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MEDICAID OVERSIGHT: EXISTING PROBLEMS AND WAYS TO STRENGTHEN THE PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTEENTH CONGRESS

FIRST SESSION

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MEDICAID OVERSIGHT: EXISTING PROBLEMS AND WAYS TO STRENGTHEN THE PROGRAM

TUESDAY, JANUARY 31, 2017

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

The subcommittee met, pursuant to call, at 10:00 a.m., in room 2123, Rayburn House Office Building, Hon. Tim Murphy (chairman of the subcommittee) presiding.

Present: Representatives Murphy, Griffith, Burgess, Brooks, Collins, Barton, Walberg, Walters, Costello, Carter, Walden (ex officio), DeGette, Schakowsky, Castor, Tonko, Clarke, Ruiz, Peters, and Pallone (ex officio).

Staff Present: Jennifer Barblan, Chief Counsel, O&I; Elena Brennan, Legislative Clerk, O&I; Paige Decker, Executive Assistant & Committee Clerk; Scott Dziengelski, Policy Coordinator, Health; Blair Ellis, Digital Coordinator/Press Secretary; Emily Felder, Counsel, O&I; Jay Gulshen, Legislative Clerk, Health; Brittany Havens, Professional Staff, O&I; Peter Kielty, Deputy General Counsel; Katie McKeough, Press Assistant; Jennifer Sherman, Press Secretary; Luke Wallwork, Staff Assistant; Gregory Watson, Legislative Clerk, C&T; Everett Winnick, Director of Information Technology; Jeff Carroll, Minority Staff Director; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Chris Knauer, Minority Oversight Staff Director; Una Lee, Minority Chief Oversight Counsel; Miles Lichtman, Minority Staff Assistant; Dan Miller, Minority Staff Assistant; Jon Monger, Minority Counsel; Dino Papanastasiou, Minority GAO Detailee; Rachel Pryor, Minority Health Policy Advisor; Matt Schumacher, Minority Press Assistant; Andrew Souvall, Minority Director of Communications, Outreach and Member Services; and C.J. Young, Minority Press Secretary.

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

Mr. MURPHY. Good morning, everyone. Welcome to the newly refurbished—well, I want to call it the Oversight and Investigation Committee room, which is sometimes used by Energy and Commerce. What a beautiful room and it should be more conducive to a good hearing.

This is the first one of the 115th Congress, so welcome here, and welcome to our witnesses today, and welcome back to my friend and colleague, Ranking Member Diana DeGette of Colorado.

This is our Medicaid oversight hearing on existing problems and ways to strengthen the program. The subcommittee convened this hearing today to examine a critical component of the Patient Protection and Affordable Care Act, Medicaid and Medicaid expansion.

As the world's largest health program, Medicaid provides healthcare coverage for over 70 million Americans and accounts for more than 15 percent of healthcare spending in the United States. In 2015 alone, Federal taxpayers spent over $350 billion on Medicaid, and the costs continue to rise each year. According to the Congressional Budget Office, the Federal share of Medicaid spending is expected to rise significantly over the coming decade, from $371 billion in 2016 to $624 billion in 2026, over 10 years.

At a time when Medicaid program costs are skyrocketing, it makes sense to ask the question, is Medicaid adequately serving our most vulnerable populations? Medicaid was originally designed as a safety net to care for health of some of our most vulnerable populations: Low-income children, pregnant women, parents of dependent children, the elderly, individuals with disabilities. And for many years serving as a psychologist, I know I've treated many kids that without their disability coverage from Medicaid, it would be a struggle for them.

But far too often, Medicaid's own rules keep it from best serving the families that it was designed to help. These restrictions surrounding Medicaid do not allow doctors and nurses the flexibility they need to arrive at the best outcome for patients. For instance, most Medicaid programs do not use physician-focused alternative payment models that can improve care and reduce costs.

And studies show that Medicaid coverage does not necessarily result in better health outcomes. One often cited study in Oregon found that Medicaid coverage increases healthcare use and improves self-reported health and mental health, while having no effect on mortality or physical health. Similarly, the National Bureau of Economic Research found that Medicaid enrollees obtained only 20 to 40 cents of value for each dollar the government spends on their behalf.

Further, reports by nonpartisan watchdogs, two of which are here today, show that the Medicaid program remains a target for waste, fraud, and abuse. Because of the size and scale of the program, improper payments, including payments made for people not eligible for Medicaid or for services that were not provided, are extremely high. The Government Accountability Office estimates Medicaid paid out over $17 billion in improper payments in fiscal year 2014 alone.

For these reasons, Medicaid has been designated as a high-risk program by the GAO for 14 years, since 2003. And despite the longstanding problems in the Medicaid program, the Patient Protection and Affordable Care Act expanded Medicaid to a whole new population. In 32 states, Medicaid benefits have been opened up to adults under the age of 65 who make less than 133 percent of the poverty level.

Since open enrollment began in October 2013, roughly 11 million individuals have signed up for Medicaid coverage under the new eligibility parameters. This means that the majority of individuals covered under ObamaCare have enrolled through the Medicaid program instead of purchasing private health insurance plans.

The costs associated with insuring the 11 million new Medicaid enrollees have been far more expensive than the Obama administration predicted. A report released by the Department of Health and Human Services found that the average cost of expansion enrollees was nearly 50 percent higher than projected. Medicaid expansion enrollees cost an average of $6,366 in fiscal year 2015, which is 49 percent higher than the agency predicted the year prior.

This means that not only are expansion enrollees expensive to insure, but the costs are difficult to predict. Further, because of the high matching rate, the Federal taxpayer is on the hook for the vast majority of expenses associated with new enrollees. Unfortunately, reports show both states and the Federal Government cannot effectively oversee and implement Medicaid expansion. The GAO found errors in Medicaid eligibility determinations that could lead to misspending of funds. Likewise, the Inspector General found troubling evidence that the Federal Government failed to implement requirements in the Patient Protection and Affordable Care Act that were supposed to improve program integrity and root out waste, fraud, and abuse.

While we all acknowledge there are serious weaknesses and deficiencies in how this program operates, we also recognize the responsibility of the Federal Government to provide a safety net to the most vulnerable among us. That means ensuring that taxpayer dollars are spent in a way that actually improves health outcomes and serves the Medicaid population. We want this to work, not hinder services. And I hope we can, in a bipartisan way, support its strengths, acknowledge the problems, and together find some solutions.

Tomorrow, the Health Subcommittee will discuss legislative solutions to strengthen Medicaid, but as we move forward with legislation, we must also be careful not to repeat the worsening problems that already exist in the program. As we will hear from our witnesses today, we have a lot of work to do and I'd like to thank our witnesses for appearing today and look forward to an informative discussion.

I now turn to the ranking member Ms. DeGette for 5 minutes.

[The prepared statement of Mr. Murphy follows:]

PREPARED STATEMENT OF HON. TIM MURPHY

The Subcommittee convenes this hearing today to examine a critical component of the Patient Protection and Affordable Care Act: Medicaid and Medicaid Expansion.

As the world's largest health program, Medicaid provides health care coverage for over 70 million Americans, and accounts for more than 15 percent of health care spending in the United States.

In 2015 alone, federal taxpayers spent over $350 billion dollars on Medicaid, and the costs continue to rise each year. According to the Congressional Budget Office, the federal share of Medicaid spending is expected to rise significantly over the coming decade, from $371 billion in 2016 to $624 billion in 2026.

At a time when Medicaid program costs are skyrocketing, it makes sense to ask the question: is Medicaid adequately serving our most vulnerable populations?

Medicaid was originally designed as a safety net to care for the health of some of our most vulnerable populations: low-income children, pregnant women, parents of dependent children, the elderly and individuals with disabilities.

Far too often, however, Medicaid's own rules keep it from best serving the families that it was designed to help. These restrictions surrounding Medicaid do not allow doctors and nurses the flexibility they need to arrive at the best outcome for patients. For instance, most Medicaid programs do not use physician-focused alternative payment models that can improve care and reduce costs.

And studies show that Medicaid coverage does not necessarily result in better health outcomes. One often-cited study in Oregon found that Medicaid coverage increases health care use and improves self-reported health and mental health while having no effect on mortality or physical health.

Similarly, the National Bureau of Economic Research found that Medicaid enrollees obtain only 20 to 40 cents of value for each dollar the government spends on their behalf.

Further, reports by non-partisan watchdogs—two of which are here today—show that the Medicaid program remains a target for waste, fraud, and abuse. Because of the size and scale of the program, improper payments—including payments made for people not eligible for Medicaid, or for services that were not provided—are extremely high. The Government Accountability Office estimates Medicaid paid out over $17 billion in improper payments in fiscal year 2014 alone.

For these reasons, Medicaid has been designated as a "high risk" program by the GAO for 14 years—since 2003. And despite the long-standing problems in the Medicaid program, the Patient Protection and Affordable Care Act expanded Medicaid to a whole new population. In 32 states, Medicaid benefits have been opened up to adults under the age of 65, who make less than 133 percent of the poverty level.

Since open enrollment began in October 2013, roughly 11 million individuals have signed up for Medicaid coverage under the new eligibility parameters. This means that the majority of individuals covered under Obamacare have enrolled through the Medicaid program, instead of purchasing private health insurance plans.

The costs associated with insuring the 11 million new Medicaid enrollees have been far more expensive than the Obama Administration predicted. A report released by the Department of Health and Human Services found that the average cost of expansion enrollees was nearly 50 percent higher than projected. Medicaid expansion enrollees costs an average of $6,366 in fiscal year 2015—which is 49 percent higher than the agency predicted the year prior.

This means that not only are expansion enrollees expensive to insure—but the costs are difficult to predict. Further, because of the high matching rate, the federal taxpayer is on the hook for the vast majority of expenses associated with new enrollees.

Unfortunately, reports show both states and the federal government cannot effectively oversee and implement Medicaid expansion. The GAO found errors in Medicaid eligibility determinations that could lead to misspending of funds. Likewise, the Inspector General found troubling evidence that the federal government failed to implement requirements in the Patient Protection and Affordable Care Act that were supposed to improve program integrity and root out waste, fraud, and abuse.

While we all acknowledge there are serious weaknesses and deficiencies in how this program operates, we also recognize the responsibility of the federal government to provide a safety net to the most vulnerable among us. That means ensuring that taxpayer dollars are spent in a way that actually improves health outcomes and serves the Medicaid beneficiaries in need.

Tomorrow, the Health Subcommittee will discuss legislative solutions to strengthen Medicaid. But as we move forward with legislation, we must also be careful not to repeat or worsen problems that already exist in the program. As we will hear from our witnesses today, we have a lot of work to do.

I would like to thank our witnesses for appearing today, and look forward to an informative discussion.

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

Ms. DEGETTE. Thank you very much, Mr. Chairman. It's good to be back for another session of Congress.

We have two new members on our side of the aisle on this subcommittee this year, and I am so happy to welcome them. Dr. Ruiz is here with us at the end. He's an actual emergency room doctor, and he'll be able to bring us so much great perspective on issues like this hearing and other hearings.

And then Scott Peters, who's not here at this moment, I am pleased he's here. He and I comprise two-thirds of the NYU law graduate delegation to Congress. So I am happy we're loading up this committee with NYU law grads.

I think I'd be deceiving myself if I thought that today's hearing was intended to actually strengthen the Medicaid program. Although I hope it's not so, I fear that this discussion about Medicaid is intended to lay the groundwork for drastic cuts to the program and eventually to repeal the Affordable Care Act's historic Medicaid expansion. So I'd like to talk a few minutes about the importance of this program and what Medicaid expansion has accomplished for the American people.

Today, more than 70 million low-income Americans, including seniors, children, adults, and people with disabilities, have access to quality health care, thanks to Medicaid. And contrary, frankly, to what my colleagues on the other side of the aisle think, the Medicaid program delivers this care efficiently and effectively. The costs per beneficiary are actually substantially lower than for private insurance and have been growing more slowly per beneficiary.

Numerous studies have shown that Medicaid has helped make millions of Americans healthier by improving access to primary and preventative care and by helping Americans manage and treat serious disease. In fact, the Medicaid program literally saves lives. Research published in the New England Journal of Medicine reported that previous expansions of Medicaid coverage for low-income adults in Arizona, Maine, and New York actually reduced deaths by 6.1 percent. The ACA's historic Medicaid expansion has let states build on this record of success and provide insurance to millions of Americans who otherwise would not have had access to health care.

Last year—and we need to think about this—more than 12 million low-income adults had healthcare coverage because of the Medicaid expansion. This is astonishing. And combined with other important provisions of the ACA, this has helped drive the uninsured rate to the lowest level in our country's history.

It's important to note these are not people who shifted from private insurance to the Medicaid expansion; this is people who had no insurance and were using the emergency rooms as their primary care facilities. In Colorado, for example, the rate of the uninsured was cut in half since the enactment of the ACA and through the expansion of Medicaid.

Now, aside from the benefits that have accrued to the people, Medicaid has actually resulted in tremendous savings for the states. Hospitals nationwide have seen their uncompensated care burden drop by $10.4 billion since the ACA became law. Denver Health Medical Center, which is in my district, this week reported to my office that their uncompensated care claims actually fell by 30 percent since passage of the ACA. This is real savings. And also,

we know that Medicaid is helping people get access to vital health care services.

I had a listening session last week in Denver about the ACA. I had 200 people show up at this listening session. And most of the people who told their heartrending stories talked about how they were employed, but they couldn't afford private insurance. And due to the Medicaid expansion, they now had mental health services. They had drug treatment and opioid treatment services. They had services for catastrophic accidents that they have had, and on and on. It got to the point where I literally had to take a packet of Kleenex out of my purse and put it on the podium, because everybody, including my staff and myself, were in tears listening to these stories. This is what the majority wants to take away and this is what we're talking about.

We can all talk about eliminating waste, fraud, and abuse in the program. We're all for that, and I would support that 100 percent. But taking away vital health care for so many millions of Americans is wrong, and we must fight against taking that important benefit away.

I yield back.

Mr. MURPHY. The gentlelady yields back.

And we don't have anybody else on our side of the aisle who wants to give an opening statement. I believe Mr. Walden is detained in a meeting and he will come back later. Perhaps over there.

Mr. Pallone, do you want to be recognized for 5 minutes?

The ranking member of the committee, Mr. Pallone, is recognized for 5 minutes.

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

Mr. PALLONE. Thank you. Thank you, Mr. Chairman. It's great to be back in our room here today. It looks really nice.

For 7 years now, Congressional Republicans have railed against the Affordable Care Act with a steady drumbeat of repeal and replace, and for 7 years they have sabotaged implementation of the law. And here we are today, Republicans are misleading the public, in my opinion, with falsehoods that the law is failing, and that could not be further from the truth.

The truth is, after 7 years of claiming they could do better, they have no plan to replace the Affordable Care Act. The subcommittee should be evaluating the impact that repeal would have on the American people and the national healthcare system, but instead, Republicans are holding yet another hearing to highlight their ongoing opposition to the law's Medicaid expansion, despite clear evidence that the expansion has made health care affordable and available for the first time to 12 million people nationwide.

Tomorrow and Thursday, the committee is holding hearings on what Republicans consider to be the first pieces of the GOP healthcare replacement plan. But the fact is that none of these bills will prevent 30 million Americans from losing their healthcare coverage. None of them will reduce the chaos in the healthcare system

that will inevitably result if Republicans successfully repeal the Affordable Care Act.

The fact is, Republicans are already creating uncertainty and instability in the individual market. This instability will ultimately result in reduced consumer choice, higher premiums, and will endanger the health and welfare of millions of Americans. In other words, the Republican-made chaos in the healthcare system has already begun.

And, of course, we're seeing the same thing with the President's immigration executive orders. I just hope that at some point our GOP colleagues join us against what I consider reckless and rash actions and oppose President Trump's actions.

Congressional Republicans continue to ask the American people to trust them and they have a plan and that somehow everything will be OK. They've repeatedly assured the American public that no one will lose coverage with a Republican replacement plan, a claim that President Trump and his advisers also continue to make.

But recently released audio at a closed-door meeting from the Republican retreat last week confirms that they simply have no plan. At that meeting, Republicans admitted that repealing the Affordable Care Act could eviscerate coverage for the roughly 20 million Americans now covered through state and Federal marketplaces as well as those covered under the Medicaid expansion. In fact, one Republican member at the retreat warned, and I quote: "We'd better be sure that we're prepared to live with the market we've created with repeal."

So my Republican colleagues are also trying to claim that the Affordable Care Act is already collapsing under its own weight and that the replacement plan will, "rescue the American people from ObamaCare." Republicans are so scared to own the chaos they are causing, they're trying to pretend that the law is imploding on its own, which could not be further from the truth.

Americans today have better health coverage and health care, thanks to the Affordable Care Act. The law's Medicaid expansion has helped improve the quality, accessibility, and affordability of health care for millions of Americans. And my colleagues would be wise to consider the impact that their actions will have on the millions of Americans who are currently benefitting from the Affordable Care Act.

If my Republican colleagues finally took their ideological blinders off, they would realize that the Affordable Care Act should not be repealed. And I say this because I don't really care about the ideology. The fact of the matter is that real people are going to be harmed if the Affordable Care Act is repealed, and I hope that at some point my Republican colleagues will admit that and that we can work together to improve the healthcare system.

I yield back.

Mr. MURPHY. The gentleman yields back.

And we'll move forward now with our witnesses. I want to ask unanimous consent, however, that the members' written opening statements be introduced into the record. And, without objection, the documents will be entered into the record.

I'd now like to introduce our five witnesses for today's hearing.

First up, we have Ms. Carolyn Yocom, director of health care at the U.S. Government Accountability Office.

Next we welcome Ms. Ann Maxwell, Assistant Inspector General in the Office of Evaluation and Inspections in the U.S. Department of Health and Human Services, Office of Inspector General.

Next, we want to welcome Mr. Paul Howard, who is a senior fellow and director of health policy at the Manhattan Institute.

As well as Mr. Josh Archambault, senior fellow at The Foundation for Government Accountability.

Last, we welcome Mr. Timothy M. Westmoreland, professor from practice, and senior scholar in health law at Georgetown University Law Center.

Welcome all of you. Thank you to all our witnesses for being here today, providing testimony before the subcommittee. I look forward to hearing from you on this important issue.

Now, you are aware that the committee is holding an investigative hearing and when doing so has the practice of taking the testimony under oath.

Do any of you have any objection to testifying under oath?

Seeing no objections, we'll move forward.

The chair then advises you are, under the rules of the House Rules Committee, entitled to be advised by counsel. Do you desire to be advised by counsel during your testimony today? Seeing nothing there too.

In that case, if you'll please rise, raise your right hand, I'll swear you in.

[Witnesses sworn.]

Mr. MURPHY. Seeing all witnesses answered in the affirmative, you are now sworn in and under oath, subject to the penalties set forth in Title 18, Section 1001 of the United States Code.

We're going to call upon you each to give a 5-minute summary of your statement.

I don't know if they'll light up in this room yet. Is there some lights down there that will go on for them when they are—we'll see. Is there something right in front of you? Green means keep talking; yellow means finish up; and then red means stop. So we want you to keep on time.

So Ms. Yocom, you may begin. You are recognized for 5 minutes.

TESTIMONY OF CAROLYN L. YOCOM, DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE; ANN MAXWELL, ASSISTANT INSPECTOR GENERAL, OFFICE OF EVALUATION AND INSPECTIONS, OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES; PAUL HOWARD, SENIOR FELLOW, DIRECTOR, HEALTH POLICY, THE MANHATTAN INSTITUTE; JOSH ARCHAMBAULT, MPP, SENIOR FELLOW, THE FOUNDATION FOR GOVERNMENT ACCOUNTABILITY; AND TIMOTHY M. WESTMORELAND, J.D., PROFESSOR FROM PRACTICE, SENIOR SCHOLAR IN HEALTH LAW, GEORGETOWN UNIVERSITY LAW CENTER

TESTIMONY OF CAROLYN L. YOCOM

Ms. YOCOM. Chairman Murphy, Ranking Member DeGette, and members of the subcommittee, it is a pleasure to be here today to discuss actions needed to prevent improper payments in Medicaid.

Medicaid finances health care for a diverse population, including children, adults, people who are elderly, or those with disabilities. It also offers a comprehensive set of acute and long-term healthcare services.

Medicaid is one of the largest programs in the Federal budget and one of the largest components of State budgets as well. In fiscal year 2016, Medicaid covered about 70 million people, and Federal expenditures were projected to total about $363 billion. Unfortunately, over 10 percent of these expenditures, over $36 billion, are estimated to be improper, that is, made for treatments or services that were not covered by the program, were not medically necessary, or were never provided.

The program's size and diversity make it particularly vulnerable to improper payments. By design, Medicaid is a Federal-State partnership, and states are the first line of defense against improper payments. The states have responsibility for screening providers, detecting and recovering overpayments, and referring suspected cases of fraud and abuse. At the Federal level, CMS supports and oversees state and program integrity efforts.

In 2010, the Patient Protection and Affordable Care Act gave CMS and States additional provider and program integrity oversight tools. The act also provided millions of low-income Americans new options for obtaining health insurance coverage through possible expansions of Medicaid or through an exchange, a marketplace where eligible individuals may compare and purchase health insurance.

My statement today focuses on four key Medicaid program integrity issues that we have identified, steps CMS has taken, and the related challenges that the agency and States continue to face.

First, with regard to ensuring that only eligible individuals are enrolled in Medicaid, CMS has taken a variety of steps to make the Medicaid process more data-driven, yet gaps exist in their efforts to ensure the accuracy of Federal and State enrollment efforts, including enrollment for those who are eligible as a result of the expansion.

As one example, we found that Federal and selected state-based marketplaces approved Federal health insurance coverage and sub-

sidies for 9 of 12 fictitious applications made during the 2016 special enrollment period.

Second, efforts to improve oversight of Medicaid managed care. CMS has provided states with more guidance on methods of identifying improper payments made to providers and has acted in response to our recommendations on requirements for states to audit managed care organizations and providing States with additional audit support, but further actions are needed. In particular, encounter data, which allow states and CMS to track services received by beneficiaries that are enrolled in managed care, are not always available, timely, or reliable.

Third, CMS has taken steps to strengthen the screening of providers. There are new risk-based initiatives for overseeing provider checks. And these are important steps, but there are additional challenges that remain to ensure that the databases check eligibility and that states can share information with each other on providers who are ineligible for coverage.

Lastly, CMS has implemented a number of policies and procedures aimed at minimizing duplicate coverage between Medicaid and the exchanges. Our work did identify some duplicate coverage; and since our report, CMS has started conducting checks on duplicate coverage and intends to perform these checks at least two times per coverage year. This could save Federal and beneficiary dollars, but CMS needs to develop this plan a little more broadly and make sure that they are assessing the sufficiency of these checks.

In closing, Medicaid is an important source of health care for tens of millions of Americans. Its long-term sustainability is critical and requires effective Federal and state oversight.

Chairman Murphy, Ranking Member DeGette, and members of the committee, this concludes my prepared statement. I'd be pleased to respond to questions.

[The prepared statement of Ms. Yocom follows:]

United States Government Accountability Office

Testimony

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

For Release on Delivery
Expected at 10:00 a.m. ET
Tuesday, January 31, 2017

MEDICAID

CMS Has Taken Steps, but Further Efforts Are Needed to Control Improper Payments

Statement of Carolyn L. Yocom
Director, Health Care

GAO-17-386T

GAO Highlights

Highlights of GAO-17-386T, a testimony before the Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, House of Representatives

Why GAO Did This Study

Medicaid, a joint federal-state health care program, is a significant component of federal and state budgets, with estimated outlays of $576 billion in fiscal year 2016. The program's size and diversity make it particularly vulnerable to improper payments. In fiscal year 2016, improper payments were an estimated 10.5 percent ($36 billion) of federal Medicaid expenditures, an increase from an estimated 9.8 percent ($29 billion) in fiscal year 2015.

States, which are responsible for the day-to-day administration of the Medicaid program, are the first line of defense against improper payments. Specifically, states must implement federal requirements to ensure the qualifications of the providers who bill the program, detect improper payments, recover overpayments, and refer suspected cases of fraud and abuse to law enforcement authorities. At the federal level, CMS is responsible for supporting and overseeing states' Medicaid program integrity activities.

This testimony highlights key program integrity issues in Medicaid, the progress CMS has made improving its oversight of program integrity, and the related challenges the agency and states continue to face. This testimony is based on 10 products and 11 recommendations. Of these 11 recommendations, 3 have been implemented based on agency action.

View GAO-17-386T. For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov

January 2017

MEDICAID

CMS Has Taken Steps, but Further Efforts Are Needed to Control Improper Payments

What GAO Found

GAO's prior work has identified four Medicaid program integrity issues—where the program is vulnerable to improper payments such as those made for services that were not covered, were not medically necessary, or were not provided—as well as actions taken by the Centers for Medicare & Medicaid Services (CMS) to address the issues and additional actions that should be taken.

- **Enrollment Verification:** In response to the Patient Protection and Affordable Care Act (PPACA), CMS established a more rigorous approach for verifying financial and nonfinancial information needed to determine Medicaid beneficiary eligibility. Despite CMS's efforts, however, there continue to be gaps in efforts to ensure that only eligible individuals are enrolled into Medicaid, and that Medicaid expenditures for enrollees—particularly those eligible as a result of the PPACA expansion—are matched appropriately by the federal government.
- **Oversight of Medicaid Managed Care:** CMS has provided states with additional guidance on their oversight of Medicaid managed care. Oversight of managed care is increasing in importance and improvements in measuring the improper payment rate are needed. For example, the estimated improper payment rate for managed care is based on a review of payments made to managed care organizations, and does not review any underlying medical documentation. GAO and the Department of Health and Human Services (HHS) Office of Inspector General have identified incomplete and untimely managed care encounter data—data that managed care organizations are expected to report to state Medicaid programs, allowing states to track the services received by beneficiaries enrolled in managed care.
- **Provider Eligibility:** PPACA included multiple provisions aimed at strengthening the screening of providers who enroll to participate in Medicaid. While the act requires that all providers and suppliers be subject to licensure checks, it gave CMS discretion to establish a risk-based application of other screening procedures, such as fingerprint-based criminal-background checks for high-risk providers. Also, CMS regulations now require that all Medicaid managed care providers enroll with the state Medicaid agency, which has the potential to improve oversight of providers in managed care. However, GAO's work based on 2 states and 16 health plans identified challenges screening providers for eligibility, partially due to fragmented information.
- **Coordination between Medicaid and the Exchange:** CMS implemented a number of policies and procedures to ensure that individuals do not have duplicate coverage (enrolled in both Medicaid and in subsidized coverage through an exchange, which is a marketplace where eligible individuals may compare and purchase private health insurance). CMS has conducted checks to identify individuals with duplicate coverage, and plans to complete these checks at least two times per coverage year, which has the potential to save federal—as well as beneficiary—dollars. However, CMS has not developed a plan for assessing whether the checks and other procedures—such as thresholds for the level of duplicate coverage deemed acceptable—are sufficient to prevent and detect duplicate coverage.

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

I am pleased to be here today to discuss program integrity efforts intended to prevent improper payments in the Medicaid program.[1] Medicaid is a federal-state health financing program projected to cover about 72 million people in fiscal year 2016 and a significant component of federal and state budgets. In fiscal year 2016, Medicaid expenditures were estimated to total about $576 billion, with the federal government spending about $363 billion and combined state spending of about $213 billion.[2] As a result of flexibility in the program's design, Medicaid consists of 56 distinct state-based programs.[3]

The program's size and diversity make it particularly vulnerable to improper payments, including payments made for treatments or services that were not covered by the program, that were not medically necessary, or that were never provided. In fiscal year 2016, improper payments totaled an estimated 10.5 percent ($36 billion) of federal Medicaid expenditures, an increase from an estimated 9.8 percent ($29 billion) in fiscal year 2015. While the percentage of improper payments is increasing, the concerns are not new; we added Medicaid to our list of

[1]An improper payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. It includes any payment to an ineligible recipient, any payment for an ineligible service, any duplicate payment, payment for services not received (except where authorized by law), and any payment that does not account for credit for applicable discounts. Improper Payments Elimination and Recovery Act of 2010, Pub. L. No. 111-204, § 2(e), 124 Stat. 2224, 2227 (codified at 31 U.S.C. § 3321 note). Office of Management and Budget guidance also instructs agencies to report as improper payments any payments for which insufficient or no documentation is found.

[2]Department of Health and Human Services, Centers for Medicare & Medicaid Services, Office of the Actuary, *2015 Actuarial Report on the Financial Outlook for Medicaid* (Washington, D.C.: 2015).

