

IMPROPER PAYMENTS IN STATE-ADMINISTERED PROGRAMS: MEDICAID

JOINT HEARING BEFORE THE SUBCOMMITTEE ON GOVERNMENT OPERATIONS AND THE SUBCOMMITTEE ON INTERGOVERNMENTAL AFFAIRS OF THE COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM HOUSE OF REPRESENTATIVES ONE HUNDRED FIFTEENTH CONGRESS

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Thursday, April 12, 2018

HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON GOVERNMENT OPERATIONS JOINT
WITH SUBCOMMITTEE ON INTERGOVERNMENTAL AFFAIRS
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
Washington, D.C.

The subcommittees met, pursuant to call, at 10:00 a.m., in Room 2154, Rayburn Office Building, Hon. Mark Meadows, chairman of the Subcommittee on Government Operations, presiding.

Present: Representatives Meadows, Palmer, Grothman, Jordan, Walker, DeSantis, Connolly, Raskin, Maloney, DeSaulnier, Norton, and Lawrence.

Mr. MEADOWS. The Subcommittee on Government Operations and the Subcommittee on Intergovernmental Affairs will come to order, and without objection, the presiding members are authorized to declare a recess at any time.

I would like to thank the gentleman from Alabama, Mr. Palmer, for his leadership on this particular issue, and certainly for the ranking members, Mr. Connolly and Raskin. We appreciate all of you being here.

As we look at the hearing today examine once again improper payments, particularly within Medicaid, it is very simple that as we look at the payments that should not have been and were made for the incorrect amounts. These issues encompass the entire Federal government, and, in fact, improper payments are a huge problem. The GAO estimates that there is over \$1 trillion in improper payments since the Fiscal Year 2003. And, again, that is \$1 trillion since 2003.

In Fiscal Year 2017 alone, the government got it wrong to the tune of \$141 billion in improper payments. This amount of money is indeed staggering. As they say back home, eventually this adds up to real money, and so it is incumbent upon all of you as we look at the testimony today to hopefully highlight how we are going to address this issue. For some of you, this is, Ms. Tinker, your first rodeo here. We will try to make sure that it is not memorable in a negative way, and so welcome.

The Department of Health and Human Services accounts for the largest amount of improper payments with over \$90 billion. The Medicaid Program accounts for over \$36 billion, or 40 percent, of the HHS improper payments. And if we think about that number, \$36 billion in taxpayer dollars that are unaccounted for for one

Federal program, it is not only staggering, but you start to look at and say why are we not addressing it.

One of the keys to addressing improper payments and restoring program integrity for the Medicaid issue is having complete, accurate, and timely data. Screening Medicaid providers with better data could prevent some of the improper payments that are made to bad actors. And I also want to stress that because we look at this, there are times when we have improper payments. There are times when some of those things are not indeed fraudulent. They are not bad actors. They perhaps are a result of our bureaucratic network that we have. I would be interested in hearing that. I am one that believes that every improper payment is not necessarily because of a bad actor.

And yet when we look at this, Ms. Tinker, you are from HHS OIG. You have illustrated the importance of providing screening in your testimony, but describing some of the cases in Virginia, in North Carolina. And in the Virginia case, one individual participated in a scheme to defraud the special caregiver program covered by Medicaid by submitting timesheets for services that were not actually provided. Those are the kind of things that we do need to go after. This individual was in jail at the time, so it is amazing how creative they were getting from the jail cell, and a simple check of his status could have stopped the fraud, and yet somehow that did not happen.

In North Carolina, a mental health facility operator defrauded Medicaid by submitting at least \$2.5 million in fraudulent claims for services never provided to the beneficiaries with developmental disabilities. Now, to support these fraudulent claims, this individual used stolen beneficiary information from a company he previously co-owned that was no longer operational. And this could have been stopped with better data and a site visit.

And when we look at these kinds of things, you would say, well, these should be easy operational checks that in the private sector if you were writing checks, you would actually say, well, if we are going to write a \$2.5 million check, you would want to make sure that it was for legitimate purposes. So, we need to look at it, and I am going to challenge all of you to look at this as if it were your own money because indeed it is. It is the people's money, and sometimes we forget when we are looking at this that it is a mom and dad, and an aunt and uncle, and, quite frankly, people who pay the taxes each and every day that we have an obligation, a stewardship, that we have to oversee.

You know, Obamacare's dramatic expansion of Medicaid has further highlighted the need for better data to determine eligibility. And if we are going to make sure that Medicaid dollars are going to those programs that they are designed to cover, we need to also look at detecting improper payments and fraud, and we need complete and accurate national data on Medicaid.

So, for almost 20 years after Congress directed States to submit such data, the transformed Medicaid statistical information is still a work in progress after 20 years. And so, it is incumbent that we come together today. I see my time has run out in terms of my opening statement, but we look forward to hearing from all of you.

And with that, I will recognize the ranking member, Mr. Raskin, for his opening statement.

Mr. RASKIN. Mr. Chairman, thank you very much, and thanks for that very fine opening statement, and thanks to all of our witnesses for testifying today.

Medicaid provides comprehensive, affordable care to more than 70 million Americans regardless of their preexisting health conditions. And I want to start just by identifying the fact that that is an historic achievement and triumph that we have a Medicaid system that is addressing the health needs of so many Americans. Roughly 40 percent of the beneficiaries are children, including nearly half of all kids with special healthcare needs, and 1 in 4 children in my home State of Maryland. 1 in 5 Medicare beneficiaries relies on Medicaid for long-term care and other benefits. Thanks to the ACA's Medicaid expansion, 12 million more Americans have gained health coverage for the very first time.

Today's hearing focuses on improper payments—excuse me—which include overpayments, underpayments, and legitimate payments with paperwork errors, as well as fraudulent payments. This year's improper payment rate, I understand, was 10.1 percent. One dollar of an improper payment is a dollar too much, whether it is a dollar at Medicaid, or the VA, or the Pentagon, or whatever program it might be, and we can all agree that 10 percent is just too high. But solving that problem must take into account the fact that all 50 States administer their own Medicaid programs, and they all have their own challenges maintaining program integrity. It is a large and decentralized system, and it can be leaky.

So, all 50 State Medicaid agencies along with the Federal Centers for Medicare and Medicaid Services must work together to lower the rate of improper payments, not only in the interest of preserving our tax dollars, but also because fraud and inefficiency threaten the stability of Medicaid and deprive enrollees of the benefits that they rightfully rely on. Fortunately, the ACA gave CMS new program integrity tools to fight fraud, including enhanced provider screening requirements, and I am eager to hear about people's perspectives on that today.

We should reject the notion that errors in Medicaid justify slashing Federal funding, or undermining the Federal/State financing structure, or imposing work requirements on Medicaid beneficiaries. I think all of these are a non-sequitur.

I hope we will use this hearing as an opportunity to learn from the experts gathered today how we can improve the Medicaid Program, and I would like to close simply by sharing an experience of one of my constituents, Alaina from Silver Spring, whose family relies on Medicaid. Her daughter has serious medical conditions affecting her heart, her lung, her airways, and her kidneys. She spent the first 5 months of her life in an ICU and had three major surgeries before she could use a ventilator and oxygen tank, which allow her now finally to breathe to this day. But she must see over a dozen specialists to receive the care that she needs. When Alaina's daughter left the hospital at 5 months old, she had incurred over \$3 million in medical bills, an amount which would be higher today, and it includes medical supplies and equipment, medications, additional procedures, and more. Alaina and her fam-

ily have depended on Medicaid and the ACA to save their family from financial ruin and to save her daughter's life.

This story reminds of why Medicaid is so important, why we have to do everything we can to strengthen this vital program, and to guarantee that every dollar is going actually to service the beneficiaries of the program. I hope this hearing brings us closer to this goal, and I thank you very much, Mr. Chairman, for convening the meeting.

Mr. MEADOWS. I thank the gentleman. The chair will recognize the gentleman from Alabama, Chairman Palmer.

Mr. PALMER. Thank you, Mr. Chairman. Today's hearing marks the continuation of the committee's close look at the rising problem of federal improper payments. As we watch the national debt continues to decline, improper payments grow with it. As Chairman Meadows pointed out, since 2003, we have sent out a trillion dollars in improper payments. I would only add to that that that is a trillion dollars plus interest. We have been operating in deficit all those years, so every dollar that we sent out improperly was a borrowed dollar.

Every year, the Federal government loses billions of taxpayer dollars because of improper payments, dollars that were intended to fund programs that serve the people that are improperly paid out or managed. In my questions I will address this a little bit more.

The Government Accountability Office has been unable to render an opinion on the Federal government's consolidated financial statement since 1997 due in part to the Federal government's inability to adequately account for and reconcile its financial activities. GAO has also stated with respect to improper payments that absent changes, the Federal government continues to face an unsustainable long-term fiscal path. This is the reason we are here today. We want to try to figure out a way to solve this.

As Chairman Meadows cited, the Federal government reported \$141 billion in improper payments last year, Fiscal Year 2017, a \$4 billion increase from just 2 years ago. Over two-thirds of these erroneous payments originated from the Department of Health and Human Services. Rapid growth and improper payments is largely attributed to the Medicaid Program, which is the focus of this hearing. Medicaid is a federally funded, State administered program that covers over 73 million people. The program represents about a sixth of the national healthcare economy and accounts for over \$36 billion in improper payment. I think it was about \$36.7 billion to be precise. The GAO has placed the Medicaid Program on its high-risk list every year since 2003. That makes 15 years and counting.

State partners are on the front lines of defense against these erroneous payments. However, the Centers for Medicare and Medicaid Services plays a critical role in monitoring and supporting State efforts to reduce and recover improper payments. Although the States have great flexibility in implementing Medicaid, they are constrained by lack of Federal guidance and overwhelmed by the vast and increasing enrollment from expansion of the program under Obamacare. Diligent and bipartisan oversight is imperative

in order to curb Medicaid's current trajectory as the fastest-growing source of improper payments.

Today we will hear from our witnesses about current efforts to strengthen Federal and State partnerships in the Medicaid Program and make an attempt to ensure program integrity. To achieve the necessary reform of Medicaid, only a whole of government oversight approach will safeguard the faith and credit of American taxpayers.

I thank the witness for coming today, and I look forward to hearing their testimony. I yield back.

Mr. MEADOWS. I thank the gentleman from Alabama. I am now pleased to introduce our witnesses: Mr. Tim Hill, deputy director at the Center for Medicaid and CHIP Services, Department of Health and Human Services. Welcome, Mr. Hill. Ms. Megan Tinker, senior advisor for legal review in the Office of Counsel to the Inspector General, Department of Health and Human Services. Welcome, Ms. Tinker. Ms. Carolyn Yocom, director of health care at the Government Accountability Office. Welcome. The Honorable Daryl Purpera, legislative auditor for the State of Louisiana, and I believe you are accompanied by Mr. Wesley Gooch, special assistant for healthcare audit, who will also be sworn in. And Mr. Andy Schneider, research professor of practice at the Center for Children and Families at Georgetown University, McCourt School of Public Policy. That is a mouthful, Mr. Schneider. Welcome. Welcome to you all.

Pursuant to committee rules, all witnesses will be sworn in before they testify, so if you will please stand and raise your right hand.

Do you solemnly swear or affirm that the testimony you are about to give is the truth, the whole truth, and nothing but the truth, so help you God?

[Chorus of ayes.]

Mr. MEADOWS. All right, thank you. You may be seated. Let the record reflect that all witnesses answered in the affirmative.

In order to allow time for discussion, please limit your testimony to 5 minutes. However, your entire written testimony will be made part of the record. And as a reminder, the clock in front of you will show the remaining time during your opening statement. The light will turn yellow which means you had better speed up, you got 30 seconds left, and red means that you are subject to being gaveled down at any time, hopefully in a light tap first, and then a stronger tap later. But we also ask you to press the button in front of you to turn on your microphone before speaking.

So, Mr. Hill, we will go ahead and recognize you for 5 minutes.

WITNESS STATEMENTS

STATEMENT OF TIM HILL

Mr. HILL. Great, thank you. Chairman Meadows and Palmer, Ranking Member Raskin, members of the subcommittee. Thank you for the invitation and the opportunity to discuss CMS' efforts to prevent and reduce improper payments in Medicaid. We share your commitment to ensuring that spending for Medicaid is de-

voted to the care and the well being of the beneficiaries that we serve and is not wasted through error or fraud.

In that regard, we greatly appreciate the ongoing work by the OIG and the GAO to highlight potential vulnerabilities in these important programs. And similarly, I want to recognize the work of this committee on these important issues, particularly with respect to Medicaid reimbursements and financing issues. I want to use my time this morning to highlight some of the foundational work we do here at CMS to promote the integrity of the Medicaid Program and then spend a little time emphasizing some of the new initiatives and approaches that this Administration has initiated in this area.

In terms of our foundational work, I like to think of our efforts as resting on a three-legged stool. The first leg of the stool is measurement. Our primary tool in this regard is the Payment Error Rate Measurement Program, or PERM. Using PERM, we measure and report on improper payments in Medicaid. The information we get from this program, in addition to just measuring and giving us a measure, actually helps us identify the underlying cause of payment error. What is it that is driving the error rate? Using this information, we can drive States to implement corrective actions to reduce improper payments and to prevent them in the future.

The second leg of the stool is partnership. We work with our State partners to provide the information, the resources, and the technical assistance they need to implement programs to safeguard Medicaid. The best illustration of our efforts in this area is our Medicaid Integrity Institute established in collaboration with the Department of Justice where we bring together State employees, CMS policy experts, our law enforcement partners, and other stakeholders to collaborate and share best practices while simultaneously staying up to date on emerging program vulnerabilities.

The final leg of the stool is a robust financial oversight activities to ensure that when States ultimately claim for a Federal match on their expenditures, Federal Medicaid funds are spent lawfully and appropriately. We use specialized accountants and financial management analysts to review State claims each quarter using trend analysis, environmental scanning, and the results of external audits to find anomalies, and request additional documentation or justifications for spending when necessary. We also engage in State-specific reviews, going on site to State Medicaid programs to ensure that State expenditures and corresponding claims for Federal funds are allowable. Last year we worked with States to resolve \$2.7 billion in questionable costs through this program.

Under the leadership of Secretary Azar and Administrator Verma, we are building on this foundation to further enhance and strengthen our oversight efforts. As you know, this Administration is fully committed to providing as much flexibility as possible to States to help them structure Medicaid programs that work for the people and the situations of their State. In return for this flexibility, we will be holding States accountable in new and important ways.

For example, for the first time ever, we are implementing a Medicaid scorecard to measure and report on Medicaid performance across three pillars: health systems, Federal administrative per-

formance, and state administrative performance. Driving improvement using the scorecard is integral to our efforts to safeguard Medicaid from unnecessary and wasteful spending.

Underpinning the scorecard initiative is the implementation of the Transformed Medicaid Information System, or T-MSIS. The data we collect in T-MSIS will drive the analytics that will help us and States improve health outcomes and improve program integrity. I am happy to report that as of today, T-MSIS includes the data for 98 percent of the beneficiaries we serve, and we expect the remaining data, which represents one State, to be live in the system shortly.

In terms of oversight of State financing problems, we have closed off financing loopholes that some States have used to generate Federal dollars to support State programs that are best supported with State-only dollars. Finally, we are bolstering our ongoing efforts to ensure that States are appropriately determining eligibility for beneficiaries in the expansion population. While we have significant existing controls in this area, we are concerned by recent OIG findings about State implementation of eligibility systems as well as the findings of our own review of State managed care rates for beneficiaries in the expansion group. The issue is a top priority for this Administration and the CMS administrator, and moving forward, CMS will continue to enhance our oversight efforts to make sure States are appropriately enrolling beneficiaries and that the Federal government is bearing only its fair share of the cost for Medicaid.

We look forward to continuing to work with our States and oversight partners and other stakeholders to improve efforts to reduce the improper payment rate in Medicaid. I thank you, and I am happy to take your questions.

[Prepared statement of Mr. Hill follows:]

STATEMENT OF

TIM HILL,
ACTING DIRECTOR, CENTER FOR MEDICAID AND CHIP SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

IMPROPER PAYMENTS IN STATE ADMINISTERED PROGRAMS: MEDICAID

BEFORE THE

U.S. HOUSE COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
SUBCOMMITTEE ON GOVERNMENT OPERATIONS AND
SUBCOMMITTEE ON INTERGOVERNMENTAL AFFAIRS

APRIL 12, 2018

Statement of Tim Hill
on
“Improper Payments in State Administered Programs: Medicaid”
U.S. House Committee on Oversight and Government Reform
Subcommittee on Government Operations and
Subcommittee on Intergovernmental Affairs
April 12, 2018

Chairmen Meadows and Palmer, Ranking Members Connolly and Demings, and members of the Subcommittees, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS's) efforts to prevent and reduce improper payments in Medicaid. We appreciate how much work this Committee has done over the years to promote program integrity and prevent improper payments, both in the programs managed by CMS and across the government. At CMS, we share this Administration's vision to ensure that Medicaid works for those it was designed to serve. By making sure taxpayer dollars are used responsibly, Medicaid program integrity plays an important role in our overall efforts to refocus Medicaid on the nation's most vulnerable populations in order to provide a more robust level of care and a strengthened program overall.

This Administration takes the integrity of the Medicaid program very seriously, and is taking a fresh look at how CMS can more effectively fulfill our responsibility to protect taxpayer dollars, including making sure States use Federal Medicaid resources properly and appropriately apply eligibility criteria. We appreciate the ongoing work done by the Department of Health and Human Services Office of Inspector General (OIG) and the Government Accountability Office (GAO) to highlight potential program integrity vulnerabilities and provide recommendations on strengthening safeguards. CMS relies on GAO and OIG recommendations to inform our improvement activities across our programs. We have taken action to address a number of the recommendations made by OIG and GAO. For example, the President's Fiscal Year (FY) 2019 Budget includes an administrative proposal to establish unique identifiers for personal care service (PCS) attendants.¹ We also requested new legislative authorities to address OIG and GAO concerns. For instance, the FY 2019 Budget requests authority to implement prepayment

¹ <https://oig.hhs.gov/oei/reports/oei-12-16-00500.pdf>

controls to prevent inappropriate PCS payments and to allow Medicaid Fraud Control Units to investigate beneficiary abuse and neglect that occurs in home- and community-based settings.² CMS will continue to identify and take additional steps to safeguard taxpayer dollars and enhance the quality of services provided to Medicaid beneficiaries while maintaining the flexibility States need to design Medicaid programs that best meet the unique needs of their residents.

