal dollars are limited, and anybody who is out there being a crook needs to be handled appropriately so the money can go to those who need it. That is where our compassion should be. It is sort of in the category of those who can, those who can't, and those who won't. And those who won't play by the rules, they need to face the consequences.

So we will be passing on other questions to you, and, to that extent, I want to thank the members for participating, and when the questions are submitted for the record, we would appreciate it if you could get back to us with prompt responses. So, to that extent, I now adjourn this hearing. Thank you.

[Whereupon, at 12:11 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. FRED UPTON

It was 12 years ago that the Government Accountability Office first sounded the alarm that the Medicaid program was a high risk for fraud and abuse. The Office of Management and Budget has designated it as one of the federal government's "high-error" programs with $17.5 billion in improper payments-third on the OMB's list. For decades, Members of both sides of the aisle have asked both Republican and Democratic administrations a very basic question: how are you going to stop the waste of billions of taxpayer dollars? Nevertheless, Medicaid continues to waste billions of taxpayer dollars, jeopardizing the care of the most vulnerable.

Put simply: this is unacceptable. Medicaid is supposed to provide our most vulnerable with vital medical services, but continued waste and fraud undermines this important goal.

For the past several years, tools have been developed, initiatives started, and regulations authored with the goal of reducing Medicaid fraud. And still, fraud in Medicaid continues to grow, not shrink. We owe it to folks in Michigan to do a better job and reverse that trend.

I appreciate the work and testimony of our witnesses. I realize that with over $310 billion spent, some element of bad actors may be unavoidable as they normally follow the money. But we must do better to protect the integrity of this vital program and the care for our most vulnerable. The testimony today provides valuable insight as we continue to work toward a fraud-free Medicaid system.

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE

May 29, 2015

TO: Members, Subcommittee on Oversight and Investigations

FROM: Committee Majority Staff

RE: Hearing entitled "Medicaid Program Integrity: Screening Out Errors, Fraud, and Abuse"

On June 2, 2015, at 10:15 a.m. in 2322 Rayburn House Office Building, the Subcommittee on Oversight and Investigations will hold a hearing entitled "Medicaid Program Integrity: Screening Out Errors, Fraud, and Abuse." Medicaid is a significant obligation for the federal government and the states, with total federal outlays of $310 billion in fiscal year (FY) 2014 alone. Given the substantial current and projected federal dollars spent on Medicaid, and evidence of substantial fraud and abuse in the program, the Subcommittee is conducting oversight to ensure that the program operates more effectively and tax dollars are spent appropriately. In particular, this hearing will examine the findings of a recent report of the U.S. Government Accountability Office (GAO), "Medicaid: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls," GAO-15-313, available here: http://www.gao.gov/products/GAO-15-313.[1]

I. WITNESSES

- Seto J. Bagdoyan, Director, Audit Services, Forensic Audits and Investigative Service, U.S. Government Accountability Office
- Shantanu Agrawal, M.D., Deputy Administrator and Director, Center for Program Integrity, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services

II. BACKGROUND

Medicaid Facts and Figures

Medicaid is a joint federal-state program that finances the delivery of primary and acute medical services as well as long-term services and supports for a diverse low-income population. Medicaid was enacted in 1965 as part of the same law that created the Medicare program. State

[1] U.S. Gov't Accountability Office, *Medicaid: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls*, GAO-15-313 (May 2015).

participation in Medicaid is voluntary, but all states, the District of Columbia, and the territories choose to participate. The Centers for Medicare and Medicaid Services (CMS) within the Department of Health and Human Services (HHS) is responsible for broad program oversight, including disbursement of matching federal funds, while states are responsible for the daily administration of their Medicaid programs. States must follow broad federal rules in order to receive matching federal funds, but have the flexibility to design their own version of Medicaid within the federal statute's framework. In addition to oversight, CMS also provides guidelines, technical assistance, and periodic assessments of state Medicaid programs.