[3]The federal government matches states' expenditures for most Medicaid services using a statutory formula based on each state's per capita income. The 56 Medicaid programs include one for each of the 50 states, the District of Columbia, Puerto Rico, Samoa, Guam, the Commonwealth of the Northern Mariana Islands, and the United States Virgin Islands.

high-risk programs in January 2003, because of the program's risk of improper payments, as well as insufficient federal and state oversight.[4]

States are the first line of defense against Medicaid improper payments. Specifically, they must comply with federal requirements to ensure the qualifications of the providers who bill the program, detect improper payments, recover overpayments, and refer suspected cases of fraud and abuse to law enforcement authorities. At the federal level, the Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS), is responsible for supporting and overseeing state Medicaid program integrity activities. The Deficit Reduction Act of 2005 (DRA) expanded CMS's oversight role by, for example, establishing the Medicaid Integrity Program and including other provisions designed to increase CMS's support for state activities to address Medicaid fraud, waste, and abuse. The DRA provided appropriations to implement the Medicaid Integrity Program, and the Patient Protection and Affordable Care Act (PPACA), enacted in March 2010, gave CMS and states additional provider and program integrity oversight tools. In particular, PPACA and its implementing regulations require state Medicaid agencies to terminate the participation of any provider that has been terminated on or after January 1, 2011, under Medicare, any other state Medicaid program, or Children's Health Insurance Program.

Beginning in 2014, PPACA also provided millions of low-income Americans new options for obtaining health insurance coverage—through the Medicaid program or through an exchange, which is a marketplace where eligible individuals may compare and purchase private health insurance. Because many low-income individuals experience income volatility, they are likely to transition between Medicaid and subsidized exchange coverage. PPACA required the creation of a coordinated eligibility and enrollment process for Medicaid and the exchanges to streamline the eligibility determination process, and to ensure that individuals are enrolled in the coverage for which they are eligible, and transferred to the appropriate form of coverage if their eligibility changes.

Streamlining eligibility determinations necessitated the adoption of new policies and information technology systems by the states, and can require significant coordination between states and the federal

[4]See GAO, *Major Management Challenges and Program Risks: Department of Health and Human Services*, GAO-03-101 (Washington, D.C.: Jan. 2003).

government. CMS oversight is crucial to ensure that determinations of Medicaid eligibility are appropriate, and that the risk of coverage gaps and duplicate coverage—generally not permitted under federal law—is minimized.

You asked GAO to testify today on program integrity issues in Medicaid, including issues associated with the Medicaid expansion. My remarks focus on four key Medicaid program integrity issues we have identified, as well as the progress CMS has made addressing them, and the related challenges the agency and states continue to face.

My remarks today are based on our large body of work on the Medicaid program, including our 2015 report on key issues facing the Medicaid program, as well as agency responses to recommendations that we have made. See appendix I for a list of related GAO products and appendix II for selected recommendations. Those reports provide further details on our scope and methodology. We conducted all of the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

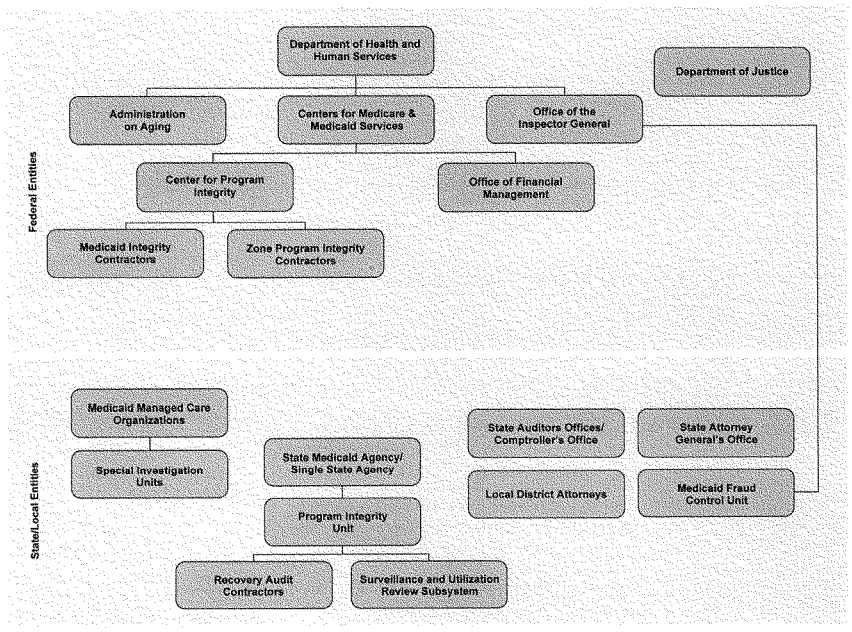
Background

Under the Medicaid program's federal-state partnership, CMS is responsible for overseeing the program, while state Medicaid agencies are responsible for the day-to-day administration of the program. Although subject to federal requirements, each state develops its own Medicaid administrative structure for carrying out the program, including its approach to program integrity. To monitor program integrity in Medicaid, CMS estimates the national improper payment rate on an annual basis through the Payment Error Rate Measurement (PERM) program. The PERM involves reviews of sampled fee for service claims, payments to managed care entities, and beneficiary eligibility determinations in the states; the national improper payment rate is a weighted average of states' rates in each of these components.

State Medicaid programs do not work in isolation on program integrity; instead, there are a large number of federal agencies, other state entities, and contractors with which states must coordinate. (See fig. 1.) Recognizing the importance of federal state collaboration on program integrity issues, in November 2016, along with the Office of Management

and Budget, we convened a meeting with state auditors, CMS, and other federal officials to discuss ways to strengthen collaboration between the federal government and the states.

Figure 1: Federal and Non-Federal Entities with Primary Oversight Responsibilities for Medicaid Program Integrity



Source: GAO. | GAO-17-386T

Note: Zone Program Integrity Contractors investigate potential fraud.

In recent years, Medicaid expenditures and enrollment grew under PPACA. Growth in enrollment is primarily due to more than half of the states choosing to expand their Medicaid programs by covering certain low-income adults not historically eligible for Medicaid coverage, as

authorized under PPACA. In addition to expanding Medicaid eligibility, PPACA required the establishment of health insurance exchanges in all states, and provided for federal subsidies to assist qualifying low-income individuals in paying for exchange coverage.[5] States may elect to establish and operate an exchange, known as a state-based exchange, or allow CMS—which is responsible for overseeing the exchanges—to do so within the state, known as a federally facilitated exchange (FFE).[6] As of March 2015, CMS operated an FFE in 34 states, and 17 states were approved to operate state-based exchanges.

Despite Steps Taken, Additional Efforts Are Needed to Control Medicaid Improper Payments

CMS has taken steps to improve Medicaid program integrity and reduce improper payments; however, additional actions should be taken to help further prevent improper payments. Specifically, our work has identified four key program integrity issues for the Medicaid program—enrollment verification, managed care, provider screening, and coordination between Medicaid and the exchanges—along with CMS's progress in addressing them, and additional necessary actions.

Ensuring that Only Eligible Beneficiaries Are Enrolled in Medicaid

Since 2011, CMS has taken steps to make the Medicaid enrollment-verification process more data-driven to improve the accuracy of eligibility determinations.[7] For example, in response to PPACA, CMS established a

[5]CMS commonly refers to the exchanges as marketplaces. Where we discuss exchanges in this testimony, we are referring only to the exchanges that offer coverage directly to individuals, rather than the exchanges that offer coverage to small businesses and are also required under PPACA. We refer to health plans purchased through the exchanges as exchange coverage and enrollment in exchange coverage with federal subsidies as subsidized exchange coverage. Federal subsidies for exchange coverage include premium tax credits, which are available to eligible individuals with incomes between 100 and 400 percent of the federal poverty level (FPL) and who do not have access to minimum essential coverage, including most Medicaid coverage. In addition, subsidies may include cost-sharing reductions for eligible individuals with incomes between 100 and 250 percent of the FPL. Medicaid plans that provide less than full benefits do not constitute minimum essential coverage and therefore do not preclude individuals from being eligible for subsidized exchange coverage.

[6]In this testimony, we refer to states with federally facilitated exchanges as FFE states. States with state-based exchanges may use the FFE information technology systems for eligibility and enrollment functions. In 2014, two states with state-based exchanges used the FFE information technology systems for eligibility and enrollment, while in 2015 three states with state-based exchanges did so.

[7]See GAO, *Medicaid: CMS Could Take Additional Actions to Help Improve Provider and Beneficiary Fraud Controls*, GAO-15-665T (Washington, D.C.: June 2, 2015).

more rigorous approach to verifying financial and nonfinancial information needed to determine Medicaid beneficiary eligibility.[8] CMS created a tool called the Data Services Hub that was implemented in fiscal year 2014 to help verify beneficiary applicant information used to determine eligibility for enrollment in qualified health plans and insurance-affordability programs, including Medicaid. The hub routes to and verifies application information in various external data sources, such as the Social Security Administration and the Department of Homeland Security. According to CMS, the hub can verify key application information, including household income and size, citizenship, state residency, incarceration status, and immigration status.

Despite CMS's efforts, there continue to be gaps in the agency's efforts to ensure that only eligible individuals are enrolled into Medicaid. In particular, our work found that federal and selected state-based marketplaces approved health insurance coverage and subsidies for 9 of 12 fictitious applications made during the 2016 special enrollment period.[9] In another study, we found that CMS also had gaps in ensuring that Medicaid expenditures for enrollees—including enrollees eligible as a result of the PPACA expansion—are matched appropriately by the federal government.[10] Specifically, we found that CMS had excluded from review federal Medicaid eligibility determinations in the states that have delegated authority to the federal government to make Medicaid eligibility determinations through the federally facilitated exchange. To address this gap in oversight of eligibility determinations, we recommended that CMS conduct reviews of federal Medicaid eligibility determinations to ascertain the accuracy of these determinations and institute corrective action plans where necessary. In October 2016, HHS provided additional information indicating that the department is relying upon operational controls within federal marketplaces to ensure accurate eligibility determinations as well as new processes that would identify duplicate coverage. However, we

[8]78 Fed. Reg. 42160 (July 15, 2013); 81 Fed. Reg. 86382 (Nov. 30, 2016).

[9]See GAO, *Patient Protection and Affordable Care Act: Results of Enrollment Testing for the 2016 Special Enrollment Period*, GAO-17-78 (Washington, D.C.: Nov. 17, 2016).

[10]See GAO, *Medicaid: Additional Efforts Needed to Ensure that State Spending is Appropriately Matched with Federal Funds*, GAO-16-53 (Washington, D.C.: Oct. 16, 2015). States that chose to expand eligibility to nearly all adults with incomes at or below 133 percent of the federal poverty level are eligible for increased federal matching rates for enrollees receiving coverage through the state option to expand Medicaid under PPACA, and where applicable, enrollees in states that expanded coverage prior to PPACA's enactment.

continue to believe that without a systematic review of federal eligibility determinations, the agency lacks a mechanism to identify and correct errors and associated payments.

Lastly, CMS requires all states to participate annually in the Eligibility Review Pilots to test different approaches to measuring the accuracy of eligibility determinations under the new beneficiary enrollment processes.[11] Oversight of beneficiary eligibility is important to program integrity. Our prior work has identified thousands of Medicaid beneficiaries involved in potential improper or fraudulent payments. Some of the concerns that we identified included beneficiaries having payments made on their behalf concurrently by two or more states, and payments made for claims that were dated after a beneficiary's death.[12]

Improving Oversight of Managed Care

CMS has taken steps to provide states with additional guidance on their oversight of Medicaid managed care organizations.[13] In October 2014, CMS made available on its website the managed care plan compliance toolkit to provide further guidance to states and managed care plans on identifying improper payments to providers. In May 2016, CMS issued a final rule on Medicaid managed care, which requires states to conduct periodic audits of financial data submitted by, or on behalf of each Medicaid managed care plan.[14] The final rule takes additional steps to improve oversight of Medicaid managed care, with some provisions applying after 2018. CMS has also taken action in response to recommendations that we made with regard to increasing guidance for

[11]In light of the changes to Medicaid eligibility standards and state eligibility systems necessitated by PPACA, CMS announced that the agency has suspended the eligibility portion of the PERM until fiscal year 2018.

[12]See GAO, *Medicaid: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls*, GAO-15-313 (Washington, D.C.: May 14, 2015). These results were from fiscal year 2011, which at the time of our reporting was the most-recent year for which reliable data were available in four selected states: Arizona, Florida, Michigan, and New Jersey. These states had about 9.2 million beneficiaries and accounted for 13 percent of all fiscal year 2011 Medicaid payments.

[13]See GAO, *Medicaid: Key Issues Facing the Program*. GAO-15-677 (Washington, D.C.: July 30, 2015).

[14]81 Fed. Reg. 27,498 (May 6, 2016).

states, requiring states to audit managed care organizations, and providing states with additional audit support.[15]

Oversight of Medicaid managed care is increasing in importance as states' use of managed care plans to deliver services has been growing.[16] More than half of all Medicaid beneficiaries are now enrolled in managed care plans, and nearly 40 percent of Medicaid expenditures are for health care services delivered through managed care.[17] The estimated improper payment rate for managed care is currently less than one percent; however, this estimate is based on a review of the payments made to managed care organizations and does not review any underlying medical documentation. Additional actions on the part of CMS and the states are critical to improving program integrity in Medicaid. In particular, we and the HHS Office of Inspector General have identified incomplete and untimely managed care encounter data.[18] Encounter data are data that managed care organizations are expected to report to state Medicaid programs, allowing states to track the services received by beneficiaries enrolled in managed care. Our work found that encounter data for 11 states were not available in a timely manner, and that 6 states had encounter data that we deemed were unreliable.

Ensuring that Only Eligible Providers Are Enrolled in Medicaid.

PPACA included multiple provisions aimed at strengthening the screening of providers who enroll to participate in Medicaid. While the act requires that all providers and suppliers be subject to licensure checks, it gave CMS discretion to establish a risk-based application of other screening procedures. According to CMS's risk-based screening, moderate- and high-risk providers and suppliers additionally must undergo pre-enrollment and post-enrollment site visits, while high-risk providers and

[15]See GAO, *Medicaid Program Integrity: Increased Oversight Needed to Ensure Integrity of Growing Managed Care Expenditures*, GAO-14-341 (Washington, D.C.: May 19, 2014).

[16]States may have different types of managed care arrangements in Medicaid. In this report, where we refer to Medicaid managed care plans, we are referring to managed care plans or organizations that provide services under a comprehensive, risk-based managed care arrangement, the most common type of managed care arrangement.

[17]See GAO, *Medicaid Managed Care: Trends in Federal Spending and State Oversight of Costs and Enrollment*, GAO-16-77 (Washington, D.C.: Dec. 17, 2015).

[18]See GAO, *Medicaid: Service Utilization Patterns for Beneficiaries in Managed Care*, GAO-15-481 (Washington, D.C.: May 29, 2015). See also Department of Health and Human Service, Office of Inspector General, *Not All States Reported Medicaid Managed Care Encounter Data as Required*, OEI-07-13-00120 (July 2015).

suppliers also will be subject to fingerprint-based criminal-background checks. This requirement may address some of the potentially fraudulent or improper payments. Additionally, CMS regulations now require that the state Medicaid agency enroll all Medicaid managed care providers, which has the potential to improve oversight of providers in managed care.

Prior to PPACA, if one state terminated a provider from its Medicaid program, a provider could potentially enroll in or continue participation in another state's Medicaid program, leaving the latter state's program vulnerable to potential fraud, waste, and abuse. Our prior work has identified hundreds of Medicaid providers who were potentially improperly receiving Medicaid payments.[19] Potential improper behavior included providers with suspended or revoked licenses, improper mailing addresses, or deceased providers.

Actions to ensure appropriate oversight of Medicaid providers, however, continue to require additional action on the part of CMS and the states. Our work, which was based on 2 states and 16 health plans, found that these states and health plans used information that was fragmented across 22 databases managed by 15 different federal agencies to screen providers—and that these databases did not always have unique identifiers.[20] Our work resulted in in a recommendation that CMS identify databases best suited for oversight of provider eligibility and coordinate with other agencies to explore the use of a unique identifier. CMS regulations now require that the state Medicaid agency enroll all Medicaid managed care providers, which has the potential to improve oversight of providers in managed care. However, CMS has not yet evaluated whether the additional database merit further action or considered ways to ensure that a unique identifier is available so that providers can be accurately identified. We also found that the 10 selected states that we reviewed used inconsistent practices to make data on ineligible providers publicly available, which could result in provider screening efforts that do not identify ineligible providers. CMS has taken action that is responsive to another recommendation on providing guidance to state Medicaid programs, establishing expectations and best practices on sharing provider screening data among states and Managed care plans. In

[19]See GAO-15-313.

[20]See GAO, *Medicaid Program Integrity: Improved Guidance Needed to Better Support Efforts to Screen Managed Care Providers*, GAO-16-402 (Washington, D.C.: Apr. 22, 2016).

addition, the recently enacted 21st Century Cures Act takes important steps to address this recommendation including requiring CMS to establish a provider termination notification database by July 2018 and requiring the agency to establish uniform terminology for reasons for provider terminations.

Minimizing Duplicate Coverage between Medicaid and the Exchanges

Regarding coordination between Medicaid and the exchanges, CMS implemented policies and procedures to ensure that individuals do not have duplicate coverage (enrolled in Medicaid and in subsidized exchange coverage). Due to changes in income and other factors, it is likely that under PPACA many low-income individuals will transition between Medicaid and subsidized exchange coverage. Our prior work found that despite CMS policies and procedures designed to prevent duplicate coverage, it was occurring. In response, CMS has conducted three checks to identify individuals with duplicate coverage. CMS has also reported that the agency intends to complete these checks at least two times per coverage year, which has the potential to save federal—as well as beneficiary—dollars.

While CMS has made progress by implementing checks for duplicate coverage, weaknesses remain. CMS has not developed a plan for assessing whether the checks and other procedures are sufficient to prevent and detect duplicate coverage. In March 2016, CMS reported that it was reviewing data on the number of people identified as having duplicate coverage through the first CMS check who subsequently disenrolled from subsidized exchange coverage. CMS reported reviewing these data as a means of assessing the effectiveness of the checks for duplicate coverage. We are continuing to monitor CMS's efforts in this area, particularly whether CMS develops a plan, including thresholds for the level of duplicate coverage it deems acceptable, to routinely monitor the effectiveness of the checks and other planned procedures to prevent and detect duplicate coverage.

In closing, Medicaid represents significant expenditures for the federal government and states, and is the source of health care for tens of millions of Americans. Its long-term sustainability is critical, and will require, among other things, effective federal and state oversight.

Chairman Murphy, Ranking Member DeGette, and Members of the Subcommittee, this concludes my prepared statement. I would be pleased to respond to any questions that you might have.

GAO Contact and Staff Acknowledgments

If you or your staff have any questions about this testimony, please contact Carolyn L. Yocom, Director, Health Care at (202) 512-7114 or YocomC@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this testimony are Ann Tynan (Assistant Director), Susan Barnidge, Leslie Gordon, Drew Long, Andrea E. Richardson, and Jennifer Whitworth.

Appendix I: Related GAO Reports

Patient Protection and Affordable Care Act: Results of Enrollment Testing for the 2016 Special Enrollment Period. GAO-17-78. Washington, D.C.: November 17, 2016.

Medicaid Fee-For-Service: State Resources Vary for Helping Beneficiaries Find Providers. GAO-16-809. Washington, D.C.: August 29, 2016.

Patient Protection and Affordable Care Act: CMS Should Act to Strengthen Enrollment Controls and Manage Fraud Risk. GAO-16-506T. Washington, D.C.: March 17, 2016.

Medicaid Managed Care: Trends in Federal Spending and State Oversight of Costs and Enrollment. GAO-16-77. Washington, D.C.: December 17, 2015.

Medicaid: Additional Efforts Needed to Ensure that State Spending is Appropriately Matched with Federal Funds. GAO-16-53. Washington, D.C.: October 16, 2015.

Medicaid: CMS Could Take Additional Actions to Help Improve Provider and Beneficiary Fraud Controls. GAO-15-665T. Washington, D.C.: June 2, 2015.

Medicaid: Service Utilization Patterns for Beneficiaries in Managed Care. GAO-15-481. Washington, D.C.: May 29, 2015.

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

Medicaid Program Integrity: Increased Oversight Needed to Ensure Integrity of Growing Managed Care Expenditures. GAO-14-341. Washington, D.C.: May 19, 2014.

Appendix II: Selected Recommendations Related to Medicaid Program Integrity

The following table lists selected recommendations GAO has made to the Department of Health and Human Services regarding Medicaid program integrity. The agency has implemented 3 of these recommendations. The agency has either not taken or has not completed steps to implement the remaining 8 recommendations, as of January 2017.

Table 1: Selected Recommendations Related to Medicaid Program Integrity

GAO Report	Recommendation
Medicaid Program Integrity: Improved Guidance Needed to Better Support Efforts to Screen Managed Care Providers. GAO-16-402, April 22, 2016	The Centers for Medicare & Medicaid Services (CMS) should: • consider which additional databases that states and Medicaid managed care plans use to screen providers could be helpful in improving the effectiveness of these efforts and determine whether any of these databases should be added to the list of databases identified by CMS for screening purposes; • collaborate with the Social Security Administration to facilitate sharing CMS's Death Master File subscription with state Medicaid programs; • coordinate with other federal agencies, as necessary, to explore the use of an identifier that is relevant for the screening of Medicaid managed care plan providers and common across databases used to screen Medicaid managed care plan providers; and • provide state Medicaid programs with guidance that establishes expectations and best practices on sharing provider screening data among states and Medicaid managed care plans.
Medicaid: Additional Efforts Needed to Ensure that State Spending is Appropriately Matched with Federal Funds. GAO-16-53, October 16, 2015	CMS should: • conduct reviews of federal Medicaid eligibility determinations to ascertain the accuracy of these determinations and institute corrective action plans where necessary; and • use the information obtained from state and federal eligibility reviews to inform the agency's review of expenditures for different eligibility groups in order to ensure that expenditures are reported correctly and matched appropriately.
Medicaid: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls. GAO-15-313, May 14, 2015	CMS should: • issue guidance to states to better identify beneficiaries who are deceased; and • provide guidance to states on the availability of automated information through Medicare's enrollment database—the Provider Enrollment, Chain and Ownership System (PECOS)—and full access to all pertinent PECOS information, such as ownership information, to help screen Medicaid providers more efficiently and effectively.
Medicaid Program Integrity: Increased Oversight Needed to Ensure Integrity of Growing Managed Care Expenditures. GAO-14-341, May 19, 2014	CMS should: • hold states accountable for Medicaid managed care program integrity by requiring states to conduct audits of payments to and by managed care organizations; • update CMS's Medicaid managed care guidance on program integrity practices and effective handling of managed care organization recoveries; and • provide the states with additional support in overseeing Medicaid managed care program integrity, such as the option to obtain audit assistance from existing Medicaid integrity contractors.

Source: GAO. | GAO-17-386T

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Mr. MURPHY. Thank you, Ms. Yocom. Now, Ms. Maxwell, you are recognized for 5 minutes.

TESTIMONY OF ANN MAXWELL

Ms. MAXWELL. Thank you. Good morning, Chairman Murphy, Ranking Member DeGette, and other distinguished members of the subcommittee. Thank you for the opportunity to appear before you today to discuss how to protect taxpayers and Medicaid patients from fraud, waste, and abuse.

I first want to give you a sense of what Medicaid fraud looks like. It can be very complex and include very different kinds of schemes. For example, in one instance, we indicted the owners of a network of over 30 nursing homes and assisted living facilities that billed for services that patients didn't need. In another example, we convicted a doctor for writing fake prescriptions for expensive drugs that were then sold on the black market or billed to Medicaid. It is exactly these type of schemes that highlight the need to protect Medicaid against unscrupulous providers who steal, at the expense of taxpayers, and put patients at risk.

Today, I want to highlight actions that we can take to better protect Medicaid from these types of fraud schemes and other vulnerabilities facing Medicaid. State Medicaid agencies and the Centers for Medicare and Medicaid, known as CMS, share responsibility for funding as well as protecting Medicaid. And we recommend they focus on three straightforward program integrity principles: Prevent, detect, and enforce.

First and foremost, CMS and states must prevent fraud, waste, and abuse. Focusing on prevention is critical and commonsense, but Medicaid programs sometimes fall short and end up chasing after providers to remove them from the program or to recover overpayments.

State Medicaid agencies should know who they are doing business with before they give them the green light to start billing. To help with that, we recommend that states fully implement criminal background checks, conduct site visits, and collect accurate data about providers.

In addition, to prevent incorrectly paying providers, we recommend that states learn from past administrative errors and proactively update their systems to prevent improper payments. Medicaid should only be paying the right amount for the right service.

The next critical program integrity safeguard is the ability to detect fraud, waste, and abuse in a timely manner. Accurate data is an essential tool for doing this. However, as we've just heard and our work shows, national Medicaid data, including data from managed care companies, has deficiencies. Sophisticated data analytics exist to detect potential fraud, to detect patient harm, and even to target oversight, but they are ineffective without accurate and timely data.

Further, without national Medicaid data, States cannot see the whole picture. For example, we found providers enrolled in one State Medicaid program that had been terminated by another state. But without shared data, States had no way of knowing this

and had to find out the hard way that they had enrolled fraudulent and abusive providers.

Finally, it's imperative to take swift and appropriate enforcement action to correct problems as well as to prevent future harm.

Federal and State enforcement efforts have very high return on investment, yielding annual recoveries in the billions of dollars and imposing criminal penalties on thousands of wrongdoers each year. However, states face challenges in taking full advantage of their administrative authorities, including suspending provider payments and terminating providers, where appropriate.

In addition, State Medicaid Fraud Control Units lack a key authority. Currently, these state units can investigate allegations of patient abuse that occur within institutions, but if that alleged abuse took place in a patient's home or a different community setting, they cannot. Medicaid patients receiving services in their home should have as many protections as those in institutions.

In closing, our work reveals a number of opportunities to improve Medicaid safeguards. In particular, a heightened focus on the program integrity principles of prevention, detection, and enforcement will help protect Medicaid now and as it evolves. Prioritizing program integrity will ensure that Medicaid funds are used as intended, to provide needed healthcare services and long-term nursing home care for those who are in the most need.

We appreciate the committee's attention to Medicaid program integrity. We've seen it strengthened in the last year, thanks to the efforts here in Congress, and we hope that our work will continue to be a catalyst for continued positive change. Thank you.

[The prepared statement of Ms. Maxwell follows:]

Testimony Before the United States House of Representatives
Committee on Energy and Commerce:
Subcommittee on Oversight and Investigations

Medicaid Oversight: Existing Problems and Ways to Strengthen the Program

Testimony of:

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Testimony of:
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Good morning, Chairman Murphy, Ranking Member DeGette, and other distinguished Members of the Subcommittee. I am Ann Maxwell, Assistant Inspector General for Evaluation and Inspections in the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS or Department). Thank you for the opportunity to appear before you to discuss existing fraud, waste, and abuse in Medicaid and ways to strengthen the program.

Created by statute in 1976, OIG remains a nonpartisan body of evaluators, auditors and investigators, deployed across the nation, to help assess and protect the integrity of Federal health and human services programs enacted by Congress. We remain committed to working with our stakeholders to achieve our shared goals of protecting patients and the taxpayer-funded programs they rely on from fraud, waste, and abuse, and promoting efficient and effective program operations.

Protecting Medicaid from fraud, waste, and abuse is an urgent priority because of its impact on the health of vulnerable individuals and its fiscal impacts on Federal and State spending. As of September 2016, more than 74 million individuals were enrolled in Medicaid, and total Medicaid spending for fiscal year (FY) 2016 was $574 billion. Thus, achieving this goal is critically important. OIG has consistently identified effective administration and strengthening the program integrity of Medicaid as among the top management challenges facing HHS.

The Office of Inspector General's Strategy for Medicaid Oversight

OIG advances its core mission of protecting the integrity of HHS programs, including Medicaid, and the people they serve by working to prevent and detect fraud, waste, and abuse. OIG offers recommendations to improve program integrity and the efficiency and effectiveness of programs and operations. When misconduct is identified, OIG takes appropriate enforcement action.

We accomplish this by focusing on the core program integrity principles of prevention, detection, and enforcement. On the basis of our experience overseeing Medicaid and other health and human services programs in the Department's $1 trillion portfolio, we know that these programs can and should be designed and operated to minimize fraud, waste, and abuse by following these same principles. Programs, and those who are accountable for their success, need effective tools (i) to prevent fraud, waste, and abuse from occurring in the first instance – such as effective gatekeeping to prevent untrustworthy individuals and entities from accessing Federal funds, risk assessment capabilities, and sound management practices; (ii) to detect fraud, waste, and abuse – through access to and effective use of high-quality data and sharing of information about potential problems; and (iii) to address problems that are detected – such as through enforcement or corrective actions.

