STRENGTHENING MEDICAID PROGRAM INTEGRITY AND CLOSING LOOPHOLES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

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STRENGTHENING MEDICAID PROGRAM INTEGRITY AND CLOSING LOOPHOLES

FRIDAY, SEPTEMBER 11, 2015

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

The subcommittee met, pursuant to call, at 9:17 a.m., in room 2322, Rayburn House Office Building, Hon. Joseph R. Pitts (chairman of the subcommittee) presiding.

Present: Representatives Pitts, Guthrie, Murphy, Burgess, Blackburn, Lance, Griffith, Bilirakis, Long, Ellmers, Bucshon, Brooks, Collins, Green, Engel, Capps, Schakowsky, Butterfield, Castor, Sarbanes, Kennedy, and Pallone (ex officio).

Also Present: Representative Mullin.

Staff Present: Clay Alspach, Chief Counsel, Health; Gary Andres, Staff Director; Leighton Brown, Press Assistant; Noelle Clemente, Press Secretary; Graham Pittman, Legislative Clerk; Michelle Rosenberg, GAO Detailee, Health; Heidi Stirrup, Health Policy Coordinator; Josh Trent, Professional Staff Member, Health; Christine Brennan, Minority Press Secretary; Jeff Carroll, Minority Staff Director; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Rachel Pryor, Minority Health Policy Advisor; and Samantha Satchell, Minority Policy Analyst.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. The subcommittee will come to order.

The chair will recognize himself for an opening statement. Today Medicaid is the world's largest health coverage program. Medicaid plays a critical role in our healthcare system, providing access to needed medical services and long-term care for some of our Nation's most vulnerable patients. The Congressional Budget Office estimates that Federal Medicaid expenditures will grow from $343 billion this year to $576 billion in 2025. At the same time, State expenditures have grown significantly, today accounting for more than 25 percent of State spending in fiscal year 2014.

Given the growing portion of the Federal budget dedicated to Medicaid and the fact that roughly one in five Americans may be served by the program in a given year, Congress has a responsibility—even a duty—to ensure that the program is safeguarded against waste, fraud, and abuse. And while there is never a perfect program, the status quo in Medicaid certainly can be improved.

The increasing size, complexity and vulnerability of Medicaid have led the GAO to designate it a high-risk program that can too easily be subjected to fraud and abuse.

Both Federal and state governments play critical roles in oversight of program integrity efforts. And while I believe states are and should be treated as full partners in the program, the reality is that Congress has a duty to expect the best from states and take commonsense steps to help prevent fraud, waste, and abuse at systemic levels. After all, protecting the integrity of the Medicaid program is about ensuring the program is not only more accountable and transparent for taxpayers, it is about safeguarding program dollars and encouraging more meaningful access to care for patients who rely on the program. And that is why I am so pleased today to be discussing several bills that will help boost the integrity, oversight and accountability of the Medicaid program.

First, a bill to be introduced by Dr. Bucshon and some of his colleagues would fix a problem identified by the HHS inspector general ensuring that providers terminated in one state don't improperly bill the system or negatively impact patients in another state.

[The bill follows:]

[DISCUSSION DRAFT]

114TH CONGRESS
1ST SESSION

H. R. _____

To amend title XIX of the Social Security Act to require States to provide to the Secretary of Health and Human Services certain information with respect to provider terminations, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

M . _____ introduced the following bill; which was referred to the Committee on _____

A BILL

To amend title XIX of the Social Security Act to require States to provide to the Secretary of Health and Human Services certain information with respect to provider terminations, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Ensuring Terminated Providers are Removed from Medicaid and CHIP Act".

SEC. 2. REPORTING ON TERMINATION OF MEDICAID PROVIDERS.

(a) IN GENERAL.—Section 1902(a)(39) of the Social Security Act (42 U.S.C. 1396a(a)(39)) is amended—

(1) by striking "provide that the State agency" and inserting the following: "provide—

"(A) that the State agency";

(2) by striking "title XVIII or any other State plan under this title" and inserting "title XVIII, any other State plan under this title, or any State child health plan under title XXI"; and

(3) by adding at the end the following new subparagraphs:

"(B) beginning 180 days after the date of the enactment of this subparagraph, in the case of a termination for cause of the participation of any individual or entity in the program under the State plan under subparagraph (A), that the State agency shall, not later than 14 business days after the date of such termination, submit to the Secretary with respect to any such individual or entity—

"(i) the name of such individual or entity;

"(ii) the provider type of such individual or entity;

"(iii) the specialty of such individual's or entity's practice;

"(iv) the date of birth, social security number, national provider identifier, Federal taxpayer identification number, and the State license or certification number of such individual or entity;

"(v) the reason for the termination; and

"(vi) a copy of the notice of termination sent to the individual or entity;

"(C) with respect to managed care entities (as defined in section 1932(a)(1)), beginning on the later of the date that is 180 days after the date of the enactment of this subparagraph or the first day of the first plan year for such an entity that begins after such date of enactment that any contract the State plan has with any such entity shall include a provision that individuals terminated for cause from participation under the program under title XVIII, this title, or title XXI be terminated from participation in the provider networks of managed care entities under this title;

"(D) for the period beginning on the date that is 180 days after the date of the enactment of this subparagraph and ending on the date on which the registration of providers under paragraph (5) of section 1932(d) is complete for the State, for a system for notifying managed care entities (as defined in section 1932(a)(1)) of the termination of individuals or entities from participation under the program under title XVIII, this title, or title XXI; and

"(E) beginning 2 years after the date of the enactment of this subparagraph, payment to the Secretary equal to the amount of the Federal share of any payments made by the State (including payments made through a managed care arrangement) to any individual or entity whose participation in the program under the State plan is terminated for cause under subparagraph (A) after the date that is 60 days after the date on which such termination is included in the database or other system under subsection (ll);".

(b) DEVELOPMENT OF UNIFORM TERMINOLOGY FOR REASONS FOR PROVIDER TERMINATION.—Not later than 180 days after the date of the enactment of this Act, the

Secretary shall issue regulations establishing uniform terminology to be used with respect to specifying reasons under subparagraph (B) of section 1902(a)(39) of such Act (42 U.S.C. 1396a(a)(39)) for the termination of the participation of certain providers in the Medicaid program under title XIX or the Children's Health Insurance Program under title XXI of such Act.

(c) TERMINATION NOTIFICATION DATABASE.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended by adding at the end the following new subsection:

"(ll) TERMINATION NOTIFICATION DATABASE.—In the case of an individual or entity whose participation in the program under title XVIII, this title, or title XXI is terminated for cause under subsection (a)(39), the Secretary shall, not later than 14 business days after the date on which the Secretary is notified of such termination, include such termination in any database or similar system developed pursuant to section 6401(b)(2) of the Patient Protection and Affordable Care Act (Public Law 111–148; 42 U.S.C. 1395cc note).".

(d) REGISTRATION OF PROVIDERS PARTICIPATING THROUGH MEDICAID MANAGED CARE ORGANIZATIONS.—Section 1932(d) of the Social Security Act (42 U.S.C.

1396u–2(d)) is amended by adding at the end the following new paragraph:

"(5) REGISTRATION OF PARTICIPATING PROVIDERS.—

"(A) IN GENERAL.—Beginning not later than one year after the date of the enactment of this paragraph, a State shall require that, as a condition on the participation in the provider network of a managed care entity of a provider that provides services to individuals who are eligible for medical assistance under the State plan under this title and who are enrolled with the entity, the provider registers with the State agency administering the State plan under this title. Such registration shall include providing to the State agency the provider's identifying information, including the name, specialty, date of birth, social security number, national provider identifier, Federal taxpayer identification number, and the State license or certification number of the provider.

"(B) RULE OF CONSTRUCTION.—Nothing in subparagraph (A) shall be construed as requiring a provider described in such subparagraph to provide services to individuals who are

not enrolled with a managed care entity under this title.".

(e) CONFORMING AMENDMENTS TO CHIP.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended—

(1) by redesignating subparagraphs (B) through (O) as subparagraphs (C) through (P), respectively;

(2) by inserting after subparagraph (A) the following new subparagraph:

"(B) Section 1902(a)(39) (relating to termination of participation of certain providers)."; and

(3) in subparagraph (N) (as redesignated by paragraph (1)), by striking "(a)(2)(C) and (h)" and inserting "(a)(2)(C) (relating to Indian enrollment), (d)(5) (relating to registration of providers participating with a managed care entity), and (h) (relating to special rules with respect to Indian enrollees, Indian health care providers, and Indian managed care entities)".

Mr. PITTS. Second, Representative Brooks and I have introduced H.R. 3444, which would operationalize a proposal in the President's budget to help reduce Medicaid and CHIP fraud in the territories of the United States.

[The bill follows:]

.....

(Original Signature of Member)

114TH CONGRESS
1ST SESSION

H. R. _____

To amend title XI of the Social Security Act to reduce Medicaid and CHIP fraud in the territories of the United States, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

Mr. PITTS (for himself and Mrs. BROOKS of Indiana) introduced the following bill; which was referred to the Committee on

---

A BILL

To amend title XI of the Social Security Act to reduce Medicaid and CHIP fraud in the territories of the United States, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicaid and CHIP Territory Fraud Prevention Act".

SEC. 2. REDUCING MEDICAID AND CHIP FRAUD IN THE TERRITORIES OF THE UNITED STATES.

Section 1108(g)(4) of the Social Security Act (42 U.S.C. 1308(g)(4)) is amended—

(1) by striking "and (4)" and inserting "and (5)"; and

(2) by adding at the end the following: "With respect to fiscal years beginning with fiscal year 2016, if Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa qualify for a payment under paragraph (6) of section 1903(a) for a calendar quarter of such fiscal year, the payment shall not be taken into account in applying subsection (f) (as increased in accordance with paragraphs (1), (2), (3), and (5) of this subsection) to such commonwealth or territory for such fiscal year.".

Mr. PITTS. Next, Representative Bilirakis has introduced H.R. 1570, a bipartisan bill which would bring increased transparency and information to Federal expenditures related to Medicaid and CHIP in U.S. territories.

[The bill follows:]

1

114TH CONGRESS
1ST SESSION

H. R. 1570

To provide for greater transparency and information with respect to Federal expenditures under the Medicaid and CHIP programs in the territories of the United States, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 24, 2015

Mr. BILIRAKIS (for himself, Mr. PIERLUISI, Mr. SABLAN, Ms. PLASKETT, Ms. BORDALLO, and Mrs. RADEWAGEN) introduced the following bill; which was referred to the Committee on Energy and Commerce

---

A BILL

To provide for greater transparency and information with respect to Federal expenditures under the Medicaid and CHIP programs in the territories of the United States, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicaid and CHIP Territory Transparency and Information Act".

SEC. 2. PUBLICATION OF INFORMATION ON FEDERAL EXPENDITURES UNDER MEDICAID AND CHIP IN THE TERRITORIES.

Not later than 180 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall publish, and periodically update, on the Internet site of the Centers for Medicare & Medicaid Services information on Medicaid and CHIP carried out in the territories of the United States. Such information shall include, with respect to each such territory—

(1) the income levels established by the territory for purposes of eligibility of an individual to receive medical assistance under Medicaid or child health assistance under CHIP;

(2) the number of individuals enrolled in Medicaid and CHIP in such territory;

(3) any State plan amendments in effect to carry out Medicaid or CHIP in such territory;

(4) any waiver of the requirements of title XIX or title XXI issued by the Secretary to carry out Medicaid or CHIP in the territory, including a waiver under section 1115 of the Social Security Act (42 U.S.C. 1315), any application for such a waiver, and any documentation related to such application (including correspondence);

(5) the amount of the Federal and non-Federal share of expenditures under Medicaid and CHIP in such territory;

(6) the systems in place for the furnishing of health care items and services under Medicaid and CHIP in such territory;

(7) the design of CHIP in such territory; and

(8) other information regarding the carrying out of Medicaid and CHIP in the territory that is published on such Internet site with respect to carrying out Medicaid and CHIP in each State and the District of Columbia.

SEC. 3. DEFINITIONS.

In this Act:

(1) CHIP.—The term "CHIP" means the State Children's Health Insurance Program under title XXI of Social Security Act.

(2) MEDICAID.—The term "Medicaid" means the Medicaid program under title XIX of the Social Security Act.

(3) TERRITORY.—The term "territory of the United States" includes Puerto Rico, the Virgin Islands of the United States, Guam, the Northern Mariana Islands, and American Samoa.

○

Mr. PITTS. Fourth, Vice Chairman of the Health Subcommittee Brent Guthrie has a bill which would incentivize States to require providers of Medicaid personal care services to have electronic verification systems in place. This commonsense proposal will ensure taxpayers only pay for the services delivered to Medicaid beneficiaries.

[The bill follows:]

SEC. __. ELECTRONIC VISIT VERIFICATION SYSTEM REQUIRED FOR PERSONAL CARE SERVICES UNDER MEDICAID.

(a) IN GENERAL.—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by inserting after subsection (k) the following new subsection:

"(l)(1) Subject to paragraph (3), with respect to any amount expended for medical assistance for home and community based services provided under a State plan under this title (or under a waiver of the plan) furnished in a calendar quarter beginning on or after January 1, 2018, unless a State requires the use of an electronic visit verification system for personal care services furnished in such quarter, the Federal medical assistance percentage shall be reduced—

"(A) for calendar quarters in 2018 and 2019, by .25 percentage points;

"(B) for calendar quarters in 2020, by .5 percentage points;

"(C) for calendar quarters in 2021, by .75 percentage points; and

"(D) for calendar quarters in 2022 and each year thereafter, by 1 percentage point.

"(2) Subject to paragraph (3), in implementing the requirement for the use of an electronic visit verification system under paragraph (1), a State shall consult with agencies and entities that provide personal care services under the State plan (or under a waiver of the plan) to ensure that such system—

"(A) is minimally burdensome;

"(B) takes into account existing best practices and electronic visit verification systems in use in the State; and

"(C) is conducted in accordance with the requirements of HIPAA privacy and security law (as defined in section 3009 of the Public Health Service Act).

"(3) Paragraphs (1) and (2) shall not apply in the case of a State that—

"(A) as of the date of the enactment of this subsection, requires the use of any system for the electronic verification of visits conducted as part of personal care services; or

"(B) does not provide under the State plan under this title (or under a waiver of the plan) for personal care services.

"(4) In this subsection:

"(A) The term 'electronic visit verification system' means a system under which visits conducted as part of personal care services are electronically verified with respect to—

"(i) the type of service performed;

"(ii) the person receiving the service;

"(iii) the date of the service;

"(iv) the location of service delivery;

"(v) the person providing the service; and

"(vi) the time the service begins and ends.

"(B) The term 'personal care services' means personal care services provided under a State plan under this title (or under a waiver of the plan), including services provided under section 1905(a)(24), 1915(c), 1915(i), 1915(j), or 1915(k) or under a wavier under section 1115.".

(b) RULES OF CONSTRUCTION.—

(1) NO EMPLOYER-EMPLOYEE RELATIONSHIP ESTABLISHED.—Nothing in the amendment made by this section may be construed as establishing an employer-employee relationship between the agency or entity that provides for personal care services and the individuals who, under a contract with such an agency or entity, furnish such services for purposes

of part 552 of title 29, Code of Federal Regulations (or any successor regulations).

(2) NO PARTICULAR OR UNIFORM ELECTRONIC VISIT VERIFICATION SYSTEM REQUIRED.—Nothing in the amendment made by this section may be construed to require the use of a particular or uniform electronic visit verification system (as defined in subsection (l)(4) of section 1903 of the Social Security Act (42 U.S.C. 1396b), as inserted by subsection (a)) by all agencies or entities that provide personal care services under a State plan under title XIX of the Social Security Act (or under a waiver of the plan).

(3) NO LIMITS ON PROVISION OF CARE.—Nothing in the amendment made by this section may be construed to limit, with respect to personal care services provided under a State plan under title XIX of the Social Security Act (or under a waiver of the plan), provider selection, constrain beneficiaries' selection of a caregiver, or impede the manner in which care is delivered.

Mr. PITTS. Fifth, I have introduced H.R. 2339, a commonsense proposal to give States better options to how lottery winnings are calculated for purposes of Medicaid eligibility. I hope we can all agree that multimillion dollar lottery winners should not be eligible to receive Medicaid, which is precisely the problem in current law that my bill would fix.

[The bill follows:]

I

114TH CONGRESS
1ST SESSION

H. R. 2339

To amend title XIX of the Social Security Act to clarify the treatment of lottery winnings and other lump sum income for purposes of income eligibility under the Medicaid program, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 14, 2015

Mr. PITTS introduced the following bill; which was referred to the Committee on Energy and Commerce

---

A BILL

To amend title XIX of the Social Security Act to clarify the treatment of lottery winnings and other lump sum income for purposes of income eligibility under the Medicaid program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. TREATMENT OF LOTTERY WINNINGS AND OTHER LUMP SUM INCOME FOR PURPOSES OF INCOME ELIGIBILITY UNDER MEDICAID.

(a) IN GENERAL.—Paragraph (14) (relating to modified adjusted gross income) of section 1902(e) of the So-

cial Security Act (42 U.S.C. 1396a(e)) is amended by adding at the end the following new subparagraph:

"(J) TREATMENT OF CERTAIN LOTTERY WINNINGS AND INCOME RECEIVED AS A LUMP SUM.—

"(i) In the case of an individual who is the recipient of qualified lottery winnings or qualified lump sum income, and whose eligibility for medical assistance is determined based on the application of modified adjusted gross income under subparagraph (A), a State may, in determining such eligibility, consider such winnings or income (as applicable) as income received on a monthly basis—

"(I) if such winnings or income (as applicable) is received in an amount that is less than $50,000, over a period of 12 months; and

"(II) if such winnings or income (as applicable) is received in an amount that is greater than or equal to $50,000, over a period specified by the State not to exceed 240 months,

in proportion to the amount of the winnings or income (as applicable).

"(ii) DEFINITIONS.—In this subparagraph:

"(I) The term 'qualified lottery winnings' means winnings from a sweepstakes, lottery, or pool described in paragraph (3) of section 4402 of the Internal Revenue Code of 1986 or a lottery operated by a multi-state or multi-jurisdictional lottery association in an amount that is not less than $20,000, including amounts awarded as a lump sum payment.

"(II) The term 'qualified lump sum income' means income that is received as a lump sum in an amount that is not less than $20,000, including income received from the transfer or sale of real or personal property from the estate (as defined in section 1917(b)(4)) of a deceased individual.".

(b) RULE OF CONSTRUCTION.—Nothing in this Act shall be construed as preventing a State from intercepting

the State lottery winnings awarded to an individual in the State to recover amounts paid by the State under the State Medicaid plan under title XIX of the Social Security Act for medical assistance furnished to the individual.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to income received as a lump sum, or winnings received pursuant to lotteries occurring, after a date specified by the State, but not earlier than the date that is 24 months before such date of enactment.

○

Mr. PITTS. Finally, Representative Mullin on the full committee has authored H.R. 1771, a bill which would close a loophole in current law identified by some GAO reporting. And this bill would amend the Social Security Act to count portions of income from annuities of a community spouse as income available to institutionalized spouses for purposes of Medicaid eligibility.

[The bill follows:]

I

114TH CONGRESS
1ST SESSION

H. R. 1771

To amend title XIX of the Social Security Act to count portions of income from annuities of a community spouse as income available to institutionalized spouses for purposes of eligibility for medical assistance, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

APRIL 14, 2015

Mr. MULLIN introduced the following bill; which was referred to the Committee on Energy and Commerce

---

A BILL

To amend title XIX of the Social Security Act to count portions of income from annuities of a community spouse as income available to institutionalized spouses for purposes of eligibility for medical assistance, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. COUNTING PORTIONS OF INCOME FROM ANNUITIES OF A COMMUNITY SPOUSE AS INCOME AVAILABLE TO INSTITUTIONALIZED SPOUSES FOR MEDICAID ELIGIBILITY.

(a) IN GENERAL.—Section 1924(b)(2) of the Social Security Act (42 U.S.C. 1396r–5(b)(2)) is amended by adding at the end the following new subparagraph:

"(E) ANNUITY INCOME.—

"(i) IN GENERAL.—In the case of payment of income from a qualifying annuity—

"(I) if payment of income is made solely in the name of the community spouse, one-half of the income shall be considered available to the institutionalized spouse and one-half to the community spouse;

"(II) if payment of income is made in the names of the institutionalized spouse and the community spouse, one-half of the income shall be considered available to the institutionalized spouse and one-half to the community spouse; and

"(III) if payment of income is made in the names of the community

spouse and another person or persons, one-half of the proportion of the community spouse's interest in such income shall be considered available to the institutionalized spouse.

"(ii) QUALIFYING ANNUITY.—In this subparagraph, the term 'qualifying annuity' means an annuity that—

"(I) is purchased after the date that is 60 months before the date specified in subparagraph (B)(ii) of section 1917(c)(1) for an amount that is equal to or greater than fair market value; and

"(II) is not described in clause (i) of subparagraph (G) of such section.

"(iii) INAPPLICABILITY OF OTHER RULES.—The rules of subparagraphs (A) and (B) shall not apply with respect to income from a qualifying annuity.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to annuities pur-

chased or established on or after the date of the enactment of this Act.

○

Mr. PITTS. It is my hope that through the policies we discuss today and through future actions by this committee, we can work together on a bipartisan basis to boost Medicaid program integrity while making the program more sustainable, accountable and transparent. I look forward to hearing our witnesses today.

I would like to yield to Congressman Mullin to introduce one of our witnesses.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

The Subcommittee will come to order.

The Chairman will recognize himself for an opening statement.