Medicaid enrollment has steadily increased over the past several years. Further, the Patient Protection and Affordable Care Act (ACA) substantially expanded Medicaid eligibility to reduce the number of uninsured citizens. Enrollment—measured by "person-year equivalents," which is the average enrollment over the course of the year—has increased from approximately 34 million in FY 2000 to more than 60 million in FY 2014.[2] Medicaid is projected to have approximately 80 million enrollees by 2021.[3]

Medicaid is a significant expenditure for the federal government and the states, with total federal outlays of $310 billion in fiscal year 2014. According to the Congressional Budget Office (CBO), the federal share of Medicaid outlays is expected to roughly double over the coming decade to more than $576 billion per year in 2025.[4] As a result, over the next ten years, Medicaid is expected to cost federal taxpayers $4.8 trillion dollars.[5]

In February 2015, GAO reported that Medicaid remains at high risk for fraud, waste, and abuse because of concerns about the adequacy of the fiscal oversight of the program, including improper payments.[6] In fact, GAO has designated Medicaid a high-risk program since 2003. CMS reported an estimated improper-payment rate of 6.7 percent, or $17.5 billion for fiscal year 2014 for the Medicaid program. This is an increase over its 2013 estimate of 5.8 percent, or $14.4 billion.

May 14, 2015 GAO Report

In July 2012, Chairman Upton and then-Oversight and Investigations Subcommittee Chairman Cliff Stearns requested that the GAO Forensic Audit and Investigative Service team perform audit and related investigative work focused on provider and beneficiary integrity for selected Medicaid state programs. For this review, GAO (1) identified and analyzed indicators, if any, of improper or potentially fraudulent payments to Medicaid beneficiaries and providers in four selected states (Arizona, Florida, Michigan, and New Jersey); and (2) examined the extent to which federal and state oversight policies, controls, and processes are in place to prevent and

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[2] Alison Mitchell, et al., Cong. Research Service, *Medicaid: An Overview*, R43357 (Jan. 2014) *available at* http://www.crs.gov/pages/Reports.aspx?PRODCODE=R43357&Source=search.
[3] *Id.*
[4] Cong. Budget Office, *Details of Spending and Enrollment for Medicaid—CBO's March 2015 Baseline* (March 2015), *available at* http://www.cbo.gov/sites/default/files/cbofiles/attachments/44204-2015-03-Medicaid.pdf.
[5] *Id.*
[6] U.S. Gov't Accountability Office, *High-Risk Series: An Update,* GAO -15-290 (Feb. 2015).

detect fraud and abuse in determining eligibility for Medicaid beneficiaries and enrolling providers. Key findings include:

- The four states examined—Arizona, Florida, Michigan, and New Jersey—had about 9.2 million beneficiaries, which accounted for 13 percent ($3.5 billion) of all fiscal year 2011 Medicaid payments. These four states were selected based on geographic distribution, Medicaid enrollment numbers, and the reliability of their data.

- About 8,600 beneficiaries had payments made on their behalf by two or more of GAO's selected states totaling at least $18.3 million. Under federal regulations, beneficiaries are not supposed to have payments made on their behalf by two or more states concurrently.

- About 200 deceased beneficiaries received at least $9.6 million in Medicaid benefits. The individuals were already deceased before apparently receiving medical services covered by Medicaid.

- About 3,600 individuals received Medicaid benefits while incarcerated in a state prison facility. In almost 390 cases totaling nearly $390,000 in payments, the beneficiary supposedly received medical services during the period of incarceration, suggesting identity theft. Medicaid also paid about $3.8 million on behalf of the remaining 3,200 individuals. Federal law prohibits states from obtaining federal Medicaid matching funds for healthcare services provided to inmates except when inmates are patients in medical institutions.

- At least 4,400 beneficiaries may have been using a virtual address as their residence address. Although Medicaid does not require physical addresses for beneficiary enrollment and eligibility determinations, the use of virtual addresses may be a way to conceal total household income and is a potential indicator of fraud. More specifically, these beneficiaries used a Commercial Mail Receiving Agency (CMRA) address—such as a United Parcel Service store—as their residence address. Medicaid paid claims totaling at least $20.5 million for the beneficiaries.

- The Social Security Numbers (SSNs) for about 199,000 beneficiaries did not match identity information contained in the Social Security Administration (SSA) bases, suggesting fraud or improper payments. The benefits paid at least $448 million to these 199,000 beneficiaries. Of these beneficiaries, 12,500 of them used a SSN never issued by SSA.

- About 90 medical providers in the selected states had their medical licenses revoked or suspected in the state in which they received payment from Medicaid during fiscal year 2011. Medicaid approved the associated claims of these cases at a cost of at least $2.8 million.

- At least 220 providers may have inappropriately used a virtual address as their physical service location. At least 47 providers had foreign addresses as their location of service,

including Canada, China, India and Saudi Arabia. Nearly 26,600 providers had addresses that did not match any United States Postal Service records.