Program Integrity Principles
Prevent – Know Who You Are Doing Business With
Detect – Identify Fraud, Waste, and Abuse in a Timely Manner
Enforce – Take Appropriate Action to Correct Problems and Prevent Future Harm

OIG operationalizes our mission by conducting audits, evaluations, and investigations, and using data analytics to identify problems or program risks; recommending improvements to address problems and prevent their recurrence; holding wrongdoers accountable; and providing guidance and tools to help well-intended participants in HHS programs to comply with the rules. OIG has an additional, unique role in Medicaid program integrity. We administer and oversee Federal grants to State Medicaid Fraud Control Units (MFCU) and assess each MFCU's performance and compliance with Federal requirements. MFCUs investigate and prosecute Medicaid provider fraud and patient abuse or neglect under State law and receive referrals of credible allegations of fraud from State Medicaid agencies. OIG investigators often partner with MFCUs on joint investigations of Medicaid fraud.

Medicaid's Existing Program Integrity Challenges and Recommendations for Improvement

For many years, OIG has designated the Medicaid program a Top Management Challenge. Our evaluations, audits, and investigations have consistently found that Medicaid and the patients that rely on it are not as protected as they could be from fraudulent institutions, agencies and providers that intend to defraud the program, and potentially harm patients. Beyond OIG, the Centers for Medicare & Medicaid Services (CMS), State Medicaid agencies, and managed care contractors have an essential responsibility to ensure Medicaid program integrity.

Today, I would like to focus on recent challenges facing Medicaid and ways we believe States, CMS, and providers could address these challenges. I will frame my testimony by the core program integrity principles of prevention, detection, and enforcement.

Prevention: Preventing bad actors from participating in Medicaid is critical, but Medicaid programs sometimes fail to do so effectively

States have not fully enacted enhanced provider screening. The most effective way to prevent fraud is to keep bad actors out of the program to begin with. However, States are not screening high-risk providers with all of the tools at their disposal. We found that in 2015, 4 years after they were required to do so, 37 States reported that they were not conducting fingerprint-based criminal background checks. In addition, 11 States were not conducting site visits, which were also required. This leaves Medicaid vulnerable to providers who may be ineligible or who may defraud the program and harm patients.

OIG has also raised concerns about the varying standards, and in some cases minimal vetting, for Medicaid personal care services providers. This leaves the Medicaid program vulnerable to financial fraud. Even more concerning, it leaves Medicaid patients vulnerable to abuse and neglect and puts patients and the program at risk

Personal Care Services Patient Harm

In Illinois, a concerned neighbor found a Medicaid beneficiary in an incoherent state. The beneficiary was ultimately hospitalized for multiple days as a result of neglect. An investigation revealed that the beneficiary's personal care attendant had not been there in over a week, yet the attendant had been submitting claims to the Illinois Home Services Program.

from individuals who should not be trusted to render care. OIG and the MFCUs have uncovered a disturbingly high number of cases of fraud and abuse by Medicaid personal care services providers. While it is important to give patients the flexibility to receive care in their homes, CMS and States must to do more to balance this goal with the real risks of harm to patients and potential fraud.

States also are not collecting and maintaining accurate ownership information about the providers they are paying. For example, when we compared Medicaid and Medicare ownership data for the same provider, Medicaid had 63 owners listed and Medicare's database had 14 owners listed. This same provider reported to OIG that it had 12 owners (and most of the 12 owners did not match those listed with Medicaid or Medicare). OIG has recommended that CMS work to develop an integrated database with provider information that Medicare and all State Medicaid programs could use. This could provide a "one-stop shop" for Federal and State program officials and for providers – reducing burden and duplication in reporting, verifying, and updating information. This also would provide the opportunity for more efficient and effective oversight to ensure that all programs have accurate and complete data to support fraud prevention and detection.

Program Integrity Principle: Know who you are doing business with and refuse business with bad actors.

OIG Recommendations: CMS should improve provider screening by working with States to implement fingerprint-based criminal background checks for high-risk providers, conduct site visits, and maintain accurate provider ownership information.

Improper payment rates indicate the need to better protect Medicaid. Estimated Medicaid improper payments totaled $29.1 billion in FY 2015. To comply with the Improper Payments Elimination and

Recovery Act of 2010, an agency must report an improper payment error rate that is at or less than the target error rate established for the fiscal year. The Medicaid target improper payment rate for FY 2015 was 6.7 percent. HHS did not meet this requirement and had an estimated improper payment rate of 9.8 percent.

Program Integrity Principle: Implement effective safeguards and sound management to prevent waste.

OIG Recommendation: HHS should work to improve payment accuracy.

Detection: Data is an essential tool for detecting fraud, waste, and abuse; however, national Medicaid data has deficiencies that hinder timely and accurate detection, and CMS and States do not always use data effectively

Proper oversight includes the capacity to detect problems in real time. This can help prevent inappropriate payments, protect patients, and reduce time-consuming and expensive "pay and chase" activities. Detecting problems is a shared responsibility for all actors in the Medicaid program: CMS, States, managed care contractors, and providers.

CMS does not have complete and accurate data needed to effectively oversee the Medicaid program. Without accurate claims data, adequate oversight of the Medicaid program is compromised. OIG has a history of work that points to the incompleteness and inaccuracy of CMS's national Medicaid database, the Transformed Medicaid Statistical Information System (T-MSIS). Without a national dataset, CMS is

unable to identify nationwide trends and vulnerabilities. This hampers program integrity efforts because fraud does not respect State boundaries.

Program Integrity Principle: Complete, accurate, and relevant data are essential to program integrity.

OIG Recommendations: CMS should establish a deadline for when national T-MSIS data will be available for multi-State program integrity efforts, and CMS and States should improve the accuracy of information about which providers are participating in Medicaid managed care.

Inaccurate information about providers in Medicaid managed care plans inhibits fraud detection and patient care. Accurate rosters of providers participating in managed care plans are essential for State and Federal oversight to detect potential fraud, waste, and abuse, as well as for patients to obtain health care. However, we found vulnerabilities in managed care organizations' data regarding their providers. Specifically, when we asked managed care organizations for a list of their providers, we found that 38 percent of them were not participating in the plan at the location listed in the State's Medicaid provider directory.

Program Integrity Principle: Complete and accurate information about providers is essential to program integrity.

OIG Recommendation: CMS should work with States to improve the accuracy of plan information and assess the number of providers offering care.

States are not ensuring that providers detect and repay overpayments in patient accounts. States must rely on providers to review credit balances in patients' accounts to detect overpayments and return them to the State. Medicaid credit balances occur when the reimbursement a provider receives

for services rendered to a Medicaid beneficiary exceeds the charges billed. We found providers sometimes failed to reconcile patient records with credit balances and report and return the associated Medicaid overpayments to State Medicaid agencies.

Program Integrity Principle: Detection of fraud, waste, and abuse is a shared responsibility.

OIG Recommendation: CMS should clarify that providers are expected to exercise reasonable diligence to identify, report, and return overpayments.

CMS and States could better use data analytics to detect providers with questionable billing patterns that may indicate fraud or harm. OIG has a history of work identifying providers who are outliers when compared to their peers either in terms of the number of patients or the amount billed. We refer to them as "questionable billers." While there is no clear evidence of fraud or abuse, patterns in the providers' behavior suggest a strong suspicion of fraud, waste, or abuse. One example of OIG's questionable-billing work is our evaluation of pediatric dentists in California. We found that 335 dental providers – representing 8 percent of California's general dentists and orthodontists – either billed for an extremely large number of services or provided certain services to an extremely large number of children. These services included pulpotomies – often referred to as "baby root canals" – and extractions. We referred those providers to the State and CMS for followup. CMS and States could do more to conduct similar analyses to OIG's to detect and followup on questionable billing that may signal fraud or abuse, especially where there is a risk of patient harm.

Program Integrity Principle: Use data analytics to detect potential fraud and patient harm and target oversight.

OIG Recommendation: CMS and States should increase monitoring of dental providers to address the questionable billing detected and to safeguard against future fraud.

Enforcement: Federal and State enforcement efforts have yielded billions of dollars in recovered funds and held thousands of wrongdoers accountable; however, CMS and States are not taking full advantage of their administrative enforcement authorities; and MFCUs lack a key authority

OIG works closely with our Federal and State partners to investigate and remediate fraud and abuse. In FY 2016, OIG investigative actions related to Medicaid resulted in 312 indictments, 348 criminal actions, and 308 civil actions. These Medicaid cases, some of which also involved Medicare, resulted in almost $3 billion in expected recoveries. We worked most of these cases jointly with MFCUs. OIG also excluded 3,635 providers and entities from Federal health programs in FY 2016.

Home Health Fraud

In a joint investigation with the District of Columbia MFCU, two owners of a home care agency were sentenced to 10 years in prison for health care fraud, money laundering, and other charges stemming from a scheme in which they and others defrauded the District of Columbia Medicaid program of over $80 million.

State MFCU investigations have a significant impact on Medicaid. In FY 2015, MFCUs collectively obtained 1,889 indictments, 1,553 convictions, and monetary recoveries of nearly $744 million. They also make program recommendations to their State Medicaid agencies on the basis of the vulnerabilities they uncover, thus also helping to prevent future fraud. However, more could be done by expanding a key authority for MFCUs to investigate patient abuse.

State Medicaid Fraud Control Units lack the authority to investigate and prosecute patient abuse or neglect in noninstitutional settings. While MFCUs can investigate and prosecute patient abuse or neglect in Medicaid-funded health care facilities and in board-and-care facilities, they do not have authority to pursue similar cases that occur in a home- or community-based setting, such as abuse or neglect by a personal care services attendant or in a clinician's office. MFCUs must instead refer any such complaints to local law enforcement, which may have less expertise in investigating patient abuse and neglect than MFCU staff. The current limitation on MFCU authority was logical when the program was established in 1978, at a time when Medicaid services were typically provided in an institutional setting. But the limitation has become outmoded as the delivery and payment for health services has increasingly shifted to in-home and community-based settings.

Program Integrity Principle: Ensure that enforcement bodies have sufficient authority to protect patients and the program.

OIG Recommendation: MFCUs should be granted the authority to investigate and prosecute patient abuse or neglect in home- and community-based settings.

Federal and State enforcement efforts are necessary to keep fraudulent and harmful providers out of the program and to hold wrong-doers accountable. OIG has identified areas in which CMS and State Medicaid agencies are not taking full advantage of their administrative enforcement authorities.

Medicaid providers terminated from one State continued participating in other States. Failure to share data on terminated providers across States is inefficient, and worse, it puts programs and patients at unnecessary risk of fraud or harm. CMS established a database meant to assist State Medicaid agencies

in denying enrollment to providers who have been terminated for cause from Medicare or by another State Medicaid agency. Yet we found that 12 percent of providers who were terminated for cause from State Medicaid agencies in 2011 continued to participate in other State Medicaid agencies as of January 2012, many continued to participate as late as January 2014. Thanks to the support of your Subcommittee, and the Committee at large, beginning in 2018, State Medicaid agencies will be required to report to the terminated-provider database so we hope to see improvements in this area.

States did not always suspend Medicaid payments to providers suspected of fraud. When program officials have credible allegations of fraud, swift response is imperative. When we reviewed use of payment suspensions by several State Medicaid agencies, we found that some did not suspend Medicaid payments to all providers with credible allegations of fraud. For example, of the 81 providers with a credible allegation of fraud in Washington, the State Medicaid agency suspended Medicaid payments to only 33 of them.

Program Integrity Principle: All appropriate steps should be taken to protect the program.

OIG Recommendation: States should suspend Medicaid payments to providers when there are credible allegations of fraud.

Conclusion: Strong Program Integrity Will Always Be Critical

OIG has documented significant challenges in protecting Federal and State Medicaid dollars from fraud, waste, and abuse, and vulnerable populations from harm. In response, OIG and its State and Federal partners have focused their resources on Medicaid fraud, and OIG has made numerous

recommendations for strengthening Medicaid program integrity. Recognizing that Medicaid program integrity is a shared responsibility, OIG has made recommendations that offer suggestions for improvements to CMS and States, as well as the down-stream managed care entities that are often the first line of defense.

Regardless of the financial arrangements between the Federal and State governments, the Medicaid program can and should be designed and operated to minimize fraud, waste, and abuse by following core program integrity principles. Better protection of Medicaid now and in the future requires strengthening the ability to prevent fraud, waste, and abuse; detecting it quickly when it does occur; and swiftly holding wrongdoers accountable. It also requires continuous vigilance to keep up with changes in the environment and constantly evolving fraud schemes.

Thank you, again, for inviting OIG to speak with you on strengthening Medicaid program integrity. We appreciate the Subcommittee's interest. Continued emphasis on program integrity will help to protect Medicaid patients from patient harm and ensure that taxpayer money is appropriately spent.

We hope that our work and this testimony will assist you in your oversight efforts to protect Medicaid patients and all taxpayers from fraud, waste, and abuse.

Mr. MURPHY. Thank you, Ms. Maxwell.

Now, Mr. Howard, you are recognized for 5 minutes.

TESTIMONY OF PAUL HOWARD

Mr. HOWARD. Thank you. Thank you, Chairman Murphy, Ranking Member DeGette, members of the committee. I'd like to thank you for the opportunity to testify today about Medicaid program oversight and ways we might strengthen the program.

Medicaid is undoubtedly a vital component of the Nation's safety net for low-income and vulnerable populations. But an open-ended, automatic Federal matching formula has had vast unintended fiscal consequences, both for the States and the Federal Government, often crowding out funding for other safety net services and supports that might have a bigger impact on the measured health of these populations and their prospects for continued economic mobility.

As you know, Medicaid is a hybrid program that, on average, pays approximately 62 percent through its Federal match, although the upper limit is around 80 and the lowest match is 50 percent. This encourages States to maximize the drawdown of Federal dollars through a number of, sometimes legally questionable, funding designs that my colleagues at GAO and HHS OIG have just mentioned. This Byzantine funding structure makes it extraordinarily difficult for the Federal Government to oversee effectively program integrity. It also encourages wealthier States to spend more on their programs to draw down more Federal dollars. In a 2010 book, Mark Pauly and John Grannemann highlighted that the highest quintile of States by income spent 90 percent more than the lowest quintile of States.

When it comes to waste, fraud, and abuse, we see New York State, which has historically spent much more than other states. Even though it has only 6 percent of the Nation's population, it has spent approximately 11 percent of total Medicaid expenditures and spends 44 percent more per enrollee. The OIG also found that over a period of 20 years, the state had an improper payment rate for its state developmental centers, which the state was overpaid by $15 billion, simply because a payment structure that the state and the Federal Government agreed to in 1990 was never updated to reflect the fact that the state had, in fact, moved the disabled out of the developmental centers and into community supports. To the state's credit, Governor Cuomo in 2011 created a Medicaid redesign team that began to address the program and began first by conceding that the program delivered poor value for beneficiaries and taxpayers.

Since then, through a number of far-reaching highly aggressive reforms, including capping most of the state's state spending outside of the disabled population, lowering that spending from 6.2 percent to 4 percent, the state has saved hundreds of millions of dollars, shifted an emphasis from institutional care to community care, and begun to address some of the behavioral components of poor helth that leave these populations using disproportionately emergency rooms.

The right way to view our healthcare dollars is not to say that Medicaid has per-unit costs that are very low and, thus, it's more

efficient. The better question to ask is, are dollars that we're automatically spending on Medicaid, might they be better purposed to other programs, either an expanded state income earned tax credit, supportive housing for the seriously mental ill, or any other support or service that might have a bigger impact on improving measured health outcomes.

My colleague Oren Cass last year put out a very important study that noted from the period of 1975 to 2012, our spending on low-income supports had doubled, but that 90 percent of the increase had gone to health care. He estimated that if our median spending, either by enrollment or per enrollee, was nationalized, we could save as much as $100 billion annually, and that is money that could be placed elsewhere in other support programs.

In short, we have thickened one strand of our safety net for low-income Americans while neglecting others. If the safety net feels threadbare in places, it's because we have encouraged the states to overspend on health care. What I'm not saying is that Medicaid has no value. There is clear research that shows that Medicaid has an extraordinary rate of return on investments in maternal health and child health.

But large rigorous, randomized, controlled experiments like the Oregon experiment have, as the chairman said, showed no increase in measured health outcomes. Other studies continue to show that the social determinants of health have a much bigger impact on mortality, obesity, asthma, and mortality from cancers like lung cancer, than simply spending more money on health insurance per se.

I'd like to suggest just a few ways we could address this disparity in conclusion. We should agree on broader safety net goals that hold the states responsible for meeting them in ways that are transparent both to the states and the Federal Government.

We should reform the financing incentives of the program to ensure that we're not incentivizing states to automatically funnel additional Federal dollars to health care. They might choose to do so, but we shouldn't effectively bribe them to do so.

And finally, CMS should continue to give more leeway to the states in programming, designing, and spending Medicaid dollars, including on nonhealth supports.

I believe that these reforms would serve both conservative and liberal ends and should be the focus of the 115th Congress. Thank you very much.

[The prepared statement of Mr. Howard follows:]

Medicaid for the 21st Century

Improving Health Outcomes, Accountability, and Efficiency in Partnership with the States

Summary

Medicaid is a vital component of our nation's safety net for low income Americans. Many physicians, nurses, and hospitals go to extraordinary lengths to provide health care to low-income populations that face many non-health related challenges, including to access to affordable housing, transportation, and employment.

But the current structure of the Medicaid program – particularly the open-ended federal matching formula, or FMAP - has led to vast unintended fiscal consequences, encouraging states (and the federal government) to devote ever larger sums to Medicaid to draw down additional generous federal matching funds not available to other state programs.

Thus, Medicaid has effectively crowded out funding for other state safety net programs that might have a greater likelihood of improving measured health outcomes. Providing a significantly increased earned income tax credit, supportive housing for the seriously mentally ill, or well-designed prisoner re-entry programs might all be better investments in the long-term health and economic mobility of low income Americans than spending more dollars on health care per se.

Congress, in consultation with the states, should reform Medicaid to ensure that federal subsidies don't encourage states to allocate ever larger sums of money to health care that might be better spent on safety net supports elsewhere, including by beneficiaries themselves. Structural reforms to federal Medicaid funding, along with greater regulatory, financial, and administrative flexibility from Washington in how states manage their Medicaid programs and

other sources of safety net spending would better serve the interests of America's most vulnerable citizens and should be a bipartisan priority of the 115th Congress.

Testimony

Chairman Murphy, Ranking Member DeGette, members of the committee. I'd like to thank you for the opportunity to testify today about Medicaid Oversight: Existing Problems and Ways to Strengthen the Program.

Medicaid is a vital component of our nation's safety net for low income Americans. Many physicians, nurses, and hospitals go to extraordinary lengths to provide health care to low-income populations that face many non-health related challenges, including access to affordable housing, transportation, and employment. Any one of these factors can make both providing care and patient compliance with recommended care exceptionally difficult.

But it is critical to understand how the current structure of the Medicaid program – particularly the structure of the open-ended federal matching formula, or FMAP - has led to vast unintended fiscal consequences, crowding out funding for other state level programs that might have a greater impact on improving measured health outcomes for the poor. Providing a significantly increased earned income tax credit, supportive housing for the seriously mentally ill, or well- designed prisoner re-entry programs might all be better investments in long term health and economic mobility for low income and vulnerable populations than spending more dollars on health care per se.

As you know, Medicaid is hybrid program, with funding responsibilities shared between the federal government and the states. Each state must meet certain federal guidelines, but each state administers its own Medicaid program. States also establish reimbursement levels for health-care providers and can, with federal approval, add optional benefits to Medicaid coverage and expand eligibility beyond the populations identified by federal baselines. In fact, even

setting aside the ACA's Medicaid expansion, every state has expanded its program to include optional populations and services.[1]

The matching rate for federal funding varies greatly by state, with poorer states receiving larger shares from the federal government. According to the most recent figures, Kentucky receives the highest federal share (79.6%), with Wyoming and Virginia close to the minimum match of 50%. On average, about 62% of Medicaid funding comes from the federal government, according to the Kaiser Family Foundation.[2] Thus, for each dollar states commit to their Medicaid program, the federal treasury automatically provides almost two more.

Because each state has an incentive to minimize its own financial responsibility while maximizing the drawdown of federal dollars, states have found ever more "creative" (and sometimes legally questionable) ways to draw down additional federal dollars.[3] This is a predictable result of the uncapped federal matching formula; it is also responsible for a byzantine web of formulas, cross subsidies, and supplemental payments that makes evaluating Medicaid program integrity and efficiency extremely challenging, and the GAO has identified it as a high risk program since 2003.[4]

What is much less often commented on is the program's regressive structure. Because poorer states have fewer resources (from a smaller tax base) available to devote to health care services, the current FMAP matching rate provides much more federal support for wealthy states compared to poorer ones. In their 2010 book, *Medicaid Everyone Can Count On*, Thomas Grannemann and Mark Pauly note that

> In general, Medicaid benefits are considerably higher in higher-income states than in lower-income states, as are Medicaid payments per beneficiary, despite the much higher federal matching percentage share in lower income states. This spending level is about 89 percent greater in the highest quintile of states by income compared to the lowest.

Pauly and Grannemann's observation is confirmed by the experience of New York, one of the highest states in Medicaid per capita spending and total spending. While the Empire State has only 6%[5] of the nation's population, it accounts for more than 11% of national Medicaid spending (in 2015, the price tag for New York's Medicaid program was estimated to be nearly $60 billion).[6]

According to a 2014 report from the Medicare and CHIP Payment and Access Commission (MACPAC) using the most recent administrative data from 2011, New York spent 44% more per Medicaid enrollee than the national average ($10,426 versus $7,236) and spent more than almost any other state across every Medicaid category: New York spent 21% more per adult enrollee than the national average ($5,297 versus $4,368), 68% more per disabled enrollee ($31,989 versus $19,031), and 56% more per aged enrollee ($25,382 versus $16,236). Spending on children was comparatively modest: New York spent only about 3% more than the national average ($2,961 versus $2,854).[7]

While differences in cost of living undoubtedly explain some fraction of the disparity between New York's figures and those of the rest of the nation, much of the gap results from the program's financial incentive to draw down additional federal dollars.

Complex and fragmented funding streams also makes it extremely difficult to provide adequate accounting controls for the program. In 2012, reports from the Congressional Committee on Oversight and Government Reform and the Office of the Inspector General at the U.S. Department of Health and Human Services revealed that New York had systematically overbilled federal taxpayers for Medicaid services for the mentally disabled for nearly 20 years.

New York's state developmental centers — which offer treatment and housing for individuals with severe developmental disabilities — had received $1.5 million annually per resident in 2009, for a total of $2.3 billion. Of that amount, the HHS Inspector General found $1.7 billion to be above actual reported costs. State centers were compensated at Medicaid payment rates *ten times* higher than the Medicaid rates paid to comparable privately run developmental centers.

How did these enormous overpayments go unnoticed for nearly two decades? According to the congressional oversight-committee report, the overbilling resulted from a funding formula agreed to by HHS and state Medicaid officials in 1990. Over the course of the following 20 years, however, HHS never audited the payment rate to ensure that it was still in line with actual costs. State officials, of course, had no incentive to bring the overpayment to the attention of federal regulators. As a result, New York benefitted from $15 billion in excessive payments.[8]

Despite its outsized spending, New York's health-care outcomes have historically ranged from poor to average compared with other states'. For example, in a 2009 report by the Commonwealth Fund, New York ranked 50th in avoidable hospital admissions.[9]

In 2011, Governor Andrew Cuomo's Medicaid Redesign Team, tasked with slowing program growth and improving patient outcomes, conceded that the state's Medicaid program offered poor value for both enrollees and state taxpayers — in part because of its excessive focus on institutional and hospital based care – and embarked on a multi-year program to right size state spending, shift spending to prevention and chronic care management, and reduce preventable hospital admissions. To the state's credit, spending growth in the program has fallen even faster than the national average in recent years, although it still faces significant challenges.[10]

Right Sizing Health Care Spending Relative to Other Safety Net Programs

Medicaid's challenges are not just programmatic – they are political. The program has developed deep roots in local and state economies, with hospitals and health care systems representing a large source of employment and revenues. Today, Medicaid is the single largest payer of the costs of long-term care services for the elderly and nursing-home care, accounting for more than 40% of both markets. It also pays for around 40% of all U.S. births, according to the National Association of Medicaid Directors.[11]

As a result, health-care providers and others who rely on Medicaid for a significant share of their incomes protest vigorously against any federal efforts to slow Medicaid spending growth. Highly organized and highly motivated stakeholders advocate for increased Medicaid payment rates and program expansion, which in turn increase their political clout.[12]

The simple reality is that U.S. health care policy is only partly about delivering better health – at nearly 20% of U.S. GDP, or $3.2 trillion, taxpayer funded subsidies for health care

spending have become industrial policy, largely walled off from the economic forces that drive productivity up and costs down in other industries.

Medicaid is often defended by pointing out the program's low reimbursement rates compared to other payers, like Medicare and private insurance. Even setting aside the access problems[13] that low reimbursements create for patients, this is the wrong way to think about the program (and health care in general).

Rather than asking whether Medicaid is paying a low, per unit cost for *services delivered*, we should be asking whether it is delivering value for the populations it serves *compared to alternative uses of the same dollars for other safety net supports and services* that might be more highly valued and more effective.

My colleague Oren Cass has written an important paper[14] on how Medicaid distorts spending for America's safety net programs and populations. He notes that,

> [from] 1975–2015, government social spending per person in poverty more than doubled, from $11,600 to $23,400. ***Rising health care expenditures accounted for more than 90 percent of that increase. For 2015–20, White House budget proposals call for 89 percent of additional social spending to target health care.*** **[emphasis added]**

Cass goes on to estimate that "over-allocation to Medicaid may exceed $100 billion annually. If states with above-median Medicaid enrollment rates or spending per enrollee in each recipient category (adult, child, disabled, etc.) returned to median levels, more than $100 billion could become available for other antipoverty programs."

When Medicaid budgets rise inexorably they crowd out other safety net spending (given that state residents have expressed tolerance for a given level of taxation that tends to be fairly "sticky"). As a share of state budgets, K-12 education spending and other safety net spending have remained relatively stagnant or fallen while Medicaid's has risen.[15]

Defenders might argue that our national emphasis on health-care spending merely reflects its high-cost, and the importance of providing health care to low-income populations. But the incentives created by hybrid federal-state system tell a different story: because only a state's *Medicaid spending* earns a generous federal match (of at least $1, sometimes $3 or $4), states will quite rationally put marginal dollars toward health care even when that spending produces a *far worse* return for recipients than alternative programs.

For instance: if New York receives one federal dollar per state Medicaid dollar and faces the choice between putting a budget increase toward education that will return $1.25 of value per dollar spent or putting it toward Medicaid with a return of $0.75 per dollar spent, it will choose Medicaid.

Why? Its dollar gets matched with a federal dollar and the total of $2 produces $1.50 of value—making a very poor use of funds end up looking like a highly attractive, positive return to the state. Even if the $1 produces almost *no* tangible return for recipients, the state is still rewarded with an extra federal dollar sloshing through its economy.

Understanding Medicaid's Value

This not to say that Medicaid has no value. This is certainly not the case. It is simply that we must remember that its value may vary widely across the populations and services it offers.

Medicaid covers low-income pregnant women and children, and (largely through the ACA's optional Medicaid expansion) childless adults, the disabled, and the elderly (through long term care or nursing homes). Studies have found high value for Medicaid funded early interventions for pregnant women and children, where the benefits may persist for decades and are clearly cost effective.[16]

But in rigorous randomized controlled experiments, like the Oregon Health Insurance Experiment, the results have been much less clear cut. Over two years, researchers found that Medicaid increased the use of both physician and ER services, improved self-reported mental and physical health measures, and reduced the financial impact of illness (including lower out of pocket costs) but did not show a significant impact on objectively measured health outcomes.

A follow-on analysis by the researchers found that each dollar of Medicaid spending only provided 20-40 cents of value to the recipient based on how much recipients expected to pay for care without Medicaid coverage, and how much that coverage impacted life expectancy.

On the other hand, Oregon's FMAP – 73 percent – ensured that the state could effectively collect roughly $3 in federal support for every $1 it spent on Medicaid coverage. That's a far greater return to the state compared to beneficiaries, and goes a long way towards explaining why states have "voted" for expanding Medicaid while starving other safety net programs.

Another study, from the New England Journal of Medicine, compared mortality rates in three states (Arizona, Maine, and New York) that expanded their Medicaid programs in the early 2000s compared to three "control" states that did not expand coverage. Of the three expansion states, only one (New York) showed a statistically significant improvement in mortality.

Arizona's increase was not statistically significant, and Maine showed a statistically significant *increase* in deaths.[17]

Medicaid undoubtedly does influence beneficiaries'' health status, but we have to keep in mind that health insurance is only one component – one input – involved in producing and sustaining good health. Many other factors influence measured health outcomes.