Today, Medicaid is the world's largest health coverage program. Medicaid plays a critical role in our health care system, providing access to needed medical services and long-term care for some of our nation's most vulnerable patients.

The Congressional Budget Office estimates that federal Medicaid expenditures will grow from $343 billion this year to $576 billion in 2025. At the same time, state expenditures have grown significantly, today accounting for more than 25% of state spending in FY 2014.

Given the growing portion of the federal budget dedicated to Medicaid—and the fact that roughly one in five Americans may be served by the program in a given year—Congress has a responsibility, even a duty, to ensure that the program is safeguarded against waste, fraud, and abuse.

While there is never a perfect program, the status quo in Medicaid certainly can be improved. The increasing size, complexity, and vulnerability of Medicaid have led the GAO to designate it a "high-risk program" that can too easily be subjected to fraud and abuse.

Both federal and state governments play critical roles in oversight of program integrity efforts. While I believe states are—and should be treated as—full partners in the program, the reality is that Congress has a duty to expect the best from states and take common-sense steps to help prevent fraud, waste, and abuse at systemic level.

After all, protecting the integrity of the Medicaid program is about ensuring the program is not only more accountable and transparent for taxpayers; it is about safeguarding program dollars and encouraging more meaningful access to care for the patients who rely on the program.

That's why I'm so pleased today to be discussing several bills that will help boost the integrity, oversight, and accountability of the Medicaid program.

First, a bill to be introduced by Dr. Bucshon and some of his colleagues would fix a problem identified by the HHS Inspector General-ensuring that providers terminated in one state don't improperly bill the system or negatively impact patients in another state.

Second, Representative Brooks and I have introduced H.R. 3444, which would operationalize a proposal in the president's budget to help reduce Medicaid and CHIP fraud in the territories of the United States.

Next, Representative Bilirakis has introduced H.R. 1570, a bipartisan bill which would bring increased transparency and information to federal expenditures related to Medicaid and CHIP in U.S. territories.

Fourth, Vice Chairman of the Health Subcommittee Brett Guthrie has a bill which would incentivize states to require providers of Medicaid personal care services to have electronic verification systems in place. This common-sense proposal will ensure taxpayers only pay for the services delivered to Medicaid beneficiaries.

Fifth, I have introduced H.R. 2339—a common-sense proposal to give states better options to how lottery winnings are calculated for purposes of Medicaid eligibility. I hope we can all agree that multi-million dollar lottery winners should not be eligible to receive Medicaid—which is precisely the problem in current law that my bill would fix.

Finally, Representative Mullin on the full committee has authored H.R. 1771—a bill which would close a loophole in current law identified by some GAO reporting. This bill would amend the Social Security Act to count portions of income from annuities of a community spouse as income available to institutionalized spouses for purposes of Medicaid eligibility.

It is my hope that through the policies we discuss today, and through future actions by this committee, we can work together on a bipartisan basis to boost Med-

icaid program integrity, while making the program more sustainable, accountable, and transparent.

I look forward to hearing from our witnesses today, and I yield to ————————.

Mr. MULLIN. Thank you, Chairman Pitts.

And it is an honor to be able to sit on a subcommittee panel with you and introduce a Nico Gomez, our CEO of the Oklahoma Health Care Authority. Nico has brought in a unique approach to sometimes an agency that can be bogged down with bureaucracy by looking outside the box, by understanding that there is always a better way to do things. As he openly admits, it wasn't his idea but it was his ability to hire good people which we constantly refer to in the private sector as being extremely smart. And he brought in an outside look by being able to get people to enroll at a simpler pace by being online. At the same time, and most importantly, it gives people and it gives the agency the ability to check the eligibility of the participant at any given time with the touch of a button. Instead of having to go through and audit them to see if they are eligible since it is based on a month-to-month income basis, they can simply push the button and find out their eligibility.

I think it is something that not just Oklahoma can benefit from but the entire country can benefit from.

So, Mr. Gomez, it is an honor to have you in D.C., even though his flight didn't get in until 3 a.m. This morning. And as you can tell, he is still drinking coffee. So Nico thank you so much for being here.

Mr. Pitts, thank you so much for the ability to introduce him.

Mr. PITTS. The chair thanks the gentleman.

Without objection, the gentleman will sit with the subcommittee today in the hearing.

The chair now recognizes Mr. Green for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GREEN. Thank you, Mr. Chairman.

And good morning, and I thank our witnesses for being here today, even if you didn't arrive until 3 a.m.

Throughout its 50-year history, Medicaid has been an adaptable, efficient program that meets the healthcare needs of millions of children, pregnant women, people with disabilities, seniors, and low-income adults. Today Medicaid serves as a lifeline to nearly 72 million Americans who depend on the program for health coverage. The Affordable Care Act included the most significant changes to the program since its creation. It expanded coverage, made improvements to promote program integrity and transparency, and advance delivery system reform.

Thanks to these provisions, the uninsured rate is at a record low. The program continues to efficiently provide coverage to enrollees. Program integrity provisions of the ACA mark a shift from the traditional pay-and-chase model to a preventative approach in which fraudulent actors are kept out of the program before they commit fraud.

Today we are examining six Medicaid proposals, efforts that truly improve transparency and program integrity is something I think we all can support.

The Affordable Care Act took major steps to improve program integrity in Medicaid, including new protocols for screening of suppliers and providers and additional authority to terminate entities that commit fraud. These are significant steps forward, and more can be done to ensure these reforms are fully implemented.

We should also continue to examine other ways to further strengthen Medicaid for all beneficiaries so that dollars are spent on quality care without inappropriately limiting access.

While we hear from all six proposals during today's hearing, I want to take the opportunity to highlight two. Prior to the passage of the ACA, if a state terminated a provider's participation in its Medicaid program, the terminated provider could potentially participate in a program of a different state. In the case of Texas, they would probably come to Oklahoma and vice verse, leaving the system vulnerable to fraud and abuse. The ACA took steps to prevent this from happening, but OIG has identified weaknesses in that process.

One of the legislative proposals will build on the ACA with some technical changes. A proposal that would achieve its intent to further reduce waste, fraud and improve quality and safety in the Medicaid program is something, again, we can all support.

I am concerned that two bills under consideration would scale back Medicaid eligibility under the guise of closing loopholes. The Affordable Care Act establishes a streamlined, coordinated eligibility determination system for Medicaid and CHIP as well as premium tax credits and cost-sharing subsidies. The approach was designed so that people can qualify for the appropriate program without gaps or duplication and move between insurance programs when their incomes change.

H.R. 2339 would undermine this by requiring states to count lump-sum income as though it were income that the individual has received for up to 20 years after it is actually received. The bill is being described as a way to prevent people who win large lottery payouts from receiving Medicaid, but this is misleading. By counting all lump-sum income as monthly income, the overwhelming the majority of people it would affect all those who receive things like workers' compensation settlements, unemployment, and retroactive disability payments. If 2339 became law, a significant number of low-income Americans who receive lump sum could be inappropriately determined ineligible for Medicaid and lose access to their health insurance.

Coverage gaps due to temporary changes in income are bad for patients, providers, and health plans and ultimately is a waste of taxpayer dollars. This is a concept MACPAC has recommended in several reports to Congress. Gaps in coverage is an issue that I have been concerned about for years. For the last several Congresses I have worked with my colleague from Texas, Representative Joe Barton, to advance legislation to require 12-month continuous enrollment Medicaid and SCHIP. Proposals that ensure Federal and state taxpayer dollars are spent appropriately on delivering quality care and prevent fraud, waste, and abuse from occur-

ring should be supported. Good program integrity holds all stakeholders accountable without unintentionally impeding the access.

I look forward to working with my colleagues on the committee to further strengthen the Medicaid program in key areas and build on the success. Again, I would like to thank our witnesses for being here today and look forward to the discussion on the legislative proposals under consideration.

And I yield back.

Mr. PITTS. The chair thanks the gentleman.

I now recognize the vice chair of the subcommittee, Mr. Guthrie, 5 minutes for his opening state.

OPENING STATEMENT OF HON. BRETT GUTHRIE, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF KENTUCKY

Mr. GUTHRIE. Thank you, Mr. Chairman. I thank you for yielding time.

I appreciate the committee holding this hearing on efforts to strengthen Medicaid by reducing waste, fraud, and abuse. In doing so we can ensure the program's longevity and effectiveness.

Earlier this year, I introduced H.R. 2446, which would require states to put in place an electronic visit verification system for personal care services. Medicaid personal care services are becoming increasingly more important as the need for them continues to grow. However there is also growing concern about the high levels of improper payments in this area.

My bill will help address these concerns by requiring states to adopt an EVV system to verify the date, time, and site of visit as well as the provider of the services. This is critical to ensure that beneficiaries receive the services they need.

Many states already operate EVV systems, and they have seen a decrease in improper payments and significant cost savings for the states.

I want to thank the subcommittee for holding this hearing; certainly Chairman Pitts for including it in today's hearing. And by strengthening Medicaid, we can ensure those who need it can rely on it in the future.

And I would like to yield time to my friend from Florida, Mr. Bilirakis.

Mr. BILIRAKIS. Thank you. Thank you, sir, I appreciate it very much.

And thank you, Chairman Pitts, for holding the hearing.

Earlier this year, I, along with the delegates from all the territories, introduced the Medicaid and CHIP Territory Transparency and Information Act, H.R. 1570. CMS reports Medicaid CHIP data for all 50 states and the District of Columbia, but not the territories. Three months after introduction, CMS has started to report Puerto Rico data but not the other territories, and the level of data is less than what is reported for states.

My bill would require CMS to provide the same data for the territories as it does for the states. Puerto Rico's Medicaid program is facing some huge problems over the horizon. As a committee, we have to make some big policy decisions, and regardless of your policy views, we have to have all the data, all the information to un-

derstand the problem and exercise proper oversight over their program if we are to attempt to address these problems going forward.

Thank you very much for the time, and I yield back.

Mr. GUTHRIE. I yield back.

Mr. PITTS. The chair thanks the gentleman.

I now recognize the ranking member of the full committee, Mr. Pallone, 5 minutes for an opening statement.

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

Mr. PALLONE. Thank you, Mr. Chairman, for convening this hearing on the six pieces of legislation before our committee. I am pleased to see that some of the bills we are considering here today are true efforts to improve program integrity in Medicaid in ways that will strengthen the Medicaid program. That is a longstanding priority of mine, and there is still some technical work to be done, but the draft proposal that would build on authority given to CMS and states to terminate fraudulent providers from the Medicaid program is a worthwhile policy.

We need to do a better job in this area to make sure that providers eliminated in one state are no longer able to cross state lines and continue to be reimbursed for bad care for beneficiaries, and this legislation will do that. And I look forward to working with my colleagues on the proposal.

The proposed legislation under consideration today that would encourage our territories, like Puerto Rico, to invest in the creation of Medicaid fraud control units that over the long term bring dollars back to beneficiaries is a no-brainer.

I have to say, however, that another bill, H.R. 1570, requiring Web site information about the territories beyond Puerto Rico is a dramatic step, and I prefer to start first with the request to the agency for that information before enacting a law to that effect. While not harmful, this approach seems rigid and misguided.

I appreciate the interest in cracking down on fraud in the personal care services and home and community-based care space. Ensuring beneficiaries actually receive quality PCS to which they are entitled is an issue of serious importance and one that I look forward to working with this committee on further. HHS and the Office of the Inspector General have published an extensive body of work examining Medicaid personal care services and has found significant and persistent compliance payment and fraud vulnerabilities that we will hear about today. I have concerns about H.R. 2446, as drafted, however. I do believe this issue should be addressed and look forward to a thorough review and assessment of recommendations for improvement.

Unfortunately, we aren't considering just program integrity bills today. The ultimate test for all Medicaid legislation should be to determine if the proposal supports overarching Medicaid objectives to strengthen coverage, expand access to providers, improve health outcomes, and increase the quality of care for beneficiaries. I believe that the majority of what we are looking at for program integrity in Medicaid today achieves these goals. However, efforts to scale back eligibility in the Medicaid program in any way is not

program integrity, and it is not closing loopholes. Proposals like the one we have here today that purports to address this so-called plight of lottery winners in Medicaid I think are completely unnecessary from a practical perspective. We have several checks in place and states already have the authority they need, but far more concerning is that H.R. 2339 is not about lottery winners at all; it is about undermining the streamlined coordinated eligibility approach the ACA established by allowing states to count lump-sum income that an individual may receive as though it were income that the individual is receiving for 1 to 20 years after actual receipt. And by "lump sum," we are not talking about lottery winners; we are talking about uncompensated care settlement payments, Social Security disability back pay. We are talking about eliminating coverage for up to 20 years for a child on Medicaid because they have a parent that finally got a break with a little bit of income from selling the family home. Proposals like these that would undermine the coverage for millions of low-income individuals, including some of our most vulnerable children and seniors, are punitive to beneficiaries.

Reviewing our final bill here today, H.R. 1771, I am pleased that perhaps we can have a discussion about long-term care insurance or the lack thereof. I appreciate this legislation's effort to ensure spousal impoverishment protections remain when one spouse must enter a nursing home.

As many of you know, I was a strong supporter of the CLASS Act that has since been repealed, and I have called repeatedly for a real discussion about a long-term care benefit that a middle-income family can depend on to be there when they need it. We have no long-term care insurance in this country, and until we are ready to have a discussion about improving options in the long-term care insurance marketplace, I am concerned about changes to Medicaid eligibility in this space even for a very small amount of individuals.

Mr. Chairman, I have said repeatedly that the Medicaid program is the bedrock of the Nation's safety net. I take protecting Medicaid seriously, and I have used some of the good program integrity proposals we have to consider here today as efforts to advance that goal. However, Medicaid is the lifeline of nearly 72 million children, elderly, and low-income individuals depend on for health coverage. And I will never support a proposal that would take that coverage away.

So I want to thank you again for calling this hearing, and I look forward to working with you further to consider some of these initiatives, Mr. Chairman, and having a thoughtful discussion. Thank you.

Mr. PITTS. The chair thanks the gentleman.

That concludes the opening statements. As usual, the written opening statements of all members will may be made part of the record. And I would like to ask unanimous consent to submit the following documents for the record: letters from the Alzheimer's Foundation of America and Sandata Technologies.

Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. PITTS. We have one panel today. I will introduce them in order of your testimony. Thank you very much for coming today.

First of all, John Hagg, Director of Medicaid Audits, Office of Inspector General, U.S. Department of Health and Human Services; secondly, we have heard from Mr. Mullin the introduction for Nico Gomez, chief executive officer for Oklahoma Health Care Authority; and finally, Trish Riley executive director of the National Academy for State Health Policy, and Commissioner, Medicaid and CHIP Payment and Access Commission.

Thank you very much for coming today. Your written testimony will be made a part of the record. You will each be given 5 minutes to summarize your written testimony.

So at this time, Mr. Hagg, you are recognized for 5 minutes.

STATEMENTS OF JOHN HAGG, DIRECTOR OF MEDICAID AUDITS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; NICO GOMEZ, CHIEF EXECUTIVE OFFICER, OKLAHOMA HEALTH CARE AUTHORITY; AND TRISH RILEY, EXECUTIVE DIRECTOR, NATIONAL ACADEMY FOR STATE HEALTH POLICY, AND COMMISSIONER, MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION

STATEMENT OF JOHN HAGG

Mr. HAGG. Good morning, Chairman Pitts, Ranking Member Green, and other distinguished members of the committee. Thank you for the opportunity to testify about the Office of Inspector General's efforts to reduce fraud, waste, and abuse and to promote quality and safety in the Medicaid program.

Protecting the integrity of Medicaid takes on a heightened urgency as expenditures and the number of beneficiaries served continues to grow.

My testimony today focuses on three specific areas of concern that the OIG has identified to be problematic.

First, terminated providers continue to participate in and bill Medicaid. Second, there are inadequate safeguards for personal care services. And third, the U.S. territories lack Medicaid fraud control units.

Prior to the passage of the Affordable Care Act, if a state terminated a provider's participation in its Medicaid program, the provider could potentially participate in another state's Medicaid program, leaving the second state vulnerable to fraud, waste and abuse. To prevent this, states are now required to terminate a provider's participation if that provider is terminated in another state. The termination has to be for cause, for example, for reasons of fraud, integrity, or quality.

Through our work, we found significant problems. Specifically, we determined that not all states submitted data on terminated providers and that much of the data that was submitted did not relate to providers terminated for cause. We also found 12 percent of providers terminated in 2011 continued participating in other states' Medicaid programs.

To further complicate states' ability to terminate providers, many states do not require providers that participate via managed care to be directly enrolled in Medicaid. If a state has not directly enrolled a provider, it cannot not terminate that provider, and it may

not even be aware that the provider is participating in its Medicaid program.

The OIG believes that CMS should, one, require states to report providers terminated for cause rather than leaving it as voluntary; two, ensure that the information reported is uniform, accurate and complete; and three, require state Medicaid programs to enroll all providers participating in Medicaid managed care.

Another problematic area within Medicaid is personal care services. These services allow many elderly people and those with disabilities to remain in their homes rather than being placed in a nursing facility. As more and more state Medicaid programs explore home care options, OIG believes it is critical that adequate safeguards exist to prevent fraud, waste and abuse in personal care services. Through our work, OIG discovered some payments for these services were improper because they were either not provided in accordance with state requirements, not supported by adequate documentation, billed during periods in which the beneficiaries were institutionalized, or were provided by attendants that failed to meet state qualifications.

Over the years, we have made a number of recommendations to CMS to address Medicaid's deficiencies within the delivery of personal care services, including requiring qualification standards for care attendants be consistent across states, requiring care attendants to be enrolled or registered with the states, and requiring dates, times and attendants' identities to be listed on Medicaid's claims. Currently, none of these recommendations have been implemented.

Another way the OIG helps protect the integrity of Medicaid is by overseeing the state Medicaid fraud control units. Fraud control units currently operate in 49 states and the District of Columbia, but none are in the five U.S. territories.

The major barrier to establishing fraud control units in the territories is the nature of Medicaid funding. Unlike Medicaid funding for the states, the territories receive a capped appropriation and routinely use the full amount appropriated. This becomes a disincentive to allocate scarce Medicaid dollars to the establishment and operation of fraud control units.

Legislation could remove the disincentive. This could be accomplished by exempting unit funding from the capped Medicaid appropriation. OIG believes that such a change would also be cost efficient, specifically in Puerto Rico, which has a total Medicaid enrollment of more than 1 million beneficiaries which is comparable to Medicaid enrollment of many medium-sized states.

In conclusion it is critical that we strengthenoversights to ensure that Medicaid funds are spent appropriately. Thank you for your interest in our work and for the opportunity to appear before you today.

[The prepared statement of Mr. Hagg follows:]

Testimony of:
John Hagg
Director of Medicaid Audits
Office of Inspector General
U.S. Department of Health and Human Services

Hearing:
"Strengthening Medicaid Program Integrity and Closing Loopholes"

House Committee on Energy and Commerce

September 11, 2015
Rayburn 2322
9:15 AM

John Hagg
Director of Medicaid Audits
Office of Inspector General
U.S. Department of Health and Human Services

Good morning, Chairman Pitts, Ranking Member Green, and other distinguished Members of the Committee. Thank you for the opportunity to testify about the efforts to reduce fraud, waste and abuse and to promote quality and safety in the Medicaid program.

Our mission at the Office of Inspector General (OIG) is to protect both the integrity of the Department of Health and Human Services' programs and operations as well as the health and welfare of the people the department serves. Overseeing the Medicaid program is a critical component of that mission. Medicaid spending totals almost $500 billion, and the program serves more than 72 million individuals. OIG advances our mission through a robust program of audits, evaluations, investigations, enforcement actions, and compliance efforts.

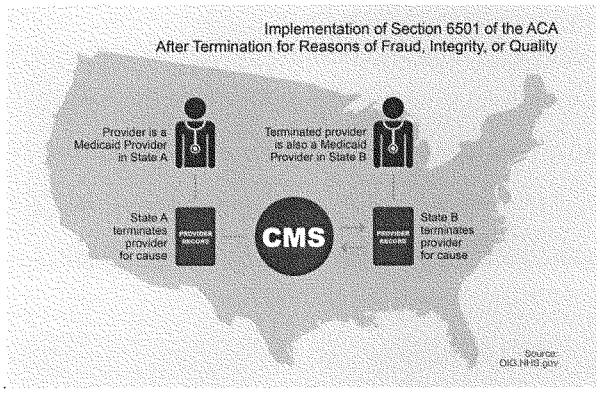
The Medicaid program provides medical assistance to low-income individuals and those with disabilities. The Federal and State governments jointly fund and administer Medicaid. At the Federal level, the Centers for Medicaid & Medicare Services (CMS) administers Medicaid. At the State level, each State administers its Medicaid program in accordance with a CMS-approved State plan. State Medicaid Fraud Control Units (MFCUs) play key roles in protecting the integrity of the Medicaid program. Among their responsibilities, MFCUs investigate and prosecute provider fraud and patient abuse and neglect. MFCUs must be single, identifiable entities of the State government and certified annually by OIG as meeting Federal requirements. Forty-nine States and the District of Columbia have established MFCUs. OIG's federal investigators also work closely with MFCUs on many criminal and civil cases involving Medicaid.

Protecting the integrity of Medicaid takes on a heightened urgency as expenditures and the number of beneficiaries served continue to grow. Many states and the District of Columbia are expanding Medicaid eligibility to include a larger group of qualifying adults pursuant to the Affordable Care Act (ACA) and Medicaid waivers. Further, States that have not expanded eligibility have also seen increases in Medicaid enrollment. OIG has a substantial portfolio of past, ongoing, and planned work addressing the Medicaid program.