- Over 50 deceased providers received Medicaid payments. These providers were deceased before the Medicaid service was provided. The Medicaid benefits totaled at least $240,000 for FY 2011.

- About 50 providers who received Medicaid payments were excluded from federal health-care programs, including Medicaid, for a variety of reasons that include patient abuse or neglect, fraud, theft, bribery, or tax evasion.

- At the conclusion of the report, GAO recommended that CMS:

  1. Issue guidance to states to better identify beneficiaries who are deceased; and

  2. Provide guidance to states on the availability of automated information through Medicare's enrollment database—the Provider Enrollment, Chain and Ownership System (PECOS)—and full access to all pertinent PECOS information, such as ownership information, to help screen Medicaid providers more efficiently and effectively.

  HHS has concurred with both recommendations.

April 29, 2015 Reuters Story

According to an April 29, 2015, Reuters story entitled "Banned from Medicare, Still Billing Medicaid," state insurance programs are continuing to pay thousands of Medicaid dollars to healthcare providers who have previously been banned from Medicare or another state's Medicaid system.[7] Reuters found that more than one in five of the thousands of doctors and other healthcare providers in the U.S. prohibited from billing Medicare are still able to bill state Medicaid programs.

III. ISSUES

The following issues may be examined at the hearing:

- What specific actions do HHS or CMS plan to take to address GAO's recommendations in this report?

- What additional sets of data can be made available and shared with the states to prevent fraudulent and/or improper Medicaid payments?

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[7] M.B. Pell and Kristina Cook, *Banned from Medicare, Still Billing Medicaid*, Reuters, Apr. 29, 2015, *available at* http://www.reuters.com/investigates/special-report/usa-medicaid-fraud.

- Is CMS using all the tools at its disposal to mitigate vulnerabilities to the Medicaid program?

IV. STAFF CONTACTS

If you have any questions regarding this hearing, please contact Jessica Donlon or Alan Slobodin of the Committee staff at (202) 225-2927.

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

2125 RAYBURN HOUSE OFFICE BUILDING
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Majority (202) 225-2927
Minority (202) 225-3641

June 24, 2015

Mr. Seto J. Bagdoyan
Director
Audit Services
U.S. Government Accountability Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Mr. Bagdoyan:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Tuesday, June 2, 2015, to testify at the hearing entitled "Medicaid Program Integrity: Screening Out Errors, Fraud, and Abuse."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on Wednesday, July, 8, 2015. Your responses should be mailed to Brittany Havens, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to brittany.havens@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: The Honorable Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachment

GAO U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

June 30, 2015

The Honorable Tim Murphy
Chairman
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
U.S. House of Representatives

The Honorable Michael C. Burgess
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
U.S. House of Representatives

Enclosed please find GAO's response to the Oversight and Investigations Subcommittee's questions for the record arising from my testimony on June 2, 2015 before the subcommittee.

Please contact me at [redacted] or [redacted] if you have any questions.

[redacted]

Seto J. Bagdoyan
Director, Audit Services
Forensic Audits and Investigative Service

Enclosure

House Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
Medicaid Program Integrity: Screening Out Errors, Fraud, and Abuse
June 2, 2015
Questions for the Record
Mr. Seto Bagdoyan

Representative Murphy

1. **CMS created a tool called the Data Services Hub (hub), which is supposed to help verify beneficiary application information used to determine eligibility for enrollment. This tool – if properly implemented – could mitigate some of the potential improper payment issues that GAO identified in its report. Has GAO conducted any work evaluating the Hub?**

    a. **Does GAO believe that the Hub has been successful in reducing the improper payment issues found based on GAO's 2011 data analysis?**

    GAO's Response: For our May 2015 report, we obtained and analyzed Medicaid claims data paid in fiscal year 2011. This was the most recent comparable data for the four states we selected for our review, Arizona, Florida, Michigan, and New Jersey. [1] Due to the age of the data, we were not able to assess the hub's effectiveness in reducing improper payments. As we note in the report, if properly implemented, the hub can help mitigate some of the potential improper-payment issues we identified in our analysis of fiscal year 2011 Medicaid claims. This would include our analysis on state residencies, deceased beneficiaries, and incarcerated beneficiaries. GAO has ongoing work for congressional requesters reviewing the effectiveness of the hub in the verification of eligibility. We plan to report on the results of this work later in the calendar year.

    b. **What is the status of the Hub? Is it fully operational? Is it helping reduce instances of fraudulent and improper payments?**

    As noted in our May 2015 report, the hub was implemented in fiscal year 2014. According to CMS, the hub can verify key application information, including household income and size, citizenship, state residency, incarceration status, and immigration status. State Medicaid programs were required to start using the hub in October 2013. Under CMS's regulations, when states receive an application, they are to use the hub to verify an individual's eligibility. As noted above, GAO has ongoing work that is reviewing the effectiveness of the hub in verification of eligibility. We plan to report on the results of this work later in the calendar year.

