MEDICARE AND MEDICAID PROGRAM INTEGRITY: COMBATING IMPROPER PAYMENTS AND INELIGIBLE PROVIDERS

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

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MEDICARE AND MEDICAID PROGRAM INTEGRITY: COMBATING IMPROPER PAYMENTS AND INELIGIBLE PROVIDERS

TUESDAY, MAY 24, 2016

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

The subcommittee met, pursuant to call, at 10:15 a.m., in room 2322 Rayburn House Office Building, Hon. Tim Murphy (chairman of the subcommittee) presiding.

Members present: Representatives Murphy, McKinley, Griffith, Bucshon, Flores, Brooks, Mullin, Collins, Cramer, DeGette, Castor, Tonko, Kennedy, Green, Welch, and Pallone (ex officio).

Staff present: Rebecca Card, Assistant Press Secretary; Ryan Coble, Detailee; Emily Felder, Counsel, Oversight and Investigations; Charles Ingebretson, Chief Counsel, Oversight and Investigations; Chris Santini, Policy Coordinator, Oversight and Investigations; Alan Slobodin, Deputy Chief Counsel, Oversight; Gregory Watson, Legislative Clerk, Communications and Technology; Jeff Carroll, Minority Staff Director; Ryan Gottschall, Minority GAO Detailee; Chris Knauer, Minority Oversight Staff Director; Una Lee, Minority Chief Oversight Counsel; Elizabeth Letter, Minority Professional Staff Member; and Andrew Souvall, Minority Director of Communications, Outreach and Member Services.

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

Mr. MURPHY. Good morning. The Oversight and Investigations Subcommittee will come to order on Medicare and Medicaid Program Integrity: Combating Improper Payments and Ineligible Providers. Welcome. And I will recognize myself for an opening statement.

The subcommittee convenes this hearing today to examine ongoing waste, fraud, and abuse in two of the federal government's biggest programs: Medicare and Medicaid. Just last year, HHS estimated approximately $89 billion in improper payments through Medicare and Medicaid. This means the federal government cannot verify the accuracy of one out of every ten payments.

The improper payments occur when federal funds go to the wrong recipient or the recipient receives the incorrect amount of funds—either an underpayment or overpayment—documentation is

not available to support a payment, or the recipient uses federal funds in an improper manner.

To be clear, not all the improper payments constitute fraud, but when the federal government cannot accurately verify that nearly ten percent of program dollars were spent according to law it is a major problem. Improper payments muddy the waters and make it harder for auditors and investigators to root out fraud and abuse. If the system is murky and confusing, that only benefits the fraudsters who take advantage of our system knowing that the chances are pretty good they can get away with it.

Although high error rates have been a persistent problem spanning many years, these rates are nevertheless concerning because Medicare and Medicaid spending is growing at a rapid pace. In 2014, Medicare spending grew 5.5 percent to $618.7 billion and Medicaid grew 11 percent to 495.8 billion. Given the growth in these programs, it is not surprising they have been targets for fraud and abuse. CMS must strengthen program integrity now or billions more may be wasted in future years.

Two nonpartisan watchdogs have released reports critical of CMS response to major program integrity challenges confronting these programs. Today we will highlight the important work by the Government Accountability Office and the Health and Human Services Inspector General that tackles two distinct challenges: the improper payments and ineligible providers.

First, I want to highlight three reports released by the HHS Inspector General in conjunction with today's hearing. These reports examine vulnerabilities within provider screening, which is a huge contributor to fraud. Two of the reports examine the issue of accuracy of databases used to enroll providers into the Medicaid and Medicare programs. Specifically, these reports look at the accuracy of provider ownership information because inaccurate provider ownership information can be a strong indicator of fraud.

In the Medicaid program, OIG found that 14 state Medicaid programs did not verify the completeness or accuracy of provider ownership or check all required exclusion databases. Moreover, nearly all providers had names on record with state Medicaid programs that did not match those on record with CMS.

For the Medicare provider database, the OIG compared three sets of owner names: 1) the names listed on Medicare enrollment records; 2) names submitted by providers directly to the OIG for their evaluation; and 3) names listed on state Medicaid enrollment records. The OIG found that nearly all providers in the OIG's review had different names on record than the state Medicaid programs.

The third report released today deals with enhanced provider enrollment screenings in the Medicaid program. While states are required to screen Medicaid providers using enhanced screening procedures, such as fingerprint-based criminal background checks and onsite visits, many states have not yet implemented these requirements.

I would like to thank the HHS and OIG for its work on these pivotal reports and for the opportunity to highlight them at today's hearing. Today we will also examine the larger body of work con-

ducted by HHS OIG and the GAO over years of audits and investigations.

And while the GAO and OIG have done a great job of highlighting Medicare and Medicaid vulnerabilities to fraud, CMS has not yet implemented some recommendations that could solve these problems. For example, back in January of 2013, the OIG found that Medicare erroneously paid over $33 million to physicians rendering services to incarcerated beneficiaries. OIG recommended that CMS modify and update its guidance so that claims were processed consistently to prevent such improper payments. However, CMS has not yet implemented this recommendation.

The subcommittee convened a hearing in June of last year to examine a troubling GAO report that highlighted Medicaid improper payments. After auditing four states with just over nine million Medicaid beneficiaries, GAO found that 200 deceased beneficiaries received at least 9.6 million in Medicaid benefits. The individuals were already deceased before apparently receiving any medical services covered by Medicaid. And 1 year later, GAO's recommendation to fix this problem is still "open" indicating CMS has not taken the necessary action.

The same report found that at least 47 Medicaid providers in four states had foreign addresses as their location of services including Canada, China, India, and Saudi Arabia. Nearly 26,600 providers had addresses that did not match any United States Postal Service records. However, CMS has not implemented GAO's recommendation to fix this problem.

It concerns me that the subcommittee held two hearings last year on wasteful spending in Medicare and Medicaid, and CMS has not yet acted on some of the recommendations suggested at those hearings. However, I understand that just last week, CMS implemented two GAO recommendations to be discussed at today's hearing. This is important progress and CMS must continue to move forward on outstanding recommendations.

[The statement of Mr. Murphy follows:]

PREPARED STATEMENT OF HON. TIM MURPHY

The subcommittee convenes this hearing today to examine ongoing waste, fraud, and abuse in two of the federal government's biggest programs: Medicare and Medicaid.

Just last year, HHS estimated approximately $89 billion dollars in improper payments through Medicare and Medicaid. This means that the Federal Government cannot verify the accuracy of one out of every ten payments.

Improper payments occur when federal funds go to the wrong recipient, the recipient receives the incorrect amount of funds—either an underpayment or overpayment, documentation is not available to support a payment, or the recipient uses federal funds in an improper manner.

To be clear: not all of the improper payments constitute fraud. But when the Federal Government cannot accurately verify that nearly 10 percent of program dollars were spent according to the law, it is a major problem. Improper payments muddy the waters, and make it harder for auditors and investigators to root out fraud and abuse. If the system is murky and confusing, that only benefits the fraudsters taking advantage of our system.

Although high error rates have been a persistent problem, spanning many years, these rates are nevertheless concerning because Medicare and Medicaid spending is growing at a rapid pace. In 2014, Medicare spending grew 5.5 percent to $618.7 billion, and Medicaid spending grew 11 percent to $495.8 billion. Given the growth in these programs, it is not surprising they have been targets for fraud and abuse.

CMS must strengthen program integrity now, or billions more may be wasted in future years.

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First, I want to highlight three reports released by the HHS Inspector General in conjunction with today's hearing. These reports examine vulnerabilities within provider screening, which is a huge contributor to fraud. Two of the reports examine the issue of accuracy of databases used to enroll providers into the Medicaid and Medicare programs. Specifically, these reports look at the accuracy of provider ownership information, because inaccurate provider ownership information can be a strong indicator of fraud.

In the Medicaid program, the OIG found that fourteen state Medicaid programs did not verify the completeness or accuracy of provider ownership, or check all required exclusions databases. Moreover, nearly all providers had names on record with state Medicaid programs that did not match those on record with CMS.

For the Medicare provider database, the OIG compared three sets of owner names: (1) the names listed on Medicare enrollment records, (2) names submitted by providers directly to the OIG for their evaluation, and (3) names listed on state Medicaid enrollment records. The OIG found that nearly all providers in the OIG's review had different names on record than the state Medicaid programs.

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I would like to thank the HHS OIG for its work on these pivotal reports, and for the opportunity to highlight them at today's hearing.

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And while the GAO and OIG have done a great job of highlighting Medicare and Medicaid vulnerabilities to fraud, CMS has not yet implemented some recommendations that could solve those problems.

For example, back in January 2013, the OIG found that Medicare erroneously paid over $33 million to physicians rendering services to incarcerated beneficiaries. OIG recommended that CMS modify and update its guidance so that claims were processed consistently, to prevent such improper payments. However, CMS has not implemented this recommendation.

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The same GAO report found that at least 47 Medicaid providers in four states had foreign addresses as their location of service, including Canada, China, India and Saudi Arabia. Nearly 26,600 providers had addresses that did not match any United States Postal Service records. However, CMS has not implemented GAO's recommendation to fix this problem.

It concerns me that the Subcommittee held two hearings last year on wasteful spending in Medicare and Medicaid, and CMS has not yet acted on some of the recommendations suggested at those hearings. However, I understand that just last week, CMS implemented two GAO recommendations to be discussed at today's hearing. This is important progress, and CMS must continue to move forward on outstanding recommendations.

Mr. MURPHY. I want to thank all the witnesses for being here today and testifying, and I now recognize ranking member from Colorado, Ms. DeGette, for 5 minutes.

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

Ms. DEGETTE. Thank you so much, Mr. Chairman. This hearing is really an important opportunity to discuss ways to strengthen two critically important government programs that serve over a hundred million Americans: Medicare and Medicaid. We are going to hear today about recent reports from the OIG and GAO about provider enrollment and screening in those two important programs. The reports remind us that we must be ever vigilant in our efforts to fight fraud and abuse.

Many of us here on the dais and of course those at the witness table have been working to fight waste, fraud and abuse and Medicare and Medicaid for many, many decades. The idea that error rates or improper payments are associated with these programs is not new. For example, a 2003 committee report found that Medicaid fraud could exceed $17 billion each year. The report went on to say, "this year, the committee will examine ways in which states could adopt more rigorous enrollment controls to keep unscrupulous providers out of their programs and to improve their program integrity standards."

I just wish we could wave our magic wands and eliminate waste, fraud, and abuse in these programs. In my almost 20 years on this committee we have assiduously worked to do that thing. But unfortunately it has been very difficult to permanently root out waste, fraud, and abuse in Medicare and Medicaid because keeping fraudulent and unscrupulous providers out of the program is just a longstanding and pervasive challenge. We are going to hear today that recent GAO and OIG reports find there is still progress to make.

I am encouraged though by recent successes of the program integrity measures which were implemented by the Affordable Care Act. The ACA provided the Department of HHS and its Office of Inspector General with a wide range of new tools and authorities for fighting fraud. We are already seeing improvements through the use of these new tools, and I believe they will continue to make a big difference going forward.

I am certainly very eager to hear from CMS about the progress. Those new tools allow program administrators to better protect tax dollars and to prevent bad providers from entering the program. For example, the ACA provided nearly $350 million in new funds for fraud control efforts. It also provided new means for collecting and sharing data between states and the federal government to screen potential providers and suppliers.

The ACA provided the HHS OIG with new authorities to impose stronger penalties on those who commit fraud and provided CMS with the ability to temporarily halt payments to suppliers suspected of fraud. CMS is also now incorporating predictive analytics to screen payments to look for patterns for fraud that were previously much harder to detect.

This new effort called the Fraud Prevention System uses computer modeling tools similar to those used by credit card companies to look for fraud patterns and to help the government recover fraudulent or improper payments. According to CMS, in just 3

years this system has allowed the agency to prevent nearly $820 million in fraudulent payments.

Mr. Chairman, I think this is good news and we should applaud the progress. New tools and authorities should allow CMS and the OIG to move away from the pay and close model and spend more time stopping bad actors from entering the program in the first place. These important new tools should greatly enhance program integrity in the Medicare and Medicaid programs, and they will help us to achieve some of the anti-fraud goals that have long been out of reach.

While these are positive developments, we will hear from the HHS OIG and from the GAO on some areas we can still improve. A recent OIG report, for example, found not all states are utilizing the tools as comprehensively as possible. I want to understand more about that report today and to hear from CMS about why this is the case and how we can work together to make sure all of the tools available are being implemented as broadly as possible.

Let me conclude, Mr. Chairman, by thanking all of the witnesses before us for the work they do to strengthen these important programs. I look forward to hearing from the auditors about what more we can do to reduce fraud and prevent fraud while maintaining the program's flexibility in delivering critical health care services.

We have consistently worked in this subcommittee on a bipartisan basis to strengthen fraud-fighting efforts in Medicare and Medicaid, and I know that this will just be another one of those important hearings in our ongoing oversight. Thank you, Mr. Chairman, and I yield back.

[The statement of Ms. DeGette follows:]

PREPARED STATEMENT OF HON. DIANE DEGETTE

Thank you, Mr. Chairman. Today's hearing is an important opportunity to discuss ways to strengthen two critically important government programs that serve over 100 million Americans: Medicare and Medicaid.

We will hear today about recent reports from the OIG and GAO on provider enrollment and screening in Medicare and Medicaid. These reports remind us that we must be vigilant in our efforts to fight fraud and abuse in these programs.

Many of us on the dais and at the witness table have been working to fight waste, fraud, and abuse in Medicare and Medicaid for decades. The idea that error rates or improper payments are associated with these programs is not new.

For example, a 2003 Committee report found that Medicaid fraud could exceed $17 billion each year. The report went on to say, "This year, the Committee will examine ways in which States could adopt more rigorous enrollment controls to keep unscrupulous providers out of their programs and improve their program integrity standards." We all know that it has been very difficult to root out fraud, waste, and abuse in Medicare and Medicaid. Keeping fraudulent and unscrupulous providers out of the program has been a longstanding challenge. And we will hear again today that recent GAO and OIG reports find there is still progress to be made. But I am very encouraged by the recent success of the program integrity measures implemented by the Affordable Care Act.

The ACA provided the Department of Health and Human Services and its Office of Inspector General with a wide range of new tools and authorities for fighting fraud. We are already seeing improvements through the use of these new tools, and I believe they will continue to make a big difference going forward. I am eager to hear more from CMS about their progress.

These new tools allow program administrators to better protect tax dollars and prevent bad providers from entering the program. For example, the ACA provided nearly $350 million in new funds for fraud control efforts. It also provided new means for collecting and sharing data between states and the federal government

to screen potential providers and suppliers. The ACA provided the HHS OIG with new authorities to impose stronger penalties on those who commit fraud and provided CMS with the ability to temporarily halt payments to suppliers suspected of fraud.

CMS is also now incorporating predictive analytics to screen payments to look for patterns of fraud that were previously much harder to detect. This new effort, called the Fraud Prevention System, uses computer-modeling tools similar to those used by credit card companies to look for fraud patterns and help the government prevent and recover fraudulent or improper payments. According to CMS, in just 3 years, this system has allowed the agency to identify or prevent nearly $820 million in fraudulent payments.

This is good news, Mr. Chairman, and we should applaud this progress. These tools and authorities should allow CMS and the OIG to move away from the "pay and chase" model and spend more time stopping bad actors from entering the program in the first place. These important new tools should greatly enhance program integrity in the Medicaid and Medicare programs, and they will help us achieve some of the anti-fraud goals that have long been out of reach.

While these are positive developments, we will hear from the HHS OIG and from GAO on some areas where we can improve. A recent OIG report, for example, found that not all of the States are utilizing these tools as comprehensively as possible. I want to understand more about that report today, and hear from CMS about why this is the case and how we can work together to ensure all tools available are being implemented as broadly as possible.

Mr. Chairman, let me conclude by thanking all of the witnesses before us today for the work they do to help strengthen the Medicaid and Medicare programs and for working so closely with this Committee.

I look forward to hearing from the auditors about what additional measures they believe we can or should take to reduce fraud while maintaining the programs' flexibility in delivering critical health care services.

This Committee has consistently worked on a bipartisan basis to strengthen the fraud fighting efforts in both the Medicare and Medicaid programs. I hope today's hearing will be a continuation of that effort. These critical programs serve millions of hard working Americans, and it is our duty to make them run as efficiently and effectively as possible.

With that, Mr. Chairman, I yield back.

Mr. MURPHY. Thank you. I don't think we have anybody else on our side that wants to make a statement, am I correct? Do you have anybody else on your side? Otherwise we can move forward.

Ms. DEGETTE. I think we are good.

Mr. MURPHY. All right, thank you. In that case, I ask unanimous consent that the members' written opening statements be introduced into the record and, without objection, the documents will be entered into the record.

I would now like to introduce the witnesses of our first panel for today's hearing. The first witness on today's panel is Ms. Ann Maxwell. Ms. Maxwell is the assistant inspector general in the Office of Evaluation and Inspections within HHS. Ms. Maxwell manages a national office of 145 evaluators completing utilization and focused evaluations intended to provide Congress and HHS with relevant, timely, and useful information.

We thank you, Ms. Maxwell, for being here and preparing your testimony. We look forward to hearing your insights.

We would also like to welcome Mr. Seto Bagdoyan. Mr. Bagdoyan is currently the director for Audit Services in GAO's Forensic Audits and Investigative Service, which is the FAIS, mission. In the FAIS he has led a broad body of work related to fraud, waste, and abuse, and the integrity of internal controls in various program areas including health care.

Thank you also for being here today, and we look forward to your comments.

Our third and final witness on today's panel is Dr. Shantanu Agrawal. Dr. Agrawal is currently serving as deputy administrator for Program Integrity and director of the Center for Program Integrity. His focus is to improve health care value by lowering the cost of care through the detection and prevention of waste, abuse and fraud in the Medicare and Medicaid programs.

Thank you, Dr. Agrawal, for being here.

So to our panel here, you are aware that the committee is holding an investigative hearing and when doing so has the practice of taking testimony under oath. Do any of you have any objections to testifying under oath?

Seeing no objections, the chair then advises you that under the rules of the House and the rules of the committee you are entitled to be advised by counsel. Do any of you desire to be advised by counsel during this hearing today?

And all indicated they do not desire to be advised by counsel, so in that case would you all please rise, raise your right hand, and I will swear you in.

[Witnesses sworn.]

Mr. MURPHY. Thank you. You are all now under oath and subject to penalties set forth in Title 18 Section 1001 of the United States Code. I am going to ask you all to give a five-minute summary of your written statement. One of the most important things is to turn the microphone on; put it as close to you as possible so we can hear.

And Ms. Maxwell, we will let you begin and give a 5-minute summary. Thank you.

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

STATEMENT OF ANN MAXWELL

Ms. MAXWELL. Good morning, Chair Murphy, Ranking Member DeGette, and other distinguished members of the subcommittee. Thank you for the invitation to share with the subcommittee opportunities to better protect Medicaid and Medicare from unscrupulous providers and improper payments.

As you mentioned in your opening statement, Chair Murphy, Medicaid and Medicare reported a combined $89 billion in improper payments. In addition, OIG found that HHS missed important performance targets. For example, Medicare fee-for-service reported an improper payment rate of 12 percent, exceeding the 10 percent goal established by law. Medicare also reported an error rate higher than its established target.

These findings indicate that HHS must redouble its efforts to pay the right provider the right amount for the right service, and pro-

vider enrollment is where it starts. Enrollment is the green light to start billing. To get that, green light providers need to clear the provider enrollment process, so the provider enrollment process is Medicaid and Medicare's chance to make sure they are not doing business with those whose business it is to commit fraud.

No one wants Medicare doing business with abusive and fraudulent providers like Dr. Fata, the oncologist who administered aggressive cancer treatments to patients who did not need them simply to increase his billing; or Medicaid paying Small Smiles, a dental chain performing unneeded root canals on children.

To help prevent these sort of egregious cases of beneficiary harm and improper payments Congress, through the Affordable Care Act, authorized a more rigorous, risk based approach to screening providers. As a result, provider types deemed by CMS to be a higher risk are now required to undergo site visits and sometimes criminal background checks. Today, I want to talk about how these ACA tools were implemented in Medicaid and in Medicare, and also the problems we've found with the databases that support these important tools.

For Medicaid, we found that state implementation of enhanced provider screening is incomplete for higher risk providers leaving Medicaid vulnerable. We found that most states have not yet started conducting criminal background checks while waiting for additional guidance from CMS. Further, 11 states are not conducting site visits. OIG recommends that CMS assist states by offering guidance, technical assistance, and improving the ability of states to rely on Medicare screening results so they don't need to duplicate that work.

For Medicare, we found that CMS' implementation of enhanced enrollment screening needs strengthening. In particular, we found that contractors were inconsistent in applying site visit procedures and not always using site visit results in enrollment decisions. The OIG recommends improving the process by improving the site visit forms, additional training, and ensuring the consistent use of site visit results in enrollment decisions.

OIG's reviews also found questionable data in Medicare's provider enrollment database. We frequently found different information when comparing owner names in Medicare and Medicaid databases. In one case, for the same provider Medicare had 14 owners listed while Medicaid had 63. It is hard to know who you're doing business with if you can't even get their names straight.

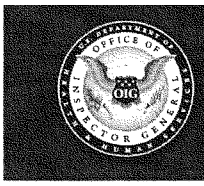
CMS and states are also lacking complete data on providers terminated for reasons of fraud, integrity or quality because not all states are reporting that information. As a result, states may enroll a provider that's already been terminated in another state. In fact, we found 12 percent of providers terminated in one state continued to participate in Medicaid and other state Medicaid programs. OIG recommends that states' reporting of terminated providers to a centralized CMS database be made mandatory.

CMS agreed that our recommendations would strengthen provider enrollment and as such we believe they should be undertaken immediately. In the longer term, we suggest CMS consider working towards consolidating Medicaid and Medicare provider enrollment

believing that it could lead to a more effective and less burdensome enrollment process.

In closing, I would like to say thank you to the subcommittee for your recognition that provider enrollment is critically important through your holding of this hearing and also your congressional action on H.R. 3716, the Ensuring Access to Quality Medicaid Providers Act. We certainly hope that our work serves as a catalyst for additional positive change to ensure that CMS and states are paying the right provider the right amount for the right service. Thank you.

[The prepared statement of Ann Maxwell follows:]



U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

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

Medicare and Medicaid Program Integrity: Combatting Improper Payments and Ineligible Providers

Testimony of:

Ann Maxwell
Assistant Inspector General
Office of Evaluation and Inspections
Office of Inspector General
Department of Health and Human Services

May 24, 2016
10:15 a.m.
Location: Rayburn House Office Building, Room 2322

Testimony of:
Ann Maxwell
Assistant Inspector General for Evaluation and Inspections
Office of Inspector General, U.S. Department of Health and Human Services

Good morning, Chairman Murphy, Ranking Member DeGette, and other distinguished Members of the Subcommittee. Thank you for the opportunity to appear before you to discuss improper payments in Medicare and Medicaid and the role that improved provider enrollment safeguards can play in protecting these programs.

OIG's mission is to protect the integrity of Department of Health and Human Services (HHS) programs and operations as well as the health and welfare of the people HHS serves. The 2014 combined expenditures for Medicare and Medicaid amounted to over one trillion dollars, and the programs served 120 million beneficiaries. OIG protects the integrity of these programs and others through robust audits, evaluations, investigations, enforcement actions, and compliance efforts.

To ensure that these essential programs can continue to serve our nation's most vulnerable populations well into the future, we must foster their sound financial stewardship. Reducing improper payments to providers is a critical element in protecting the financial integrity of the Medicare and Medicaid programs. Although not all improper payments are fraud, nor even overpayments, all improper payments pose a risk to the financial security of these programs. The estimated levels of improper payments in these programs indicate that HHS must remain vigilant in its efforts to pay the right provider the right amount for the right service. In its Fiscal Year (FY) 2015 Agency Financial Report (AFR), HHS reported the estimated improper payments for Medicare and Medicaid to be approximately $88.8 billion.

One way to protect Medicare and Medicaid from improper payments is to have strong enrollment safeguards to prevent ineligible providers from ever entering the program and to identify those with whom HHS does business. The Centers for Medicare & Medicaid Services (CMS) and States can prevent inappropriate payments, protect beneficiaries, and reduce time-consuming and expensive "pay and chase" activities by ensuring that providers engaging in fraudulent or abusive activities are not allowed to enroll in Medicare and Medicaid. Of course, this vigilance must be balanced with the need to maintain a relatively burden-free system for eligible providers.