Restoring a Strong Federal-State Relationship through Flexibility and Accountability

Although the Federal government establishes general guidelines for the program, States design, implement, and administer their own Medicaid programs. The Federal government matches State expenditures on medical assistance based on the Federal medical assistance percentage (FMAP), which can be no lower than 50 percent. Ultimately, States and the Federal government share mutual obligations and accountability for the integrity of the Medicaid program and the development, application, and improvement of program safeguards necessary to ensure proper and appropriate use of both Federal and State dollars.

However, far too much of States' time is spent mired in a maze of one-size-fits-all Federal laws, regulations, and processes that often do not translate to better health outcomes. Our aim is to restore a strong State-Federal relationship while also modernizing the program to deliver better outcomes for all populations being served and protecting taxpayer dollars.

CMS has outlined a bold agenda to transform the Medicaid program that is centered on three key pillars: flexibility, accountability, and integrity. CMS believes that States understand best the unique needs of their residents and has committed to restoring balance to the Federal and State partnership. This commitment to flexibility is being fulfilled through efforts that include relieving burdensome regulatory requirements, speeding the processing of waivers and State Plan Amendments, and opening new avenues to State-led reforms through demonstrations. But this new flexibility must be balanced by a system that holds States accountable for producing improvements in program outcomes, as well as appropriate Federal oversight of program integrity to protect the American taxpayers. CMS is committed to achieving this balance and has

² <https://oig.hhs.gov/oei/reports/oei-12-16-00500.pdf>

developed a strategy that prioritizes accountability and integrity protections with a high return on investment.

A core component of this effort is confronting the program integrity challenges that were created when the Patient Protection and Affordable Care Act (PPACA) significantly expanded Medicaid eligibility, allowing States to enroll childless, non-disabled adults with incomes below 138 percent of the poverty level. It also provided States with an enhanced Federal contribution toward this newly eligible population, covering 100 percent of these costs from 2014 through 2016, 95 percent of costs in 2017, and 94 percent this year. This match rate will decline until 2020, at which point States will receive an ongoing 90 percent match for this newly eligible population. This enhanced Federal match increases the need for robust Federal oversight since States receive a higher percentage match for someone who is determined to be newly eligible for Medicaid. In 2016, an estimated 11.2 million Medicaid enrollees were classified as newly eligible, and, from 2016 through 2025, Medicaid expenditures for newly eligible adults are projected to amount to \$806 billion (\$741 billion paid by the Federal government)³.

CMS believes that the risk associated with the incentives created by the enhanced match require us to make sure that States are making correct eligibility determinations. For example, OIG recently conducted reviews of newly eligible beneficiaries in three States and identified potential vulnerabilities in eligibility determinations. OIG found that in a sample of 130 beneficiaries, New York did not determine eligibility for 37 beneficiaries in accordance with Federal and State requirements and did not provide supporting documentation to verify that beneficiaries were newly eligible for 4 potentially ineligible beneficiaries.⁴ OIG found that in a sample of 150 beneficiaries, California made payments on behalf of 27 ineligible and 14 potentially ineligible beneficiaries.⁵ OIG found that in a sample of 120 beneficiaries, Kentucky did not determine eligibility for 9 beneficiaries in accordance with Federal and State requirements.⁶ CMS appreciates the work that the OIG has already done to identify vulnerabilities in the eligibility

³ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2016.pdf>

⁴ <https://oig.hhs.gov/oas/reports/region2/21501015.asp>

⁵ <https://oig.hhs.gov/oas/reports/region9/91602023.asp>

⁶ <https://oig.hhs.gov/oas/reports/region4/41608047.asp>

determination processes in some expansion States, which informs our approach to confronting and addressing the program integrity challenges created by the Medicaid expansion, ensuring that the law is followed and Federal taxpayers are protected.

In addition to eligibility concerns, the per newly eligible enrollee costs are much higher than previously expected. In its 2016 report, the CMS Office of the Actuary estimates that Medicaid expansion enrollees cost an average of \$5,926 in FY 2016, which is 64% higher than the \$3,606 pre-enrollee cost they projected in the 2014 report.⁷ CMS estimated that Medicaid expansion enrollees would be 27 percent less expensive than those previously enrolled in FY 2016. However, per-enrollee spending on expansion enrollees was 28 percent higher than previously eligible non-disabled adult enrollees in FY 2015 and 14 percent higher in FY 2016.⁸

Most States covered newly eligible adults through managed care programs. Due to the limited historical data and experience for the newly-eligible adult Medicaid expansion population prior to 2014, developing and reviewing managed care capitation rates was more challenging than for populations of individuals traditionally eligible for Medicaid. In particular, there was uncertainty regarding assumptions for pent-up demand and the health status of new enrollees, leading to the possibility of greater utilization of services than that of other adult enrollees already covered by Medicaid.

To address the uncertainty regarding this population, some States employed risk mitigation strategies in setting their managed care rates. Under this approach, the State requires managed care plans to pay at least 85 percent of their capitation rates on health care expenditures for their enrollees. If the plan ultimately spends under 85 percent, they are required to remit the difference to the State. The State is then required to pay back the Federal portion of those costs to the Federal government. Because of the enhanced match prescribed by the ACA, 100 percent of the costs for this population was covered by the Federal government for the first three years. The Administration is aware of concerns that managed care rates resulted in significant profits for insurance companies, and is committed to reviewing these rates and is taking action when

⁷ *CMS Medicaid Actuarial Report 2014. CMS Medicaid Actuarial Report 2016.*

⁸ *Id.*

appropriate. For example, CMS initiated oversight action to ensure that the State of California resolves a collection issue and returns a significant amount of funding owed to the Federal government related to the State's Medicaid expansion.

Financial Management

Oversight of States' financial management of their Medicaid programs is a critical component of our work and is vital to ensuring that Federal Medicaid funds are spent lawfully and appropriately. We take our responsibility to ensure that States correctly report their Medicaid expenditures seriously. CMS oversight over State expenditures is a careful balance of ensuring that States receive the appropriate Federal share, while also ensuring that Federal funds are only spent on allowable activities in the Medicaid program.

Every quarter, States must submit to CMS their estimated quarterly expenditures costs and CMS distributes a monetary advance; States may submit a supplemental request for additional funding if their original request proves insufficient, but they must provide justification for doing so. To verify that actual expenditures reconcile with the received monetary advance, CMS (in accordance with statutory and regulatory requirements) requires States to report actual expenditures and include supporting documentation such as invoices, cost reports, and eligibility records to ensure that the Federal financial participation matches with States' actual expenditures. These reports must be submitted within 30 days after the end of the budget quarter, and this process applies whether or not some or all of a State's expenditures are authorized through a State plan or a section 1115 demonstration. CMS employs a team of accountants and financial management specialists in regional offices to review these submissions, look for anomalies, and request additional documentation or justifications as necessary.

These accountants and financial management specialists also perform focused financial management reviews of specific Medicaid service and administrative expenditures, which generally involves reviewing a sample of paid claims related to certain types of Medicaid services. CMS staff have frequent communication with States in order to provide clarification and guidance around allowable expenses. These individuals also perform audit resolution tasks and coordinate with State auditors and OIG to ensure that State expenditures and corresponding

claims for Federal matching funds are allowable. In FY 2017, CMS worked with States to resolve \$2.1 billion and recover an additional \$647 million from States, totaling \$2.7 billion in questionable costs. Furthermore, an estimated \$457 million in questionable reimbursement was actually averted due to the funding specialists' preventive work with States to promote proper State Medicaid financing.

Enforcement

In addition to State flexibility, the Administration is also focused on accountability. When a State provides inadequate documentation or justification for Medicaid claims, CMS can issue deferrals and disallowances. A deferral withholds funds from the State until additional clarification or documentation is received from the State regarding Medicaid expenditures claimed. A disallowance is a formal determination by CMS that a claimed expenditure or portion of a claim by a State for Federal funds is unallowable or is not supported by the State's documentation. States have the right to appeal a disallowance, in whole or in part. CMS has taken disallowances or deferrals for a wide range of issues. For example, CMS has disallowed Federal Financial Participation because of providers not meeting conditions of participation to be enrolled as a Medicaid provider, not having administrative cost allocation plans in place and lacking documentation support for a claimed expenditure. We take this enforcement responsibility seriously and are committed to ensuring that CMS stays current in issuing these types of actions to ensure that improperly spent funds are recovered in a timely manner. We will not ignore States' improper spending, even when it occurred in previous years.

In addition to taking action to address improper activities, CMS is also committed to addressing State financing practices that are not an appropriate use of Federal taxpayer dollars. CMS recognizes that one of the biggest risks to the Federal budget was the continued abuse of Medicaid waiver financing. As such, late last year, CMS took action to wind down some section 1115 demonstration projects that raised oversight concerns. These designated State health program (DSHP) demonstrations provided Federal funding for State expenditures that were previously funded entirely by the State, without Federal funds. Since 2005, CMS has approved over \$25 billion in Federal spending for these State-funded programs in 10 States.

One stated purpose of Federal DSHP funding was to ensure the continuation of these beneficial State programs while the State was incurring additional expenditures for health service delivery reform or expansion under the demonstration project. However, the result has been that many States are not contributing State funds toward these delivery system reform efforts. Instead, these States are primarily relying on dollars freed up by the Federal Medicaid contribution to DSHP to draw down additional Federal Medicaid matching expenditures to support delivery system reforms. On December 15, 2017, we issued new policy guidance closing this financing loophole.

Improper Payments in Medicaid

Through the Payment Error Rate Measurement (PERM) program, CMS annually estimates the improper payment rate and a projected dollar amount of improper payments for Medicaid⁹ using an open and transparent process, as required by statute.¹⁰ This measurement and reporting process is one of many tools CMS uses to identify and address areas at risk for – and factors contributing to – improper payments. It is important to remember that not all improper payments constitute fraud or result in monetary loss to the government. An improper payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. For example, if a physician provides a legitimate service to a legitimate beneficiary but accidentally fills out the paperwork incorrectly or is missing documentation, this would be considered an improper payment.

The PERM program measures and reports an estimate of the improper payment rate for Medicaid. Because it is not feasible to verify the accuracy of every Medicaid payment, CMS uses a statistically valid methodology that samples a subset of payments, then extrapolates to the “universe” of payments. Through the PERM program, CMS reviews States in cohorts, or cycles. There are three total cycles, each including 17 States; one cycle is reviewed every year, meaning each State is reviewed once every three years. From within each State, a stratified random sample of payments is selected and reviewed for errors. The PERM program measures three

⁹ <https://www.hhs.gov/sites/default/files/fy-2017-hhs-agency-financial-report.pdf>

¹⁰ Established by the Improper Payments Information Act of 2002 (IPIA) and amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA) and the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA).

components: fee-for-service, managed care, and eligibility. The findings are used to estimate a national improper payment rate. The national Medicaid improper payment rate includes findings from the most recent three cycle measurements so that all 50 States and the District of Columbia are captured in one rate. For FY 2017, the Medicaid improper payment rate was 10.10 percent, a decrease from FY 2016 (10.48 percent).¹¹

Through the improper payment rate measurement, CMS identifies and classifies types of errors and shares this information with each State. States then analyze the findings to determine the root causes for improper payments by error type, which is necessary for a State to develop and implement effective corrective actions. Similar to recent years, the driver of the Medicaid improper payment rate was State difficulties complying with provider screening, enrollment, and National Provider Identifier (NPI) requirements. Although the 17 States reviewed this year had better compliance results for Medicaid compared to their previously measured cycle, non-compliance with the provider screening, enrollment, and NPI requirements is still a major contributor to the Medicaid improper payment rate. Additionally, Medicaid improper payments due to no or insufficient medical documentation increased in FY 2017.

CMS recognizes the importance of regular eligibility reviews and is also implementing a Medicaid Eligibility Quality Control (MEQC) program for States in the two off-cycle years of PERM reviews. In particular, MEQC requires States to review their eligibility processes in years when they are not subject to a PERM review and is intended to help States ensure that their corrective actions are addressing issues identified as part of PERM.

Working with States to Address Error Causes

CMS works closely with States following each measurement cycle to develop State-specific corrective action plans (CAPs) to reduce these errors. All States are responsible for implementing, monitoring, and evaluating the effectiveness of their CAPs, with assistance and oversight from CMS. When developing the CAPs, States focus their efforts on the major causes of improper payments where the State can clearly identify patterns.

¹¹ <https://www.hhs.gov/sites/default/files/fy-2017-hhs-agency-financial-report.pdf>

In addition to the development, execution, and evaluation of the State-specific CAPs, CMS has implemented corrective actions to specifically address compliance with Medicaid provider screening, enrollment, and revalidation efforts to reduce errors related to this category. Specific corrective actions include implementing new claims processing edits, converting to a more sophisticated claims processing system, and continuing to implement process improvements to the provider enrollment process to make it easier for ordering and referring providers to enroll in the program. In addition, State Medicaid agencies may rely on Medicare's enrollment and screening of providers. For example, since May 2016, CMS has offered a data compare service that allows a State to rely on Medicare's screening, in lieu of conducting State screening, particularly during revalidation. This allows States to remove dually-enrolled providers from their revalidation workload. Using the data compare service, a State provides an extract of Medicaid provider enrollment data to CMS and then CMS returns information indicating the providers for which the State can rely on Medicare's screening.¹² In addition, CMS issued guidance to allow States to rely on any site visits conducted by CMS for a provider that has an approved Medicare enrollment status. CMS has also worked with the Federal Bureau of Investigation to publish guidance to help States implement fingerprint-based criminal background checks for high risk providers. CMS also provides ongoing guidance, education, and outreach to States on Federal requirements for Medicaid enrollment and screening. In addition, CMS continues to update the Medicaid Provider Enrollment Compendium¹³ to provide additional sub-regulatory guidance to assist States in applying the regulatory requirements.

CMS procured a State Assessment Contractor to assist with ongoing State technical assistance and process improvements related to provider screening and enrollment.¹⁴ The contractor assessed compliance with provider screening and enrollment requirements, conducted a gap analysis, and developed strategic blueprints to help States improve processes. In addition to the

¹² Alabama, Arizona, California, Idaho, Iowa, Louisiana, Maine, Michigan, New Mexico, New York, Ohio, Oregon, Pennsylvania, Texas, the District of Columbia, Vermont, and Virginia have participated in the data compare service

¹³ <https://www.medicaid.gov/affordable-care-act/downloads/program-integrity/mpec-6232017.pdf>

¹⁴ In FY 2017, the State Assessment contractor visited Alabama, California, Connecticut, Indiana, Iowa, Nevada, Ohio, Oregon, and Texas.

State Assessment Contractor visits, CMS continues to conduct State site visits to assess provider screening and enrollment compliance, and provide technical assistance.¹⁵

CMS has also worked with the Social Security Administration (SSA) to provide access to the death information SSA maintains in its records (also called the Death Master File, or DMF). Previously, States had raised concerns with the costs of completing the SSA-DMF check as part of provider screening. In May 2017, CMS made DMF data available to some States via the same file server where States have access to Medicare provider file extracts, Medicare revocations, Medicaid terminations, and OIG sanctions (i.e., suspensions, debarments, and exclusions). CMS has begun expanding access to the DMF data to additional States, beyond the pilot States, and will continue to do so.

Insufficient documentation is another contributing factor to the national Medicaid improper payment rate. To help address these types of errors, State CAPs also include provider communication and education to reduce errors related to these categories. These methods include: holding provider training sessions and meetings with provider associations; issuing provider notices, bulletins, newsletters, alerts, and surveys; implementing improvements and clarifications to written State policies emphasizing documentation requirements; and performing more provider audits to identify areas of vulnerability and target solutions.

Outreach and education to States is also an important component of our efforts to lower the Medicaid improper payment rate, and we are committed to giving States the tools they need to be successful. In addition to providing States with informational bulletins and guidance, we offer and facilitate education and training options, such as those offered through the Medicaid Integrity Institute, and provide States with reports to help them identify areas of concern through efforts such as State program integrity reviews.

¹⁵ CMS internally provided screening and enrollment assistance through visits to Delaware, Georgia, Minnesota, Missouri, North Carolina, South Carolina, Virginia, and the District of Columbia in FY 2017

Modernizing the PERM Program

This Administration is committed to making the PERM program as accurate and as effective as possible in measuring the Medicaid improper payment rate so that CMS and States can take appropriate corrective actions. On June 29, 2017, CMS published a final rule¹⁶ implementing policy and operational improvements to the PERM program that will reduce State burden, improve program integrity, and promote State accountability.

Eligibility Reviews in the PERM Program

As a first step, beginning in the FY 2019 reporting period, the PERM program will once again measure the current improper payment rate for the eligibility component, under a revised methodology. In light of changes made by the Patient Protection and Affordable Care Act to the way States adjudicate eligibility for applicants for Medicaid, CMS did not conduct the eligibility measurement component of the PERM program for FYs 2014 through 2018 in order to update the eligibility component measurement methodology and related PERM program regulation. During this time, the FY 2014 national eligibility improper payment rate¹⁷ was being used as a proxy rate, and all States conducted a pilot program with rapid feedback for improvement (known as Eligibility Review Pilots) to maintain oversight of State eligibility determinations.

To reduce State burden and improve review accuracy and consistency, under our new rule, beginning with the FY 2019 reporting period a Federal contractor will conduct PERM eligibility reviews with support from each State. Unlike under the previous rule, the eligibility reviews will be conducted on the beneficiary associated with the same fee-for-service and managed care payments that were sampled, helping to also reduce the burden on each State.