For instance, a 2006 survey from researchers at Harvard University famously found "Eight Americas," broadly grouped by longevity and health status. Asians lived the longest, with Asian women in Bergen County, NJ, living an impressive three years longer on average than women in Japan, the country with the largest national female life expectancy: 91 years compared to 88. Young and middle-aged African Americans living in high-risk urban areas fared worse, as did rural whites living in Appalachia and the Mississippi. Lower income whites living in the northern plains states and Dakotas lived longer than middle-income whites. Other research of has found that descendants of Scandinavians in the U.S. have higher incomes, higher educational attainment, and even live longer than other Americans.[18]

A 2016 study in JAMA by Raj Chetty et al found that "geographic differences in life expectancy for individuals in the lowest income quartile were significantly correlated with health behaviors such as smoking, but were not significantly correlated with access to medical care, physical environmental factors, income inequality, or labor market conditions."[19]

A May 2016 study published in Health Affairs underscored the importance of the social determinants of health by noting that "states with a higher ratio of social to health spending (calculated as the sum of social service spending and public health spending divided by the sum

of Medicare spending and Medicaid spending) had significantly better subsequent health outcomes for the following seven measures: adult obesity; asthma; mentally unhealthy days; days with activity limitations; and mortality rates for lung cancer, acute myocardial infarction, and type 2 diabetes."

If we're interested in supporting better health, and better lives, for low income populations, we need to bring much more nuance to our discussions - and greater balance to our safety net spending.

To Cut or Not to Cut is Not the Right Question

I realize that today's hearing is not about solutions. But I would like to suggest a few guidelines given the programmatic and fiscal realities policymakers confront.

Federal policy debates revolve around spending levels – which given existing deficit and debt trends is entirely understandable. And I agree with former OMB director Peter Orszag (President Obama's first budget director) that "health care reform is entitlement reform." We cannot address our budget woes without slowing the growth of health care spending.

But if we were to become more agnostic about the value of an additional dollar in Medicaid spending compared to other uses of the same dollars – especially if we share programmatic savings between states and federal taxpayers - states would have a much greater incentive to consider the relative tradeoffs between competing safety net programs given their relative impact and efficiency in improving the lives and well-being of the poor. Finding more effective ways to lift people out of poverty can, in turn, help us bend the health care cost curve.

Setting a predictable national budget framework for all safety net programs – based on the persons served, not the programs funded – should be framed in this way, not as a pure exercise in budget cutting.

Shifting more spending to the poor directly, through an expanded EITC, would also help to obviate the political obstacles involved in reordering spending priorities, since third party providers often have much greater ability to lobby for their preferred spending priorities (and thus protect and expand them), and little direct accountability to the populations they ostensibly serve.

Expanding direct financial assistance would also give low-income households spending discretion over safety net supports. They could decide whether to allocate an additional marginal dollar to health care services, or some other higher value priority – like education or housing. With low-income Americans gaining more market power, we should also expect providers to develop more affordable health care options in more accessible settings so they can compete for those marginal dollars.

An all funds-on-deck approach to safety net funding would also allow policymakers to better evaluate programs based on their objective performance, or provide more direct financial assistance to low income families. Targeted programs and interventions, carefully controlled and measured, are more likely to bear the fruit we want – improved health and economic mobility. This can allow us to scale up good programs, and phase out poor ones.

Many more small scale, state-based experiments are preferable than continuing a system where health care spending increases are essentially on autopilot. To better address the diverse needs of low-income and vulnerable populations, I recommend that:

1. Congress and the states should agree on broad national programmatic goals for safety net services – including economic mobility, attachment to work, and improved health care outcomes – and then hold states accountable for reaching specific goals for specific populations.

2. Reform efforts should focus on reducing or eliminating incentives to continue to shift vast amounts of federal and state safety net funds to health care compared to other safety net supports and services. Streamlining and consolidating federal programs to support large block grants of federal funds for all safety net services (on a person-centered basis, i.e., based on metrics like poverty rates, number of disabled, etc.) would be one potential approach. States might still decide to spend a disproportionate share of their funding on health care, but federal structures should not effectively bribe them to do so.

3. If we continue to fund Medicaid separately, CMS should continue to support and accelerate state level reforms by standardizing Medicaid (1115) waivers and allowing states the option of accepting either block grants or per capita caps (or perhaps some mix of both, depending on the population addressed). States should also be allowed to use Medicaid funds for alternative non-health related purposes, like an expanded state EITC. CMS can also help states improve their own health care markets by supporting data enclaves that pool Medicare, Medicaid, and private claims data (with appropriate privacy protections) to help identify efficient providers; benchmark, test, and scale up new

payment models; identify and address antitrust issues (like provider or insurer consolidation); and even allow entrepreneurs to re-bundle and re-price health care services to more effectively meet the needs of Medicaid beneficiaries.

4. The Centers for Medicaid and Medicare Innovation (CMMI) can also help states identify and design rigorous trials for testing alternative programs designed to address the social determinants of health, monitor the performance of state Medicaid waiver programs and disseminate best practices, or assist in the any development of other tools (like reference pricing, competitive bidding, or value-based insurance design) that states believe can improve measured health outcomes for Medicaid enrollees or meet other programmatic goals.

Any savings generated from program innovations should be shared between federal and state taxpayers, to encourage continued state innovation and experimentation.

Additional challenges will need to be navigated to address legitimate state concerns about the sustainability of federal support and changing economic conditions. Federal spending can be made explicitly countercyclical, for instance, to address state budget weakness in the event of a recession.

But all of these challenges and concerns are tractable.

Without comprehensive changes to Medicaid's financing and administrative structure, along with broad programmatic flexibility and clearer goals from Washington, Medicaid reform will continue to be episodic and halfhearted. Costs will continue to climb unchecked without commensurate offsetting improvements for beneficiaries.

This does not mean that federal policymakers should simply hand states cash and then walk away. Transparency and accountability for health and non-health related outcomes should allow policymakers to work with states – and program beneficiaries – to modernize and strengthen America's safety net programs.

Of course, there is no silver bullet for Medicaid reform that will work for every population, in every state.

But this is precisely why states need much greater flexibility—and much better incentives—to experiment with a wide variety of tailored approaches for safety net programs, while simultaneously putting health care spending on a more sustainable trajectory.

Both liberal and conservative policy priorities could be met by such an approach. That doesn't guarantee its success, but it should at least guarantee a productive conversation.

Thank you and I welcome your questions.

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[2] "Federal and State Share of Medicaid Spending," Kaiser Family Foundation, 2015.
[3] "States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection," U.S. Government Accountability Office, July 2014.
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[6] "Federal and State Share of Medicaid Spending," Kaiser Family Foundation, 2015.
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[11] "Long-Term Services and Supports," National Association of Medicaid Directors, 2017.
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[15] Ibid, 11
[16] Sarah Miller and Laura R. Wherry, "The Long-Term Effects of Early Life Medicaid Coverage," University of Michigan, August 2015.
[17] Benjamin Sommers, et. al., "Mortality and Access to Care among Adults after State Medicaid Expansions," *New England Journal of Medicine* 367, no. 11 (September 2012).
[18] Christopher Murray, "Eight Americas," *Harvard Magazine*, January-February 2007.
[19] Raj Chetty, et. al., "The Association Between Income and Life Expectancy in the United States, 2001-2014," *Journal of American Medicine* 315, no. 16 (2016).

Mr. MURPHY. Thank you, Mr. Howard.

Mr. Archambault, you are recognized for 5 minutes.

TESTIMONY OF JOSH ARCHAMBAULT

Mr. ARCHAMBAULT. Chairman Murphy, Ranking Member DeGette, and members of the committee, my name is Josh Archambault and I work at the Foundation For Government Accountability, a think tank that is active in 37 States, specializing in health and welfare reform.

This morning, I'd like to highlight how the ACA's Medicaid expansion has worsened problems for the truly needy, and I'd like to start with a video.

[Video played.]

Mr. ARCHAMBAULT. Sadly, Skyler's story represents just one of nearly 600,000 individuals currently sitting on waiting lists for Medicaid services. Individuals with developmental disabilities, traumatic brain injuries, and mental health disorders who are less likely to receive the needed care now that Medicaid has been expanded.

The ACA expanded Medicaid to a brand new population, which consists largely of childless, able-bodied adults who are working age, and have only dimmed the hopes further for families like Skyler.

But the problems go much farther beyond situations like hers. The Governor of Arkansas, due to expansion costs, has proposed nearly a billion dollars in cuts to traditional Medicaid, primarily from patients with expensive medical needs, the developmentally disabled, and the mentally ill is what he said.

So why is this happening around the country? The new ObamaCare expansion population is awarded a higher match rate. This funding formula has pernicious unintended consequences. Let me explain it this way: If a state needs to balance its budget, which they all do need to every year, state officials have to turn to Medicaid, because it's the biggest line item, also growing faster than revenue. If you want to save one state dollar in state funds, on average, you need to cut just over $2 from the traditional Medicaid population, the aged, the blind, the disabled, pregnant women, and children. But if they want to save that same $1 in state funds for the expansion population, this year they need to cut $20. I know you all can guess who faces cuts first, and it's heartbreaking.

Over enrollment under ObamaCare's Medicaid expansion will encourage states into even deeper cuts. Data from 24 of the expansion states show that enrollment has been over by 110 percent on average, more than double initial estimates. The cost overruns have been significant. Just to name a few, California found themselves 222 percent over budget; Ohio, $4.7 billion or 87 percent over budget. These enrollment and budget trends mean fewer resources for the truly needy.

Now, history could have warned us of this. Arizona and Maine both expanded Medicaid to the same able-bodied childless adult population before the ACA, and both had to take measures to rein in costs. Arizona had to stop a number of organ transplants. Maine capped enrollment, created wait lists. This happened even without

the lopsided extra funds that follow expansion enrollees, which brings me to my last point, concerns over eligibility issues.

FGA's work around the country has found deep systemic problems. First, states need to be checking eligibility far more frequently; and second, states need to be checking more data when they check eligibility. Life changes such as moving out of state, getting a raise, or death are going unnoticed for far too long, and meanwhile, states continue to cut checks to managed care companies for cases that no longer qualify for the program.

My written testimony highlights a couple of those states that have had bipartisan success in tackling this waste and fraud, but much more is needed. Thank you.

[The prepared statement of Mr. Archambault follows:]

STATEMENT BY
JOSH ARCHAMBAULT, MPP

Hearing on "Medicaid Oversight: Existing Problems and Ways to Strengthen the Program"
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

United States House of Representatives
January 31, 2017

Josh Archambault
Senior Fellow
Foundation for Government Accountability (FGA)
[redacted]

Summary

Medicaid faces many challenges. ObamaCare's Medicaid expansion has exacerbated many of those problems and added some new ones, mostly at the cost of the vulnerable. Unlike traditional Medicaid, Medicaid expansion:

1) Transforms the program into an income-based entitlement.
2) Serves able-bodied, working-age adults, almost all of whom do not have children.
3) Provides a higher reimbursement rate for expansion enrollees, which results in heartbreaking unintended consequences for the truly vulnerable.

Medicaid spending growth at the state level is far outpacing revenue growth and is redirecting limited resources away from education, public safety, and infrastructure. As states balance their budgets, Medicaid is often the first place to look as it is the biggest line-item in almost every state. Unfortunately, for a state to save $1.00 in state funds this year, they would need to cut $20 from the expansion population. On the other hand, states would need to cut only $2.32 (on average) from the truly needy in traditional Medicaid. Several pre-ACA expansions are highlighted as examples where the truly vulnerable were directly harmed.

Medicaid expansion was implemented based on promises of modest enrollment and costs, assistance to hospitals, additional jobs, and lower uncompensated care. Yet in every state with available data, enrollment has skyrocketed beyond projections, by an average of 110 percent. Some states have signed up more than *four times* as many able-bodied adults as they said would ever enroll. Meanwhile, nearly 600,000 individuals sit on waiting lists for Medicaid services. These include those with developmental disabilities, traumatic brain injuries, and mental illnesses.

Finally, long running issues for the traditional Medicaid population such as high emergency room utilization, access concerns, and deep eligibility issues remain.

Chairman Murphy, Ranking Member DeGette, and Members of the Committee,

Thank you for this opportunity to bring a state perspective to the important issue of protecting our most vulnerable citizens on Medicaid. My name is Josh Archambault and I serve as a Senior Fellow at the Foundation for Government Accountability (FGA), a think tank that specializes in health and welfare issues and is active in thirty-seven states.

This morning I would like to highlight some of the challenges in Medicaid programs around the country and how Medicaid expansion has exacerbated these problems in many states. Sadly, many of the issues I highlighted as I testified in front of the Health Subcommittee in 2013 still remain and in fact have gotten worse under the Patient Protection and Affordable Care Act (ACA). I want to start by talking about the ACA's Medicaid expansion and its impact on the truly vulnerable in our country.[1]

1. Who Gains Under ACA Medicaid Expansion and How It Hurts The Truly Needy

Under the ACA, commonly known as ObamaCare, state policymakers may expand Medicaid eligibility to cover able-bodied, working-age adults earning up to 138 percent of the federal poverty level.

It is important to understand that this expansion differs greatly from traditional Medicaid in distinct ways:

1) The ACA expansion transformed the program from a historical safety net into an income-based entitlement.
2) New expansion enrollees are very different from those on traditional Medicaid as the new population consists of able-bodied, working-age adults, almost all without children.

3) The new expansion population is awarded a higher reimbursement rate. Unfortunately, this new funding formula leads to some pernicious unintended consequences that impact the truly vulnerable.

To be very clear, Medicaid expansion does not cover the elderly, individuals with disabilities on waiting lists, or even poor children — patients most frequently considered among the nation's most vulnerable and most in need of support. Instead, ObamaCare expands Medicaid eligibility to a new group of able-bodied, working-age adults who do not traditionally qualify for long-term welfare. Nationally, more than 82 percent of these able-bodied adults have no dependent children.[2]

In addition, nearly half of this ObamaCare Medicaid expansion population does not work at all, even during favorable economic times.[3] Only one-fifth are employed full-time, year-round. Unlike most social service entitlement programs, Medicaid currently does not have a work requirement, meaning states are expanding eligibility for taxpayer-funded Medicaid to an able-bodied, non-working adult population. There continue to be concerns in the economic research community about the negative labor market impact of expanding Medicaid to this new group of individuals as it can discourage work, depress earnings, and reduce labor-force participation.[4]

In part because of these negative incentives, many of these able-bodied adults have transitioned from employer-based insurance to taxpayer-funded public insurance. For example, in Massachusetts, Governor Charlie Baker recently highlighted in a letter to Congress that, since the implementation of the ACA, roughly 500,000 previously privately insured residents now receive public coverage.[5] Medicaid expansion and the resulting crowd out of private coverage have contributed to significant and sustained budget problems for states.

a. ObamaCare expansion funding threatens the truly vulnerable

ObamaCare's new Medicaid entitlement for working-age, able-bodied adults ultimately redirects limited state and federal resources away from some of the most needy individuals. These vulnerable individuals already struggle in a tattered Medicaid safety net. Care is frequently fragmented, access to quality care is often low, and health outcomes remain lackluster.

But the pressures ObamaCare presents to the truly vulnerable do not stop there. The ACA also created a perverse funding formula that results in states making cuts from the truly needy with disabilities or dependent children.

ObamaCare does not change the funding structure for patients covered by traditional Medicaid. States continue to receive their regular matching rate for providing coverage to low-income children, seniors, and individuals with disabilities. These rates range from a low of 50 percent to a high of 83 percent, depending on a state's per-capita income. On average, the federal government pays for roughly 57 percent of current Medicaid expenditures.

But the matching rates for Medicaid expansion are much different. States that expanded Medicaid for able-bodied adults under ObamaCare receive an enhanced matching rate for this new Medicaid population. The enhanced matching rate started at 100 percent in 2014. This year, it dropped to 95 percent and gradually declines to 90 percent by 2020, should Congress choose to keep the law in place or not significantly restructure its funding.

To reiterate, only the ACA's new group of able-bodied adults qualify for this enhanced funding. States do not receive an enhanced matching rate for the truly vulnerable patients already eligible for or enrolled in Medicaid. This means states receive more funding for able-bodied adults than they do for patients the Medicaid safety net was originally intended to protect – children, the elderly, and individuals who are blind or disabled.

Medicaid is now the single largest line-item in most state budgets and has been for years. For example, in Massachusetts, Medicaid accounts for 40-plus percent of the entire budget.

In most states, Medicaid spending is growing faster than state revenues. As an example, Kentucky's Medicaid commissioner recently stated that the agency now projects that every single new dollar of state revenue will be spent on Medicaid over the next ten years – and that the state will still be short the dollars needed to support the growing Medicaid spending. Put another way, not a single new revenue dollar would be left to invest in critical state services for educating children, providing public safety, or offering tax relief. Lawmakers in all states – blue, purple, and red – are starting to realize the Pac-Man effect that Medicaid is having on their budget.

Given the size of the Medicaid program, one of the only tools policymakers have to balance their budgets is to rein in Medicaid spending. But in order to save $1.00 in state Medicaid spending, states must make an average of just over $2 in total cuts to their traditional Medicaid programs.[6] This is because state funds typically cover only 43 percent of traditional Medicaid costs.

Amount of cuts to Medicaid spending on expansion individuals needed to save $1.00 in state spending

2017	2018	2019	2020
$20.00	$16.67	$14.29	$10.00

Source: Foundation for Government Accountability

On the other hand, states would need to cut services and benefits for the able-bodied, childless adult expansion population by a staggering $20 just to save a single state dollar in this

year.[7] This gives states a massive financial incentive to cut from traditional Medicaid first – a program for the truly needy – rather than cut funding for expansion.

b. States that previously expanded Medicaid made cuts that impacted truly needy

The most vulnerable patients in states that previously expanded Medicaid (pre-ACA) to childless adults were the targets of devastating cuts to services. Arizona, for example, expanded Medicaid eligibility to able-bodied, childless adults in 2000.[8] However, the state quickly discovered its Medicaid expansion would cost taxpayers four times what was initially expected. Instead of cutting expansion benefits, in 2010, Arizona eliminated Medicaid coverage for heart, liver, lung, pancreas and bone marrow transplants for traditional Medicaid enrollees in order to pay for the growing costs of its Medicaid expansion.[9] Truly vulnerable Medicaid patients in desperate need of life-saving organ transplants did not receive them so adults with no disabilities could keep receiving taxpayer-funded Medicaid coverage.[10]

Today, as the ACA expansion begins to make a direct impact on states, cuts to the truly vulnerable are being put on the table once again.

In Arkansas, Governor Asa Hutchinson has proposed nearly $1 billion in cuts to the traditional Medicaid program.[11] The governor said he "expects the cuts to come primarily from payments for services to patients with expensive medical needs, such as nursing-home residents, the developmentally disabled and the mentally ill." Meanwhile, nearly 3,000 Arkansans with disabilities are on the state's Medicaid waiver waiting list.

In Alaska, Governor Bill Walker's administration has proposed cuts to services for those with developmental disabilities.[12] They have also moved to cut general fund spending on Medicaid by $90 million.[13]

States also often reduce and delay payments to doctors, hospitals and other health care providers which worsens access for those on Medicaid. Maine, which expanded Medicaid eligibility to able-bodied, childless adults in 2002, saw expansion costs greatly exceed initial projections, forcing the state to cap enrollment at various times, draw up waiting lists of patients in need of services and lengthen payment cycles.[14] By 2013, Maine's accumulated unpaid hospital bills for Medicaid patients reached a staggering $500 million.[15]

Unfortunately, these types of traditional Medicaid cuts are only a preview of what's to come if Medicaid expansion is left in place. With expansion running billions of dollars over budget nationally, it is only a matter of time before more services for the most vulnerable are impacted.

2. Medicaid Expansion Has Failed to Deliver on Its Promises

Policymakers in a number of states that expanded Medicaid often did so citing promises of saving taxpayer money, creating jobs, and preventing hospitals from closing. Unfortunately, many of those promises have not come true as hoped for.

a. Medicaid expansion enrollment and costs have skyrocketed

Newly-obtained data from twenty-four expansion states shows that at least 11.5 million able-bodied adults have now enrolled in ObamaCare expansion – an overrun of 110 percent, or more than double initial projections.[16] Some states have signed up more than *four times* as many able-bodied adults as they said would ever enroll.

STATE	MAX ENROLLMENT	ACTUAL ENROLLMENT	AS OF DATE	OVER PROJECTIONS
Arizona	297,000	397,879	9/2016	34%
Arkansas	215,000	324,318	10/2016	51%
California	910,000	3,842,200	5/2016	322%
Colorado	187,000	446,135	10/2016	139%
Connecticut	113,000	186,967	12/2015	65%
Hawaii	35,000	35,622	6/2015	2%
Illinois	342,000	650,653	4/2016	90%
Iowa	122,900	139,119	2/2016	13%
Kentucky	188,000	439,044	12/2015	134%
Maryland	143,000	231,484	12/2015	62%
Michigan	477,000	630,609	10/2016	32%
Minnesota	141,000	207,683	12/2015	47%
Nevada	78,000	187,110	9/2015	140%
New Hampshire	45,500	50,150	8/2016	10%
New Jersey	300,000	532,917	1/2015	78%
New Mexico	149,095	235,425	12/2015	58%
New York	76,000	285,564	12/2015	276%
North Dakota	13,591	19,389	3/2016	43%
Ohio	447,000	714,595	8/2016	60%
Oregon	245,000	452,269	12/2015	85%
Pennsylvania	531,000	625,970	4/2016	18%
Rhode Island	39,756	59,280	12/2015	49%
Washington	262,000	596,873	7/2016	128%
West Virginia	95,000	174,999	12/2015	84%
Combined	**5,452,842**	**11,466,254**		**110%**

TheFGA.org

This enrollment explosion has led to significant cost overruns. Here are just a few examples:

- Alaska: $61 million (42%) over-budget in the first year
- California: $14.7 billion (222%) over-budget in the first 1.5 years
- Colorado: $550 million (45%) over-budget in the first 1.5 years
- Illinois: $2 billion (70%) over-budget in the first 2 years
- Iowa: $338 million (56%) over-budget in the first 1.5 years
- Kentucky: $3 billion (107%) over-budget in the first 2.5 years
- New Mexico: $600 million (45%) over-budget in the first 1.5 years
- North Dakota: $67 million (114%) over-budget in the first year
- Ohio: $4.7 billion (87%) over-budget in the first 2.75 years
- Oregon: $2 billion (128%) over-budget in the first 1.5 years
- West Virginia: $198 million (46%) over-budget in the first full fiscal year

These enrollment and budget trends mean even fewer resources will be available for services to seniors, poor children, and individuals with disabilities.

Nationwide, there are nearly 600,000 individuals currently sitting on waiting lists for Medicaid services.[17] These are people with developmental disabilities, traumatic brain injuries, and mental illnesses who are less likely to receive needed care now that Medicaid has been expanded.

Since Illinois expanded Medicaid under ObamaCare, more than 750 individuals with developmental disabilities have died while on waiting lists for needed Medicaid services.[18] In

Arkansas, 79 members of the state's waiting list have died since the legislature voted to expand Medicaid through ObamaCare.[19] That experience has repeated itself across the country.

In order to stop the bleeding, Congress should immediately freeze enrollment in expansion states, and not allow new states to expand. This would provide states with an opportunity to unwind their expansions and refocus existing resources on the most vulnerable.

b. Expansion has not cured hospital ills

Supporters of expansion argued that adding more enrollees would accomplish some important outcomes in our health system. Unfortunately, many of those have not come to fruition. For example, expansion has not stopped hospitals from closing. Hospitals have closed in expansion states across the country including Arizona, Arkansas, California, Illinois, Kentucky, Massachusetts, Minnesota, Nevada, and Ohio.

According to Moody's Investors Services, the leading provider of credit ratings for hospitals, there is no significant difference in financial health of hospitals in states that expanded Medicaid and states that have not.[20]

Medicaid expansion jobs have not materialized either. In Iowa, consultants promised 2,400 new hospital jobs as the result of Medicaid expansion. Instead, the state has lost roughly 980 hospital jobs. In Arkansas, consultants promised over 1,000 new hospital jobs; the state instead lost 819 hospital jobs in the first 18 months of expansion. And in Kentucky, experts promised to create over 5,000 new hospital jobs, but instead lost over 1,200 in the first year of expansion.[21]

And although there is limited data available, experts remain critical about the promised drop in uncompensated care. In New Hampshire, state actuaries estimated that uncompensated care would go down by roughly $10 million after expansion. But after calculating in new costs and

lost revenue from shifting people out of private insurance and into Medicaid, New Hampshire hospitals are projected to lose more than $47 million as a result of Medicaid expansion.[22]

3. Traditional Medicaid Has Numerous Problems

Medicaid has been afflicted by concerns over its quality, access, and financing for decades. Even then-President Obama famously said, "...We can't simply put more people into a broken system that doesn't work."[23]

a. ER utilization is high

Medicaid enrollees continue to utilize emergency rooms at high levels. Low reimbursement rates may account for the elevated ER visits by Medicaid patients. They are roughly twice as likely to visit an ER compared to both the uninsured and Medicare patients and four times more likely than the privately insured. To make matters worse, a majority of these visits have been found to be avoidable. For example, in Massachusetts, more than 55 percent of visits to the ER were deemed "avoidable/preventable" for Medicaid beneficiaries.[24] Despite promises that Medicaid expansion would lower emergency room use, the best evidence available suggests that it is doing the opposite.[25]

b. Access remains a major concern

My 2013 testimony also highlighted some deeply concerning access issues from around the country including only 14 percent of offices in Barnstable County on Cape Cod accepting Medicaid.[26]

A New England Journal of Medicine article highlighted that very sick children in Cook County, Illinois on the Children's Health Insurance Program struggle to get an appointment and

for the few offices that did accept Medicaid, the wait times for an appointment were twice as long as for kids on private insurance.[27]

Children on Medi-Cal (Medicaid in California) seeking a urologist found that roughly 60 percent of providers did not accept Medicaid and 75 percent of the offices that did not accept Medicaid patients were unable to suggest another office that would.[28]

c. Eligibility checks are not conducted frequently enough or in enough detail

The problems with eligibility checks for Medicaid and exchange subsidies have been well documented by the Government Accountability Office (GAO), and at the state level for those that have bothered to check the federal government's work.[29] States need to be checking far more data sources to determine and redetermine eligibility. Yet the problems around eligibility run even deeper as most states fail to check eligibility frequently enough to identify major life changes, meaning resources for the truly needy are instead spent on individuals who no longer qualify.

Improving the integrity of eligibility checks, especially for Medicaid enrollees, is critical to protecting resources for the truly needy. This kind of reform has a proven track record and wide bipartisan support.[30]

These close-to-real-time data checks provide monitoring during the whole year – they flag when someone gets a new job or increases work hours, moves out of state, gets married, deposits a large asset, or even passes away. By cross-matching existing state data and new commercial data sources more frequently, states can protect limited resources for those who truly need them.

Recent audits have highlighted why these checks are so crucial. Over the course of two years, Illinois identified more than 14,000 individuals who had died – some as earlier as the 1980s – but were still enrolled in Medicaid.[31-32] A similar audit in Arkansas revealed more than 43,000

individuals on Medicaid who did not live in the state, with nearly 7,000 having no record of ever living there.[33] More than 20,000 Medicaid enrollees were also linked to high-risk identities – including individuals using stolen identities or even fake Social Security numbers.[34] Michigan has recently identified more than 7,000 lottery winners receiving some kind of public assistance, including individuals winning up to $4 million jackpots in the state lottery.

A 2014 legislative audit of Minnesota's Medicaid agency found nearly 17 percent of enrollees were ineligible for benefits, with more than half of the cases needing additional verification to determine eligibility. Auditors were able to identify several applications who had under-reported income – in many cases by up to $70,000 per year – had failed to report changes in income, or even had moved out of state.[35]

An audit in 2013 of the Nebraska Health Insurance Premium Payment program—a component of the state's Medicaid program—found that the state lacked appropriate documentation in every single reviewed case file, calling into question the entirety of expenditures made under the program.[36] More than three-quarters of the audited cases had received incorrect payments, with auditors identifying several cases of apparent fraud.

A 2006 federal audit found that eight percent of New York's Medicaid payments were made on behalf of individuals who were ineligible, but nevertheless enrolled in the program.[37] A follow-up audit in 2013 found a significant number of cases for which case files had missing or invalid Social Security numbers, individuals were enrolled in the same program multiple times, or the files lacked any documentation to support the eligibility determination at all.[38]

A state and federal review of Ohio's Medicaid spending in 2008 found that nearly 10 percent of Medicaid payments were improper.[39] Nearly all of these improper payments were caused by errors and insufficient documentation in eligibility determinations.

States should use enhanced data-matching technology to verify and crosscheck income, residency, identity, employment, citizenship status, and other eligibility criteria for all welfare enrollees and applicants.

Federal law only requires states to perform these checks once a year and does not require any kind of active monitoring of income or other categorical requirements. But life changes happen much more frequently. Federal data shows that individuals in poverty typically remain there for only a short time. By reducing the amount of time between these periodic checkups, states can catch costly eligibility errors sooner and preserve limited resources for the truly needy.