As requested by the Committee, my testimony today will focus on three specific areas in need of corrective action within the Medicaid program, including terminated providers continuing to participate in and bill Medicaid, adequate safeguards being implemented to prevent fraud in personal care service and a lack of MFCUs in the U.S. territories.

Terminated Providers Continue to Participate in and Bill Medicaid

Prior to passage of the ACA, if a State terminated a provider's participation in its Medicaid program, the provider could potentially participate in another State's Medicaid program, leaving the second State's program vulnerable to fraud, waste, or abuse committed by that provider. To prevent this, the ACA broadly requires States to terminate a provider's participation in their Medicaid programs if that provider is terminated from another State Medicaid or Medicare program. CMS, in regulations, clarified that this requirement applies only to providers terminated "for cause" (i.e., for reasons of fraud, integrity, or quality).



Note: State A refers to the State that initiates a provider's termination for cause. State B refers to any other State where this provider is providing services or to where the provider could move.

OIG found weaknesses in the CMS process for sharing termination information among the States. The ACA requires CMS to establish a process to make available to State agencies information about providers terminated from the Medicare, Medicaid, and CHIP programs so that States can identify those providers who are required to be terminated. To implement this requirement, CMS established a data-sharing process that allows State Medicaid agencies to voluntarily report to a central database providers whom the agencies terminated for cause from their programs and to retrieve information about providers who were terminated for cause by Medicaid programs in other States. We found that not all State Medicaid agencies were reporting to the database and that not all of the submitted records met the CMS definition of a for cause termination.

OIG also found that providers terminated in one State continued to participate in other States' Medicaid programs. Specifically, we found that 12 percent of providers who were terminated for cause from State Medicaid programs in 2011 continued to participate in other States'

Medicaid programs, notwithstanding the requirement that such providers be terminated in all States. About half of these providers remained listed as participating in Medicaid in other States until as late as January 2014, and about one-third of these participating providers received payments for services rendered to Medicaid beneficiaries after the providers' terminations for cause.

Some of the challenges that States face include: not having a comprehensive data source for identifying all terminations for cause as well as difficulty differentiating such terminations from other administrative actions that a State reports. Of the 41 States that used managed care in 2012 to deliver Medicaid services, 25 did not require providers who participated via managed care to be directly enrolled with the State Medicaid agency. This further complicated said States' ability to terminate providers. If a State has not directly enrolled a provider, it cannot terminate that provider, and it may not even be aware that the provider is participating in its Medicaid program. Of the 295 providers who were reported by States as terminated for cause but who continued to participate in other States, 91 were not directly enrolled with the State Medicaid agencies.

To address these issues identified in our reports, we have recommended that CMS:

- Require each State Medicaid agency to report all providers terminated for cause.
- Ensure that the shared information contains only records that meet CMS's criteria for terminations for cause.
- Work with States to develop uniform terminology to clearly denote terminations for cause.
- Require that State Medicaid programs enroll all providers participating in Medicaid managed care.

CMS concurred with our recommendations and has stated that it is committed to improving Medicaid program integrity efforts.

Adequate safeguards to prevent fraud in Personal Care Services

Personal care services such as bathing, light housework, or meal preparation, allow many elderly people and those with disabilities or chronic or temporary conditions to remain in their homes rather than be placed in a nursing facility or other institutionalized care setting. Eligible beneficiaries can receive these services under Medicaid State plan options or waivers. The services must be provided at home or another approved location and follow a specific plan of care. These services are typically performed by care attendants.

OIG is committed to ensuring that personal care services provided under Medicaid have adequate safeguards to prevent fraud, waste, and abuse. Over the last decade, OIG has issued

numerous reports on the topic of personal care services and conducted numerous investigations involving personal care services fraud. A 2012 report entitled personal care services: *Trends, Vulnerabilities, and Recommendations for Improvement* synthesized our body of work and offered new and comprehensive recommendations to address vulnerabilities that we have identified. Our work in this area continues to demonstrate that significant problems remain.

OIG also found that payments for personal care services were improper because the services were not provided in compliance with State requirements, were unsupported by documentation, were provided during periods in which the beneficiaries were institutionalized and were provided by attendants who did not meet State qualifications. We have also found that existing program safeguards intended to prevent improper payments and ensure medical necessity, patient safety and quality have often been ineffective.

Through our reports, we made a number of recommendations to CMS to address the deficiencies we identified, including:

- Making qualification standards for care attendants more consistent.
- Requiring care attendants to be enrolled or registered with the State and requiring dates, times, and attendants' identities to be listed on claims to Medicaid.
- Expanding Federal requirements and guidance to reduce variation of requirements for claims documentation, beneficiary assessments, plans of care, and supervision of attendants across States.
- Issuing guidance to States regarding adequate prepayment controls.
- Assessing whether additional controls are needed to ensure that personal care services are allowed under program rules and are provided.
- Providing States with the data to identify overpayments when beneficiaries are receiving institutionalized care.

In response, CMS agreed that more needs to be done at the Federal and State levels to ensure appropriate billing for personal care services and has agreed to take a number of steps to address the recommendations made by OIG.

Medicaid Fraud Control Units

Another way that OIG helps protect Medicaid from fraud and abuse and Medicaid beneficiaries from harm is by overseeing State Medicaid Fraud Control Units (MFCUs). OIG evaluates MFCU operations, ensures that the MFCUs comply with grant requirements, compiles statistics on performance, and manages the awarding of Federal funds to them.

State MFCUs play the primary role for Medicaid in the investigation and prosecution of provider fraud and patient abuse or neglect in health care facilities. MFCUs, usually part of the State Attorney General's office, operate under an interdisciplinary model, employing attorneys,

auditors, and investigators, and are typically responsible for both the investigation and the criminal and or civil prosecution of cases. Each MFCU receives a 75 percent Federal match under the program; new MFCUs receive a 90 percent Federal match for an initial 3-year period. In fiscal year 2014, MFCUs employed 1,957 staff and spent over $235 million in both Federal and State funds.

MFCUs reported a total of 1,318 criminal convictions for fiscal year 2014, including 956 for provider fraud and 362 for patient abuse or neglect. MFCU criminal and civil cases contributed to reported monetary recoveries of over $2 billion for the fiscal year. This translates to a return on investment of $8.53 in recoveries for each dollar expended in Federal and State funds.

MFCUs operate in 49 States and the District of Columbia. Under the Medicaid statute, all States – defined to include the District of Columbia and the five U.S. territories – are required to have a MFCU as a feature of their Medicaid State plan, unless the State receives a waiver from the Secretary. All five U.S. territories and the State of North Dakota do not maintain a MFCU.

The major barrier to establishing a MFCU in Puerto Rico and the other territories is the nature of Medicaid funding for the territories. Unlike Medicaid funding for the 50 States and the District of Columbia, the territories receive a capped appropriation to provide both Medicaid services and most administrative costs, which would include operation of a MFCU. Although the ACA provided a temporary increase in the amount of Medicaid funding to the territories, they routinely use the full amount of their capped appropriation for Medicaid services and essential administrative costs. This becomes a significant obstacle to the allocation of scarce Medicaid dollars to the establishment and operation of a MFCU.

The lack of a MFCU in Puerto Rico, the territory with the largest Medicaid program by far, is a particular concern. OIG believes that the addition of a MFCU in this jurisdiction is important to protect the program and its beneficiaries from fraud, and to protect residents of health care facilities from abuse or neglect. Puerto Rico has a total Medicaid enrollment of more than 1 million people, comparable to the Medicaid enrollment in many medium-size States. OIG has a significant investigative workload in Puerto Rico that includes over 117 criminal convictions and $12 million in civil settlements from calendar year 2012 to date.

Legislation could remove the disincentive to establish MFCUs in the territories. This could be accomplished by exempting MFCU funding from the capped Medicaid appropriation. OIG believes that such a change would also be cost-efficient, especially in Puerto Rico. Current data demonstrate that MFCUs generate positive returns on investment. Puerto Rico officials have expressed interest to OIG in establishing a MFCU but have not been able to get approval for it.

Conclusion

We have a substantial body of Medicaid-related work, both underway and planned, to ensure that taxpayer dollars are spent for their intended purposes. This work will examine additional critical issues that were not discussed in my testimony today, such as eligibility determinations for the Medicaid expansion population, Medicaid payments for medical equipment and supplies, health care provider taxes, and Medicaid payments to managed care organizations

Given the growth of the Medicaid program, OIG believes it is critical that we continue to conduct effective oversight to ensure that funds are spent appropriately and that steps are taken to improve the quality of care for Medicaid beneficiaries.

Thank you for the opportunity to testify about the Office of Inspector General's work in the Medicaid program.

Mr. PITTS. The chair now recognizes Mr. Gomez 5 minutes for your summarization.

STATEMENT OF NICO GOMEZ

Mr. GOMEZ. Good morning, Chairman Pitts and Ranking Member Green, and distinguished committee members, good morning. It is honor to share Oklahoma's perspectives and experiences on a critically important topic like program integrity in an ever changing healthcare delivery environment. It is important to note that this testimony is that of only one state's program. It is not made on behalf of any of the other states or associations. Equally important is acknowledgment that solutions offered here are not to the exclusive benefit of Oklahoma. This testimony highlights and reinforces the need for state flexibility rather than uniform mandates.

Oklahoma maintains a dedication of integrity in every aspect of our Medicaid program. Recent changes have included improving the process for determining member eligibility, provider contracting and enrollment, claims payments, medical necessity, asset verification, and service verification. Prior to the implementation of the Affordable Care Act, Oklahoma made investments toward developing the Nation's first fully automated, realtime online enrollment system. Currently, two-thirds of Oklahoma's applicants for Medicaid are received from a personal or public computer through our online system.

When added to the benefit of our community partners, more than 99 percent of our applications processed in the community are processed in realtime using a rules-based decision engine. In addition to relieving a tremendous administrative burden, this system allows for realtime enrollment, while strengthening the state's ability to verify reported information with various sources, including the Social Security Administration, Department of Homeland Security and the Oklahoma Employment Security Commission.

Oklahoma's pride is in its constant dedication to improving its program's integrity reflected in its payment error rate measurement. The Payment Error Rate Measurement Program is an audit conducted by CMS on a 3-year rolling average to measure the accuracy of payments made to Medicaid covered goods and services. The audit takes into consideration member eligibility, provider eligibility, and medical necessity. Oklahoma's most recent PERM audit identified a.24 percent error rate, .24 percent amongst the lowest of the 17 states with the same cycle. Most states are around 9 percent.

This success is a testament to the engaged provider services and training infrastructure as well as Oklahoma's continual audits to using PERM criteria in the interim during and between PERM audits, something we are very proud of.

Many of the issues being addressed in the upcoming hearings are issues that Oklahoma is facing or has attempted to address in the past.

One issue in particular we have attempted to address on our own and now with the help of Congressman Mullin we are able to address in H.R. 1771. Since its creation, the statutes and regulations governing the Medicaid program have been amended numerous times and now consist of complex, interrelated provisions that are

often difficult to understand. One such area surrounds standards to prevent spousal impoverishment. Medicaid statutes allow the spouse of a Medicaid applicant for long-term care to keep a certain amount of his or her resources so that he or she is not required to become impoverished before their spouse can receive long-term care. Unfortunately, individuals are now using court-recognized loopholes to transfer significant resources to a spouse, transfers that would normally disqualify them from Medicaid.

States have denied applicants who are clearly above Medicaid's income standards or resource limit standards only to have the court order the approval of such applications as a result of certain estate-planning loopholes that they recognize are contrary to Medicaid's intended purpose but can only be corrected by Congress.

In an attempt to curtail the practice, Oklahoma denied such application using this loophole that resulted in the Morris v. Oklahoma Department of Health and Human Services. Morris is the seminal 10th Circuit decision which directly impacts not only Oklahoma but five other states in the circuit, but it also has been extended and relied upon in at least three other Federal circuits and several state courts.

The Court's rulings essentially permits a married couple to shelter potentially unlimited amounts of assets through the use of nonassignable, nontransferable annuities in order for the spouse in need of medical care to qualify for Medicaid. In reversing the district court, the court of appeals stated, although we understand the district court's concerns regarding the exploitation of what can only be described as a loophole in the Medicaid statutes, we conclude that the problem can only be addressed by Congress.

The passage of H.R. 1771 would be a needed step towards preserving shrinking resources that would help empower states to ensure those applicants truly in need can still access quality services. I would like to thank Congressman Markwayne Mullin for agreeing to working with the states remedying this and look forward to working together with the committee. And with that, I conclude my remarks and am happy to answer any questions.

[The prepared statement of Mr. Gomez follows:]

Written testimony prepared for the United States House of Representatives Energy and Commerce Committee, Subcommittee on Health- September 11, 2015

It is an honor to share Oklahoma's perspectives and experiences on a critically important topic like program integrity in an ever-changing health care delivery environment. It is important to note that this testimony is that of only one state's program and is not made on behalf of other states or associations. Equally important is the acknowledgment that solutions offered here are not to the exclusive benefit of Oklahoma. This testimony highlights and reinforces the need for state flexibility rather than uniform mandates.

Oklahoma maintains is a dedication to the integrity of every aspect of our program. Recent changes have included improving the process for determining member eligibility, provider contracting and enrollment, claims payment, medical necessity, asset verification, or service verification.

Prior to the implementation of the Affordable Care Act, Oklahoma made investments toward developing the nation's first fully automated, real-time online enrollment system. Currently, two-thirds of Oklahoma's applications for Medicaid are received from a personal or public computer through our online system. When added to the applications from partners in the community on behalf of applicants, over 99% are being processed in real-time, through a rules-based decision engine. In addition to relieving a tremendous administrative burden, this system allows for real-time enrollment while strengthening the state's ability to verify reported information with various sources including: Social Security Administration; Department of Homeland Security; and Oklahoma Employment Security Commission.

Oklahoma's pride in its constant dedication to improving its program integrity is reflected in its payment error rate measurement (PERM). The PERM program is an audit conducted by CMS on a three-year rolling cycle to measure the accuracy of payments made for Medicaid covered goods and services. The audit takes into consideration member eligibility, provider eligibility and medical necessity. Oklahoma's most recent PERM audit identified a 0.24% payment error – the lowest amongst the 17 states within the same cycle. This success is a testament to an engaged provider services and training infrastructure, as well as Oklahoma's continual audits using PERM criteria during the interim between PERM audits.

Many of the issues being addressed during the upcoming hearing are issues that Oklahoma is facing, or has attempted to address in the past.

HR 1771

Since its creation, the statutes and regulations governing the Medicaid program have been amended numerous times, and now consist of complex, interrelated provisions that are often difficult to understand. One such area surrounds standards to prevent "spousal impoverishment." Unfortunately, individuals are now using court-recognized loopholes to transfer significant resources to a spouse, transfers that should disqualify them from Medicaid. There are primarily two statutes (42 USC § 1396p and 42 USC §1396r) that are being misused, which if not corrected conceivably could bankrupt Medicaid. States have denied applicants who are clearly above Medicaid's income and/or resource limits, only to have courts order the approval of such applications as a result of certain estate planning loopholes that they recognize are contrary to Medicaid's intended purpose, but can only be corrected by Congress.

Medicaid statutes allow the spouse of a Medicaid applicant for long-term care to keep a certain amount of his/her resources, so that he/she is not required to become impoverished before their spouse can receive care. The spouse of the applicant is referred to as the "community spouse," while the applicant is referred to as the "institutionalized spouse." The amount the community spouse is allowed to retain is called the community spouse resource allowance, or CSRA. In general, Medicaid will divide the couple's total resources in half to determine the CSRA.

The maximum amount of the CSRA is about $117,000, which is set by CMS. The maximum resource amount of the institutionalized spouse varies by state; in Oklahoma, it is $2,000. The resources exceeding the CSRA must be spent down in order for the institutionalized spouse to qualify for Medicaid.

Morris v. Ok. Dept. of Human Services is the seminal 10th Circuit decision, which directly impacts not only Oklahoma and five other states in the circuit, but has also been extended or relied upon in at least three other federal circuits and several state courts. The court's ruling essentially permits a married couple to shelter a potentially unlimited amount of assets, through the use of non-assignable, non-transferable annuities, in order for the spouse in need of medical care to qualify for Medicaid. In reversing the district court, the Court of Appeals stated: **"Although we understand the district court's concerns regarding the exploitation of what can only be described as a loophole in the Medicaid statutes, we conclude that the problem can only be addressed by Congress."**

Although the *Morris* case only involved the relatively small sum of $54,000, in the wake of that decision, other applicants have not surprisingly taken advantage of the court's ruling and have purchased similar annuities to shelter significantly greater assets. For example, in another

reported case (Jantzen), the couple sought to shelter approximately $215,000, forcing Oklahoma to pay for medical care for an individual who quite clearly is not one of Oklahoma's "neediest citizens" for whom Medicaid assistance was intended. Faced with budgetary constraints, it also means that Oklahoma was forced to divert funds that should have been used for others who truly are in need.

The rationale of the court's decision in *Morris* and similar cases has since been extended by courts in Oklahoma and by at least on 10th Circuit decision to other financial vehicles that similarly thwart Medicaid's intended purpose. In particular, we have seen a significant increase in the use of non-assignable, non-transferable promissory notes to shelter assets, which the courts have thus far condoned. The impact is the same: significant amounts of wealth can be protected, forcing the states to pay for medical care that the applicant would otherwise first be required to pay. In Oklahoma, applicants have attempted to use such tactics to shelter more than $1 million in resources, and have been used as a matter of routine in applications involving assets in the $250,000 to $600,000 range. These schemes are not unique to Oklahoma, and the abuse creates a strain on states' budgets, depleting Medicaid funds that are intended to assist the most vulnerable population.

The passage of H.R. 1771 would help stem the exploitation of Medicaid funds that the courts permit because they believe the law is not sufficiently clear. While it doesn't address the separate issue of promissory notes, the amendment would no longer allow annuities to be used as a vehicle to avoid Medicaid's 60-month look back period that restricts certain transfers of assets to determine the institutionalized spouse's Medicaid eligibility for long term care.

HR 2446

Oklahoma, like many other states, is no stranger to electronic visit verification (EVV) for personal care services. For a little over five years, our largest home and community-based services waiver has been using EVV technology that has proven to be very valuable. Simply stated, the benefit to employing these systems is three fold:

1) confirmation of service delivery reduces gaps in care plans and strengthens program integrity;
2) helps to assure member safety; and
3) saves money.

Through the first three years of the EVV system, Oklahoma had over a 5 to 1 return on its investment through resulting cost savings. There were definite lessons to be learned during implementation, which should be considered before scaling a program up to a level where it is mandatory. Consideration of how EVV systems will interact with claims payment and processing should be given priority in order to maintain solid program integrity. In addition, contingencies should exist to allow for technology issues that may arise so they can be handled without interrupting services.

HR 2339

The issue of lottery winnings was one recently identified and actions have already been taken at the state level in Oklahoma in order to prepare for potential changes at the federal level. Oklahoma House Bill 1619 directs the Oklahoma Lottery Commission to notify the Oklahoma Health Care Authority of lottery winnings up to a certain amount to verify a recipients continued

eligibility is appropriate. The state is aware that because of loopholes in calculating monthly income, it is possible for a member to not lose eligibility if the winnings are taken as a lump sum. Since people lose eligibility at the end of the month using the applicable ten day notice requirement, they would just have to apply at the beginning of the following month. In Oklahoma, with online enrollment a member could lose eligibility before midnight on the last day of the month and reapply at 12:01 a.m. the next day and receive it right back.

Possible eligibility without H.R. 2339 by using 10-day notice (Member with $1000 monthly income and $48,000 won in March)

Month	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Income	$1,000	$1,000	$49,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000
Eligible	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

With H.R.2339 (Member with $1000 monthly income and $48,000 won in March with winnings spread over 12 months)

Month	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Income	$1,000	$1,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000
Eligible	Y	Y	Y	N	N	N	N	N	N	N	N	N

Mr. PITTS. The chair thanks the gentlemen.

I now recognize Ms. Riley 5 minutes for your summary.

STATEMENT OF TRISH RILEY

Ms. RILEY. Good morning, Chairman Pitts, Ranking Member Green, and members of the subcommittee.

I have served as the commissioner of MACPAC, the Medicaid and CHIP Payment and Access Commission, since its inception in 2010. As you know, MACPAC is a congressional advisory body charged with analyzing and reviewing Medicaid and CHIP policies and making recommendations to Congress, the Secretary, and the states on issues affecting these programs.

I am one of 17 members appointed by the GAO.

While I am also executive director of the National Academy for State Health Policy, my comments today solely reflect the work of MACPAC.

We very much appreciate the opportunity to be here today as the subcommittee considers changes to the Medicaid program. The Commission shares the subcommittee's interest in ensuring Federal and state taxpayer dollars are spent appropriately on delivering quality, necessary care, and preventing fraud, waste and abuse from taking place. When designed and implemented well, program integrity policies and procedures should ensure that eligibility decisions are made correctly, prospective and enrolled providers meet Federal and state participation requirements, services provided to enrollees are medically necessary and appropriate, and provider payments are made in the correct amount for the appropriate services.

The Commission has identified and shared with you through our reports to Congress a number of challenges associated with implementation of an effective and efficient Medicaid program integrity strategy, including overlap between Federal and state responsibilities, insufficient collaboration and information sharing among Federal agencies and the states, diffusion of authority among multiple Federal and state agencies, lack of information on the effectiveness of program integrity initiatives, and appropriate performance measures. We also identified concerns about lower Federal matching rates for state activities not directly related to fraud control; incomplete and outdated data; and few program integrity resources for delivery system models other than fee for service.