Increasing Reporting Accuracy and State Accountability

The new rule takes steps to increase the reliability and consistency of the data collected, so we can more effectively provide oversight. For example, improper payments will be cited if the Federal share amount is incorrect (even if the total computable amount is correct). Under

¹⁶ <https://www.federalregister.gov/documents/2017/07/05/2017-13710/medicaidchip-program-medicare-program-and-childrens-health-insurance-program-chip-changes-to-the>

¹⁷ During this time, for the purpose of computing the overall national improper payment rate, the Medicaid eligibility component improper payment rate is held constant at the FY 2014 national rate of 3.11 percent.

previous regulations, improper payments were only cited on the total computable amount (i.e., Federal share plus State share).

Under both the previous rule and the current rule, the national sample size equals the total of the State-specific sample sizes. However, under the new rule, the national sample size is determined first and distributed among the States; under the previous rule, State-specific sample sizes were determined first and added together to total the national sample size. State-specific sample sizes are based on factors such as each State's expenditures and previous improper payment rate.

States will continue to implement CAPs for all errors and deficiencies; however, there will be more stringent requirements added for States that have consecutive PERM eligibility improper payment rates over the three percent national standard established in statute.¹⁸ In addition, States will have to provide an evaluation of whether actions they take to reduce eligibility errors will also avoid increases in improper denials.

Potential payment reductions/disallowances in statute¹⁹ will be applicable for eligibility reviews conducted during PERM years in cases where a State's eligibility improper payment rate exceeds the three percent national standard. CMS will only pursue disallowances if a State does not demonstrate a good faith effort to meet the national standard.

Medicaid Program Integrity

In addition to our work to measure and prevent improper payments, CMS utilizes many tools across our programs to fight fraud, waste, and abuse. We work with partners across the public and private health care sectors to share and apply valuable data and information about bad actors, emerging schemes, and best practices. CMS provides a variety of educational materials and guidance to make sure States, beneficiaries, providers, contractors, and plans have the information they need to improve their own efforts to fight fraud, waste, and abuse. For example, CMS published guidance to States on Medicaid fraud prevention, provider screening and enrollment initiatives, and State-specific program integrity review reports. We also facilitate

¹⁸ Social Security Act, Section 1903(u)

¹⁹ Social Security Act, Section 1903(u)

States' efforts to address fraud, waste, and abuse within their Medicaid programs by offering technical assistance, education, collaborative audits, and access to relevant Medicare data. Throughout our efforts, we are cognizant of the need to balance an appropriate level of accountability with the need to avoid overburdening States and providers.

Improving Data to Support Program Integrity

As technology advances across the health care industry, data will continue to play an increasing role in our program integrity efforts. As a payor and steward of taxpayer dollars, one of our most important roles is to share valuable data and facilitate its use among our Federal and State law enforcement partners, States, providers, and plans. That's why improving Medicaid and CHIP data and systems is a high priority for CMS. Through strong data and systems, CMS and States can drive toward better health outcomes and improve program integrity, performance, and financial management in Medicaid and CHIP. CMS has been working with States to implement changes to the way in which administrative data is collected by moving from the Medicaid Statistical Information System (MSIS) to the Transformed-MSIS (T-MSIS). More robust, timely, and accurate data via T-MSIS will strengthen program monitoring, policy implementation, and oversight of Medicaid and CHIP programs. It will also enhance CMS's and States' ability to identify potential fraud, waste, and abuse and improve program efficiency. T-MSIS will also reduce administrative burden on States by streamlining the reporting process and reducing the number of reports and data requests CMS requires.

As part of the transition to T-MSIS, CMS has strengthened its reporting requirements by standardizing definitions, expanding the data being collected, adding data quality enhancements, and improving the timeliness of data submission by moving from quarterly to monthly State data submissions.

CMS is working to transition all States to T-MSIS and has made significant progress. As of March 8, 2018, 49 States, the District of Columbia, and Puerto Rico have begun submitting T-MSIS data. These entities represent 98 percent of the Medicaid and CHIP population. CMS

continues to work with the remaining States to help them submit data and expects all States to report T-MSIS data.²⁰

With a majority of States submitting T-MSIS data, CMS has begun to develop tools for T-MSIS users, as well as work with States to improve the quality of data submitted. For example, CMS is developing a data quality assessment for users, which aggregates data quality findings in a user-friendly tool. These efforts will help States report complete and comparable T-MSIS data which CMS plans to use for program oversight efforts.

CMS has requested that States provide complete and accurate T-MSIS data. However, CMS is dependent on States and their associated staffing and resources necessary to improve the quality of their data. CMS will continue to share information across States on known T-MSIS data limitations and will implement ways in which States can collaborate on an ongoing basis regarding T-MSIS implementation.

Medicaid Integrity Institute (MII)

As a payor, we work jointly with law enforcement to support State efforts to address fraud, waste, and abuse across our programs. Because Medicaid is a Federal-State partnership, CMS works closely with our State partners to provide them with the tools and knowledge to effectively operate their programs. For example, in collaboration with the Department of Justice (DOJ), CMS established the Medicaid Integrity Institute (MII), a program that offers courses on a variety of Medicaid program integrity issues for Medicaid employees and certain stakeholders. The mission of the MII is to provide effective training tailored to meet the ongoing needs of State Medicaid Program Integrity employees, with the goal of raising national program integrity performance standards and professionalism. Since 2008, the MII has provided professional education to more than 7,000 Medicaid employees from every State, the District of Columbia, and Puerto Rico. As the first national Medicaid integrity training program, the MII provides a unique opportunity for CMS to offer substantive training, technical assistance, and support to the States in a structured learning environment. The MII focuses on developing a comprehensive

²⁰ <https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/index.html>

program of study addressing aspects of Medicaid program integrity to include: fraud investigation, data mining and analysis, and case development.

In FY 2017, the MII presented 20 courses, and has an additional 21 scheduled through FY 2018. One of these courses, held last month, was entitled “Emerging Trends in Medicaid: Beneficiary Eligibility and Fraud.” This course was designed to focus on State Medicaid agencies’ efforts both to ensure the accuracy of beneficiary eligibility determinations and to deter beneficiary fraud, waste, and abuse. Course participants included Federal and State employees whose responsibility is in beneficiary eligibility and/or fraud, regardless of where those activities are administered within the State Medicaid agency. The course focused on: best practices in determining eligibility; data sources that assist in eligibility determination, program oversight, and fraud and abuse identification; policies that support identifying and deterring beneficiary fraud, waste, or abuse; and individual case studies in beneficiary eligibility and fraud. Because of State and Federal interest in this topic, additional courses focusing specifically on beneficiary eligibility and beneficiary waste, fraud, and abuse will be scheduled in FY 2019.

In addition, CMS and the MII hold an annual advisory group meeting with senior State program integrity officials comprising the Medicaid Fraud and Abuse Technical Advisory Group (TAG). The TAG provides CMS and the MII with critical input and recommendations for training topics and courses for the following year. The TAG provides State agency updates and guidance on what issues the States are facing in order to provide Subject Matter Experts (SMEs) for each course. The TAG is divided into workgroups that are charged with identifying and developing suggestions that can be shared during the monthly TAG call with States, CMS, and the MII. The success of the MII lies largely with the commitment of our State partners. The tailored courses are identified in the yearly meeting with the MII advisory group and developed by working group experts from States, CMS, and the MII. As a result, “Emerging Trends in Medicaid” courses in FY 2017 and FY 2018 have included Personal Care Services, Opioids, and Third Party Liability.

State Program Integrity Reviews

State program integrity reviews²¹ provide effective support and assistance to States in their efforts to combat fraud, waste, and abuse. Through these reviews, CMS assesses the effectiveness of the State's program integrity efforts, including its compliance with Federal statutory and regulatory requirements. After completing two separate comprehensive, regulation-based review cycles for every State, the District of Columbia, and Puerto Rico, CMS made a strategic shift in FY 2014 to conduct more focused reviews of high-risk program integrity areas tailored to specific challenges facing States. Recent onsite reviews focused on specific areas of program integrity concern, including oversight of managed care organizations, provider screening and enrollment, personal care services, and non-emergency medical transportation.

To supplement the onsite-focused reviews, CMS initiated desk reviews of program integrity efforts. These reviews allow CMS to increase the number of States that receive such customized program integrity oversight by conducting offsite reviews of documentation submitted by States on specified topics. Recent desk review topics included provider terminations, Medicaid Recovery Audit Contractors, implementation status of PERM CAPs, and State program integrity review CAPs. As another means of providing assistance to States, CMS has developed toolkits to address frequent findings. The toolkits identify common issues observed to help States better understand the requirements and provide practical solutions that States can implement to help them improve compliance with Federal regulations.

Unified Program Integrity Contractors (UPICs) and Collaborative Audits

The Unified Program Integrity Contractors (UPICs) consolidate Medicare and Medicaid program integrity functions, phasing out the Zone Program Integrity Contractors and the Audit Medicaid Integrity Contractors. The UPICs merge these separate contracting functions into a single contractor, in a geographic area, with responsibility to conduct program integrity audit and investigation work across Medicare and Medicaid operations. The UPIC contracting structure provides CMS with a flexible vehicle to address the complex landscape of program integrity across both Medicare and Medicaid. This means that the same contractor can conduct audits and

²¹ For individual reports please visit: <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/State-Program-Integrity-Review-Reports-List.html>

investigations of providers enrolled in both Medicare and Medicaid, and can more easily make connections across the two programs.

As part of the UPICs' work, collaborative audits are conducted to augment a State's audit capacity by leveraging the resources of CMS and its UPICs, resulting in more timely and accurate audits. These audits combine the resources of CMS and the UPICs to assist States in addressing suspicious payments, including algorithm development, data mining, auditors, and medical review staff. This approach more effectively uses resources in support of States in their program integrity efforts. The collaborative process includes a discussion between the State and CMS regarding potential audit issues and the States' provision of Medicaid Management Information System data for data mining. The State, together with CMS, determines the audit processes the UPICs follow during the collaborative audit. In some instances, the UPICs conduct the entire audit. In other cases, the UPICs supplement State efforts by providing medical review staff and other resources.

Healthcare Fraud Prevention Partnership (HFPP)

CMS is engaging with the private sector in new ways to better share information and data to combat fraud. The Healthcare Fraud Prevention Partnership (HFPP) is a voluntary, public-private partnership between the Federal government, State agencies, law enforcement, private health insurance plans, employer organizations, and healthcare anti-fraud associations to identify and reduce fraud, waste, and abuse across the healthcare sector. HFPP partners regularly collaborate, share information and data, and conduct cross-payer studies to achieve these objectives. The HFPP applies multiple methods to detect anomalies; scan for suspect activities; and create informational content, such as white papers, to communicate its work to the larger public. Given the HFPP's broad membership encompassing a variety of players interested and involved in detection of fraud, waste, and abuse in the healthcare system, it is uniquely positioned to examine emerging trends and develop key recommendations and strategies to address them. The HFPP currently has almost 100 partners, including over 20 State and local

agencies²² and is continuing to grow strategically by adding new partners and finding ways to proactively identify areas of mutual concern.

Health Care Fraud and Abuse Control (HCFAC) Program

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a comprehensive program to combat fraud committed against all health plans, both public and private. The legislation required the establishment of a national Health Care Fraud and Abuse Control (HCFAC) program, under the joint direction of the Attorney General and the HHS Secretary, acting through OIG. The HCFAC program is designed to coordinate Federal, State and local law enforcement activities with respect to health care fraud and abuse.

Through the fraud, waste, and abuse prevention and enforcement efforts of the HCFAC program, in FY 2016 the Federal government won or negotiated over \$2.5 billion in health care fraud judgments and settlements, and it attained additional administrative impositions in health care fraud cases and proceedings. As a result of these efforts, as well as those of preceding years, in FY 2016 over \$3.3 billion was returned to the Federal government or paid to private persons. Of this \$3.3 billion, the Medicare Trust Funds received transfers of approximately \$1.7 billion during this period, and over \$235.2 million in Federal Medicaid money was similarly transferred separately to the Treasury as a result of these efforts.²³

Conclusion

We share the Subcommittees' 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. By making sure taxpayer dollars are used responsibly, Medicaid program integrity plays an important role in our overall efforts to refocus Medicaid on the nation's most vulnerable populations in order to provide a more robust level of care and a strengthened program overall.

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

²² <https://hfpp.cms.gov/about/current-partners.html>

²³ <https://oig.hhs.gov/publications/docs/hcfac/FY2016-hcfac.pdf>

stewards of the program, and CMS and States work together closely to carry out these responsibilities.

Mr. MEADOWS. Thank you, Mr. Hill.

Ms. Tinker, you are recognized for 5 minutes.

STATEMENT OF MEGAN TINKER

Ms. TINKER. Good morning, Chairman Meadows and Palmer, Ranking Members Connolly and Raskin, and other distinguished members of the subcommittees. I am Megan Tinker of the Office of the Inspector General. Thank you for inviting me to discuss improper payments in Medicaid and the need for robust national Medicaid data.

Medicaid is a \$574 billion program that touches the health and welfare of 69 million Americans. In 2016, Medicaid estimated improper payments totaled \$36 billion. Today I will highlight recommendations that OIG has made to help States and CMS secure the data necessary to reduce improper payments.

OIG's work clearly shows that in order to gain the full benefit of 21st century data analytics, Medicaid needs comprehensive national data. We recommend that CMS and States focus on OIG's core program integrity principles: prevention, detection, and enforcement. First, prevent improper payments by using data to keep bad actors and ineligible beneficiaries from participating in Medicaid. Second, detect improper payments by using data to identify potential fraud, waste, and abuse. And third, enforce, take swift and appropriate enforcement actions to correct problems and prevent future harm.

Our work shows that States often lack the necessary data to prevent bad actors from participating in Medicaid. Doing so effectively can reduce and prevent improper payments. For example, OIG has raised concerns that States are not conducting required provider screenings such as criminal background checks. Preventing improper payments also means ensuring Medicaid only serves eligible beneficiaries. OIG's review of three States found that their enrollment data systems sometimes lacked the ability to reliably make proper eligibility determinations, which could result in incorrect payments. Quality data are vital to decreasing improper payments and to ensuring a high-performing Medicaid program.

CMS has made progress in implementing T-MSIS, which is the Transformed Medicaid Statistical Information System. T-MSIS is a national system to aggregate Medicaid claims data. As of this month, as Mr. Hill said, almost all States are reporting data to T-MSIS. However, there is more to do to make sure that the data can be used effectively to prevent and detect improper payments and fight fraud, waste, and abuse.

Improper payments and fraud do not respect State borders. Without complete and uniform national data, fraud schemes affecting multiple States are difficult to detect because we cannot see the whole picture. Utilization and spending patterns may not appear problematic until compared with other States. CMS must remain vigilant and ensure that States are consistently reporting data elements to T-MSIS, and that those are the data elements that will best inform program integrity efforts.

In addition, an ever-increasing number of Medicaid patients receive some or all of their services through managed care. OIG's work has shown that States' Medicaid managed care data was in-

complete when submitted to CMS. As a result, both Federal and State governments lack the transparency to ensure proper oversight.

OIG has seen the benefits of data in identifying and targeting bad actors in Medicare. For example, last summer the Medicaid Fraud Strike Force used comprehensive Medicare data, including data on opioid prescribing, to conduct the largest national healthcare fraud takedown in history. Over 400 individuals were charged for their alleged participation in healthcare fraud schemes, responsible for \$1.3 billion in fraud losses across numerous States. We cannot replicate this type of enforcement action in the Medicaid Program because we still lack comprehensive national Medicaid data.

It remains to be seen whether T-MSIS will live up to its potential. That is why it is critical that CMS persist in ensuring the availability of complete, accurate, and timely national Medicaid data. Such data are essential to preventing, detecting, and decreasing improper payments, and to the efficiency and effectiveness of the Medicaid Program.

Thank you for the opportunity to testify this morning. I am happy to answer any questions you may have.

[Prepared statement of Ms. Tinker follows:]



Testimony Before the United States House of Representatives

Committee on Oversight and Government Reform:

Subcommittee on Government Operations

Subcommittee on Intergovernmental Affairs

Improper Payments in State-Administered Programs: Medicaid

Testimony of:

Megan H. Tinker

Senior Advisor for Legal Review

Office of Counsel to the Inspector General

Office of Inspector General

Department of Health and Human Services

April 12, 2018

10:00 a.m.

2154 Rayburn House Office Building

Testimony of:

Megan H. Tinker

Senior Advisor for Legal Review

Office of Inspector General, U.S. Department of Health and Human Services

Good morning, Chairmen Meadows and Palmer, Ranking Members Connolly and Raskin, and other distinguished Members of the Subcommittees. I am Megan Tinker, Senior Advisor for Legal Review in the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS or the Department). Thank you for inviting me to discuss improper payments and the need for national Medicaid data to strengthen the program.

Created by statute in 1976, OIG is an independent body of auditors, evaluators, and investigators, deployed across the Nation, to help assess and protect the integrity of the Department's programs enacted by Congress. We remain committed to working with our stakeholders to achieve our shared goals of protecting beneficiaries and the taxpayer-funded programs they rely on from fraud, waste, and abuse, and promoting efficient and effective program operations.

Protecting Medicaid from fraud, waste, and abuse is an urgent priority because of its impact on the health and welfare of millions of Americans and on Federal and State spending. OIG has an extensive body of work examining vulnerabilities in Medicaid and recommending improvements to address high improper payments, the lack of program integrity safeguards, and health and safety concerns. Key to addressing each of these critical issues is robust, national Medicaid data that are complete, accurate, and timely.

In fiscal year (FY) 2016, Medicaid served more than 69 million enrollees at a cost of \$574 billion. Medicaid serves more people than any other Federal health care program and represents one-sixth of the national health care economy. To ensure that Medicaid can continue to serve our Nation's most vulnerable populations well into the future, we must foster sound financial stewardship. Reducing improper payments is a critical element in protecting the financial integrity of Medicaid. Although not all improper payments are fraud – or even overpayments – all improper payments pose a risk to the financial security of these programs.