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

Representative Burgess

1. **CMS raised its improper payment target rate for Fiscal Year 2015 to 6.7 percent (the same rate as the actual improper payment rate for Fiscal Year 2014) from the 5.6 percent improper payment target rate for Fiscal Year 2014. Was the raising of the target rate for improper payments an appropriate and effective internal control practice?**

   GAO's Response: Our May 2015 report notes that in fiscal year 2014, CMS reported an estimated improper-payment rate of 6.7 percent, or $17.5 billion, for the Medicaid program, which was an increase over its 2013 estimate of 5.8 percent or $14.4 billion. As part of our work, we did not evaluate whether or not raising the target rate for improper payment was an appropriate and effective internal control practice. We have not conducted the work necessary to answer this question.

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

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Congress of the United States

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COMMITTEE ON ENERGY AND COMMERCE

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July 24, 2015

Dr. Shantanu Agrawal
Deputy Administrator and Director
Center for Program Integrity
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Dr. Agrawal:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Tuesday, June 2, 2015, to testify at the hearing entitled "Medicaid Program Integrity: Screening Out Errors, Fraud, and Abuse."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests with a transmittal letter by the close of business on Wednesday, July 8, 2015. Your responses should be mailed to Brittany Havens, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to brittany.havens@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: The Honorable Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachments

Dr. Agrawal's Hearing
"Medicaid Program Integrity"
Before
E&C O&I Subcommittee
June 2, 2015
Answers as of hearing date

Attachment 1—Additional Questions for the Record

The Honorable Tim Murphy

1. **The Public Assistance Report System (PARIS) is supposed to help states check to see if an applicant or enrollee is already enrolled in another state's Medicaid program. HHS' Office of Inspector General recommended that CMS issue guidance to help states comply with the requirement for participating in PARIS. CMS indicated that it would do so by March of this year. Was this implemented on time? If not, why not?**

Answer: CMS met with state Medicaid agencies on April 15, 2015, to review the statute and policies regarding the use of PARIS by state Medicaid agencies. During this discussion, CMS reviewed the requirements outlined in the State Medicaid Director Letter issued June 21, 2010, and offered technical assistance to states. State representatives had the opportunity to ask questions and identify challenges related to PARIS participation and reporting. A follow-up meeting is scheduled for June 17, 2015, to provide an opportunity for new questions and feedback.

   a. **What are (if any) impediments to states' participation in PARIS?**

Answer: Based on our recent discussions, no state reported any impediments to participation in PARIS. CMS shares your interest and commitment to ensuring effective, consistent state use of PARIS. One of CMS' larger priorities is to provide states with the tools to make accurate eligibility determinations. Since 2010, as GAO noted, states have made improvements to their Medicaid eligibility and enrollment systems. In 2013, for the first time, states were required to submit a verification plan to CMS, indicating, among other things, their use of PARIS. CMS met with each state to discuss how electronic data sources, including PARIS, were used, and changes the state would need to make to comply with Medicaid requirements. In 2014, states resubmitted their verification plans, again identifying their use of PARIS. All states with finalized verification plans reported to CMS that they have electronic data matching with PARIS.

   b. **What actions has CMS taken or plans to take against states that are not appropriately using PARIS?**

Answer: Under CMS rules, states are required to submit their data and check PARIS. Based on a recent OIG finding about the use of PARIS by states, CMS provided technical assistance to state eligibility experts on the need and requirement for states to use PARIS and recommended that states perform quarterly matches. We will continue to monitor state progress and use of

PARIS and provide technical assistance to states as needed. As states are updating their verification plans, we will use this as an opportunity to ensure that states are appropriately participating in PARIS.

2. Is CMS tapping into all available government databases to cross-check provider and beneficiary information to combat waste, fraud, and abuse in the Medicaid program? For example, is CMS cross-checking against the FDA debarment list?