My testimony today focuses on how HHS's improper payment rates did not meet targets as well as insights into the implementation of the new provider enrollment safeguards authorized by the Patient Protection and Affordable Care Act (ACA) to better screen providers in an effort to protect Medicare and Medicaid from paying fraudulent and abusive providers.

IMPROPER PAYMENT RATES INDICATE NEED TO BETTER PROTECT MEDICARE AND MEDICAID

Medicare and Medicaid accounted for $88.8 billion, or almost 99 percent, of the $89.8 billion in improper payments that HHS reported in its FY 2015 AFR. Traditional Medicare fee-for-service alone accounted for $43.3 billion, or almost one-half, of the improper payments that HHS reported. Medicaid improper payments totaled an additional $29.1 billion. OIG has identified reducing improper payments as an organizational priority necessary to ensuring the long-term health of HHS programs, especially Medicare and Medicaid.

To improve accountability for the administration of funds, Federal agencies are required to annually report information on the agencies' improper payments to the President and Congress. For FY 2015, HHS did not fully comply with these reporting requirements. OIG has looked into HHS's noncompliance with these requirements for the Medicare and Medicaid programs and has issued annual reports on the topic since 2012. Two findings from the most recent report are described below.

HHS's Error Rate Percentage for Medicare Fee-for-Service Exceeded 10 Percent

To comply with the Improper Payments Elimination and Recovery Act of 2010, an agency must report an improper payment rate of less than 10 percent (a statutorily required target level) for each program determined susceptible to significant improper payments. HHS did not meet this requirement as it reported an estimated improper payment rate for the Medicare Fee-for-Service program of 12.1 percent in FY 2015. Although Medicare Fee-for-Service improper payments exceeded the 10 percent threshold, the error rate decreased 0.6 percentage points from its estimated FY 2014 level of 12.7 percent.

HHS Did Not Meet All Goals for Reducing Improper Payments

In FY 2015, HHS did not meet its established improper payment targets for four programs – Medicare Advantage; Medicaid; Children's Health Insurance Program (CHIP); and Child Care Development Fund. In FY 2014, HHS set FY 2015 targets of 8.5 percent for the Medicare Advantage program and 6.7 percent for Medicaid. However, the actual improper payment rates for FY 2015 were 9.5 percent for Medicare Advantage (1 percentage point over the goal) and 9.8 percent for Medicaid (3 percentage points over the goal).

Primary Causes of Improper Payments and Plans for Reducing Them

In its FY 2015 AFR, HHS attributed about 69 percent of Medicare Fee-for-Service improper payments to errors associated with insufficient documentation and the remaining improper payments to medical necessity errors (about 17 percent) and administrative or process errors (about 14 percent). HHS said that the primary reason for Medicaid improper payments relates to States' difficulties bringing their systems into compliance with new requirements, including requiring screening of providers under a risk-based process prior to enrollment.

HHS described a variety of corrective actions it is taking to address improper payments in both the Medicare and Medicaid programs. For example, in the Medicaid program, HHS has engaged with States to proactively address issues identified in their Corrective Action Plans, facilitated national best practice calls to share ideas across States, offered ongoing technical assistance, and provided additional guidance, as needed.

For our part, OIG has long been at the forefront of measuring, monitoring, and recommending actions to prevent improper payments, including developing the first Medicare payment error rate in 1996, a time when there were few error rate models in Government. In addition to reviewing and reporting on HHS's annual improper payment information, OIG audits, evaluations, and investigations identify improper payments for specific services and items, assess internal control and payment vulnerabilities, and make recommendations to prevent future improper payments. For example, we found that hospices inappropriately billed Medicare over $250 million for general inpatient care and made recommendations to CMS, such as conducting prepayment reviews, that may help prevent improper payments. In the FY 2015 AFR, HHS reported that the improper payment rate for home health care claims increased to 59 percent, up by 7.57 percentage points since the last reporting period. Considering this statistic, and the results of prior OIG work, home health care is an area ripe for corrective action and reducing improper payments. In fact, we have audits underway to determine whether home health agencies across the country complied with Medicare requirements.

One key component of a strategy for minimizing improper payments is to take steps to ensure that only eligible providers are allowed to enroll in the Medicare and Medicaid programs. Provider enrollment safeguards are important tools in helping prevent improper payments. My comments on provider enrollment safeguards will highlight four OIG reports, three of which are being released to this Subcommittee today. As mentioned, the ACA strengthened provider enrollment by expanding who gets screened and how they get screened. These reports will inform today's conversation and enhance our combined efforts to ensure that the Medicare and Medicaid programs maximize the valuable tools the ACA provided.

PROVIDER ENROLLMENT IS A CRITICAL SAFEGUARD

Preventing ineligible providers from entering the Medicare and Medicaid programs not only reduces improper payments, but also prevents patient harm. Unfortunately, there are numerous examples of Medicare and Medicaid providers causing significant harm to patients. One such example includes an oncologist with multiple facilities who administered aggressive cancer treatments and other therapies to patients who did not need them to increase the provider's billings to Medicare. The unnecessary therapy and excessive medications led to significant health problems for a number of patients. Another example includes a number of dentists in a pediatric dentistry company. These pediatric dentists performed medically unnecessary dental services, including baby root canals, on young children covered by Medicaid. These dental facilities did not let parents accompany their children, placed children in unreasonable confinement, and caused significant physical pain to this vulnerable population of children.

Strong provider safeguards at the beginning of the enrollment process and ongoing verification to ensure that enrolled providers continue to meet Medicare and Medicaid requirements allow CMS to better protect beneficiaries from harm and reduce improper payments. Through the ACA, Congress provided CMS and States the authority for enhancements to the enrollment screening process.

ACA authorized additional screening tools designed to strengthen provider enrollment

The ACA strengthened provider enrollment processes for Medicaid and Medicare by expanding who gets screened and how they get screened. The ACA screening requirements, as implemented in regulation, apply not only to the provider, but also to all those who have an ownership or controlling interest in the provider. Additionally, the ACA authorized enhanced screening tools, including verifying provider information, placing providers in risk categories, increasing site visits, and requiring fingerprinting. In 2011, CMS began assigning providers to one of three risk categories: limited, moderate, or high risk. The extensiveness of provider screenings depends on provider risk categories. Providers assigned to the high-risk category are subject to a more extensive review than those in the lower-risk categories. Chart 1 provides a description of what screening is required for each risk category.

Chart 1: ACA screening requirements for each risk category

Type Of Screening Required	Limited	Moderate	High
Verify any provider/supplier-specific requirements established by Medicare and Medicaid	X	X	X
Conduct license verifications	X	X	X
Check databases (to verify Social Security Number; the National Provider Identifier; the National Practitioner Data Bank licensure; an OIG exclusion; taxpayer identification number; death of individual practitioner, owner, authorized official, delegated official, or supervising physician)	X	X	X
Conduct unscheduled or unannounced site visits		X	X
Check fingerprint-based criminal history records			X

Implementation by States and CMS of this stronger, risk-based approach needs improvement to truly strengthen provider enrollment in Medicaid and Medicare. OIG has identified a number of opportunities for States' Medicaid programs and CMS to prevent ineligible providers from enrolling in Medicaid and Medicare, as described below. CMS concurred with all of our recommendations related to working with State Medicaid Agencies to strengthen provider enrollment, as well as our provider enrollment recommendations for Medicare.

State Medicaid Agencies should fully implement ACA screening tools

Implementing the ACA required screening activities is critical to safeguarding the Medicaid program as it is expanded to serve more beneficiaries. The ACA requires States to more uniformly screen providers according to the risk for fraud, waste, and abuse that they pose to Medicaid. In addition, to help ensure that CMS and State Medicaid agencies identify potentially fraudulent providers prior to their initial enrollment in Medicaid, providers must disclose the identity of any person or entity who has ownership or controlling interest.

However, when reviewing moderate- and high-risk providers, OIG found that State implementation of ACA screening procedures is incomplete. States with incomplete screening activities enrolled thousands of providers categorized as posing a high or moderate risk to Medicaid without conducting fingerprint-based criminal background checks. This leaves the Medicaid program vulnerable to providers who may be ineligible or who may defraud the program and harm patients in the process.

Some States recently reported incomplete implementation of fingerprint-based criminal background checks and site visits. Specifically, 37 States reported not having fingerprint-based criminal background checks while waiting for CMS to require them. CMS did not require fingerprint-based criminal background checks until June 2015, more than 4 years after the other Medicaid enhanced provider screening activities went into effect. In addition, 11 States reported that they had not implemented site visits, which were required during the period reviewed.

OIG also uncovered problems with provider ownership disclosure. For States to identify potentially fraudulent providers, as well as those that may be associated with excluded individuals or entities, State Medicaid agencies must be aware of those with whom they are doing business. Yet, OIG found that few State Medicaid agencies requested that providers disclose all Federally required ownership information. In addition, 14 State Medicaid agencies reported not verifying the completeness or accuracy of required provider ownership information. Additionally, OIG found that 14 State Medicaid agencies reported not confirming that individuals or entities that providers disclosed as owners were not excluded from other State Medicaid agencies.

OIG Recommends

- CMS assist States in fully implementing the tools provided to them through the ACA. Specifically, States should implement fingerprint-based criminal background checks for high-risk providers and conduct site visits.
- CMS work with State Medicaid agencies to improve the collection and verification of provider ownership information to ensure completeness and accuracy.

CMS should do more to strengthen ACA enhanced enrollment safeguards in Medicare

To fully benefit from the new authorities that the ACA provided, CMS needs to strengthen implementation of enhanced enrollment screening in Medicare. For instance, OIG found gaps in CMS contractors' verification of key information on enrollment applications that could leave Medicare vulnerable to ineligible providers. OIG also found that CMS contractors were inconsistent in applying site visit procedures and using site visit results for enrollment decisions. The purpose of site visits is to determine whether a provider is operational and meets all applicable Medicare standards. However, OIG found that contractors approved hundreds of applications where site visit inspectors found providers to be nonoperational. We followed up with one contractor to determine under what circumstances it would approve enrollment with an

unfavorable site visit result. The contractor reported that it had not reviewed the site visit results in some cases, should have conducted more research on the provider location in others, or may have provided an incorrect location for the site visit. OIG also found that, site visit inspectors were sometimes inconsistent in their determination of whether a site was operational and sometimes provided contradictory information on site visit forms.

Despite these gaps, CMS achieved some positive outcomes as a result of the new screening tools. For example, when CMS revalidated current providers' enrollment using the new screening tools, OIG found that the number of revocations and deactivations substantially increased.

While there are some positive results from the new screening tools, OIG has identified several potential vulnerabilities in the enhanced enrollment process. To address these vulnerabilities and prevent ineligible providers from enrolling in Medicare, OIG recommends that CMS take practical steps to ensure effective oversight of enrollment data to ensure that contractors are performing their activities appropriately and that enhancements are producing intended results.

OIG Recommends

- CMS monitor contractors to ensure they are verifying information on enrollment applications.
- CMS improve the execution and use of site visits by:
  - revising site visit forms so that they can be more easily used by inspectors,
  - improving quality assurance oversight and training of site visit inspectors, and
  - ensuring that contractors are appropriately considering site visit results when making enrollment decisions.

CMS must improve Medicare and Medicaid provider data systems

OIG has a history of work pointing to problems in CMS's Medicare enrollment data system, the Provider Enrollment, Chain and Ownership System (PECOS). The information in PECOS should aid CMS in tracking enrollment and revalidation trends as well as to help determine whether CMS contractors are abiding by program requirements. However, OIG has found PECOS to be incomplete and inaccurate. Additionally, OIG has found inaccuracies in a separate database that CMS established for storing information about providers terminated from the Medicare and Medicaid programs. The database is meant to assist State Medicaid agencies in denying enrollment to providers who have been terminated from Medicare or by another State Medicaid agency.

OIG has historically found PECOS data to be incomplete, inconsistent and inadequate. In 2013, OIG found that provider data were inconsistent between the National Plan and Provider Enumeration System and PECOS for 97 percent of records. Addresses, which are essential for contacting providers and identifying trends in fraud, waste, and abuse, were the source of most inaccuracies and inconsistencies. Also, OIG recently found that PECOS did not contain all the information needed for CMS to effectively oversee whether its contractors are performing their activities appropriately and that enhancements are producing intended results. OIG found that shortcomings in PECOS rendered CMS unable to leverage data to determine whether enhancements were strengthening provider enrollment.

More recently, OIG has also found vulnerabilities in the accuracy of provider ownership information within PECOS. Specifically, we compared provider ownership names in PECOS with names that State Medicaid agencies had on file for the same providers. We found that for nearly all providers in our review, owner names in PECOS did not match those on record with the State Medicaid agencies. This means that Medicare and Medicaid information for the same providers does not match. Further, when we compared PECOS data with provider ownership names that we collected directly from providers, we found that over three-quarters of them did not match.

An example helps illustrate the issues we found with provider enrollment information. When we asked for ownership names from a provider enrolled in both Medicare and Medicaid, the provider reported having 12 owners. In the State Medicaid agency's database, this same provider was listed as having 63 owners. And finally, Medicare's PECOS database listed the provider with 14 owners. Most of the 12 owners reported to OIG did not even match those listed with Medicaid or Medicare.

The prevalence of nonmatching owner names raises concern about the completeness and accuracy of information about Medicare providers' ownership in PECOS, and in State databases. If PECOS does not accurately and completely capture provider ownership information for Medicare providers, CMS does not know exactly with whom it is doing business, and its ability to provide adequate oversight of the Medicare program is compromised. High-quality PECOS data are equally important to State Medicaid agencies. To streamline the enrollment process and save resources, States are allowed to use Medicare screening results – assuming the provider is also enrolled in Medicare – rather than screening a provider again for Medicaid. However, many States reported that they did not take advantage of this option because of concerns about the completeness and accuracy of the PECOS data.

OIG also found weaknesses in the CMS process for collecting and sharing data on providers terminated from Medicaid for reasons of quality, integrity, or fraud. Specifically, there is not a comprehensive CMS data source for identifying all provider terminations for cause. The ACA required CMS to establish a process to make available to State agencies information about

providers terminated from the Medicare, Medicaid, and CHIP programs so that States do not enroll providers who have been terminated in other States and can identify those enrolled providers who are required to be terminated. To implement this requirement, CMS established a central database that allows State Medicaid agencies to voluntarily report providers whom the State agencies terminated for cause from their programs and to retrieve information about providers who were terminated for cause by Medicaid programs in other States. We found that not all State Medicaid agencies were reporting to the database and that not all of the submitted records met the CMS definition of a for-cause termination.

The lack of this comprehensive database allows providers terminated in one State to continue participating in other States' Medicaid programs. OIG found that 12 percent of providers who were terminated for cause by State Medicaid agencies in 2011 continued to participate in other State Medicaid programs as of January 2012, notwithstanding the requirement that such providers be terminated in all States. About half of these providers remained listed as participating in Medicaid in other States until as late as January 2014, and about one-third of these participating providers received payments for services rendered to Medicaid beneficiaries after the providers' terminations for cause.

OIG Recommends

- CMS ensure that PECOS includes data that relate to the enhancements implemented for the provider enrollment process and that contractors enter all required data.
- CMS enable States to substitute Medicare screening data by ensuring the accessibility and quality of PECOS data.
- CMS require each State Medicaid agency to report all terminated providers.

To promote further efficiencies, we recommend that CMS develop a central system for States to submit and access results from other States. CMS could eventually consider creating a consolidated enrollment system that covers both Medicare and Medicaid. A joint enrollment system would reduce duplication and inconsistency across government programs and would also reduce the burden on providers. Providers would no longer have to separately provide enrollment information, including ownership information, to CMS and to their respective States' Medicaid programs.

CONCLUSION

We appreciate the Subcommittee's interest in these important issues. Increased attention to CMS improper payments and provider enrollment safeguards will help keep our Medicare and Medicaid programs safe and secure, while protecting beneficiaries from patient harm and ensuring that taxpayer money is appropriately spent. To that end, we continue to urge CMS to fully address OIG's recommendations related to improving provider enrollment safeguards. While we are encouraged by CMS's commitment to strong provider enrollment safeguards, our work has demonstrated that more could be done to strengthen the implementation of enhanced provider screening in Medicare and to fully implement enhanced provider screening in all State Medicaid agencies. Until such time, these programs are not as protected as they could be from ineligible providers who intend to defraud the program and potentially harm beneficiaries in the process.

OIG is encouraged that CMS concurred with all of our recommendations referenced in this testimony and stated that it is strongly committed to program integrity efforts in Medicare and Medicaid. We look forward to continuing to work with CMS to implement all of the recommendations expeditiously so that CMS can take maximum advantage of the array of tools afforded to it by the ACA to protect Medicare and Medicaid resources and the beneficiaries these programs serve.

OIG believes it is critical that we continue to conduct effective oversight to ensure that funds are spent appropriately and that steps are taken to improve the quality of care for Medicare and Medicaid beneficiaries. We have a substantial body of Medicare- and Medicaid-related work, both underway and planned, to ensure that beneficiaries are protected from harm and taxpayer dollars are spent for their intended purposes.

Thank you again for inviting OIG to speak with the Subcommittee today on improper payments in Medicare and Medicaid and the role that improved provider enrollment safeguards can play in reducing them. We hope that our work and this testimony will assist you in your oversight efforts to protect these programs.

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

STATEMENT OF SETO J. BAGDOYAN

Mr. BAGDOYAN. Thank you. Chairman Murphy, Ranking Member DeGette, and members of the subcommittee, I am pleased to be here today to discuss key findings from our complementary reviews of screening controls CMS uses to detect and prevent enrollment fraud from Medicare providers and suppliers in its provider enrollment chain and ownership system, also known as PECOS.

As context, Medicare, which is on GAO's high risk list for potential improper payments and fraud, involves significant expenditures for the federal government totaling about $569 billion in fiscal year 2015. CMS estimates that about 60 billion of these expenditures, or 11 percent, involved improper payments.

In our June 2015 review, we found that controls for screening providers and suppliers listed as deceased or excluded from participating in federal health care related programs appear to be generally working. However, we identified weaknesses in two other controls.

First, we identified weaknesses in CMS' verification of practice locations. Medicare providers must submit addresses of practice locations from which they offer services. The software CMS used at the time to validate addresses didn't flag potentially ineligible addresses such as commercial mail receiving agencies, also known as CMRA, which include mailbox rental stores. It also didn't flag vacant or invalid addresses, i.e., those where providers or suppliers no longer reside or those not recognized by Postal Service systems.

Of about 981,000 addresses in PECOS we examined using Postal Service software, about 105,000 initially appeared questionable. That is, they were either CMRAs, vacant, or invalid. Based on a projectable sample of 496 addresses, we estimated that about 23,400 of the questionable addresses were potentially ineligible and 5,500 of these had associated to claims paid.

CMS' 2014 guidance revision actually scaled back address verification steps conducted by its contractors. CMS' previous guidance had encouraged contractors to conduct additional verification steps such as using Google Maps and performing site visits. However, CMS' revised guidance doesn't require such steps beyond contacting the provider. And accordingly, by reducing verification steps, CMS has increased Medicare's vulnerability to potential fraud.

We recommended CMS incorporate flags into its software to help identify questionable addresses and revise its current guidance to enhance verification of practice locations. CMS agreed with the first recommendation and recently implemented it and is considering implementing the second recommendation. We continue to believe additional address verification steps to be an essential control.

Second, we identified weaknesses in the verification of medical licenses. Medicare physicians are required to hold an active license in the state they practice in and report any final adverse actions to CMS. Such actions include license suspensions or revocations by any state licensing authority.

We found 147 of the 1.3 million physicians in PECOS had received a final adverse action, but were either not revoked from the system or revoked much later, and 47 were paid about $2.6 million in claims. In March 2014, CMS began providing a report to its contractors to improve licensure reviews, however this report only included current licensure status for states in which providers enrolled. It didn't include the full adverse action history of these providers or their licenses in other states, creating the opportunity for ineligible physicians to enroll into PECOS.

We recommended CMS collect additional licensure information to ensure providers are self-reporting all final adverse actions, and CMS agreed with this recommendation and has recently implemented it. In our April 2016 review, we reported that while CMS has taken steps to improve Medicare provider criminal background check controls, it has opportunities to recover about $1.3 million in potential overpayments made prior to control improvements to 16 enrollees we identified with criminal backgrounds. CMS said it is considering action in this regard.

Finally, as I close, we made 600 referrals from our work to CMS for action. To date, CMS has removed 251 providers from PECOS while affirming the eligibility of 227 others with action pending on the rest. The removal of ineligible providers originally missed by existing controls underscores our ongoing concerns about inherent risk of improper payments and fraud in PECOS.

Mr. Chairman, this concludes my statement. I look forward to the subcommittee's questions.

[The prepared statement of Seto J. Bagdoyan follows:]

United States Government Accountability Office

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

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MEDICARE PROGRAM

Continued Action Required to Address Weaknesses in Provider and Supplier Enrollment Controls

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

GAO-16-703T

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

I am pleased to appear before you today to discuss our previous work on the controls used to verify the eligibility of Medicare providers and suppliers and potential opportunities to recover overpayments to providers with criminal backgrounds.[1] Medicare is the federally financed health-insurance program for persons age 65 or over, certain individuals with disabilities, and individuals with end-stage renal disease.[2] In fiscal year 2015, Medicare paid $568.9 billion for health care and health care–related services. According to the Centers for Medicare & Medicaid Services (CMS)—the agency within the Department of Health and Human Services (HHS) that administers the Medicare program—an estimated $59.6 billion (10.5 percent) of that total was paid improperly.[3] Due to the large dollar amount involved in improper payments, the Office of Management and Budget has placed Medicare on its list of high-error programs.[4] Further, because of its size, complexity, and susceptibility to

[1]GAO, *Medicare Program: Additional Actions Needed to Improve Eligibility Verification of Providers and Suppliers*, GAO-15-448 (Washington, D.C.: June 25, 2015); *Medicare: Opportunities Exist to Recover Potential Overpayments to Providers with Criminal Backgrounds*, GAO-16-365R (Washington, D.C.: Apr. 13, 2016).

[2]Medicare consists of four parts. Medicare Part A covers items such as inpatient hospital care. Part B services include physician and outpatient hospital services. Medicare Part C or Medicare Advantage is a Medicare private plan, while Medicare Part D is an outpatient prescription drug benefit.

[3]An improper payment is defined as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. It includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), and any payment that does not account for credit for applicable discounts. Improper Payments Elimination and Recovery Improvement Act of 2012, Pub. L. No. 112-248, § 3(a)(1), 126 Stat 2390 (codified at 31 U.S.C. § 3321 note).

[4]The Office of Management and Budget designates a program as "high-error" based on improper-payment information in agencies' annual Performance and Accountability Reports and Agency Financial Reports. Specifically, a program is considered high-error if it has improper payments greater than $10 million and over 2.5 percent of all payments made under that program, or if the program has more than $100 million in estimated improper payments.

mismanagement and improper payments, we have designated Medicare as a high-risk program.[5]

To enroll in Medicare and bill for services provided to Medicare beneficiaries, CMS requires prospective providers and suppliers to be listed in the Provider Enrollment, Chain and Ownership System (PECOS). PECOS is a centralized database designed to contain providers' and suppliers' enrollment information. According to CMS, there were about 1.9 million health-care providers and suppliers enrolled in PECOS as of December 31, 2015.

My remarks today highlight the key findings of our June 2015 report on CMS's Medicare provider and supplier enrollment-screening procedures and our April 2016 report on potential overpayments to providers with criminal backgrounds. Accordingly, this testimony discusses the extent to which selected enrollment-screening procedures are designed and implemented to prevent and detect the enrollment of ineligible or potentially fraudulent Medicare providers and suppliers into PECOS.

In June 2015, we reported on the implementation of four enrollment-screening procedures that CMS uses to prevent and detect ineligible or potentially fraudulent providers and suppliers from enrolling into PECOS, including verifying provider practice locations and physician licensure status, and screening for providers and suppliers listed as deceased or excluded from participating in federal programs or health care–related programs. To assess the extent to which CMS had controls to verify the eligibility of Medicare providers and suppliers, we reviewed CMS procedural manuals and directives, and interviewed CMS officials about provider and supplier enrollment-screening procedures. We matched the list of providers and suppliers present in PECOS, as of March 29, 2013, and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers, as of April 6, 2013 (the most-current data available at the time of our review) to the following databases: (1) the United States Postal Service (USPS) Address Matching System Application Program Interface;[6] (2) Federation of State Medical Boards (FSMB) licensure data;

[5]GAO, *High-Risk Series: An Update*, GAO-15-290 (Washington, D.C.: February 2015).