In FY 2016, estimated improper Medicaid payments totaled more than \$36 billion. The Centers for Medicare & Medicaid Services (CMS) must do more to ensure States pay the right provider, the right amount, for the right service, on behalf of the right beneficiary. My testimony addresses those concepts within the framework of OIG's core program integrity principles of prevention, detection, and enforcement—highlighting the importance of high-quality Medicaid data for program integrity across all three principles.

Program Integrity Principles

Prevent – Know Who You Are Doing Business With

Detect – Identify Fraud, Waste, and Abuse in a Timely Manner

Enforce – Take Appropriate Action to Correct Problems, and Prevent Future Harm

Prevention: State Medicaid programs do not always effectively screen providers or correctly determine beneficiary eligibility.

The most effective way to prevent improper payments and fraud in Medicaid is to keep bad actors and ineligible beneficiaries out of the program to begin with. Complete and reliable data can help States do this. Without it, States may not know with whom they are doing business.

States have not fully enacted enhanced provider screening.

To ensure that Medicaid pays the right provider, the program must be able to identify the providers with whom it is doing business and keep bad actors out of the program. Preventing bad actors from entering the Medicaid program not only reduces improper payments, but also prevents the potential for patient harm.

States are required to screen providers according to the risk for fraud, waste, and abuse that they pose to Medicaid. However, States face challenges in meeting requirements to screen high-risk providers, including conducting fingerprint-based criminal background checks and site visits. Previous OIG work found that many States had yet to complete fingerprint-based criminal background checks and site visits. OIG made recommendations to CMS to assist States with completing these activities. CMS concurred with OIG's recommendations and has provided assistance to States. However, CMS continues to extend the deadline for completion of fingerprint-based criminal background checks, indicating that States are still working on provider enrollment. OIG has ongoing work to provide a status update on implementation of fingerprint-based criminal background checks.

It is important that CMS ensure that States timely and fully implement these critical safeguards, as even a single bad actor could defraud Medicaid of millions of dollars and endanger beneficiaries. For example, in Virginia, two individuals conspired to defraud a special caregiver program covered under Medicaid by submitting timesheets for payment for services that were never rendered. This scheme took place while one of the individuals was incarcerated. A State criminal background check could have revealed that one of the individuals had been convicted and might have helped prevent this fraud scheme.

In another example, in North Carolina, a mental health facility operator submitted fraudulent claims to Medicaid seeking reimbursement for services that were never provided to beneficiaries with developmental disabilities. The operator submitted at least \$2.5 million in fraudulent claims using stolen beneficiary information from a defunct company that he previously co-owned, and received more than \$2 million in reimbursements from Medicaid. State site visits could have revealed that the beneficiaries whose identities had been stolen from the defunct company were not actually receiving services.

These cases exemplify why OIG recommends that **CMS should improve provider screening by working with States to implement fingerprint-based criminal background checks and site visits for high-risk providers.**

It is important to know with whom Medicaid is doing business, not only to prevent improper payments to ineligible providers, but also to protect beneficiaries. OIG has raised concerns about the varying standards, and in some cases, minimal vetting, for Medicaid personal care services (PCS)

providers. This leaves the Medicaid program vulnerable to financial fraud. Even more concerning, it leaves Medicaid patients vulnerable to abuse and neglect. For example, an elderly woman in Idaho was hospitalized to treat malnutrition and dehydration because the caregiver failed to provide water and food. Suspecting she was a victim of neglect, investigators served a search warrant and found that she had been living in filth despite the fact that Medicaid was paying a PCS attendant to care for her everyday needs. **OIG continues to recommend that CMS establish minimum Federal qualifications and screening standards for all PCS attendants.**

For provider screening to be truly effective, States need timely, complete, and accurate data to efficiently and effectively identify the providers with whom they are doing business. To that end, OIG has issued several recommendations to CMS aimed at the development of a central repository or “one-stop shop” with provider information that all States and Medicare can use. This could reduce data-collection duplication and burdens on States and providers and improve the completeness and accuracy of the data available to Medicaid, the Children’s Health Insurance Program (CHIP), and Medicare. The President’s FY 2019 Budget request includes a proposal to consolidate provider enrollment screening for Medicare, Medicaid, and CHIP.

States are not always correctly determining Medicaid eligibility for beneficiaries.

Correctly determining beneficiary eligibility is vital to the accuracy of Medicaid payments. To ensure that Medicaid makes payments on behalf of the right beneficiary, it is critical to determine whether the beneficiary receiving services is actually eligible for Medicaid. Recent OIG audits of three States estimated that more than \$1.2 billion in Federal Medicaid payments have been made on behalf of

potentially ineligible and ineligible beneficiaries. Lack of enrollment data systems functionality was a key contributor to these payments.

OIG recently reviewed whether certain States were correctly determining eligibility, following changes made by the Affordable Care Act (ACA) to Medicaid eligibility rules. ACA allowed States to expand Medicaid eligibility for certain low-income adults and claim a higher Federal Medical Assistance Percentage for those who are newly eligible under the expansion. As a result of States incorrectly determining beneficiaries' eligibility, payments made on behalf of these beneficiaries could be incorrect, resulting in the shift of costs from the State to the Federal Government. OIG reviews of Medicaid eligibility determinations by California, New York, and Kentucky reveal that these States did not comply with Federal and State requirements to verify applicants' income, citizenship, identity, and other eligibility criteria. In total, across these three States, OIG estimated that more than \$580 million in Federal Medicaid payments were made on behalf of 183,579 potentially ineligible beneficiaries, and about \$655 million in payments made on behalf of 413,349 ineligible beneficiaries—over \$1.2 billion in total for more than 596,000 beneficiaries. Both human and system errors contributed to these payments, with some enrollment data systems lacking the ability to (1) deny or terminate ineligible beneficiaries; (2) properly redetermine eligibility when a beneficiary aged out of an eligibility group; (3) maintain records, per Federal requirements, relating to eligibility determinations and verifications; and (4) retrieve and use information from other Government databases, such as those managed by the Social Security Administration and Department of Homeland Security.

To ensure compliance with Federal and State requirements for determining Medicaid eligibility, we recommended that States ensure that enrollment data systems are able to verify eligibility criteria, develop and implement written policies and procedures to address vulnerabilities, and undertake redeterminations as appropriate.

Detection: Complete and reliable national Medicaid data are necessary for effective program oversight and management and to detect bad actors.

Proper oversight includes the capacity to detect problems in real time. This can help prevent improper payments, protect patients, and reduce time-consuming and expensive “pay and chase” activities. Detecting problems is a shared responsibility for all actors in the Medicaid program: CMS, States, managed care contractors, and providers. The lack of national Medicaid data hampers the ability to quickly detect improper payments, fraud, waste, or quality concerns, both within States and across the Nation. Unscrupulous providers committing fraud or engaging in patient harm do not respect State boundaries.

CMS must ensure the completeness and reliability of data in the Transformed Medicaid Statistical Information System.

Through the Balanced Budget Act of 1997, Congress mandated that States submit data to provide for a national Medicaid dataset. The Transformed Medicaid Statistical Information System (T-MSIS) is a joint effort by CMS and the States to address previously identified problems with national Medicaid claims and eligibility data. CMS’s goals for T-MSIS are to improve the completeness, accuracy, and timeliness of Medicaid and CHIP data.

CMS began testing T-MSIS with 12 volunteer States starting in 2011 as a means to replace the Medicaid Statistical Information System as an enhanced national Medicaid dataset, after which CMS set a goal of having all States submit T-MSIS data by July 2014. CMS subsequently extended that deadline several more times. After multiple missed implementation deadlines, technological problems, competing priorities, and other implementation delays, as of last month 49 States and the District of Columbia had begun reporting data to T-MSIS.

As CMS and States continue to work toward full implementation, the completeness and reliability of T-MSIS data must be a top priority. A quality national Medicaid dataset is essential to States' and the Federal Government's ability to effectively and collaboratively administer and ensure the integrity of Medicaid. Fraud schemes affecting multiple States are very difficult to detect without comprehensive national data. Localized schemes can also be harder to detect without national data. Utilization or spending patterns may not appear problematic until compared against another State's experience or national averages. Recognizing such schemes in one State can alert other States to indicators of fraudulent or abusive practices that may be occurring in their jurisdiction. This information can lead to referrals to State law enforcement agencies like the State Medicaid Fraud Control Units or joint investigations across State lines. For example, it is important for CMS to ensure that the same data elements are being consistently reported across States, are uniformly interpreted across all States, and that those actually being reported will best inform program management and oversight. To accomplish this, OIG recommends that **CMS establish a deadline for when national T-MSIS data will be available**

for multi-State program integrity efforts. Without a fixed deadline, some States and CMS may not make the full implementation of T-MSIS a management priority.

CMS Should Ensure That States Report Encounter Data for All Managed Care Entities.

Managed care encounter data are among the most critical to be included in T-MSIS. Approximately 80 percent of all Medicaid beneficiaries receive part or all of their services through managed care. State Medicaid agencies contract with managed care entities to deliver health services and perform certain administrative functions, such as data collection and reporting. Most importantly, managed care entities are required to report medical claims data, known as encounter data, to States that then report the data to CMS via T-MSIS. Encounter data include detailed information about the services provided to Medicaid beneficiaries enrolled in managed care. Like Medicaid claims for services provided on a fee-for-service basis, encounter data are the primary record of services provided to Medicaid beneficiaries enrolled in managed care. The Society of Actuaries calls encounter data “the single most important analytical tool for health plans and health programs. Without accurate and timely data, it is not possible to analyze costs, utilization or trends; evaluate benefits; or determine the quality of services being provided.”

However, previous work by OIG found that States’ Medicaid managed care encounter data were incomplete. Reasons that States cited for their failure to report complete information included the inability to collect encounter data from some managed care entities and limitations in the State’s data systems. CMS has made progress in addressing this problem, including regulatory requirements, guidance, and an ongoing data quality monitoring review of submissions of encounter data through

T-MSIS. However, more must be done to ensure that the data necessary to provider program integrity in Medicaid managed care are complete, accurate, and timely. As a result, **we continue to recommend that CMS ensure that States report encounter data for all managed care entities.**

Enforcement: The lack of quality national Medicaid data hampers enforcement efforts.

Complete and reliable data are critical to identifying improper payments and to Federal and State enforcement efforts to keep fraudulent and harmful providers out of Medicaid and hold bad actors accountable.

National Medicaid data holds the promise of supporting and amplifying enforcement efforts. We have seen this potential realized in Medicare. For example, in July 2017, OIG and its law enforcement partners conducted the largest National Health Care Fraud Takedown in history. Sophisticated data analytics were critical. The end result—charges against more than 400 defendants across 41 Federal districts for their alleged participation in health care fraud schemes involving about \$1.3 billion in false billings—protected the programs and sent a strong signal that theft of taxpayer funds will not be tolerated. Notably, 120 defendants, including doctors, were charged for their roles in prescribing and distributing opioids and other dangerous narcotics, and 295 providers were served with exclusion notices for conduct related to opioid diversion and abuse. A concurrent [data brief](#) underscored the magnitude of the problem by identifying concerns about extreme use and questionable prescribing of opioids in Medicare Part D. That is the power of data— leveraged by skilled auditors, investigators, and analysts—to protect the program and bring bad actors to justice.

Unfortunately, we cannot replicate this type of analysis and enforcement action in Medicaid. Despite CMS's progress in implementing T-MSIS, we presently lack national Medicaid data that are complete and comparable across States. Decreased improper payments and savings achieved through improved program integrity could provide funding for increased services and assessments of the value of these services to a larger number of beneficiaries.

Conclusion

OIG continues to identify effectively overseeing Medicaid as a top management challenge for HHS. Challenges include longstanding program integrity vulnerabilities, such as the limitations in national Medicaid data that make it more difficult to detect and address improper payments and fraud. Quality national Medicaid data allow for the transparency necessary to determine whether Medicaid is paying the right provider, the right amount, for the right service, on behalf of the right beneficiary. Data can help accelerate enforcement efforts, reduce costs, improve quality of care, and identify best practices. While CMS and States have made important strides to improve Medicaid data, it remains to be seen whether T-MSIS will live up to its potential. Ultimately, T-MSIS will be only as useful as the data it receives. This is why CMS must ensure the completeness and reliability of T-MSIS data and improve provider enrollment data to prevent unscrupulous providers from gaining entry to Medicaid. Such data are essential to the efficiency, effectiveness, and integrity of Medicaid regardless of how it is structured.

As a modern OIG, we are using data and technology in innovative ways to enhance and target our oversight efforts. By leveraging advanced data analytic techniques to detect potential vulnerabilities

and fraud trends, we are better able to target our resources to those areas and individuals most in need of oversight. Quality Medicaid data are key to replicating these successes for Medicaid program integrity efforts. While neither CMS nor State Medicaid agencies presently have the data necessary to support a 21st century Medicaid program, we believe this Committee's continued oversight will help ensure the high-quality data needed for a well-functioning Medicaid program. Thank you for the opportunity to testify on this important topic.

Mr. MEADOWS. Thank you, Ms. Tinker.
 Ms. Yocom, you are recognized for 5 minutes.

STATEMENT OF CAROLYN YOCOM

Ms. YOCOM. Chairman Meadows, Chairman Palmer, Ranking Members Connolly and Raskin, and members of the subcommittee, I am pleased to be here to discuss oversight efforts in Medicaid. This joint Federal/State program financed healthcare services for over 70 million low-income and medically needy individuals, including children and people who are elderly or disabled.

Medicaid is a significant component of Federal and State budgets with nearly \$600 billion in estimated outlays for 2017. Due to concerns about the adequacy of oversight, Medicaid has been on our list of high-risk programs since 2003.

The partnership between the Federal government and States is a central tenet of the Medicaid Program. Within broad Federal requirements, States have flexibility to design and implement Medicaid based on their unique needs. The overall program is overseen at the Federal level by CMS. However, despite oversight efforts by CMS, overall improper payments continue to increase from \$29 billion to \$37 billion between Fiscal Year 2015 and 2017.

My statement today will focus on three broad areas critical to improving Medicaid oversight: addressing data challenges, strengthening Federal oversight, and improving and expanding Federal and State collaboration.

First, data challenges. CMS oversight relies on State-reported data that address multiple aspects of Medicaid, including expenditures and utilization of services. We and others have reported that insufficiencies in these data have affected CMS' ability to ensure proper payments and beneficiaries' access to care. We have raised concerns about the usefulness of state-reported data due to issues with completeness, accuracy, and timeliness.

To address these longstanding concerns, CMS has worked to develop a reliable national repository, T-MSIS. Implementing T-MSIS as has been and will continue to be a significant multiyear effort. Nearly all States are reporting some T-MSIS data. While recognize this progress, more work is needed before CMS or States can use T-MSIS for program oversight. For example, it remains unclear when all States will report complete and comparable T-MSIS data, and how CMS and States can use these data to improve the program.

Second, strengthening program oversight. Our work has identified other areas where CMS should take action. CMS has implemented many of our related recommendations, yet additional actions are needed to further strengthen program oversight.

First, our work has identified risks associated with provider enrollment and beneficiary eligibility. Continuing to develop strategies to address these risk and monitor progress will improve CMS oversight and reduce improper payments. Second, additional oversight is needed to ensure that Medicaid beneficiaries are able to access necessary healthcare services. This is particularly critical for beneficiaries who rely on long-term services and supports as well as behavioral needs, including treatment for those with opioid use

disorders. It is important to note that Medicaid is the largest payer for both long-term and behavioral healthcare.

Third, collaboration between the Federal government and the States. Identifying and sharing program integrity practices is critical, and there are challenges, but also some successes, here. In March 2017, we reported that collaborative audits in which CMS worked with States in partnership have great potential, but they are limited in their current use. We recommend that CMS take steps to remove barriers that limit State participation in these audits. In 2016, CMS, GAO, and a select group of State audit officials met to discuss future collaboration and specific areas of concern in Medicaid. Involving the State auditors in program oversight adds an important arsenal to reducing improper payments in Medicaid.

Lastly, in 2012, CMS created the Healthcare Fraud Prevention Partnership to study and share healthcare-related information on fraud, waste and abuse. Participants have told us that the partnership helped them identify potentially fraudulent providers and foster information sharing.

Chairman Meadows and Palmer, Ranking Members Raskin and Demings, and members of the subcommittee, this concludes my prepared statement, and I will be pleased to answer any questions you might have.

[Prepared statement of Ms. Yocom follows:]



United States Government Accountability Office

Testimony

Before the Subcommittee on Government Operations and the Subcommittee on Intergovernmental Affairs, Committee on Oversight and Government Reform, House of Representatives

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MEDICAID

Opportunities for Improving Program Oversight

Statement of Carolyn L. Yocom
Director, Health Care

GAO Highlights

Highlights of GAO-18-444T, a testimony before the Subcommittee on Government Operations and the Subcommittee on Intergovernmental Affairs, Committee on Oversight and Government Reform, House of Representatives.

Why GAO Did This Study

Medicaid, a joint federal-state health care program, is a significant component of federal and state budgets, with total estimated outlays of \$596 billion in fiscal year 2017. The program's size and diversity make it particularly vulnerable to improper payments. In fiscal year 2017, improper payments were an estimated \$37 billion of federal Medicaid expenditures, an increase from an estimated \$29.1 billion in fiscal year 2015.

The partnership between the federal government and states is a central tenet of the Medicaid program. Medicaid allows significant flexibility for states to design and implement their programs based on their unique needs. These programs are administered at the state level and overseen at the federal level by CMS. The resulting variability of state Medicaid programs complicates federal efforts to oversee program payments and beneficiaries' access to services.

This testimony focuses on the need for (1) better data, (2) improved oversight, and (3) greater federal-state collaboration to safeguard Medicaid program integrity. This testimony is based on GAO reports issued between May 2015 and January 2018 on the Medicaid program.