Better verification already has a proven track record in the states. In the first 10 months of operation, Pennsylvania's award-winning Enterprise Program Integrity initiative identified more than 160,000 ineligible individuals who were receiving benefits, including individuals who were in prison and even millionaire lottery winners, resulting in nearly $300 million in taxpayer savings.[40]

In Illinois, an independent vendor identified eligibility errors in half of the cases it reviewed during the first year of operation.[41] By the end of that first year, the state had removed roughly 300,000 individuals from the program as a result of the initiative. In the second year, the state removed an additional 400,000 individuals. State officials projected that the enhanced program integrity initiative would save taxpayers $350 million per year. Based on the results of the second year, taxpayers can now expect to save between $390 million and $430 million per year.

Conclusion

While every state and Medicaid program is different, there are some universal troubling trends that Congress must address immediately. Solving these problems requires creative thinking and a true partnership with states to eradicate the billions of dollars of waste, fraud, and abuse that is preventing the level of care to be targeted at those that need it the most. It requires a departure from the current mindset that having access to a Medicaid card is the same as having access to a medical professional. It requires us all to ask the tough question — are the billions we are spending as a country serving the best interest of the beneficiaries and of the taxpayers?

I appreciate the opportunity to share some of my thoughts with you all today and look forward to answering any questions you may have.

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[1] Sections of my testimony are pulled from FGA research and publications and permission of the authors has been given.
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[36] Ibid.
[37] Ibid.
[38] Ibid.
[39] Ibid.
[40] Ibid.
[41] Ibid.

Mr. MURPHY. Thank you.

I now recognize Mr. Westmoreland for 5 minutes.

TESTIMONY OF TIMOTHY M. WESTMORELAND

Mr. WESTMORELAND. Mr. Murphy, Ms. DeGette, and members of the committee—subcommittee, thank you for the invitation to speak today.

I take a backseat to no one on program integrity issues in the Medicaid program. People who care about Federal programs have to work to ensure that Federal funds are well used. Program integrity problems are, however, not new. Military contractors cheated the Union Army during the Civil War. Where money is being spent, whether it be private, State, or Federal, and no matter how good the cause, there are bad actors trying to steal it.

Program integrity efforts are especially important in Medicaid. This is because billions of dollars are at stake, as are the health and well-being of most vulnerable people in America. This importance is well illustrated by the fact that at the same time the ACA expanded Medicaid coverage, it also made significant improvements in program integrity efforts.

But as important as combatting fraud and abuse in Medicaid is, policymakers should keep it in perspective. As big as they are, the numbers must be viewed as what they are and as a whole.

First, we should be careful about our terms. Not all of what is labeled improper payments, in the vernacular, is fraud or even mistaken. Most are appropriate, but simply badly documented, and may even be underpayments. And the actual loss to the government is much smaller than it may appear. The OIG and the GAO footnotes in my testimony cite to this terminology.

But, as the prepared statements of GAO and OIG witnesses at today's hearing have outlined, HHS has already implemented many efforts to address the more serious problems of program integrity. Some of these efforts are longstanding and some of them are just underway, but there are many efforts focused on making sure that Medicaid is spending its money well, and they are having an effect.

But I am especially concerned today that policymakers often respond to waste, fraud, and abuse with blunt instruments aimed at the wrong targets. Any review of the actual Medicaid program dollars that were stolen or misspent will reveal that the major culprits are unscrupulous providers. Pharmaceutical companies that price gouge, equipment suppliers that don't deliver, and Medicaid mills of doctors, dentists, and clinics that provide unnecessary services if they provide services at all. But all too frequently, the political and legislative response is to institute cuts or restrictions on beneficiaries and the providers who actually care for them.

There is simply nothing in the recent reviews of program integrity that justify the policy proposals that are now on the table and before this committee. Reduced/capped Federal funding does nothing to improve program integrity, but it does put coverage at risk for low-income Americans and shifts the cost for the most expensive services to States, localities, providers, and charities. This is wrong.

Program integrity problems are meaningful only when they are considered in the context of the many successes of the Medicaid

program. For example, the Medicaid expansion of the ACA means that 11 million people have Medicaid coverage who did not have it 3 years ago. The percentage of people without insurance in America is at an all-time low of 8.9 percent. The burden of uninsured care in hospitals in expansion states is down 39 percent, and costs to those states are commensurately lower.

Rural hospitals in expansion states are at half the risk of closure of those in nonexpansion states. Community health centers are seeing 40 percent more patients. People with serious mental illnesses are 30 percent more likely to receive services in the expansion states. Services for opioid addiction are available to working-age adults, often for the first time.

The Medicaid expansion of the ACA has fundamentally repaired a longstanding mistake in the program. People always had to fit into some sort of category, but this categorical eligibility has never made sense. Poor women need health insurance both before and after they have babies. Poor children keep needing health insurance even when they turn 19. Poor people with chronic illnesses need health insurance before they become disabled. Poor older adults need health insurance when they are 64, not suddenly when they are 65.

The real problems here are poverty and uninsurance. In the 32 states that have adopted the Medicaid expansion, where making this part of the insurance system finally make sense, and be fair for vulnerable people. Please do not turn back this response.

Lincoln did not give up on the Civil War because the government was sold bad mules. We do not stop buying drugs because drugmakers charge fraudulent prices. We punish the wrongdoers, correct the price, and get the treatment to the people in need. That is what should be done here. Don't reverse all this progress by rationalizing that program integrity problems demand wholesale legislative changes in Medicaid. There are real babies in that bath water.

Thank you.

[The prepared statement of Mr. Westmoreland follows:]

Statement of Timothy M. Westmoreland, J.D.

To the Subcommittee on Oversight and Investigations

Committee on Energy and Commerce

January 31, 2017

Mr. Murphy, Ms. DeGette, and Members of the Subcommittee, thank you for the invitation to speak to you today.

My name is Tim Westmoreland. I am a professor from practice at Georgetown University Law Center, where I teach health law, among other topics. I do want to be clear, however, that I am testifying in my personal capacity today and that the views I present are my own. I believe that the reason I was invited today is not because of my academic work but because I was the director of the Medicaid and CHIP programs during the last years of the Clinton Administration.

Because of that work, I take a backseat to no one on program integrity issues in the Medicaid program. When I took the Medicaid director job, combatting fraud and abuse was one of my top priorities. I worked closely with both the GAO and the OIG at that time and, in fact, have testified several times with them before the Congress. Ensuring program integrity is often a thankless task, but people who care about Federal programs have to work to ensure that Federal funds are well used.

Program integrity problems are, however, not new. Military contractors cheated the Union Army during the Civil War.[1] This gave rise to the False Claims Act of 1863,[2] sometimes known as "Lincoln's Law."[3] This law is still actively used to protect the Federal fisc, including on some occasions, the Medicaid program.[4] From at least 1863 onward, it is a truth universally acknowledged that any place where money is being spent—whether it be private, State, or Federal, and no matter how good the cause—there are bad actors trying to steal some of it.

Program integrity efforts are especially important in Medicaid. This is because billions of dollars are at stake as are the health and well-being of the most vulnerable people in America. Those bad actors who steal from this program are not engaged in a heist of luxury goods; they are stealing the very means of survival from people who have nowhere else to turn and from the honest doctors and hospitals who furnish needed services to them. This importance is well illustrated by the fact that at the same time the

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[1] See L. Lahman, "Bad Mules: A Primer on the False Claims Act" (Oklahoma Bar Journal, April 9, 2005), available at http://www.okbar.org/members/BarJournal/archive2005/Aprarchive05/obj7612fal.aspx ("The Federal False Claims Act (FCA) was enacted in part because of bad mules. During the Civil War, unscrupulous early day defense contractors sold the Union Army decrepit horses and mules in ill health, faulty rifles and ammunition, and rancid rations and provisions among other unscrupulous actions." [Citations omitted.])

[2] Now codified at 31 U.S.C. 3729 et seq., available at https://www.law.cornell.edu/uscode/text/31/3729

[3] See, e.g., "Celebrating the 150th Birthday of Lincoln's Law" (Forbes, March 6, 2013), available at http://www.forbes.com/sites/realspin/2013/03/06/celebreating-the-150th-birthday-of-lincolns-law-privatized-fraud-fighting/#3135614a47da

[4] See, e.g., Department of Justice, "Justice Department Recovers over $3.5 Billion from False Claims Act Cases in Fiscal Year 2015" (Press release, December 3, 2015), available at https://www.justice.gov/opa/pr/justice-department-recovers-over-35-billion-false-claims-act-cases-fiscal-year-2015

Affordable Care Act (ACA) expanded Medicaid coverage, it also made significant improvements in program integrity efforts (as the GAO and OIG each observe).

But, as important as combatting fraud and abuse in Medicaid is, policymakers should keep it in perspective. No statistic makes sense if you do not consider the denominator as well as the numerator. As big as they are, the numbers must be viewed as what they are and as a whole.

First, we should all be careful about our terms. Not all of what is labeled "improper payments" are fraud or even mistaken; many are appropriate but simply badly documented (and may even be underpayments), and the actual loss to the government is much smaller than it may appear.[5]

But, even so, the worst of the worst estimates using the broad term "improper payments" in Medicaid (including underpayments, overpayments, errors, and insufficient documentation) is 10%.[6] That is a bad number that should be dramatically reduced. But,

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[5] See PaymentAccuracy.gov at https://paymentaccuracy.gov/faq/; also "Medicaid and CHIP 2015 Improper Payments Report" (HHS, November 2015) available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/Downloads/2015MedicaidandCHIPImproperPaymentsReport.pdf, saying "[T]hese errors do not necessarily represent payment to illegitimate providers who should have not been enrolled in Medicaid or CHIP and do not necessarily represent examples of abuse or fraud. Rather the majority of erroneous payments represented situations where information required for payment was missing from the claims or states did not follow the appropriate process for enrolling providers. Had such information been on the claims and/or had the state followed the correct enrollment process, the claims may have been payable."

[6] See CMS, "Medicaid and CHIP 2015 Improper Payments Report," id.

keeping it in perspective, it is actually less than the overhead-and-profit costs that are routine in private health insurance, costs that do not represent the provision of needed health services but that are taken for granted.[7] [8]

Moreover, as the prepared statements of the GAO and OIG witnesses at today's hearing have outlined, HHS has already implemented many efforts to address the more serious problems of program integrity. Some of the efforts are longstanding and some of them are just underway, but there are many activities focused on making sure that Medicaid is spending its money well and they are having an effect.

But I am especially concerned that policymakers often respond to waste, fraud, and abuse with blunt instruments aimed at the wrong targets. Any review of the actual Medicaid program dollars that were stolen or misspent will reveal that the major culprits are unscrupulous providers: pharmaceutical companies that price-gouge; equipment suppliers that don't deliver; and Medicaid-mills of doctors, dentists, and clinics that

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[7] D. Archer "Medicare is More Efficient than Private Health Insurance," (Health Affairs Blog, September 20, 2011), available at http://healthaffairs.org/blog/2011/09/20/medicare-is-more-efficient-than-private-insurance/; cf. "The average adjusted [ACA Medical Loss Ratio] was 89.5% in the large group market, 85.0 percent in the small group market, and 78.8 percent in the individual market." GAO, "Medical Loss Ratios" (GAO-12-90R, October 31, 2011) available at http://www.gao.gov/new.items/d1290r.pdf

[8] Indeed, the ACA's imposition of a Medical-Loss Ratio that limits private insurance overhead and profit to as much as 15-20% was greeted with some controversy. See, T. Jost, "Implementing Health Reform: The Minimum Loss Ratio and Summary of Benefits and Summary of Benefits and Coverage" (Health Affairs Blog, May 13, 2012), available at http://healthaffairs.org/blog/2012/05/13/implementing-health-reform-the-minimum-loss-ratio-summary-of-benefits-and-coverage/

provide unnecessary services if they provide any services at all.[9] But all too frequently the political response is to institute cuts or restrictions on beneficiaries and the providers who actually care for them. Inadequate protections of millions of dollars should not be an excuse for cutting billions of dollars from States and for taking insurance from millions of people.

There is simply nothing in the recent reviews of program integrity that justifies the policy proposals that are now on the table and before this Committee. Rather than further supporting constructive State and Federal efforts to ensure that every dollar is well spent, these proposals would slash and cap Federal funding not just for the bad actors but for the good guys who are acting on behalf of people who are eligible and in need. Reduced, capped Federal funding does nothing to improve program integrity. But it does put coverage at risk for low-income Americans and shifts the costs for the most expensive services to States, localities, providers, and charities.

This is wrong. Program integrity problems are meaningful only when they are considered in the context of the many successes of Medicaid. Oscar Wilde defined a

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[9] See, e.g., "Health Care Fraud Abuse Annual Report: 2015" (HHS and DOJ, February 2016), available at https://oig.hhs.gov/publications/docs/hcfac/FY2015-hcfac.pdf; D. Heath, "Senate Report Recommends Ouster of Large Dental Chain from Medicaid" (Center on Public Integrity July 23, 2013), available at https://www.publicintegrity.org/2013/07/23/13029/senate-report-recommends-ouster-large-dental-chain-medicaid-program; K. Young and R. Garfield, "Spending and Utilization of Epi-Pen Within the Medicaid Program" (Kaiser Family Foundation (KFF), October 7, 2016), available at http://kff.org/medicaid/issue-brief/spending-and-utilization-of-epipen-within-medicaid/#footnote-199903-10;

cynic as someone "who knows the price of everything and the value of nothing."[10] In that vein, too often the discussion is just of the payments of Medicaid, when in fact you can understand the real value of the program only by looking at what it is paying for.

For example, the Medicaid Expansion of the ACA means that:

- 11 million Americans have Medicaid coverage who did not have it three years ago.[11]
- The percentage of people without insurance in America is at an all-time low of 8.9%.[12] Most people have their coverage through employer-sponsored insurance, and the Exchanges are covering millions more, but Medicaid is a major part of this improvement.
- The burden of uninsured care in hospitals in Expansion States is down 39%,[13] and costs to those States are commensurately lower.[14]
- Rural hospitals in Expansion States are at half the risk of closure of those in non-Expansion States.[15]

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[10] O. Wilde, "Lady Windermere's Fan" (1892) in *The Plays of Oscar Wilde* (1988).
[11] R. Rudowitz, S. Artiga, and K. Young, "What Coverage and Financing is at Risk Under a Repeal of the ACA Medicaid Expansion?" (KFF, December 6, 2016), available at http://kff.org/medicaid/issue-brief/what-coverage-and-financing-at-risk-under-repeal-of-aca-medicaid-expansion/
[12] CMS, "Medicaid and CHIP: Strengthening Coverage, Improving Health (January 2017), available at https://www.medicaid.gov/medicaid/program-information/downloads/accomplishments-report.pdf
[13] R. Rudowitz and R. Garfield, "New Analysis Shows States with Medicaid Expansion Experienced Declines in Uninsured Hospital Discharges," (KFF, September 2015), available at http://files.kff.org/attachment/issue-brief-new-analysis-shows-states-with-medicaid-expansion-experienced-declines-in-uninsured-hospital-discharges
[14] J. Perkins and I. McDonald, "50 Reasons Medicaid Expansion is Good for Your State" (National Health Law Program, January 2017).

- Community health centers are seeing 40% more patients.[16]
- Unmet health care needs among low-income adults in Expansion States has declined by more than 10% and use of preventive services has increased.[17]
- People with serious mental illness are 30% more likely to receive services in Expansion States.[18]
- Services for opioid addiction are available to working-age adults, often for the first time.[19]
- Financial security has been increased and personal debt has been lowered in Expansion States.[20] Medicaid expansion is also associated with a decline in personal bankruptcies.[21]

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[15] D. Bachrach, P. Boozang, A. Herring, and D. Reyneri, "States Expanding Medicaid See Significant Budget Savings and Revenue Gains" (State Health Reform Assistance Network, March 2016), available at http://statenetwork.org/wp-content/uploads/2016/03/State-Network-Manatt-States-Expanding-Medicaid-See-Significant-Budget-Savings-and-Revenue-Gains-March-2016.pdf

[16] J. Paradise, "Community Health Centers: Recent Growth and the Role of the ACA" (KFF, January 18, 2017), available at http://kff.org/report-section/community-health-centers-recent-growth-and-the-role-of-the-aca-issue-brief/

[17] CMS, supra, n. 12.

[18] B. Han, et al., "Medicaid Expansion Under the Affordable Care Act: Potential Changes in Receipt of Mental Health Treatment Among Low-Income Nonelderly Adults With Serious Mental Illness," (American Journal of Public Health, October 2015), available at http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2014.302521?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed

[19] D. Bachrach, P. Boozang, A. Herring, and D. Reyneri, "Medicaid: States' Most Powerful Tool to Combat the Opioid Crisis," (State Health Network, July 2016), available at http://statenetwork.org/wp-content/uploads/2016/07/State-Network-Manatt-Medicaid-States-Most-Powerful-Tool-to-Combat-the-Opioid-Crisis-July-2016.pdf

[20] L. Hu, et al., "The Effect of the Patient Protection and Affordable Care Act's Medicaid Expansions on Financial Well-Being" (National Bureau of Economic Research, April 2016), available at http://nber.org/papers/w22170.

[21] T. Gross and M. Notowidigdo, "Health Insurance and the Consumer Bankruptcy Decision: Evidence from Expansions of Medicaid" (Journal of Public Economics, March 2011), available at http://isiarticles.com/bundles/Article/pre/pdf/48303.pdf

The Medicaid Expansion of the ACA has fundamentally repaired a longstanding mistake in the program. For almost 50 years, Americans could get help only if they were poor *and something else:* Poor and pregnant, poor and a child, poor and with a disability, poor and elderly. Just being poor and uninsured was not enough. People had to fit into some sort of category.

But this "categorical eligibility" has never made sense. Poor women need health insurance both before and after they have their babies. Poor children keep needing health insurance even when they turn 19. Poor people with chronic illnesses need health insurance before they become totally disabled. Poor older adults need health insurance when they're 64, not suddenly when they are 65. The real problems are poverty and uninsurance. Categorical eligibility has irrationally rationed a sensible response.[22]

In the 32 States that have adopted the Medicaid Expansion, we are making this part of the American insurance system sensible and fair for vulnerable people. Please do not turn back this response.

Lincoln did not give up the Civil War because the government was sold bad mules. We do not stop buying drugs because drug-makers charged a fraudulent price.[23] We

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[22] See, e.g., comment by Joe Parks, director of the Missouri Medicaid program, a State that has not expanded coverage: "The best way to get treatment if you're addicted to drugs in Missouri is to get pregnant." Bachrach, supra.
[23] Department of Justice, "GlaxoSmithKline to Plead Guilty and Pay $3 Billion to Resolve Fraud Allegations and Failure to Report Safety Data: Largest Health Care Fraud

punish wrongdoers, correct the price, and get the treatment to people in need. That is what should be done here.

Don't reverse all this progress by rationalizing that program-integrity problems demand wholesale legislative change in Medicaid. There are real babies in that bathwater

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Settlement in US History" (Press Release, July 2, 2012), available at https://www.justice.gov/opa/pr/glaxosmithkline-plead-guilty-and-pay-3-billion-resolve-fraud-allegations-and-failure-report; see generally, Office of Inspector General (HHS), "OIG Compliance Program Guidance for Pharmaceutical Manufacturers" (April 2003), available at https://oig.hhs.gov/fraud/docs/complianceguidance/042803pharmacymfgnonfr.pdf

Mr. MURPHY. Thank you.

I now recognize myself for 5 minutes of questioning.

Ms. Yocom, your October 2015 report found gaps that limit CMS's ability to check for different eligibility groups. Newly eligible under expansion—the newly eligible under expansion and previously eligible are appropriately matched with Federal funds.

Now, in the Federal facilitated exchange states, CMS will not be able to assess the accuracy of eligibility determinations until 2018. Does this create the potential for improper payments then?

Ms. YOCOM. Well, it certainly creates a lot of uncertainty about what is going on with eligibility and whether progress is being made. The decision to suspend the estimate of eligibility was based on trying to give States time to understand the new rules and the new range of matching rates that could be applied.

From our perspective, though, transparency of the process and how it is proceeding would not be a bad thing. It would be good to know what's going on.

Mr. MURPHY. OK, thank you. In States that determine eligibility, GAO found that eight out of the nine States audited identified eligibility determination errors and improper payments associated with those errors. Are those errors reflected in the CMS eligibility determination error rate, and does CMS correct these errors, and why or why not?

Ms. YOCOM. Right now, they are not reflected in the eligibility rate estimates that CMS puts out. Instead, there is a rate that was produced a couple of years ago of 3.1 percent, and that's being applied until 2018.

Mr. MURPHY. Why is it applied until 2018?

Ms. YOCOM. I'm not sure of the reasoning for that year. I think time, I guess.

Mr. MURPHY. Was that an accurate number? You said that 1 percent. Is that an accurate number that's being applied?

Ms. YOCOM. It's a number I believe that goes back to 2013 or 2014.

Mr. MURPHY. Just continuing that on. So this relates to my next question. I've heard that CMS has put a freeze on measuring eligibility determinations for Medicaid. What does this freeze mean, and how will we will measure eligibility errors and improper payments?

Ms. YOCOM. It means that we're relying on an error rate that's about 3 or 4 years old, yes, and that we don't right now know what's going on with the eligibility determinations.

Mr. MURPHY. So we're using old data that's not accurate anymore. We're asking a question, what's the error rate? You're saying, we don't know, so we're going to use a number from a few years ago?

Ms. YOCOM. That is correct.

Mr. MURPHY. OK. Now, so if a parent asks their child, how did you do on your report card, and they say, got all As, it could be accurate, except if you're maybe dealing with a high school senior that you didn't ask specifically and say, I'm just assuming the grades I got in third grade, I'm just continuing to carry those over year to year, so I'm a valedictorian. Now, that doesn't make sense, of course, but you're saying the same thing applies here?

Ms. YOCOM. Yes. Right now, they are not publishing or I believe even calculating an improper payment rate right now. They are working with the states on a state-by-state basis.

Mr. MURPHY. So when people make a statement everything is fine, these are staying pretty stable, we just have inaccurate data we're working with. See, we want to fix this, but we don't have accurate data to help us know how big the problem is. Is that correct?

Ms. YOCOM. At this point, we don't know.

Mr. MURPHY. OK. Mr. Archambault, since we can't measure the actual eligibility improper payments due to this freeze that's been imposed in the past administration, let's try and get an idea of the types of eligibility errors and how much they cost the Federal Government.

Do you have any examples from your work of improper eligibility determinations and how that translates to improper spending?

Mr. ARCHAMBAULT. Sure. There's a couple of states that I highlight in my written testimony.

In Illinois, in 2012, they passed a law to hire an outside third-party vendor to look at eligibility errors. And their track record has actually been quite impressive. In their first year, they found about 300,000 individuals who are ineligible for Medicaid; and in their second year, they actually found 400,000 individuals who were ineligible for their program.

And it runs the gamut from individuals who had passed away in the 1980s who were still on their program to individuals who were simply moving out of state, got a raise, didn't report that information. The State of Arkansas recently also did a review of their Medicaid program and found things like 43,000 individuals who didn't live in the state who remained on their Medicaid program, 7,000 of who had never lived in the state.

Mr. MURPHY. Are those people who are making Medicaid claims, do we know?

Mr. ARCHAMBAULT. So in many cases, this is why it's so important. As states have moved towards the managed care environment, it almost doesn't matter. States continue to cut a check to managed care companies regardless of whether those individuals are showing up to the doctor or not. That's why this is even more important now that states have moved in that direction.

Mr. MURPHY. So it's hundreds of thousands of people are in this category that they're still getting paid even though they're not alive, in the state, or getting care.

Mr. ARCHAMBAULT. Correct. In some cases, it's just waste. If somebody moves and is still Medicaid eligible, we just want to make sure two States aren't paying two different managed care companies for their care. In other cases, it's outright fraud.

Mr. MURPHY. Do we have a total dollar value for that?

Mr. ARCHAMBAULT. When you're not measuring, it's very hard to see. But I will say that my written testimony goes through and documents a number of State audits that show eligibility is a huge issue when it comes to applications.

Mr. MURPHY. Thank you. My time is expired.

Ms. DeGette, 5 minutes.

Ms. DEGETTE. Thank you, Mr. Chairman.

Ms. Maxwell, you talked about the complex investigations that your agency is undertaking into some of these Medicaid fraud issues. These investigations involve large numbers of personnel and also technical support. Is that right? They're complex investigations, correct?

Ms. MAXWELL. Absolutely. We partner with the State Medicaid fraud control units.

Ms. DEGETTE. And do you know approximately how many people at your agency are involved in these investigations?

Ms. MAXWELL. Well, in some respects, we all are. So even though the Inspector General has a cadre of inspectors, we're also auditors, evaluators, lawyers, and all of us contribute to the fraud-fighting efforts of the Inspector General's Office.

Ms. DEGETTE. OK. Are you familiar with the executive order that President Trump issued on January 22nd, in which he said that, "No vacant positions existing at noon on January 22nd, 2017, may be filled and no new positions may be created except in limited circumstances"?

Ms. MAXWELL. I am familiar with that.

Ms. DEGETTE. Has your agency determined will that freeze the hiring at your agency?

Ms. MAXWELL. Given that it's quite new, there hasn't been an assessment yet of how that will affect the OIG, but I can tell you, as you have pointed out, that the work that we do does rely on personnel. We use sophisticated data analytics.

Ms. DEGETTE. Let me stop you then. If the personnel at your agency, the hiring was frozen, what would that do to your ongoing fraud investigations?

Ms. MAXWELL. We would need to double down and do as much as we could with the resources that we have.

Ms. DEGETTE. Would it impact those investigations?

Ms. MAXWELL. Absolutely. We need the personnel to analyze the data in order to fight fraud most effectively.

Ms. DEGETTE. Thank you.

Now, I wanted to ask you a quick question, Mr. Archambault, and the question I wanted to ask you, you showed that really heartrending tape about the young girl who was on a waiting list for quite some length of time for the care she needed. She was in Arkansas, is that correct?

Mr. ARCHAMBAULT. Correct.

Ms. DEGETTE. And the Governors of the States decide whether they are going to use that money for cases like that or others—they decide how they're going to use the Medicaid money that comes to their states. Isn't that correct?

Mr. ARCHAMBAULT. Within limits.

Ms. DEGETTE. Yes.

Mr. ARCHAMBAULT. The Federal Government sets the guidelines by which they have to——

Ms. DEGETTE. But the Governor of Arkansas decided where that money would be spent and decided not to put it into that kind of a program. Is that right?

Mr. ARCHAMBAULT. Again, the question and point that I am trying to make——

Ms. DEGETTE. No. My question is yes or no.

Mr. ARCHAMBAULT. As far as the wait list is concerned?

Ms. DEGETTE. The Governor decided how to allocate that money. Is that correct?

Mr. ARCHAMBAULT. They have funds that come in, and they can decide to invest in buying down a wait list.

Ms. DEGETTE. And that's the Governor that decides that.

Mr. ARCHAMBAULT. In a nonexpansion state, we have seen states buy down their wait list.

Ms. DEGETTE. OK, thank you very much. Yes or no would have worked.

I want to ask you, Mr. Westmoreland, a couple questions. Now, uncompensated care costs are what hospitals pay for patients that cannot pay their bills. Is that correct?

Mr. WESTMORELAND. Yes.

Ms. DEGETTE. Who bears the cost of uncompensated care?

Mr. WESTMORELAND. It's a complicated question, but the direct costs are usually borne by state and municipal governments, because they pay for public general hospitals.

Ms. DEGETTE. And then where do they get their money from?

Mr. WESTMORELAND. By and large, they get their money from taxpayers.

Ms. DEGETTE. OK. Now, I talked in my opening statement about how the ACA Medicaid expansion is driving uncompensated care costs lower. Can you briefly explain why that's correct?

Mr. WESTMORELAND. Yes. If a hospital is dealing with people who have no source of insurance, it, by and large, can provide the services and then chase them down. And people oftentimes have no money or declare bankruptcy.

In the instance in which they are insured, either through the exchanges or through the Medicaid program, then the hospital can turn to a third-party payer and they are no longer uncompensated care if they can get some payment from those insurances or from Medicaid.

Ms. DEGETTE. OK. Now, some of the States that did not expand the Medicaid component of the ACA have not experienced as large a reduction in uncompensated care costs. Is that correct?

Mr. WESTMORELAND. Yes.

Ms. DEGETTE. And why is that?

Mr. WESTMORELAND. Those states are still dealing with the same number of people without health insurance who are low income. The states who have expanded have a source to turn to, their Medicaid program, which is in the Medicaid expansion situation, largely paid for by the Federal Government.

Ms. DEGETTE. Great.

Thank you. I yield back.

Mr. MURPHY. The gentlelady yields back.

I now recognize Mr. Barton for 5 minutes.

Mr. BARTON. Well thank you, Mr. Chairman. I am glad to be a part of the first oversight hearing. I'm glad we have some new blood on the subcommittee. We have a new doctor on the Democratic side. I'm glad to have him. We have Dr. Burgess on our side. So when the bloodletting begins, we'll have two doctors that can take care of us and keep us going.