[6]In this statement, we refer to the USPS Address Management System Application Program Interface as the USPS address-management tool.

(3) the Social Security Administration's (SSA) full death file;[7] and (4) the HHS Office of Inspector General's (OIG) List of Excluded Individuals and Entities (LEIE) to determine whether ineligible or potentially fraudulent Medicare providers, suppliers, and DMEPOS suppliers were in PECOS. For the USPS address-management tool, we selected a generalizable sample from the addresses that the USPS address-management tool identified as being a Commercial Mail Receiving Agency (CMRA), vacant, or invalid and took additional steps to confirm whether the practice location address was an eligible address. In addition, we obtained Medicare claims data from 2005 through 2013 from CMS for all of our matches to determine how much the providers and suppliers were paid with Medicare funds, if at all, while they may have been ineligible. On the basis of our discussions with agency officials and our own testing, we concluded that the data elements used for this report were sufficiently reliable for our purposes. In November 2015, February 2016, and May 2016, CMS officials provided us with updates on actions taken to address our three recommendations made in the June 2015 report. From August 2015 through May 2016, CMS officials also provided updates on the actions taken on the cases we referred.

In April 2016, we reported on a fifth enrollment-screening process CMS used to conduct criminal-background checks on Medicare providers and suppliers. To assess the extent to which CMS had controls in place to verify criminal-background information for providers and suppliers in PECOS, we matched the PECOS data of approximately 1.2 million unique physicians and nonphysicians as of March 2013 to data from the Federal Bureau of Prisons and the National Sex Offender Registry as of February 2014, by Social Security number, name, and date of birth, to identify potentially ineligible providers.[8] We also reviewed CMS supporting documentation and interviewed agency officials. We also

[7]SSA maintains death data including names, Social Security numbers, dates of birth, and dates of death. SSA shares a comprehensive file of this death information, which includes state death data, with certain eligible entities, including CMS, according to SSA. We used this comprehensive file, which we call the "full death master file," for our analysis. A subset of the full death master file that does not include state death data is available to the public.

[8]Our findings are based on data from 2013, the most-current data available to us at the time of our review. CMS implemented new procedures in April 2014 to update its criminal-background check process. Although CMS has new procedures in place, the results of our review of the 2013 data provide an opportunity for CMS to recover potential overpayments that were made prior to putting the revised procedures in place.

calculated Medicare claims that were paid to providers while they were potentially ineligible. We assessed the reliability of data and determined that these databases were sufficiently reliable for the purpose of our review. More details on our scope and methodology can be found in the issued reports.[9] In May 2016, CMS officials provided us with an update on the 66 providers we referred to CMS for further review. We conducted the work on which this statement is based in accordance with generally accepted government auditing standards.[10]

Limitations Exist in Certain CMS Screening Procedures for Preventing and Detecting Enrollment of Ineligible or Potentially Fraudulent Medicare Providers and Suppliers

In our June 2015 and April 2016 reports examining CMS screening procedures, we found weaknesses in CMS's verification of provider practice location, physician licensure status, providers listed as deceased or excluded from participating in federal programs or health care–related programs, and criminal-background histories. These weaknesses may have resulted in CMS improperly paying thousands of potentially ineligible providers and suppliers. We made recommendations to address these weaknesses, which CMS has indicated it has implemented or is taking steps to address. Additionally, as a result of our work, we referred 597 unique providers and suppliers to CMS. According to CMS officials, they have taken some actions to remove or recover overpayments from the potentially ineligible providers and suppliers we referred to them in April 2015 and April 2016, but CMS's review and response to the referrals are ongoing.

Practice Location Verification Procedures

In our June 2015 report, we found thousands of questionable practice location addresses for providers and suppliers listed in PECOS, as of March 2013, and DMEPOS suppliers, listed as of April 2013.[11] Under federal regulations, providers and suppliers must be "operational" to

[9]GAO-15-448 and GAO-16-365R.

[10]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.

[11]GAO-15-448. All providers and suppliers must list a physical practice location address in their application, regardless of provider or supplier type.

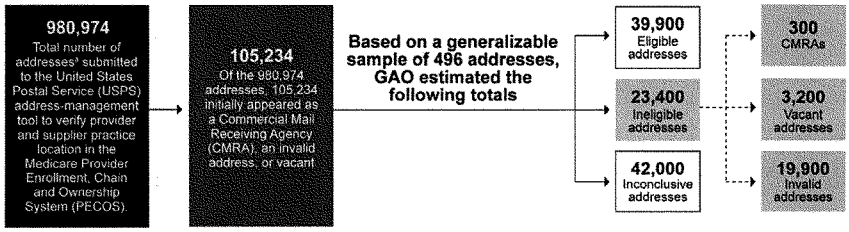
furnish Medicare covered items or services, meaning that they have a qualified physical practice location that is open to the public for the purpose of providing health care–related services. The location must be properly staffed, equipped, and stocked to furnish these items or services. Addresses that generally would not be considered a valid practice location include post office boxes, and those associated with a certain type of CMRA, such as a United Parcel Service (UPS) store.[12] We checked PECOS practice location addresses for all records that contained an address using the USPS address-management tool, a commercially available software package that standardizes addresses and provides specific flags on the address such as a CMRA, vacant, or invalid address.[13] As illustrated in figure 1, on the basis of our analysis of a generalizable stratified random sample of 496 addresses, we estimate that about 23,400 (22 percent) of the 105,234 addresses we initially identified as a CMRA, vacant, or invalid address are potentially ineligible addresses.[14] About 300 of the addresses were CMRAs, 3,200 were vacant properties, and 19,900 were invalid.

[12]On the basis of USPS guidance, a CMRA is a third-party agency that receives and handles mail for a client. Not all CMRAs would disqualify an applicant from PECOS enrollment. For example, a hospital may be legitimately designated as a CMRA and could be considered an eligible practice location. Post office boxes and drop boxes are not acceptable except in some cases where the provider is located in rural areas.

[13]The USPS address-management tool includes addresses as of December 15, 2013. This software is not currently being used by CMS. Instead, CMS uses the other software—called Finalist—to standardize practice location addresses. A vacancy refers to a provider or supplier that is no longer at the location provided on the application form. USPS would flag a location as vacant if it used to deliver mail there and has not delivered mail there in more than 90 days. An invalid address is when an address is not recognized by USPS, was incorrectly entered in PECOS, or was missing a street number.

[14]As part of our initial analysis using the USPS address-management tool, we identified 105,234 (about 11 percent) of the 980,974 address listed in PECOS that appeared in the USPS address-management tool as a CMRA, a vacant address, or an invalid address. For more information on our estimates and methodology, see GAO-15-448.

Figure 1: GAO Sample Estimates of Provider and Supplier Practice Location Addresses in PECOS Using the USPS Address-Management Tool



Source: GAO. | GAO-16-703T

Note: Estimated numbers do not add to totals due to rounding. All estimates in this figure have a margin of error, at the 95 percent confidence level, of plus or minus 10 percentage points or fewer. These data are from March 2013 (Medicare providers and suppliers) and April 2013 (suppliers of durable medical equipment, prosthetics, orthotics, and supplies).

[a]We did not submit addresses of providers in PECOS that reassigned their benefits to a group. These providers did not have a practice location address listed in PECOS and were not included in our work.

Of the 23,400 potentially ineligible addresses submitted as practice locations, we estimate that, from 2005 to 2013, about 17,900 had no claims associated with the address, 2,900 were associated with providers that had claims that were less than $500,000 per address, and 2,600 were associated with providers that had claims that were $500,000 or more per address. Because some providers are associated with more than one address, it is possible that some of the claim amounts reported may be associated with a different, valid practice location. Due to how we compiled claims by the National Provider Identifier, we were unable to determine how much, if any, of the claim amount may be associated with a different, valid address.

In our June 2015 report, we found limitations with CMS's Finalist software used to validate practice location addresses. The Finalist software is one technique used by the Medicare Administrative Contractors (MAC) and the National Supplier Clearinghouse (NSC) to validate a practice

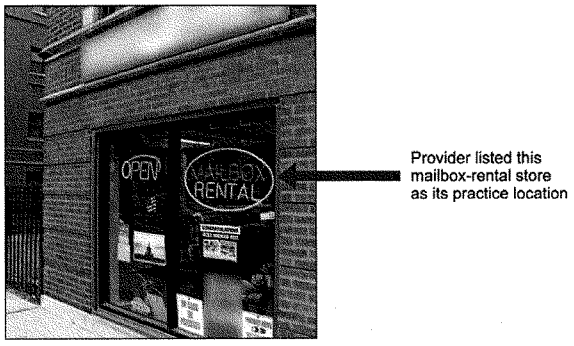
location.[15] According to CMS, Finalist is integrated into PECOS to standardize addresses and does so by comparing the address listed on the application to USPS records and correcting any misspellings in street and city names, standardizing directional markers (such as NE or West) and suffixes (such as Ave. or Lane), and correcting errors in the zip code. However, the Finalist software does not indicate whether the address is a CMRA, vacant, or invalid address—in other words, whether the location is potentially ineligible to qualify as a legitimate practice location. CMS does not have these flags in Finalist because the agency added coding in PECOS that prevents post office box addresses from being entered, and believed that this step would prevent these types of ineligible practice locations from being accepted.

Further, some CMRA addresses are not listed as post office boxes. For example, in our June 2015 report we identified 46 out of the 496 sample addresses that were allowed to enroll in Medicare with a practice location that was inside a mailing store similar to a UPS store. These providers' addresses did not appear in PECOS as a post office box, but instead were listed as a suite or other number, along with a street address. Figure 2 shows an example of one provider we identified through our search and site visits as using a mailbox-rental store as its practice location and where services are not actually rendered. This provider's address appears as having a suite number in PECOS and remained in the system as of January 2015. According to our analysis of CMS records, this provider was paid approximately $592,000 by Medicare from the date it enrolled in PECOS with this address to December 2013, which was the latest date for which CMS had claims data at the time of our review.[16]

[15]CMS contracts with the MACs and the NSC to manage the enrollment process. MACs are responsible for verifying provider and supplier application information in PECOS before the providers and suppliers are permitted to enroll into Medicare. The NSC is responsible for verifying information regarding DMEPOS suppliers.

[16]The claims amount was calculated based on all claims associated with the National Provider Identifier that was listed on the matched address. Because some providers are associated with more than one address, it is possible that some of the claim amounts reported may be associated with a different, valid practice location. Due to how we obtained compiled claims by the National Provider Identifier, we were unable to determine how much, if any, of the claim amount may be associated with a different, valid address.

Figure 2: Mailbox Rental Store with a Suite Number Address Used as a Provider Practice Location



Source: GAO. | GAO-16-703T

Our June 2015 report also found locations that were vacant or addresses that belonged to an unrelated establishment. For example, we visited a provider's stated practice location in December 2014 and instead found a fast-food franchise there (see fig. 3—the name of the franchise has been blurred). In addition, we found a Google Maps image dated September 2011 that shows this specific location as vacant. Although the provider was not paid by Medicare from the date this practice location address was flagged as vacant, by remaining actively enrolled into PECOS, the provider may be eligible to bill Medicare in the future.

Figure 3: Fast-Food Franchise Listed as Provider's Practice Location

Source: GAO. | GAO-16-703T

In March 2014, CMS issued guidance to the MACs that revised the practice location verification methods by requiring MACs to only contact the person listed in the application to verify the practice location address and use the Finalist software that is integrated in PECOS to standardize the practice location address. Additional verification, such as using 411.com and USPS.com, which was required under the previous guidance, is only needed if Finalist cannot standardize the actual address.[17] In our June 2015 report, we noted that our findings suggest that the revised screening procedure of contacting the person listed in the application to verify all of the practice location addresses may not be sufficient to verify such practice locations. For example, two providers in our sample of 496 addresses that the USPS address-management tool flagged as CMRA, invalid, or vacant successfully underwent a MAC revalidation process in 2014. The MAC used the new procedure of calling

[17]411.com is an online directory of contact information for people and businesses. USPS.com offers the ZIP Code Lookup tool, which standardizes addresses using USPS address records.

the contact person to verify the practice location. Each of these two providers had a UPS or similar store as its practice location.

To help further improve CMS's enrollment-screening procedures to verify applicants' practice location, we made two recommendations to CMS in our June 2015 report. First, we recommended that CMS modify the CMS software integrated into PECOS to include specific flags to help identify potentially questionable practice location addresses, such as CMRA, vacant, and invalid addresses. The agency concurred with this recommendation. On May 16, 2016, CMS provided us with supporting documentation that shows that the agency replaced its current PECOS address verification software to include Delivery Point Verification (DPV)—which is similar to the software we used when conducting the work in the June 2015 report—as an addition to the existing functionality. According to CMS officials, this new DPV functionality flags addresses that may be CMRA, vacant, or invalid. By updating the address verification software, CMS can ensure that providers with ineligible practice location are not listed in PECOS.

Second, we recommended in our June 2015 report that CMS revise its guidance for verifying practice locations to include, at a minimum, the requirements contained in the guidance in place prior to March 2014. Such a revision would require that MACs conduct additional research, beyond phone calls to applicants, on the practice location addresses that are flagged as a CMRA, vacant, or invalid address to better ensure that the address meets CMS's practice location criteria. The agency did not concur with this recommendation, stating that the March 2014 guidance was sufficient to verify practice locations. However, our audit work shows that additional checks on addresses flagged by the address-matching software as a CMRA, vacant, or invalid can help verify whether the addresses are ineligible. As our report highlighted, we identified providers with potentially ineligible addresses that were approved by MACs using the process outlined in the existing guidance. Therefore, we continue to believe that the agency should update its guidance for verifying potentially ineligible practice locations. In February 2016, CMS officials told us that, as part of configuring the PECOS address verification software to include the DPV functionality and flag CMRAs, vacancies, invalid addresses, and other potentially questionable practice locations, the agency plans to validate the DPV through site visits and follow its current process to take administrative action if the results are confirmed. CMS officials told us that they believe that by implementing the first recommendation by incorporating software flags and revising its guidance for verifying potentially ineligible practice location, if necessary, the second

recommendation will be addressed. As of May 17, 2016, CMS had not provided us with details and supporting documentation of how it will revise its guidance. Accordingly, it is too early for us to determine whether the agency's actions would fully address the intent of the recommendation. We plan to continue to monitor the agency's efforts in this area.

CMS has taken some actions to remove or recover overpayments from potentially ineligible providers and suppliers that we referred to it, based on our June 2015 report. On April 29, 2015, we referred 286 unique providers to CMS for further review and action as a result of our identification of providers with potentially ineligible practice location address. From August 2015 to May 2016, CMS has provided updates on these referrals. On the basis of our analysis of CMS's updates, CMS has taken the following actions:

- taken administrative action to remove the provider or collect funds for 29 of the providers,[18]
- corrected the invalid addresses for 70,
- determined that the questionable location was actually valid for 84, and
- determined that the provider had already been removed from the program for 102.

However, CMS did not take action on 1 provider because it was unable to find the practice location for this provider.

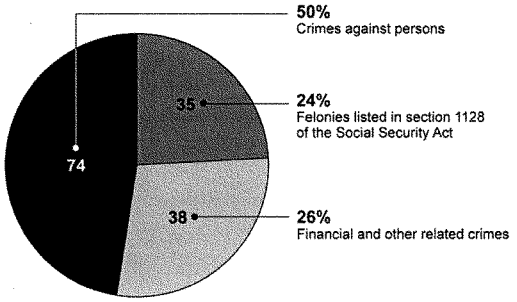
Applicants' Licensure Information Verification

In our June 2015 report, we found 147 out of about 1.3 million physicians with active PECOS profiles had received a final adverse action from a state medical board, as of March 2013. Adverse actions include crimes against persons, financial crimes, and other types of health care–related felonies. These individuals were either not revoked from the Medicare program until months after the adverse action or never removed (see fig. 4).[19]

[18]According to CMS, it plans to collect about $7,900 from 2 of the 29 providers.

[19]GAO-15-448.

Figure 4: Summary of the Adverse License Actions Related to 147 Physicians Who Were Not Revoked for Months or Never Removed from Medicare, as of March 2013



Source: GAO. | GAO-16-703T

All physicians applying to participate in the Medicare program must hold an active license in the state they plan to practice in and also to self-report final adverse actions, which include a license suspension or revocation by any state licensing authority. CMS requires MACs to verify final adverse actions that the applicant self-reported on the application directly with state medical board websites. We found that because physicians are required to self-report adverse actions, the MACs did not always identify unreported actions when enrolling, revalidating, or performing monthly reviews of the provider.[20] As a result, 47 physicians out of the 147 physicians we identified as having adverse actions have been paid approximately $2.6 million by the Medicare program during the time CMS could have potentially barred them from the Medicare program between March 29, 2003, and March 29, 2013.

[20]According to CMS guidance, when an applicant first enrolls into Medicare, MACs must corroborate adverse legal actions and licensure information directly with state medical board websites. MACs must research all enrolled providers each month using multiple state medical board websites in their respective jurisdictions. Medicare providers must go through the revalidation process every 5 years.

Some of the adverse actions that were unreported by physicians occurred within the state where the provider enrolled in PECOS, while others occurred in different states. For example, we identified a physician who initially enrolled into Medicare in 1985 and was suspended for about 5 months in 2009 by the Rhode Island medical board. In 2011, his information was revalidated by the MAC. This provider did not self-report the adverse action, and the MAC did not identify it during its monthly reviews or when revalidating the provider's information. CMS bars providers that are already enrolled in Medicare who do not self-report adverse actions for 1 year. This individual billed Medicare for about $348,000 during the period in which he should have been deemed ineligible. CMS officials highlighted that delays in removing physicians from Medicare may occur due to MAC backlogs, delays in receipt of data from primary sources, or delays in the data-verification process.

In March 2014, CMS began efforts to improve the oversight of physician license reviews by providing the MACs with a License Continuous Monitoring report, which was a good first step. However, the report only provides MACs with the current status of the license that the provider used to enroll in the Medicare program. Without collecting license information on all medical licenses, regardless of the state the provider enrolled in, we concluded that CMS may be missing an opportunity to identify potentially ineligible providers who have license revocations or suspensions in other states, which can put Medicare beneficiaries at risk.

To help improve the Medicare provider enrollment-screening procedures, in our June 2015 report we recommended that CMS require applicants to report all license information including that obtained from other states, expand the License Continuous Monitoring report to include all licenses, and at least annually review databases, such as that of FSMB, to check for disciplinary actions. The agency concurred with the recommendation, but stated it does not have the authority to require providers to report licenses for states in which they are not enrolled. While providers are not currently required to list out-of-state license information in the enrollment application, CMS can independently collect this information by using other resources. Therefore, we clarified our recommendation to state that CMS should collect information on all licenses held by providers that enroll into PECOS by using data sources that contain this information, which is similar to the steps that we took in our own analyses.

In February 2016, CMS officials told us that CMS will take steps to ensure that all applicants' licensure information is evaluated as part of the screening process by MACs and the License Continuous Monitoring

report, as appropriate, and will also regularly review other databases for disciplinary actions against enrolled providers and suppliers. In May 2016, CMS officials stated that CMS has established a process to annually review databases and has incorporated the FSMB database into its screening process. On May 19, 2016, CMS officials provided us with supporting documentation that shows that the FSMB database was incorporated into its automatic screening process. By incorporating the FSMB database into its automatic screening process, CMS will be able to regularly check this database for licensure updates and disciplinary actions against enrolled providers and suppliers, as well as to collect all license information held by providers that apply to enroll in PECOS.

On April 29, 2015, we referred the 147 unique providers to CMS for further review and action as a result of our identification of revoked licenses. On the basis of our analysis of CMS's updates as of May 2016, CMS has taken the following actions:

- taken administrative action to remove the provider or collect funds for 21 providers,[21]
- determined that the provider had already been removed from the program for 48,
- determined that the adverse actions were disclosed or partially disclosed for 71, and
- has ongoing reviews of 6.

CMS did not take action on 1 provider because it was unable to find the adverse action for this provider.

Deceased and Exclusion Verification Procedures

In our June 2015 report, we found that about 460 (0.03 percent) out of the 1.7 million unique providers and suppliers in PECOS as of March 2013 and DMEPOS suppliers as of April 2013 were identified as deceased at the time of the data we reviewed.[22] The MAC or CMS identified 409 of the

[21]According to CMS, it plans to collect $40,300 from 2 of the 21 providers.

[22]GAO-15-448. To help ensure that Medicare maintains current enrollment information and to prevent others from utilizing the enrollment data of deceased providers and suppliers, MACs are required to check that providers and suppliers in PECOS are not deceased.

460 providers and suppliers as deceased from March 2013 to February 2015. Additionally, 38 out of the 460 providers and suppliers we found to be deceased were paid a total of about $80,700 by Medicare for services performed after their date of death until December 2013, which was the most-recent date CMS had Medicare claims data available at the time of our review. Not identifying a provider or supplier as deceased in a timely manner exposes the Medicare program to potential fraud. It is unclear what caused the delay or omission by CMS and the MACs in identifying these individuals as deceased or how many overpayments they are in the process of recouping.

On April 29, 2015, we referred 82 unique providers to CMS for further review and action as a result of our identification of providers whose status was deceased. From August 2015 to May 2016, CMS has provided updates on these referrals. On the basis of our analysis of CMS's updates, CMS has taken the following actions:

- taken administrative action to remove the provider for 4 of the providers,[23]
- determined that the provider had already been removed from the program for 25,
- determined that the provider had already been removed from the program but updated the provider's PECOS profile to reflect the date of death for 22, and
- started but not completed the review on 31 providers that were reported to be deceased and had submitted claims for payments.[24]

We found in our June 2015 report that about 40 (0.002 percent) out of the 1.7 million unique providers and suppliers enrolled in PECOS were listed in LEIE, as of March 2013.[25] These individuals were excluded from participating in health care–related programs. Of those 40 excluded providers and suppliers, 16 were paid approximately $8.5 million by

[23]According to CMS, it will not collect any claims on any of the 4 providers.

[24]The remaining 31 cases were provided to CMS in April 2015. In October 2015, the agency confirmed that it will review these cases. As of May 2016, CMS has not provided supporting documentation that it has completed the review of theses providers.

[25]GAO-15-448.

Medicare for services rendered after their exclusion date until the MAC or the NSC found them to be excluded.[26] When we followed up with the MACs in September and October 2014, we found that the MACs had removed 38 of the 40 providers and suppliers from PECOS from March 2013 to October 2014. However, for two matches that we identified, the MACs had not taken any action.[27] Given the small number of cases identified (40) and the MACs' removal of 38 out of these 40 providers during our review, we did not make a recommendation to CMS. On April 29, 2015, we referred the two providers that the MACs did not remove, as well as the 16 providers that were paid $8.5 million by Medicare for services rendered after their exclusion date, to CMS for further review and action. From August 2015 to May 2016, CMS has provided updates on these referrals. On the basis of our analysis of CMS's updates, CMS did not take action on 2 providers because CMS deemed the providers eligible. Further, CMS has not completed the review on 14 providers that were reported to be excluded and had submitted claims for payments.[28]

Criminal-Background Screening Procedures

As part of CMS's enrollment-screening process, CMS has controls in place to verify criminal-background information for providers and suppliers in PECOS. CMS may deny or revoke a provider's or supplier's enrollment in the Medicare program if, within the 10 years before enrollment or revalidation of enrollment, the provider, supplier, or any owner or managing employee of the provider or supplier was convicted of a federal or state felony offense, including certain felony crimes against persons, that CMS has determined to be detrimental to the best interests

[26]We calculated the Medicare claims data paid from 2005 to 2013 to the excluded providers and suppliers by considering only claims paid for services rendered after the exclusion date through the date CMS or MACs found the providers or suppliers to be excluded, since providers' and suppliers' exclusion periods could have expired after March 2013.

[27]One MAC conducted additional research on one of the two providers and found that the provider was listed in the HHS OIG list; however, it was not in the Medicare Exclusion Database. It is unknown why the provider was not listed in the Medicare Exclusion Database. The other MAC searched the other provider and did not identify this provider in the System for Award Management or LEIE.