View GAO-18-444T. For more information, contact Carolyn Yocom at (202) 512-7114 or yocomc@gao.gov.

April 12, 2018

MEDICAID

Opportunities for Improving Program Oversight

What GAO Found

The Centers for Medicare & Medicaid Services (CMS) has taken steps to improve Medicaid program integrity and reduce improper payments; however, GAO has identified areas where additional, or continued, action could help strengthen program integrity and ensure beneficiaries' access to services. These actions include improving data quality, oversight, and federal-state collaboration.

Need for better data. As GAO has previously reported, a fundamental challenge to the oversight of the Medicaid program is the lack of complete, accurate, and timely data. This challenge has hindered CMS's ability to ensure the appropriate use of federal and state dollars for beneficiary care. Without reliable data, CMS is unable to effectively monitor who is providing services, or the type of services provided. CMS has taken steps to develop reliable Medicaid data, most notably with the Transformed Medicaid Statistical Information System, which will collect more information on beneficiaries. This system could improve CMS's ability to identify improper payments and help ensure beneficiaries' access to services, but additional work is needed. In December 2017, GAO made two recommendations to CMS to improve the completeness and comparability of the data from this system and CMS's plans for oversight. The agency concurred with the recommendations, but has not yet implemented them.

Need for stronger oversight. GAO has previously identified areas where stronger CMS oversight will help the agency better manage program risks, and improve beneficiaries' access to needed health care services.

- **Manage program risks.** From May 2015 to December 2017, GAO made 11 recommendations that could help CMS better assess the risk of fraud, as well as ensure that only eligible providers—particularly those in managed care—and beneficiaries are enrolled and participating in the Medicaid program. The agency generally concurred with these recommendations, but has not yet implemented them.
- **Access to services.** From August 2017 to January 2018 GAO made eight recommendations aimed at ensuring that beneficiaries with a limited ability to care for themselves—such as those with disabilities, complex health needs, or infants with neonatal abstinence syndrome—have access to necessary services. The agency concurred with the recommendations, but has not yet implemented them.

Need for greater federal-state collaboration. GAO has previously reported that collaborative activities between the federal government and the states—such as sharing promising program integrity practices—are important to improving oversight of the Medicaid program. Recent examples of such activities include a national Medicaid training program for state officials and partnerships to combat Medicaid fraud. However, in March 2017, GAO also found that barriers—such as communication problems between CMS contractors and state officials—have limited the use of collaborative audits, which have the potential to identify substantial overpayments to providers. GAO recommended that CMS identify opportunities to address these barriers. CMS agreed with the recommendations, but has not yet implemented them.

Chairmen Meadows and Palmer, Ranking Members Connolly and Demings, and Members of the Subcommittees:

I am pleased to be here today to discuss oversight efforts intended to prevent improper payments in the Medicaid program.¹ This federal-state program is one of the nation's largest sources of funding for medical and other health-related services, covering acute health care, long-term care, and other services for over 73 million low income and medically needy individuals in fiscal year 2017. In that same year, estimated federal and state Medicaid expenditures were \$596 billion. The size and complexity of Medicaid make the program particularly vulnerable to improper payments—including payments made for people not eligible for Medicaid or made for services not actually provided. Due to concerns about the adequacy of fiscal oversight, Medicaid has been on our list of high-risk programs since 2003.²

Despite efforts to reduce improper payments in the Medicaid program by the Centers for Medicare & Medicaid Services (CMS), which oversees the program, overall improper payments continue to increase—rising to about \$37 billion in fiscal year 2017 compared with \$29.1 billion in fiscal year 2015. The Medicaid program alone accounted for 26.1 percent of the fiscal year 2017 government-wide improper payment estimate. It is critical to take appropriate measures to reduce improper payments, as dollars wasted detract from our ability to ensure that the individuals who rely on the Medicaid program—including children, and individuals who are elderly or disabled—are provided adequate care.

The partnership between the federal government and states is a central tenet of the Medicaid program. Within broad federal requirements, states have significant flexibility to design and implement their programs based

¹An improper payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. It includes any payment to an ineligible recipient, any payment for an ineligible service, any duplicate payment, payment for services not received (except where authorized by law), and any payment that does not account for credit for applicable discounts. See 31 U.S.C. § 3321 note. Office of Management and Budget guidance also instructs agencies to report as improper payments any payments for which insufficient or no documentation is found.

²See GAO, *High-Risk Series: Progress on Many High-Risk Areas, While Substantial Efforts Needed on Others*, GAO-17-317 (Washington, D.C.: Feb. 15, 2017).

on their unique needs, resulting in 56 distinct Medicaid programs.³ These programs are administered at the state level and overseen at the federal level by CMS, an agency within the Department of Health and Human Services (HHS). The resulting variability of state Medicaid programs complicates federal efforts to oversee program payments and beneficiaries' access to services.

My testimony today will focus on three actions important to improving oversight of the Medicaid program:

1. addressing data challenges that limit CMS's ability to ensure the appropriate use of federal Medicaid dollars;
2. strengthening federal oversight to address program risks that can help reduce improper payments, as well as ensure appropriate care for beneficiaries; and
3. improving federal-state collaboration to strengthen program oversight.

My remarks are based on our large body of work examining the Medicaid program, specifically our reports issued and recommendations made from May 2015 to January 2018. (See app. I for selected recommendations and a list of related GAO reports at the end of this statement.) Those reports provide further details on our scope and methodology. We conducted all of the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

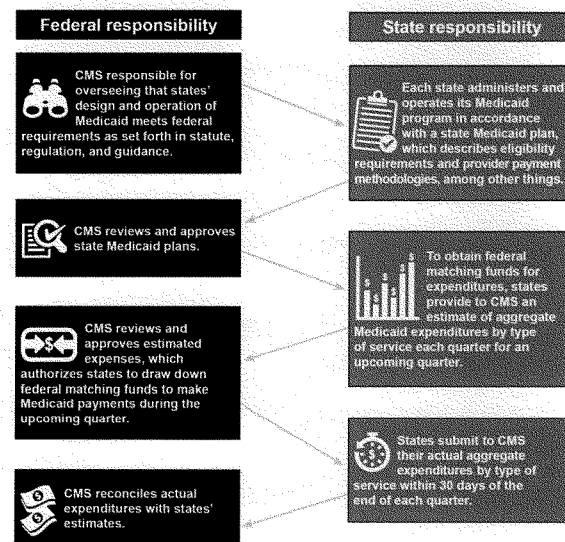
Background

Under Medicaid's federal-state partnership, CMS provides oversight and technical assistance for the program, and states are responsible for administering their respective Medicaid programs' day-to-day operations—including determining eligibility, enrolling individuals and providers, and adjudicating claims—within broad federal requirements. Federal oversight includes ensuring that the design and operation of state programs meet federal requirements and that Medicaid payments are

³Medicaid programs are administered by the 50 states, the District of Columbia, American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands.

made appropriately. (See fig. 1 for a diagram of the federal-state Medicaid partnership framework.) Financing Medicaid is also a fixture of the federal and state partnership, with the federal government matching most state Medicaid expenditures using a statutory formula based, in part, on each state's per capita income in relation to the national average per capita income.

Figure 1: Federal-State Medicaid Partnership Framework



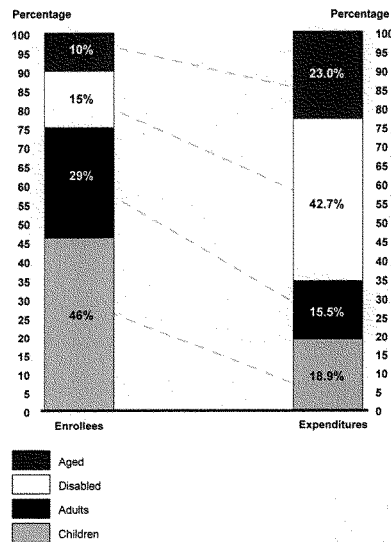
Source: GAO. | GAO-18-444T

Note: If a state wishes to make amendments to its state Medicaid plan, it must seek approval from the Centers for Medicare & Medicaid Services (CMS). Similarly, a state that desires to change its Medicaid program in ways that deviate from certain federal requirements may seek to do so through a Medicaid demonstration approved under section 1115 of the Social Security Act, which is outside of its state Medicaid plan. States must submit an application describing the proposed demonstration to CMS for review. CMS will specify the special terms and conditions that encompass the requirements for an approved demonstration.

Medicaid Covers a Wide Variety of Services for Low-Income and Medically Needy Populations

Medicaid provides coverage to a diverse group of beneficiaries, including certain categories of children, parents and other non-elderly adults, pregnant women, and individuals who are disabled or aged 65 and older. The health care needs and costs of these populations vary. For example, in fiscal year 2013—which are the most recent reliable data—children and adults constituted the majority—75 percent—of enrollees; however, the bulk of Medicaid expenditures—66 percent—were for aged and disabled enrollees. (See fig. 2.)

Figure 2: Medicaid Enrollment and Expenditures by Eligibility Group, Fiscal Year 2013



Source: GAO analysis of Medicaid and CHIP Payment and Access Commission (MACPAC) data. | GAO-18-444T

Note: Enrollees include individuals in 50 states and the District of Columbia who were enrolled in Medicaid during fiscal year 2013. Expenditures include both federal and state funds for 46 states and the District of Columbia, but exclude spending for administration. Payments from the Centers for Medicare & Medicaid Services to cover the costs of providing care to uninsured patients at

disproportionate share hospital are also excluded. Due to anomalies in the expenditure data, MACPAC excluded Rhode Island and Vermont from the expenditure data.

The program covers a comprehensive set of services, including physician, and inpatient and outpatient hospital care; and is also a particularly significant source of health care coverage and financing for certain services. For example, Medicaid is the nation's primary payer of long-term services and supports, including nursing home care and home- and community-based services, which allow individuals to live more independently and age in their homes. Medicaid is also the nation's largest source of funding for behavioral health services, including treatment related to mental health and substance use conditions.

States also have flexibility in determining how their Medicaid benefits are delivered. Many states deliver all or some services through contracted managed care organizations. For example, states may contract with managed care organizations to provide a specific set of Medicaid-covered services to beneficiaries and pay them a set amount per beneficiary per month; pay health care providers for each service they provide on a fee-for-service basis; or rely on a combination of both delivery systems. Managed care continues to be a growing component of the Medicaid program. In fiscal year 2017, expenditures for managed care represented almost 50 percent of total federal program expenditures, compared with 38 percent in fiscal year 2014.

States also have the flexibility to innovate outside of many of Medicaid's otherwise applicable requirements through Medicaid demonstrations approved under section 1115 of the Social Security Act.⁴ Demonstrations allow states to test new approaches to providing coverage and to improve quality and access or generate savings or efficiencies. For example, under demonstrations, states have

- extended coverage to certain populations,
- provided services not otherwise eligible for Medicaid, and

⁴Under section 1115 of the Social Security Act, the Secretary of Health and Human Services may waive certain Medicaid requirements and approve new types of expenditures that would not otherwise be eligible for federal Medicaid matching funds for experimental, pilot, or demonstration projects that, in the Secretary's judgment, are likely to promote Medicaid objectives. See 42 U.S.C. § 1315(a). The Secretary has delegated the approval and administration of Medicaid section 1115 demonstrations to CMS, which requires that such demonstrations be budget neutral to the federal government; that is, the federal government should spend no more for Medicaid under a state's demonstration than it would have spent without the demonstration.

-
- made payments to providers to incentivize delivery system improvements.

As we have previously reported, nearly three-quarters of states had CMS approved demonstrations as of November 2016. In fiscal year 2015, federal spending under demonstrations represented a third of all Medicaid spending nationwide.

CMS Must Address Data Challenges, Which Hamper Its Oversight of Medicaid

Our previous body of work has shown that underlying data challenges in the Medicaid program have persistently hindered CMS's ability to ensure the appropriate use of federal and state dollars for beneficiary care. CMS oversight relies in large part on state-reported data on multiple aspects of the Medicaid program, including expenditures and utilization of program services. We and others have reported that insufficiencies in these data have affected CMS's ability to ensure proper payments and beneficiaries' access to care. Specifically, we have previously raised concerns about the usefulness of state-reported Medicaid data, because of issues with completeness, accuracy, and timeliness. Examples of these data issues include the following:

- **Expenditure data.** CMS relies on a dataset known as the CMS-64, which is used to collect state-reported data on aggregate expenditures. These data are used to reimburse states for the federal share of program spending. In our prior work, we concluded that available Medicaid expenditure data do not provide CMS with sufficient information to consistently ensure that Medicaid payments are proper.⁵ For example, we found in 2015 that CMS does not collect accurate state data on Medicaid enrollment by eligibility type in the CMS-64, thus complicating the agency's ability to identify erroneous expenditures due to incorrect eligibility determinations.⁶
- **Utilization data.** In our prior work, we concluded that utilization data in the Medicaid Statistical Information System—which states used to provide beneficiary-based data on eligibility and covered health care services, among other things—were incomplete and reported late. These types of data are important to both CMS and the states for

⁵See GAO, *Medicaid: Program Oversight Hampered by Data Challenges, Underscoring Need for Continued Improvement*, GAO-17-173 (Washington, D.C.: Jan. 6, 2017).

⁶See GAO, *Medicaid: Additional Efforts Needed to Ensure that State Spending is Appropriately Matched with Federal Funds*, GAO-16-53 (Washington, D.C.: Oct. 16, 2015).

Medicaid program oversight and evaluation. We noted that without better data, CMS may not be able to identify patterns that indicate inappropriate provider billing, or ensure that beneficiaries have access to covered services.

As we have previously reported, the lack of complete and timely data has limited CMS's oversight. Without reliable data, CMS is unable to effectively monitor who is providing services, or the type, amount, and dates of such services. For example, in January 2017, we found that the most recent Medicaid personal care services data were from 2012, and only 35 states had finished reporting for that year.⁷ Further, 15 percent of claims lacked provider identification numbers, over 400 different procedure codes were used to identify the services, and the quantity and time periods varied widely. Without better data, we concluded that CMS is unable to effectively monitor who is providing personal care services or the type, amount, and dates of services.

Additionally, our prior work has found that the lack of complete and reliable data on services delivered in Medicaid managed care—known as encounter data—presents a significant oversight challenge for CMS given that over three-quarters of Medicaid beneficiaries were enrolled in managed care in 2014.⁸ In July 2015, HHS's Office of Inspector General reported that states were not complying with federal requirements regarding the submission of Medicaid encounter data in the Medicaid Statistical Information System. Specifically, it determined that 11 states did not report encounter data for all managed care plans operating in their states in fiscal year 2011, as required.⁹

As part of its efforts to address longstanding data concerns, CMS has taken steps toward developing a reliable national repository for Medicaid data, most notably the Transformed Medicaid Statistical Information System (T-MSIS). T-MSIS will collect more information on enrollees than

⁷See GAO, *Medicaid: CMS Needs Better Data to Monitor the Provision of and Spending on Personal Care Services*, GAO-17-169 (Washington, D.C.: Jan. 12, 2017). Personal care services provide assistance to beneficiaries of all ages who have limited ability to care for themselves, because of physical, developmental, or intellectual disabilities. Personal care services assist beneficiaries with activities of daily living such as bathing, dressing, and toileting.

⁸See GAO, *Medicaid: Service Utilization Patterns for Beneficiaries in Managed Care*, GAO-15-481 (Washington, D.C.: May 29, 2015).

⁹See HHS-OIG, *Not All States Reported Medicaid Managed Care Encounter Data as Required*, OEI-07-13-00120 (Washington, D.C.: July 2015).

the Medicaid Statistical Information System—such as their citizenship, immigration, and disability status—as well as expanded diagnosis and procedure codes associated with their treatments. States will report data more frequently than they did for the Medicaid Statistical Information System and T-MSIS also includes approximately 2,800 automated quality checks, which should improve the timeliness and quality of data that states report. By providing more standardized data on various aspects of Medicaid—such as spending or utilization rates—states could be better positioned to compare their programs with other states, thereby improving their ability to identify and correct program inefficiencies.

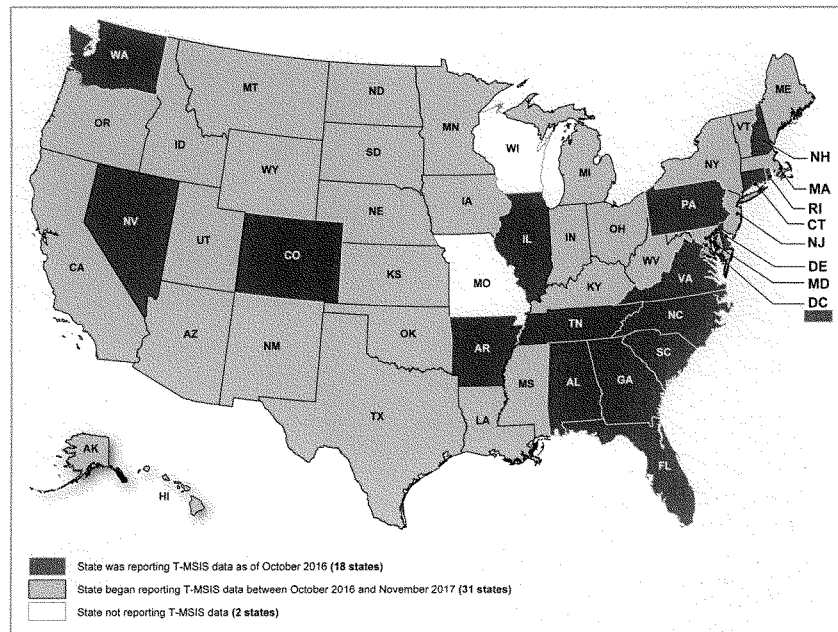
Implementing the T-MSIS initiative has been a significant, multi-year effort. CMS has worked closely with states and has reached a point where nearly all states are reporting T-MSIS data. The T-MSIS initiative has the potential to improve CMS's ability to identify improper payments, help ensure beneficiaries' access to services, and improve program transparency, among other benefits. While recognizing the progress that has been made, we recently noted that more work needs to be done before CMS or states can use these data for program oversight. Some examples of this work include the following:

- **Incomplete data.** CMS has made progress in the number of states reporting T-MSIS data. As we previously reported, from October 2016 to November 2017, the number of states reporting T-MSIS information increased from 18 to 49.¹⁰ (See fig. 3.) However, the data being reported were not always complete. None of the six selected states in the sample we reviewed were reporting complete T-MSIS data as of August 2017.¹¹ State officials said that certain unreported elements were contingent on federal or state actions, while others were not applicable to their state's Medicaid program. However, we found that states did not always document the reasons for missing data, such as whether they planned to report data elements in the future or when they would report complete data.