Specifically, the Commission recommended that the Secretary of HHS should collaborate with states to create feedback loops to simplify and streamline program integrity requirements, determine which current Federal program integrity initiatives are most effective, and take steps to eliminate programs that are redundant, outdated, or not cost-effective.

In addition, in order to enhance states' ability to detect and prevent fraud and abuse, the Commission has recommended that the Secretary should develop methods for better quantifying the effectiveness of program integrity activities. The Secretary should assess analytic tools for detecting and preventing fraud and abuse and promote the use of those tools that are most effective.

In addition, the Department should improve dissemination of best practices in program integrity and enhance program integrity training programs.

The measures before the subcommittee today also speak to other policy objectives of interest to the Commission, including simplification, transparency, and the alignment of policies across Federal health programs. Even so, I want to clarify that MACPAC has not reviewed nor expressed its views on the merits of the six specific initiatives that are the focus of today's hearing. My written statement provides technical comments on the potential implications of these proposals and issues that could be addressed as the subcommittee considers them.

Again, thank you very much for this opportunity to appear before the committee, and we would of course be happy to provide technical information from the staff or to answer questions today.

[The prepared statement of Ms. Riley follows:]

MACPAC

Advising Congress on
Medicaid and CHIP Policy

Statement of
Trish Riley, Commissioner

Medicaid and CHIP
Payment and Access Commission

Before the
Subcommittee on Health
House Committee on Energy and Commerce

September 11, 2015

Summary

The Medicaid and CHIP Payment and Access Commission shares this Subcommittee's interest in ensuring federal and state taxpayer dollars are spent appropriately on delivering quality, necessary care and preventing fraud, waste, and abuse from taking place. When designed and implemented well, program integrity policies and procedures should ensure that eligibility decisions are made correctly; prospective and enrolled providers meet federal and state participation requirements; services provided to enrollees are medically necessary and appropriate; and provider payments are made in the correct amount and for appropriate services.

The Commission has identified and shared with you through our reports to Congress a number of challenges associated with implementation of an effective and efficient Medicaid program integrity strategy, including: overlap between federal and state responsibilities; insufficient collaboration and information sharing among federal agencies and states; diffusion of authority among multiple federal and state agencies; and lack of both information on the effectiveness of program integrity initiatives and appropriate performance measures. We also identified concerns about lower federal matching rates for state activities not directly related to fraud control; incomplete and outdated data; and few program integrity resources for delivery system models other than fee for service.

Specifically, the Commission recommended that the Secretary of the U.S. Department of Health and Human Services should collaborate with states to create feedback loops to simplify and streamline program integrity requirements, determine which current federal program integrity initiatives are most effective, and take steps to eliminate programs that are redundant, outdated, or not cost-effective.

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- H.R. 1570: Medicaid and CHIP Territory Transparency and Information Act
- H.R. 1771: Changes to Counting of Income from Annuities
- H.R. 2339: Treatment of Lottery Winnings and Other Lump Sum Income
- Requiring Electronic Visit Verification System for Personal Care Services under Medicaid
- Ensuring Terminated Providers are Removed from Medicaid and CHIP
- Medicaid and CHIP Territory Fraud Prevention Act

MACPAC

Advising Congress on
Medicaid and CHIP Policy

Statement of Trish Riley, Commissioner

Medicaid and CHIP Payment and Access Commission

Good morning Chairman Pitts, Ranking Member Green, and Members of the Subcommittee on Health. I am Trish Riley and I have served as a Commissioner of MACPAC, the Medicaid and CHIP Payment and Access Commission, since it was created in 2010.

As you know, MACPAC is a congressional advisory body charged with analyzing and reviewing Medicaid and CHIP policies and making recommendations to Congress, the Secretary of the U. S. Department of Health and Human Services (HHS) and the states on issues affecting these programs. I am one of 17 members, led by Chair Diane Rowland and Vice Chair Marsha Gold, appointed by U.S. Government Accountability Office (GAO). While I am also executive director of the National Academy for State Health Policy, the insights I will share this morning reflect the work and approach of MACPAC. We appreciate the opportunity to be here today as this subcommittee considers changes to the Medicaid program.

The Commission shares this Subcommittee's interest in ensuring federal and state taxpayer dollars are spent appropriately on delivering quality, necessary care and preventing fraud, waste, and abuse from taking place. When designed and implemented well, program integrity policies and procedures should ensure that eligibility decisions are made correctly; prospective and enrolled providers meet federal and state participation

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Specifically, the Commission recommended that the Secretary of HHS should collaborate with states to create feedback loops to simplify and streamline program integrity requirements, determine which current federal program integrity initiatives are most effective, and take steps to eliminate programs that are redundant, outdated, or not cost-effective.

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H.R. 1570: Medicaid and CHIP Territory Transparency and Information Act

This legislation would require the Centers for Medicare & Medicaid Services (CMS) to publish and periodically update the following information regarding Medicaid and CHIP programs in the five U.S. territories (American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands):

- income levels for program eligibility;
- the number of enrollees in Medicaid and CHIP;
- state plan amendments (SPAs) and waivers in effect under Medicaid and CHIP;
- Medicaid and CHIP expenditure information;
- the systems in place for "the furnishing of health care items and services" under Medicaid and CHIP;
- the design of CHIP; and
- any other information that CMS posts with respect to states.

While such information is currently available for state Medicaid programs, it should be noted that Medicaid operates differently in the U.S. territories than it does in the states. In the five U.S. territories, federal Medicaid spending is limited to annual spending caps. (In fiscal year 2014, Puerto Rico accounted for about 90 percent of Medicaid spending in the territories.) The federal Medicaid statute explicitly exempts territories from a variety of provisions affecting eligibility and payment rules. In addition, for American Samoa and the Northern Mariana Islands, current law allows the Secretary to waive almost any federal

Medicaid requirement that applies to states with the exception of the federal matching rate, capped grant amount, and the requirement that payment can be made only for services otherwise coverable by Medicaid (§1902(j) of the Social Security Act).

Of the five territories, Puerto Rico is the only territory for which information on enrollment, eligibility, and SPAs that is comparable to states is now available on Medicaid.gov.

H.R. 1771: Changes to Counting of Income from Annuities

In the case of payment of income from a qualifying Medicaid annuity (described below), this bill would consider one-half of the annuity income as being available to an institutionalized spouse regardless of whether the payment was made in the names of both the institutionalized spouse and the community spouse, or solely in the name of the community spouse. In the case where payment is made in the names of the community spouse and another person or persons, one-half of the proportion of the community spouse's interest in such income would be considered as available to the institutionalized spouse.

Annuities are used as a vehicle for protecting community spouse assets while still qualifying for Medicaid coverage of long-term services and supports (LTSS), particularly for couples in which one spouse remained in the community. Because Medicaid does not count a community spouse's income (within state-specific limits) in determining the institutionalized spouse's Medicaid eligibility, by converting assets to income via an annuity a couple can conserve more of their resources for the community spouse.

Currently, annuities conforming with certain rules that make them Medicaid-compliant can reduce the amount of countable assets that are used to determine Medicaid eligibility for an institutionalized spouse. Typically a couple would need to "spend down" a portion of their assets (determined by their state's spousal impoverishment limits) in order for the institutionalized spouse to qualify for Medicaid. By converting their assets to an annuity, couples are reducing the amount they need to spend down.

This legislation would tighten Medicaid eligibility by requiring that couples make more of their assets countable as income. In addition, it might serve as a disincentive for couples to purchase annuities in the future and at present increase payments to the Medicaid program. No data are readily available to indicate how many people would be affected by this measure or the financial impact on the Medicaid program. Given that Supplemental Security Income and the Medicaid spousal impoverishment standard allow a maximum community spouse resources minimum of $23,844 and a maximum resource standard of $119,220, the number of couples for whom Medicaid-compliant annuities are currently advantageous is likely quite small.

H.R. 2339: Treatment of Lottery Winnings and Other Lump Sum Income

This bill would provide states with a new option in their Medicaid and CHIP programs regarding the treatment of lump-sum payments, including lottery winnings, under federal income-counting rules known as modified adjusted gross income (MAGI). While lump sums for Medicaid and CHIP purposes are currently treated under MAGI as income solely in the month they are received, the bill would allow states to prorate lump sums of at least $20,000 over multiple months. The two approaches available to states would depend on the amount of the lump-sum income:

- if the income is less than $50,000, the amount could be divided over 12 months; and
- if the income is at least $50,000, the amount could be divided over a period specified by the state, not to exceed 240 months (20 years).

This bill would likely reduce the number of lottery winners and lump-sum beneficiaries who would otherwise qualify for Medicaid or CHIP in the month(s) after receiving their payments. It is worth noting, however, that during the first month in which the lump sum is counted, the revised policy would make such individuals more likely to be determined eligible than under current law because only a prorated amount would be considered income for that month. We are not aware of any data on the number of individuals who would be affected.

As this subcommittee is no doubt aware, one of the purposes of the move to using MAGI for eligibility determinations was to eliminate state-based differences in income counting rules, simplifying program rules and facilitating alignment of

determinations between Medicaid, CHIP, and exchange coverage. Because the bill creates a new state option for counting income, it would introduce state variation in MAGI, thus requiring exchange-based determinations to take state-specific income-counting policies into account. In addition, new guidance would be needed from both HHS and the U.S. Department of the Treasury for situations where gaps in coverage could occur because of differing income-counting rules.

Requiring Electronic Visit Verification System for Personal Care Services under Medicaid

This legislation would reduce the federal medical assistance percentage (FMAP) for home and community-based services (HCBS) provided under a state plan or waiver for states that do not implement electronic visit verification systems for personal care services. States would have until January 1, 2018 to implement electronic visit verification (EVV) systems before FMAP reductions begin. After that date, the amount of FMAP reduction for states not implementing the systems increases over time, from a reduction of 0.25 percentage points for calendar quarters in 2018 and 2019, up to a reduction of 1 percentage point for calendar quarters in 2022 and beyond.

Personal care services are nonmedical services (such as assistance with activities of daily living like bathing and dressing) provided by a personal care attendant. Currently, all 50 states and the District of Columbia offer such services either as a state plan option or through waivers or demonstrations. These services allow frail elderly and people with disabilities to stay in their homes rather than rely on institutional care. In FY 2013, Medicaid spent $11.9 billion on personal care services, accounting for 16 percent of all Medicaid-financed home and community-based services and 8.2 percent of Medicaid-financed long-term services and supports.

The HHS Office of Inspector General (OIG) and others have raised concern over improper payments and fraud, waste, and abuse related to personal care services. Among its concerns, OIG has noted the lack of documentation for billed services. For example, a 2008 OIG study found that claims for personal care services often did not specify the dates when services were

provided. In addition, in many instances, overlapping claims could not be identified due to the practice of so-called span billing which allows agencies to submit claims for services provided over a certain time period (e.g., a week or month) without specifying the dates when services were actually provided. OIG has also found cases where claims were in excess of 24 hours a day. Moreover, in many states, personal care attendants are not required to be registered with state Medicaid programs or have a unique identifier for claims.

Electronic visit verification systems require personal care attendants to confirm the beginning and end of a service visit for a particular beneficiary, typically by calling into a telephone system or by using an electronic device. They may also collect additional information such as the exact global positioning system (GPS) location where system was accessed to confirm that the attendant was at the beneficiary's home, or wherever services were authorized to be provided. Thus, these systems ensure that beneficiaries receive services that are authorized and that visits being claimed were actually provided.

States that have implemented these systems include Florida, Illinois, Louisiana, New York, Ohio, South Carolina, Tennessee, Texas, and Washington. However, some have done so for a limited time (for example, Texas only completed implementation statewide this past June) and thus there is little research about effectiveness of implementing such system on reducing improper payments. States have projected savings; for example, a Louisiana official recently estimated that the state Medicaid program will save $16.7 million and the Texas Health and Human Services Commission estimates 3 to 5 percent savings from implementation of electronic verification.

Ensuring Terminated Providers are Removed from Medicaid and CHIP

This legislation would require states to submit to CMS within 14 days of the termination of any individual or entity:

- the name of the individual or entity;
- the provider type and specialty;
- the date of birth, address, Social Security number or taxpayer identification number, national provider identifier, and state license or certificate number;

- the reason for the termination; and
- a copy of the notice sent to the provider.

States would also be required to add terms to contracts with Medicaid managed care organizations (MCOs) requiring that any provider terminated for cause from Medicare, Medicaid, or CHIP be terminated from participation in Medicaid or CHIP provider networks.

Within 14 business days of notification by the state, CMS will include each provider termination in a termination notification database or similar system developed pursuant to section 6401(b) (2) of the Patient Protection and Affordable Care Act (ACA; P.L.111-148). Two years after enactment, states will be required to repay the federal share of any payments made to a provider (including payments made through an MCO) who was terminated from Medicaid or CHIP more than 60 days after the date in which the termination information was made available in the database.

Federal rules (42 CFR 455 Subpart B) already require states to terminate the enrollment of any provider that is terminated on or after January 1, 2011 by Medicare or by Medicaid or CHIP in any other state. These rules also require states to routinely check a number of federal databases, including the List of Excluded Individuals and Entities mandated by the HHS OIG. However, states are not currently required to report information on Medicaid and CHIP provider terminations to a national database, nor are there standardized reasons for terminations that facilitate cross-state comparisons. CMS developed a database to make exclusion information available to all state Medicaid agencies to facilitate compliance with section 6401 of the ACA. In 2014, the HHS OIG reviewed this voluntary system and reported that many states did not report information to the national database and that the data that was reported was often insufficient or inaccurate.

This bill would facilitate state termination of providers terminated by Medicare or by Medicaid or CHIP in other states. It would also provide an additional incentive for states to conduct timely checks of the database by requiring the return of the federal share of payments made to providers more than 60 days after the date by which states have access to information on their termination by Medicare or another state.

States are not currently required to ensure that all MCO contracted providers are enrolled in Medicaid or CHIP or subject to the screening requirements of 42 CFR 455 Subpart B. CMS has proposed a new rule that would require states to enroll all MCO providers that are not otherwise enrolled with the state to provide services to Medicaid beneficiaries under fee for service, including all applicable screening and disclosure standards. This bill would provide statutory authority for CMS to require Medicaid and CHIP managed care plans to terminate providers who are terminated from Medicare or other state Medicaid and CHIP programs.

Medicaid and CHIP Territory Fraud Prevention Act

This bill amends Section 1108(g)(4) of the Social Security Act to exclude expenditures associated with the establishment or operation of a Medicaid Fraud Control Unit (MFCU), as described in 1903(a)(6), from the explicit limits on federal financial participation for the territories. Such exclusions would be similar to existing exclusions for operation of an approved Medicaid Management Information System and electronic health record incentive payments.

Because Medicaid funding to the territories is capped, territories routinely use the full amount of that funding to pay for Medicaid services and essential administrative functions and historically have not wanted to divert funds to establish an MFCU. None of the five territories has established such a unit, although Puerto Rico has recently expressed interest in doing so.

The HHS OIG has proposed encouraging the territories to establish MFCUs by eliminating the existing financial disincentive, and the President's FY 2015 budget proposed appropriating funding to establish and operate a MFCU while retaining the same amount of appropriated dollars for Medicaid services and essential administrative functions.

Mr. PITTS. The chair thanks the gentlelady. That concludes the opening statements. We will now begin questions, and I will recognize myself 5 minutes for that purpose.

Mr. Hagg, the U.S. territories are already required by law to have a Medicaid fraud control unit. Is that correct?

Mr. HAGG. I believe that is correct, yes.

Mr. PITT. Given that, can you explain why the territories do not already have such units and how H.R. 3444, the Medicaid and CHIP Territory Fraud Prevention Act, would encourage their creation?

Mr. HAGG. Yes. I think they don't have fraud control units now has to do with how their Medicaid programs are structured or how the funding of those programs are structured. In the territories, the Medicaid programs are capped, unlike the states, where it is open-ended. To create fraud control units, the funding that it would take to start up the units and then to operate the units would take away from trying to provide for services for beneficiaries in the territories. I think that is a difficult decision for them, taking away funds that could be used to provide services.

The bill will move the funding that would be required to run the fraud control units out of that capped amount. And so it should take that disincentive from creating a program away.

Mr. PITTS. Thank you.

And, Mr. Hagg, your work found that the lack of uniform terminology for the reasons for provider terminations caused challenges for state agencies. Can you please explain the challenges created, how the policy we are discussing today could help resolve those challenges?

Mr. HAGG. Well, you know as far as uniform terminology, we performed two studies involving terminated providers. The first was looking at the action CMS had taken to create a central data system that would house all of the providers that had been terminated. And looking at that data set, we found some states didn't submit any data at all. We found some states that submitted data, but the data wasn't complete. They were missing, for example, an address for the provider. And then as far as uniform terminology, we found that some states were submitting providers that had been terminated for reasons other than cause, reasons other than fraud or integrity or abuse issues. So say for example in a state if they terminated a provider because of billing inactivity, some states would submit that information to the central database, other states potentially could look at that database and say, "We need to terminate that provider as well," even though there wouldn't be a reason to. So only providers terminated for cause should be submitted to that central data system; not other ones.

And so uniform terminology or guidance provided by CMS about uniform terminology could help correct that issue.

Mr. PITTS. Mr. Gomez, according to the GAO, some states have indicated that the use of annuities as a Medicaid planning tool have increased in recent years, despite congressional action most recently as part of the Deficit Reduction Act to eliminate this loophole. Has Oklahoma seen an increase in the use of annuities in recent years? And if so, why do you think this is the case?

Mr. GOMEZ. Mr. Chairman, thank you.

Yes, we have seen an increase in the number of annuities as, quite frankly, families have found ways to avoid the 5-year lookback on income and assets. And it has allowed also a growth in the number of promissory notes too, which this amendment doesn't deal with. But it is a growing issue where we have allowed the annuity to be able to shelter assets so the spouse can in the community—the spouse, the institutionalized spouse, will be able to qualify for the program when the assets are there to be able to help pay for the services provided.

Mr. PITTS. Mr. Gomez, do you think it is appropriate for millionaires or multimillionaires to be receiving Medicaid while at the same time there are disabled children on the waiting lists for home and community-based services?

Mr. GOMEZ. That is why we are here, Mr. Chairman, is because we have, in Oklahoma, have cut the program hundreds of millions of dollars over the last couple of years, and every time we cut the program, we recognize that there are potential families that are getting access to the Medicaid program who are not financially qualified. So to answer your question, no.

Mr. PITTS. So if I told you that states are barred from disenrolling multimillionaire lottery winners from Medicaid, I would assume that you would find this troubling, yes?

Mr. GOMEZ. Yes, I would find that troubling.

Mr. PITTS. Furthermore, while the Federal Government is paying 100 percent of the cost of Medicaid expansion, including the medical bills of millionaire lottery winners, there are disabled children and HIV patients on waiting lists for some Medicaid programs, so do you think it is fair to use Medicaid dollars to pay for lottery winners?

Mr. GOMEZ. The purpose of Medicaid is to provide coverage for low-income families and other categorically related individuals who meet certain eligibility requirements. And it is an income-based program, so it is very difficult to make an argument for anybody above a low-income.

Mr. PITTS. Can you explain how it is that Medicaid policy permits million or multimillion dollar lottery winners to retain Medicaid coverage when they can clearly afford to purchase their own health insurance?

Mr. GOMEZ. Well, the way the system is set up now through Medicaid is we look at eligibility on a month-by-month basis we are not able to look at it from a, so a person could receive a lottery winning within a given month and then come back and reapply the next month and be qualified for the program, which I don't believe that was the program's intent.

Mr. PITTS. I see my time is expired.

I recognize the ranking member, Mr. Green, 5 minutes for questions.

Mr. GREEN. Thank you, Mr. Chairman.

Mr. Gomez how many recipients, how many people receive Medicaid in Oklahoma on any given day?

Mr. GOMEZ. Over a given course of a year, we will serve about 1 million Oklahomans. Oklahoma only has about 3.6, 3.7 million Oklahomans, so more than 25 percent of our population is utilizing the Medicaid program in a given year.

Mr. GREEN. How many people have you identified that are either using the lottery exception or even the annuity in Oklahoma? Do you have a number?

Mr. GOMEZ. Ranking Member Green, I do not have a number, but I am happy to provide that to the committee for the record.

Mr. GREEN. Do you think it would be more than 100 out of the million people?

Mr. GOMEZ. I would really hesitate to speculate, but I am happy to give you the information.

Mr. GREEN. I would love to see that information because I would like to see—obviously we want folks who need the program to get it, but if we also through up some impediment, we may end up excluding people who really do need it but again thank you.

One of the reasons the Affordable Care Act changed from the previous asset test of Medicaid into the current modified adjusted gross income formulas is to streamline and coordinate eligibility between Medicaid and health insurance marketplaces.

Ms. Riley, can describe the complexity of implementing this legislation for purposes of keeping coverage streamlined and coordinated? Do you think the legislation moves us backwards in a patchwork system where we potentially have 50 different rules for eligibility?

Ms. RILEY. Well, I understand the concern of wanting to be sure that we have a quality affordable healthcare system and that we have investments in coverage that are appropriate. That said, there has been enormous undertaking in the states, through the Affordable Care Act, to try to integrate the eligibility systems between the Federal marketplace and Medicaid. And I think giving states options to change some of that, could certainly make it more complex.

Mr. GREEN. Would this potentially create additional cost at the Federal level and particular with the Federally facilitated marketplaces in 37 states?

Ms. RILEY. I think it could. Again, this would be a state option so it is unclear how each state would tweak its eligibility determinations, and as such when integration with the Federal marketplace to try to streamline and make eligibility smoother and simpler, would require the Federal marketplace to have to make a tweak to its Federal system for each change that every state makes.