[28]The remaining 14 cases were provided to CMS in April 2015. As of May 2016, CMS has not provided supporting documentation that it has completed the review of theses providers.

of the program and its beneficiaries.[29] In our April 2016 report, we found that 16 out of 66 potentially ineligible providers we identified with criminal backgrounds received $1.3 million in potential overpayments. These providers were convicted of drug and controlled substance, health-care, mail and wire fraud, or sex-related offenses and were enrolled in Medicare before CMS had implemented more-extensive background check processes in April 2014.

Before CMS revised procedures for reviewing the criminal backgrounds of existing and prospective Medicare providers and suppliers in April 2014, the agency relied on verifying applicants' self-reported adverse legal actions by checking whether providers and suppliers had previously lost their licenses because of a conviction such as a crime against a person. CMS also checked whether the HHS OIG had excluded providers and suppliers from participating in federal health-care programs. According to CMS, it also relied on Zone Program Integrity Contractors (ZPIC) to identify providers and suppliers with a conviction history. However, CMS did not always have access to federal or state offense information that identified the cause of a provider's or supplier's license suspension or exclusion from participating in federal health-care programs, which could have led to an earlier ineligibility date.

In our April 2016 report, we found 52 providers whose offenses occurred before the removal effective date that was provided to us by the MACs and 14 additional providers that CMS did not remove. As mentioned earlier, out of these 66 providers, 16 were paid about $1.3 million by Medicare through the fee-for-service program. Specifically, 10 providers were paid about $1.1 million between the time they were initially convicted of a crime and the time that they were officially removed from the program, and six other providers that were not removed were paid about $195,000 during the year after their conviction. We referred all 66 cases to CMS for further review and requested an initial status update on these providers by June 20, 2016. On May 16, 2016, CMS stated that it determined that 52 of the providers had already been deactivated or revoked; however, our report indicates that these providers were deactivated and revoked and the effective removal date needed review. Further, CMS indicated that it will continue to review these providers to

[29] 42 C.F.R. § 424.535 and 42 C.F.R. § 424.530.

determine whether additional updates or actions are needed since we found that theses providers had offenses that occurred before the removal effective date that was provided by the MACs. Further, CMS informed us that it will continue to review the remaining 14 providers.

Additionally, in April 2016, we reported that in April 2014 CMS implemented steps that provide more information on the criminal backgrounds of existing and prospective Medicare providers and suppliers than it obtained previously. Specifically, CMS supplemented its criminal-background controls by screening provider and supplier criminal backgrounds through an automated screening process. Under this revised process, MACs are to review an applicant's self-reported license information and whether the applicant has been excluded from participating in federal health-care programs. In addition, CMS receives information from ZPICs, which provide a conviction history on providers and suppliers they investigate. The automated-screening contractor is to supplement these controls by conducting criminal-background checks on providers, suppliers, and organization principals (i.e., individuals with 5 percent or more ownership in the business). The contractor uses third-party vendor applications available to the public to conduct the criminal-background checks. As a result, CMS and its contractors obtain greater access to data about federal and state offenses and the ability to conduct a more-comprehensive review of provider and supplier criminal backgrounds than in the past.

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

GAO Contact and Staff Acknowledgments

If you or your staff have any questions about this testimony, please contact me at (202) 512-6722 or bagdoyans@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement.

Individuals making key contributions to this testimony were Latesha Love, Assistant Director; Gloria Proa; Ariel Vega; and Georgette Hagans. Additionally, Marcus Corbin; Colin Fallon, and Maria McMullen provided technical support; Shana Wallace, Jim Ashley, and Melinda Cordero provided methodological guidance; and Brynn Rovito and Barbara Lewis provided legal counsel.

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Mr. MURPHY. Thank you. I appreciate it.

Dr. Agrawal, you are recognized for 5 minutes. Make sure the mic is close to you, please.

STATEMENT OF DR. SHANTANU AGRAWAL

Dr. AGRAWAL. Thank you. Chairman Murphy, Ranking Member DeGette, and members of the subcommittee, thank you for the invitation to discuss the Centers for Medicare and Medicaid Service's efforts to strengthen program integrity in the Medicare and Medicaid programs. We share the subcommittee's commitment to protecting beneficiaries and taxpayer dollars by ensuring only legitimate providers participate in our programs and reducing improper payments. I appreciate your longstanding interest in these important issues and I know you're interested in hearing about results and progress that we are making.

A critical component of progress comes from working with our colleagues in the HHS Office of Inspector General and the Government Accountability Office to address vulnerabilities they've uncovered. In the last year, CMS has implemented 38 GAO recommendations and 122 OIG recommendations across all CMS programs and has submitted documentation for approximately 100 additional GAO recommendations and 129 OIG recommendations for their review and closure. For example, we've made the address verification improvements that GAO recommended as part of their report last year. We also appreciate the work that the OIG is releasing today.

Provider enrollment is the gateway to the Medicare program. In the past, the provider enrollment process was a largely manual process which included manual checks of the information providers submitted. Since the ACA, we have made significant improvements to provider enrollment.

We've moved to a largely automated system utilizing risk based screening and other mechanisms to target our efforts and protect beneficiaries and taxpayer dollars. In 2015, we completed revalidating all current providers and suppliers under these new requirements. These new provider enrollment authorities have saved the Medicare program an estimated $1.4 billion since March 2011.

These administrative actions are part of a larger set of provider enrollment and screening activities which have saved the Medicare program 2.4 billion in avoided costs in total. This includes stopping the billing of more than 570,000 providers or suppliers. Increased screening efforts have led CMS to deny nearly 7,300 applications last year alone, preventing these providers or suppliers from ever submitting a single claim. Additionally, CMS has performed over 290,000 site visits to verify that a provider or supplier's practice location meets Medicare requirements.

The Affordable Care Act also requires that states conduct similar screening of providers participating in their Medicaid programs. While states and the federal government share Medicaid program integrity responsibilities, states bear the primary accountability for provider screening, credentialing and enrollment.

As their partners, CMS has taken a number of steps to assist states in fulfilling these requirements. CMS has dedicated staff to coordinate directly with each state, and we are providing technical assistance and extensive guidance such as the Medicaid Provider

Enrollment Compendium to assist states on those efforts. This includes giving states direct access to the PECOS database and allowing states to use a Medicare enrollment screening to meet Medicaid screening requirements, thereby reducing duplication of efforts.

We are also continuing our work to prevent improper payments across our programs. While we have made some progress, we know we have more work to do. It's important to remember that improper payments are not typically fraudulent payments. Rather, they are usually payments made for items or services that do not include the necessary documentation, that are incorrectly coded, or that do not meet Medicare's coverage and medical necessity criteria.

For example, over two-thirds of the Medicare fee-for-service improper payment rate comes from insufficient documentation. These are often instances in which a well-intentioned legitimate provider treated a Medicare beneficiary but didn't successfully complete their paperwork.

CMS has taken a number of corrective actions to address improper payments including expanding the use of prior authorization to make sure services are provided in compliance with Medicare coverage, coding and payment rules before services are rendered and claims are paid. We're increasing efforts to educate providers by offering additional guidance and simplifying policy requirements as well as conducting probe and educate pre-payment reviews for certain services.

As I stated earlier, we're also working with states in a number of ways to help them meet Medicaid provider enrollment requirements which are a significant driver of the Medicaid improper payment rate. CMS is committed to our efforts to prevent waste, abuse, and fraud in the Medicare and Medicaid programs, protecting both taxpayers and beneficiaries. The GAO and OIG are critical partners in these continuous improvements and these continuous efforts.

We look forward to continuing our partnership with GAO and OIG to work together on additional ways to identify and eliminate vulnerabilities and to strengthen both of these programs. Thank you, and I look forward to your questions.

[The prepared statement of Dr. Agrawal follows:]

STATEMENT OF

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

ON

"MEDICARE AND MEDICAID PROGRAM INTEGRITY: COMBATTING IMPROPER PAYMENTS AND INELIGIBLE PROVIDERS"

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

MAY 24, 2016

Statement of Shantanu Agrawal, M.D., on
"Medicare and Medicaid Program Integrity:
Combatting Improper Payments and Ineligible Providers"
U.S. House Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
May 24, 2016

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

CMS understands that it has a responsibility to make sure our programs pay the right amount, to the right party, for the right beneficiary, in accordance with the law and agency and state policies. CMS is focused on preventing fraud, waste, and abuse in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). Historically, CMS and our law enforcement partners have been dependent upon "pay and chase" activities, by working to identify and recoup fraudulent payments after claims were paid. Now, CMS is using a variety of tools, including innovative data analytics, to keep fraudsters out of our programs in the first place and to uncover fraudulent schemes and trends quickly before they drain valuable resources from our Trust Funds.

Insight and recommendations from the Government Accountability Office (GAO) and the Department of Health and Human Services Office of Inspector General (HHS-OIG) are a critical component of these efforts. In the last year, we have implemented 38 GAO recommendations and 122 recommendations from the HHS-OIG across all CMS programs, and have submitted

approximately 100 additional recommendations to the GAO and 129 to the HHS-OIG for their review and closure.

Our efforts to implement GAO and HHS-OIG recommendations stretch across our programs. For example, CMS will eliminate the use of beneficiaries' Social Security Numbers on Medicare cards by April 2019, as required by the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA), a step that both GAO[1] and HHS-OIG[2] have recommended to protect beneficiaries and prevent fraudulent activity. Based on input from the HHS-OIG[3], GAO, and stakeholders, over the past several years, CMS has broadened its initial focus of strengthening beneficiary access to prescribed drugs to also address fraud and drug abuse by making sure Part D sponsors implement effective safeguards and provide coverage for drug therapies that meet safety and efficacy standards. Today, CMS requires Part D plan sponsors to have drug utilization review systems, policies, and procedures designed to ensure that a review of the prescribed drug therapy is performed before each prescription is dispensed to an enrollee in a sponsor's Part D plan. CMS also issued a Final Rule that both establishes a new revocation authority for abusive prescribing patterns and requires most prescribers of Part D drugs to enroll in Medicare or have a valid opt-out affidavit on file. CMS has made a number of enhancements to the provider enrollment and revalidation process as the GAO has recommended,[4] which is described in more detail below. CMS also recently finalized the first overhaul of Medicaid and CHIP managed care regulations in more than a decade[5], and addresses several recommendations that the HHS-OIG has made in recent years[6] to strengthen program integrity in Medicaid and CHIP Managed Care. The final rule strengthens the fiscal transparency and integrity in Medicaid and CHIP managed care by requiring more transparency in the managed care rate setting process, adding a standard for the calculation and reporting of medical loss ratios, identifying minimum standards for

[1] http://www.gao.gov/products/GAO-13-761
[2] http://oig.hhs.gov/oei/reports/oei-02-10-00040.pdf
[3] http://oig.hhs.gov/oei/reports/oei-03-13-00030.pdf
[4] For more information: https://blog.cms.gov/2016/02/22/cms-strengthens-provider-and-supplier-enrollment-screening/
[5] https://www.federalregister.gov/articles/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered
[6] See, for example, OIG, *State and CMS Oversight of the Medicaid Managed Care Credentialing Process* (OEI-09-10-00270) (Nov. 2013), available at *http://oig.hhs.gov/oei/reports/oei-09-10-00270.pdf*; OIG, *Excluded Providers in Medicaid Managed Care Entities* (OEI-07-09-00630) (Feb. 2012), available at *https://oig.hhs.gov/oei/reports/oei-07-09-00630.pdf*; OIG, *Medicaid Managed Care: Fraud and Abuse Concerns Remain Despite Safeguards* (OEI-01-09-00550) (Dec. 2011), available at *http://oig.hhs.gov/oei/reports/oei-01-09-00550.pdf*.

provider screening and enrollment, expanding managed care plan responsibilities in program integrity efforts, and adding requirements related to encounter data submissions.

Our efforts strike an important balance: protecting beneficiary access to necessary health care services and reducing the administrative burden on legitimate providers and suppliers, while ensuring that taxpayer dollars are not lost to fraud, waste, and abuse. Fraud can inflict real harm on beneficiaries. Beneficiaries are at risk when fraudulent providers perform medically unnecessary tests, treatments, procedures, or surgeries, or prescribe dangerous drugs without thorough examinations or medical necessity. When we prevent fraud, we ensure that beneficiaries are less exposed to risks and harm from fraudulent providers, and are provided with improved access to quality health care from legitimate providers while preserving Trust Fund dollars.

Fraud Prevention System

In addition to traditional provider-enrollment activities, CMS' sophisticated predictive analytics technology, the Fraud Prevention System (FPS), identifies investigative leads to further protect the Medicare program from inappropriate billing practices and provide oversight on provider-enrollment actions. Since CMS implemented the technology in June 2011, the FPS has identified or prevented $820 million in inappropriate payments by identification of new leads or contribution to existing investigations; including approximately $242 million in cost-avoidance savings from revoking provider billing privileges as a result of FPS leads.[7]

CMS is required to have the HHS-OIG certify the savings and costs of the FPS. CMS achieved certification in the second and third year of the program. For the first time in the history of federal health care programs, the HHS-OIG certified a methodology to calculate cost avoidance due to removing a provider from the program. This is a critical achievement as moving towards prevention requires a clear measurement of the future costs avoided. During the third year (defined in statute as January 2014 – December 2014), the FPS identified or prevented $454 million in inappropriate payments through actions taken due to the FPS or through investigations

[7] Report to Congress: Fraud Prevention System Third Implementation Year. Available at: http://www.cms.gov/About-CMS/Components/CPI/Center-for-program-integrity.html

expedited, augmented, or corroborated by the FPS. Total savings were 80 percent higher in the third year than the savings from the previous implementation year, with a nearly 10:1 return on investment (ROI).

Provider Enrollment

A critical component to preventing fraud, waste and abuse is to ensure that only legitimate providers have the ability to bill our programs in the first place. Provider enrollment is the gateway to billing our programs, and CMS is engaging in new efforts to make sure that only legitimate providers are enrolling in Medicare, Medicaid, and CHIP. By preventing fraudulent or unqualified providers or suppliers from enrolling in the program and removing existing unqualified providers and suppliers, CMS ensures that fewer beneficiaries are exposed to risks and harm, and taxpayer dollars are spent only on services provided by legitimate providers and suppliers.

The Affordable Care Act provided tools, including the use of risk-based screening of providers and suppliers, to enhance our ability to screen providers and suppliers upon enrollment and identify those that possibly may be at heightened risk for committing fraud. In February 2011, CMS finalized regulations to implement categorical risk-based screening of newly enrolling Medicare and Medicaid providers and suppliers and revalidate all current providers and suppliers under new requirements established by the Affordable Care Act. Provider and supplier types in the "limited risk" category undergo verification of licensure, verification of compliance with federal regulations and state requirements, and various database checks. Provider and supplier types in the "moderate risk" or "high risk" categories undergo additional screening, including unannounced site visits. Additionally, owners with a five percent or greater direct or indirect ownership interest in a provider or supplier that are in the high risk category must consent to criminal background checks including fingerprinting. This risk based approach to provider screening allows CMS to target our resources as efficiently as possible, applying the most scrutiny to higher risk categories while limiting the burden and requirements on the types of providers and suppliers that pose a lower risk.

We are seeing real results from our efforts, and we estimate that Affordable Care Act authorities have saved the Medicare program $1.4 billion from revocations since March 2011, protecting both beneficiaries and the Medicare Trust Funds. These actions are part of a larger set of provider enrollment and screening activities which have saved the Medicare program $2.4 billion in avoided costs.[8] These savings reflect the actions CMS has taken to deactivate billing privileges for more than 543,100 providers and suppliers that do not meet Medicare requirements, and to revoke the enrollment and billing privileges of an additional 34,800 providers and suppliers since 2011.[9] Increased screening efforts have led CMS to deny 7,293 applications in the last 12 months (February 2015-February 2016) based on improved enrollment screening, preventing these providers or suppliers from ever submitting a claim.

Provider Enrollment in Medicare

Before they can bill Medicare, all providers and suppliers are required to undergo a baseline screening, including confirmation of the provider's or supplier's Social Security Number through the Social Security Administration and license and certification through the state licensing boards; and searches in the General Services Administration's (GSA) System for Award Management for Government contracting exclusion (suspension and debarments) and the HHS-OIG's exclusion list for all individuals listed on the application. Additionally, all Medicare providers and suppliers already enrolled prior to the new screening requirements becoming effective were sent revalidation notices, and those that did not respond or did not meet these new screening requirements had their billing privileges deactivated or revoked.

To enroll in the Medicare program, a provider or supplier may submit its enrollment application online using the Provider Enrollment, Chain and Ownership System (PECOS) or by paper by sending a CMS-855 to its Medicare Administrative Contractor. PECOS is a centralized database

[8] These savings estimates use the same methodology as the identified "costs avoided by revoking billing privileges" savings measure that was certified by the OIG in the 2nd and 3rd Year FPS Reports to Congress. Please see CMS' Report to Congress: Fraud Prevention System Third Implementation Year, for more information (available at: http://www.cms.gov/About-CMS/Components/CPI/Center-for-program-integrity.html). While these particular estimates have not been certified by the OIG, they reflect comparable calculations applied to actions taken under authorities provided in both the Affordable Care Act and CMS' previously existing authorities.

[9] Deactivated providers and suppliers have their Medicare billing privileges stopped; however, their billing privileges can be restored upon the submission and approval of an updated enrollment application. Revoked providers and suppliers have their Medicare billing privileges terminated and are barred from re-entering the Medicare program for a period of one to three years, depending on the severity of the revocation.

that contains providers' and suppliers' enrollment information. When enrolling in Medicare, providers and suppliers (including physicians and non-physician practitioners) are required to supply on their application the address of the location from which they offer services, and we are taking steps to ensure that providers are practicing at the addresses they say they are in accordance with GAO's recommendations.

CMS is enhancing our address verification software in PECOS to better detect vacant or invalid addresses or commercial mail reporting agencies (CMRAs). Earlier this year, as recommended by the GAO, CMS replaced the previous PECOS address verification software with new software that includes Delivery Point Verification (DPV) in addition to the previous functionality. This new DPV functionality flags addresses that may be vacant, CMRAs, or invalid addresses. CMS is now continuously monitoring and identifying addresses that may have become vacant or non-operational after initial enrollment. This monitoring is done through monthly data analysis that validates provider and supplier enrollment practice location addresses against the U.S. Postal Service address verification database. Earlier this year, CMS also began deactivating providers and suppliers that have not billed Medicare in the last 13 months.[10] This approach will remove providers and suppliers with potentially invalid addresses from PECOS without requiring site visits. This work will strengthen the integrity of the Medicare program while minimizing burden on the provider and supplier community.

Additionally, CMS uses site visits to verify that a provider's or supplier's practice location meets Medicare requirements, which helps prevent questionable providers and suppliers from enrolling or maintaining enrollment in the Medicare program. As of May 2016, CMS has performed over 290,000 site visits on Medicare providers and suppliers since 2011. CMS has the authority, when deemed necessary, to perform onsite review of a provider or supplier to verify that the enrollment information submitted to CMS or its agents is accurate and to determine compliance with Medicare enrollment requirements.[11] Under this authority, CMS has increased site visits,

[10] Note: Providers and suppliers that may be exempted from the deactivation for non-billing include: those enrolled solely to order, refer, prescribe; or certain specialty types (e.g., pediatricians, dentists and mass immunizers (roster billers)).
[11] 42 C.F.R. 424.517

initially focusing on those providers and suppliers receiving high reimbursements by Medicare that are located in high risk geographic areas.

CMS has also made additional improvements to the National Site Visit Contractor (NSVC) training processes since the HHS-OIG completed a review of provider enrollment activities.[12] All NSVC inspectors are required to receive CMS approved training and testing and undergo annual retraining. In addition, reminders and updates to procedures are provided to the inspectors throughout the year through bulletins and newsletters. All site inspections are reviewed by an NSVC official before being submitted to CMS. In addition, certain site inspections undergo a second level of quality assurance by an independent official that includes interviews with the provider and the inspector. CMS may take corrective action based on the results of this process.

CMS Oversight of State Medicaid Provider Enrollment

Because Medicaid is jointly funded by states and the Federal Government and is administered by states within Federal guidelines, both the Federal Government and states have key roles as stewards of the program, and CMS and states work together closely to carry out these responsibilities.

States bear the primary responsibility for provider screening, credentialing, and enrollment for Medicaid. CMS has taken several steps to help states fulfill the requirement created by the Affordable Care Act to revalidate Medicaid providers. CMS has provided states with direct access to Medicare's PECOS enrollment database, as well as monthly PECOS data extracts that states can use to systematically compare state enrollment records against available PECOS information. CMS assigned staff to coordinate directly with each state and is providing extensive guidance and technical assistance to assist states on their revalidation efforts.

CMS published several toolkits to help address some of the most frequent findings from state program integrity reviews in the area of provider enrollment, both in fee-for-service and managed care. The toolkits address a wide range of issues, including issues with provider disclosures of ownership and control, business transactions, and criminal convictions; federal

[12] http://oig.hhs.gov/oei/reports/oei-03-13-00050.asp

database checks for excluded parties; and the reporting of adverse actions taken against providers to the HHS-OIG. The toolkits identify common issues observed and provide practical solutions that states can implement.[13] CMS has also taken several steps to help states conduct site visits and perform fingerprint-based criminal background checks for the relevant categories of providers.

In March 2016, CMS released additional guidance in the Medicaid Provider Enrollment Compendium[14] to help states in implementing various enrollment requirements including the site visit requirements and provider ownership disclosure requirements. CMS worked with the Federal Bureau of Investigation to publish guidance to help states implement fingerprint-based criminal background checks for providers in the high risk category.[15] CMS continues to help states implement the provider ownership disclosure requirements and other requirements through regular state program integrity reviews to assess the effectiveness of states' program integrity efforts.

As discussed earlier, CMS also recently finalized a rule[16] strengthening program integrity in Medicaid managed care by identifying minimum standards for provider screening and enrollment and expanding managed care plan responsibilities in program integrity efforts.

Enrollment Moratoria

CMS has used authority provided by the Affordable Care Act to impose temporary enrollment moratoria. The moratoria temporarily halted the enrollment of new home health agencies (HHAs) and ground ambulance suppliers in certain geographic areas, giving CMS the opportunity to analyze and monitor the existing provider and supplier base, as well as further focus additional fraud prevention and detection tools in these areas. CMS consulted with HHS-OIG and the Department of Justice, and found that fraud trends warranted these moratoria. Part of CMS' work included a review of key factors of potential fraud risk, including findings of a

[13] https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/frequent-findings-toolkits-121714.html
[14] https://www.medicaid.gov/affordablecareact/provisions/downloads/mpec-032116.pdf
[15] https://www.medicaid.gov/federal-policy-guidance/downloads/smd060115.pdf
[16] https://www.federalregister.gov/articles/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered

disproportionate number of providers and suppliers relative to beneficiaries, and extremely high utilization rates relative to comparable geographic areas. All the geographic areas named in the moratoria ranked high in these fraud risk factors. After imposing the initial moratoria on July 31, 2013, 848 HHAs and 14 ambulance companies in all geographic areas affected by the moratoria had their applications denied.[17]

Earlier this year, CMS released a Moratoria Provider and Supplier Services and Utilization Data Tool.[18] The tool uses ambulance and HHA paid claims data within CMS systems for Medicare fee-for-service beneficiaries. The data, which do not contain any individually identifiable information about Medicare beneficiaries or their providers, cover the period from October 1, 2014 to September 30, 2015, and are updated quarterly. The tool includes interactive maps and a dataset that shows national-, state-, and county-level provider and supplier services and utilization data for selected health service areas. For the first release, the data provide information on the number of Medicare ambulance suppliers and home health providers servicing a geographic region, with moratoria regions at the state and county level clearly indicated, and the number of Medicare beneficiaries who use one of these services. The data can also be used to reveal the degree to which use of these services is related to the number of providers and suppliers servicing a geographic region. Provider and supplier services and utilization data by geographic regions are easily compared using the interactive maps.

Efforts to Identify and Address Improper Payments

CMS takes seriously our responsibility to limit improper payments and ensure that taxpayers' dollars are spent wisely. It is important to remember that improper payments are not typically fraudulent payments. Rather, they are usually payments made for items or services that do not meet Medicare or Medicaid's coverage and medical necessity criteria, that are incorrectly coded, or that do not include the necessary documentation. Correctly recording and documenting medical services is an important part of good stewardship of these programs, and we strive to improve these practices among providers serving Medicare, Medicaid, and CHIP beneficiaries.