Answer: In the last five years, CMS has undertaken the most serious effort in the history of the Medicaid program to improve provider enrollment and verify beneficiary eligibility. The Affordable Care Act and accompanying Federal regulations have established a modernized, data-driven approach to verification of financial and non-financial information needed to determine Medicaid and CHIP and Marketplace eligibility. States now rely on available electronic data sources to confirm information included on the application, and promote program integrity, while minimizing the amount of paper documentation that consumers need to provide.

In 2012, CMS issued regulations to require States to use the Data Services Hub (Hub) to verify applicant eligibility upon enrollment and at least annually thereafter. States are able to use this to identify applicants and beneficiaries who may be incarcerated, deceased, or do not meet Medicaid eligibility requirements. States can also validate applicants' Social Security Numbers (SSNs) using the Hub. CMS also required every state to submit a verification plan describing their verification policies and procedures including confirmation that the state verifies SSNs.

States are also required to use PARIS to identify individuals who are enrolled in Medicaid in more than one state. PARIS is a system for matching data from certain public-assistance programs, including State Medicaid programs, with selected Federal and state data for purposes of facilitating appropriate enrollment and retention in public programs. In certain circumstances, PARIS may also be used as a tool to identify individuals who have not applied for Medicaid coverage, but who may be eligible based on their income.

The Affordable Care Act required CMS to implement risk-based screening of providers and suppliers who want to participate in Medicare, Medicaid, and CHIP, and CMS put these additional requirements in place for newly enrolling and revalidating relevant providers and suppliers in March 2011. This enhanced screening requires certain categories of providers and suppliers that have historically posed a higher risk of fraud to undergo greater scrutiny prior to their enrollment or revalidation in Medicare, Medicaid, and CHIP. States are also required to conduct reviews and revalidations of their Medicaid and CHIP providers by March 2016. States must repeat this process at least once every five years.

State Medicaid agencies may rely on the screening done by CMS for dually-enrolling providers to assist them in complying with these requirements. CMS has been proactive about assisting States with provider enrollment and revalidation screening. In April 2012, we provided States with direct access to Medicare's enrollment database-the Provider Enrollment, Chain, and Ownership System (PECOS). In October 2013, in response to input from States, CMS began providing access to monthly PECOS data extracts that States could use to systematically

compare state enrollment records against available PECOS information. We have also provided States with training and technical assistance on using PECOS.

As part of the Medicare enrollment screening process, CMS has reviewed the FDA's debarment and disqualification lists, and found that the data does not contain the adequate personal identifiers required for confident systematic data matching and immediate action. When CMS last reviewed the FDA list, it contained only about 100 names. Therefore CMS has focused efforts on expanding the use of greater value sources such as the Federal Government's System for Awards Management website (SAM), which now includes GSA's Excluded Parties List System (EPLS), and OIG's List of Excluded Individuals and Entities (LEIE), which provide clear and definitive data that is immediately actionable. Individual providers, owners, Authorized and Delegated officials, and managing employees are validated upon enrollment to ensure applications from entities identified in SAM, EPLS and the LEIE are not approved.

3. **Current CMS regulations require states to screen beneficiaries annually for deceased individuals in Medicaid. Do you think screening more frequently could help prevent deceased beneficiaries receiving benefits?**

    a. **Is this kind of process doable? Are there administrative constraints to screening more often than once per year?**

Answer: Current Medicaid regulations require states to redetermine beneficiaries' eligibility on an annual basis. The Affordable Care Act established new requirements for streamlined eligibility and enrollment processes, including the use of electronic data matching. To the extent that information is available through electronic data sources, states must utilize those sources first. The Department of Health and Human Services established the Hub to ensure that states have reliable and consistent access to real-time eligibility data from Federal agencies, including the Social Security Administration (SSA), and in 2012, CMS issued regulations requiring states to utilize the Hub. SSA's death information is included in this access which gives states a readily-available source of information on deceased individuals at the time of an individual's application to the Medicaid benefit.

In addition to data accessed through the Hub, states continue to rely upon their own electronic data sources, which may include direct data matches to SSA. Many states have policies to conduct more frequent checks of beneficiary status against the information in SSA's records and state vital-records systems. As states continue to automate their eligibility and enrollment processes, it becomes less labor-intensive to utilize electronic data sources. For states that want to develop and implement new policies, we are well-positioned to provide them with technical assistance. CMS concurred with the GAO recommendation to provide additional guidance to states in this area. CMS is aware of states that are more frequently checking death information maintained by SSA, and we plan to identify and share best practices from those states.