Mr. GREEN. Is it correct, and I am reading the legislation that it is potentially applying to anything such as Social Security disability back payments, workers' compensation, in any amount at all and the state would prorate the amount monthly for up to 20 years even if you no longer have access to those funds?

Ms. RILEY. I am sorry I didn't hear the end of the question, I am sorry.

Mr. GREEN. Would this legislation potentially applying the Social Security disability back payments, workers' compensation, or any amount at all that the state could pro rate that would amount to monthly up to 20 years even though it is not available to them over that 20 years?

Ms. RILEY. Yes. It is my understanding of the bill that it would do just that. Certainly we all appreciate the lottery issues, but as

written lump sums could be SSDI payments, disability payments, and others.

Mr. GREEN. We have a lot of program integrity bills that we are considering today that are focused on niche areas. I want to take a step backward and look more globally at the landscape, the program integrity in Medicaid. Can you describe MACPAC's work on program integrity to date?

Ms. RILEY. I can. We have taken a very serious look at program integrity both in our March 2012 report and our March 2013 report to the Congress. We have seen a real complexity in program integrity where there are multiple state and Federal agencies that have various aspects of program integrity, including the Department of Justice, numerous Health and Human Services agencies, and state governments, often competing often redundant. And we have suggested that there is a real need to streamline those activities, to look where there is redundancy, and to find out where the best practices exist among the states.

Importantly, while we invest in Medicare fraud control units with a 75-25 match, we do not invest in other activities states need to undertake to prevent fraud at that same level, notably the administration of the program.

Mr. GREEN. Thank you.

Mr. Chairman, I have some other questions I would like to submit to Ms. Riley on highlights, low-matching rates for activities not directly related to fraud control, and things like that. I appreciate MACPAC's reports and hope that Congress can act on those both to save Federal money, but also—because in Texas, our match is about 65 percent Federal, about 35 percent state, and somewhere along the way we need to match that. We want the states' participation but we also want to make it to where it is we can get that fraud that we are looking at.

Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman.

We will submit the followup questions to you in writing. Please respond.

The chair now recognizes the vice chairman of the subcommittee, Mr. Guthrie, 5 minutes for questioning.

Mr. GUTHRIE. Thank you, Mr. Chairman. I appreciate that very much. First, I have a unanimous consent request to enter into the record a letter from ResCare.

Mr. PITTS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. GUTHRIE. Thank you, Mr. Chairman.

This is a question for Mr. Hagg. We agree it is important to ensure that patients receive the services they are supposed to and that taxpayer resources are protected. In that vein, I introduced H.R. 2446, which would require states to use electronic visit verification for personal care services under Medicaid. So I would like to discuss some the work your office has done in this area of fraud and abuse of personal care services.

In 2012, in your year 2012 portfolio report on personal care services, you outline a series of audits that were done in eight locations, seven states and then one city, that identified over $582 mil-

lion in questionable costs. There was a wide error rate from zero percent in one state to over 40 percent in another.

Can you walk us through some of the issues you found in those audits, and what were the most frequent problems you saw?

Mr. HAGG. Yes, I would be glad to. The main issues we found were providers submitting claims that didn't follow all of the Federal and state requirements. Some examples would be just across-the-board qualifications of the attendants not being met, things like background checks, specific training, things like that. We found that proper supervision wasn't provided. There is a certain level of supervision for the attendants, and in some cases, it wasn't always met. We found instances where physician approval or authorization hadn't been set up for the service to be provided. We found instances where plans of care hadn't been approved or set up. Other cases where there was just a lack of documentation. Without the documentation, you can't tell if it is just sloppy record keeping or if the service was never provided. We found a lot of instances where we had a bill for a specific beneficiary yet we knew from data match that beneficiary was in an institution, a hospital or a nursing home, at the same time.

Those are the main type things. There are a lot of different areas across the board, a lot of high error rates, a lot of dollars as you point out. But those are I think the main buckets of the problems that we found.

Mr. GUTHRIE. Thank you. Your report also outlined a number of concerns about quality of care for beneficiaries receiving personal care service due to some of these problems. Can you outline how the Medicaid beneficiary suffers because of some of these instances?

Mr. HAGG. Well, the quality of care issues that came out of those reports, what we tried to do in a lot of those audits, not in every one but a lot of them, we tried to interview the beneficiaries receiving services. And a lot of the responses we received back had to do with the attendant stealing from the beneficiary or abusing them, or threats of abuse. I think there were cases of abandonment where the attendant would be out shopping for groceries or someplace with the beneficiary, and they would say: My shift is up. It is time for me to go, and they would leave them there. Those are the type of quality type of issues that we mainly identified.

Mr. GUTHRIE. Thank you. And the electronic visit verification systems provide information on the date, time, duration location of service as well as the type of service performed. How do you think the availability of such information will help minimize the problems you identified?

Mr. HAGG. Well, I think it would help. Of the problems that I have laid out, some of them I don't think would be addressed by the electronic visit verification, but some would. When you have cases of lack of documentation, I would think EVV would help clear that up. You are either providing the service at that location or you are not.

The same thing with beneficiaries who are in institutions at the same time were receiving a bill at the same time. The same thing for where we have time sheets of an attendant that says they were

in a different location yet we have a bill for somebody else. I think EVV would help or may help address those type issues.

Mr. GUTHRIE. Thank you. Those are my questions, and I yield back my time.

Mr. PITTS. The chair thanks the gentleman.

Now I recognize the ranking member of the full committee, Mr. Pallone, 5 minutes for questions.

Mr. PALLONE. Thank you. I understand that we have a piece of legislation here to tighten up eligibility in the Medicaid long-term care space, and I think this bill has been drafted in a way that it is careful, unlike the other eligibility legislation under consideration today, and it is drafted to guard against unintended consequences that can be harmful for beneficiaries.

However, I still remain concerned about tightening eligibility in Medicaid when overall we have no other alternative for people of low and moderate income to invest in long-term care planning so that a long-term care benefit is there for people when they need it. So before we start tightening up on Medicaid, we need to have a real conversation on long-term care in this country so that we don't take away the lifeline for people without having any other options in place.

The reality is that this legislation would change the historical consideration of a spouse's income as separate and that is a big precedent to set in the absence of long-term care reform in this country.

In addition, I understand that income and resource counting in the various eligibility pathways for long-term care in the Medicaid program are incredibly complex already.

Ms. Riley, I know that MACPAC has done a fair amount of work in Medicaid, so can you give us an overview of the commission's work on long-term care and any recommendations you have in that regard?

Ms. RILEY. I am very happy to. Obviously, this is an area of great concern for the Commission, given that Medicaid does pay, as you say, 61 percent of all the long-term care costs in the Nation, and on the converse to the point of the cost effectiveness, while long-term care clients represent about 6 percent of users, they use 51 percent of Medicaid dollars. So it is an area of great concern to the Commission.

To date, we have looked and have reported to you about the managed care, managed care initiatives and long-term care, at rebalancing between home and institutional care, and about the data needs that we really have to address to be able to address some of the broader issues.

On our plate for future work is to look at the merits of standardizing functional assessments affecting who gets into coverage, to look strongly at the quality measures in long-term care, to focus on housing and assisted living, and particularly to look at how the new Medicaid managed care regulations may impact efforts to manage care and long-term care.

Mr. PALLONE. And I understand used to be the Director of Aging in Maine. What areas of recommendations can you share for our consideration based on the challenges that you encountered in your operational experience?

Ms. RILEY. I am aging in place. That was a very long time ago.

Mr. PALLONE. Well we are all aging in place.

Ms. RILEY. I think the tragedy is that we still have a situation where in this country the majority of long-term care services are still paid for by Medicaid—we had hoped 30 years ago that might not be the case—and that Medicaid funding remains a critically important program.

I think way back in those days we were just beginning state recovery efforts, which relate very much to the work here, very important efforts to make sure Medicaid is spent properly and efficiently and effectively. And I think what one learns running the programs is the devil is always in the details. It is very difficult to think about how to implement these kind of programs, and one needs to think about all the alternatives and the administrative demands and the costs of those and weigh those against what the benefit will be.

Mr. PALLONE. I can just say I guess many people probably already know this, but I just hate the whole spend down provision. I think it is awful. I am so tired after 27 years in Congress of having these people call up my office who are involved in spend down and all the terrible implications of that. And I would really like to see them—and I know not to take away from the chairman or our Republican colleagues, I know they are not going to be in favor of some kind of Medicare, new Medicare benefit for long-term care, but I really think we need to, we really need to do that at some point because the way we operate where we make people spend down and then go on Medicaid is just, I can't imagine, I have never looked, but I can't imagine any other country in the world operates that way. It is just the most stupid thing to do. And availability of long-term care insurance is very, very limited. If anything, it seems like it is more limited.

And I know that when we did the Affordable Care Act, that we were subject to certain spending limitations. And so we really couldn't address this. We tried to do the CLASS Act and that got repealed with regard to community-based care. But for constitutional care, we just can't continue to operate this way. And I just hope at some point, Mr. Chairman, even though there may be Republican opposition, that we can have some kind of hearing or deal with this larger issue of paying for long-term care in a different way than we do. So thank you very much.

Mr. PITTS. The chair thanks the gentleman.

I now recognize Dr. Burgess 5 minutes for questions.

Mr. BURGESS. Thank you, Mr. Chairman. I will try to find a microphone where I can actually see the panelists. It may be difficult so I apologize if I am talking to you through someone. OK, Mr. Pallone brought up some points and actually used the debate to say the Republicans were not interested enough in long-term care.

Look, I haven't been on this committee nearly as long as Mr. Pallone. I will in no universe be able to spend the amount of years on the committee that Mr. Pallone has spent. But I do remember the Deficit Reduction Act of 2005. And we talked at that time about things we might do to get people interested in purchasing long-term care insurance who could afford it. And that was met with a

lot of resistance. Now, I buy my health insurance in the individual market, and as a consequence, I pay for that with after-tax dollars. So those are really expensive dollars to have to spend.

And we do the exact same thing to people who want to provide long-term care insurance for themselves or their families. They pay for it with after-tax dollars, and there has been an absolute stonewall providing any type of recognition that this was a benefit or this was an activity that we would like to encourage people to do.

I can think of no more loving gift that a parent can give to their children than to carry long-term care insurance so that they, the parent, are not a burden to their children. Not everyone can afford long-term care insurance. I understand that. I pay for a policy myself. I understand how the policies are sometimes difficult to find, and, yes, they can be expensive. We have made that harder. We made that harder with the Affordable Care Act when the CLASS Act provision was thrown in at the last minute, very little consideration, no hearings, no evidence collected. And as a consequence, companies that were involved in providing long-term care insurance, because the assumption was then made that, hey, the Affordable Care Act is now taking care of long-term care insurance, when it wasn't, and we had to abandon the provisions of the CLASS Act because they were so bad and a classic insurance death spiral that now people are, in fact, left with less than they had before.

So I apologize. I didn't mean to go off topic, but I felt that there needed to be some counterbalance to that debate. Now since I am off-topic already let me stay of off topic.

Mr. Gomez, your Governor, Mary Fallin, who served with us here in the House of Representatives several years ago, and we miss her, but we do value her service to the people of Oklahoma as their chief executive, she signed a bill last March or April that was a requirement for prescription drug monitoring, the requirement for physicians to check against a database before prescribing certain drugs. We have had I don't know how many hearings this year in the Health and Oversight Subcommittees on prescription drug abuse.

And we go back and forth with the prescription drug monitoring issue. But you guys solved it in your State when Governor Fallin signed that into law—well, it will go into effect I guess in November. So you haven't quite solved it yet. But you are on the road to doing that. When Governor Fallin was at the National Governors Association meeting this summer and Secretary Burwell was addressing that meeting, she asked Secretary Burwell about, would it be possible to require that same type of prescription drug monitoring in Medicaid? And I guess my confusion then is why does being on Medicaid somehow exempt someone from prescription drug monitoring? Or is it that this is such a good idea, we ought to use it, since there is a Federal jurisdiction for Medicaid, that we should apply it in a Federal sense across the country? Can you clarify that for me?

Mr. GOMEZ. Let me clarify by what is happening in Oklahoma is Governor Fallin and that legislation has empowered the use of a realtime database that is available to physicians and pharmacies and for us in the Medicaid program to be able to monitor prescription drug abuse in the program. And it requires physicians to look

at, when they make a prescription, to look and see if there has been some abusive pattern, physician shopping, or ER diversion, something like that, to where they have been able to see it.

Mr. BURGESS. Right. We get that. We have authorized the monitoring program here in this committee. It is called NASPER. We are in a fight with the appropriators, so they have got their own—so is there anything that prevents Oklahoma from using the database for their Medicaid patients?

Mr. GOMEZ. No. We actually have access to the database today.

Mr. BURGESS. So the same requirement that will be there for anyone else is there for Medicaid patients?

Mr. GOMEZ. Yes, sir.

Mr. BURGESS. This is an important point because, I mean, the CDC has already pointed out where the prescription drug, the difficulties with prescription drugs are expanding, state expenses and Federal expenses for prisons, jails, what have you, recovery programs. So it is extremely, if we want to talk about saving money in Medicaid, it seems to me this is one of the places where we should focus.

Mr. Hagg and Ms. Riley, let me just ask a brief question. The problem with third-party liability, a state that is paying a Medicaid bill for someone who actually has coverage from another insurance company, and there is a GAO report from—now it is over 10 years ago. It has been very frustrating to me that this cannot be, this is a problem that cannot be fixed, but is the issue of somebody who has got coverage with a regular indemnity insurance plan and yet the state is picking up the tab because that person is also covered by Medicaid. In other words, Medicaid should be the provider of last resort, not first resort. Can either of you address that?

Mr. HAGG. I would be glad to try. Over the years, we have done a little bit of work involving third-party liability. Clearly, there is probably more work that needs to be done. I know states go to great efforts through contractors and through their own staff to try to identify people on Medicaid who do have other insurance with data matches and other actions to try to recoup that money that they would have spent for those beneficiaries or to try to prevent it from going out the door to begin with. I think states do a pretty good job with that. But just like anything, there is more work that needs to be done.

Mr. BURGESS. Not according to the GAO report, but I may talk to you more about that further because it is not an insignificant amount of money we are talking about. It can be as much as 25 percent in some States.

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

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentlelady from California, Ms. Capps, for 5 minutes of questions.

Mrs. CAPPS. Thank you, Chairman Pitts and also Ranking Member Green, for holding this hearing. And we have another topic that I think we need to address, I hope we can, in terms of long-term healthcare needs. But our Nation's Medicaid Program is a critical safety net for all Americans who know that if they fall on hard times, they will not need to sacrifice their access to health care. The Affordable Care Act took great strides in streamlining eligi-

bility to the program, ensuring that it would be there for those who need it. And many of these bills would help—that we are addressing today—would help strengthen this program further. And they should be supported. But I want to focus on one which I have heard here today, H.R. 2339. And I believe that is not one of these that should be supported. I am curious about the situation of a young child whose parent may receive a lump-sum payment. So to be clear, and I think this is a common misperception, the parent receives the lump sum. But it is actually the child who is the Medicaid enrollee. And that is what the misconceptions are about. The Medicaid Program in this case is for the child. As we all know, the majority of Medicaid enrollees are children. And this is followed closely by low-income elderly and by disabled individuals, with a very small proportion of parents and low-income adults rounding out the program.

Ms. Riley, if a child's parent received a lump sum for any amount, $50,000 or whatever, and then, of course, that would be taxed I am sure, but the child is actually the Medicaid enrollee. Would the bill, as drafted, potentially count against the child's eligibility not just 1 month, but from then on? I will let you answer that question or address it.

Ms. RILEY. As I understand the bill, it would, indeed, have that potential. And our staff could certainly do some more technical analysis on that.

Mrs. CAPPS. How long could that amount potentially count against the child's Medicaid eligibility?

Ms. RILEY. As I understand the bill, if it was over $50,000, it could count for 20 years.

Mrs. CAPPS. So that that lump-sum amount, no matter what the parent or adult spent it on, would make sure this child was not eligible for a very long time.

Ms. RILEY. That would be how I would read the bill, yes.

Mrs. CAPPS. So you are saying it is possible this bill could be interpreted in a way that would cause a child to lose Medicaid eligibility for the rest of their childhood, even if the family's financial status were to change in the next 5, 10, or 20 years or even in the next month because that lump sum is a precarious amount in some respects.

Ms. RILEY. Right. And it gets stretched over months, yes.

Mrs. CAPPS. Right. I think this actually has, as it is being interpreted differently by many, I find it very concerning in the underlying challenges because it is, the truth is that H.R. 2339 could have many unintended consequences, consequences that could keep poor kids from care really for their lifetime and leave many others in limbo because the eligibility isn't an overnight thing. So please comment, I have some other time and this is the topic I wanted to address, if you would like to make further statement about it.

Ms. RILEY. I think that is a possibility. I think the definition is broad. And I think it would also depend on how each state would interpret it. So it would also be a variation in the program across states.

Mrs. CAPPS. I see. So this is something that I can't support. And I hope my colleagues will reconsider their, if they are supporting it, because I think on the surface it may seem very attractive, but

underneath there's some unintended consequences that I think could be very harmful. And it goes back to the basic thought that it is the parents who receive the benefit when it actually is Medicaid in most cases in this case are designed to benefit poor children and those with disabilities. Thank you.

I yield back the balance of my time.

Mr. PITTS. The chair thanks the gentlelady and now recognizes Dr. Murphy for 5 minutes for questions.

Mr. MURPHY. Thank you, Mr. Chairman.

Thank you, panel, for being here.

As we are talking about the integrity here, one of the things we had a hearing on in our Oversight and Investigations subcommittee, which I chair, was the idea that Medicaid has $17.5 billion in improper payments and maintains a high threshold of tolerance on that. I want to talk about one area where it is not just going after those who are being fraudulent but a policy within Medicaid—and Mr. Hagg particularly, get your comments on this—in HHS' OIG report from March of this year, it was entitled "Second Generation Antipsychotic Drug Use Among Medicaid-Enrolled Children: Quality-of-Care Concerns." I don't know if you are familiar with this report.

Mr. HAGG. Not overly, no.

Mr. MURPHY. OK. Then I will give you some information on it.

Mr. HAGG. Great.

Mr. MURPHY. They describe in there that 8 percent of second generation antipsychotics, otherwise known as SGAs, were prescribed for the limited number of medically accepted pediatric conditions, only 8 percent. That means 92 percent of claims that were not prescribed for medically accepted pediatric indications were off label, off label. There is a quality of care concern that was identified in this report and medical records where 67 percent of claims for SGAs prescribed for children. And there was two or more problems for 49 percent. I will read you one of the case studies.

A 4-year-old child diagnosed with ADHD and a mood disorder in which—this was reviewed by a child and adolescent psychiatrist. They said there was no evidence in the child's medical history of any monitoring while the child was taking the sampled SGA. The reviewer stated that individual, family, and behavioral therapy should have been attempted before initiating treatment with drugs. However, there was no evidence in the child's medical record indicating that such therapies were attempted. They also went on to say that the child was prescribed four psychotropic drugs during the review period of which two were antipsychotics. The reviewer noted there was no appropriate doses prescribed of antipsychotics for this child's condition. And the reviewer stated that the treatment with the SGA was not appropriate for a 4-year-old.

Now, it made a series of recommendations. First, to work with state Medicaid Programs to perform utilization review of SGAs prescribed to children. Second, CMS should work with State Medicaid Programs to conduct periodic reviews of medical records associated with claims for SGAs prescribed to children. And, third, CMS should work with states to consider other methods of enhanced oversight of SGAs prescribed to children, such as implementing peer-reviewed programs. Apparently, CMS concurred with all these

recommendations. Are you familiar with any of this? Do you know if any progress was made on any of these recommendations?

Mr. HAGG. Unfortunately, I am not familiar with that work. I would be glad to take questions back to my colleagues at the OIG and get back to you with answers.

Mr. MURPHY. Would you, please? Thank you.

Either of you familiar with this as state issues?

Ms. RILEY. It is very serious issue. And I know, I believe that is the report, Congressman, that spoke specifically to foster children and their disproportionate use of these.

Mr. MURPHY. Yes, in 2011, talked about foster children. This looked at a wider range of kids. But, yes, you are right about that too.

Ms. RILEY. I know that MACPAC has taken that under very serious attention and is looking at, particularly around the focus on foster children, and we reported on that in our June 2015 report to Congress.

Mr. MURPHY. So here is something I am thinking for the states and also with regard to your office too, sir, we are all very concerned about people who are involved with waste, fraud, and abuse. But there is a Medicaid policy that says you can't see two doctors in the same day, same day doctor rule. So the pediatrician identifies, a mother brings a 17-year-old to the doctor and says, "I am very concerned, my son is talking to himself; he is hearing voices; he is doing poorly in school; he has lost his friends; he is isolated," and that pediatrician rightfully says, "We need to have you see a psychiatrist immediately. This is a very serious concern. Oh, you are on Medicaid? I am sorry, you have to go home." This is the rule.

And so what happens is, I wonder if this is perhaps one of the reasons why over 72 percent of antipsychotic drugs are prescribed by nonpsychiatrists. You can imagine the outrage if I said 72 percent of heart surgeries were performed by people who weren't surgeons. So what I see here is while people may be operating within the rules of Medicaid, it may be actually inviting these kind of improper cases. So when we look at what has happened in the past where this committee has rightly been concerned, 50 deceased providers and 50 providers who have been excluded from Medicaid and people on suspended or revoked licenses can all bill Medicaid, my concern is we have rules within Medicaid that say just because you have an M.D. or D.O. After your name, you can still prescribe. But we end up with what I think is a pretty amazing report from the Office of Inspector General saying something is wrong here. And I hope that this is something that States comment on and your office comments on too and recognizes that part of the problem we have here is to fix this.