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[17] https://www.federalregister.gov/articles/2016/02/02/2016-01835/medicare-medicaid-and-childrens-health-insurance-programs-announcement-of-the-extended-temporary

[18] https://data.cms.gov/moratoria-data

While some progress has been made, we must and we will continue our work to reduce the improper payment rates in Medicare, Medicaid, and CHIP. We experienced reductions in the Medicare-fee for service error rate from 2014 to 2015, as CMS's "Two Midnight" rule and corresponding educational efforts led to a reduction in improper inpatient hospitals claims. The improper payment rate for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) also decreased. Corrective actions implemented over a six-year period, including the DMEPOS Accreditation Program, contractor visits to large supplier sites, competitive bidding, and a demonstration testing prior authorization of power mobility devices, contributed to the reduction in the improper payment rate for these items and supplies.

We know we have more work to do to sustain this progress and meet improper payment rate reduction targets. One area in Medicare fee-for-service on which we are focusing our efforts is in home health services, which have had particularly high improper payment rates in recent years, mainly due to documentation errors. To address this, CMS has made changes to what providers need to submit in order to comply with our payment policies and clarified these policies for providers. CMS believes clarifying requirements will lead to a decrease in these errors and improve provider compliance with regulatory requirements, while continuing to strengthen the integrity of the Medicare program. To ensure providers understand the regulations and documentation requirements, CMS has implemented a probe and educate program for all home health agencies. This program reviews a small number of claims for every home health agency, identifies whether the reviewed claims complied with Medicare policies, and offers education to providers who require assistance in properly documenting home health claims.

CMS has also implemented additional prior authorization models to help make sure services are provided in compliance with Medicare coverage, coding, and payment rules before services are rendered and claims are paid. Through prior authorization, a request for provisional affirmation of coverage is submitted for review before a service is furnished to a beneficiary and before a claim is submitted for payment. Prior authorization does not create additional documentation requirements or delay medical service. It requires the same information that is currently necessary to support Medicare payment, but earlier in the process. Prior authorization is an

effective way to promote compliance with Medicare rules for some items and services and to help prevent improper payments before they occur.

In addition to certain power mobility devices (PMDs), CMS is now utilizing a prior authorization process in certain states for non-emergent hyperbaric oxygen therapy and repetitive scheduled non-emergent ambulance transports.[19] Lastly, CMS published a final regulation on December 30, 2015 establishing a prior authorization program for certain durable medical equipment, prosthetics, orthotics, and supplies items frequently subject to unnecessary utilization.[20]

The Medicare Prior Authorization of PMDs Demonstration was initially implemented in California, Illinois, Michigan, New York, North Carolina, Florida, and Texas. Since implementation, we have observed a decrease in expenditures for PMDs in the demonstration states and non-demonstration states. Based on claims processed from September 1, 2012 through June 2015, monthly expenditures for the PMD codes included in the demonstration decreased from $12 million to $3 million in the seven original demonstration states, without affecting beneficiary access to appropriate services. Subsequently, we expanded the demonstration to twelve additional states[21] on October 1, 2014. Based on claims processed from September 1, 2012 through June 2015, monthly expenditures in these twelve additional states decreased from $10 million to $2 million. On July 15, 2015, we extended the demonstration for all nineteen states until August 31, 2018. Monthly expenditure also decreased in the non-demonstration states, from $10 million in September 2012 to $3 million in June 2015.[22]

We also have more work to do to meet error rate reduction targets in Medicare Advantage, Medicaid, and CHIP. To better address and prevent improper payments in Medicare Advantage,

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[19] For more information: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Prior-Authorization-Initiatives/Prior-Authorization-Initiatives-.html

[20] https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Prior-Authorization-Initiatives/Downloads/DMEPOS_6050_Final_12_30_15.pdf

[21] Maryland, New Jersey, Pennsylvania, Indiana, Kentucky, Ohio, Georgia, Tennessee, Louisiana, Missouri, Washington, and Arizona.

[22] https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/PMDDemoOctoberStatusUpdate10142015.pdf

in December 2015, CMS issued a Request for Information (RFI)[23] to solicit feedback on a proposal to contract with one or more Recovery Auditors (RA) to identify and correct improper payments in Medicare Advantage through a significantly expanded Risk Adjustment Data Validation (RADV) audit initiative. As a result of existing RADV audits and new regulations requiring Medicare Advantage organizations to report and return identified overpayments, during FY 2015, Medicare Advantage Organizations reported and returned approximately $650 million in overpayments.

Medicaid and CHIP also experienced increases with their improper payment rates from fiscal year 2014 to 2015. Similar to FY 2014, the primary reason for the increase was related to state difficulties bringing systems into compliance with certain requirements, including that all referring or ordering providers be enrolled in Medicaid and that states screen providers under a risk-based screening process prior to enrollment. While these requirements will ultimately strengthen Medicaid's integrity, it is not unusual to see increases in improper payment rates following the implementation of new requirements because it takes time for states to make systems changes required for compliance.

Conclusion

CMS is deeply committed to our efforts to prevent waste, fraud and abuse in Medicare and Medicaid programs, protecting both taxpayers and the beneficiaries that we serve. The GAO and HHS-OIG are critical partners in these continuous improvement efforts, and both programs are stronger today as a direct result of their insights. We look forward to continuing our partnership with GAO and OIG to work together on additional ways to identify and eliminate vulnerabilities and to strengthen both of these programs.

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[23] https://www.fbo.gov/index?s=opportunity&mode=form&id=83f1ec085c52a81a6a6ce7cba3ffbc5d&tab=core&_cview=0

Mr. MURPHY. Thank you. We will now begin questions. I will begin and recognize myself for 5 minutes. First, Ms. Maxwell, I want to discuss what this improper payment rate really does mean. Some kinds of fraud would not actually be captured in the improper payments, am I correct?

Ms. MAXWELL. That's correct.

Mr. MURPHY. And some fraud schemes would remain undetected through auditing and data mining, and sometimes you actually need human intelligence such as whistle blowers or investigators especially when it comes to patient services, is that correct?

Ms. MAXWELL. Absolutely.

Mr. MURPHY. And even though there are data mining tools for provider addresses that are inaccurate, you still are going to have to have some investigators go on site, those boots on the ground to determine whether or not a provider is legitimate. Is that your view as well?

Ms. MAXWELL. Absolutely.

Mr. MURPHY. OK. And Mr. Bagdoyan, if improper payments don't capture many types of fraud, then is the CMS improper payment rate really a good indicator of payments that should not have been made?

Mr. BAGDOYAN. Well, I think it's probably not the best indicator for fraud——

Mr. MURPHY. Bring your microphone closer.

Mr. BAGDOYAN. I'm sorry. It's probably not the best indicator for fraud monitoring, but in terms of improper payments it's probably the best available as long as the methodology used to develop it is executed properly. But that's obviously a contingency on each agency that reports these numbers.

Mr. MURPHY. Exactly. Dr. Agrawal, both HHS and GAO have cited numerous concerns with the Medicare administrative contractors' decision to enroll and revalidate providers into the Medicare program. CMS hires outside contractors to verify provider eligibility.

So specifically, reports from both agencies identify several instances in which the contractors approved enrollment applications even though the provider site visit did not meet CMS standards. So in one OIG report, contractors conducting site visits found that 651 provider facilities were not even operational despite notes such the facility is closed, on the doors, or this building has been vacated and suite appears closed and abandoned, over half of those providers still made it on to Medicare's enrollment system. So how is CMS holding the contractors accountable for poor enrollment decisions? What are you doing?

Dr. AGRAWAL. Yes. I think that's an important question and I appreciate the work of the OIG in this area. There were specific recommendations contained in their report which we have acted on. So they have, for example, recommended streamlining, simplifying the site visit forms which we are working on.

Mr. MURPHY. Well, is it the form's fault? I am asking how you are going to hold them accountable.

Dr. AGRAWAL. I think in part we want to make sure that the process works well. That if——

Mr. MURPHY. Well, it doesn't.

Dr. AGRAWAL. Well, that if that there are elements of the process that need to be changed like the way contractors interact with each other, the forms that they utilize, that we make those changes. Then——

Mr. MURPHY. I don't want to go down that road. If it says this place is closed, there is nothing there, there is a padlock on the door, what paperwork is going to help you to understand that that facility is closed and you shouldn't be billing out of that facility? That is you.

Dr. AGRAWAL. Sure.

Mr. MURPHY. What are you going to do? Are you going to revoke their ability to have a contract? Are they going to be fined for sending you fraudulent information? What is it?

Dr. AGRAWAL. I think part of the answer is prevention to make sure that changes are made to ensure better processes in the future. Part of it is looking at the referrals that the OIG has given us, which we are working through to better understand exactly what——

Mr. MURPHY. That is enough. I have had enough double talk. Look, show me that slide up here of the trend. I want to—no, because I want to get the point. I want you to hold these guys accountable.

Dr. AGRAWAL. Sir, if you'll give me a couple minutes or even a few seconds, I can add to that point.

Mr. MURPHY. OK, I will give you a chance.

Dr. AGRAWAL. Thank you. So like I said, I think getting to specific cases where things might have fallen through the cracks as indicated in the OIG report is really important, because then we can have specific discussions with the contractors about what transpired and hold them appropriately accountable.

Mr. MURPHY. OK.

Dr. AGRAWAL. Without that evidence and data we would be having a, you know, high level, general discussion.

Mr. MURPHY. Well, I appreciate that because they have given you some real valuable data, and I know you are a problem solver because you are an emergency room physician.

I want to show a slide up here of a trend, if they can show that slide, please. This is on the Medicare fee-for-service programs. And does it look like the error rate is moving in the right direction here over the last—which one is it? There we go. Does that look like it is moving in the right direction, that error rate? It doesn't seem to me. Am I correct?

Dr. AGRAWAL. I think what you see in that chart is a significant increase in the error rate when new requirements are created that providers have to meet.

Mr. MURPHY. OK.

Dr. AGRAWAL. And that was driven largely by the ACA. Necessary requirements for program integrity to make sure that we are paying for the right service to the right beneficiary.

Mr. MURPHY. Is it a valid metric? Do you think these are valid metrics or do we need to be looking at other metrics when it comes to——

Dr. AGRAWAL. I think we have to be careful about what it is and what it isn't. It is not a very good measure of fraud. It would not

capture the most common fraud scheme which is prosecuted on a daily basis which is the presence of kickbacks in a provider relationship.

Mr. MURPHY. Sure.

Dr. AGRAWAL. What the improper payment rate does is it compares billing, the claims that we receive against medical records that the provider has and that we don't see at the time of claims payment. If you were to just look at claims payments in and of itself, CMS pays claims accurately an extremely high percentage of the time, well over 99 percent of the time.

What the cert contractor does or the improper payment contractor does is it grabs a sample of 50,000 claims out of a pool of a billion, and then it asks for the underlying medical record documentation from the physician or DME company or whatever, and it looks at that documentation and compares it against the claim.

Again, we don't see that documentation at the time of claims payment, something that we are changing through things like prior authorization. And roughly 12 percent of the time there's a discrepancy between what's in the medical record simply not being sufficient enough to justify a claim——

Mr. MURPHY. Thank you. I know I am over time. And I appreciate that and that is important to get those records correct, and I appreciate what Ms. DeGette brought up in terms of the number of payments that you are correcting. I think it was about 800 and some million dollars, and that is good news.

It is just with these other things, I am sure you are aware of the frustration of the American people in this, and Congress. When we are trying to find money for programs we are told we don't have it. To see it going to foreign offices or places that are closed it is very frustrating to us, particularly as we are trying to find funding for some things to help save lives in mental health.

Dr. AGRAWAL. Could I just comment on that a little bit? So removing all of those places, again because the way the improper payment rate is measured and it looks at medical records, it does not do site visits, it does not talk to beneficiaries or providers, closing those places would not have an impact on the improper payment rate, right. This is a medical record review that is compared against claims.

Mr. MURPHY. I understand. I understand. I am talking about payments to places that are closed.

And Ms. DeGette, you are recognized for 5 minutes.

Ms. DEGETTE. Thank you, Mr. Chairman. I think we all agree we need to reduce waste, fraud and abuse. We can just stipulate to that on a permanent basis, OK. Yes.

Mr. MURPHY. So ordered.

Ms. DEGETTE. One of the problems that we have had as we heard from the OIG is that the states with respect to Medicaid have not fully implemented provider screening tools like fingerprinting, criminal background checks and site visit. The deadline for the states to complete revalidation from all the providers has slipped as has the deadline for full implementation of criminal background checks.

And so I guess I want to ask you, Dr. Agrawal, if you have some sense if the states are having to lead in preventing fraud in Med-

icaid, what can we do to make those states who are lagging behind comply?

Dr. AGRAWAL. Yes, I appreciate the question. You correctly point out that states really have to take the lead in terms of safeguarding their own——

Ms. DEGETTE. This is a state-administered program.

Dr. AGRAWAL. Exactly right. So, and I appreciate very much the recommendations from both OIG and GAO on these issues. We have responded by trying to provide technical assistance to the states, literally giving states a person that they can call directly on my team to make sure that they are aware of the requirements and can get whatever assistance they need to meet them.

Ms. DEGETTE. And what kind of response are you getting from the states?

Dr. AGRAWAL. I think generally it's really interactive. I mean, they do want more guidance. That led us to release the Medicaid Provider Enrollment Compendium earlier this year to give them that. They wanted more access to Medicare enrollment data so we gave them real-time access to our enrollment data.

They wanted access to law enforcement data so we actually negotiated on their behalf real-time access to the FBI state level criminal data, which we believe all of those efforts and states really taking a proactive stance on this will help get them into compliance.

Ms. DEGETTE. Well, I also want to ask you about the improper payment rate for the Medicaid program that the chairman was referencing with his chart which increased last year from 6.7 percent to 9.8 percent. Do you know what has driven the uptick in the improper payment rate?

Dr. AGRAWAL. Yes. First, let me say the way the improper payment rate in Medicaid is calculated is that we sample 19 states every year at three cycles of—I'm sorry, 17 states that then get us over a 3-year period to assess the entire Medicaid program. What that means is we are currently in cycle 3 now. The first cycle was 2 years ago, and that was the first time that new ACA requirements were introduced in the PERM measurement.

These ACA requirements are things like provider enrollment, things like making sure that we have the NPI——

Ms. DEGETTE. Right, OK.

Dr. AGRAWAL [continuing]. Of attending physician on every claim. So those are driving the rate at this point.

Ms. DEGETTE. So this is your third year. So why has the rate gone up, because you are still completely getting the data?

Dr. AGRAWAL. No. Well, I think the rate has gone up because of lack of complete state compliance with these new ACA requirements. And so we expected to see a trend of frankly increase every year as we sampled more and more states and looked at how they were implementing——

Ms. DEGETTE. And so what can we do to make the rate go down?

Dr. AGRAWAL. Yes, great question. So——

Ms. DEGETTE. Thank you.

Dr. AGRAWAL. I think it is the combination of numerous different efforts. It is working with states, collaborating with them, making sure that they're clear on these requirements, giving them access to the data if they need it. We have provided federal matching

funds for system changes so that they can get NPIs reported on claims.

It's not a single solution, it's a multitude of solutions to ultimately get states moving in the right direction. And if they don't, if, you know, those solutions don't work, then I think we have to talk seriously about accountability for the states.

Ms. DEGETTE. So I just want to thank you for that and I just want to add, if there is something your agency thinks Congress can be doing to help this nudge this along we are happy to do it.

And I would like to point out, earlier this year the House passed H.R. 3716, the Ensuring Access to Quality Medicaid Providers Act which our own Representative Bucshon and Welch co-sponsored. And what this does is it requires states to report the termination of an individual or entity from its Medicaid program to a database maintained by the CMS. The Administration supports the bill. The House passed it by 406 to 0, so maybe we could get our friends on the other side of the Capitol to pass it. That might be beginning assistance, but anything else we can do, we are really serious about this.

And the chairman is right. People say all the time, well, we can fund this. We should just eliminate waste, fraud, and abuse. But it is not so easy to do especially when you are relying on the states. So I appreciate you and your efforts and I appreciate the other agencies in helping you to find new tools to do it. Anything we can do to participate, let us know.

Thanks, and I yield back.

Dr. AGRAWAL. Thank you.

Mr. MURPHY. The gentlelady yields back. I now recognize the vice chairman of this committee, Mr. McKinley of West Virginia, for 5 minutes.

Mr. MCKINLEY. Thank you, Mr. Chairman. To try to get through a series of questions quickly with you, the first is perhaps with Mr. Bagdoyan. Just quickly, do you think that telemedicine is contributing to the potential abuse?

Mr. BAGDOYAN. That's an excellent question, Mr. McKinley, but that's not in the scope of the work I've done and I have no expertise in that. So I couldn't respond to that.

Mr. MCKINLEY. OK. Could you find out from someone in the panel or elsewhere is what the impact that could be, because people practicing without license in a state there could be abuse. I would like to follow up with that.

Now with Dr. Agrawal, thank you for once again appearing before us, there are a series of questions I have quickly with you. We talk about this pay and chase, but before I get to the pay and chase issue what about using the technology that we have today, the internet, Skype, whatever, to be able to try to get some of that utilization particularly for people that have, groups that have abused the system or maybe have been mischarging?

Could we, do you have an idea of what the cost would be to implement something, then in real time you would be able to make a phone call or a Skype information or something to be able to get that for a pre-approval before they offer these services? Have you looked into that what that cost could be?

Dr. AGRAWAL. Yes. I think very important question. We have tried diligently over the last few years to move away from a pay and chase model to one that emphasizes prevention. Along the lines of your question, we've implemented the Fraud Prevention System which is a predictive analytics technology. Congress authorized the implementation of this system as well as funded it for its initial 4 years of implementation.

Mr. MCKINLEY. What about just someone picking up the phone or talking to someone, a real person? Not a press one or press two, but actually talking to somebody. I have got this patient and these are the conditions, is this going to be OK?

Dr. AGRAWAL. Well, what you are highlighting essentially is a prior authorization process which is used extensively.

Mr. MCKINLEY. I don't want to do it for everyone, as that penalizes everyone. I am looking at people that have perhaps been known to have made mistakes before so that we clarify, so it is a very single. So you have not looked into it—because I really want to get to my last two questions quickly.

We have one of the things when we meet back in the district we keep hearing there is a lack of uniformity in the application for reimbursement and different rules are being applied to different regions of the country.

I know in West Virginia and in Ohio there is a separation of just over a thousand feet. The river separates between West Virginia and Ohio. But yet the contractors are two different contractors, and using almost exactly the same circumstance the one in Ohio is being reimbursed differently than the one in West Virginia. And similarly to that, that the denial rate, the initial denial rate is 90 percent. Ninety, 89 percent for West Virginia, but in Ohio it is only ten percent.

So as a result of that denial rate, a lot of the West Virginia providers are having to go out and get lines of credit and increase their cost of doing business because they are not being reimbursed in a timely fashion. What are we going to do? Why is there such a disparity between two regions separated by merely a thousand feet?

Dr. AGRAWAL. Without the specifics of a case it's hard to comment, but there are legitimate——

Mr. MCKINLEY. We sent CMS those specifics. So we have not heard back, so we can send them again.

Dr. AGRAWAL. I would love to certainly see them and be happy to follow up with you. There are lots of things that can drive differences across geographies. First, the way that providers practice, the way that they submit bills to the agency——

Mr. MCKINLEY. Ninety percent versus ten percent?

Dr. AGRAWAL. There are also other coverage decisions that are different, like local coverage determinations that can vary from one region of Medicare to another. So a multitude of factors can figure into this. Again, I'm happy to work on a particular case if that would be relevant for you.

Mr. MCKINLEY. Well, I think it is more than just a particular case. It is something uniformly when I go back to the district this is something we hear from providers time and time again. Because we enjoy the—we are right there on the border. We can contrast

what they are doing in Ohio for reimbursement as compared to what they are in West Virginia. So I guess we can have further conversation, but I appreciate your answers on this and I hope we can work together.

The last is this thing, you have instituted a 3-year demonstration program to possibly do a prior authorization. Why is it across the board? Why isn't it more just for those that have a history of perhaps violating the system? Because that way everybody is being punished this way. This doesn't make sense.

Dr. AGRAWAL. We have implemented through a demo approach prior authorization in ambulance services, again in certain geographies, in certain DME supplies and certain geographies. We have found that prior auth can be a really useful tool because it narrows that gap between the medical record and the claim which helps to reduce the improper payment rate and reduce expenditure kind of accordingly.

I'm very open to more focused prior authorization, really focused on bad actors and folks that have high denial rates. However, I think before we get there we have to get more experience.

Mr. MCKINLEY. What I want to get at it is the use of technology that we have today.

Dr. AGRAWAL. Sure.

Mr. MCKINLEY. If we have all this internet access let's use it and be able to—so I yield back my time.

Dr. AGRAWAL. I appreciate it.

Mr. MURPHY. The gentleman yields back, and I recognize the gentlelady from Florida, Ms. Castor, for 5 minutes.

Ms. CASTOR. Thank you very much, Mr. Chairman, and good morning and thank you to the panel. I am glad we have the opportunity to discuss rooting out the fraudsters in Medicare and Medicaid and tackling the problem of insufficient documentation, because we want every dollar in Medicare and Medicaid to go to the health services of our neighbors.

And when you look at the size and scope of all of the health services under Medicare and Medicaid it really is daunting. Over 125 million Americans receive their health services that way, whether it is in the hospital or the doctor's office or under Medicaid in skilled nursing or for our neighbors with disabilities. So because of the size and the scope, fraud and improper payments have been an ongoing challenge.

But with the passage of the Affordable Care Act in 2010, we now have these more effective, more significant new tools to go out to go after these fraudsters and try to reduce some of the improper payments. I think everyone wants the agencies to be as nimble and as aggressive and as effective as you can be about doing this.

So Dr. Agrawal, I would like to ask you about the Affordable Care Act's anti-fraud measures and how they have strengthened Medicare and Medicaid. Share with us, what are the most effective tools now that we are 6 years after the adoption of the ACA? I know it was kind of cloudy early on. People, heck, we are still voting to repeal it here in the Congress, but in the meantime we have wanted you to be as aggressive as possible on using these new tools.

What are the most effective new tools so far that were provided under the Affordable Care Act?

Dr. AGRAWAL. Sure. So in the ACA, provider enrollment is an extremely useful tool. I think we have significantly changed the way we enroll providers from pre-ACA years. And while there are clearly are refinements that we can continue to make, I just want to remind everybody that we have revalidated every single provider and supplier in Medicare.

Through that and other actions we have disenrolled over 500,000 providers who are no longer able to build a program. Just from site visits and finding nonoperational providers we've removed 1,900 providers from the system, from licensure checks over 19,000. So again I think the numbers are important. We can clearly continue to make progress, but that's a really useful set of tools for us.

We also have new tools that put us on the prevention end of our activities, so things like payment suspensions where we are able to suspend all payments to a provider pending an investigation and potentially other administrative actions. That prevents us from making payments to potentially bad providers on the front end.

Working with Medicare and increased Medicare and Medicaid data sharing, another feature of the ACA, I think extremely important, can continue to be improved. But that allows us to see when a state has taken an action against a provider to see if it should be duplicated in Medicare, and for states to exchange data with each other.

We've seen significant state uptake of that kind of transparency to each other and seen some real results with refinements that we will continue to work on. So I think without the ACA we would be in a substantially different place in this program than where we are today.

Ms. CASTOR. Ms. Maxwell, the same question. You highlighted at the beginning of your testimony that the Affordable Care Act provisions now provide more rigorous tools to root out fraudsters and to tackle insufficient documentation. From your point of view, what have been the most effective tools provided under the ACA?

Ms. MAXWELL. Thank you for the question. We do believe the tools really change the possibilities for the strengthening of the provider enrollment. And while we looked at the implementation of both Medicaid and Medicare, what we really came away with was the potential for maximizing their utilization.

We think the tools have great promise and we want to make sure that Medicaid and Medicare are extracting the full promise from those tools, so that the Medicaid systems implement all the tools that are available to them and the Medicare program implements them to their fullest degree. So we think they have tremendous potential and we hope that our recommendations will be of assistance in making them even stronger.

Ms. CASTOR. So you have both highlighted problems with state implementation, whether it is the criminal background checks or getting some things done. My time is running out, but if you could quickly say is this a capacity problem at the state level? Is there a reluctance at the state level because of the political cloud that has hung over the Affordable Care Act for many years? Or is it just a lack of funds, a lack of action, a lack of technical know-how?