I want to focus the panel's attention on a few numbers. The first number is 20 trillion. The second number is 325 million. Our national debt is about $20 trillion, give or take a trillion or two. We have around 325 million Americans. If you divide 325 million into 20 trillion, you get about 66, 67 thousand dollars that every American owes of the national debt.

Our hearing memo says there's 70 million people that are covered by Medicaid. You subtract the 70 million people covered by Medicaid from 325 million citizens, it means there are 250 million Americans that owe not only their share of the national debt but also the $66,000, $67,000 times 70 million that the Medicaid recipients owe, because, by definition, Medicaid recipients are below the poverty level and they can't pay it back.

Those are big numbers. We're spending at the Federal level about $350 billion a year, and the states are adding another $150 billion. So we're spending about $500 billion a year to provide health care for low-income Americans. That may or may not be sustainable, but we know that we can't sustain adding half a trillion to a trillion dollars every year to the national debt.

We all want to keep Medicaid, but we want to improve it, and that's what this oversight subcommittee is looking at. How do we improve Medicaid so that we get more bang for the buck, real health care to real people that need it, and yet make it affordable so that taxpayers who are funding it can continue to fund it.

Mr. Howard, you talked about, in your opening statement, a little bit about New York, with 6 percent of the population, getting 11 percent of the Medicaid dollars. Do you want to explain to the subcommittee why that's so or would you like for me to explain it?

Mr. HOWARD. Thank you, Congressman.

There is clearly an incentive, given the open-ended Federal match, for wealthier states, both because of ideology and simply because they have a larger tax base, to draw down more Federal dollars. It also inhibits attempts to pursue program efficiency.

When you think of a state like New York, let's say New York wanted to design a more efficient primary care program that saved a million dollars. Because of the 50 percent Federal match, it would have to cut spending by $2 million. So there's a ratchet inherent in the open-ended Federal match that tends to bid up state spending for the states that have the funds to do it, but makes it very hard to turn the ratchet around and correct it and find more efficient ways to deliver care. And I think that's a challenge facing the Nation, not just, of course, for Medicaid, but for private insurance and Medicare as well.

In an environment where there is no incentive for providers to look outside the box, new ways to deliver care more efficiently, more cost-effectively, they simply don't pursue those areas.

I think some of the changes that Governor Cuomo has instituted in New York, if they were done by a Republican administration, I think we would have heard howls of outrage; but because it is a Democratic administration, you capped spending, you ended automatic payment increases. You did a lot of things that are very "progressive," but are really nonpartisan ways to improve program efficiency. And I think that other states and the Federal Government

should look at ways to give states more program efficiency and better incentives.

Mr. BARTON. Do you think it would be appropriate to look at the way the formula allocates Medicaid dollars per se to try to harmonize it with current low-income populations across the Nation?

Mr. HOWARD. I think that's an important tool. I think states would also really appreciate the opportunity to be able to spend Medicaid dollars on non-health-related supports that might actually—in terms of accessing other services—that might make those populations both more compliant with care and in better health in the long term. I think they would be very open to that.

Mr. BARTON. My time is about to expire. I'm going to have some questions for the record dealing with block-granting programs back to the states.

I do want to welcome Mr. Westmoreland back to the committee. Nobody yet has admitted it, but at one point in time, he was one of the brain trusts on the minority side and helped Mr. Waxman and Mr. Dingell actually create the Affordable Care Act. And we appreciate your expertise coming back before the committee.

Mr. WESTMORELAND. It's nice to be back in 2123.

Mr. BARTON. I yield back, Mr. Chairman.

Mr. MURPHY. We now recognize Mr. Pallone for 5 minutes.

Mr. PALLONE. Thank you, Mr. Chairman.

My questions are to Mr. Westmoreland. Mr. Westmoreland, Mr. Archambault made some claims illustrated with a video regarding one individual's experience specifically with the Arkansas Medicaid program's home and community-based services waiting list. And I'm concerned that Mr. Archambault in his testimony attributed a causal relationship between Medicaid expansion and HCBS waiting lists and that somehow the Medicaid expansion he claims exacerbates or causes these waiting lists. I don't believe that to be true. I don't think that the facts show that it's true. I think the wait lists are a result of state decisions, and cutting or capping or block-granting Medicaid will only make the situation worse.

And I like to use anecdotes. I remember a couple years ago I went to a conference in Houston with Mr. Green. I think Mr. Burgess was there too. And in between the health conference, I went over to the Texas Children's Hospital at the Medical Center, and I talked to the officials there. It was a beautiful place with this beautiful lobby, but literally people, particularly mothers with their children, were just literally camped out in the lobby of this place that looked like a hotel. And I asked, why are they all here? It was because they couldn't access the emergency room because there were so many people that they were literally waiting for hours to use the emergency room with their kids. So this notion that somehow the Medicaid expansion is causing the waiting list—I think it's just the opposite. I think that it's the lack of Medicaid expansion in these states that's causing the problems in most situations.

In any case, let me just ask you some questions, Mr. Westmoreland. Can you provide some background on the HCBS waivers in the Medicaid program? Isn't it true that the decision to have an HCBS waiting list is a state flexibility; that is, they are a direct result of state choices on the design of their Medicaid programs

and the amount of resources states make available to provide HCBS?

Mr. WESTMORELAND. Yes. There's no restriction at the Federal level on how much a state may turn to HCBS instead of to traditional institutional services. It's a state decision.

Mr. PALLONE. So, if I can just summarize, states decide whether to limit their HCBS waivers to a defined number of slots and to create waiting lists once those slots are filled, and CMS allows states to increase or decrease the number of slots as they wish. And isn't it actually true that, in the case of Arkansas, the Federal Government would be willing to pay 69 percent of the cost of care if the state chose to increase the number of its slots and that, until January 1 of this year, the state was spending none of its own funds on the expansion population?

Mr. WESTMORELAND. I have to admit I don't know the specifics of the last part of your question, but other than that, I would say yes. It's entirely a state decision, and Arkansas has made the decision of the size of the waiver.

Mr. PALLONE. And isn't it also true that 12 states and the District of Columbia have no waiting lists at all and that the overwhelming majority of those states that have no waiting lists have actually also expanded Medicaid?

Mr. WESTMORELAND. I believe so, yes, sir.

Mr. PALLONE. Isn't it also true that the two states with the longest waiting lists are Texas and Florida, which have not expanded Medicaid—of course, I use my example, my anecdotal evidence there at the Children's Hospital at the Texas Medical Center—but these are the two states that have the longest waiting lists?

Mr. WESTMORELAND. I know that Texas and Florida have not expanded. I did not know that they were the longest waiting lists. I know that they have waiting lists.

Mr. PALLONE. My problem is that I just think there's no evidence that states are choosing to expand Medicaid or keep their expansions at the expense of vulnerable people waiting for HCBS and that examining state choices on both expansion and HCBS waivers actually leads to a contrary conclusion. If anything, all the Federal expansion dollars only strengthen the Arkansas economy and revenues and improve the finances of providers by reducing uncompensated care, as has been shown in multiple states around the Nation. I think it just makes basic sense. If states expand Medicaid, they're getting 100 percent Federal dollars, and they have a lot more money to care for people; it's only going to be natural that they have more money to spend on people who are eligible. So this notion that somehow, by cutting the expansion or eliminating the expansion, cutting Medicaid, getting rid of Medicaid, there's no way in the world that that's going to help the situation with people who are trying to seek care. They're just going to end up in an emergency room. They're going to be waiting for the emergency room. They're not going to get preventative care. They're not going to see a doctor. None of it makes sense. If you wanted to comment.

Mr. WESTMORELAND. If I may, Mr. Pallone, I'd like to juxtapose your comment with that of Chairman Barton, who points out that possibly there will be proposals to block-grant and cap the Federal funding. I have to say that, if the Congress adopts capped funding

for Medicaid, we're going to see more, not fewer, waiting lists. Less funding and the loss of the individual entitlement services is exactly what's underlying the story in that video. And if the program is capped and Federal participation is limited, it will only get worse, not better.

Mr. PALLONE. Thank you.

Mr. MURPHY. Now I recognize the new vice chairman of the subcommittee, Mr. Griffith of Virginia.

Mr. GRIFFITH. Thank you, Mr. Chairman.

Mr. Archambault, get out your money. Are you ready? All right. So my understanding of your testimony was that you were, in fact, saying that the states have to make choices with their limited resources, and that the Federal Government under the ACA is going to lower its Medicaid expansion money down to 90 percent. As states find themselves with larger burdens than was anticipated when they expanded Medicaid, they have to make decisions on where it's cut. And we have created through the ACA—and I say "we" loosely because I wasn't here when they voted on that—but the Congress and the government created a situation where the states are rewarded for cutting traditional Medicaid, which deals mostly with children and people who are in greater need, and that, because of that disincentive or that incentive to spend it on the new folks, the newly found under Medicaid, under the new categories, we create the situation where states are having to make a decision as to whether they quicken the shortage on the waivers, get rid of those waivers as fast as they can, or whether they spend that money somewhere else. Was my understanding correct?

Mr. ARCHAMBAULT. Correct, Congressman. There's both direct and indirect outcomes as related to expansion. And my point is that we are not fulfilling the promises to the most vulnerable in our society, wait list or not, but we are making new promises to an able-bodied population that does not qualify for long-term welfare benefits in any other place. And states are being put in a situation where they're having to make very tough decisions and making cuts in reimbursement rates that directly impact those with developmental disabilities, those in nursing homes. The access and quality questions that have surrounded Medicaid for decades will only get worse for the truly needy.

Mr. GRIFFITH. And so what you're saying is we need to pay attention to that, and we need to make sure that we have incentives that encourage people to take care of the truly needy and the young. And maybe we need to refigure that formula out. That is what you're saying?

Mr. ARCHAMBAULT. Absolutely. I think as part of the repeal-and-replace discussion, as we're talking about changing Medicaid going forward, it absolutely must be on the table. And we would strongly recommend looking at freezing new enrollment in expansion states and not allowing other states to expand so you can address this underlying issue of refocusing programs on the truly needy.

Mr. GRIFFITH. We have a real habit of doing that.

Mr. Howard, I want to ask you, and the reason I say "get your money out" is because I thought the $20 bill versus the $2 was very instructive, Mr. Archambault.

Mr. Howard, you touched on this, but you didn't get into detail. We have a situation where, even in traditional Medicaid, we have rewarded states that play games. Virginia elected not to have a sick tax. That's what it was called when there was a proposal a number of years ago, a couple decades ago, to start taxing the beds of the sick so that they could create that money and then put it into Medicaid and then get matching money from the Federal Government. Even though we were at a fairly low match, that would have given us those $2 from money that we collected from sick people. But many states have come up with these various schemes to get money by claiming that they're charging more. And what they're really doing is creating some kind of a sick tax scheme. And shouldn't we put a stop to that—over time? I'm not saying we have to get rid of it immediately. But shouldn't we over time be trying to get rid of that so that everybody knows what exactly they're getting and not having to charge sick people money so we can get more money for Medicaid?

Mr. HOWARD. The Federal Government has capped the amount of provider taxes that states are able to use, but still we're talking a very significant amount of money. I think the last estimate from GAO was about $25 billion. Many, many states use these provider taxes. They use enhanced payment rates for state-owned facilities, intergovernmental transfers to draw down and raise their effective Federal match.

Mr. GRIFFITH. And while they may be legal, there's some real ethical questions about that, isn't there?

Mr. HOWARD. Well, it's a real issue of program efficiency, absolutely.

Mr. GRIFFITH. OK. Because I want to move on to something else. I heard somebody earlier say that ObamaCare wasn't collapsing, and that was some myth. I got to tell you: We have got all kinds of numbers. Twenty-five percent average increase. Nearly a third of U.S. counties have only one insurer. A trillion in new taxes. 4.7 million Americans had to change their healthcare plan because they got kicked off of the plan that they liked. All kinds of problems out there.

But you know what I find instructive is anecdotal. It happened to me yesterday twice. After church, a group of us generally go to lunch. I try to stay out of politics at lunch, and a discussion broke out at the other end of the table I was not involved in where they were talking about, what do we do as we go forward? And one fellow said: Look, as a Christian, I don't mind paying some more money, but when my insurance rates for my family have gone from to $450, $500, to $1,250 a year and I'm getting less insurance, it's hurting my family. And that's a problem.

Later that evening, at a small group gathering of different people, there was a big discussion about whether or not a family could afford to justify spending money for their daughter, who had the flu—several families had been ravaged by flu over the last couple of weeks—because they, in order to afford health insurance, they had gotten such a high deductible; it was going to cost them $75 to get Tamiflu. And they were debating whether or not they should do that if their other kids got it and what they should do as they

go forward. These are real-life examples of how ObamaCare is, in fact, failing the American people.

I yield back.

Mr. MURPHY. The gentleman yields back.

I now recognize Ms. Castor for 5 minutes.

Ms. CASTOR. Thank you, Mr. Chairman.

Well, thank goodness for Medicaid in America, especially back home in Florida. 3.6 million Floridians rely on Medicaid for their health services. A lot of my neighbors in skilled nursing, Alzheimer's patients, Medicaid is the lifeline for these families. Not to mention, 50 percent of children in Florida rely on Medicaid to go see the pediatrician and get their checkups, along with the State Children's Health Insurance Program. And Florida didn't expand Medicaid, so that 3.6 million number are really our neighbors in nursing home or community-based care or children or my neighbors with disabilities. And based upon what they tell me, Medicaid is working for them. It works.

Medicaid spending growth is lower than private health insurance. It's lower than Medicare. That's because sometimes states try to get by on the cheap in paying providers. That's one place for reform, that we could improve access if we would pay our providers a little bit more and do better there. Medicaid is flexible. I've watched in Florida as they've moved to a managed care system. I have questions about that, but that was a decision of the state. They had all that flexibility under Medicaid. They've also began a change toward more home and community-based services to help keep older folks out of skilled nursing, which can be very expensive.

But we have to remain mindful about the fiscal cost and fiscal responsibility. That's why, in the Affordable Care Act, we passed a lot of new program-integrity provisions to strengthen Medicaid. The most important provisions involved a shift from the traditional pay-and-chase model to a preventative approach by keeping fraudulent suppliers out of the program before they can commit fraud. All participating providers in Medicaid and CHIP programs must be screened upon enrollment and revalidated every 5 years. So think about that as you move toward repeal of the Affordable Care Act. Why would we want to repeal these important program-integrity provisions relating to Medicaid? I don't think that's the path that we all want to go down.

What this is, though, I think the real fear is that this whole terminology of block grants and per-capita caps is simply a stalking horse for less care for my neighbors back in Florida and all Americans. For every Alzheimer's patient, for every child that needs to go see the pediatrician, I want folks to be aware of what block grants and per-capita caps means because it sounds good. But what that means is devastation and sabotage to the Medicaid program.

Mr. Westmoreland, describe the impact on the delivery of healthcare services to Americans if this approach is taken, block grants and per-capita caps.

Mr. WESTMORELAND. As I understand some of the proposals that are Medicaid, the basic point is to limit Federal participation and the state costs of running the Medicaid program. As healthcare costs grow over time, the states will be left holding the bag for

those increased state costs, for Medicaid costs. And as changes occur in the population, as the baby boomer demographic enters into the population, as more and more services are provided for people with disabilities, as prescription drug costs go up, the increased cost over time will not be matched by the Federal Government. States will be left holding the bag.

Ms. CASTOR. And isn't it interesting that some Republican Governors believe this approach will have disastrous consequences for their ability to care for their older neighbors, neighbors with disabilities, and children. For example, a Republican Governor from Massachusetts, in a letter to Congressman Kevin McCarthy, stated: We are very concerned that a shift to block grants or per-capita caps for Medicaid would remove flexibility from states as the result of reduced Federal funding. States would most likely make decisions based mainly on fiscal reasons rather than the healthcare needs of vulnerable populations and the stability of the insurance market.

Could you elaborate a little more what this would mean? In my state, they may not raise taxes. That's the choice, though, isn't it? Raise taxes to support our neighbors or cut?

Mr. WESTMORELAND. If Federal participation is limited in these fashions, it's the only way that would respond to Mr. Barton's concerns about deficit reduction. If Federal participation is limited in that fashion, then the states will have a choice either of reducing the number of people that they serve, cutting back and rationing the services to those people, or raising state and local tax.

Ms. CASTOR. And, Mr. Chairman, thank you.

I'd like to ask unanimous consent to enter into the record, if anyone is interested in learning more about Medicaid, March of Dimes and a number of experts are having a lunch-provided forum tomorrow—or, excuse me, Thursday, February 2, 12:30 to 1:30, right here in Rayburn in the Sam Johnson Room, Rayburn 2020, to learn why Medicaid matters to kids. I encourage you all to attend.

Mr. MURPHY. Could you send a copy over to me? Thank you.

I now recognize Dr. Burgess for 5 minutes.

Mr. BURGESS. Thank you, Mr. Chairman.

I want to thank our panelists for being here today. Very, very interesting discussion. Certainly a very timely discussion.

Ms. Yocom, let me ask you, Chairman Murphy was, I think, directing some of his questions about improper eligibility determinations, and one of the things that has concerned me for some time is the issue of third-party liability, a Medicaid patient who has actually other insurance but also has Medicaid. And my understanding is what happens is sometimes it's hard to collect from the party of the first part, the commercial insurer. Medicaid is more straightforward, so you end up in a situation where the person who should be responsible for the bill, the insurance company who has been contracted to provide care for that patient, actually is inadvertently kind of let out of the equation because it just becomes easier to chase the dollars in the Medicaid system. Is that a real phenomenon?

Ms. YOCOM. It is. We did some work, I believe in part for your office, that took a look at third-party liability on some of the issues that the Medicaid program encountered. Some of the issues are

about information systems and just being aware of the coverage, but then, even within that, it's about the interaction between the State Medicaid programs and the insurance companies and being able to assert the fact that they should be paying first.

Mr. BURGESS. So to what extent are the states able to address the underpayments by commercial insurers and the overpayments by Medicaid?

Ms. YOCOM. We did make some recommendations to CMS to provide additional support and data on these issues. I would need to check to see whether or not they had been implemented and a little more about the specific.

Mr. BURGESS. I'm given to understand that this is not a trivial problem, that there are a significant number of dollars involved. Is that correct?

Ms. YOCOM. Yes, yes.

Mr. BURGESS. And I think it's safe to say that it does vary from state to state. Some states do better than others. So you, if I recall correctly, back in the mid-2000s, in 2005, 2006, 2007, you had created a list of states where the percentages of dollars left behind were attributed to each state. And there were some significant differences. I think Texas was kind of middle of the pack. Iowa did very well. Some other states did very poorly. Do I recall that correctly?

Ms. YOCOM. I believe that's right. And I think some of it is that the more health plans involved, I think the harder it can be. Some of the states that had a smaller group of insurers to work with I think were sometimes able to establish better relationships.

Mr. BURGESS. Well, it just gets to the point. I mean, that was a GAO report of over 10 years ago. Is this problem fixable? Is it worth fixing?

Ms. YOCOM. I think there have been some fixes done, but I'm not sure I remember well enough to tell you much more than that right now.

Mr. BURGESS. OK. I'll just let the subcommittee know there is some very insightful legislation coming on this subject, and I hope people will join me on that.

Ms. Maxwell, let me to ask you: Just staying on the third-party liability issue, you've discussed Medicaid overpayments in regard to providers not reconciling credit balances with the state. Is that correct?

Ms. MAXWELL. That's correct.

Mr. BURGESS. So it stands to reason, since states are not active in tracking down third-party liability claims, they're aware of beneficiaries with overlapping coverage that might receive services that are unintentionally paid for both by third parties and the State Medicaid plan. Is that a reasonable assumption?

Ms. MAXWELL. Correct.

Mr. BURGESS. Is it possible for states to take advantage of in-house data like this to approach practices that might not have reconciled their credit balances?

Ms. MAXWELL. Yes. That's what our recommendation focuses on: the ability of states to identify those overpayments and then recover them. In the report, we identified $25 million in which credit balances had not been reconciled and states had not been able——

Mr. BURGESS. State that number again.

Ms. MAXWELL. $25 million for, I believe it was eight states.

Mr. BURGESS. But it is not an inconsequential number. It is a number worthy of our attention, even though we deal with big numbers up here. Mr. Barton talked about trillions of dollars and dazzled everybody with that. But even focusing on these amounts is important, is it not?

Ms. MAXWELL. Absolutely. From the Office of the Inspector General's perspective, every dollar counts. Every dollar that is overpaid or goes to a fraudulent provider means there's a dollar less to provide services.

Mr. BURGESS. Thank you.

And, Mr. Chairman, I just want to point out that, as of 10 days ago or so, the day before inauguration, we had roundtables with the Governors up here, both on the Senate side and the House side, and it was one of the most impactful days that I have seen up here. There was so much energy and enthusiasm on the part of the Governors who want reforms in their system. They want this to be right. They want to deliver the care to their citizens. There's not unanimity of opinion whether it's a block grant or beneficiary allotment, a lot of discussion around the moving parts, but I will just tell you I was very encouraged at the level of involvement of our Governors in this issue.

Thank you. I yield back.

Mr. MURPHY. Thank you.

I now recognize the gentleman from New York, Mr. Tonko, for 5 minutes.

Mr. TONKO. Thank you. Thank you, Mr. Chair, and welcome to our panelists.

Mr. Archambault, I know that, in your testimony, you addressed the waiting list and the corresponding decline of services or inability of services. I know that our ranker, Representative Pallone, asked you a bit about this or the panel about it, and I just want to dig a little deeper into a claim that you did make where you insinuate that expanding Medicaid will lead to the 600,000 individuals on Medicaid waiting lists being less likely to receive services. First of all, can you explain what you mean by Medicaid waiting lists? I assume you're referring to the waiting list that some states maintain to receive home and community-based waiver services. Is that correct?

Mr. ARCHAMBAULT. Correct.

Mr. TONKO. So I would ask, do you know which state has the longest waiting list for home and community-based services?

Mr. ARCHAMBAULT. It's usually related to population. You're going to have more people who are usually eligible for the program, but there's not a straight correlation that way.

Mr. TONKO. Well, my information tells me that Texas is that list that has the longest waiting list. It's at some 163,000-plus people in 2014. And do you know how Texas' waiting list, of that 163,000, has been affected by the expansion of Medicaid?

Mr. ARCHAMBAULT. The data usually is a year or two delayed, so it's hard to draw a direct correlation. I would just point out that, if we want to make sure that we're fulfilling the promises to the

most vulnerable, I think getting lost in this discussion is that Medicaid is crowding out spending——

Mr. TONKO. Well——

Mr. ARCHAMBAULT [continuing]. Of all kinds, whether it's education, whether it's public safety or infrastructure, or the waiting list. I don't want to——

Mr. TONKO. I would suggest it depends on what states are doing with their Medicaid program, but Texas has not expanded its Medicaid, so that was the answer that I would share with you.

It's very interesting now that we look at some of these data. Mr. Archambault, do you know which state has the second longest waiting list for home and community-based services?

Mr. ARCHAMBAULT. Again, it depends on the population by category, and there's no correlation between expansion or not. The concern is even states that have expanded also have waiting lists. So, for me, it's about priorities. And for state lawmakers, they are being put in a very tough position where they're not able to help families like Skylar's, and that's deeply concerning to me.

Mr. TONKO. Well, Florida is the second in that list of Medicaid numbers, and they have not expanded with their Medicaid issue. And, you know, I think we can sense a pattern here, so we need to cut to the chase. Fully 61 percent of those individuals on waiting lists for home and community-based services live in the 19 states that have not expanded Medicaid. My home State of New York, one of the most populated in the country and one which has enthusiastically expanded Medicaid, maintains a waiting list of zero individuals for HCBS waiver services and a track record that has really begun to be very favorable about per-capita costs for Medicaid. So it's difficult for me to see the real-world correlation that is addressed in testimony like yours where expanding Medicaid and waiting lists for home—where there's a contrast or a choice that has to be made between expanding Medicaid or waiting lists that grow for home and community-based services. Do you have any actual evidence at all that speaks to that expansion and any correlation with HCBS?

Mr. ARCHAMBAULT. So, again, the point is that, when you talk to Governors and state policymakers, they are being put in the position where, in Arkansas, they have been trying for years to address issues like families like Skylar. Now they are having to——

Mr. TONKO. Just yes or no. Is there any correlation that you can cite? And I'll remind you: you're under oath. So is there any correlation that you can cite?

Mr. ARCHAMBAULT. What I will say is there is no correlation. It's not a yes-or-no question.

Mr. TONKO. So the answer to my question is no.

Mr. ARCHAMBAULT. There is no correlation, expansion or not, on whether you have a wait list.

Mr. TONKO. So, unfortunately, what we're seeing here from our witnesses today is a parade of alternative facts designed to obscure the simple truth.

Medicaid expansion is working. It has provided health insurance to over 12 million people, and my colleagues on the other side of the aisle are engaged in a cynical attempt, I believe, to pit good versus good in an attempt to gut this program and rip health care

away from millions of Americans. I find it unacceptable. I find it shameful, and I don't think we should sit quietly while people's right to health care is being threatened. With that, I just yield back the balance of my time.

Mr. MURPHY. Thank you.

I now recognize Ms. Brooks for 5 minutes.

Mrs. BROOKS. Thank you, Mr. Chairman.

I don't think that trying to explore waiting list questions and waiting list issues is an attempt to gut Medicaid. In my view, it's an attempt to strengthen the services and the ability to provide people with developmental disabilities, traumatic brain injuries, mental illnesses, and ensure that those people on these significant wait lists receive care. And I would like to go back to you, Mr. Archambault, with respect to—because I do think it's more complex than a simple yes or no, is there a correlation, or is there not a correlation? So could you please go into greater detail with respect to what your foundation, what you all have found with respect to the waiting lists, with respect to the people who are on the waiting lists, with respect to what the states want to do with the waiting lists? I'm going to let you use most of my time.

Mr. ARCHAMBAULT. Sure. Thank you, Congresswoman.

I would just say that to focus on a waiting list is a vacuum.

Mrs. BROOKS. I'm sorry. What do you mean by "it's a vacuum"?

Mr. ARCHAMBAULT. Some states have delivered care—the phrase that I'm sure you're all very familiar with: You've seen one State Medicaid program, you've seen one. Some states have decided to take their people that would qualify for a waiting list and include it into an 1115 waiver request and deliver services in a different way. My point is that the principles by which we have as a country for our safety net is that we make sure that a safety net program accomplishes a few things. One, is it targeted and tailored to the truly needy? Are we living up to the promises that we are making to these families and individuals before we make new promises?

Mrs. BROOKS. And is it fair to say that those currently on waiting lists in the states are the truly needy? Is there any dispute about that?

Mr. ARCHAMBAULT. I think there would not be, and I would be happy to explore it, but I'm not sure how intellectual disabilities or mental illness would be seen as ones that we wouldn't want to try to help.

Mrs. BROOKS. People typically who cannot take care of themselves.

Mr. ARCHAMBAULT. Correct——

Mrs. BROOKS. Is that correct? People who are often not working. Is that correct?

Mr. ARCHAMBAULT. Correct.

Mrs. BROOKS. People who truly are incapable of taking care of them physically or mentally themselves.

Mr. ARCHAMBAULT. Correct. And this was the traditional Medicaid population pre-ACA—was the aged, the disabled, pregnant women, and children—that we were trying to fulfill that promise to. The ACA changed that discussion.

Mrs. BROOKS. And how did the ACA change that discussion?

Mr. ARCHAMBAULT. Well, expanded to a population that is the vast majority 82 percent childless, able-bodied adults. So, again, these are individuals that don't qualify for TANF. They don't qualify for long-term food stamps. They have not traditionally been a population. And what's really, really important for us to remember here is our goal is not to get people to stay on Medicaid. Ultimately, we want to make sure that they have better health outcomes, and I think most of us would agree ideally it's if they're able to work, that they're out in the workforce supporting themselves and on private insurance. And that's ultimately I think where we want to be as a country, and that's the discussion that we need to be having.

Mrs. BROOKS. And is it fair to say that most of the people who are on the waiting list who are the developmentally disabled, traumatic-brain-injured people, and those with serious mental illness are always going to be on Medicaid?

Mr. ARCHAMBAULT. Correct.

Mrs. BROOKS. It's a different type of population.

Mr. ARCHAMBAULT. Correct.

Mrs. BROOKS. And what has been your discussion and findings with the Governors with respect to how most of them would like to take care of this population? If there's consensus among Governors, what is the Governors' and the legislature's view with respect to this population?

Mr. ARCHAMBAULT. Yes. I think there's ongoing concern by Governors that they're not going to be able to support these. Now, I will say there are exceptions to that rule, and if you look at the State of Kansas or the State of Maine, those Governors have been able to buy down their wait lists. I think Maine was gone from 1,700 individuals down to 200 individuals.

Mrs. BROOKS. How did they do it?