This committee, everybody in this committee knows we have to fix things in mental health. People have got some tremendous ideas how we are going to do this. But I hope this is one of those areas that Medicaid can also review to fix this harm that is happening to our children.

Thank you. I yield back.

Mr. PITTS. The chair thanks the gentleman.

Now recognizes the gentlelady from Florida, Ms. Castor, 5 minutes for questions.

Ms. CASTOR. Thank you, Mr. Chairman.

And good morning. Like many of the other members, I am very concerned with the unintended consequences of H.R. 2339. Medicaid eligibility was recently updated. And it was tied to the modified adjusted gross income measure to streamline eligibility and prevent gaps in coverage. Now, H.R. 2339 proposes a surgical change in the law to prevent lottery winners from maintaining Medicaid eligibility. But as currently drafted, children and other individuals may be affected by the change. In MACPAC, a relatively quick review of this legislation, can the Commission foresee problems with implementation and unintended consequences?

Ms. RILEY. We don't take positions on particular pieces of legislation. The staff has looked at this. And I think the concerns are around the definition of lump sum and the discussions we have earlier that, in fact, it could catch payments for disability, for an accident, for somebody who has been paid a disability payment. We know that there is a 2-year wait for people for SSDI. And then there is often a lump-sum payment for the person who may, in fact, have medical bills to pay. So I think the issue here would be the issue of how broad the definition is.

Ms. CASTOR. Right. So we have some work to do here. Many of the bills on the agenda today target provider fraud and individual eligibility. But I would like to ask you all as experts whose responsibility is it to enforce Medicaid and the Social Security Act statutes when a state does not follow the law? Mr. Hagg?

Mr. HAGG. Well, CMS is responsible for the broad Federal oversight of the program.

Ms. CASTOR. I know this probably has never happened in Oklahoma. But, generally speaking, what is your answer?

Mr. GOMEZ. Well, CMS has the oversight. And it is one of those things where we have auditors in our office every day looking at every aspect of the program, both Federal and state level.

Ms. CASTOR. OK.

Ms. RILEY. CMS.

Ms. CASTOR. And can you give me an example where a state was in violation of the law under Social Security Act, Medicaid statutes, and they took action and addressed the situation?

Mr. HAGG. Yes. A lot of the examples that we see in that area have to do with state financing arrangements, mechanisms the states use to help fund the state's share of Medicaid payments. At times, we see states pushing the limits or working in gray areas to try to obtain Federal Medicaid funds in some cases when they shouldn't be, when it is inappropriate. And those are examples when CMS would need to jump in and take action.

Ms. CASTOR. Ms. Riley, what about when a state limits access to care and, for example, children are being denied access to pediatricians or specialists? Have you seen an example where CMS came in and did some kind of enforcement action or exercised their oversight?

Ms. RILEY. Let me get back to you and ask the staff to make sure that we do a comprehensive review. But there certainly is CMS oversight.

Ms. CASTOR. Mr. Gomez, do you know of an example there?

Mr. GOMEZ. Speaking for Oklahoma, in my 15 years in the Medicaid Program, we have never found, been found to have violations.

Ms. CASTOR. Here is what I am getting at, and if you all can look at this situation, at the end of December, a Federal court judge said to the State of Florida that your restrictive networks for specialists and pediatricians, they are so restrictive that you have, in effect, denied access to care for kids to medical services. They weighed in on reimbursement rates that are so low that they can't get doctors to participate.

During the 8 months, in the interim, the State of Florida, rather than stepping up and saying, "OK, we are going to rectify the situation," has said, "Talk to the hand, no. In fact, we are going to continue to limit these networks." And all of the children's medical directors across the state now are in protest because children now are being screened out. They don't have access to specialists. And it would seem that, especially after the Armstrong case by the U.S. Supreme Court, that it really is up to CMS to enforce and step in. I don't know what else these kids can do if they have to rely on Federal regulators.

Ms. RILEY. And that is the charge of the Medicaid and CHIP Payment and Access Commission. It is the broad set of activities in which we are engaged. And I am not familiar with this particular case. But I am certain—we have a Commission meeting coming up, and I can assure you it will be one of the topics we talk about.

Ms. CASTOR. Kids across Florida would be grateful if the Commission would take a look. Thank you.

Mr. PITTS. The chair thanks the gentlelady and now recognizes the gentleman from New Jersey, Mr. Lance, 5 minutes for questions.

Mr. LANCE. Thank you very much. And good morning to you all. My last name is Lance. I am sitting here because I would like to interact with the distinguished panel. I don't know a lot about this issue, but I am certainly interested in it. And I come from a small family law practice where, on occasion, middle-aged children come into the law practice—my late father and my twin brother who practices law now—wishing to impoverish their parents. And we throw them out of the office. And this is an issue that concerns me greatly.

Now, am I right, did I hear you say, Ms. Riley, that 60 percent of all nursing home costs are through the Medicaid Program?

Ms. RILEY. Long-term services and support.

Mr. LANCE. And am I right that 37 percent of all child births in this country are through Medicaid?

Mr. GOMEZ. In Oklahoma, it is about 60 percent.

Mr. LANCE. Sixty percent of child births. Now, Medicaid, as I understand it, is a shared program?

Mr. GOMEZ. Yes, sir.

Mr. LANCE. Costs borne by the Federal Government and costs borne by the State Government?

Mr. GOMEZ. Yes, sir.

Mr. LANCE. But it is not equal across this country. And it depends on the state—is that accurate?—as to percentages?

Mr. GOMEZ. Yes, sir.

Mr. LANCE. And in Oklahoma, what is the percentage?

Mr. GOMEZ. This October, it will be 60.99 percent.

Mr. LANCE. Roughly 61 percent is paid by——

Mr. GOMEZ. The Federal Government.

Mr. LANCE [continuing]. The Federal Government. That certainly is not true in all of the states?

Mr. GOMEZ. No, sir.

Mr. LANCE. I live in New Jersey. And we pay more than most states. Is that accurate?

Mr. GOMEZ. I believe so.

Mr. LANCE. And there are states that pay as much as 50 percent. And New Jersey is one of them. So this is not a program that is equal across the United States.

Now specifically regarding the impoverishment of parents or of a spouse, you are telling me, Mr. Gomez, that the 10th Circuit has ruled that there can be no clawback for annuities? Is that what are your telling me?

Mr. GOMEZ. Yes, sir.

Mr. LANCE. Could you explain that in a little greater detail to me? Because this certainly interests me greatly.

Mr. GOMEZ. Let me find the note on that particular section.

Mr. LANCE. Take your time. Here in Washington, everybody is in too much of a rush.

Mr. GOMEZ. The rationale of the court's decision in Morris and similar cases has been extended in other courts in at least on the 10th Circuit decision to other financial vehicles that similarly thwart Medicaid's intended purpose. In particular, we have seen an increase in the use of non-assignable, nontransferable promissory notes. But that is not the issue, but the issue of annuities, to shelter assets, which the courts have——

Mr. LANCE. And this means that a couple go to an insurance company and give that insurance company $100,000 or $200,000 or $5000,000, purchasing an annuity. And then when one of the couple go into a nursing home, there is the claim that that half of the marital unit is impoverished and the other spouse can receive 100 percent of the annuity. Is that what is occurring?

Mr. GOMEZ. Yes, sir.

Mr. LANCE. And the 10th Circuit said that was legal?

Mr. GOMEZ. What they are saying is that, the court's ruling essentially permits a married couple to shelter potentially an unlimited amount of assets through a non-assignable, nontransferable annuity in order for the spouse of medical need to qualify for Medicaid.

Mr. LANCE. And is that based upon the fact that we have not contemplated that here and the Mullin legislation would rectify that?

Mr. GOMEZ. Let me go back and say Medicaid statutes allow for a spouse of a Medicaid applicant for long-term care services to keep a certain amount of his or her resources.

Mr. LANCE. I understand that.

Mr. GOMEZ. So the amount of the spouse of the applicant is referred to as community spouse and the institutionalized spouse. The amount the community spouse is allowed to retain is called the

community spouse resource allowance, CSRA. So, in general, Medicaid will divide that couple's total resources in half to determine the CSRA. What the 10th Circuit said is that money can be diverted in that where the spend down can be achieved and still protect——

Mr. LANCE. Thank you. I am sure this is not a large problem in the number of persons who utilize this loophole. But I certainly think that it should be closed and closed pronto. And I commend Congressman Mullin in his efforts. And I think the purpose of the law is not to permit this type of diversion. And I certainly think that it borders on fraud and, in my opinion, is immoral.

Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman.

I now recognize the gentlelady from Illinois, Ms. Schakowsky, for 5 minutes of questions.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman. We have talked about that personal care services may be an area that is vulnerable to fraud. And we must make sure that beneficiaries are receiving the services that they need at the right time in the right way. However, I have concerns about a penalty on the State's FMAP in an environment with Medicaid, where Medicaid Programs really are struggling right now administratively.

So, Ms. Riley, I know that MACPAC has not extensively studied this issue. But the Commission has looked at Medicaid administrative infrastructure. Could you tell us, what are some of the challenges that are being faced in this space?

Ms. RILEY. In the verification space? The states have an array of activities which they pursue. And I think the notion of electronic validation raises questions about the cost of that. It is, again, the cost-benefit tradeoff. I think there are 9 or 10 states that currently have those systems. They have said that they are succeeding in getting savings from those activities. But I don't, we are not aware of any evaluations that have been underway or completed that would tell us really what the cost-benefit analysis of that verification activity is.

Ms. SCHAKOWSKY. That is what I am concerned about. Because if the state doesn't implement the electronic verification system, under this legislation that is being considered, they face a cut in their Medicaid reimbursement. But there aren't any start-up funds or implementation funds before the penalty begins to go into effect. So is it possible that when States spend Medicaid dollars to build these systems, they are going to need to decrease the spending that they have on services? Basically, what is the tradeoff?

Ms. RILEY. Well, it is obviously a laudable goal to make sure we root out any fraud and abuse in this very important area. It is a $16 billion spend. The elderly and people with disabilities depend on these services. That said, I think it is a good example of one of the issues that MACPAC has raised in one of its reports. We pay fraud and abuse and fraud control units with a 75/25 match. But we pay for the activities like EVV with a 50/50 match. So there are not startup funds, and there is sort of a disincentive to do the frontend activity with a lower match rate, but a higher match rate to go get them when there is a mistake or fraud has occurred. So I think it raises an important question that MACPAC has raised

in the past about whether we ought to invest differently in state administrative functions that could better prevent fraud and abuse.

Ms. SCHAKOWSKY. So is this decision-making underway right now at MACPAC?

Ms. RILEY. It was a recommendation from MACPAC in I believe our March 2012 report and a discussion that we have had numerous times with the states. It is really frustrating that one wants to do more to prevent fraud and abuse. And that enhanced match could address. Of course, that is a cost to the Federal Government, so it is easy to talk about and difficult to do. But I think it is, again, a balancing act of how much to invest after the fact to go and recoup from fraud and abuse practices versus before the fact to try to prevent them. And EVV is a good example of such an initiative.

Ms. SCHAKOWSKY. So how can we get at a real cost-benefit analysis then?

Ms. RILEY. I think it would be useful, there are the 10 states like Oklahoma that are now engaged in EVV. And I think it would be a fairly quick kind of study. And I will certainly speak with our staff about whether we can take a look at that.

Ms. SCHAKOWSKY. OK. I do want to go back to this issue that was raised by Representative Castor about the issue of the treatment of lottery winnings and other lump-sum income. You spoke to it a bit. I mean, it is one thing to talk about a lottery winner and, you know, millions of dollars or whatever. But it really does lump, if you will, together these other things—and you actually raise the issue of disability. I am really worried about that, that, as you pointed out, that disabled individuals frequently have to wait a year or more, you mentioned 2 years, for their application to be processed for disability. And that is after the mandatory 2-year waiting year. And, generally, they are paying for other living expenses and medical bills during that time. So if they are eventually determined to be eligible for SSDI and then get a lump-sum payment to cover that waiting period but that then deprives them of the Medicaid benefit, then how are they to pay back all the expenses that they had while they were waiting?

Ms. RILEY. I think that is a question in the drafting of the bill about how broadly one defines "lump sum."

Ms. SCHAKOWSKY. I just think that putting those two things together, that there ought to be—I totally get somebody strikes it lucky and gets the lottery. But I am over my time. Thank you.

Mr. PITTS. The chair thanks the gentlelady.

I now recognize the gentleman from Florida, Mr. Bilirakis, 5 minutes for questions.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it.

Commissioner Riley, our U.S. territories have Medicaid programs. But unlike the states, they have different rules that govern their Medicaid Program, such as eligibility or payment rules. Can you briefly talk about how their program may differ from the mainland if you think CMS should provide this type of information on its central Web site like they do for the states?

Ms. RILEY. Again, Congressman, we haven't taken a position on this. But the MACPAC has long been a supporter of good, consistent data from all the states and territories. I think this bill in-

cludes the same sorts of information states now must report. So it is very much related and would be consistent with what states now have to report.

Mr. BILIRAKIS. Thank you. Thank you.

According to Puerto Rico's Resident Commissioner, the Ways and Means Green Book used to have a chapter on social welfare programs from the territories, such as Medicaid. However, that chapter has been removed because a nonpartisan Congressional Research Service, CRS, could not find enough publicly available information to keep it accurate and up to date.

Commissioner Riley, MACPAC is the nonpartisan legislative branch agency that provides Congress with policy and data analysis for Medicaid and CHIP. If Congress needs information to make policy decisions, for example, if the ACA Medicaid funding for Puerto Rico will be entirely spent before 2019, what does MACPAC have to do to find information on the territories to carry out your advisory role?

Ms. RILEY. That is a very good question. We have a wonderful staff who provide detailed information to us. And we can certainly take a look at how much we report on the territories.

Mr. BILIRAKIS. Thank you. Please get back to me on that as well.

Ms. RILEY. We will.

Mr. BILIRAKIS. Mr. Hagg, do the territories have the same Medicaid data reporting requirements as the 50 states and the District of Columbia? If so, can you think of a reason why CMS would not include the same information about the territories as they do for the 50 states and D.C.?

Mr. HAGG. I believe they do have the same reporting requirements. And no, I can't think of a reason why it couldn't be shared.

Mr. BILIRAKIS. OK. Good. Mr. Hagg, again, I know that you don't take positions on pieces of legislation. I understand that. But, in general, does OIG typically favor greater transparency?

Mr. HAGG. Yes.

Mr. BILIRAKIS. In general.

Mr. HAGG. Yes. In general, more transparency is better than less.

Mr. BILIRAKIS. Very good. Thank you.

I yield the rest of my time to Representative Guthrie.

Mr. GUTHRIE. Thank you. Thank you for yielding. I want to clarify a question just before, one of the questions was about the cost of EVV Programs and on the states, and my legislation mandates providers use EVV. It does not mandate that states purchase or spend anything to create its own program or moving forward. The disparity between EVV and fraud system is not a disincentive at all. And states should still have an incentive. And there are already people out there that are doing EVV and the states aren't building a program, aren't setting up a program. It is not separate and distinct. There are people currently doing this, so it wouldn't cost the states money. I just want to clarify that point. Thank you.

Mr. PITTS. The chair thanks the gentleman.

I now recognize the gentleman Mr. Butterfield 5 minutes for questions.

Mr. BUTTERFIELD. Thank you very much, Mr. Chairman. Thank you for holding this important hearing today.

Thank you to the witnesses for your attendance. Mr. Chairman, several weeks ago, we all celebrated the 50th anniversary of Medicaid. It was a great day. The benefits of Medicaid cannot be overstated. More than 72 million Americans rely on this program. Seventy-five percent of children who live in poverty in this country depend on Medicaid. Greater than 10 million school-aged children who live in poverty depend on Medicaid.

I represent, Mr. Chairman, one of the poorest congressional districts in the country. More than one out of every four people in North Carolina's first congressional district lives in poverty. One out of three of our children live in poverty. Medicaid is absolutely critical to my constituents. It is especially important to children in eastern North Carolina. As I child, I graduated from high school in 1965, the year of the enactment of Medicaid. And I recall, as a child, as a high school student, none of my classmates ever, ever, ever received any type of medical treatment or dental treatment because they couldn't afford it because 90 percent of our school students lived in poverty.

Democrats on this committee have done our part to strengthen Medicaid. I want all Americans to understand and appreciate the importance of Medicaid. The Affordable Care Act, which was drafted by this committee, it actually strengthened Medicaid. I remember the debate so well. It strengthened Medicaid's integrity by requiring regular risk-based grading of providers and suppliers. The ACA increased termination authority to ensure that malicious actors cannot participate in the program. And so it is abundantly clear that the ACA improved the integrity of the Medicaid Program across the board.

So I am interested in hearing more today about how to ensure that the ACA termination requirements are upheld. We want to uphold those in each and every state. I am also interested in protection Medicaid beneficiaries from potentially harmful changes to eligibility.

Mr. Hagg, Director Hagg, thank you. The integrity of the Medicaid Program is critical to ensure that beneficiaries are not taken advantage of. It is important that the Federal Government and our States work together to ensure Medicaid beneficiaries have access to care, reliable care. Can you describe, sir, whether the ACA strengthened the law to prevent providers terminated for cause from operating in other states?

Mr. HAGG. It did, yes. There is a requirement that if a provider is terminated in one state or Medicare, they are required to be terminated in other states as well. So, yes, it is a very good upfront program integrity control to ensure that bad actors aren't able to access state Medicaid programs.

Mr. BUTTERFIELD. Has the ACA had a positive impact as of this date in reducing the number of terminated providers from operating in other states?

Mr. HAGG. Yes, it has. It is a start for sure. It was CMS' responsibility to try to set up a central data system that would house all the terminated providers so that other states could access. Based on our work, we found various limitations with that database. We found that, based on some testing we performed, there are some providers still that are terminated in one state that are still oper-

ating in other states. And we have made recommendations on how to improve that so those things don't happen any longer.

Mr. BUTTERFIELD. If you know, will the draft legislation that I am working on in conjunction with Mr. Bucshon address the recommendations made by OIG to further eliminate the participation of terminated providers?

Mr. HAGG. Most of the problems we found would be addressed. The one difference I would point out is we have recommended that providers who operate in managed care environments be required to enroll as providers. I believe the legislation talks about having the providers register with the state and then a process of having the state notify the managed care network if that provider should be terminated. That is a good start. We believe having them enroll rather than register would create that direct legal authority between the state agency and the provider.

Mr. BUTTERFIELD. All right.

Finally, Commissioner Riley, you mentioned in your testimony that Federal rules are already in place to prevent providers terminated in one state from operating in others. Are those Federal rules as a result of the ACA law that we have been talking about?

Ms. RILEY. I believe that is correct.

Mr. BUTTERFIELD. Would you agree that the ACA has strengthened the Medicaid Program's integrity?

Ms. RILEY. Yes. And I think CMS has restructured and strengthened its work with the states as well.

Mr. BUTTERFIELD. Thank you. Thank all three of you.

I yield back.

Mr. PITTS. The chair thanks the gentleman.

I now recognize the gentleman from Indiana, Dr. Bucshon, for 5 minutes of questions.

Mr. BUCSHON. Thank you, Mr. Chairman.

Along that same line, Mr. Hagg, we were talking about, Mr. Butterfield was talking about, does CMS require reporting into their system? Because from the information I have, at this point, over a year and a half after your recommendation, 4 ½ years after the ACA requirement, CMS does not require such reporting of terminated providers. Is that true or not true?

Mr. HAGG. That is my understanding as well. We have made the recommendation that it be required. I think CMS said they concur with our recommendations. But then they pointed to information provided to states that talks about being encouraged. It doesn't talk about being required.

Mr. BUCSHON. You probably know in government agencies, if you encourage something, it never happens; you have to require it most likely. And other than that, have they given an explanation of why they haven't required it?

Mr. HAGG. Beyond that, no.

Mr. BUCSHON. OK. Can you also talk about the challenges that states may have faced in complying with the Medicaid requirements to terminate a provider's participation in their Medicaid program if that provider is terminated for cause from a Medicaid Program from another state?

Mr. HAGG. Sure. The challenges are that there needs to be a central data set that states can look to to determine whether a provider has been terminated in another state.

Mr. BUCSHON. So really CMS needs to have a required reporting to a database?

Mr. HAGG. We believe so, yes.

Mr. BUCSHON. OK. And in your opinion, does the draft bill address this challenge, some of the states' challenges do you think?

Mr. HAGG. My understanding, the draft bill makes it a requirement, yes. Again, the one thing I would point out is that we do recommend that managed care providers enroll rather than register.

Mr. BUCSHON. Understood. And we are also talking about for cause. So can you give maybe some examples of why a provider would be terminated for cause from the Medicaid Program?

Mr. HAGG. Yes, for cause would be they have committed fraud or patient abuse. Or some other type of billing privilege that they have abused. Rather than just being an inactive biller, that wouldn't be for cause.

Mr. BUCSHON. Is there quality determinations in there too?

Mr. HAGG. Absolutely, yes. If there is some type of patient abuse or a quality care issue, absolutely.

Mr. BUCSHON. And that would be reported to the state or to CMS if they had those issues?

Mr. HAGG. If the state is aware of that, that type of abuse, then, yes. If they terminate that provider for cause, they should report that provider to CMS.

Mr. BUCSHON. Mr. Gomez, could you talk maybe about the process of terminating providers from your state Medicaid Program and how that process works in your state?