Ms. MAXWELL. Well, the states reported to us that they were facing operational challenges with specifics in terms of the fingerprint background checks. It's a new process for them. It's difficult to operationalize, and also resource concerns.

Ms. CASTOR. Dr. Agrawal.

Dr. AGRAWAL. I think that's right. These are complicated expectations that we are placing on the states. There's lots of requirements. There are, I think, a lot of operational challenges. I think that is why they're asking for more data, access to more guidance, which we are providing. These things will take time, but I see states making progress.

Ms. CASTOR. Thank you very much.

Mr. MURPHY. The gentlelady's time is expired. I recognize the gentleman from Virginia, Mr. Griffith, for 5 minutes.

Mr. GRIFFITH. Thank you very much, Mr. Chairman. If I could pick up on the questioning that the gentlelady was asking, you indicated, and I may have misunderstood that there were some complications and I would address this to Ms. Maxwell or Dr. Agrawal, there were some complications but it sounded like when I was listening to the testimony that we were talking about fingerprinting and criminal background checks and many of the states are already doing that for lots of other things. Why is that complicated?

Dr. AGRAWAL. I think what we've heard from the states is that they'd like better access to real-time law enforcement data so that their fingerprint checks are higher in accuracy. And we heard that loud and clear from a number of states. They also wanted more guidance about how we implemented these checks in Medicare.

So we've given them that guidance, and then on their behalf got them access to FBI state level criminal data so that they can bump their fingerprint checks against that database. And so we look to states now making significant progress since we've armed them with these tools.

Mr. GRIFFITH. I guess I am just curious, because checking both the national and the state with the fingerprint has been something that has been done, background checks have been done for quite some time at least in the Commonwealth of Virginia that I represent, but I didn't realize some states were not doing that.

Mr. Bagdoyan, in your testimony you have indicated of course, and we have already heard today about the weaknesses in the CMS' verification of provider practice location, physician licensure status, et cetera, and you said you had made some recommendations which CMS indicated they would implement or are taking steps to address.

What specifically did you recommend to them that they might do to improve that because obviously it is a little shocking when you find out that we have got money potentially going to empty office buildings or to a UPS mail drop?

Mr. BAGDOYAN. Right. Well, thank you for your question. Regarding the locations it was a software issue, a screening software issue where it was lacking some critical flags like whether it's a mailbox, whether it's an empty lot, or it's just not recognized by the Postal Service. So CMS took this to heart, they did some work and went ahead and upgraded the software with a new package that has

these flags. This is a relatively recent development so we'll see going forward how effective that's going to be.

Regarding——

Mr. GRIFFITH. And do you think that was the software providers' problem? Because it seems to me that that would have been something normal that we shouldn't in 2016 or even in 2015 be thinking, well, shucks, we ought to check to see if somebody really is there. Is that something new, or is this just that their software failed them?

Mr. BAGDOYAN. It's not new. We have the software from the Postal Service that we use at GAO for various forensic audits. It's relatively inexpensive and easy to use. However, at the time CMS purchased its own software, I'm not sure what kinds of requirements definitions they made of the contractor or requirements to the contractor regarding requirements of the software. So I can't speak to that in any depth, but forward-looking CMS is moving in the right direction.

Mr. GRIFFITH. And I appreciate that. But Ms. Maxwell, if the Postal Service has a system that they use for this that GAO uses to check up on things, why did you all go out and spend money on something else? And can you tell me, I know you may not have that off the top of your head, but can you give us the information on how much you spent on a software program when the Postal Service had one that was fairly effective and easy to use, according to Mr. Bagdoyan?

Ms. MAXWELL. If I'm understanding your question correctly, I believe that's directed to CMS, about the database?

Mr. GRIFFITH. Yes.

Ms. MAXWELL. We did not look particularly at that. The work that we did looked at the information that was in the data system about provider ownership and found discrepancies in that information as well. And in totality, I would say having the correct address, having the correct owner's name is critical to making the proper enrollment decision. You need that information to make a decision.

Mr. GRIFFITH. So I should have asked that question of you.

Dr. AGRAWAL. I was thinking of bailing her out, but then——

Mr. GRIFFITH. So why are we, I mean, how do I tell my taxpayers back home that we are getting our dollars' worth when we are going out and reinventing the wheel, when the Postal Service already has something that would at least tell us whether or not that was an address that actually existed or was in the middle of the river somewhere?

Dr. AGRAWAL. Right. So the Postal Service, I think the GAO identified a very useful tool for us. We have integrated that into our systems. Now, there's a difference in integrating a tool like that into your systems, making sure that it cross-talks with other databases, making sure that you have a process behind it that's very different than what's conducted in an audit where a few people get access with a license to the database. So it will inherently be more expensive to actually get it fully integrated with our other work.

I also do want to make the point that the data is a great source of lead information, but it also can produce false positives. So we saw that in the sample provided to us by the GAO as well.

Mr. GRIFFITH. My apologies because my time is out, but I have got two things I would like for you all to respond to at a later date. One, how do you rank with the private industry as far as your being able to identify fraud; and two, I like telemedicine, so let's figure out a way we can make that work because I heard somebody else say earlier they were worried about that creating fraud, but for rural districts it is very important. And I yield back.

Dr. AGRAWAL. Thank you.

Mr. MURPHY. Thank you. Mr. Pallone is recognized for 5 minutes.

Mr. PALLONE. Thank you.

Dr. Agrawal, thank you for appearing here today. The Affordable Care Act gives CMS a number of new tools and expanded authorities to reduce fraud and improper payments in both Medicaid and Medicare. For example, the ACA required increased scrutiny of providers and suppliers who have historically posed a higher risk of fraud or abuse to either program, and this heightened screening process applies to providers and suppliers that are attempting to enroll in these programs or are revalidating their participation.

So let me ask, Dr. Agrawal, can you describe how CMS uses this risk based screening method and applies different standards to providers and suppliers in each category of risk, and how does this approach help us protect against fraud and how does this compare to what private payers do before they enroll providers and suppliers?

Dr. AGRAWAL. Sure. So the ACA required that we segment provider categories into three different risk groups: a high risk, a moderate risk, and a limited risk. Certain enrollment and screening requirements are applied across the board, often the ones that we can do in an automated fashion like confirming licensure or certification.

There are certain other screening requirements that are leveraged against a higher risk provider types. Newly enrolling DME companies, for example, or home health agencies, these are provider categories that have had historical issues with fraud in that group. And so we've leveraged greater tools to address their enrollment like site visits, criminal background checks that are fingerprint based.

So what this enrollment approach allows us to do is really respond to the risk where it exists. We've done that in collaboration with law enforcement, with the Office of Inspector General in making sure that we are not overburdening providers but at the same time getting additional data so that we can make the right enrollment decision.

Mr. PALLONE. Now how many providers and suppliers have been subject to the enhanced screening requirements at this point in the Medicare program?

Dr. AGRAWAL. So at this point all of them have. We've done that in an automated fashion, but also through the revalidation process which went to every single provider and supplier in Medicare, about 1.6 million. What we've seen as far as results is 500,000 providers that don't meet our requirements for one reason or another.

Nineteen thousand of those were merely for licensure requirements. They didn't have the appropriate certification. Another about 1,900 that weren't operational. So again these are, I think, important numbers. They show the impact of this kind of screening.

Mr. PALLONE. And certain ones of those have lost their ability to bill Medicare then as a result?

Dr. AGRAWAL. Absolutely.

Mr. PALLONE. OK. I wanted to go Ms. Maxwell. I think these screening tools show promise in lowering fraud rates and I am sure that HHS OIG sees the importance of using them, but also understand that you believe they need to be more widely used particularly by some state Medicaid programs, and the OIG found that a number of states were lagging behind in implementing provider enrollment and screening procedures.

So Ms. Maxwell, does the HHS OIG see value in these tools, and how do we help states use them more comprehensively?

Ms. MAXWELL. The goal of our work is to ensure the maximum value from these tools both for the Medicaid program and for the Medicare program. And you're absolutely right that we believe that the way to do that for the Medicaid program is to have all the tools implemented. We know not many states are already doing the criminal background checks, some states are not doing site visits, and some states are going to miss their revalidation deadline. So I think that's the way to strengthen the Medicaid program.

Mr. PALLONE. But how are you going to help the states use these things more comprehensively?

Ms. MAXWELL. Our recommendation is for CMS to assist. As we've been talking about here it does certainly rely on the states to step up and to implement many of these tools, but we see a way for CMS to assist them, providing technical assistance, providing more guidance that we heard states really wanted.

In addition, there's a possibility of reducing burden on the states by allowing them to better substitute their screening for Medicare screening. And we heard from states that they often were reluctant to do that out of concerns with the data in the Medicare enrollment database.

Mr. PALLONE. OK. Let me go back to Dr. Agrawal for my last question. Can you give us an update on what you are doing to help the states get to the finish line, and what is the crux of the issue here? Do states need additional technical assistance and guidance?

Dr. AGRAWAL. Sure, and I think it dovetails nicely with what the OIG has recommended. We are providing more technical assistance. Every single state has a person they can call in my office for help and guidance on how to implement these requirements. We put out the most comprehensive set of guidances really in the last few months that we have ever provided to the states so that they know step by step what they have to do to meet all of their enrollment requirements.

We've given them real-time access to Medicare data and the guidance that if we have already enrolled and screened a Medicare provider they don't have to duplicate that effort on their end, which is better for the state, better for the provider. And finally we've given them access to criminal justice or law enforcement data to

make sure that they can implement the fingerprint based background checks through an FBI database that they have now real-time access to.

Mr. PALLONE. All right. Thanks so much. Thanks, Mr. Chairman.

Mr. MURPHY. I now recognize Mr. Bucshon for five minutes.

Mr. BUCSHON. Thank you, and thank you to the witnesses. I had practiced cardiovascular and thoracic surgery before. I think most of you, many of you know that. So I understand some of this from a provider perspective.

We did pass legislation in the House, 3716, and I think the Senate will be taking that up. It is common sense to prevent providers from going to another state and getting on the system when they have been fraudulent or ineffective practitioners in the previous state.

Medicare by the way does a good job in their billing services. I mean, when I was in practice electronic claims paid more quickly in general than the private sector and more accurately in many respects. So I just want to say that there are things that the Medicare system does very well.

There are things that because of the size of the program there is some trouble. One of those, and you talk about incorrect payments being, Dr. Agrawal, two-thirds being documentation issues. I can tell you why that is and you probably can tell me too, because it has to do with the complexity of sometimes physician documentation.

I was a surgeon. I will give you an example. Right after the surgery I always did a handwritten note about what I did in the case. I didn't have the codes specifically in front of me and describe the procedure exactly the way that it might say, especially now under ICD–10, so and that will be paid probably fairly quickly based on my handwritten operative note.

And then when the dictated note comes through, which sometimes can be weeks, there may be a slight discrepancy, and then when you go back and review the case you will find a discrepancy in billing and say that that is an improper payment. So some of that I don't know what you can do to address, I mean, address that situation. It is difficult as a provider sometimes to make everything perfectly line up even though there is no intent to defraud the program.

Dr. AGRAWAL. Yes. That's a great and very concrete example, Dr. Bucshon. So I think you might be right that you might generate an improper payment unfortunately from that note, maybe not. But I think what's important to keep in mind for you and your colleagues is that is not fraud, right, nor would anybody at the agency——

Mr. BUCSHON. Right.

Dr. AGRAWAL [continuing]. Say that you have tried to commit fraud. That shows you in a real-world, I think, example how we differentiate improper payments from the more concerning fraud and abuse activity. You're absolutely right, also, about our documentation requirements, so I think there's a few things we can do. We are working on educating physicians and other providers about what those requirements are through our probe and educate and other kinds of approaches.

Second, I think we can streamline some of our requirements where appropriate, so if there are excess requirements that no longer belong I think we have looked at them and decreased them wherever possible. You saw this in the two-midnight rule and the home health face-to-face requirement.

And three, and I think again a useful tool that we are exploring is prior authorization. It's getting to see that medical record before a service is offered so that the physician isn't on the hook, and then before a payment is made so that we are really being preventive of issues.

Mr. BUCSHON. Yes, I think that is good because a lot of those numbers could be improved. I mean, well intended practitioners, you know, you end up having an improper payment and you are on this percentage list, but it really is not.

Another thing is, is fraud a moving target? Obviously it is. I mean, my concern is as I mentioned, Medicare and many other payers are going to electronic payment method. In fact, Medicare, I think you have to do that if you want to participate. Do we have strong enough cyber experts? Is any of this related to cyber related type of issues through Medicare? I mean, is—or not?

Dr. AGRAWAL. Yes. You're absolutely right that fraud is a moving target, which is why I think it's important to invest in flexible tools that you can use across a variety of issues. I mean, things like automated screening. Things like automated real-time claims checking.

I think cybersecurity is definitely a priority for the agency. We have focused on it. We track medical identity theft issues or potential issues so that we can intervene where appropriate. Congress has recently required and funded a change to the Medicare HICN number so that we can be more proactive on these kind of identify theft issues. I do think that that's a component of the world that we are seeing and we're being proactive in making sure our systems are secure and then we respond to vulnerabilities where they are.

Mr. BUCSHON. OK, and I am running out of time. But the other thing is, is in certain respects maybe we need to look at whether or not criminal penalties for defrauding the federal government and this type of thing are strong enough to deter people from trying to do it. Someone said years ago, they asked a bank robber why they robbed banks, and because they said that is where the money is. These programs have billions and billions of potential money and that is why this is an ongoing struggle.

And Dr. Agrawal, I just want to say I appreciate your efforts in what you are doing. I know that it is a difficult problem to tackle and I know that you are trying to do the best job that you can to get ahead of this. Thank you. I yield back.

Dr. AGRAWAL. Thank you. I appreciate it.

Mr. MURPHY. Now Mr. Tonko is recognized for 5 minutes.

Mr. TONKO. Thank you, Mr. Chair, and welcome to our panelists. Under the ACA, the secretary of HHS has the authority to implement a temporary moratorium on the enrollment of new Medicare providers and suppliers. This is particularly useful, I believe, because if CMS sees a possible trend in fraud such as overutilization of a certain type of service or product, new enrollment can be tem-

porarily suspended while suspect activity is investigated. This approach ensures that if a bad actor enters the program, the fraud can be limited and corrective actions or additional controls can be put in place.

So with that said, Ms. Maxwell, can you tell us why having the ability to temporarily suspend enrollment for suppliers or providers is an important tool, and what can it do for reducing fraud or abuse?

Ms. MAXWELL. Thank you for that question. We are here to talk about the critical role that provider enrollment plays and that is part of the tools that are available. We want to make sure that the programs are not doing business with people whose intent is to defraud the program, and the way to do that ideally is to prevent them from getting in the program in the first place. So we were talking about the particular role of screening tools, but the moratorium offers a different tool to prevent that from happening.

Mr. TONKO. And also, Ms. Maxwell, can you explain for us why having a temporary moratorium helps us from further limiting the pay and chase problem that has been so problematic over the years?

Ms. MAXWELL. Absolutely. As I said in my opening statement, enrollment is the green light to start treating beneficiaries and to start billing. And so our best opportunity to not let that happen is to prevent them getting in the program in the first place. So that would be strong provider enrollment screening tools, moratorium, and other ways to make sure that we know exactly who we're doing business with and we are comfortable letting them treat our patients and paying them.

Mr. TONKO. And also, CMS has the authority to temporarily suspend enrollment in certain categories of suppliers or providers. This is a useful tool, I would think, in reducing fraud and abuse also. So Dr. Agrawal, can you explain how enrollment moratoria have boosted the agency's efforts to limit fraud and improper payments in the Medicare programs?

Dr. AGRAWAL. Sure. And I agree with Ms. Maxwell that closing that doorway to Medicare can be a very important tool. The moratoria essentially allows us to pause enrollment in a certain geographic area for certain providers.

We have implemented it in the areas of home health and ambulance services in a number of geographic areas. We're currently evaluating the impact of the moratorium. It certainly allows us to step up our efforts in those areas as well as working with law enforcement. What we have found so far is that in moratoria area we have removed about 900 providers that no longer meet our requirements or that after an investigation are found to be fraudulent or abusive of the program.

So I think it can be a very useful tool to open up that investigative possibility. And we have also, we are working with states to approve any moratoria that they would like to implement in the Medicaid program.

Mr. TONKO. Great. And how often would you say these tools are reached to?

Dr. AGRAWAL. I'm sorry?

Mr. TONKO. How often are you reaching to this kind of tool in the kit? Is it frequent? Is it——

Dr. AGRAWAL. I think with respect to the moratoria we want to be careful with it. We want to make sure that we are implementing it in clear geographic areas where there is saturation of certain provider types. We put out data for the public recently to better understand where we are seeing these issues, clearly showing problems in the areas we have the moratorium.

I think while we gather data on what it's doing, what it allows us to accomplish, I want to be very careful that we don't just sort of use it all over the place and potentially impact legitimate access to services.

Mr. TONKO. And then also, Dr. Agrawal, what steps are being taken by CMS to ensure that enrollment moratoria do not adversely affect Medicare beneficiaries' access to medical assistance?

Dr. AGRAWAL. Yes. So I think part of it is being really methodical about where we implement the moratoria, making sure that we're responding to clear indicators of market saturation. We are also tracking access to services in real time, making sure that beneficiaries continue to enjoy the legitimate access to services, and working with states so that there's on the ground reporting. If the data doesn't show it we might still hear anecdotes and other inputs from the states.

So far I will tell you, given where we started and the extreme levels of market saturation, we are not at a place yet really in any of the moratoria area where we would start to impinge upon legitimate access to services.

Mr. TONKO. OK. Well, it is good to know, and I thank you all again for serving as witnesses on this important topic, so thank you. I yield back.

Mr. MURPHY. The gentleman yields back. Thank you. I now recognize Mr. Collins of New York for 5 minutes.

Mr. COLLINS. Thank you, Mr. Chairman. And boy, I thought I was upset the last time we got together, and I can't even get my mind around this, Dr. Agrawal. And since you are part of my stump speech on pretty much a weekly basis, and I don't mean that in a complimentary way, I do know your name well.

So 2013, error rate 5.8. Oh, what was your goal in '14? 5.8. Not exactly a private sector mindset. Didn't hit 5.8, hit 6.7. Oh, so the next year your goal was 6.7. Ah, didn't hit that either. It was 9.8. Can I kind of connect these dots? Is your goal this year 9.8? You just keep raising it. What is your goal this year?

Dr. AGRAWAL. Congressman, I think what you're referring to is what we expect to see in the Medicaid improper payment rate as——

Mr. COLLINS. Yes, that is all I am asking. It was 5.8, went to 6.7, went from 6.7 to 9.8. What is your goal this year? Do you have one? Is it 9.8?

Dr. AGRAWAL. Congressman, I can get you that goal, but I will tell you that——

Mr. COLLINS. Oh, you don't even have it.

Dr. AGRAWAL. I will tell you that we expect to see the numbers——

Mr. COLLINS. Now you have really blown my mind. We are halfway into 2016, and in your position you can't even tell me what your expected error rate is this year? We don't work in the same universe. Lean Six Sigma, as I brought that up last time. We allow in the private sector three errors, 3.4 errors per million transactions. 3.4. You had 97,800 errors per million last year. 97,800.

Could you imagine, Mr. Chairman, what we would be talking about today if American Express screwed up 97,800 transactions out of a million? Could you imagine if Google or Amazon screwed up 97,800 transactions out of a million? I can't even conceive of the outrage.

And Dr. Agrawal, here we sit today with last year your goal was 67,000 per million, you got 97,800, and here we are at the end of May in 2016 and you can't even tell me today what error rate is your goal for 2016. I am guessing you have blown the mind of everybody in this room and anybody watching this.

Taxpayers in my world as we have argued on this committee and others, even the other day Zika virus, we need more money. We want more money. We don't have more money. We want more spending for NIH cancer research. That is the one thing that I can assure you that the Democrats remind us of all the time, we want more money. You know, we have to balance our deficits, our debt and our obligation to taxpayers and future generations.

And here you are in your seat accepting 97,800 errors per one million transactions, and from the tone of what I have heard so far I would presume you actually think you are doing a good job. Is that a fair statement? Do you think you are doing a good job? That is a yes or no. Do you think you are doing a good job?

Dr. AGRAWAL. There are clearly improvements that we are working on making.

Mr. COLLINS. You know what, again you can't even answer a question. Are you doing a good job? That is a yes or no. Do you think you are? Yes or no.

Dr. AGRAWAL. There are clearly improvements that we are working on making.

Mr. COLLINS. And has everyone heard me ask him a yes or no question and you heard the answer? He couldn't even answer yes or no. I think you can understand why—last year I asked Dr. Agrawal a straightforward question. I said, "Dr. Agrawal, if you worked for me how long do you think you would last?" Took Agrawal about 20 seconds to answer that question and at the end his comment was, respectfully, Mr. Congressman, I hope I never work for you.

So let me answer the question right now and be clear because we never really got there. If you worked for me you would be fired this afternoon. And I yield back.

Mr. MURPHY. The gentleman yields back. Do you need to——

Ms. DEGETTE. Chairman, I find it very abusive of the witnesses and I just, I think that is really objectionable. I would just like to put that in the record.

Mr. MURPHY. Well, I would like to see if the witness has an answer that he wants to respond.

Dr. AGRAWAL. No, I don't.

Mr. MURPHY. Thank you. Then I recognize Mr. Green for 5 minutes.

Mr. GREEN. Thank you, Mr. Chairman. Last year, CMS reported that its advanced analytics computer system called the Fraud Prevention System did find and prevented 820 million in improper payments for the first 3 years of use. This system assisted predictive analytics to identify billing patterns that appear suspect, may be improper or even fraudulent. The Fraud Prevention System is similar to systems used by credit card companies.

Dr. Agrawal, can you explain in more detail how this system works and how it is applied and how CMS has used it to protect tax dollars?

Dr. AGRAWAL. Sure. So the Fraud Prevention System—and we do appreciate the support Congress has provided to implement and fund this system—what it does is it streams Medicare claims in real time, about four and a half million claims per day. It bumps those claims against established algorithms, which are predictive algorithms and other kinds, based on what we find going on in the field that are indicative of potential fraud or abuse. And it flags both the claims and the associated providers so that it can prioritize and protect the downstream investigations.

The impact from the FPS has clearly been extremely important. It put us clearly on a path away from pay and chase towards prevention where we can prioritize the right investigations and take actions more quickly. The OIG has certified the ROI from the system showing that it is very positive, and we look forward to releasing more data soon on how the system has continued to progress.

Mr. GREEN. And since that system was similar to those used by credit card companies in the private sector, do you compare your successes, compare your failures, with the private sector?

Dr. AGRAWAL. We are constantly communicating with the private sector. I meet regularly with my correlates in the private sector to see how they do their business on, across the range of things that we're engaged in from analytics to provider enrollment.

What we see, what we are using the FPS for is sort of two main missions. One is to directly deny claims wherever we can, so if a claim comes in that shouldn't be paid on the face of it we will deny that claim through the FPS. And second, to really direct our investigative resources so that they're being well spent and producing real return.

And again, here, I think we've seen significantly improved returns on investment, 5 to 1, 2 years ago, 10 to 1 last year, and we're—oh, I'm sorry, 10 to 1, 2 years ago, and we're working on numbers for last year to release.

Mr. GREEN. OK. As I mentioned in the beginning of my questions, CMS reported last year that the Fraud Prevention System has assisted in identifying and preventing about 820 million in inappropriate or improper payments. Can you tell me more about this figure and how did CMS accomplish this?

Dr. AGRAWAL. Sure. The FPS, in addition to being able to deny claims where there's clear payment policy and the claim doesn't meet it, what it's also able to do is identify new providers that might not have yet sort of shown up on our radar based on the field

work and intelligence that we have and it can also corroborate data that we already have, making the investigation more efficient.

What we do is we work with our investigators to get from them knowledge that they have from the field in doing this kind of work to let us know what kind of analytical models would be helpful in their work, what kind of data they need to see on the front end that would be helpful.

What we've found is that by taking that input in and putting it into the Fraud Prevention System, we can actually give investigators access to data that they might otherwise take weeks, maybe even months to put together themselves. This allows them to act as quickly as possible on the data that they're seeing and to intervene. I'll give you one example.