4. **According to the GAO report, CMS has not explored the feasibility of states using the full death master file in the periodic screening of individuals, outside of the initial enrollment or the annual revalidation period. Why not? Are there plans to study this?**

Answer: Regarding beneficiary enrollment, CMS provides access, through the Hub, to SSA's composite service, which includes access to death information maintained by SSA. This data match is used by states at application and CMS also provides this service for eligibility redeterminations. States can at any time use their existing data connections with SSA, and many states do use their own data sources to conduct more frequent checks of beneficiary status. CMS continues to work with states to determine additional approaches – such as identifying and sharing best practices from states that more regularly check death information maintained by SSA – to better identify deceased beneficiaries. We will also continue to provide state-specific technical assistance as needed.

Regarding provider enrollment, States may use PECOS to identify individual Medicare providers that may have been deactivated due to death. Based on the Interagency Agreement established between CMS and SSA, CMS cannot directly share the death master file with the States. States are expected to get the data directly from SSA or other data sources they may have available to them.

5. **GAO identified 47 providers—in just four states—with foreign addresses as their location of business, including Canada, China, India, and Saudi Arabia. How was it possible that a provider could list a foreign address? Could this happen still today? Why or why not?**

Answer: CMS shares your interest in ensuring the effective use of taxpayer resources and ensuring Medicaid providers deliver safe, high-quality care. The Affordable Care Act requires that a State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States. CMS issued guidance related to this policy on December 30, 2010 (see State Medicaid Director Letter # 10-026). Among other things, the guidance clarifies that if it is found that payments have been made to financial institutions or entities outside of the United States, states must recover these payments and must forward any Federal match for such payments to CMS consistent with the guidelines specified in Federal regulations. The guidance also notified states that the prohibition would take effect June 1, 2011, half-way through the time-period studied by the GAO. A disproportionately-smaller percent of the payments GAO identified – 28 percent – occurred after these new rules took effect.

The Honorable David McKinley

1. **It seems as though the continuously increasing complexity of the Medicaid payment system has to be adding to the error or improper payment rates. Is there any effort being made to standardize pre-certification and billing processes for all providers?**
2. **Electronic medical records were intended to facilitate the accurate and timely flow and management of patient information. Is there any evidence that the EMRs are contributing to the increased error or improper payment rate?**

Answer to 1 and 2: The Payment Error Rate Measurement (PERM) program measures improper payments in the Medicaid and CHIP programs and produces state and national-level improper payment rates for each. The improper payment rates are based on reviews of the fee-for-service (FFS), managed care, and eligibility components of Medicaid and CHIP in the fiscal year under review. All referring/ordering providers are now required to be enrolled in Medicaid, states must screen providers under a new risk-based screening process prior to enrollment, and the attending provider National Provider Identifier (NPI) must be on all electronically-filed institutional claims. While these requirements will ultimately strengthen the integrity of the program, they require systems changes, and, therefore, many states had not fully implemented these new requirements. We have no evidence suggesting that the rise in the use of electronic medical records negatively impacted the FY 2014 PERM rate.

Although the Federal Government establishes general guidelines for the program, States design, implement, and administer their own Medicaid programs. Medicaid programs have flexibility, under broad Federal rules, to establish administrative requirements. Where possible, CMS provides guidance, technical assistance and shares best practices across states. CMS has provided states with training and direct access to the Medicare enrollment system, PECOS. Through the PECOS system, states can view specific enrollment data for each provider including site visit information, fingerprint status, enrollment status, and other key identifiers. In addition, CMS offers regular custom data extracts of key Medicare enrollment information for use by all states. CMS continues to expand efforts in assisting the states.

The Honorable Michael C. Burgess

1. **GAO released a report regarding third party liability in January of this year and made recommendations that focused on CMS' need to better support states through facilitation of information sharing and providing guidance to the states. Has CMS taken any steps towards providing additional guidance to the states to allow for increased monitoring and oversight of third party liability efforts?**

Answer: HHS will continue to look at ways to provide guidance to states, to allow for continued sharing of proven effective practices and to increase awareness of initiatives under development among the states. CMS already has taken several actions:

- Developed a work plan to implement GAO's recommendations;
- Briefed the Coordination of Benefits/Third Party Liability (COB/TPL) Technical Advisory Group (TAG) on the report findings and recommendations;
- Reminded the TAG State Representatives (10 state Medicaid program COB/TPL officials, each representing all states in a specific geographic region of the United States) of their responsibilities to solicit COB/TPL issues from all states within their regions for TAG discussion with CMS, and to share resulting CMS guidance with the states;
- Requested and received assistance from the TAG State Representatives to solicit from all states effective state practices and innovative ideas for publication by CMS.