¹⁰See GAO, *Medicaid: Further Action Needed to Expedite Use of National Data for Program Oversight*, GAO-18-70 (Washington, D.C.: Dec. 8, 2017).

¹¹See GAO-18-70.

Figure 3: States' Transformed Medicaid Statistical Information System (T-MSIS) Reporting Status, as of November 2017



Sources: GAO summary of Centers for Medicare & Medicaid Services information; Map Resources (map). | GAO-18-444T

- **Comparability of data.** Officials in selected states noted that a national repository of T-MSIS data could allow them to compare their Medicaid program data—such as spending or utilization rates—to other states, which could potentially improve their oversight.¹²

¹²See GAO-18-70.

However, these same state officials expressed concerns that states did not convert their data to the T-MSIS format in the same ways. These inconsistencies could make cross-state comparisons difficult.

- **Plans for using data for oversight.** Although CMS has taken steps to begin using T-MSIS data, CMS officials acknowledged in August 2017 that they had yet to outline how best to use T-MSIS data for program monitoring, oversight, and management, because they were still largely focused on working with the remaining states to begin reporting T-MSIS data, analyzing the quality and usability of the T-MSIS data, and preparing the data for research purposes.¹³ In December 2017, we recommended that CMS articulate a specific plan and associated time frames for using T-MSIS data for oversight. We concluded that absent a specific plan and time frames, CMS's ability to use these data to oversee the program, including ensuring proper payments and beneficiaries' access to services, is limited. The agency concurred with the recommendation, but has not yet implemented it.

While recognizing the progress that has been made, more work needs to be done before CMS or states can use the T-MSIS data for program oversight. It remains unclear when all states will report complete and comparable T-MSIS data, and how CMS and states will use them to improve oversight. In December 2017, we recommended CMS take additional steps to expedite the use of T-MSIS for program oversight, and the agency concurred with our recommendation, but has not yet implemented it. Further delays in T-MSIS's use limit the agency's ability to reverse the trend of rising improper payments in the Medicaid program, underscoring the need for CMS to take additional steps to expedite the use of these data.

CMS Needs to Strengthen Oversight to Address Program Risks and Ensure Access to Care

CMS has taken steps to improve Medicaid program integrity and reduce improper payments. However, our work has identified several key areas where CMS should strengthen program oversight to address program risks that can result in improper payments, and ensure beneficiaries' access to needed health care services.

¹³See GAO-18-70.

CMS Must Strengthen Oversight to Manage Program Risks

In federal programs, it is necessary to identify program risks in order to design and implement strategies to mitigate these risks. For Medicaid, our work has identified program risks associated with provider enrollment and beneficiary eligibility. Developing strategies to address these risks and monitor progress will improve CMS's ability to oversee the significant amount of funds expended in the Medicaid program and reduce improper payments. Below, we identify several examples of the recommendations we have made to address program risks, and what, if any, steps CMS has taken in response to our recommendations. (See table 1.)

Table 1: Examples of Actions Recommended by GAO to Address Medicaid Program Risks

Program risks	GAO findings and recommendations	Status and GAO response
Managing fraud risks	In December 2017, we assessed the Centers for Medicare & Medicaid Services' (CMS) antifraud efforts and found, among other things, that while the agency has shown commitment to combating fraud and has taken steps to identify fraud risks, it has not conducted a fraud risk assessment for Medicaid or developed a risk-based antifraud strategy. ^a	CMS concurred with these findings and our recommendations for the agency to conduct a fraud risk assessment and to develop a risk-based antifraud strategy for Medicaid, but has not yet implemented them. We will monitor CMS's actions.
Ensuring that only eligible providers are enrolled in Medicaid	In April 2016, based on two states and 16 health plans, we identified challenges to screening providers in Medicaid managed care for eligibility, partially due to fragmented information. ^b In turn, we made four recommendations aimed at assessing the databases used to screen providers, improved collaboration and coordination with other federal agencies on sharing databases and establishing a common identifier across databases, and providing guidance to state Medicaid agencies.	CMS has addressed two of the four recommendations. One remaining recommendation directs CMS to determine whether any of the databases used by states and health plans to screen providers should be added to the list of the databases identified by CMS for screening purposes. To implement the recommendation, CMS will need to determine whether the remaining databases it has studied should be added to its list and take the appropriate action. For the other remaining recommendation, CMS needs to explore the use of a common identifier for screening Medicaid managed care providers across databases. We will continue to monitor CMS's actions.
Ensuring that only eligible beneficiaries are enrolled in Medicaid	In October 2015, we identified gaps in CMS's efforts to ensure that only eligible individuals are enrolled into Medicaid, and that Medicaid expenditures for enrollees—particularly those eligible as a result of the Patient Protection and Affordable Care Act expansion—are matched appropriately by the federal government. ^c	In response to the Act, CMS established a more rigorous approach for verifying financial and nonfinancial information needed to determine Medicaid beneficiaries' eligibility. The agency stated that it would include reviews of federal eligibility determinations in states that have delegated that authority as a part of its review of states' eligibility determinations. The results of this effort will be reported in 2019. We will continue to monitor this effort to determine if the agency is ascertaining the accuracy of federal eligibility determinations and taking corrective action where necessary.

Source: GAO | GAO-18-444T

Note: See appendix I for a more complete description of these recommendations and their accompanying reports.

^aSee GAO, *Medicare and Medicaid: CMS Needs to Fully Align Its Antifraud Efforts with the Fraud Risk Framework*, GAO-18-88 (Washington, D.C.: Dec. 5, 2017).

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

^cSee GAO, *Medicaid: Additional Efforts Needed to Ensure that State Spending is Appropriately Matched with Federal Funds*, GAO-16-53 (Washington, D.C.: Oct. 16, 2015). Under the Patient Protection and Affordable Care Act, state Medicaid expenditures for certain Medicaid enrollees are subject to higher federal matching percentages.

CMS Should Improve Oversight to Ensure Access to and Provision of Necessary Services

Our prior work has shown that oversight is needed to ensure that Medicaid's low-income and medically needy population is able to access necessary health care services. This is particularly important for individuals with disabilities and complex health needs. Beneficiaries who have limited ability to care for themselves rely on long-term services and supports, including nursing home care and home- and community-based services. Others with opioid use disorders often rely on Medicaid to receive necessary behavioral health treatment. Oversight to ensure access and the quality of these services is particularly critical given that Medicaid is the largest payer of services for both of these groups. Below, we identify several examples of our concerns about access to and provision of Medicaid services, the recommendations we have made, and what steps, if any, CMS has taken in response to our recommendations. (See table 2.)

Table 2: Examples of Program Areas Requiring Action to Improve Access to and Provision of Medicaid Services

Program area	GAO recommendations	Status and GAO response
Oversight of access and quality in managed long-term services and supports	In August 2017, we recommended that the Centers for Medicare & Medicaid Services (CMS) take steps to better identify and obtain key information—namely, provider network adequacy; critical incidents that may cause abuse, neglect, or exploitation of beneficiaries; and appeals and grievances—which are necessary to oversee states' efforts to monitor beneficiary access to quality managed long-term services and supports. ^a	The agency stated that it will consider this recommendation as it conducts its review of managed care regulations to prioritize beneficiary outcomes and state priorities. The agency stated that it will continue to assist states through technical guidance and other means and is in the process of enhancing its capacity to measure and monitor care and quality for these services and others. We will continue to monitor CMS actions in this area.

Program area	GAO recommendations	Status and GAO response
Improving assessments of individuals' needs for home- and community-based services (HCBS)	In December 2017, we reported that CMS had not addressed risks associated with providers (individual or managed care plans) conducting beneficiary needs assessments. ⁵ When providers conduct such assessments, they can face potential conflicts that could lead to inappropriate levels of care for beneficiaries in HCBS programs. ⁶ Also, we found that CMS had not consistently required states to follow its 2013 guidance that managed care plans not be involved in assessments used to determine eligibility for HCBS. We recommended that CMS ensure that all HCBS programs have requirements for states to address providers' potential for conflicts of interest in conducting assessments.	CMS agreed with our recommendations, but has not yet implemented them. We will continue to monitor CMS's actions.
Assessing the expansion of medication-assisted treatment (MAT) for opioid abuse ⁷	In October 2017, we reviewed federal efforts to expand access to comprehensive substance use services, including MAT. According to CMS, states are using the flexibility of demonstrations to cover a full continuum of care for individuals with substance use disorders, including short-term residential treatment. The Department of Health and Human Services (HHS) has some needed information for evaluating its efforts to expand access to MAT, but more information is needed. ⁸ In particular, we recommended that the agency establish targets related to expanding access to MAT, and establish timeframes for this evaluation.	HHS concurred with both recommendations, but has not yet implemented them. We will continue to monitor HHS's actions.
Implementing HHS's strategy to address neonatal abstinence syndrome.	In October 2017, we reviewed HHS's published strategy for addressing neonatal abstinence syndrome—a withdrawal condition in newborns occurring from the prenatal use of opioids or other drugs—most of whom are covered under Medicaid. We found that HHS has yet to determine how and when the recommendations from its strategy will be implemented. ⁹ We recommended that HHS should expeditiously develop a plan—including priorities; roles and responsibilities of stakeholders; timeframes; and methods for assessing progress—for implementing the recommendations included in its strategy to address neonatal abstinence syndrome.	HHS concurred that it should expeditiously address neonatal abstinence syndrome, but noted implementation of the strategy is contingent on funding. We will continue to monitor HHS's actions.

Source: GAO | GAO-18-444T

⁵See GAO, *Medicaid Managed Care: CMS Should Improve Oversight of Access and Quality in States' Long-Term Services and Supports Programs*, GAO-17-632 (Washington, D.C.: Aug. 14, 2017).

⁶Needs assessments are a process to collect data on functional needs, health status, and other areas that are used to determine individuals' eligibility for HCBS, and to plan services, such as the amount of services needed. Effective needs assessments help states ensure appropriate access to, and manage utilization of, services and therefore costs.

⁷See GAO, *Medicaid: CMS Should Take Additional Steps to Improve Assessments of Individuals' Needs for Home- and Community-Based Services*, GAO-18-103 (Washington, D.C.: Dec. 14, 2017).

⁶For those who are addicted to or misuse opioids, MAT has been shown to be an effective treatment, which combines behavioral therapy and the use of certain medications, such as methadone and buprenorphine.

⁷See GAO, *Opioid Use Disorders: HHS Needs Measures to Assess the Effectiveness of Efforts to Expand Access to Medication-Assisted Treatment*, GAO-18-44 (Washington, D.C.: Oct. 31, 2017).

⁸See GAO, *Newborn Health: Federal Action Needed to Address Neonatal Abstinence Syndrome*, GAO-18-32 (Washington, D.C.: Oct. 4, 2017).

Greater Federal-State Collaboration Is Needed to Strengthen Program Oversight

The federal government and the states play important roles in reducing improper payments in the Medicaid program. CMS is responsible for broad oversight of the program, while states have had primary responsibility for ensuring the integrity of the Medicaid program by preventing, identifying, and correcting improper payments. Collaborative activities—such as identifying and sharing promising program integrity practices—are important to improving Medicaid oversight and we have previously recommended that CMS take steps to collect and share promising program integrity practices.¹⁴ As we have previously noted, because states are the first line of defense against Medicaid improper payments, CMS should also take steps to address barriers that limit effective collaborations. Some recent examples of collaborative activities that promote program integrity include the Medicaid Integrity Institute (MII), coordination meetings with state auditors, and partnerships to combat Medicaid fraud.

- **The Medicaid Integrity Institute.** In a 2017 report we noted that CMS established the MII, the first national Medicaid training program for state program integrity officials in 2007.¹⁵ The MII offers substantive training and support in a structured learning environment at no cost to the states, with almost 3,800 attendees participating in on-site courses from fiscal years 2012 through 2015. One of the important benefits of the MII reported by state officials and course participants is the opportunity to meet with and learn from program integrity officials from across the country in formal and informal settings. In the classroom, participants learn from state officials who serve as faculty for the MII courses, and from each other through in-class discussions. While on-site at the MII, there are also informal opportunities for information sharing that can lead to further state-to-state collaboration.

¹⁴See GAO, *Medicaid Program Integrity: CMS Should Build on Current Oversight Efforts by Further Enhancing Collaboration with States*, GAO-17-277 (Washington, D.C.: Mar. 15, 2017).

¹⁵See GAO-17-277.

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- **Coordination with state auditors.** Similarly, in another 2017 report we noted that CMS and selected state audit officials held meetings in November 2016 and May 2017 to discuss specific areas of concern in Medicaid and future collaboration.¹⁶ We facilitated the November 2016 meeting, and participated in and presented prior audit results at the May 2017 meeting. These meetings served as a platform to discuss challenges with Medicaid oversight. For example, at the November 2016 meeting, state auditors discussed challenges they have had accessing data needed for Medicaid managed care oversight. Additionally, the state auditors and CMS officials discussed some of the benefits of coordination, with the state auditors noting that they can assist CMS's state program integrity reviews by identifying program weaknesses.
 - **Partnerships to combat Medicaid fraud.** In 2012, CMS created the Healthcare Fraud Prevention Partnership (HFPP) to share information with public and private stakeholders, and to conduct studies related to health care fraud, waste, and abuse. According to CMS, as of October 2017, the HFPP included 89 public and private partners—including Medicare- and Medicaid-related federal and state agencies, law enforcement agencies, private health insurance plans, and antifraud and other health care organizations.¹⁷ The HFPP has conducted studies that pool and analyze multiple payers' claims data to identify providers with patterns of suspect billing across private health insurance plans. In August 2017, we reported that the partnership participants separately told us the HFPP's studies helped them identify and take action against potentially fraudulent providers and payment vulnerabilities of which they might not otherwise have been aware, and fostered both formal and informal information sharing.¹⁸
 - **Collaborative audits.** CMS oversees and supports states, in part, by hiring contractors to audit Medicaid providers and facilitating state practices to improve program integrity. In recent years, CMS made changes to its Medicaid program integrity efforts, including a shift to collaborative audits—in which CMS contractors and states work in partnership to audit Medicaid providers. In March 2017, we reported that collaborative audits have identified substantial potential

¹⁶See GAO, *Medicare and Medicaid: CMS Needs to Fully Align Its Antifraud Efforts with the Fraud Risk Framework*, GAO-18-88 (Washington, D.C.: Dec. 5, 2017).

¹⁷See GAO-18-88.

¹⁸See GAO, *Medicare: CMS Fraud Prevention System Uses Claims Analysis to Address Fraud*, GAO-17-710 (Washington, D.C.: Aug. 30, 2017).

overpayments to providers, but barriers—such as staff burden or problems communicating with contractors—have limited their use and prevented states from seeking audits or hindered the success of audits.¹⁹ We recommended that CMS address the barriers that limit state participation in collaborative audits. CMS concurred with this recommendation and has taken steps to address them for a number of states, but has not yet made such changes accessible to a majority of states.

Chairmen Meadows and Palmer, Ranking Members Connolly and Demings, and Members of the Subcommittees, this concludes my prepared statement. I would be pleased to respond to any questions you may have.

GAO Contacts and Staff Acknowledgments

If you or your staff members have any questions concerning this testimony, please contact me at (202) 512-7114 or yocomc@gao.gov. Contact points for our Office of Congressional Relations and Public Affairs may be found on the last page of this statement. Other individuals who made key contributions to this testimony include Leslie V. Gordon (Assistant Director), Summar Corley (Analyst-in-Charge), Daniel Klabunde, Drew Long, Vikki Porter, and Jennifer Whitworth.

¹⁹See GAO-17-277.

Appendix I: Selected GAO Recommendations to Improve the Oversight of the Medicaid Program

The following table lists selected recommendations we have made to the Department of Health and Human Services, the Centers for Medicare & Medicaid Services, and the Office of Management and Budget regarding oversight of the Medicaid program, as well as a matter for congressional consideration. These recommendations remain unimplemented, as of March 2018.