We have a model that's focused on ambulance providers, ambulance services. What we found was by giving access to an investigator for in that model they were able to take an action based on $1,500 worth of claims that had been sent in to the agency because we had short cut the time for that data investigation and for them to get to the administrative action.

That really moves us towards a prevention system where, otherwise without the FPS that provider might have billed the program for far more money before they were ultimately caught.

Mr. GREEN. Well, and I know, and I represent a Houston area where one time we were the wheelchair, motorized wheelchair capital of the world, I think, and also with ambulance with transfers. How do you anticipate the program will work in the coming years? Do you see similar results getting better, so to speak?

Dr. AGRAWAL. Yes. We are focused on continuous improvement of that program. So we have recently acquired a new contractor and we'll be building the 2.0 version of the system. Our aims are to make the system more efficient so that models can be implemented more quickly, more efficiently for lower cost to help continue to improve the ROI.

We also would like to direct these models to address a wider spectrum of activities so that there are still fraud and abuse oriented models, but also other ones that are looking at waste and outlier behavior to help direct other kinds of audit resources. And finally, really bolstering and boosting the kinds of edits that we have in the system so that claims can be denied even without the need for a subsequent investigation.

Mr. GREEN. OK. Thank you, Mr. Chairman.

Mr. MURPHY. The gentleman yields back. I now recognize Mr. Flores of Texas for 5 minutes.

Mr. FLORES. Thank you, Mr. Chairman, and I thank the panel for joining us today. I want to expand on some of the prior questions from Mr. Green and Mr. Collins. Let me start by saying this.

Earlier, the panel discussed the new tools that resulted from the ACA, but all of us here today know that HHS and CMS reportedly made $89 million in improper payments in 2015 alone. We also know that there are additional costs associated with these improper payments. So the critical issue is, what is HHS and CMS doing to deal with these?

And so I want to continue, I want us to think outside the box for a minute. Not in the typical model the way the federal bureauc-

racy thinks about things, but about how would we do this if we were a private entity. And Mr. Collins talked about the differences in the error rates between the federal government and also between that and between the private sector. We have seen the same issues at the IRS in terms of improper refunds. It seems to be a bureaucracy culturally related issue more than anything else.

And so, Mr. Agrawal, I would ask you this question. Well, let me say this. I will give you some stats that I have that are a little different than what Mr. Collins had. If you look at Visa's global fraud rate it's 0.06 percent or 6 cents for every $100 that has been of transactions. If you look at CMS it is $10 per $100. So could you tell us, Dr. Agrawal, why the error rate is so high for a federal program versus the private sector?

Dr. AGRAWAL. Yes. I think it's important, Congressman, to differentiate again the improper payment rate from fraud. As we've been discussing the improper payment rate is primarily driven by documentation issues. Really, it's incapable of uncovering the kind of fraud that we are clearly all concerned about.

Those documentation issues are what we are working on. They drive 70 percent of the Medicare fee-for-service rate. There's a host of things that we can do to try to get it down, but primarily focused around getting providers more up to speed with our requirements, making sure the requirements are right, and then as much as possible in areas of high error really looking at that documentation before payments are made so that we can make sure that errors are not produced, that the right payments are being made, and ultimately that appeals are unnecessary because we won't be denying claims or there won't be a post-pay review that then leads to a denial.

So I think it can be better in that regard, but those are the major initiatives that we have around us.

Mr. FLORES. Earlier today you had said something that you collaborate with your private sector colleagues or peers. What has CMS learned from the private sector and what do you intend to try to implement based on those learnings?

Dr. AGRAWAL. Sure. Yes, so we have, I think, near constant contact with the private sector, my analogs in private insurance companies that are looking at the same issues. The first thing I'd say is, as a government agency we have to be transparent, appropriately so, about things like the improper payment rate.

Private insurers also have the same sets of issues. They have documentation errors and coding errors that they see in their systems that are just not made transparent to the public because they're not required to be. So their approaches are very similar to ours. They have implemented prior authorization to a far greater degree than what we've been able to do so far because we are acting within the authorities that we have and there are proposals, a President's budget proposal to increase those authorities. So they use that as a very common tool.

I think, secondly, they use provider enrollment just as we do. What I often hear from my colleagues is that they use Medicare enrollment as their gold standard. If somebody has met Medicare enrollment requirements they assume that they can meet their own

enrollment requirements, but where they have extra flexibility is the ability to network however they choose.

So if there is a provider that is simply not driving value for their network that they don't need that many of a particular provider type in their network, the provider's producing a lot of errors, they can just remove them from the network. They don't have to actually go through the process of trying to prove that the provider was fraudulent or abusive. That's a level of flexibility that frankly doesn't exist in the Medicare or Medicaid programs.

Mr. FLORES. Ms. Maxwell, what are some things that the federal government can do to emulate the private sector to be more judicious with taxpayer dollars?

Ms. MAXWELL. I can offer some ways in which the Office of Inspector General has tackled this issue that I think have been successful, and that is really targeting our approach and putting a wide array of disciplines and resources where we see problems, watching those problems get driven down and then moving our focus to someplace else.

So for example, we have a concerted effort in home health and we watch those payments go down a billion dollars a year. We know there's a high payment rate in ERFs in patient rehab facilities. We're focusing resources there. So I think we have found tremendous success in the IG's office in gathering people across disciplines and really focusing them on high risk areas.

Mr. FLORES. OK. I have run out of time, but if any of my colleagues have some leftover time I will take that and continue this line of questioning. Thank you, and I yield back.

Mr. MURPHY. Thank you. I will recognize Mr. Mullin of Oklahoma for 5 minutes.

Mr. MULLIN. Thank you, Mr. Chairman. Excuse me, Doctor, if I get your name wrong, but it is Agrawal?

Dr. AGRAWAL. Agrawal. I think you got it.

Mr. MULLIN. OK. Well, it is the Oklahoma accent if I didn't get it. You know, a couple of questions and some follow-up questions, the controls that CMS has put in how do we know they are working?

Dr. AGRAWAL. Well, I think there's a variety of controls and we see that they're working because they're having impact. So something like provider enrollment we can see——

Mr. MULLIN. Measurable impact how? And I say this because in our state in Oklahoma we are having to take some serious cuts to Medicaid. And the one thing we have been looking at in our task force is from cutting down on the fraud and abuse. So what specifically can you show us that the controls are actually working?

Dr. AGRAWAL. I can show you, including in Oklahoma, the over 500,000 providers that are no longer allowed to bill the program. I can show you, including in Oklahoma, the site visits that have produced nonoperational settings that have been kicked out of the program; the providers that don't have appropriate licensure that have been kicked out of the program. I can show you the $5 billion in payments that we have stopped from going out the door just last year prior to any payments being made. There's impact from the Fraud Prevention System.

Mr. MULLIN. What is the percentages of the improper payments right now?

Dr. AGRAWAL. In the Medicare fee-for-service program it's 12.1 percent.

Mr. MULLIN. What was it in 2014?

Dr. AGRAWAL. It was lower. I'm sorry, it was higher. It was 12.5 or 12.6 percent.

Mr. MULLIN. So we have dropped two percentage points?

Dr. AGRAWAL. About 0.5, I think.

Mr. MULLIN. Well, you said 0.2 and 0.7; is that what you said?

Dr. AGRAWAL. Yes.

Mr. MULLIN. And how long have these controls been in effect?

Dr. AGRAWAL. Well, every year we have to do new things to try to get the improper payment rate down, so sometimes it's expanding efforts that we have already underway, other times it's new efforts.

Mr. MULLIN. But we are talking about a half of a percentage point. It is still well over ten percent. In a company, in any company that would be disastrous. I mean, in any company making that much improper payments would sink any business. And we are OK with that?

Dr. AGRAWAL. We are not OK with that. We are——

Mr. MULLIN. Then if we can identify where the improper payments are, then why can't we do something to change it?

Dr. AGRAWAL. Well, it's——

Mr. MULLIN. If you can identify the percentage at 12.2 percent, then you can identify the source because that is the only way you can come up with the dollars. So——

Dr. AGRAWAL. Correct, we can. So the primary sources of the improper payment rate are home health providers. They have an over 50 percent rate in home health billing.

Mr. MULLIN. Does it have anything to do with, because you keep talking about the doctors themselves of the facilities themselves. Are we looking at the patient?

Dr. AGRAWAL. The improper payment rates are it's driven by documentation——

Mr. MULLIN. I am talking about fraud and abuse as a whole.

Dr. AGRAWAL. But it is not driven by fraud and abuse, right. The improper payment rate is driven by documentation problems. Seventy percent of the rate is provider-driven documentation issues. That is in, for example, the home health space, lack of coordination between the ordering physician and the home health agency to take care of the patient.

Mr. MULLIN. So where would you see it to be in a year from now? You recognize 12.2 percent, so where would you like it to be in a year?

Dr. AGRAWAL. I would like it to be significantly lower.

Mr. MULLIN. What is significant, a half of a percentage point?

Dr. AGRAWAL. I don't wake up every day trying to figure out how I can massage——

Mr. MULLIN. I would.

Dr. AGRAWAL [continuing]. The number by 0.1, 0.2.

Mr. MULLIN. You would if as a business owner——

Dr. AGRAWAL. I wanted to implement——

Mr. MULLIN. I have been a business owner my whole life. And I promise you, you pay attention to the pennies, the dollars take care of themselves. So a half a percentage point here and there and everywhere else, yes, it does take a significant impact over time. So if I was you I would wake up every morning.

Dr. AGRAWAL. Congressman, I think you have connected two things that shouldn't be. So lowering the improper payment rate will not necessarily change the amount of expenditure of the program, and that is because in order to——

Mr. MULLIN. How do you figure if you have got 12.2 percent of improper payments that it wouldn't make a significant impact? What is 12.2 percent? How much is that?

Dr. AGRAWAL. Let me answer that question, sir. So since documentation problems are the primary driver of the rate, what we can do by better educating providers and looking at documentation on the front end is that they meet our requirements. That would knock down the rate but not necessarily the expenditure.

Mr. MULLIN. How much did we spend on improper payments last year?

Dr. AGRAWAL. I believe in the Medicare fee-for-service program it was on the order of about 45 billion, according to the number.

Mr. MULLIN. $45 billion.

Dr. AGRAWAL. Right.

Mr. MULLIN. And we don't think that is going to have a significant impact?

Dr. AGRAWAL. What I said, and I want to be specific about that is lowering the improper payment rate might not alter the expenditure. We have seen that in certain examples.

Mr. MULLIN. Well, it would sure help the taxpayers knowing that $45 billion isn't going out the door when we can identify that it is 12.2 percent and yet we can't stop it.

Mr. Chairman, I yield back.

Mr. MURPHY. I now recognize Mr. Bilirakis for 5 minutes.

Mr. BILIRAKIS. Thank you. Thank you, Mr. Chairman. Thanks for letting me sit in on this hearing.

Ms. Maxwell, back in December, the IG's Office issued a report titled, CMS Could Not Effectively Ensure That Advanced Premium Tax Credit Payments Made under the Affordable Care Act Were Only for Enrollees Who Paid Their Premiums. The question, can you talk about what the Inspector General's Office found and what they recommended, please?

Ms. MAXWELL. Thank you for the question. Yes, ensuring appropriate payments in the marketplace program is a priority for the OIG just like it is for the Medicaid and Medicare program. And I am generally aware of the audit that you are talking about, although I was not specifically involved in it.

So generally, my understanding of the findings is that we found some weaknesses in CMS's internal controls to ensure the accuracy of cost sharing payments for qualified individuals in the marketplace. And my understanding of those internal weaknesses is that CMS at the time was relying on self-attestation from the insurers about the amounts that CMS owed the insurers and had no independent way to verify that information.

But as I said, that's what I know of the topic but I am not an expert. We do have experts on that topic back in the office and I'd be happy to get them in touch with you to brief you further and in more detail about that report.

Mr. BILIRAKIS. Oh, I appreciate that. Has CMS implemented all the IG's recommendations?

Ms. MAXWELL. I am not familiar with that but I'd be sure to get back to you with that information, yes.

Mr. BILIRAKIS. OK. How about this? Has the Inspector General inspected CMS' new automated processing system?

Ms. MAXWELL. The APS?

Mr. BILIRAKIS. I do not believe that is in our work plan right now. We are looking more broadly at the totality of their enhanced provider screening system.

Mr. BILIRAKIS. How about this? Is CMS' automated processing system in place for both federal-run and state-run exchanges?

Ms. MAXWELL. I am not aware, and again I would refer you to the experts back in the office.

Mr. BILIRAKIS. My understanding is that CMS did not comment on your second recommendation, the IG's recommendation for sharing payment data with the IRS to verify an individual's Form 1095–A at tax time. Can you explain what needs to be done and why is this so important?

Ms. MAXWELL. We take all of our recommendations seriously and expect engagement with the operating division around them. Again, I think you'd be best off talking to the team that did the work and could brief your staff on all the details and where we are with our engagement with CMS to implement those recommendations.

Mr. BILIRAKIS. But you can't tell me why it is important that they comply?

Ms. MAXWELL. I am so sorry, but that is outside of the work that I typically do and I am not that familiar with that study.

Mr. BILIRAKIS. All right. Well, I am going to follow up.

Ms. MAXWELL. Please do. Thank you.

Mr. BILIRAKIS. All right, thank you. I yield back, Mr. Chairman.

Mr. BUCSHON. Would the gentleman yield some of his time for me?

Mr. BILIRAKIS. Yes, I will, absolutely.

Mr. BUCSHON. Thank you. I just want to clear up with Dr. Agrawal, we were talking that last line of questioning about improper payments because I made the comments about physician documentation.

I mean, and again clarify the difference between an improper payment, what percentage of improper payments do you think ultimately are resolved and found to be proper payments? I would imagine they are a very, very high percentage. And what percentage approximately would be considered fraudulent? There is a separation. I just want to clarify that and give you a chance to clarify that again.

Dr. AGRAWAL. Yes, I appreciate it. So I think what we find when we work with providers, make sure that they're educated on the documentation requirements, simplify those requirements where

necessary that we can actually get significant improvements in the rate.

I'll give you two examples. In the DME space, which is historically at a very high rate, we've seen a 30 percent reduction in just the last year; a similar 30 percent reduction in the hospital inpatient rate. Both of those are driven by new policy, the two-midnight rule as one example, as well as a probe and educate approach where we literally have gone to every single hospital in the country, pulled a claim sample to educate them on how better to send in the supporting documentation for that claim.

So we can see significant impact in the improper payment rate, but again we might be spending very similar if not the same amount of money because we're bringing people up to speed on what's required. I can't give you an actual estimate of fraud either as it relates to the improper payment rate or on its own. There just isn't a validated statistical methodology for generating a fraud rate. We are working on that in a pilot approach at CMS. Part of the challenge is for fraud you have to prove intentionality, and so that's challenging from a methodological standpoint.

Mr. BUCSHON. Thank you, I yield.

Mr. BILIRAKIS. And I will yield back. Thank you.

Mr. MURPHY. Mr. Flores, did you want the next 30 seconds?

Mr. FLORES. I don't think—no.

Mr. MURPHY. OK, then I will recognize Ms. Brooks for 5 minutes.

Ms. BROOKS. Thank you, Mr. Chairman. In 2014, nine employees in a dental center from my district in Anderson, Indiana, were charged with Medicaid fraud. Not only did the dental center submit false and inflated bills for dental services to the Indiana Medicaid program costing taxpayers well over $300,000, one of the practices, one of the individuals was not even licensed to practice yet continued to bill the Medicaid program for services.

Indiana's Attorney General Greg Zoeller put it best when he said, and I quote, when an ineligible provider engages in fraud to wrongly bill Medicaid for millions of dollars it is a violation of the public trust as we know and demonstrates contempt for the taxpayers, and it is as simple as that.

And this story is not unique. In the last 10 years, GAO has released at least seven reports indicating the possibility of fraud or improper payments in the Medicaid program. Health and Human Services OIG has released at least 31 reports and three more reports were released today.

So it truly is astonishing that after 10 years of albeit thoughtful reports, many reports, we have continued to allow our nation's largest health insurance programs to run really with this much fraud for this long of a period of time. But I am encouraged that we are continuing as a subcommittee to push for answers that protect beneficiaries as well as taxpayer dollars.

Ms. Maxwell, I am curious. The OIG report released today deals with enhanced provider enrollment screening in the Medicaid program. And while states are required to screen Medicaid providers using the enhanced screening procedures such as fingerprint based criminal background checks and site visits, many states haven't yet implemented these requirements. What is the significance of this

finding in the report and how will it impact improper payment rates?

Ms. MAXWELL. Thank you for the question. It is critical to get provider enrollment correct for the very reasons you mentioned. We do not want Medicaid paying providers who are unlicensed. We do not want Medicaid paying providers who are intent on defrauding the program. Our report points to the vulnerabilities that still exist in Medicaid provider enrollment, and primarily those vulnerabilities have to do with they have not instituted all of the tools available to them.

You mentioned the fingerprint criminal background check. There is also site visits. And in terms of the impact I can't quantify that precisely, but I do know from our report that 27 states reported that 25,000 high risk providers were enrolled in the Medicaid program without the benefit of those criminal background checks.

Ms. BROOKS. And so is it fair to say that CMS with respect to these findings you have provided a pretty clear pathway forward as to how they should implement these provider screenings.

Ms. MAXWELL. Yes. In the body of six reports that I'm addressing here today, we have over 20 recommendations that we believe are practical implementation fixes to make the tool stronger.

Ms. BROOKS. With respect to the Medicare provider database, OIG compared three sets of owners' names: the names listed on Medicare enrollment records, names submitted by providers directly to OIG for their evaluation, and names listed on state Medicaid enrollment records. And the OIG found that nearly all providers in the OIG's review had different names on record than the state Medicaid programs.

What is the significance of this finding and why does it matter that the databases didn't match? And is this an administrative issue or is it a possible indicator of fraud from your view?

Ms. MAXWELL. We are very concerned about that finding and I thank you for bringing it up. We think it is a concern that needs to be addressed to strengthen provider enrollment. And to just start with your methodological question, we matched those names. If those names were similar but the not the same we counted them as a match.

So we don't think we're actually capturing just clerical error, we think we're capturing a real schism between the two databases. The reason it's important is we want to know who we're doing business with. And if we don't know who we're doing business with we don't know whether or not they were excluded, and we have a lot of history with fraud of people being excluded from the program and then getting back in behind a straw owner.

And in fact, recently, the New York Medicaid program paid a straw owner $60 million over the course of multi-years' fraud scheme, three pharmacies, he was a front for his father who had been excluded from the program. So it has significant consequences, this mismatched data.

Ms. BROOKS. And like you mentioned in the previous question, there was a list of 20 recommendations that you have made. How about with respect to this matching of the databases? What should CMS do with your findings with respect to this?

Ms. MAXWELL. Well, first of all, we have referred the mismatches to CMS to look particularly at those cases so they can rectify the discrepancies between the data that we found. More long term, there are recommendations to improve the data, to verify the data, and then ultimately to think about better coordination between Medicaid and Medicare. We think better coordination could lead to a more effective system and a system that's less burdensome on providers.

Ms. BROOKS. Thank you. My time is up and I will yield back.

Mr. MURPHY. Thank you. We are going to wrap up. I am going to recognize Ms. DeGette for 5 minutes for any other comments or questions.

Ms. DEGETTE. Thank you. Thank you, Mr. Chairman. I just want to clarify a couple of things. Frequently here in Congress we try to get our government agencies to act like private businesses and it doesn't always translate a hundred percent.

But Ms. Maxwell, something you said kind of rang a bell with me which is the way that your agency is dealing with a lot of these thorny problems is you are taking this interdisciplinary approach, you are focusing on one problem, you are applying all of your resources to that and then you are moving to the next one. That is very similar to what they do at Toyota.

And in fact at Denver Health, which is my, in Denver it is the public safety net hospital, and provider in Denver, Pattie Gabow who was our previous CEO of Denver Health, she applied that same kind of thinking to when they would have thorny problems there and they actually were able to do things like reduce medical care errors and so on and so forth. And so I think some of those principles can be applied.

Dr. Agrawal, I am wondering what your agency thinks about taking some of those innovative approaches to approaching really thorny problems, focusing in on the issue, taking an interdisciplinary approach, coming up with solutions and moving on.

Dr. AGRAWAL. Yes. I absolutely agree with you that is the right way of continuous improvement and making the changes that we're describing. We do work in an interdisciplinary way across and, you know, within CMS and across different agencies.

We work very closely with OIG and GAO having, you know, frequent interaction to make sure that we are thinking about the recommendations in the right manner, that we are working towards a common solution that we can both agree with. We also work very closely with our payment policy experts, our coverage experts, and coding experts to making sure that we are implementing good solid controls on the front end.

Ms. DEGETTE. Now you heard a lot of concerns on both sides of the aisle today, Dr. Agrawal, about this increasing number for the inaccurate or improper payments. And while you are not able to give a specific number today, if we had this very same hearing next year given the changes that you are implementing in consultation with the other agencies, do you believe this number will be substantially lower?

Dr. AGRAWAL. I believe it will be lower. My hope is that it will be lower, and it is because we are implementing a multitude of

changes around some of the biggest drivers of the rate that we are trying to impact the numbers.

Ms. DEGETTE. I am going to tell the chairman to schedule this hearing again next year. And one last thing, Ms. Maxwell talked about 20 recommendations and there are a lot of other recommendations that the GAO and the IG have made. What is your agency's position with respect to those recommendations and do you disagree with any of them, are you implementing them?

Dr. AGRAWAL. I think the recommendations are generally very important. All the recommendations that we have talked about today I think the agency has agreed with. The issue with the recommendations is that some are quite relatively easier to implement than others, systems changes that we can make relatively quickly. Others take far more time. They require larger programmatic changes, regulatory changes, perhaps even some statutory changes, and that's where I think you see certain recommendations open for a longer period of time.

But as I mentioned in the opening, we have worked to close between GAO and OIG over a hundred recommendations this past year and have shared with them over a hundred more that we believe can be closed based on the work that we have done.

Ms. DEGETTE. And Ms. Maxwell, would you agree that CMS is trying to implement your recommendations?

Ms. MAXWELL. Yes, I would. Our goal is to push positive change and so we work very, very closely with CMS to implement a recommendation.

Ms. DEGETTE. And Mr. Bagdoyan.

Mr. BAGDOYAN. Yes, I would agree with that definitely. As Dr. Agrawal mentioned, it is a back and forth. Sometimes we don't see eye to eye in terms of what they've done and whether it meets the spirit of a recommendation we would like to close, but the interaction is very active and quite productive.

Ms. DEGETTE. And just one last thing, Dr. Agrawal. You mentioned that sometimes you might need statutory changes. If you do, please come to us because we would be happy to work with you on that. Thank you, and I yield back.

Dr. AGRAWAL. Thank you.

Mr. MURPHY. I think I am going to recognize myself. Just some wrap-up questions here.

Mr. Bagdoyan, on June 2015, the GAO report found vulnerabilities in the provider eligibility system for both invalid addresses and physicians with revoked licenses. CMS issued guidance in March of 2014 to reduce the amount of independent verifications conducted by contractors, and GAO says this guidance increases the program's vulnerability to potential fraud. So why would this guidance increase fraud?

Mr. BAGDOYAN. Well, if you dial back the verification steps and you essentially can meet the new guidance by picking up the phone, dialing a provider and asking them is this your address and the provider says yes and you leave it at that, that obviously is a potential concern that as to the thoroughness of the verification.

Now to CMS' credit, they are going to take another look at the guidance issue once they've had a chance to test the new software in terms of screening for addresses and then make a determination

as to whether to upgrade the guidance to what it was before or change it further.

Mr. MURPHY. Well, we will look forward also to get us a follow-up on if that worked.

Ms. Maxwell, is it true that unscrupulous providers continue to enroll in the Medicare program?

Ms. MAXWELL. Unfortunately, yes.

Mr. MURPHY. And by implementing screening requirements we can keep bad providers out we hope and reduce improper payment?

Ms. MAXWELL. That is absolutely the goal.

Mr. MURPHY. Can you explain what kind of changes will help?

Ms. MAXWELL. Absolutely. I would say out of the 20-plus recommendations that we're featuring in our reports, the most critical are to ensure that the ACA tools are implemented fully. And that for Medicaid means all the tools are in place, and for Medicare that means full implementation of the tools they have in place.