2. **On May 30, 2015, the Dallas Morning News published an article discussing lowly rated private nursing home facilities receiving Medicaid funds. Available at http://www.dallasnews.com/news/metro/20150530-public-hospitals-help-nursing-home-operators-get-federal-funds.ece.**

    a. **Recognizing that most fraud controls are state-based, are there any federal Medicaid policies that prevent states from looking at lowly rated facilities and preventing these facilities from receiving federal funds?**

Answer: There are no Federal requirements that prohibit a state from investigating a provider for suspicious billing practices or poor quality of care. Federal regulations require states to conduct pre-payment and post-payment claims review for utilization review and fraud. States operate agencies that survey providers such as nursing homes to determine that they meet all requirements, and to investigate complaints about the quality of care. If a state determines a provider is not in compliance with the Medicaid program requirements, CMS would expect the state to take appropriate action.

    b. **Can you comment on what was identified in the Dallas Morning News article as a loophole for private low performing facilities drawing down CMS funding designed for public facilities to provide better quality or better coordinated care?**

Answer: CMS is aware of the news article and is working with the state to obtain a better understanding of this particular payment arrangement. States develop the payment methodologies that are used to pay their Medicaid providers, and, through the state plan review

process, CMS reviews and approves these methodologies. The methodologies that states use to set Medicaid rates must be consistent with efficiency, economy, and quality of care; however, states have the flexibility to base Medicaid payment on particular performance or quality of care measures. CMS has taken strides to generally encourage states to establish payment methodologies that reward providers on the basis of quality achievement or improvement. Such methodologies strengthen the health care delivery system and can result in significant savings to the states. CMS would welcome the opportunity to assist Texas in developing a performance based payment methodology for Texas nursing facilities.

c. The state seems to identify that this is an issue. The state plans to take regulatory steps. Is there anything that CMS could do in the interim to help Texas in these efforts?

Answer: CMS fully supports Texas in taking steps to address this issue. Ultimately, the state must amend its Medicaid state plan payment methodology to update the criteria that providers must meet to receive these payments. We are committed to working with Texas to address the issue as expeditiously as possible and will assist the state in developing state plan payment methodologies that are consistent with efficiency, economy, and quality of care while incorporating an appropriate source of the non-Federal share.

d. CMS recently released comprehensive payment information. We know who the high utilizers are. We know who the low quality star providers are in certain sectors. Is there anything in federal regulations that prevents states from implementing safeguards against excessive utilization or simply processing payments to suspicious low quality facilities?

Answer: No, there is nothing in Federal regulations that would prevent a state from implementing safeguards against excessive utilization or taking appropriate action to address poor performing facilities. In fact, states are required to implement a state-wide surveillance and utilization review program that safeguards against unnecessary or inappropriate use of Medicaid services and excess payments. States are also required to conduct pre-payment and post-payment claims review for utilization review and fraud. As Medicaid is a Federal-state partnership that is funded with both Federal and state funds, states have an incentive to ensure that appropriate program safeguards, including utilization review programs, are in place.

The Honorable Richard Hudson

1. **North Carolina is currently considering using managed-care to help control Medicaid costs. Managed-care (versus fee-for-service) can be a cost-effective delivery system of Medicaid benefits. What steps is CMS taking to ensure that there is program integrity and it doesn't become a program that is more susceptible to fraud?**

Answer: CMS recently proposed the first major update to Medicaid and CHIP managed care regulations in more than a decade that will modernize the programs' rules to strengthen the delivery of quality care in Medicaid or CHIP. The proposed rule would require states to screen Medicaid and CHIP managed care providers consistent with the requirements for Medicaid and Medicare fee-for-service providers, which includes reviewing Federal databases to determine whether the provider is ineligible to participate in public programs. Assuming it is finalized, this proposed approach may result in administrative and cost efficiencies by providing the option to eliminate duplicative screening activities as part of the credentialing process for network providers and having that function performed instead by states (or, in the case of dually-participating providers, by Medicare contractors) for all providers. Under the proposed rule, every provider rendering a service to a Medicaid or CHIP beneficiary, whether in fee- for-service or managed care, would be screened utilizing the same criteria.