Mr. GOMEZ. We have a 30-day with cause termination and a 60-day without cause termination.

Mr. BUCSHON. So I am talking about the process of, how do you determine that it is for cause? Who does that in your state, for example? I am just trying to get——

Mr. GOMEZ. We have a Medicaid Fraud Control Unit, as each state does, and we rely heavily on them in the determination of fraud. And then we actually have through our contracting system the ability to go—if we have a new provider coming into the state—the ability to go look on the database and see if that provider has been terminated in other state.

Mr. BUCSHON. So, for example, I was a physician before. So there are physicians that get their privileges terminated at their hospital for a variety of reasons, right. Does that type of information get to the state?

Mr. GOMEZ. It does. We have an agreement with the licensure boards in order to be able to share that information. If there is a licensure issue, we will be able to take appropriate action within our contract.

Mr. BUCSHON. Thank you, Mr. Chairman.

I yield back.

Mr. PITTS. The chair thanks the gentleman.

I now recognize the gentleman from Maryland, Mr. Sarbanes, 5 minutes for questions.

Mr. SARBANES. Thank you, Mr. Chairman.

Ms. Riley, I apologize if the topic has been touched upon already or this question in particular. But I am interested in this, the bill that relates to someone converting assets to income through purchase of an annuity and the proposed change for how that might be handled. I gather that right now there is some protections that make the state the ultimate beneficiary of annuity proceeds in the case where that spouse dies. So there is a way for the state to benefit.

But now there is a proposal to I guess divide in half the proceeds during the period in which both spouses are alive, one being in the institution and the other being still at home. And I just wondered if you could speak to what you think, first, the incidence of, like, how frequently do you have a sense the situation is even arising where somebody is doing that annuity purchase under circumstances where there is a spouse that is institutionalized, and then within that universe, how often it is the case that the amounts we are talking about would be such that you could argue that they were trying to kind of waste or hide or redirect assets that would otherwise create a profile that would disqualify the spouse from institutional care?

And I would imagine, as well, that if somebody for the right reasons was converting assets to an income stream, that if you required that 50 percent of that be allocated to the institutionalized spouse, you might create a situation where the spouse that remains at home would actually qualify faster for institutional care based on their profile because there is a reduced amount of income available to them. So in terms of the income profile, you might actually be adding someone onto the state's burden who otherwise because of a smartly purchased annuity would be able to cover their expenses through that if they ultimately ended up in an institutionalized setting. So maybe you could comment on some of those issues.

Ms. RILEY. The law currently protects the spouse at home to a max of $119,000. I don't believe there is any data that I am aware of, we can certainly have the staff look at this, that talks about the number of people who would be eligible for this kind of annuity. I suspect it is small. And you are correct, there remain the estate recovery provisions for long-term care, so that the state is compelled by Federal law to go after the remaining estate after the death of the spouse.

Mr. SARBANES. All right. Thank you.

I have no other questions.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from New York, Mr. Collins, 5 minutes for questions.

Mr. COLLINS. Thank you, Mr. Chairman.

I want to thank all the witnesses as well. We are delving into something. And I do think, regardless if there is some disagreement, we all do agree no one wants to see the system gamed. As Mr. Lance said, you know, he will throw somebody out of the office if they walk in to explicitly game the system.

But a couple other questions, I may delve into that a little bit, but my question, Mr. Gomez, the electronic verification system that—Oklahoma uses that as I understand?

Mr. GOMEZ. Correct.

Mr. COLLINS. Give me an idea of what Oklahoma would consider the return on that investment, was an investment to get into that.

Mr. GOMEZ. We actually with that independently evaluated. We have been in the EVV system for a little over 5 years. And the first 3 of that system, Oklahoma has had a 5-to-1 return on its investment through cost savings and cost avoidance.

Mr. COLLINS. That is what I expected. And I guess I would just point out for anyone who is a little bit worried that whether the Federal Government piece is 75/25 or 50/50, I know if I am running a State and the return is 5 to 1, I don't even need the Federal Government to pay any of it. There is smart, and there is stupid. So while we would all like to see perhaps if you are in the state the Federal Government paying 75 percent, I don't know too many things in life that are 5 to 1. So, Mr. Gomez, I appreciate that.

Now, we talked a little bit about annuities. I think Mr. Sarbanes made it sound like if there is an annuity, half of that annuity goes to the community spouse, and half goes to the institutional spouse. But isn't it true that in gaming the system, the annuity can give 100 percent to the community spouse?

Mr. GOMEZ. That is my understanding, yes.

Mr. COLLINS. Right. And that is a big difference. So it isn't like they are buying this annuity and giving half the money to the institutionalized spouse. In fact, the whole way of gaming the system is buying an annuity where none of it goes to the institutional spouse. The community spouse gets all of the benefit going forward, and it doesn't count. I mean, that is how you game the system. So I just wanted to be clear. It was left kind of hanging there that in the annuity, half of that would be going to the institutionalized spouse, and that is not the case.

In your written testimony, Mr. Gomez, you also mentioned promissory notes. You didn't really cover that. And I think we know what annuities are, and it is certainly clear how that could be gamed. Can you maybe in just a very short time, is there also an issue on promissory notes?

Mr. GOMEZ. Yes. I think what we are seeing as we are dealing with the annuities in the state of Oklahoma, we are seeing the practice then change to a number of applicants using the court's logic to extend that to promissory notes, to where, again, they are using, it is the same impact, so it is where you are able to shelter some of the wealth from that in a way that is not intended.

Mr. COLLINS. So I guess it just goes back, there is creativity in the financial world as we saw with derivatives. That didn't go so well. But there are hedge funds out there. The minute smart people get together and say how are we going to game the system—whether it is on taxes or, in this case, on impoverishing yourself—there is a lot of folks that make a lot of money coming up with the next financial product to get past the law. And I guess the real issue here is the fact that Congress plays a role. Is that really what the courts ruled? It was almost like saying: We know this is wrong, but if Congress doesn't act, there is nothing we can do.

Mr. GOMEZ. Correct. That is what the 10th Circuit effectively said.

Mr. COLLINS. And I guess, the other thing that came out in the hearing, one of the things about going almost last is you get to

hear the other testimony, is some thought, frankly, by the other side that parents aren't responsible for their kids. Oh, my God, the parent won the lottery; the kid might not be on Medicaid. I think it is the fundamental responsibility of parents in the United States to take care of their kids. If they have got money and wealth, their kids shouldn't be on Medicaid. And if there is a way, because somebody has won the lottery literally, their kids shouldn't be on Medicaid. We shouldn't apologize for the fact the family is wealthy now; the kids aren't going to be on Medicaid. That is what parents do. They take care of their kids.

So, again, back to this piece, and we have nuanced the issue of spreading it out over 1 month. But it isn't like you count it, if they win $100,000, that $100,000 doesn't count every month for the next 20 years to disqualify the child. It counts now for 1 month. But if you won a few thousands dollars, a state could decide how to implement this. And if they did spread it over time, it might be $100 dollars a month, and that is not going to disqualify the child anyway. There was some insinuation that this one-time winning of, $20 million is $20 million, but $20,000 would then disqualify this child from Medicaid for the rest of their life. But if you took $20,000 and you then spread it over 20 years, that is $1000 a year. Then you spread that over 12 months, you are talking about $90 a month. That is not going to disqualify a child from Medicaid, is it, Ms. Riley?

Ms. RILEY. I don't believe so. I think the example is a higher number. And I think that is the issue with the definition.

Mr. COLLINS. Sure. And if it is $20 million, the kid shouldn't be on Medicaid. We do have to be careful in our wording. But in this case, as far as I know, it would go back to the states to decide how to implement it. States are not in the business of hurting their own citizens and certainly not hurting children. At some point, at the Federal level, we just need to trust the judgments of our elected is officials in the 50 states and our territories to do what is right by their folks and not try to nuance this in a way that, quite frankly, is disingenuous.

Thank you, Mr. Chairman. I yield back.

Mr. PITTS. The chair thanks the gentleman, now recognizes the gentleman from New York, Mr. Engel, for 5 minutes for questions.

Mr. ENGEL. Thank you, Mr. Chairman.

Thank you, Mr. Green.

You know, nobody wants anyone to game the system. I certainly don't. And I think that we need to crack down if people are gaming the system for sure. But I think we have to be careful not to imply that somehow Medicaid needs to be denigrated because people are gaming the system. Medicaid is something that is very, very important. It is a critical safety net. There is some hostility around here toward it, and I think that we need to point out how important it is. There are 72 million Medicaid beneficiaries. There are many Americans who face economic hardship or sudden exorbitant healthcare costs. And I want to talk about my state of New York. We have made significant strides in our efforts to reform Medicaid, both in terms of cutting costs and improving the quality of care that patients receive. Governor Cuomo, in June, announced that over the past year, Medicaid spending per person in New York fell

to a 13-year low. And during the same period, the Affordable Care Act allowed more than half a million additional New Yorkers to enroll in Medicaid, which is, I think, a significant step in the effort to reduce the number of Americans who are uninsured. New York has also had success boosting program integrity through the use of corporate integrity agreements. And these agreements are extended to providers that had compliance issues, an alternative to barring the said providers from the Medicaid Program and consequently triggering service shortages to beneficiaries. Corporate integrity agreements afford these providers opportunities to improve their compliance and set up mechanisms through which their compliance can be monitored more closely.

In 2013, corporate integrity agreements allowed New York's Medicaid Program to save over $58 million. That is significant. So, Ms. Riley, I would like to ask you this, I understand that MACPAC has recommended that CMS disseminate best practices concerning program integrity so that states may replicate other states' successes. Would New York's success, as I just mentioned, using corporate integrity agreements be considered a best practice worth emulating? And, more broadly, can you speak to the value of focusing more of our efforts on sharing best practices like the example I have outlined?

Ms. RILEY. MACPAC is very much concerned about that. There is quite a disparate set of activities across the states. And I think the New York example sounds very intriguing. I think part of the problem is we don't have a good definition of what best practices are and what works and what doesn't. So it would be helpful to be able to have a set of criteria against which to measure state activities and then disseminate those that work across the country. And it was very much a recommendation of MACPAC.

Mr. ENGEL. Thank you. So if something works in one state, it may not work in every state, but it may work in many more states?

Ms. RILEY. That is right. It may not work in Oklahoma, but Oklahoma may be able to tweak it a bit so it works better. And that certainly is an experience that we have seen in MACPAC.

Mr. ENGEL. Thank you. My second question concerns H.R. 1771. Mr. Sarbanes referred to a little bit. It would modify the manner in which spousal income purchase through an annuity would be considered in evaluating eligibility for nursing home coverage. And let me, Ms. Riley, go to you again. I know that MACPAC has done a lot of work regarding long-term care in the U.S. Is it accurate to say that Medicaid provides the sole form of long-term care insurance in the U.S. today?

Ms. RILEY. It provides 61 percent of all spending on long-term care services.

Mr. ENGEL. As a follow up, can you speak to the importance of protections against spousal impoverishment in states with high costs of living, like New York? Might this legislation have the unintended consequences of leaving a community spouse with very meager resources because she happens or he happens to live in a high-cost-of-living state like New York?

Ms. RILEY. Well, I think that is always a question in these adjustments about the difference in cost of living across the country. And that is a very legitimate question. Obviously, today spouses

are protected up to the limit of $119,000. It is interesting to think about the unintended consequence that could occur if this bill passes and that would be to wonder if people would stop buying annuities and then maybe become eligible sooner. It is a question, I think, without an answer at this point.

Mr. ENGEL. But something we should look into?

Ms. RILEY. I think always the unintended consequences are the most difficult to contemplate but need to be considered.

Mr. ENGEL. Thank you very much.

Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from Virginia, Mr. Griffith, 5 minutes for questions.

Mr. GRIFFITH. Thank you, Mr. Chairman. Thank you very much for holding this hearing. As always, these hearings are very enlightening. I came in today without any questions related to annuities and long-term care insurance, and now I have all kinds of questions.

But let me say this, Ms. Riley has indicated—and I didn't look it up—but she has been in this field for quite some time and the hope had been that long-term care insurance would help offset some of what Medicaid is having to pay. Folks are going to look at the money, when you are talking about putting a loved one into a nursing home, they are going to look at this as a tax avoidance situation, as opposed to tax evasion. A lot of folks today have said, this is immoral or nobody wants to game the system. The people are going to find a way to hang onto their assets if they can.

And one of the things we have to be careful of, and, Mr. Chairman, we may need to have a roundtable discussion among our members, we have to be careful that we don't go too far in a direction because people are going to figure out a way. And one of those ways is to go through a divorce, as long as the spouse who is the spouse in the nursing home or incapacitated in some way needing the care is competent. Because they want to pass assets on to their children, they are going to figure out a way. And if the only way left is divorce, they will divorce. They will reach a property settlement agreement. They will transfer all the money to the healthy spouse. And then the healthy spouse will start working on ways to get that to the children. People will do that.

So this is a complicated issue. It is not one where we need folks on each side of the aisle pointing the finger at the other side of the aisle. We need to see if we can't come up with a new paradigm, a new way to do this.

I don't have the answer, Mr. Chairman. But I have heard a lot of concern on a lot of issues regarding promissory notes, et cetera, annuities. But we need to figure out a way that we can make it so that it is affordable for the average American family to have a loved one in long-term care without losing everything they have worked for 45 or 50 years. And they are going to want to pass it on to their kids. So as long as even the incapacitated party is competent, they are going to figure out a way. And they are going to game, if you want to call it gaming the system, they are going to game the system because in the long-term, it is better off for their loved ones. So I don't know the answer. But let's not think there is a quick and easy solution.

And I think, Ms. Riley, you would agree with that.

Ms. RILEY. Yes, sir. I think there is some good news and that is if one is concerned about the spending in Medicaid on long-term care, when I started in this field, Medicaid spending for long-term care was about 75 percent of the total bill, as I recall. And so we have improved economic conditions, improved income supports for older people; some use of long-term care insurance has changed that situation.

Mr. GRIFFITH. And, Mr. Hagg, I got off on that and what I was really going to ask about was in your written testimony, the OIG has a body of work related to healthcare provider taxes and how that impacts Medicaid Programs. I have a bill in that would do some lowering. The President's Fiscal Commission recommended eliminating the use of provider tax providing for non-Federal share of Medicaid funding.

Can you just discuss that issue in the minute and 40 seconds I have left?

Mr. HAGG. We have done some recent work involving healthcare provider taxes. In one state we looked at a healthcare provider tax that didn't follow the existing rules that are in place. To us, it looked like it would have been impermissible. In talking to the state about it, the state said, they disagreed, they didn't think it was a healthcare tax at all. They just said it was a general gross receipts tax, and therefore those Federal Rules did not apply. We issued a report to CMS. CMS responded by saying they agreed with the position we had taken, but they felt like they hadn't done a good enough job of providing clear guidance to the states on what was expected. So I think sometime about last year they put out a letter providing that guidance, and at some point, we plan to follow up at the appropriate time to make sure that guidance is now being followed.

Mr. GRIFFITH. Well, I think we need to do something. Virginia historically has tried to follow the rules, but for those states that have done other things creatively to figure out way to make the finances work for their states, they have eaten up some of the money and really put Virginia at a disadvantage. And so Virginia has consistently rejected a so-called bed tax but many states have that. We think other states are gaming the system to our detriment, and so we would like to see it be a level playing field and everyone know what the rules are.

So thank you for your work on that.

With that, Mr. Chairman, I yield back.

Mr. PITTS. The chair thanks the gentleman.

And now the chair recognizes the gentlewoman from Indiana, Mrs. Brooks, 5 minutes for questions.

Mrs. BROOKS. Thank you, Mr. Chairman.

To the panel, thank you all so much for being here and for helping us understand these complex issues. I am a former United States Attorney and so I have worked with my state's Medicaid Fraud Control Unit, I think we called it MFCU is the acronym that I recall. It has been a few years, but I understand all too well the nationwide prevalence of the problem of Medicaid fraud, and I am encouraged by the fact that the committee is taking up the issues of program integrity.

I also am very pleased that Chairman Pitts has introduced, and I am working with him, on H.R. 3444, the Medicaid and CHIP Territory Fraud Prevention Act because it is important that our territories also have Medicaid Fraud Control Units. And I want to dive into that a little bit further.

Can you, Mr. Hagg, really just talk with us, and I know Chairman Pitts started out by talking about the units and how they are funded and so forth, but can you give us, based on your experience with the Fraud Control Units in the states, can you explain further why this is a wise investment of our Federal dollars to make sure that the territories set up Medicaid Fraud Control Units?

Mr. HAGG. Well, in general, yes, the Fraud Control Units in states, they are the groups that are primarily responsible for investigating Medicaid fraud. They are also responsible for investigating patient abuse when it occurs in healthcare facilities. Now we would be supportive in expanding that, their authority over patient abuse. Right now, they have authority when it occurs in the hospital or nursing home. But if patient abuse occurs in a home-based setting, for example, they currently don't have the authority to investigate that, and we think that is something that should be expanded.

The Fraud Control Units do a great job. They, I think, 2014 had about 2 billion in recoveries, around 1,300 or so in convictions. It equates to about a return of 8 ½ to 1 for every dollar spent, they return about 8 ½. So we think they are very important in Medicaid program integrity.

Mrs. BROOKS. Thank you. You anticipated my next question, which was actually about the amount of recovery that the units, that the Medicaid Fraud Control Units across the country have recovered, and that is $2 billion that is reinvested for other patients, is that correct? Or how is the $2 billion then when it is recovered by the government units that recover it, how is that money used?

Mr. HAGG. I am not sure exactly how that process works. But certainly, yes, it is, it is more money available that can be used to provide legitimate healthcare services to Medicaid beneficiaries that need the services.

Ms. BROOKS. I think just to repeat, that was $2 billion recovered.

Mr. HAGG. Two billion.

Mrs. BROOKS. How many Medicare fraud units are there in the country right now roughly?

Mr. HAGG. There are 50, 49 states and the District of Columbia.

Mrs. BROOKS. Thank you. And Mr. Gomez can you just share with me the experience in Oklahoma and the work that Oklahoma is doing, the benefits, and how do states like Oklahoma feel about the fact that the territories don't have Medicaid Fraud Control Units?

Mr. GOMEZ. Well, I think for Oklahoma we take a lot of pride in making sure that we have appropriate program integrity pieces in place, and we actually do counsel states with our territories and try to share information in terms of how to improve the integrity of the system, even if they don't happen to have some of the resources that other states or territories have. So we do a lot of sharing of information to see what we are seeing on certain activities and how can we share that information to strengthen other programs.

So when we find in Oklahoma, when we find weaknesses in the program using technology, we try to fix it in the system so we can prevent that money instead of a pay-and-chase situation preventing on the front end.

Mrs. BROOKS. I think Mr. Hagg brought up while I initially was more focused on the fraud aspects and the amount of money that would be recovered, I think your point about the Medicaid Fraud Control Units being, are they actually the primary units investigating patient care issues, Mr. Hagg?

Mr. HAGG. Patient care issues that occur in healthcare facilities, yes.

Mrs. BROOKS. OK.

And, Ms. Riley, any comments you would like to make based on your experience about Medicaid Fraud Control Units and the patient care issues?

Ms. RILEY. They clearly are an important front line and they rest in attorneys general offices and work closely with Medicaid programs, and so it certainly seems that the territories could benefit from that kind of support.

Mrs. BROOKS. And so because the territories don't have these, is that not happening now then, the patient care issues with respect to healthcare facilities, how is that being monitored then?

Ms. RILEY. There are a variety of ways that states look at patient care, not just through the fraud lens, and there are numerous reports and numerous activities of state licensing boards as well as Medicaid agencies that look at the quality of patient care.

Mrs. BROOKS. Thank you.

Thank you. I yield back.

Mr. PITTS. The chair thanks the gentlelady and now recognizes the gentlelady from North Carolina, Mrs. Ellmers, 5 minutes for questions.

Mrs. ELLMERS. Thank you, Mr. Chairman.

And thank you to our panel, and I will just start off by saying I have a few questions here, and I apologize for not being here for the full committee. It is getting back to town, and being the third day back, we are all pretty busy, and I had some other issues I had to take care of. But I want to start, Mr. Gomez, asking you about the Deficit Reduction Act, so I guess my point is if I ask you a question that has already been presented, please indulge me because I apologize for the redundancy.

But in the Deficit Reduction Act of 2005, implemented new policies that intended to try to close the loopholes related to the use of annuities as a Medicaid planning device. However, based on the testimony that has taken place today and just what I have listened to, it obviously has not achieved that goal.

Can you please explain what the DRA did and why that has not sufficiently closed the loopholes?

Mr. GOMEZ. I think the best way I can explain it is the relevant findings of the 10th Circuit Court where we took this issue from Oklahoma, so couples can purchase a qualifying annuity payable to the community spouse without affecting the institutionalized spouse's eligibility for Medicaid benefits. So couples can purchase the annuities as a lawful spend down of the institutionalized spouse's resources. The court will only limit transfers made to the

community spouse after the applicant has been deemed eligible for Medicaid assistance so it allows for the unlimited transfer of resources before the applicant is approved. The DRA actually was trying to, had that 5-year look back and this is a way to get around that.

Mrs. ELLMERS. OK, so along the line of, in the discussion again on annuities, the 2014 GAO report of elder law attorneys told the GAO undercover investigators that annuities could be created quickly and thus are a tool for last minute Medicaid planning. Is this something that you have seen in Oklahoma, and typically how many months elapse between the creation of an annuity and the submission of the Medicaid application?