I would say another critical recommendation is featured in H.R. 3716 which is to ensure that providers that are terminated in one state are not able to enroll in another state. Finally, we recommend a better coordination between the two systems leading to less duplication of resources across federal and state government, as well as less duplicate burden on providers.

Mr. MURPHY. All right, thank you. I just want to say too, and my colleague and others have talked about this, really getting some of the private sector involved in this. We look at models such as we talked about Toyota, there are other companies out there doing this whose job it is to find more effective and efficient ways of doing this.

I appreciate the work that GAO has done in this to try and improve things. And look, it is frustrating for us as members here to come back year after year in meeting after meeting as Oversight Committee and try and find ways, an indication that something is improving. It is very frustrating as we see those graphs increasing as the amount that is there.

I strongly encourage you to, just because you can't meet a metric, that isn't a reason to change it from something and 5 percent to 6 percent or whatever else that might be. No doubt you would never do that in medicine. I would never do that in my practice. None of us would do that. It is a matter of always trying to drive it down to zero, otherwise we become tolerant of that.

So what we want to know in terms of your goal of recovering here and particularly the concern I have is how are you going to measure this? It sounds like the metrics have changed over time. And so how do we measure a success or failure in this in a way that you can be held accountable for that is appropriate? It sounds like these are changing. Can you give me some feedback?

Dr. AGRAWAL. Yes. I think the improper payment rate measurement is a validated methodology that does measure something important, right. It does measure provider compliance with our rules and requirements. Now addressing the rate isn't just a matter of, it's a matter of frankly working with providers to make sure that they're doing their best to adhere to these requirements.

I think the other thing that would help is making sure that our dialogue around the rates are pretty clear about what they meas-

ure, what they don't, what leads to improvement. If the improper payment rate is viewed primarily as expenses that should not have occurred in the first place, I think frankly that is a misunderstanding of the rate. I think it's a misunderstanding of what it measures. For us to assume that it's a measure of fraud sort of implies that almost every provider interacting with the program would then be guilty of some level of fraud. I think that is an inappropriate conclusion.

So I think what would help, certainly we can look at other ways of measuring impact. We have moved to ROI as a really common measurement across all of our programs. We have looked at administrative actions and where we have been able to take those actions, the number of providers impacted. I think improper payment still has a utility to it as long as we can get the discussion around it correct.

Mr. MURPHY. Well, we want to see that and as Ms. DeGette said we are going to have you back here. We need to know this. We want to find these things out. We want to see success. We want to see change on this. I repeat again, our frustration with finding funding for programs specifically in Medicare and Medicaid. We have got to make some changes.

We have to, for one it is clear we want to provide some different services for people who are mentally ill and it is frustrating to have to tell them no, that we can't get service for those who need it, but money goes to those who are committing crimes and we want that to stop.

That being the case, having no further questions, I want to state here that I would like to thank all the members and the witnesses and members that participated in today's hearing. I remind members they have 10 business days to submit questions for the record, and ask that the witnesses all agree to respond promptly to the questions. We will have some further questions for you. So with that this subcommittee is adjourned.

[Whereupon, at 12:09 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. FRED UPTON

Today, we take a close look at strengthening program integrity within the Medicare and Medicaid programs.

This is a bad news—good news hearing.

The bad news is that reports from the Government Accountability Office and the Health and Human Services Inspector General identify weaknesses in how CMS roots out fraud, waste and abuse.

These reports tell the story of CMS paying out millions of taxpayer dollars on behalf of beneficiaries who turned out to be incarcerated or deceased. They tell the story of physicians who enrolled for Medicare payments and listed addresses located in Saudi Arabia, and at the location of a Five Guys' burger joint, and CMS did not notice. They explain how CMS continued to pay some physicians whose licenses were revoked, or had been convicted of health care fraud or patient abuse. Overall, these reports show that, despite recent strides, CMS must stay vigilant to combat new and emerging threats to program integrity.

The good news is that there are more tools available to CMS to combat these improper payments. As Medicare and Medicaid continue to grow in size and cost, CMS must use every tool in its box to prevent taxpayer dollars from being spent fraudulently or wastefully.

CMS has recently implemented some new enrollment methods to help screen out fraudulent or ineligible providers. However, there are concerns that they are not being implemented in the best way. A report published last month by the OIG found

missing data in the enrollment system, and "gaps" in contractors' verification of key information on enrollment applications that could leave Medicare vulnerable to illegitimate providers.

For example, contractors conducting site visits found 651 provider facilities were not operational. Despite notes such as the "facility does not exist," "building has been vacated," and "suite appeared closed and abandoned," over half of those providers made it into Medicare's enrollment system.

Even though this one example constitutes a small percentage of the 16,000 site visits total, it is a symptom of the larger problem. It does not matter how good the processes are if they are not implemented correctly.

But there have been steps toward improvement. Just days before today's hearing CMS implemented two open GAO recommendations. We look forward to CMS implementing additional recommendations, so we can continue the important work of strengthening the integrity of these critical programs. Every dollar is important when it comes to Medicare and Medicaid. And we owe it to our seniors and the most vulnerable folks in Michigan and across the country to ensure resources are being spent wisely on their quality of care.

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

May 20, 2016

TO: Members, Subcommittee on Oversight and Investigations

FROM: Committee Majority Staff

RE: Hearing entitled "Medicare and Medicaid Program Integrity: Combatting Improper Payments and Ineligible Providers"

On May 24, 2016, at 10:15 a.m. in 2322 Rayburn House Office Building, the Subcommittee on Oversight and Investigations will hold a hearing entitled "Medicare and Medicaid Program Integrity: Combatting Improper Payments and Ineligible Providers."

Medicare and Medicaid are large and fast-growing federal programs, representing significant financial outlays for both states and the federal government. In 2014, Medicare spending grew 5.5 percent to $618.7 billion, and Medicaid spending grew 11 percent to $495.8 billion.[1] In recent months, the Government Accountability Office (GAO) and the Department of Health and Human Services Office of the Inspector General (OIG) have released several reports that present evidence of substantial fraud and abuse in Medicare and Medicaid programs.

The findings in these reports raise questions about the Centers for Medicare and Medicaid Services' (CMS) effectiveness in rooting out waste, fraud, and abuse in these programs. This hearing will examine two distinct challenges faced by CMS in implementing these programs: (1) preventing improper payments; and (2) ensuring that providers are properly eligible and enrolled. This hearing will also provide an opportunity to discuss the ways in which CMS can operate the Medicare and Medicaid programs more effectively and appropriately by implementing recommendations to address these challenges.

I. WITNESSES

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

[1] Centers for Medicare and Medicaid Services, National Health Expenditure Data, NHE Fact Sheet 2014, available at: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html (last visited May 12, 2016).

II. BACKGROUND

The purpose of this hearing is to strengthen Medicare and Medicaid program integrity by exploring two major approaches: eliminating improper payments and strengthening provider enrollment.

a. Improper Payments

This hearing will examine the Department of Health and Human Services (HHS) improper payment error rates impacting both the Medicare and Medicaid programs. In 2015, HHS reported approximately $89 billion in improper payments made through Medicare, Medicaid, and other public health programs.[2] Improper payments occur when federal funds go to the wrong recipient, the recipient receives the incorrect amount of funds (either an underpayment or overpayment), documentation is not available to support a payment, or the recipient uses federal funds in an improper manner.[3] The OIG is required to review and report on agencies' annual improper payment information included in their Agency Financial Reports (AFRs) to determine compliance with the Improper Payments Act of 2002 (IPIA).[4] Every year, the HHS OIG audits HHS's compliance with IPIA as amended, and assesses HHS's performance in reducing and recapturing improper payments. In a report issued May 11, 2016, the HHS OIG found that HHS did not fully comply with the IPIA as amended, for FY 2015.[5] Specifically, HHS did not achieve targets or goals for certain programs, including Medicare fee-for-service, Medicare Advantage, Medicaid, and the Children's Health Insurance Program (CHIP).[6] It was also found that HHS did not meet requirements to implement a plan to reduce improper payments.[7]

1. Medicare Improper Payments

In its report, the OIG noted that HHS failed to meet improper payment rate reduction targets, and reduce improper payment error rates to below 10 percent for the Medicare Fee-For-Service (FFS) program.[8] While HHS has referenced a number of actions to address improper payments through Corrective Action Plans (CAPs), the reported error rate exceeded IPIA's 10 percent benchmark. For FY 2015, the Medicare Fee-For-Service program's improper payment was 12.09 percent, meaning that 12 percent of payments issued to providers either should not

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[2] Department of Health and Human Services, Fiscal Year 2015 Annual Financial Report for 2015, *available at* http://www.hhs.gov/sites/default/files/afr/fy-2015-hhs-agency-financial-report.pdf.
[3] Definition of Improper Payment, PAYMENTACCURACY.GOV, *available at:* https://paymentaccuracy.gov/content/faq#1 (last visited May 19, 2016).
[4] The Improper Payments Information Act of 2002 (IPIA) requires OIGs to annually report to the President and Congress on the agencies' improper payments, as amended by The Improper Payments Elimination and Recovery Act of 2010, and the Improper Payments Eliminations and Recovery Improvement Act of 2012 (IPERIA), hereinafter as IPIA, as amended.
[5] Department of Health and Human Services, Office of the Inspector General, *U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 But Did Not Fully Comply for Fiscal Year 2015*, (May 2016).
[6] *Id.*
[7] *Id.*
[8] *Id.*

have been made, or were reimbursed for an incorrect amount.[9] In response to this finding, HHS cited insufficient documentation and medical necessity errors as the causes for the high error rate.[10]

Improper payments resulting from insufficient documentation and medical necessity errors could be resolved through the use of claims processing codes. For example, prior OIG work on Medicare improper payments found that over $33 million was erroneously paid to providers rendering services to incarcerated beneficiaries.[11] Medicare generally does not pay for services rendered to individuals who are incarcerated in correctional facilities. However, federal requirements allow Medicare payment if state or local law requires incarcerated beneficiaries to repay the cost of medical services.[12] Health care providers indicate this exception by placing a specific code, or exception code, on the claims submitted for payment. Yet, CMS did not have policies and procedures to review information after the improper payment had been made, resulting in a system that could not recover improper payments. Consequently, CMS did not notify the contractors to recoup any of the $33,587,634 in improper payments. To date, OIG's recommendation to ensure that all claims with exception codes are processed consistently and pursuant to Federal requirements remains unimplemented with CMS.[13]

2. Medicaid Improper Payments

Additionally, the OIG found the overall error rate for Medicaid was 9.78 percent, far off from HHS's goal error rate of 6.7 percent, and the error rate for Medicaid's CHIP increased from 6.50 percent in FY 2014 to 6.80 percent for FY 2015.[14] The OIG noted that the Medicaid program did not achieve its target due to administrative errors made by the state or local agencies, and recommended that HHS work with the states to bring their respective systems into compliance.

As state Medicaid programs continue to explore home care options like Personal Care Services (PCS), it is critical that ample safeguards are in place to prevent improper payments contributing to fraud, waste, and abuse in PCS. Several OIG audits and evaluation reports have found that PCS payments were improper because the services: (1) were not provided in compliance with state requirements, (2) were unsupported by documentation indicating the services had been rendered, (3) were provided during periods in which the beneficiaries were in a hospital or nursing home reimbursed by Medicare or Medicaid, and/or were provided by PCS attendants who did not meet state qualification requirements.[15] Moreover, OIG work has indicated that existing program safeguards intended to ensure medical necessity, patient safety,

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[9] *Id.*
[10] *Id.*
[11] Department of Health and Human Services, Office of the Inspector General, *Medicare Improperly Paid Providers Millions of Dollars for Incarcerated Beneficiaries who Received Services During 2009 through 2011* (Jan. 2013).
[12] *Id.*
[13] Department of Health and Human Services, Office of Inspector General, *Compendium of Unimplemented Recommendations,* (April 2016).
[14] *Id.* at 5.
[15] See, Department of Health and Human Services, Office of Inspector General, *Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement,* (November 2012).

quality, and prevent improper payments were often ineffective.[16] The OIG recommended that CMS should promulgate regulations to reduce significant variation in states' PCS laws and regulations by creating or expanding federal requirements, and issuing operational guidance for claims documentation and beneficiary assessments.

Moreover, the OIG has identified several areas for improvement with CMS's database on terminated providers. Pursuant to the Patient Protection and Affordable Care Act (PPACA), CMS established a web-based portal, the Medicaid and Children's Health Insurance Program State Information Sharing System (MCSIS), to share information on terminated providers. The OIG found that as of June 1, 2013, MCSIS contained records on terminated providers submitted by CMS and thirty three state Medicaid agencies, and did not contain records from the remaining state Medicaid agencies.[17] The OIG also found that over half of MCSIS records did not contain National Provider Identifiers (NPIs), a critical data element for accurately identifying providers.[18] The OIG recommended that CMS require reporting of all terminations "for cause."[19] While CMS agreed with the OIG's recommendation, CMS has yet to indicate whether it planned to require state reporting of terminations "for cause."[20]

Last year, the GAO also released a report highlighting the frequency of improper payments and fraud within the Medicaid program,[21] and it was the subject of a hearing before the Oversight and Investigations Subcommittee in June 2015. After auditing four states with just over 9 million Medicaid beneficiaries, GAO found:

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

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

- The Social Security Numbers (SSNs) for about 199,000 beneficiaries did not match identity information contained in the Social Security Administration (SSA) bases, suggesting fraud or improper payments. The benefits paid at least $448 million to these

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[16] *Id.*
[17] See, Department of Health and Human Services, Office of Inspector General, *CMS'S Process for Sharing Information About Terminated Providers Needs Improvement,* (March 2014).
[18] *Id.*
[19] *Id.* at 12.
[20] *Id.*
[21] U.S. Gov't Accountability Office, *Medicaid: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls*, GAO-15-313 (May 2015).

199,000 beneficiaries. Of these beneficiaries, 12,500 of them used a SSN never issued by SSA.

To better protect against fraud and improper payments, GAO recommended that CMS provide better guidance to states on how to identify deceased beneficiaries. This recommendation is still "open," indicating that GAO does not believe CMS has taken necessary actions pursuant to the report.[22]

b. Provider Eligibility

The Subcommittee will also look into provider enrollment weaknesses with both the Medicare and Medicaid programs. Vulnerabilities within provider enrollment not only contribute to the problem of improper payments and fraudulent billing, but also raise questions on potential patient harm and quality of care issues.

1. Reports from the Government Accountability Office

Of the $554 billion paid to providers through Medicare in FY 2014, CMS estimates that about 10 percent, or $60 billion was paid improperly.[23] According to GAO, flaws in the eligibility verification process for Medicare providers and suppliers contribute to those improper payments. There are approximately 1.8 million different providers and suppliers that bill Medicare. These providers enroll through the Provider Enrollment, Chain and Ownership System (PECOS), a centralized databased designed to contain providers' and suppliers' enrollment information. CMS largely relies upon contractors to verify the provider's eligibility and root out fraud and abuse.[24] However, CMS guidance in March 2014 reduced the amount of independent verification conducted by contractors, which GAO says "increase[es] the program's vulnerability to potential fraud."[25]

In a June 2015 report entitled "Additional Actions Needed to Improve Eligibility Verification of Providers and Suppliers," GAO identified two main "weaknesses" in CMS's procedures to detect ineligible or fraudulent providers and suppliers: (1) verification of provider practice locations and (2) physician licensure status.[26]

With regard to the verification of provider practice locations, GAO found that CMS' method to validate addresses does not flag potentially ineligible addresses, such as a UPS store mailbox, or vacant, or invalid addresses.[27] Of the 105,234 addresses GAO initially identified as

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[22] U.S. Gov't Accountability Office, *Medicaid: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls: Recommendations, available at:* http://www.gao.gov/products/GAO-15-313, (last visited May 17, 2016).
[23] Government Accountability Office, *Additional Actions Needed to Improve Eligibility Verification of Providers and Suppliers*, (June 2015).
[24] *Id.*
[25] *Id.*
[26] *Id.*
[27] *Id.*

invalid, 23,400 or 22 percent are potentially ineligible for Medicare providers and suppliers.[28] For example, one provider listed an address that currently houses a fast food restaurant.[29] Another provider listed a UPS store as its address.[30]

Concerning physician licensure status, Medicare program requirements state that physicians must hold an active license in the state in which they plan to practice, and must self-report final adverse actions, such as suspensions or revocations of licensure. However, CMS does not provide contractors charged with verifying physician eligibility with information regarding adverse-actions against that physician, or if the physician has medical licenses in other states. GAO found that, as of March 2013, 147 out of 1.3 million physicians listed as eligible had received a final adverse action for crimes against persons, financial crimes, and other types of felonies, such as substance abuse, health-care, fraud or patient abuse.[31] These 147 physicians had not been revoked from the Medicare program until months after the adverse action, or were never removed.[32]

Often, adverse events slip through the cracks because CMS contractors rely upon physicians to self-report these adverse events. For example, GAO identified a physician whose California license was suspended in 2008 due to sexual misconduct.[33] The physician then applied for a Missouri state medical license and was granted a license and enrolled into the Medicare program in 2010. During this physician's first year in the program, he billed Medicare approximately $113,000.[34]

In April 2016, the GAO released an update to its June 2015 report, which considers a new background check process CMS implemented after GAO had conducted its audit. This report explains that CMS could recover about $1.3 million in potential overpayments to 16 potentially ineligible providers with criminal backgrounds, due to new processes in place.[35] In April 2014, CMS implemented more extensive background check processes, and GAO's report had not captured data after 2013. Before April 2014, CMS did not initially have, and therefore did not use, the original felony conviction date that ultimately made the provider ineligible to participate in Medicare. However, GAO did not evaluate the effectiveness of the new process because the most recent data available to GAO were based on procedures in place in 2013.

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[28] About 300 of the addresses were Commercial Mail Receiving Agencies, such as UPS; 3,200 were vacant properties; and 19,900 were invalid, or did not exist. Of the 23,400 potentially ineligible addresses, 2,900 were associated with providers that had claims that were less than $500,000, and 2,600 were associated with providers that had claims that were $500,000 or more per address.

[29] Government Accountability Office, *Additional Actions Needed to Improve Eligibility Verification of Providers and Suppliers*, June 2015.

[30] *Id.*

[31] *Id.*

[32] *Id.*

[33] *Id.*

[34] *Id.*

[35] Government Accountability Office, *Medicare: Opportunities Exist to Recover Potential Overpayments to Providers with Criminal Backgrounds*, (April 13, 2016).

Last year, the GAO also released a report highlighting concerns about CMS' screening of ineligible providers.[36] This report found that, out of the four states audited, about 90 medical providers had their medical licenses revoked or suspended in the state in which they received payment from Medicaid during fiscal year 2011. Medicaid approved the associated claims of these cases at a cost of at least $2.8 million. GAO also found that at least 47 providers had foreign addresses as their location of service, including Canada, China, India, and Saudi Arabia. Nearly 26,600 providers had addresses that did not match any United States Postal Service records.

To mitigate these problems, GAO recommended that CMS provide guidance to states on the availability of automated information through Medicare's enrollment database—PECOS—and full access to all pertinent PECOS information, to help screen Medicaid providers more efficiently and effectively. This recommendation is still "open," indicating that GAO does not believe CMS has taken necessary actions pursuant to the report.[37]

2. Report from the HHS Inspector General Office

The HHS OIG also recently examined the issue of provider enrollment and eligibility screening, and released its report in April 2016, entitled "Enhanced Enrollment Screening of Medicare Providers: Early Implementation Results."[38] This report chronicled CMS's new enrollment screening process, which aims to prevent illegitimate providers from enrolling in Medicare. This new screening placed providers in risk categories, increased site visits, required fingerprinting, and denied enrollment to providers who have unresolved overpayments. Despite some positive strides, the HHS OIG expressed concerns that the new process did not solve all the existing problems.

According to the report, CMS's implementation of enhanced enrollment screening needs "strengthening."[39] CMS relies on an enrollment data system, PECOS, as its centralized repository for all provider enrollment information; however, PECOS lacks data needed to evaluate the outcomes of enrollment screening enhancements.[40] Data such as (1) denials and returns of enrollment applications, (2) risk category designations for each enrolling provider, and (3) reasons providers submitted enrollment applications, were not consistently maintained in PECOS. In addition, results from a provider's site visit and the Medicare contractors' decision to enroll a provider cannot be directly linked, making it difficult to evaluate provider enrollment outcomes.[41]

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[36] U.S. Gov't Accountability Office, *Medicaid: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls*, GAO-15-313 (May 2015).
[37] U.S. Gov't Accountability Office, *Medicaid: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls: Recommendations, available at:* http://www.gao.gov/products/GAO-15-313, (last visited May 17, 2016).
[38] Department of Health and Human Services, Office of the Inspector General, *Enhanced Enrollment Screening of Medicare Providers: Early Implementation Results*, April 2016.
[39] *Id.*
[40] *Id.*
[41] *Id.*

Finally, OIG expressed concerns about CMS' ability to conduct oversight over the new screening process. The OIG found that "gaps in contractors' verification of key information on enrollment applications that could leave Medicare vulnerable to illegitimate providers."[42] The OIG also noted that contractors were "inconsistent" when conducting site visits and how results were utilized in making enrollment decisions.[43] OIG found that CMS could address both issues through implementation of enhancements such as site visits and PECOS improvement, to ensure that providers are being effectively screened for entry into Medicare.

3. Forthcoming OIG Reports

The OIG has recently notified the Committee that three additional reports will be released in conjunction with the upcoming hearing. These reports continue the examination of vulnerabilities within Medicare and Medicaid provider screening, and provide CMS with additional recommendations to enhance program integrity within both programs.

In the forthcoming report entitled, "*Medicaid Enhance Provider Enrollment Has Not Been Fully Implemented*" (OEI-05-13-00520), the OIG surveyed states and requested data about their use of risk-based screening. The ACA requires states to screen Medicaid providers according to their risk for fraud, waste, and abuse using enhanced screening procedures such as fingerprint-based criminal background checks and site visits. 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. As a result, the OIG has recommended that CMS assist states in implementing fingerprint-based criminal background checks for all high-risk providers, and overcoming challenges in conducting site visits.

The OIG plans on releasing another Medicaid report entitled, "*Medicaid: Vulnerabilities Related to Provider Enrollment and Ownership Disclosure*" (OEI-04-11-00590), which determined the extent to which states requested and verified provider ownership information and checked exclusions databases. By verifying ownership, states can prevent inappropriate payments and protect the integrity of services being rendered to beneficiaries. The OIG found that fourteen state Medicaid programs reported they did not verify the completeness or accuracy of provider ownership, nor did they check all required exclusions databases. Moreover, nearly all providers reviewed by the OIG had names on record with state Medicaid programs that did not match those on record with CMS. The OIG has recommended that CMS require state Medicaid programs to verify the completeness and accuracy of provider ownership, and ensure that state Medicaid programs check exclusions databases as required.

In April 2016, the OIG released a report assessing enrollment screenings of Medicare providers.[44] The OIG also plans on releasing another report evaluating Medicare enrollment screenings, specifically looking at how inconsistencies with provider ownership disclosure, could allow potentially fraudulent providers to enroll in the Medicare system. Findings from this study are discussed in the forthcoming report, "*Medicare: Vulnerabilities Related to Provider Enrollment and Ownership Disclosure*" (OEI-04-11-00591). The OIG compared three sets of

[42] *Id.*
[43] *Id.*
[44] *Id.* at 38.

owner names for selected providers. Specifically, they compared: (1) the names listed on Medicare enrollment records, (2) names submitted by providers directly to the OIG for their evaluation, and (3) names listed on state Medicaid enrollment records. Also, the OIG surveyed CMS's Medicare Administrative Contractors to learn how they verify provider exclusions when processing Medicare enrollment applications. The OIG found that two of the eleven CMS contractors did not check all required exclusions databases, and that nearly all providers in the OIG's review had different names on record with other state Medicaid programs. To warrant effective provider enrollment screening, the OIG has recommended that CMS ensure its contractors check exclusions databases, and review providers that submitted nonmatching owner names on enrollment records.

III. ISSUES

The following issues may be examined at the hearing:

- What is CMS doing to reduce improper payments and payment error rates with the Medicare and Medicaid programs?
- What steps has CMS taken to enhance program integrity when enrolling providers into Medicare and Medicaid?
- How is CMS ensuring that terminated providers are no longer enrolled in one Medicaid program and other state programs?
- What progress has CMS made on the numerous unimplemented recommendations made by HHS OIG and GAO?

IV. STAFF CONTACTS

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