Mr. ARCHAMBAULT. Well, they got some budget sanity. They did not expand Medicaid, and so they have been able to focus on eligibility, as we have talked about today, to make sure that their programs are truly focused on those that are the most needy, the aged, the blind, the disabled. And they've made that a priority in their states, and they've had success in buying down their wait lists.

Mrs. BROOKS. I think we need to continue to explore the states that have found ways to have little to no wait lists. I certainly hope today our Governor, Governor Holcomb, is formally submitting an application to CMS for a Medicaid waiver to continue our successful Healthy Indiana Plan for an additional 3 years. It's an outstanding program that I hope folks on both sides of the aisle—it is a way to save and to help those who truly need it. It can be replicated. I believe it's an incredible model that can work.

Unfortunately, we still have a waiting list in Indiana. We don't want a waiting list. But I certainly hope that, with the new nominee to lead CMS, Seema Verma, a Hoosier, we can make all of Medicaid a far stronger and better program. With the controls in place, as a former U.S. attorney, I've worked with the MFCU units. We need to do more to support them. We need to do more to support all of these efforts to make sure that our truly vulnerable are protected.

With that, I yield back.

Mr. MURPHY. OK.

I now recognize Ms. Clarke for 5 minutes.

Ms. CLARKE. I thank you, Mr. Chairman, and I thank our ranking member.

Before I get into my actual questioning, I actually want to respond to Mr. Howard because, as a proud New Yorker, I must correct the impression left by your characterization of the Empire State. Are you aware that the New York State's Medicaid Redesign Team has been a national leader in controlling costs and improving quality for Medicaid members? The Empire Center for Public Policy, self-described as a physically conservative think tank and government watchdog, released an analysis in September of 2016 that New York Medicaid spending per recipient has dropped from $10,684 to $8,731, or 18 percent, between 2010 and 2014, at nearly twice the national average.

According to the independent New York State Comptroller's Office, the MRT restrained total Medicaid spending growth to only 1.7 percent annually during the period of fiscal year 2010 to 2013. This marks a significant reduction over the trend for the previous 10 years of 5.3 percent. During the same 3-year period, Medicaid re-enrollment grew by more than half a million people. Billions of dollars have been saved, and per-recipient spending has been slashed. In fiscal year 2014 and 2015 alone, a total of $16.4 billion was saved thanks to the MRT initiative. This track record of success led the Comptroller's Office to declare that MRT represents the most comprehensive restructuring of New York's Medicaid system since the program began in 1966. And we have no waiting list.

I would like to now turn to Mr. Westmoreland. In Mr. Archambault's written testimony, he cited numerous concerns about Medicaid expansion. However, he ignores the fact that this program has also had a positive impact on the quality of life and health for millions of Americans. He also ignored the fact that many of the positive impacts, such as cost savings, from preventative medical exams and early detection and treatment of disease will result in future cost savings to the states and the Federal Government. I am a strong supporter of Medicaid expansion because I see the significant value of the program. I'm interested in improving the program and not destroying it.

So, Mr. Westmoreland, Mr. Archambault claims that the Medicaid expansion funding threatens the truly vulnerable. Can you clarify why this is not the case?

Mr. WESTMORELAND. I'd begin with first challenging the discussion, as I did in my testimony, of who's truly vulnerable. I want to be clear that not all people with disabilities, cognitive, traumatic brain injury, any of those discussions that have been ongoing, were traditionally eligible for Medicaid. It was tied to a 75-percent poverty and receipt of SSI, and many people whom we would all consider to be disabled have never been eligible for the Federal Medicaid program until the enactment of the ACA. So let's start with those people.

Secondly, I would point out that there have been significant studies, economic and macroeconomic studies, some by business schools, some by economists, showing that states actually have significant budget savings and revenue gains by having the Medicaid expan-

sion in their state. So I think that it's clear that states benefit on a financial basis and that their citizens benefit on their financial basis in the ways that I outlined in my testimony.

Ms. CLARKE. Mr. Westmoreland, both Mr. Archambault and Mr. Howard claimed that Medicaid expansion poses an unsustainable burden on state budgets. Can you clarify why this is not the case? Why have most states that have expanded Medicaid actually experienced net budgetary savings associated with the expansion?

Mr. WESTMORELAND. Yes. Let's start with the healthcare expenses that, as we discussed earlier, there are fewer uncompensated care costs within the state. In addition to that, there is an influx of Federal funds into the state to pay for healthcare services, and those Federal funds have a reverberating multiplier effect in the state economy. And, finally, states are able to provide, as you suggested, preventive and early-intervention services that might not have been available to uninsured adults before and actually lower the ongoing healthcare costs for those people.

Ms. CLARKE. It is my understanding that numerous studies have disproven the myth that Medicaid expansion diminishes work incentives. Is that correct?

Mr. WESTMORELAND. Yes, ma'am.

Ms. CLARKE. I yield back the balance of my time, Mr. Chairman.

Mr. MURPHY. Thank you.

Now I recognize a new member to our subcommittee, the gentleman from Michigan, and Reverend, Mr. Tim Walberg.

Welcome aboard here to our committee.

Mr. WALBERG. Thank you, Mr. Chairman.

Mr. Archambault, I appreciate the safety net illustration, that we want to have safety nets. We don't want to have safety nets forever for people. I remember, I never worked over a safety net, but I remember working at U.S. Steel South Works and third helper of going out and being responsible to swing a sledge and take the plug out of a heat of molten steel and had a fall-protection strap on me. I appreciated that, but when the shift ended, I didn't want that strap. I wanted to move on. That's a laudable goal, that we find ways to make sure that people who truly need that safety net have it, that we make sure that we don't waste it on others who don't and encourage them to move on in a very positive way.

I'd like to ask you for a further response from your testimony, and also, Ms. Maxwell, I'd like for you to comment after Mr. Archambault. Your testimony references some of the waste and fraud issues that face our Medicaid programs, individuals that have passed away decades ago, individuals using high-risk or stolen Social Security numbers, and tens of thousands who had moved out of state yet remained on Medicaid. What can we do to combat some of these problems more effectively?

Mr. ARCHAMBAULT. So there's a number of things that we would recommend, and thank you, Congressman, for the question. The first one is allow states to check eligibility more frequently. Under the ACA, there was a change that states could only redetermine eligibility once a year unless they were given a reason to recheck eligibility. We have found that states that are able behind the scenes to access data internally within state government but also through third-party vendors, if they're able to run those on a quar-

terly or monthly basis, they're finding that these people, individuals have life changes, just like all of us. So, whether they move or they die or whether they get a significant raise, we need to make sure that we find that sooner rather than later. Otherwise, we're just wasting money, and I believe that there's bipartisan agreement on that, that we need to make sure. The other thing is that we need to make sure that the Federal databases, which we haven't talked a lot about, the quality of the data in those is quite poor. If you talk to state leaders, they will complain constantly about how late the data is, out of date, and it's not flexible enough. So making sure that states are able to look for dual enrollment, for example—and the Food Stamp program is moving in this direction. We should be doing it for Medicaid, just to make sure that we're not wasting money as a result of individuals moving across state lines.

Mr. WALBERG. Thank you.

Ms. Maxwell, could you add to that?

Ms. MAXWELL. Thank you. I would love to. I would definitely echo what we just heard about the crucial need for better Medicaid data. Lack of data hampers the ability to understand these programmatic issues for policy decisions but it also significantly deters us in trying to find fraud, waste, and abuse. In addition to that impacting detection, we also need to think about protecting the Medicaid program from fraud ever happening in the first place. So again, in addition to the data, we would encourage CMS to continue to work with states to improve enhanced provider screening to make sure that providers that get in the program are the providers we want to get in and are who we want to pay.

Mr. WALBERG. Thank you.

Mr. Archambault, an audit in Arkansas revealed more than 43,000 individuals on Medicaid who did not live in the state, with nearly 7,000 having no record of ever living there. More than 20,000 Medicaid enrollees were also linked to high-risk identities, including individuals using stolen identities, fake Social Security numbers, et cetera. Something of interest to me in Michigan, has recently identified more than 7,000 lottery winners receiving some kind of public assistance, including individuals winning up to $4 million. Those jackpots are something that ought to encourage them not to be on Medicaid assistance.

Mr. Archambault, do these individuals get approved for and stay enrolled in the Medicaid program, and is it the Federal Government or the states dropping the ball?

Mr. ARCHAMBAULT. Well, Congressman, maybe a little bit of both, to answer that question. And I think what's really important here is that there are some policy changes that have happened. The Affordable Care Act removes an asset test for the Medicaid program, by and large. There's some that it still applies to. But as a result, these sorts of outlier cases admittedly, but when an individual wins $4 million, takes a lump-sum payment, they may not qualify that month, but the very next month, they would qualify for this program and can remain on. Let alone we're not checking for 12 months in most cases, so we wouldn't know. The point I'm making here is we need to make sure that these gaping holes that exist, we have data in many cases within a state government. We

have data across state lines. And the Federal Government needs to incent states to say: Look, if you are doing this on a more regular basis and identifying fraud, you can take a little bit of that savings to pay for those efforts. This points to Mr. Howard's point that that is not the incentive that's inherent in the current financing structure that we have set up.

Mr. WALBERG. Thank you.

My time has expired.

Mr. MURPHY. I now recognize Dr. Ruiz for 5 minutes.

Mr. RUIZ. Thank you, Mr. Chairman.

As many of you know, I grew up the son of farm workers in the medically underserved community of Coachella. I have seen firsthand what it means when a community is medically underserved and when they cannot access care. I can tell you this: If it was not for Medicaid, the Coachella Valley and regions like mine all across the country would not have access to health care that every one of us up on this dais and our families enjoy. If we repeal Medicaid expansion, people will lose healthcare coverage. They will stop seeing their doctors because the costs will be too high, and they will stop taking their lifesaving prescriptions because they are too expensive. In California alone, the nearly 3.5 million individuals who enrolled in Medicaid under the ACA expansion provision could lose their coverage. That's millions of families losing access to health care. And if we repeal Medicaid expansion, uncompensated costs will increase, straining our Nation's healthcare system, which will drive up costs for everyone because, you see, when people don't have health insurance, they don't stop getting sick. And our emergency departments do not turn someone away because they don't have insurance. Emergency physicians treat the patients, like they should. So the hospitals have to make up the costs. And in 2014 alone, Sutter Health Systems in California saw a decrease in uncompensated care by 45 percent in 2014. All hospitals in my district, in particular San Gorgonio Hospitals, have seen a drop in uninsured patients in the emergency department by half. So we need to expand Medicare even more, make it more efficient and more desirable for providers to see more Medicaid-insured patients.

Listen, fraud is bad, and political amplification of the problem to wrongfully justify cutting health insurance for sick patients is bad. So here's the possible common ground. Here's what I think we can both agree on. If we start with the premise that we want to cover more uninsured, economically struggling families like the middle class and more vulnerable families, then we're on the same page. But if you start with the ideological goal to cut or end Medicaid, then you'll breed mistrust, and millions of people will be harmed, including the middle class. So the real question—and the real question, Mr. Howard, is, are sick and injured people getting the care they need? Because anything short of this is negligence. So let's tackle fraud so that we can expand coverage to more struggling, uninsured middle class families.

So the question that I have, Ms. Yocom, if you were to choose one thing that you can do to combat fraud, if there's one action that you can take that we can make the biggest difference in the system, what would that be?

Ms. YOCOM. I think it's around the providers, making sure that we have eligible providers who are in good standing and that those who are not in good standing and should not be providing services aren't going across states to provide services.

Mr. RUIZ. Thank you.

Ms. Maxwell, the one thing, the one thing that would make the biggest difference?

Ms. MAXWELL. I would absolutely have to go back to the data. Without that sort of transparency, we cannot see what's happening in the program. We have a lack of data across the Nation and also data coming in from the managed care companies.

Mr. RUIZ. Thank you.

Mr. Howard, the one thing, if you had one thing that you can change to make the biggest difference in fraud, what would it be?

Mr. HOWARD. In fraud in particular?

Mr. RUIZ. Medicaid.

Mr. HOWARD. Yes. Engage data transparency, as my colleague here on the dais was just saying. Medicaid data should be enclaved for all the states to look at so they can benchmark provider performance and engagement.

Mr. RUIZ. Thank you.

Mr. Westmoreland, what does the evidence suggest about how Medicaid expansion is making health care more affordable? Is there evidence, for instance, that Medicaid expansion is reducing patients' need to forego medical care due to costs?

Mr. WESTMORELAND. Medicaid expansion is highly associated with a decline in personal bankruptcies. It is also associated with greater financial security for families who are newly eligible.

Mr. RUIZ. So these are middle class families who are having some economic security because of the Medicaid expansion. What does the body of evidence say about how Medicaid expansion has affected patient access to primary care and preventative care?

Mr. WESTMORELAND. Those beneficiaries who are newly insured under the Medicaid expansion have much higher rates of traditional sources of care, seeing primary care, and using preventive health services.

Mr. RUIZ. Thank you very much.

My closing statement is, if this is leading to increase in expansion for economically struggling middle class families, then, you know, I'm in.

But if the ultimate goal is to create a facade and amplify a problem politically to then justify policies that will hurt the middle class and that would decrease health insurance, then I'm not in.

So let's tackle fraud so that we can expand more health coverage to middle class families.

Thank you very much.

Mr. MURPHY. Thank you.

Now we're recognizing another new member of our committee from, I think, UCLA, former state assemblywoman, state senator, mayor, Congresswoman Mimi Walters of California. You're recognized for 5 minutes.

Mrs. WALTERS. Thank you, Mr. Chairman.

My questions will be directed to Mr. Archambault. The supporters argued that Medicaid expansion would increase jobs. Has this happened?

Mr. ARCHAMBAULT. There's been a number of studies where the consultant predictions have been very off, whether it be enrollment or jobs. In particular, they are Iowa, Tennessee, where there were predictions of gains in hospital jobs and healthcare jobs as it related to expansion, and the opposite has actually taken place, where there has been a loss in healthcare jobs.

Mrs. WALTERS. OK. And during the conception of the ACA, supporters argued that Medicaid expansion would stop hospital closures. Has this been the case?

Mr. ARCHAMBAULT. So it certainly has not stopped hospital closures. In a number of states, hospitals have still closed. And I think it's important to realize that the supporters' claim that it is a silver bullet to stop closures has not been true. So you could list off Arizona, Massachusetts, a number of these states where they have expanded, and hospitals have still closed.

Mrs. WALTERS. OK.

And, finally, Medicaid expansion was projected to lower emergency room use. However, you pointed out that the evidence suggests that emergency room use has increased after expansion and that many emergency room visits by Medicaid beneficiaries were deemed to be avoidable. Can you explain what might have led to this outcome?

Mr. ARCHAMBAULT. Sure. And my experience is not just influenced by the ACA. I live in Massachusetts and worked on RomneyCare and have studied RomneyCare very closely. And one of the things that becomes apparent is, both in the expansion population and the traditional Medicaid population, is folks are not getting coordinated care because they are showing up to the ERs at a much higher rate than those that are privately insured or even uninsured. And so, as a result, these are the questions that we need to ask about the effectiveness of the program, the quality of the care that individuals are getting. There's been a number of surveys looking at, how many of these visits are avoidable? And, unfortunately, at least in Massachusetts, those surveys found that 55 percent of Medicaid visits to the ER were unavoidable.

Mrs. WALTERS. Thank you.

I believe my time is expired.

Mr. MURPHY. I then recognize Ms. Schakowsky for 5 minutes.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman.

The Affordable Care Act has just been a blessing for so many people in our country. Twelve million more Americans have access to health care.

Mr. Westmoreland, Governors across the country submitted letters in response to Representative McCarthy's request to describe the impact of the ACA and the expansion of Medicaid within their states. I'm assuming that you've seen some of these letters. For the record—

Mr. WESTMORELAND. Yes, ma'am.

Ms. SCHAKOWSKY. Even some Republican Governors appeared to have positive things to say about the expansion of Medicaid in their state. For example, the letter from my home State of Illinois

stated that our—the Governor stated that our Medicaid population "now stands at 3.2 million, almost one quarter of the state's population," and it went on to urge Republican leaders in Congress to "carefully consider the ramifications of proposed changes." Similarly, Governor Sandoval of Nevada stated in his letter to Mr. McCarthy that, "I chose to expand the Medicaid program to require managed care for most enrollees and to implement a state-based health insurance exchange." These decisions made health care accessible to many Nevadans who never had coverage options before.

So, Mr. Westmoreland, can you briefly touch upon how the residents of states that expanded Medicaid under the ACA have benefited, such as Illinois and Nevada?

Mr. WESTMORELAND. I'm sorry. I didn't understand the last part of the question.

Ms. SCHAKOWSKY. I cited Illinois and Nevada, but can you briefly touch on how the residents of states that did expand Medicaid under the ACA have been benefited?

Mr. WESTMORELAND. Let's begin with 11 million people have Medicaid coverage who didn't have it before, and many of those people are in serious need. I would point out and agree with you that, of the Governors who wrote to Mr. McCarthy, none of them requested repeal, I believe. And 16 of the states were governed by Republican Governors. And Ohio, Mr. Kasich, one of your former colleagues, I think was most passionate in describing not only how it has benefited the residents of Ohio to have services but that, indeed, he believed that it was a moral duty to continue to cover these people under Medicaid.

Ms. SCHAKOWSKY. Thank you for that.

And can you briefly touch on how—let's see, I also wanted to mention there are other examples, Republican-led states as you have said, that have had positive outcomes for their residents. And beyond providing healthcare benefits to an additional 12 million people, how has Medicaid expansion helped states manage their budgets? Has it had a positive impact?

Mr. WESTMORELAND. As I suggested earlier, there have been business school studies and economic studies suggesting that states who have expanded Medicaid have had not only a net increase in Federal funds coming into the state, but they've also enjoyed some revenue increases because of the reverberating effects and providing those funds in hospitals. I would also point out to you that there is a long-term study to be done of how productivity might actually be improved by people having healthcare services who previously were denied those services.

Ms. SCHAKOWSKY. Thank you. Some of the letters I was referring to seem to raise concern by Republican Governors that changes to the Medicaid program would produce destabilizing cost shifts to the states. For example, Governor Baker of Massachusetts in his letter to Mr. McCarthy said, "Medicaid is a shared Federal-state partnership." Proposals that suggest that states may be provided with more flexibility and control must not result in substantial and destabilizing cost shifts to states.

So is there a valid concern of a major cost shift under the Republican proposals you are seeing, such as proposals to block-grant

Medicaid or impose per-capita caps on spending? Should states be concerned about major cost shifts?

Mr. ARCHAMBAULT. States should be very concerned. The first question is, what level will the initial block grant and its formula be set at? But the major question for states to focus on is how the evolution, the increase of funding in the future, will evolve as compared with the actual cost of providing healthcare services to the number of people who need them. As I suggested earlier, states will be left holding the bag for both medical inflation and the number of people who have no health insurance.

Ms. SCHAKOWSKY. And what about, for those that are receiving health care through ACA's Medicaid expansion, are they at risk, particularly if they block-grant the Medicaid program?

Mr. ARCHAMBAULT. Well, first, I would suggest that my colleagues on this panel would point out that—suggest that those people should be the first to go off of the healthcare rolls and that they would return to traditional Medicaid populations as they've existed over the last 20 or 30 years, so I would suggest that the people who are on Medicaid expansion are the people who are most likely to be on the chopping block to begin with.

But, secondly, I would say that, as every state, expansion or no expansion, experiences the growth in healthcare costs that is almost inevitable, looking at CBO or any other projections, if the states are left holding the bag and they do not have a guarantee of Federal funds, they're going to be cutting back on everyone.

Ms. SCHAKOWSKY. Thank you.

I yield back.

Mr. MURPHY. Thank you.

Another new member of our committee, Mr. Costello of Pennsylvania. I appreciate you being here. You're recognized for 5 minutes.

Mr. COSTELLO. Thank you.

Ms. Maxwell, if I could ask a couple of questions on HHS OIG, has the number of criminal investigators increased or decreased over the years?

Ms. MAXWELL. The number of criminal investigators specifically?

Mr. COSTELLO. Yes.

Ms. MAXWELL. I think, right now, we are below our FTE ceiling. We are still trying to hire more.

Mr. COSTELLO. How many more do you think you need to hire?

Ms. MAXWELL. Well, we would hire as many as you let us, but w need about 1,700 FTEs—that's where we're pegged for, the entire OIG.

Mr. COSTELLO. True or false, for every $1 expended in the OIG, $7.70 is returned to the Health Care Fraud and Abuse Control Program?

Ms. MAXWELL. That is true.

Mr. COSTELLO. Has that been a consistent return?

Ms. MAXWELL. As far as I know, it's been around $7, and it's the same thing for the Medicaid Fraud Control Units. They also had that similar ROI.

Mr. COSTELLO. You conducted a review of State Medicaid agencies presented with allegations of provider fraud. Did you find that state agencies properly suspended Medicaid payments to those providers?

Ms. MAXWELL. They did not make full use of those tools.

Mr. COSTELLO. Which is to say they did suspend all——

Ms. MAXWELL. They did not. Although, in a number of the cases where they did not suspend, the MFCU ultimately cleared the provider of wrongdoing.

Mr. COSTELLO. Very good. On the issue of program integrity, since your work has repeatedly found CMS' oversight of states claiming of matching dollars is inadequate to safeguard Federal dollars, what more could CMS be doing to ensure the integrity of Medicaid matching?

Ms. MAXWELL. There are a number of things along the program integrity principles I've outlined that we believe CMS could do in conjunction with the states. Given that CMS and states share fiscal risk, we believe they should share accountability. So, as I mentioned, prevention, helping states implement the enhanced provider screening, helping them drive down improper payment rates, and then, of course, the data to be able to understand the program and detect fraud. And more importantly, the data helps us home in on fraud, waste, and abuse and really target our oversight activities so that we can get this tricky balance right between trying to have really strong program integrity but also not put an undue burden on its providers.

Mr. COSTELLO. I'm going to shift this question to Mr. Archambault, but after he answers, anyone else feel free to respond, including what you just mentioned about the issue of, specifically, enhanced data-matching technology.

Because it seems to me that if you have technology and you have data, when we're talking about the ACA change which only requires states to perform one check per year, knowing that we have the data, knowing that we're a pretty technologically advanced society, it would be, I think, a little bit easier to go about detecting ineligibility or fraud or anything of the sort to cut down on those who are ineligible from being accepted into the Medicaid program.

Mr. Archambault, I see in your written testimony, in the first 10 months of operation, Pennsylvania's award-winning Enterprise Program Integrity Initiative identified more than 160,000 ineligible individuals who were receiving benefits, including individuals who were in prison and even millionaire lottery winners, resulting in nearly 300 million in taxpayer savings.

What can we do in order to pivot to real-time identification of something that doesn't seem quite right, rather than just relying on that one moment in time annually, to beef up program integrity here?

Mr. ARCHAMBAULT. So I think there's a number of things that the Federal Government can do to enable states to do this.

The first one is that if they are investing state dollars in some of these efforts, if they are able to find cases that are ineligible, for them to be able to keep a piece of that savings up front and more than they get to save now, given the funding formula that we have.

The other one is let them check more frequently.

And then the third one is to make sure that the actual data that the Federal Government is allowing access to is timely or allows states to go somewhere else to get it from a private vendor if the Federal Government's data is not timely enough.

Ms. MAXWELL. Yes, I would agree that the coordination and sharing of data is critical between the Federal and State governments. One area where we found a real problem is, when providers are enrolled, they're asked who their owners are so we know who we're doing business with. And, in one case, we found that the State Medicaid agency thought there were 63 owners, Medicare thought there were 14 owners, and they told us there were 12. So, trying to coordinate this data so all the programs know who we're doing business with.

In addition, we recommend that the Medicare data be improved so that Medicaid can actually share that and reduce the provider burden, in terms of letting them enroll in both different programs.

Mr. COSTELLO. That gets, Ms. Yocom, to your point about the duplicate eligibility issue, correct?

Ms. YOCOM. Yes, it does. And while we are a technologically advanced society, the Medicaid program truly is not. States' data systems are pretty antiquated, and there is a lot of work to do to get good data systems that are more flexible and more agile.

Mr. WESTMORELAND. If I could, sir, I would also say that the recently published managed care organization rule provides for a substantial improvement in data systems. And I would ask this—and this committee actually accelerated the effective date of that with your 21st Century Cures Act.

I would ask you to keep the MCO rule in mind as you move forward with the question of whether regulations will be withdrawn in the early part of this—in the early part of this administration. I think it's a valuable addition to try to be able to find who—I agree with all my colleagues that the data systems need to be improved, and I think the MCO rule does that.

Mr. COSTELLO. Thank you all for your comments.

Mr. MURPHY. Thank you.

And now, recognizing another new member of our committee, the owner of Carter's Pharmacy. Is that a place where we might see someone like Ellie Walker and Opie serving drinks at the Walker's store?

Mr. CARTER. Very much so.

Mr. MURPHY. But understanding of small-town medical care, good to have you on board here. Buddy Carter of Georgia's First District.

Mr. CARTER. Thank you. Thank you, Mr. Chairman.

And thank all of you for being here. We appreciate your participation.

I want to preface my questions by apologizing if I ask you something you weren't prepared for. And if you don't know the answer, if you'll just simply tell me that you can get me the answer, that will be fine.

Ms. Maxwell, I understand, looking at your bio last night, that you have some expertise on the 340B program.

Ms. MAXWELL. I do.

Mr. CARTER. I don't want to get into that program; however, I want to explain to you a situation that exists in my district.

I have a hospital in my district that was participating and receiving moneys from the 340B program, and because they didn't meet

the threshold, they were put out of that program. Now, they got back in it.

As I understand, there are two different levels that you can be at, as a sole community provider and also as a disproportionate share.

Ms. MAXWELL. Yes. Those are both covered entities.

Mr. CARTER. OK. Well, they got back in it as a sole community, OK? But what the CEO is telling me is that, because they can't get back as a disproportionate share, that they're losing over $300,000 a month. Now, that is significant for them. I'm sure it's significant for anyone, but for this hospital system it's very significant.

Now, he also is telling me that the formula that is used for that, that Medicaid participation, the Medicaid rate is also in that formula to determine whether they are a sole community or whether they're in the disproportionate share.

And what I'm hearing is that those states that did not expand Medicaid, like the State of Georgia, that they are put at a disadvantage, in that we aren't eligible for that. Is that true? Is that the case?

Ms. MAXWELL. I'm going to have to take your offer to get back to you on that.

Mr. CARTER. OK.

Ms. MAXWELL. My expertise really is in the pricing of the 340B drugs themselves and not as much in this disproportionate share. But I know there have been issues, and I certainly know there are people in our office that can answer that question, and we'll get back to you as soon as we can.

Mr. CARTER. OK. Well, that's fair enough.

But my question is twofold: first of all, if that is the case; secondly, if that was the intention. Was that the intention, to penalize states that didn't expand Medicaid so that they couldn't receive these dollars, or was it an incentive to get those states to expand Medicaid?

Ms. MAXWELL. I couldn't speak to the legislative intent.

Mr. CARTER. OK. Well, please include that in your answer. That's one of the things——

Ms. MAXWELL. Absolutely. Will do.

Mr. CARTER. I'm going to move now to Mr. Archambault and ask you, the video that you showed there—now, understand, I spent 10 years in the Georgia State legislature, all on Health and Human Services, so I understand about Medicaid. And we did the hospital bed tax in order to draw more dollars down, as was brought up by one of my fellow members earlier. In fact, they are looking at reauthorizing that again this year. And you bring up a valid point about how states balance budgets, because, quite honestly, we did it that way, and that was one of the reasons why.

But my question is about the video you showed. Now, I am a strong believer that Medicaid should include the aged, blind, and disabled. In fact, I think that if—and if you'll help me—that most of the costs in the Medicaid program can be attributed to the ABD. Would that be—and what percentage would that be? Seventy, 80 percent?

Ms. Yocom, do you——

Ms. YOCOM. I think it's at least two-thirds.

Mr. CARTER. At least two-thirds?

Ms. YOCOM. Yes.

Mr. CARTER. OK. And we're all in agreement that that's most of it.

But my question, Mr. Archambault, was why didn't this patient—why wasn't this patient eligible as disabled? It would seem to me like they wouldn't have had to have waited on the waiver.

Mr. ARCHAMBAULT. So, Congressman, thank you for the question. And I think it is important to know that we are talking about a couple different things here. What we were talking about in particular for her, for Skylar and her mother, is that there are some services that she could have access to under these waiver programs.

So, for Skylar, you can't just call a neighbor to babysit. You need to have certain skill sets to be able to be able to watch her, given her condition. And so this would allow access to those services.

It's not that individuals are completely off of Medicaid; it's that we are talking about, are we providing the services that we have promised to individuals in a holistic manner to be able to take care of these most needy?

Mr. CARTER. OK. Well, understand, again, I am one who believes that Medicaid should be taking care of that group. And once you get past that, now, we can have a discussion and we can debate who's to be covered and who's not to be covered. But I honestly believe, as a healthcare professional, that they should be covered.