Table 3: Selected GAO Recommendations to Improve the Oversight of the Medicaid Program

GAO Report	Recommendation
<i>Medicaid Assisted Living Services: Improved Federal Oversight of Beneficiary Health and Welfare Is Needed.</i> GAO-18-179. January 5, 2018.	<p>The Centers for Medicare & Medicaid Services (CMS) should:</p> <ul style="list-style-type: none"> provide guidance and clarify requirements regarding the monitoring and reporting of deficiencies that states using home and community-based services (HCBS) waivers are required to report on their annual reports; establish standard Medicaid reporting requirements for all states to annually report key information on critical incidents, considering, at a minimum, the type of critical incidents involving Medicaid beneficiaries, and the type of residential facilities, including assisted living facilities, where critical incidents occurred; and ensure that all states submit annual reports for HCBS waivers on time as required.
<i>Medicaid: CMS Should Take Additional Steps to Improve Assessments of Individuals' Needs for Home- and Community-Based Services.</i> GAO-18-103. December 14, 2017.	<p>CMS should:</p> <ul style="list-style-type: none"> ensure that all types of Medicaid HCBS programs have requirements for states to avoid or mitigate potential conflicts of interest on the part of entities that conduct needs assessments that are used to determine eligibility for HCBS and to develop HCBS plans of service. These requirements should address both service providers and managed care plans conducting such assessments.
<i>Medicare and Medicaid: CMS Needs to Fully Align Its Antifraud Efforts with the Fraud Risk Framework.</i> GAO-18-88. December 5, 2017.	<p>CMS should:</p> <ul style="list-style-type: none"> provide fraud-awareness training relevant to risks facing CMS programs and require new hires to undergo such training and all employees to undergo training on a recurring basis; conduct fraud risk assessments for Medicare and Medicaid that include respective fraud risk profiles and plans for regularly updating the assessments and profiles; and create, document, implement, and communicate an antifraud strategy that is aligned with and responsive to regularly assessed fraud risks. This strategy should include an approach for monitoring and evaluation.
<i>Medicaid: Further Action Needed to Expedite Use of National Data for Program Oversight.</i> GAO-18-70. December 8, 2017.	<p>CMS should:</p> <ul style="list-style-type: none"> take additional steps to expedite the use of the Transformed Medicaid Information System (T-MSIS) data for program oversight. Such steps should include, but are not limited to, efforts to (1) obtain complete information from all states on unreported T-MSIS data elements and their plans to report applicable data elements; (2) identify and share information across states on known T-MSIS data limitations to improve data comparability; and (3) implement mechanisms, such as the Learning Collaborative, by which states can collaborate on an ongoing basis to improve the completeness, comparability, and utility of T-MSIS data; and articulate a specific plan and associated time frames for using T-MSIS data for oversight.

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GAO Report	Recommendation
<i>Opioid Use Disorders: HHS Needs Measures to Assess the Effectiveness of Efforts to Expand Access to Medication-Assisted Treatment.</i> GAO-18-44. October 31, 2017.	The Department of Health and Human Services (HHS) should: <ul style="list-style-type: none"> establish performance measures with targets related to expanding access to medication assisted treatment (MAT) for opioid use disorders; and establish timeframes in its evaluation approach that specify when its evaluation of efforts to expand access to MAT will be implemented and completed.
<i>Newborn Health: Federal Action Needed to Address Neonatal Abstinence Syndrome.</i> GAO-18-32. October 4, 2017.	HHS should: <ul style="list-style-type: none"> develop a plan—which includes priorities, timeframes, clear roles and responsibilities, and methods for assessing progress—to effectively implement the recommendations related to neonatal abstinence syndrome identified in the <i>Protecting Our Infants Act: Final Strategy</i>.
<i>Medicaid Managed Care: CMS Should Improve Oversight of Access and Quality in States' Long-Term Services and Supports Programs.</i> GAO-17-632. August 14, 2017.	CMS should: <ul style="list-style-type: none"> take steps to identify and obtain key information needed to oversee states' efforts to monitor beneficiary access to quality services, including, at a minimum, obtaining information specific to network adequacy, critical incidents, and appeals and grievances.
<i>Medicaid Program Integrity: CMS Should Build on Current Oversight Efforts by Further Enhancing Collaboration with States.</i> GAO-17-277. March 15, 2017.	CMS should: <ul style="list-style-type: none"> identify opportunities to address barriers that limit states' participation in collaborative audits; collaborate with states to develop a systematic approach to collect promising state program integrity practices; and collaborate with states to create and implement a communication strategy for sharing promising program integrity practices with states in an efficient and timely manner.
<i>Medicaid: CMS Needs Better Data to Monitor the Provision of and Spending on Personal Care Services.</i> GAO-17-169. January 12, 2017.	CMS should: <ul style="list-style-type: none"> establish standard reporting guidance for personal care services collected through T-MSIS to ensure that key data reported by states, such as procedure codes, provider identification numbers, units of service, and dates of service, are complete and consistent; better ensure, for all types of personal care services programs, that data on provision of personal care services and other HCBS collected through T-MSIS claims can be specifically linked to the expenditure lines on the CMS-64 that correspond with those particular types of HCBS services; better ensure that personal care services data collected from states through T-MSIS and the Medicaid Budget and Expenditure System comply with CMS reporting requirements; and develop plans for analyzing and using personal care services data for program management and oversight.
<i>Medicaid Managed Care: Improved Oversight Needed of Payment Rates for Long-Term Services and Supports.</i> GAO-17-145. January 9, 2017.	CMS should: <ul style="list-style-type: none"> require all states to collect and report on progress toward achieving managed long-term services and supports program goals, such as whether the program enhances the provision of community-based care; establish criteria for what situations would warrant exceptions to the federal standards that the data used to set rates be no older than the three most recent and complete years; and provide states with guidance that includes minimum standards for encounter data validation procedures.

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GAO Report	Recommendation
<i>Medicaid: Program Oversight Hampered by Data Challenges, Underscoring Need for Continued Improvement.</i> GAO-17-173. January 6, 2017.	<p>CMS should:</p> <ul style="list-style-type: none"> take immediate steps to assess and improve the data available for Medicaid program oversight, including, but not limited to, T-MSIS. Such steps could include (1) refining the overall data priority areas in T-MSIS to better identify those variables that are most critical for reducing improper payments, and (2) expediting efforts to assess and ensure the quality of these T-MSIS data.
<i>Improper Payments: Strategy and Additional Actions Needed to Help Ensure Agencies Use the Do Not Pay Working System as Intended.</i> GAO-17-15. October 14, 2016.	<p>Congress should:</p> <ul style="list-style-type: none"> consider amending the Social Security Act to explicitly allow the Social Security Administration to share its full death file with Treasury for use through the Do Not Pay (DNP) working system. <p>The Office of Management and Budget (OMB) should:</p> <ul style="list-style-type: none"> develop guidance that clarifies whether the use of DNP's payment integration functionality is required and—if required—the circumstances and process in which agencies may obtain an exemption from this requirement; develop a strategy—and communicate its strategy through guidance—for how agencies should use the DNP working system to complement existing data matching processes and whether and how agencies should consider using the DNP working system to streamline existing data matching; develop and implement monitoring mechanisms—such as goals, benchmarks, and performance measures—to evaluate agency use of the DNP working system; develop a process for comparing agency reporting on the use of the DNP working system to available sources, such as OMB guidance and DNP working system adjudication reports; and revise its guidance to clarify whether agencies should report on their uses of all of the functionalities of the DNP working system in their agency financial reports.
<i>Medicaid Program Integrity: Improved Guidance Needed to Better Support Efforts to Screen Managed Care Providers.</i> GAO-16-402. April 22, 2016.	<p>CMS should:</p> <ul style="list-style-type: none"> consider which additional databases that states and Medicaid managed care plans use to screen providers could be helpful in improving the effectiveness of these efforts and determine whether any of these databases should be added to the list of databases identified by CMS for screening purposes; and coordinate with other federal agencies, as necessary, to explore the use of an identifier that is relevant for the screening of Medicaid managed care plan providers and common across databases used to screen Medicaid managed care plan providers.
<i>Medicaid: Additional Efforts Needed to Ensure that State Spending is Appropriately Matched with Federal Funds.</i> GAO-16-53. October 23, 2015.	<p>CMS should:</p> <ul style="list-style-type: none"> conduct reviews of federal Medicaid eligibility determinations to ascertain the accuracy of these determinations and institute corrective action plans where necessary; and use information obtained from state and federal eligibility reviews to inform the agency's review of expenditures for different eligibility groups in order to ensure that expenditures are reported correctly and matched appropriately.
<i>Medicaid: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls.</i> GAO-15-313. May 14, 2015.	<p>CMS should:</p> <ul style="list-style-type: none"> provide guidance to states on the availability of automated information through Medicare's enrollment database—the Provider Enrollment, Chain and Ownership System—and full access to all pertinent system information, such as ownership information, to help screen Medicaid providers more efficiently and effectively.

Source: GAO. | GAO-18-444T

Related GAO Reports

Medicaid Assisted Living Services: Improved Federal Oversight of Beneficiary Health and Welfare is Needed. GAO-18-179. Washington, D.C.: January 5, 2018.

Medicaid: CMS Should Take Additional Steps to Improve Assessments of Individuals' Needs for Home and Community-Based Services. GAO-18-103. Washington, D.C.: December 14, 2017.

Medicaid: Further Action Needed to Expedite Use of National Data for Program Oversight. GAO-18-70. Washington, D.C.: December 8, 2017.

Medicare and Medicaid: CMS Needs to Fully Align Its Antifraud Efforts with the Fraud Risk Framework. GAO-18-88. Washington, D.C.: December 5, 2017.

Opioid Use Disorders: HHS Needs Measures to Assess the Effectiveness of Efforts to Expand Access to Medication-Assisted Treatment. GAO-18-44. Washington, D.C.: October 31, 2017.

Newborn Health: Federal Action Needed to Address Neonatal Abstinence Syndrome. GAO-18-32. Washington, D.C.: October 4, 2017.

Medicare: CMS Fraud Prevention System Uses Claims Analysis to Address Fraud. GAO-17-710. Washington, D.C.: August 30, 2017.

Medicaid Managed Care: CMS Should Improve Oversight of Access and Quality in States' Long-Term Services and Supports Programs. GAO-17-632. Washington, D.C.: August 14, 2017.

Medicaid Program Integrity: CMS Should Build on Current Oversight Efforts by Further Enhancing Collaboration with States. GAO-17-277. Washington, D.C.: March 15, 2017.

High-Risk Series: Progress on Many High-Risk Areas, While Substantial Efforts Needed on Others. GAO-17-317. Washington, D.C.: February 15, 2017.

Medicaid: CMS Needs Better Data to Monitor the Provision of and Spending on Personal Care Services. GAO-17-169. Washington, D.C.: January 12, 2017.

Related GAO Reports

Medicaid Managed Care: Improved Oversight Needed of Payment Rates for Long-Term Services and Supports. GAO-17-145. Washington, D.C.: January 9, 2017.

Medicaid: Program Oversight Hampered by Data Challenges, Underscoring Need for Continued Improvement. GAO-17-173. Washington, D.C.: January 6, 2017.

Improper Payments: Strategy and Additional Actions Needed to Help Ensure Agencies Use the Do Not Pay Working System as Intended. GAO-17-15. Washington, D.C.: October 14, 2016.

Medicaid Program Integrity: Improved Guidance Needed to Better Support Efforts to Screen Managed Care Providers. GAO-16-402. Washington, D.C.: April 22, 2016.

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

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

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

Mr. MEADOWS. Thank you, Ms. Yocom.

Mr. Purpera, is that how you say it? You can go ahead and correct me. Everybody does.

Mr. PURPERA. That is how you say it.

Mr. MEADOWS. Okay, all right. Well, the gentleman from Louisiana is recognized for 5 minutes.

STATEMENT OF HONORABLE DARYL PURPERA

Mr. PURPERA. Thank you, sir. Mr. Chairman and members, Daryl Purpera, legislative auditor for Louisiana. I really come to speak with you specifically today about the underutilization of State auditors across our Nation in the fight against fraud, waste, abuse, and improper payments.

I have heard it mentioned here 2 times today that it is a \$36 billion problem. I want to remind everyone that is Federal dollars. There is an additional \$20 billion or so of State dollars that are also being misspent.

I want to talk to you specifically about how the State auditors roll. State auditors are required by the Single Audit Act to audit the Medicaid Program, so that is one of our jobs responsibilities. We get our instructions from the OMB through what is called a compliance supplement. That is kind of the audit program, what are we to do. And I want to talk to you about some inadequacies in this.

The Medicaid Program has as a key determination point for eligibility is the income component based upon modified adjusted gross income of the recipient. However, the compliance supplement, the document that we are to operate under, specifically tells the State auditor that we are not to test Medicaid eligibility based upon modified adjusted gross income. Now, the rationale behind that is because CMS has some other oversight mechanisms. Well, in the State of Louisiana, that other oversight mechanism is part of this pilot program, but that task was given to our department of health. So, you have the department who is administering the program auditing itself when it comes to eligibility using the modified adjusted gross income. That is a scope limitation for the auditor, a significant departure from auditing procedures.

State auditors also do not have access to data that we need, specifically Federal tax information. Access to the Federal tax information is restricted by 26 USCA 6103, Federal law. We have access to the tax data when we are auditing our Department of Revenue. So, if my auditors are auditing our Department of Revenue, we have got the Federal tax data. But if I am auditing over at the Department of Health and Hospitals looking at my Medicaid Program, now I cannot use the very thing that I can use over here on my right hand. I cannot let my left hand see it. So, it is a counterproductive restraint upon us.

Furthermore, the Federal regulations do not require the examination of Federal tax data when making eligibility determinations. We learned that 25 States actually use Federal tax data, but the remainder do not use the Federal tax data. But since we are basing the program on modified adjusted gross income, I would think it would be wise to use the Federal tax data. The other databases that we are using do not encompass all income categories. For ex-

ample, it does not include self-employment, farming and fishing, rents, royalties, retirements, pensions, and alimony, and many other things. And so, we are kind of operating the program with our hands tied behind our back.

I also want to talk to you about what I believe is the costly effect of the reasonable compatibility standard. The reasonable compatibility standard came about with the Affordable Care Act, and it is a policy or a rule of the CMS. And what it does it allows an individual to attest to an income when they are applying for Medicaid, and the State agency is to verify that income by using electronic data sources such as wage data. And so, if they attest to, say, 138 percent of Federal poverty limit and that is my attested-to income, but the State looks over at the wage data and sees that the individual makes, let's say 150 percent of Federal poverty limit, in the State of Louisiana, we use a reasonable compatibility standard of 25 percent. That individual is going to be deemed eligible even though their income is higher than the 138 percent. And so, I believe that's a standard that not only creates a significant problem for auditors because we really can't see where the line is anymore, but it's also we've extended the upper limit of Medicaid eligibility by doing that.

Now, why are these issues important to me? Let me tell you why they're important. In 2017, our State formed the Medicaid Fraud Task Force. I chair that committee. It's a legislative committee. We did a test, and we took 860,000 individuals, basically our adult population, and we asked our Department of Revenue, because I can't get the data. We asked our Department of Revenue to compare what the individuals put on their Medicaid application, compare it to their tax returns. Eighty-three thousand individuals came back as they had a tax return income of \$20,000 or more different than what was on their Medicaid application. We can't make any conclusions from that, but it does point to a significant risk that there is a problem. In addition, 48 percent of the applicants had household sizes for their tax returns different than their Medicaid. Now, I realize the rules are a little different, but they're very much the same.

I believe that we need to be looking for new audit approaches, and the State auditors needs to be right in the middle of this. Currently, dollars are flowing from the Federal government to our attorney generals to prosecute fraud, but very few dollars are going to our State auditors all around our Nation to help prevent and detect these improper payments before they happen.

Thank you, gentleman. I'll take any questions you have.

[Prepared statement of Mr. Purpera follows:]



Testimony by Legislative Auditor Daryl Purpera, CPA, CFE
To the Joint Meeting of the Subcommittee on Government Operations
& the Subcommittee on Intergovernmental Affairs
April 12, 2018 at 10:00 a.m.
Room 2154 of the Rayburn House Office Building

Chairmen and members, my name is Daryl Purpera and I am the Legislative Auditor for the State of Louisiana. With me is Mr. Wesley Gooch, Special Assistant for Healthcare Audit. I was elected by the Louisiana Legislature to serve as Louisiana's Legislative Auditor in 2010 and have a total of 34 years of government auditing experience. My office is provided constitutionally within the Legislative branch of Louisiana government. I am also Chairman of the Louisiana Task Force on Coordination of Medicaid Fraud Detection and Prevention Initiatives. I serve as an executive committee member for the National Association of State Auditors, Comptrollers, and Treasurers (NASACT), as well as the National Association of State Auditors (NSAA).

I have come today to speak to you specifically about the underutilization of the State Auditor's in the fight against fraud, waste, abuse, and improper payments in the Medicaid program. While I will focus on the issues we face with regard to the Medicaid program, these comments apply also to other programs such as the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF). I come as a professional government auditor and not a Medicaid, SNAP, or TANF expert. What I am about to testify to today, is the ongoing result of collaboration of my office, the Louisiana Medicaid Fraud Task Force, NASACT, NSAA, and the United States Government Accountability Office (GAO). My comments will focus on the (1) inadequate audit requirements, (2) the auditors' lack of adequate access to Federal Tax Data, and (3) costly effect of the Reasonable Compatibility Standard, and (4) the need for a new approach to auditing Medicaid programs.

I began these efforts after learning that the Centers for Medicare and Medicaid Services (CMS) estimates that the projected loss from improper Medicaid payments exceeds \$50.6 billion each year across our nation. Of that amount, federal dollars account for \$29.1 billion while the states collectively account for the remaining \$21.5 billion¹. At a time when our country and many states are facing difficult financial decisions, finding a way to help stem this fraud, waste, and abuse and other improper payments is critical.

¹ CMS 2015 Medicaid and CHIP Improper Payments Report (www.cms.gov/Research-Statistics-Data-and-Systems)

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Single Audit Requirements

State Auditors across our nation are required annually to audit the various federal programs such as Medicaid under the Single Audit Act. The Single Audit Act of 1996 was enacted to streamline and improve the effectiveness of audits of federal awards expended by states, local governments, and not-for-profit entities, as well as to reduce audit burden. The Single Audit Act requires these audits, referred to as “single audits” to be conducted by an independent auditor. Single audits have a significant public interest component as they are relied on by state and federal agencies as part of their administrative responsibilities for determining compliance with the requirements of federal awards by non-federal entities.

The Single Audit Act gives the Director of the Office of Management and Budget (OMB) the authority to develop government-wide guidelines and policy on performing audits to comply with the Act. The most recent OMB regulation issued for this purpose is Title 2 U.S. Code of Federal Regulations (CFR) Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance). It includes uniform cost principles and audit requirements for federal awards to nonfederal entities and administrative requirements for all federal grants and cooperative agreements. The audit requirements are provided to independent auditors, like my office, through program Compliance Supplements.

Now, I will begin to address what I believe to be significant deficiencies in the audit process that are likely resulting in fraud, waste, abuse, and other improper payments going undetected year after year and thereby costing our taxpayers substantial precious resources.