Mr. GOMEZ. Please allow me to get back with you on that length of time, I don't know, but we certainly would be happy to get that back to you for the record.

Mrs. ELLMERS. Ms. Riley, do you have a comment on that at all?

Ms. RILEY. I don't, but we would be happy to look at.

Mrs. ELLMERS. That would be great because that gives us a little bit better perspective when we are talking about timelines.

Mr. Hagg, your office, OIG, has a long history of raising serious concerns to waste, fraud, and abuse involving personal care services and having the discussion I was listening very closely to my colleague from Indiana in a very interesting conversation.

You have already made numerous recommendations to CMS.

What actions has CMS taken in response to your recommendations and how can the legislation that we are discussing here today really help to fulfill some of the goals that haven't been met?

Mr. HAGG. Involving personal care services, we have made a number of recommendations. I think CMS is generally in agreement with those recommendations that more guidance is needed, that more uniformity is needed. I think there is maybe a disagreement in how you go about doing that because of the limited Federal Rules that are there now and all the problems we found we felt like a regulation was needed to really spell out what the Federal Government is looking for. I think CMS doesn't want to go that far, and maybe that is part of the problem with whether the recommendations have been implemented or not. Certainly with the problems we found, electronic verification would I think address some of those issues, not all of them, but it would address some of them.

Mrs. ELLMERS. Great. Well, thank you very much. And like I said, this is a really important hearing for us, and we really do appreciate your input on this. Hopefully we will be able to craft that legislation in the manner that will make some real hurdles and improvement so thank you.

Mr. Chairman, thank you, again, and I yield back the remainder of my time.

Mr. PITTS. The chair thanks the gentlelady. That concludes the questions of the members.

The members will have followup questions. We will send those to you in writing. We ask you to please respond promptly.

This has been a very interesting, very informative, and excellent hearing. We thank you for your testimony, and we look forward to

working together on behalf of the people to address these issues that we have heard about today.

I remind, members that they have 10 business days to submit questions for the record, and members should submit their questions by the close of business on Friday, September 25.

Without objection, the subcommittee is adjourned.

[Whereupon, at 11:30 a.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

September 10, 2015

Chairman Fred Upton
House Energy and Commerce Committee
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Ranking Member Frank Pallone
House Energy and Commerce Committee
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Subcommittee Chairman Joe Pitts
House Energy and Commerce Committee
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Ranking Member Gene Green
House Energy and Commerce Committee
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Upton, Subcommittee Chairman Pitts, Ranking Member Pallone, and Subcommittee Ranking Member Green:

On behalf of the Alzheimer's Foundation of America (AFA), a nonprofit organization that unites more than 2,300 member organizations nationwide with the goal of providing optimal care and services to individuals confronting dementia, and to their caregivers and families, I am writing in support of H.R. 2446 which would require the use of electronic visit verification (EVV) for personal care services furnished under the Medicaid program. The legislation will soon be considered by your committee.

With seventy percent of persons with Alzheimer's disease cared for in the home, personal and home care attendants are essential members of the care team in providing necessary services and giving the family assistance and relief to continue to care for the patient. Home care aide services are integral in helping those living with dementia maintain their independence and delaying nursing home placement.

Persons with dementia, however, often suffer from cognitive decline and can be vulnerable targets for elder fraud and abuse. EVV can act as a quality check and increase accountability of home health aides. Requiring EVV will ensure that the proper home care aide is making the visit and that the verified person is allowed in the home.

EVV will also help avoid "phantom visits" where an aide fails to show up for an appointment. Those with cognitive difficulties might not be able to fully comprehend that a visit did not occur. In these cases, not only are care needs not met, the absence will likely go unreported and the Medicaid program will be billed.

EVV pilot projects have demonstrated saving scarce Medicaid resources. In Dade County Florida, which mandates EVV, Medicaid saw $19 million in savings during first year of implementation. Texas has seen a 5-7% cost reduction in just the first four months of the programs roll-out.

Given that implementation of EVV can enhance safety while lowering fraud and saving resources, AFA supports requiring use of EVV for Medicaid home care aide visits and urges the House Energy and Commerce Committee to approve the legislation.

Sincerely,

Charles J. Fuschillo, Jr.
President and CEO

September 9, 2015

Chairman Fred Upton
House Energy and Commerce Committee
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Ranking Member Frank Pallone
House Energy and Commerce Committee
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Subcommittee Chairman Joe Pitts
House Energy and Commerce Committee
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Ranking Member Gene Green
House Energy and Commerce Committee
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Upton, Subcommittee Chairman Pitts, Ranking Member Pallone, and Subcommittee Ranking Member Green:

Sandata Technologies, LLC appreciates the opportunity to provide a statement for the record for the House Energy and Commerce Subcommittee on Health's hearing on Strengthening Medicaid Program Integrity and Closing Loopholes.

Medicaid personal care services (PCS) provide assistance to the elderly, people with disabilities, and individuals with chronic or temporary conditions so that they can remain in their homes and communities, and avoid moving to more costly facilities. PCS consist of non-medical services supporting activities of daily living, including bathing, dressing, light housework, money management, meal preparation, and transportation. PCS generally are provided by an attendant to vulnerable care-dependent persons, such as the elderly, infirm, or disabled.

PCS, which are currently offered as either a State plan optional benefit or through various demonstrations and waivers in all 50 states represents a significant expense. For example, in 2011, Medicaid costs for PCS totaled approximately $12.7 billion.

"Between 2006 and August 2012, the Office of Inspector General at the U.S. Department of Health and Human Services (OIG) produced 23 audit and evaluation reports on PCS.6 OIG's audit and evaluation work revealed a pattern of improper PCS payments linked to lack of compliance with State policies and

NEW YORK • Headquarters
26 Harbor Park Drive
Port Washington, NY 11050
T. 516.484.4400
F. 516.484.6084

www.sandata.com

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requirements. Additionally, the work demonstrated that existing program safeguards intended to ensure medical necessity, patient safety, and quality and prevent improper payments were often ineffective. Furthermore, according to the OIG, PCS fraud — including many cases in which the care attendants and the beneficiaries acted as co- conspirators to scam the Medicaid system — is on the rise, representing more cases investigated by State Medicaid Fraud Control Units than any other type of Medicaid fraud." (Source: http://oig.hhs.gov/reports-and-publications/portfolio/portfolio-12-12-01.pdf)

Electronic Visit Verification™ ("EVV™") supports service delivery and mitigates the potential for fraud, waste and abuse within home care, while preserving the benefits of PCS for those people needing care. EVV prevents fraud BEFORE claims are submitted. EVV captures time, attendance and care plan information entered by the home care worker at the point of care. For example, Sandata's EVV program saved the State of Florida over $20 million and cut home care costs by 50% in the first year of the program.

Sandata supports Mr. Guthrie's bill requiring the use of EVV for PCS, as national adoption of EVV technology supports:

- **Fraud, waste and abuse deterrence:** EVV systems have proven they prevent the most common fraud schemes.;
- **Verification and documentation of visits, including tasks and times:** EVV records the identity of the caregiver, the person receiving care, times, and tasks delivered during the visit and verifies that information against the schedule/authorization.
- **Focus on Quality:** Adoption of EVV solutions allow states to define and focus on quality metrics that make sense for each program. For example, Tennessee's EVV program focuses on timely care delivery and member satisfaction. The Texas EVV program focuses on accurate and automated visit verification. Each state can identify key metrics to create EVV quality standards that are right for their needs.

We appreciate your time and attention to this matter.

Sincerely,

Tom Underwood
President and CEO, Sandata Technologies, LLC

NEW YORK • Headquarters
26 Harbor Park Drive
Port Washington, NY 11050
T. 516.484.4400
F. 516.484.6084

www.sandata.com

9901 Linn Station Road
Louisville, Kentucky 40223-3808

502.394.2100
Fax: 502.394.2206

www.ResCare.com

September 10, 2015

The Honorable Brett Guthrie
Vice Chairman
Subcommittee on Health
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Guthrie:

As one of the country's largest providers of Medicaid funded home and community based services, ResCare commends and supports your efforts to mandate electronic visit verification (EVV) systems. EVV systems strengthen the integrity of Medicaid funded programs and improve the efficiency of providers such as ResCare.

Based on program integrity, and efficiency, ResCare implemented EVV systems in our operations across the country beginning in 2001. We have spent precious time and resources to develop fully integrated systems that allow for technology upgrades. Technology in the EVV world is evolving rapidly.

It is vitally important that responsible providers who have already voluntarily adopted, developed and implemented EVV systems not be penalized by a directive from States for a one-size fits all, prescriptive plan. There should not be a mandated requirement by the States to use EVV systems provided solely by 3rd party EVV providers who have contracted directly with respective States. Providers who can demonstrate that an existing in-house EVV system meets enumerated essential criteria should be allowed to continue use of that system in each respective state in which they operate. ResCare, for example, provides services in more than 40 states, and it would be burdensome, highly inefficient and counter productive to the limited funding in Medicaid to require a multi-state provider to comply with EVV systems unique to each state together with a multitude of 3rd party EVV providers mandated by each state.

9901 Linn Station Road
Louisville, Kentucky 40223-3808

502.394.2100
Fax: 502.394.2206

www.ResCare.com

For the record, let me say again, we SUPPORT the use of EVV.

We believe the revised draft language presented in today's hearing is a significant improvement over H.R. 2446 as originally introduced, and look forward to working with you and the committee to offer our suggestions for additional minor, but significant improvements.

ResCare congratulates you for your leadership on this important issue.

Sincerely,

Ralph Gronefeld
President and CEO

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
WASHINGTON, DC 20515–6115
Majority (202) 225-2927
Minority (202) 225-3641

October 5, 2015

Mr. John Hagg
Director of Medicaid Audits
Office of Inspector General
Department of Health and Human Services
330 Independence Avenue, S.W.
Washington, DC 20201

Dear Mr. Hagg:

Thank you for appearing before the Subcommittee on Health on September 11, 2015, to testify at the hearing entitled "Strengthening Medicaid Program Integrity and Closing Loopholes."

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 October 19, 2015. Your responses should be mailed to Graham Pittman, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to graham.pittman@mail.house.gov.

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

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

Additional Questions for the Record

Questions from the Honorable Representative Bilirakis

1. Do the territories have the same reporting requirements that states have for their Medicaid program?

OIG does not have direct knowledge or expertise regarding Medicaid reporting requirements for the Territories. Thus, we recommend directing this question to the Centers for Medicare & Medicaid Services or to the HHS Office of the General Counsel.

2. Are there other things that the territories should be providing to increase the level of transparency and accountability in their Medicaid program?

We have not undertaken a study of the adequacy of Medicaid reporting by the Territories, so we are unable to offer specific recommendations on the topic.

Questions from the Honorable Representative Brooks

1. The Medicaid and CHIP Territory Fraud Prevention Act provides for additional federal funding for territories to create Medicaid Fraud Control Units. Given your experience with the Fraud Control units in the states, please explain why you think this is a wise investment of federal dollars?

    a. If so, from these statistics are you able to roughly estimate how much might be saved in the territories by ensuring the MFCUs are operational?

Generally, MFCUs have been wise investments for the Federal Government. For example, for FY 2014, the existing 50 MFCUs were responsible for monetary recoveries of $2.0 billion, and the Federal and State governments expended $235 million in funding for their operation, which translated to a return on investment of $8.53 for each dollar invested. While the results for individual MFCUs vary, it is rare for an MFCU not to bring a positive return on investment. Recovery amounts, as well as grant expenditures and other statistical information for each of the MFCUs, is available on the OIG Web site at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp (Expenditures and Statistics), in a chart format and as part of an annually updated interactive map.

Territories may be able to capture similar results by establishing their own MFCUs. For example, based on our own investigative experience in Puerto Rico, we believe that the investment of Federal dollars for an MFCU may bring substantial returns. From calendar year 2012 to date, OIG's investigations in Puerto Rico have resulted in over 117 criminal convictions and $12 million in civil settlements. Puerto Rico has a large Medicaid population, comparable to that of many medium-sized states. Based on our experience investigating Medicare and Medicaid fraud in the Territory, we believe there is an important opportunity for a Puerto Rico MFCU to have significant impact, in imposing criminal penalties as well as in recovering monetary amounts.

2. However, while we know generally that the MFCUs routinely bring positive returns on investment, we are unable to estimate a specific savings amount for establishing MFCUs in each

of the territories. Additionally, if a territory does not believe establishing a Unit is cost effective, the territory can seek a waiver from the Secretary of Health and Human Services (HHS). Do you have statistics on the amount of dollars recovered or saved as a result of the operation of Medicaid Fraud Control Units? For example, on average, for every dollar invested in a Medicaid Fraud control Unit, how many dollars are recovered?

For FY 2014, the existing 50 MFCUs were responsible for monetary recoveries of $2.0 billion. The Federal and State governments in FY 2014 expended $235 million in funding for MFCU operations, which translated to a return on investment of $8.53 for each dollar invested. For FY 2013, the MFCUs were responsible for recoveries of $2.5 billion, which translated to a return on investment of $10.90 for each dollar invested.

October 5, 2015

Mr. Nico Gomez
CEO
Oklahoma Health Care Authority
2401 N.W. 23rd Street
Oklahoma City, OK 73107

Dear Mr. Gomez:

Thank you for appearing before the Subcommittee on Health on September 11, 2015, to testify at the hearing entitled "Strengthening Medicaid Program Integrity and Closing Loopholes."

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 October 19, 2015. Your responses should be mailed to Graham Pittman, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to graham.pittman@mail.house.gov.

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

Sincerely,

Joseph R. Pitts

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

JOEL NICO GOMEZ
CHIEF EXECUTIVE OFFICER

MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

October 12, 2015

The Honorable Joseph R. Pitts
Chairman, Subcommittee on Health
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Dear Congressman Pitts:

Your question regarding the benefits of a Medicaid Fraud Control Unit (MFCU) is simultaneously simple and complex. Put simply, the MFCU is the law enforcement extension to the Medicaid Program's program integrity group (PI). The more complex answer requires a more thorough look at the responsibilities and the ultimate goals of each group. The essence of MFCU is threefold; punishment both criminally and civilly, reduction of recidivism and finally to reimburse the program as much as possible for the fraud, waste and abuse within the system. Conversely, the PI group is focused on the program as a whole and locating and recovering those funds paid out inappropriately. Ultimately, however, both groups share a common goal of insuring the integrity of the Medicaid Program for the state.

The two groups are required by federal regulations to maintain independence from each other. However, in reality they are each a necessary part of the other. The most effective MFCU and PI relationship requires open sharing of information on fraud, waste and abuse. Benefits of an effective MFCU and PI group includes quick responses to suspected fraud. For example, referrals from the MFCU to the PI group allow suspension or termination of bad actors with a high level of confidence that fraud is factually occurring and not hypothetically. Referrals from the PI group to the MFCU allow an immediate and thorough investigation resulting in the recovery of funds to the program.

Sincerely,

Joel Nico Gomez

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
WASHINGTON, DC 20515–6115
Majority (202) 225-3927
Minority (202) 225-3641

October 5, 2015

Ms. Patricia Riley
Commissioner
Medicaid and CHIP Payment and
Access Commission
1800 M Street, N.W.
Washington, DC 20036

Dear Ms. Riley:

Thank you for appearing before the Subcommittee on Health on September 11, 2015, to testify at the hearing entitled "Strengthening Medicaid Program Integrity and Closing Loopholes."

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 October 19, 2015. Your responses should be mailed to Graham Pittman, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to graham.pittman@mail.house.gov.

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

Sincerely,

Joseph R. Pitts

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

Questions for the Record from the Honorable Gus Bilirakis
Hearing entitled "Strengthening Medicaid Program Integrity and Closing Loopholes"
September 11, 2015
Medicaid and CHIP Payment and Access Commission

Q1: In your testimony you alluded to the Medicaid program in the territories having different rules for eligibility and payment than in the mainland. How are Medicaid programs in the territories different than in the 50 states?

A1: Medicaid programs in the five U.S. territories operate differently than in the 50 states and the District of Columbia. For the purposes of Medicaid and the State Children's Health Insurance Program (CHIP), territories are considered states unless otherwise indicated.[1] Specifically, their Medicaid programs are subject to annual limits on federal financial participation and have a statutorily imposed federal medical assistance percentage (FMAP).[2,3] Furthermore, federal statute excludes the territories from the following provisions:

- extending eligibility to poverty-related children and pregnant women,[4] and qualified Medicare beneficiaries;[5]
- facing repayments under Medicaid eligibility quality control;[6]
- facing limits in their ability to rely on provider taxes and donations;[7]
- receiving and paying funds to disproportionate share hospitals;[8]
- implementing spousal impoverishment protections when determining eligibility for nursing home services;[9]
- offering Transitional Medical Assistance;[10]
- paying the federal government based on the Medicare Part D clawback;[11] and
- implementing an asset verification program through financial institutions.[12]

Additionally, American Samoa and the Northern Mariana Islands are uniquely eligible for broad waivers under section 1902(j). This authority allows the Secretary of the U.S. Department of Health and Human Services (HHS) to exempt them from every federal Medicaid policy except for:

- the federal matching rate available to the territories;
- the capped grant amounts set for territories' Medicaid programs; and
- that payment can only be for services otherwise coverable by Medicaid.[13]

Puerto Rico, Guam, and the U.S. Virgin Islands, while ineligible for Section 1902(j) waivers, are additionally exempt from freedom of choice requirements.[14]

All five territories are permitted to establish income-based eligibility using local measures rather than the federal poverty level (FPL). For example, territories can participate in Medicaid expansion under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) by expanding Medicaid to adults earning less than 133 percent of the local poverty level. The Centers for Medicare & Medicaid Services (CMS)

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[1] §1101(a)(1) of the Social Security Act (the Act).
[2] §1108(f) of the Act.
[3] §1905 (b)(2) of the Act.
[4] §1902(l)(4)(B) of the Act.
[5] §1905(p)(4)(A) of the Act.
[6] §1903(u)(4) of the Act.
[7] §1903(w)(7)(D) of the Act.
[8] §1923(f)(9) of the Act.
[9] §1924(a)(4)(B) of the Act.
[10] §1925(c)(2) of the Act.
[11] §1935(c)(1)(A) of the Act.
[12] §1940(a)(4) of the Act.
[13] §1902(j) of the Act.
[14] §1902(a)(23) of the Act.

has approved state plan amendments (SPAs) incorporating these new eligibility groups for Puerto Rico, the U.S. Virgin Islands, and Guam.[15,16,17] As the only U.S. territory participating in the Supplemental Security Income (SSI) program, the Commonwealth of the Northern Mariana Islands extends Medicaid eligibility to all individuals receiving SSI cash payments, and to all individuals meeting up to 150 percent of SSI income and asset requirements.[18] American Samoa uses a presumed eligibility system in which CMS pays for Medicaid expenditures based on the estimated percentage of the population earning less than 200 percent of the local poverty level.[19]

Q2: Do the territories have the same reporting requirements that states have for their Medicaid program?

A2: Unless otherwise specified, territories are considered states for the purposes of Medicaid and CHIP and are subject to the same requirements.[20] Under rules promulgated by HHS for CHIP, the territories are not considered states for the purpose of required quarterly reporting of statistical and program expenditure CHIP data.[21] There is no comparable exemption under federal Medicaid regulations.

Q3: Are there other things that the territories should be providing to increase the level of transparency and accountability in their Medicaid programs?

A3: CMS recently added information on Medicaid enrollment, eligibility, waivers, and SPAs to the Medicaid website for American Samoa, the U.S. Virgin Islands, and the Commonwealth of the Northern Mariana Islands. At the time of this hearing, Puerto Rico was the only territory for which this information was available. Data on expenditures are limited and information for Guam (with the exception of its SPAs) is not available on Medicaid.gov.

Q4: Under the ACA, the territories received a block grant of funds for usage in their Medicaid program.

Q4a: Does MACPAC know what these funds have been used for?

A4a: As you note, the territories are allotted fixed amounts of federal funding for their Medicaid programs. Territories routinely use the full amount of federal Medicaid funding available to them, presumably consistent with the requirements outlined in the Medicaid statute and regulations. MACPAC does not have an independent source of information to determine how the territories are using these funds.

Q4b: These funds were set to expire in 2019. It is believed that Puerto Rico will exhaust their funds before that date. Has MACPAC looked at the draw down rate for these funds and does MACPAC have any estimate on when these funds will be exhausted?

A4b: MACPAC has not analyzed territories' spending of their fixed allotments for Medicaid and thus cannot provide an estimate of when Puerto Rico might exhaust its funds.

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[15] Center for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2014. Attachment to Puerto Rico Medicaid State Plan. May 30, 2014. New York, NY: CMS. http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/PR/PR-14-002-MM1.pdf.

[16] Center for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015. Attachment to the U.S. Virgin Islands State Plan. June 1, 2015. New York, NY: CMS. http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/VI/VI-15-0003.pdf.

[17] Center for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2014. Attachment to Guam State Plan. May 30, 2014. San Francisco, CA: CMS. http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/GU/GU-14-05-MM1.pdf.

[18] Center for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015. Commonwealth of the Northern Mariana Islands. http://www.medicaid.gov/medicaid-chip-program-information/by-state/cnmi.html.

[19] Center for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015. American Samoa. http://www.medicaid.gov/medicaid-chip-program-information/by-state/American-Samoa.html

[20] §1101(a)(1) of the Act.

[21] 42 CFR 457.740.

Q4c: What would happen when those funds are depleted, whether it happens in 2019 or an earlier date?

A4c: Once territories' Medicaid allotments have been depleted, territories would have to fund the difference from their own budgets. They could also make programmatic changes, such as restricting benefits or eligibility, to reduce their total spending on Medicaid.