Mr. ARCHAMBAULT. And, Congressman, that's my exact point, is that we are extending new promises to able-bodied, largely childless adults before fulfilling that promise.

Mr. CARTER. OK. Good. Thank you for that.

Very quickly, I'm sorry I don't have much time, Mr. Howard, I just wanted to ask you, HHS now projects that newly eligible Medicaid patients are going to cost $6,366 per enrollee in 2015 and that this is a 49-percent increase in what they had projected before. Why is that? Why are they costing more?

Mr. HOWARD. Congressman, it may be because, in these new expansion programs, states have raised their reimbursement rates to providers to get these newly eligible populations in the system. That's my understanding.

Mr. CARTER. It would appear to me, if the—again, I get back to the aged, blind, and disabled. If they were already included, they are the most expensive. And why are they—I'm sorry. I know I'm running past my time. It just baffles me why it's gone up that much.

Mr. MURPHY. OK.

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

Mr. MURPHY. OK. Thank you.

I'm now going to recognize Mr. Collins for 5 minutes.

Mr. COLLINS. Thank you, Mr. Chairman.

I'm going to be directing this to you, Mr. Howard, but some background: I'm western New York, and New York, as we all know, is one of the highest states in Medicaid per capita spending and total spending. And while New York only has 6½ percent of the Nation's population, it accounts for over 11 percent of the national Medicaid spending. And according to a 2014 report from Medicare

and CHIP Payment and Access Commission, using data from 2011, New York spent 44 percent more per Medicaid enrollee than the national average.

There's all kind of complex and fragmented funding streams that make it very difficult to provide adequate accounting controls for the program.

So the question is this: In 2012, a report from the HHS Office of the Inspector General revealed that New York had systematically overbilled Federal taxpayers for Medicaid services for the mentally disabled for 20 years. New York State developmental centers, which offer treatment and housing for individuals with severe developmental disabilities, had received 1.5 million annually per resident in 2009, for a total of 2.3 billion. State centers were compensated at Medicaid payment rates 10 times higher than the Medicaid rates paid to comparable privately run developmental centers.

So the simple question is, how could these overpayments go unnoticed for 20 years?

Mr. HOWARD. Congressman, it's because there is simply no financial incentive for the states to go back and police their systems in a way that would result in a significant decrease in Federal funding.

The State of New York actually settled with HHS, I believe, for $1.63 billion for overpayments. I think it was 2009 through 2011. So, to some extent, the problem was remedied, but the reality is, as I said before, the ratchet only goes one way.

Congresswoman Clarke pointed out earlier that Governor Cuomo has had quite a bit of success, which I noted in my testimony, in bringing down the payment rate—pardon me, for the growth rate for Medicaid. I think if someone who had an R by their name had suggested what is effectively for New York State a cap on growth of the most nondisabled part of the program, that it would be held to 30 percent effectively below the historical payment rate for the program, I think there would have been cries of poverty and that we'd be throwing people out of the program. Miraculously, New York State providers found ways to significantly decrease their spending by hundreds of millions of dollars.

I think that the belief that significant flexibilities or block grants or per capita caps would automatically mean less delivery of care ignores that economists on the right and left center of the aisle believe there's significant opportunities for efficiency in health care. And until we give states better programmatic and financial goals to seek out that efficiency, we are not going to be getting the best outcome for every dollar we're spending on health.

Mr. COLLINS. Well, being a New Yorker and bringing this up, I would have to say, while they apparently negotiated a significant settlement, it in fact did not reimburse the Federal Government for 20 years of egregious behavior which I would say was deliberate. You can't be charging 10 times the national average for 20 straight years and try to, you know, prove that this was not intentional.

So, you know, we talk about R's and D's. I have to wonder, if there wasn't a D behind the President's name and a D behind our Governor's name, if that settlement would have come closer to reimbursing the U.S. taxpayers for what I think was grand theft auto.

So another question about New York. Well, by the way, the reason I come at this the way I do, as a county executive of Erie County, largest upstate county, we're one of only a handful of states where the counties have to pay a share. And, by the way, on DSH and IGT for UPL, the counties pay 100 percent of the Federal match. The state pays nothing.

In the case of Erie County, my county, second, third, fourth city in the United States, city of Buffalo, 110 percent of our property taxes went to Medicaid. We couldn't raise enough property tax to even pay our county's share of Medicaid because of the way New York State runs this program. We had to supplement it with sales tax revenue. That's why I get a little emotional when I find out the state's been cheating for 20 years, especially the way they handle the counties.

But, also, as I understand it, in a 2009 report, New York State ranked last in affordable hospital admissions—last. So our outcomes are so poor. What is going on in New York? And we've only got 20 seconds, but——

Mr. HOWARD. Just very quickly, I think there's also consensus that the amount of spending we put on health care does not automatically correlate to better outcomes. So if you look at a scatter plot of state spending per enrollee, it's all over the map, and outcomes are all over the map, because there's an increasing body of research that says health behaviors, not access to care, not insurance, dictate long-term health outcomes. We just need to think about health differently.

Mr. COLLINS. And I couldn't agree more that there's no correlation between spending and outcome.

Thank you very much for your testimony.

Mr. MURPHY. We now recognize the chairman of the full committee. Welcome back. Mr. Walden, you are recognized for 5 minutes.

Mr. WALDEN. Thank you, Mr. Chairman, and thank you for conducting this oversight hearing.

I want to thank our witnesses today for your extraordinary testimony. It's very valuable in the work we're engaged in.

I want to focus on data and high risk, and especially to both the GAO and to the HHS OIG. Because my understanding is for 14 years running Medicaid has been on your high-risk list for a problem. What's behind that? Is that because CMS does not collect the right data to begin with?

Ms. YOCOM. I think there's a couple of things behind it. One is the nature of the partnership itself, that by the time the Federal Government is reviewing expenditures, the expenditures have occurred, so that prevention-the ability is——

Mr. WALDEN. That's always lacking?

Ms. YOCOM [continuing]. Always challenging.

The second piece really is about data. You simply cannot run a program this large when you can't tell where the money is going and where it has been. We need better data.

Mr. WALDEN. And so have you made recommendations to CMS to collect better data, and have they ignored those recommendations? Or what's the issue there?

Ms. YOCOM. We have a report coming out in just a few days that might answer that question a little more fully, but I think Ms. Maxwell can now.

Mr. WALDEN. Well, feel free to go ahead and share it today if——

Ms. MAXWELL. The IG has been focused on this area for quite some time. We have followed the evolution of the national data and continue to push CMS to create a deadline for when they think that data will be available, specifically for program integrity reasons.

Mr. WALDEN. So one of the issues that's come up in the press is this issue of woodworking. Everybody's trying to count numbers here. And I like what you said about let's get to quality outcomes, but off that for a minute. So there's this issue of woodworking, how many people are eligible before that are being counted now as if they're new eligibles.

And my question is, do we know that answer? And, second, are there states that are getting reimbursed at a higher rate, as if we were paying for newly eligibles at what would be, what, a 95 percent rate now, when in fact those individuals were actually always eligible and the state should be compensated at a lower rate?

Do we know any data surrounding that, how many people are actually, quote/unquote, woodworking? Have states been reimbursed at a higher rate when they should have been reimbursed at a lower rate?

Ms. MAXWELL. I can't speak to the working number specifically. I can tell you the IG has the same question that you have, and we have work underway to answer that exact question. So are states pulling down reimbursement for eligible beneficiaries as if they were in the newly eligible category——

Mr. WALDEN. Correct.

Ms. MAXWELL [continuing]. When, instead, they should have been enrolled in traditional Medicaid? That work will be forthcoming.

Mr. WALDEN. Do you have a timeline on when you think you may have answers for us on that?

Ms. MAXWELL. We have four states that we're looking at. The first two states probably in the next couple of months, and then the other two probably later in the year.

Mr. WALDEN. Can you reveal what those four states are?

Ms. MAXWELL. I can if you give me a minute.

Mr. WALDEN. OK.

Ms. YOCOM. And while she——

Mr. WALDEN. Ms. Yocom?

Ms. YOCOM [continuing]. Is looking, we did issue some work that looked at this question, and we did identify some issues where it appeared that people were not accurately categorized by whether they received the 100-percent match or a state expansion match or their regular FMAP. We did identify problems there.

And one of the recommendations that is still outstanding in this area has to do with the fact that CMS adjusted the eligibility differences but then did not circle back and correct the financing that occurred. So we think those two things need to be related. If you identify an eligibility issue—either way, if the matching rate is off, it should be corrected.

Mr. WALDEN. Yes.

Ms. YOCOM. CMS is starting to look at that, but——

Mr. WALDEN. It could be a big number. We don't know. But it's an important thing to get right.

I remember I spent about 4 ½, 5 years on a community hospital board at a time when the Federal Government decided to go after virtually every hospital and allege billing misbehavior, shall we say, going back, I don't know, 8, 9, 10 years. And the threat to the hospitals was, we will use the RICO statute because you have engaged in criminal practice because of multiple cases.

And it just strikes me that they were willing to do that there. Everybody had to settle, because nobody wanted to go down that path. We know the government sometimes gets it wrong, but, oh, we'd never go after the government with RICO.

What is happening here with these states I guess is a legitimate question when we've got people that are aged, blind, disabled waiting to get on? Are we—and a limited resource. And we don't have the data. That's what you're telling me, isn't it?

Ms. MAXWELL. Yes. And I have the states. So we will have data on the four States, and they are Kentucky, California, New York, and Colorado.

Mr. WALDEN. Kentucky, California, New York, Colorado. And your timeline, again, to probably conclude your analysis?

Ms. MAXWELL. The first couple will be probably be final in the next month or two, and then the final two will be later this year.

Mr. WALDEN. All right.

Ms. MAXWELL. We'll be sure to let you know.

Mr. WALDEN. And if we could do one thing with CMS to help you be able to do your job the way you want to do it, what would that be, Ms. Yocom?

Ms. MAXWELL. Oh, I hate to keep saying it, but it's got to be the data. We just absolutely need the data.

Mr. WALDEN. Ms. Yocom, same?

Ms. YOCOM. Yes, I would agree.

Mr. WALDEN. OK. If there are specific items related to data, please get those to us. I'll be happy to work with the incoming CMS Administrator, and we will do our best to get you the data. Because it's important to all of us for our decisionmaking. And we know we have people waiting on the list, can't get access to care. And we've got to get the waste and the fraud out. We've got to get them off this risk list.

Thank you very much for your testimony.

Mr. Chairman, thanks for your leadership on this.

Mr. MURPHY. The chairman yields back.

I have one more question I want to ask Mr. Howard. And this relates to trying to find some other ways of saving money and providing more effective care within Medicaid. And it has to do with more alternative payment models as a way to reduce costs. That being physicians, providers, hospitals are paid to take care of the patient, as opposed to a fee for service, which is every time someone shows up, you bill them. It's sort of like paying a carpenter based upon how many nails he puts in a house. He'll put a lot of nails in that house.

Whereas, an alternative payment model, whether it is making calls to the patient to check up on their medication, to remind them of their appointment, to counsel them, to keep them out of the emergency room, to get effective care, those sort of approaches.

So I'm thinking, in linking with the Medicaid amount, HHS estimated the improper payments from Medicaid amounted to 30 billion in 2015, with an error rate hovering around 10 percent. At the same time, studies like the Oregon Medicaid Experiment showed that Medicaid coverage does not necessarily result in better health outcomes, as we talked about before.

So what do you think about these alternative payment models as a way of saying that the skin in the game is also the physicians and hospitals, to make sure that they are doing all they can to keep the patients healthy?

Mr. HOWARD. Absolutely, I think that experimenting with these models is critical. You need the data to be able to understand who is the best provider. We talk a lot about waste, fraud, and abuse. That's certainly a big problem. But estimates from even people like Donald Berwick are that 20, potentially 30 percent of care is either ineffective or wasted.

And there are providers that we know are doing terrific jobs at a fraction of the cost; hospitals across the street from another hospital providing care more efficiently. If we had data transparency, we could encourage more competition among those across these payment models.

Mr. MURPHY. Can you get us information on how you would see those things worked out?

Mr. HOWARD. Absolutely.

Mr. MURPHY. The committee would appreciate that.

Ms. DeGette, do you have a followup comment?

Ms. DEGETTE. I just had a couple comments, Mr. Chairman.

The first thing is that here's something we can agree on in a bipartisan way, is getting you folks the data that you need. So I'll just echo what Mr. Walden said. Whatever specific suggestions you have, let us know. And, also, I'm assuming that you need that staffing, that if we freeze your hiring, that's going to be a problem.

I just want to make a couple of comments about the Medicaid expansion, which is, first of all, a lot of people—I keep hearing people today say that we really want to make sure that people who have chronic and severe diseases, like the videotape we saw, get services, and that's absolutely true. And then people on the other side keep talking about able-bodied adults.

And I would just point out that 80 percent of the people who are getting the Medicaid expansion are working. So, you know, they might be able-bodied adults, but they have jobs, and they were uninsured before because either their employers didn't offer insurance or because the insurance that they could get was too expensive. And so these people were going without health care, which, as Mr. Westmoreland and others said, that just increases the costs for everybody because of the costs of uncompensated care.

And if there's ways—I was just talking to Mrs. Brooks about this. If there's ways that we can find efficiencies in the program—all of us are for more efficiencies, and we're for delivering health care in a more cost-effective way, not just within Medicaid but

within private insurance too. And this is something, again, I think that we could work in a bipartisan way to make this happen. But just to say, well, we shouldn't give the Medicaid expansion because these people are, quote, "able-bodied" adults is not understanding who's getting it.

I just want to close with an email that I got from my best friend from South High School in Denver, Colorado. We are not spring chickens anymore. And here's what my friend Lori Dunkley—she sent this to me a couple weeks ago, without solicitation. She just sent it to me.

"I just want to add my story to others you are hearing about the Affordable Care Act. I was laid off during the recession and lost a lot of my retirement stability. Then, at age 54, I looked for a job for 3 years without success. I had no health insurance. Finally, I fell back on my journalism skills and landed work writing for several neighborhood papers. This has worked out fine, but only because of getting insurance through the ACA. I make very modest money, and so I qualify for the expanded Medicaid program. What a godsend. Since I am not yet Medicare age but too old for the job market, I don't know what I'd do without this help."

This is the people that we're talking about. So we have to figure out how we're going to give health care to the 11 to 12 million people who have gotten health care because of this Medicaid expansion. That's what we're talking about.

Thank you, Mr. Chairman.

Mr. MURPHY. The gentlewoman yields back.

And this will bring to a conclusion this hearing of the Subcommittee on Oversight and Investigations. I'd like to thank the witnesses and all members that participated in today's hearing.

I remind members they have 10 business days to submit questions for the record, and I ask the witnesses all agree to respond promptly to the questions.

Thank you so much for being here.

And, with that, this subcommittee is adjourned.

[Whereupon, at 12:25 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. GREG WALDEN

Thank you, Mr. Chairman. And welcome to the first E&C hearing of the 115th Congress. Today, we are taking a closer look at the Medicaid program to ensure the program is operating effectively, that Americans who are eligible for the program have access to, and actually receive, the quality care that they deserve, and that tax dollars are spent appropriately.

In Fiscal Year 2015, total spending of the Medicaid program was $509 billion, 62 percent of that was paid for by the federal government. According to the Congressional Budget Office, the federal share of Medicaid spending is expected to rise significantly over the next decade.

While Medicaid provides coverage to millions of low-income and disabled Americans, the program is not immune to challenges—including increasing costs, fraud, and errors with eligibility determination that result in millions of wasted taxpayer dollars. Meanwhile, some of America's most frail and needy citizens remain on waiting lists. We need to ensure that eligible beneficiaries of the program have access to high quality care, while being good stewards of hardearned taxpayer dollars.

This hearing is an important part of the continued oversight that our committee, the Inspector General and the Government Accountability Office have conducted over this vast program.

All of us here today agree that Medicaid is an essential program for the population that it serves. With Medicaid expansion, and the rapid growth of the program, we can't shy away from asking the tough questions. Program integrity and oversight are vital to ensure we don't get stuck in an 'auto-pilot' spending pattern that doesn't serve the beneficiaries of the program by improving their overall health outcomes.

We look forward to a productive dialogue with our witnesses today, to discuss the troubling findings in the reports and audits conducted by the GAO and HHS OIG. We also hope to examine the effects that Medicaid expansion has had on states' budgets and beneficiaries.

Tomorrow, our Health Subcommittee will hold a hearing focused on solutions to fix some of the problems plaguing the Medicaid program. And on Thursday, our Health Subcommittee will examine insurance reforms. It's an important first week back in the hearing room as we explore ways to rebuild our health care system.

I would like to thank the witnesses for testifying today and look forward to hearing from this distinguished panel.

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

January 27, 2017

TO: Members, Subcommittee on Oversight and Investigations

FROM: Committee Majority Staff

RE: Hearing entitled "Medicaid Oversight: Existing Problems and Ways to Strengthen the Program."

On January 31, 2017, at 10:00 a.m. in 2123 Rayburn House Office Building, the Subcommittee on Oversight and Investigations will hold a hearing entitled "Medicaid Oversight: Existing Problems and Ways to Strengthen the Program." Medicaid is one of the nation's largest health programs and represents a substantial financial obligation for the federal government and the states. Given the sizeable current and projected federal dollars expended through the Medicaid program, the Subcommittee is conducting oversight to ensure that the program operates effectively, tax dollars are spent appropriately, and that patients receive the quality care that they deserve. This hearing will examine the findings of reports issued by the Government Accountability Office (GAO) and the Department of Health and Human Services Office of the Inspector General (HHS OIG) that present evidence of waste, fraud, and abuse in the Medicaid program.

I. WITNESSES

- Carolyn L. Yocom, Director, Health Care, U.S. Government Accountability Office;
- Ann Maxwell, Assistant Inspector General, Office of Evaluation and Inspections, Office of Inspector General, U.S. Department of Health and Human Services;
- Paul Howard, Senior Fellow, Director, Health Policy, The Manhattan Institute;
- Josh Archambault, Senior Fellow, The Foundation for Government Accountability; and
- Timothy M. Westmoreland, Professor from Practice, Senior Scholar in Health Law, Georgetown University Law Center

II. BACKGROUND

Medicaid is a joint federal-state entitlement program that finances the delivery of medical services for a diverse, low-income population. State participation in Medicaid is voluntary, but

all states, the District of Columbia, and the territories choose to participate. States must follow broad federal rules in order to receive matching federal funds, but have programmatic flexibility within the federal statute's framework. A total of 72.8 million Americans received health coverage through state Medicaid programs or the related Children's Health Insurance Program (CHIP) as of June 2016.[1]

Prior to passage of the Patient Protection and Affordable Care Act (PPACA), Medicaid eligibility was generally limited to low-income children, pregnant women, parents of dependent children, the elderly, and individuals with disabilities.[2] The PPACA substantially expanded Medicaid eligibility to include individuals under the age of 65 with incomes up to 133 percent of the federal poverty level.[3] In 2012, the Supreme Court ruled that the enforcement mechanism requiring states to expand Medicaid was unconstitutional, which essentially made Medicaid expansion optional for the states.[4] Currently, 32 states have elected to expand Medicaid under the new parameters set out in the PPACA.[5]

Of the roughly 20 million individuals who enrolled in insurance through the health care insurance exchanges created under the PPACA, about 14.5 million enrolled in Medicaid and CHIP coverage.[6] Of those 14.5 million, about 10.7 million were newly eligible for Medicaid under the PPACA expansion parameters, and 3.4 million were previously eligible for Medicaid but had not enrolled in the program.[7]

Since the passage of the PPACA, all states have seen an increase in Medicaid enrollment. From September 2013, when open enrollment under PPACA began, to September 2016, enrollment in Medicaid or CHIP increased by 15.7 million among 49 states reporting, amounting to a 27.9 percent increase.[8] The 32 states that have expanded Medicaid saw the largest growth in enrollment, of 35.7 percent, or 13.3 million between September 2013 and September 2016.[9] In 22 states, enrollment increased by at least 25 percent.[10] Although most of the growth was a result of newly eligible adults enrolling in states that expanded the program, Medicaid has grown, regardless of expansion, in all but two states.

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[1] Centers for Medicare and Medicaid Services, *Medicaid & CHIP Monthly Application, Eligibility Determinations, and Enrollment Reports,* June 2016, *available at:* https://www.medicaid.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-enrollment-data/medicaid-and-chip-application-eligibility-determiniation-and-enrollment-data.html.
[2] Alison Mitchell, et al., Congressional Research Service, *Medicaid: An Overview, R43357* (August 2015).
[3] *Id.*
[4] National Federation of Independent Business (NFIB) v. Sebelius, 132 S. Ct. 2566 (2012).
[5] *Status of State Action on the Medicaid Expansion Decision*, Kaiser Family Foundation, http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0 (last updated Jan. 1, 2017).
[6] U.S. Dept. of Health & Human Serv., *Health Insurance Coverage and the Affordable Care Act*, Mar. 3, 2016.
[7] Medicaid Expansion Enrollment, Kaiser Family Foundation, http://kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0 (last visited Jan. 25, 2017).
[8] *Medicaid Enrollment Changes Following the ACA*, Medicaid and CHIP Payment and Access Commission, https://www.macpac.gov/subtopic/medicaid-enrollment-changes-following-the-aca/ (last visited Jan. 25, 2017).
[9] *Id.*
[10] *Id.*

Medicaid is a significant expenditure for the federal government and the states, with total spending of $509 billion in Fiscal Year (FY) 2015, of which 62 percent was paid by the federal government and 38 percent was paid by the states.[11] According to the Congressional Budget Office (CBO), the federal share of Medicaid outlays is expected to rise significantly over the coming decade, from $371 billion in 2016 to $624 billion in 2026.[12]

The size of the Medicaid program lends itself to challenges and vulnerabilities related to program integrity resulting in waste, fraud, and abuse of the program. Prior to passage of the PPACA, the program suffered high improper payment rates and reporting errors, eligibility errors, and provider fraud. Medicaid expansion has created new challenges such as improper eligibility determinations, inaccurate federal matching rates, and insufficient data collection.

In an effort to combat these problems, multiple agencies at the federal and state levels are involved in program integrity and oversight of the Medicaid Program. Federal agencies involved in ensuring program integrity include the Centers for Medicare and Medicaid Services (CMS), HHS OIG, and GAO. Program integrity initiatives are designed to combat waste, fraud, and abuse, while oversight efforts focus on preventing fraud and abuse through effective program management and addressing problems after they occur through investigations, recoveries, and enforcement activities.[13]

GAO Reports

The GAO added Medicaid to their list of high-risk programs in 2003 due to the program's size, growth, diversity of programs, and concerns about the adequacy of fiscal oversight.[14] As a result, the GAO has released a large body of work surrounding Medicaid, including but not limited to eligibility determination, enrollment controls, duplication in coverage, and ensuring that state spending is appropriately matched with federal funds. Their program integrity work estimates that more than $29 billion in FY 2015 was wasted on improper payments alone.[15] The GAO remains concerned that CMS has not provided sufficient guidance, or sufficiently coordinated with other federal agencies, to help ensure that only eligible providers participate in the program. The agency also notes that there continue to be gaps in CMS's efforts to ensure that only eligible individuals are enrolled into Medicaid, and that Medicaid expenditures for enrollees are matched appropriately by the federal government.[16]

After the passage of the PPACA, the GAO conducted numerous audits to assess additional risks to the integrity of the Medicaid program due to the new federal matching rate for newly eligible individuals under Medicaid expansion and the new eligibility determination

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[11] *Medicaid Enrollment & Spending Growth: FY 2016 & 2017,* The Henry K. Kaiser Family Foundation, Commission of Medicaid and the Uninsured, October 2016, *available at:* http://files.kff.org/attachment/Issue-Brief-Medicaid-Enrollment-&-Spending-Growth-FY-2016-&-2017

[12] Congressional Budget Office, *Details of Spending and Enrollment for Medicaid—CBO's March 2016 Baseline* (March 2016), *available at:* https://www.cbo.gov/sites/default/files/recurringdata/51301-2016-03-medicaid.pdf b

[13] Alison Mitchell, et al., Congressional Research Service, *Medicaid: An Overview, R43357* (August 2015).

[14] U.S. Gov't Accountability Office, *High Risk List – Medicaid,* http://www.gao.gov/highrisk/medicaid_program/why_did_study (2015).

[15] *Id.*

[16] *Id.*

process (health care insurance exchanges). In October 2015, the GAO examined state and CMS efforts to properly allocate federal matching funds for the newly eligible Medicaid populations in expansion states. CMS assesses the accuracy of eligibility determinations and examines states' expenditures to ensure they are attributed to the accurate eligibility group, but a GAO report found gaps in these review systems, which could result in inappropriate spending.[17] For example, in the federal facilitated exchange states, CMS will not be able to assess the accuracy of eligibility determinations until 2018, creating the potential for improper payments. Further, CMS does not consider information obtained from its eligibility determination errors when reviewing state expenditures, which prevents CMS from identifying erroneous expenditures due to incorrect eligibility determinations.

To determine the accuracy of eligibility determinations, the GAO has conducted undercover testing by applying for Medicaid and private coverage in federal and state marketplaces with fictitious identities. Federal and state marketplaces are required to verify application information to determine eligibility for Medicaid benefits, such as a social security number, citizenship status, and household income. To conduct its audit, the GAO made eight fictitious applications for Medicaid coverage, and those fictitious applicants were approved for coverage in all but one case.[18] In three of the cases, the applicants were approved for Medicaid coverage, even though they provided invalid social security numbers. In the other four cases, the fake applicants received subsidized private coverage in lieu of Medicaid, although the applicants either did not provide a social security number, or provided an invalid immigration document number.

HHS OIG Reports

The HHS OIG has also conducted a substantial body of work related to Medicaid. Their work has covered topics from provider fraud, beneficiary fraud, and overpayments to states. In particular, the OIG has conducted numerous audits to evaluate measures passed as part of the PPACA that were intended to increase program integrity in the Medicaid program.

Section 6402(a) of the PPACA amended the Social Security Act to require that providers report and return overpayments within 60 days of identifying the overpayment or the date any corresponding cost report is due. In August 2015, the OIG found that providers did not always reconcile patient records with credit balances and report and return the Medicaid overpayments to state agencies.[19] Credit balances occur when a provider receives a duplicate payment for the same services from multiple sources–the Medicaid program or a third-party. The audit found that providers did not identify overpayments because states generally did not require that providers exercise reasonable diligence to find overpayments. The report notes that some providers did not

[17] Gov't Accountability Office, GAO-16-53, Additional Efforts Needed to Ensure That State Spending Is Appropriately Matched With Federal Funds (2015).
[18] Gov't Accountable Office, GAO-16-784, Results of Undercover Enrollment Testing for the Federal Marketplace and a Selected State Marketplace for the 2016 Coverage Year (2015); Gov't Accountable Office, GAO-16-792, Final Results of Undercover Testing of the Federal Marketplace and Selected State Marketplaces for Coverage Year 2015 (2016).
[19] Inspector Gen., Dep't. of Health & Human Serv., Providers Did Not Always Reconcile Patient Records with Credit Balances and Report and Return the Associated Medicaid Overpayments to State Agencies (2015).

reconcile patient records for more than six years. The OIG estimated that the states could recover federal Medicaid overpayments of nearly $17 million.[20]

The PPACA also requires the states terminate any providers already terminated for cause in another state. Despite this requirement, the OIG found that twelve percent (295 of 2,539) of providers terminated for cause in 2011 continued participating in other states' Medicaid programs as of January 2014.[21] This amounted to $7.4 million paid to 94 providers for services performed after each provider was terminated for cause by another state. The OIG recommended that CMS require each state Medicaid agency report all terminated providers. While CMS concurred with this recommendation, CMS has not yet required states to report terminations for cause.

In May 2016, the OIG released a report which evaluated the states' compliance with a PPACA requirement that all states screen Medicaid providers using enhanced screening procedures such as fingerprint-based criminal background checks and site visits.[22] The OIG found that most states reported not having fingerprint-based criminal background checks, and some states reported that they have not implemented site visits. Failing to implement these required program integrity measures allows unscrupulous providers to continue to defraud the Medicaid program.

III. ISSUES

The following issues may be examined at the hearing:

- The federal controls that aim to minimize waste, fraud, and abuse within the Medicaid Program;
- Federal agencies' compliance with new program integrity requirements in the PPACA; and
- The effect that Medicaid expansion has had on beneficiaries and the value of the coverage that they receive.

IV. STAFF CONTACTS

If you have any questions regarding this hearing, please contact Emily Felder or Brittany Havens of the Committee staff at (202) 225-2927.

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[20] *Id.*
[21] Inspector Gen., Dep't. of Health & Human Serv., Providers Terminated from One State Medicaid Program Continued Participating in Other States (2015)
[22] Inspector Gen., Dep't. of Health & Human Serv., Medicaid Enhanced Provider Enrollment Has Not Been Fully Implemented (2016).

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