The proposed rule also would add several components to strengthen Medicaid and CHIP managed care plans' program integrity through administrative and managerial procedures that prevent, monitor, identify, and respond to suspected provider fraud. This would include implementation of procedures for internal monitoring, auditing, and prompt referral of potential compliance issues within the managed care plan; mandatory reporting of potential fraud, waste or abuse to the state; mandatory reporting of any potential changes in an enrollee's circumstances that may impact Medicaid eligibility as well as changes in a provider's circumstances that may impact that provider's participation in the managed care plan's network; and the suspension of payments to a network provider when the state determines a credible allegation of fraud exists.

Attachment 2—Member Requests for the Record

During the hearing, Members asked you to provide additional information for the record, and you indicated that you would provide that information. For your convenience, descriptions of the requested information are provided below.

The Honorable Michael C. Burgess

1. **CMS uses the payment error rate measurement (PERM) program to determine the national payment error rate for Medicaid. The program is measured using a 17-state, 3-year rotation to produce and report national program error rates. Why was this method chosen? How long has CMS been using this method to determine the improper payment rate? Is it possible for CMS to assess each state's error rate on a yearly basis? If not, why not?**

Answer: The PERM program measures improper payments in the Medicaid and CHIP programs and produces state- and national-level improper-payment rates for each. The improper-payment rates are based on reviews of the fee-for-service (FFS), managed care, and eligibility components of Medicaid and CHIP in the fiscal year under review.

PERM uses a 17-state rotational approach to measure improper payments in Medicaid and CHIP for the 50 states and the District of Columbia over a three year period. As a result, each state is measured once every three years.

FY 2014 represents the seventh year that CMS calculated improper-payment rates for all components of the Medicaid program (FFS, managed care, and eligibility), meaning that all 50 states and the District of Columbia have been measured at least twice. The improper payment rate reported in the Department of Health and Human Services' Agency Financial Report is a rolling rate that includes findings from the most recent three measurements. Thus, each time a group of 17 states is measured under PERM, the previous findings for that group of states are dropped from the calculation and the newest findings added in.

This method was chosen because it was determined to be statistically valid and to ensure the effective stewardship of both Federal and state resources. Assessing each state's error rate on a yearly basis would be costly and burdensome to both states and CMS. Further, there would not be sufficient time between measures for states to implement corrective actions.

The Honorable Susan Brooks

1. **How many federal and state employees are responsible for the administration of Medicaid?**

Answer: Staff throughout CMS and our regional offices perform work related to the administration of the Medicaid program. CMS tracks full-time employees (FTEs) by component and funding source and not by the program on which they work. There are approximately 375

FTE in CMS' Center for Medicaid and CHIP Services (CMCS), the Center responsible for Medicaid, as well as other activities, including CHIP and State Grants and Demonstrations. CMS does not generally collect comprehensive data on state employees performing work related to the administration of Medicaid.

The Honorable Markwayne Mullin

1. **How many criminal referrals has CMS made to federal or state law enforcement over the past five years?**

Answer: From calendar year 2010-2015, CMS's Center for Program Integrity made 2,989 referrals to law enforcement for matters involving Medicare Fee-For-Service, and 2,275 referrals to law enforcement for matters involving Medicare Advantage and Part D.[1] State agencies have primary responsibility for state-level law-enforcement referrals; therefore, CMS does not have complete data on the number of such referrals for Medicaid. When a state determines that a credible allegation of fraud exists regarding a Medicaid provider, the state is required to suspend payments to that provider unless the state, following required analysis and documentation procedures, determines that it has good cause not to suspend payments. A state is required to refer all credible allegations of fraud to its Medicaid Fraud Control Unit or other law-enforcement agency for further investigation in accordance with Federal regulations and CMS's performance standards for suspected fraud referrals.[2]

[1] The 2015 data reflects only a partial year of reporting. The HHS Office of Inspector General (OIG) is the primary recipient of CPI fraud referrals. However, if OIG does not accept a case, it may be referred to DOJ, (including referrals specifically to the Federal Bureau of Investigation), or state agencies.

[2] https://www.cms.gov/FraudAbuseforProfs/Downloads/fraudreferralperformancestandardsstateagencytomfcu.pdf