Inadequate Audit Requirements

The Medicaid program has, as a key determination of eligibility, an income component based on the Modified Adjusted Gross Income (MAGI) of the recipient. However, the Compliance Supplement for Medicaid² specifically provides that the auditor should not test eligibility for determinations based on MAGI. The guidance states that “Detailed testing is performed under the Medicaid and CHIP Eligibility Review Pilots, which serve as CMS’s oversight of Medicaid and CHIP eligibility determination during the initial years of Affordable Care Act implementation.” As a result of this guidance, state auditors, and other independent auditors, do not conduct the audit work needed to ensure that recipients meet the income

² Compliance Supplement Medicaid Cluster 4-93.778-15, Section E.1

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requirements of the programs using MAGI information. Further, I have learned that CMS, through its Pilot program, assigned the Louisiana MAGI eligibility review to the Louisiana Department of Health, the agency responsible for administering the Medicaid program. Therefore, there is no independent review of income eligibility. This scope limitation upon the state auditor is a significant departure from proper auditing procedures. Basically, in many cases, no independent reviewer is looking at this key component of eligibility.

State Auditors Do Not Have Access to Federal Tax Information

Access to the MAGI data is restricted by federal law. 26 USCA 6103(d)(2) restricts the state auditor's access to federal tax information (FTI) to "...for the purpose of, and only to the extent necessary in, making an audit of the..." state tax agency. As a result, my office may access federal tax data when, and only when, auditing the Louisiana Department of Revenue. I cannot use this same tax data to audit Medicaid, SNAP, or TANF. What this means is the information I can hold in my right hand while auditing our tax agency, I cannot let my left hand use while auditing our Medicaid agency. This is a significant, counterproductive restraint placed upon the independent state auditor.

Furthermore, federal regulations for administering the Medicaid program do not require the examination of federal tax data when making eligibility determinations or subsequent renewals. We found that while 25 state Medicaid agencies utilize federal tax information (FTI) in some manner, the remainder does not. CMS policy allows states to choose which electronic data sources are used. Some of these sources, for example, wage data, does not include all sources of income sources, such as self-employment, and can therefore lead to incorrect eligibility conclusions. Again, because MAGI is a key component of eligibility determination, I believe the use of FTI should be mandatory.

Costly Effect of Reasonable Compatibility Standard

CMS rules provide that states may incorporate a process known as the reasonable compatibility standard (RCS) during their enrollment process. Under this process, when an applicant attests to an income amount that falls within eligibility standards (138% Federal Poverty Level) but electronic information, such as state workforce data (wage records), exceeds the eligibility maximum, the state may use the applicant attested income as long as the difference between the two does not exceed the predetermined RCS. Louisiana adopted an RCS of 25%. Therefore, under this process, an applicant could have an income as much as 172% of FPL and still be considered eligible. The original intent of the RCS appears to have been the streamlining

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of the eligibility process, not expanding the income level of eligibility. CMS has indicated that this process assists individuals when they move between Medicaid and the Federal Facilitated Exchange (FFE) since the FFE uses a 25% RCS. However, what this does not consider is that in the FFE program, any under-reporting of income by a recipient is verified through the filing of their annual IRS tax form and any amounts of assistance that were incorrectly provided are reduced from the taxpayers refund. The Medicaid program has no process in place to rectify instances where the RCS has resulted in individuals being deemed eligible and given services, but are later determined to have not actually qualified for the program.

Why These Issues are Important

Now let me tell you why I believe this to be so important. During Louisiana's 2017 Regular Legislative Session, the Louisiana Task Force on Coordination of Medicaid Fraud Detection and Prevention Initiatives (Task Force) was created. I've had the pleasure to chair this Task Force and it includes members of the Louisiana legislature as well as the Louisiana Department of Health and Department of Revenue. As part of our work, we conducted a test of eligibility based on state tax records. Our sample included 860,000 Louisiana Medicaid applicants which was basically the entire 2016 adult population of Medicaid recipients. Approximately 39% of recipients had filed 2016 Louisiana tax returns or roughly 335,400 recipients. Of those that filed, 25% or 83,850 had gross incomes that differed by \$20,000 or more than the amounts reported to Medicaid. Sixty-two percent, or 207,948, had tax incomes that differed by \$10,000 or more than the amounts reported to Medicaid. While we cannot make final conclusions based on this data, it does indicate a significant possibility that those individuals with incomes greater than amounts permitted by the program will be considered eligible for Medicaid thereby increasing the cost to both the state and federal governments. For example, if the 83,850 recipients mentioned above were discovered to have been ineligible, this could be costing the program from \$352 million to \$503 million annually.

Our test also considered the household size which is another component of eligibility determinations. The results of the test indicated that 48% of applicants had household sizes for Medicaid that differed from their tax basis household size. Again, this indicates a risk that Medicaid household size is not accurate and may result in individuals being considered eligible when they are not. The Task Force made numerous recommendations and I have provided you a copy of those for your information.

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Fee-For-Service to Managed Care

As state Medicaid programs move from traditional fee-for-service (FFS) to managed care, the OMB audit requirements have not kept up with the shift in risk. While fee-for-service audit requirements are rather detailed, managed care audit requirements focus only on whether the Medicaid recipient is eligible and whether the state made the proper per member per month (PMPM) premium payment. There are no audit requirements to consider the encounters claims from the managed care plans, the actual managed care payments to providers, the managed care plans' program integrity efforts, or the qualifications of the managed care providers that are not enrolled Medicaid providers. New managed care regulations were released in 2016 and some of this audit gap will be addressed as these new regulations are phased in and implemented.

Need For New Audit Tools

With the changes in program delivery and the identification of the high rate of improper payments, a new audit approach is needed that utilizes data analytics to enhance our results. Data analytics provides the tools designed to aid the analyst, auditor or investigator as they attempt to extract, from data sources including millions of transactions, the information most meaningful to their audit. Data analytics enables auditors to narrow their focus and efforts on those areas of greatest risk. In addition, the use of predictive modeling enables the auditor to use known schemes of fraud, waste and abuse to identify those transactions with highest risk based upon observed behavior within the data. The ultimate goal of this process is identifying those transactions or behaviors that demonstrate the greatest risk. In addition, state auditors should be provided access to both state and federal tax data to properly audit the income portion of eligibility determinations. Furthermore, we have learned that what happens in one state is most likely happening in others. Therefore, sharing of data, algorithms, behavior models, and results enables the auditor to multiply the success of this program.

Results So Far

The early results that have been published by the Louisiana Legislative Auditor include:

- In October 2016, we reported that the Louisiana Department of Health (LDH) did not properly identify Medicaid recipients who had moved out of state. Because managed care recipients are funded much like an insurance policy through a per-member per-month fee, the LDH erroneously paid nearly \$1 million in premiums with an additional \$1.5 million in questionable payments. Using data analytics, we determined that over

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thirteen thousand recipients had no claims over a four year period and of those, 413 had out of state addresses. A review of 160 of these recipients confirmed that all 160 were living outside of Louisiana on a permanent basis. Our LDH continues to investigate the bulk of the thirteen thousand questionable recipients and implement controls to prevent reoccurrence.

- In March 2017, we reported that LDH paid \$6.4 million over a four-year period in dental claims that violated program rules and another \$4.4 million that may have violated program rules. Using data analytics, we matched paid claims against program rules resulting in over one-hundred thousand claims that did not comply with program rules.
- In March 2017, we reported that LDH paid \$1.4 million in duplicate Medicaid payments. Using data analytics, we isolated payments LDH made under two or more different Medicaid ID's for the same service, provided during the same period, for the same individual.
- In March 2017, we reported that LDH paid \$620,000 in payments for overlapping services and \$326,915 to direct care workers while the recipients were hospitalized or in nursing facilities.
- In September 2017, we reported that LDH paid \$4.2 million in improper payments that violated certification rules for laboratory services or involved invalid laboratory procedure codes.
- In October 2017, we reported that LDH's managed care plans had paid \$150,196,886 through T1015 all-inclusive claims without required accompanying detail increasing risk that appropriate services were not provided, claims were unbundled, or not covered.
- In November 2017, we reported that LDH paid \$717,820 in improper payments for 712 deceased recipients.

Other state auditors have used data analytics and issued numerous reports disclosing:

- Disallowed drug claims including excess drug quantities, missing or invalid prescriptions, and unauthorized or inappropriate refills.
- Inappropriate Premium Payments including:

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- Improper or questionable premium payments for recipients who were subsequently dis-enrolled retroactively and the Managed Care Operator (MCO) was not at risk during the disenrollment periods
- Overpayments for FFS claims for recipients whose services had been covered by managed care
- Claims billed with incorrect information pertaining to other health insurance
- Recipients diagnosed with end state renal disease who were entitled to Medicare coverage at the time of claim
- Improper episodic payments to home health care providers, and
- Overpayment for newborn claims that had been submitted with incorrect birth weights
- Administrative MCO costs including:
 - Overpaid MCOs in mainstream managed care premiums attributable to administrative costs and incorrect calculation of actuarial sound rates
 - Overpaid for services procured through a corporate affiliate that should have been classified as administrative costs
 - Overpaid due to un-allowed administrative costs included in rate structure
- Incorrectly identified providers as 340B providers, consequently, the drug claims that these providers had submitted were improperly excluded from the Medicaid Drug Rebate Program

My office is continuing projects that will be completed shortly including:

- Using data analytics to identify instances where per member per month payments continued to be made to the managed care plans while the Medicaid recipient was incarcerated. Any payments made while the recipient was incarcerated would be considered improper payments.
- Using data analytics to determine if the Louisiana Medicaid agency is obtaining valid data from the managed care plans that allow the agency and auditors to identify the actual provider who provided the service, the exact location of the service provided, and what organization was paid for the service. Without reliable provider information, further data analytic efforts to identify potential fraud, waste, and abuse is greatly hampered.

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- Using data analytics to identify Medicaid recipients who are enrolled with a managed care plan but have not been provided any services for multiple years. This lack of utilization of services could identify recipients who are no longer living in the state, are now deceased, or are incarcerated. Also, to determine what outreach efforts the managed care plan is making to encourage preventative health care by the recipients.
- Using multiple state data sources to identify a potentially high-risk eligibility population to test the validity of state processes for determining initial eligibility and future renewals. Our project will determine whether state practices meet federal regulations, especially for income determinations.

New Approach to Auditing Federal Programs Is Needed

What I am proposing is the creation of a national, collaborative audit approach focused on reducing fraud, waste, abuse, and other improper payments. Such an approach may provide an immediate impact at both the federal and state levels and could offer a clear path to reducing Medicaid, SNAP, and TANF costs without reducing needed assistance to those served. This approach will build on infrastructure that already exists and it will build upon the successes some states have already achieved to enhance their audit capacity.

In addition to the hindrance of access to federal tax information, the state auditors also face budgetary challenges to properly fund these vital audit functions. Since many state auditors charge their client agencies for audits performed and attempt to keep audit costs at the lowest possible level, they are rarely able to do more than is minimally required.

I believe that a solution should be sought that establishes a national audit framework, directly funded with federal funds, that is focused on reducing fraud, waste, abuse and other improper Medicaid payments. Given the size of the program, I have no doubt it will result in a positive return on investment.

This concludes my prepared remarks and I, as well as Mr. Gooch are available to answer any questions you may have.

Mr. MEADOWS. Thank you so much.
 Mr. Schneider, you are recognized for 5 minutes.

STATEMENT OF ANDY SCHNEIDER

Mr. SCHNEIDER. Thank you, Mr. Chairman, and good morning, Ranking Members Connolly and Raskin, and members of the subcommittees. I'm Andy Schneider, a research professor of the practice at the Center for Children and Families. The Center is an independent, nonpartisan policy and research organization based in the McCourt School of Public Policy at Georgetown University. Our mission is to expand and improve high-quality, affordable health coverage for America's children and families, particularly those with low and moderate incomes. I want to emphasize I'm here in my individual capacity, and my views do not necessarily represent the views of Georgetown University.

Thank you for the invitation to testify. I'm especially honored to be here. I had the privilege of serving as chief health counsel to the full committee in 2007 and 2008, and I know from that experience how important the oversight efforts of this committee's members and staff can be to making government work better. And thank you for holding this hearing which I think is in the best tradition of government oversight.

Medicaid is an enormously important health insurer for America's low-income children and families. A growing body of research, added to just this week by analysts at America's Health Insurance Plans, demonstrates that Medicaid is working well for children and adults alike, giving them access to care and preventive services at levels similar to those who have commercial coverage. All that said, Medicaid is not perfect. It can and should be improved by, among other things, reducing the rate of improper payments. And I hope today's hearing will get us to that result.

I want to make three quick points. First, Medicaid's 10.1 percent improper payment rate is too high, and it needs to come down. There is a clear path forward to bringing it down, a path that the Office of Inspector General is also urging this morning, which is to fully implement the provider screening and enrollment requirements that are already on the books. By identifying bad actors, keeping them out of the program, provider screening and enrollment will protect children and families and other Medicaid beneficiaries from substandard care, at the same time preventing the theft or diversion of Federal and State funds from their intended use.

Secondly, I want to underscore a point made by Mr. Hill. Payments made to fraudulent providers are clearly improper, but improper payments are not the same as fraud. Fraud is a deception or misrepresentation made by a person or entity with the intent of receiving an unauthorized payment. Improper payments in contrast are payments that should not have been made or that were made in an incorrect amount. They include payments made to providers who have defrauded the program, but they also include unintentional documentation errors, noncompliance with provider screening, and enrollment requirements.

The way to reduce fraud as well as improper payments generally is to screen providers before allowing them to treat Medicaid bene-

ficiaries and bill the Medicaid Program. And that is true whether you are in a fee-for-service or in a managed care mode.

My last point is that Medicaid is a successful health insurer for 4 in 10 of our Nation's children, in large measure because of its Federal/State financing partnership. And as GAO testified this morning, CMS can improve that partnership by improving its expenditure and utilization data and strengthening its oversight. Disrupting that partnership by capping Federal Medicaid payments to States will not improve the oversight, it will not prevent fraud, and it will not reduce improper payments. Instead, it will put low-income children and families at severe risk for rationing of care.

I look forward to your questions.

[Prepared statement of Mr. Schneider follows:]



Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

Testimony of

Andy Schneider, Research Professor of the Practice,
Center for Children and Families, McCourt School of Public Policy,
Georgetown University

on

"Improper Payments in State-Administered Programs: Medicaid"

before the

Subcommittee on Government Operations

and

Subcommittee on Intergovernmental Affairs

House Committee on Oversight and Government Reform

2154 Rayburn House Office Building

March 21, 2018

Good morning Chairman Meadows and Chairman Palmer, Ranking Members Connolly and Raskin, and Members of the Subcommittees. I am Andy Schneider, a Research Professor of the Practice at the Center for Children and Families.

The Center for Children and Families is an independent, nonpartisan policy and research center based in the McCourt School of Public Policy at Georgetown University. Our mission is to expand and improve high-quality, affordable health coverage for America's children and families, particularly those with low and moderate incomes.

I want to emphasize that I am here in my individual capacity and that my views do not necessarily represent the views of Georgetown University.

Thank you for the invitation to testify. I am especially honored to be here because I had the privilege of serving as Chief Health Counsel to the full Committee in 2007 and 2008. I know from personal experience how important the oversight efforts of this Committee's Members and staff can be to making government work.

The Committee's institutional role is particularly important for programs like Medicaid, on which over 70 million Americans depend for basic health and long-term care services. The focus of this hearing—federal and state efforts to identify, prevent, and recover improper payments in Medicaid—is in the finest tradition of the Committee's exercise of its oversight responsibilities. I applaud the Committee's interest and diligence.

From 2013 through 2016 I served as a Senior Advisor to the Center for Medicaid and CHIP Services, where my portfolio included program integrity in Medicaid. During that time, I had an opportunity to see dedicated CMS career staff and state Medicaid agency staff work to strengthen the administration of the program. A good deal of progress was made, but there is room for improvement.¹ I hope this hearing will help inform the Committee about the path forward.

I want to stress three points:

- First, Medicaid is the nation's most important health insurance program for low-income children and families. It covers 40 percent of our country's children without regard to pre-existing conditions. The research shows that it works for children and for families, which helps to explain the program's popularity. Central to the program's success is its 50-year-old federal-state financing partnership. Disrupting that partnership by capping federal Medicaid payments to states will put low-income children and families in severe jeopardy for rationing of care.
- Second, despite its success, Medicaid is not perfect. The program's 10.1 percent improper payment rate is too high and needs to come down. There

is a clear path forward for bringing it down: fully implement the provider screening and enrollment requirements that are already on the books. By identifying bad actors and keeping them out of the program, provider screening and enrollment will protect children and families and other Medicaid beneficiaries from substandard care while at the same time preventing the theft or diversion of federal and state funds from their intended use.

- Finally, payments made to fraudulent providers are clearly improper, but improper payments are not the same as fraud. Fraud is a deception or misrepresentation made by a person or entity with the intent of receiving an unauthorized payment. Improper payments, in contrast, are payments that should not have been made or that were made in an incorrect amount. They include unintentional documentation errors as well as noncompliance with the provider screening and enrollment requirements. Capping federal Medicaid payments to states will do nothing to reduce fraud. The way to reduce fraud—as well as improper payments—is to screen providers before allowing them to treat Medicaid beneficiaries and bill the Medicaid program, whether in fee-for-service or in managed care.

Medicaid is the nation’s most important health insurance program for low-income children and families.

Medicaid covers over 37 million children and over 9 million parents.² (The Children’s Health Insurance Program (CHIP) covers roughly 9 million additional children).³ About four out of every ten children in America are covered through Medicaid or CHIP.⁴

Medicaid guarantees eligible children coverage for preventive services, including periodic screening for physical and mental health problems, developmental delays, and vision, hearing and dental issues. It also covers needed diagnostic and treatment services to address problems identified by the periodic screenings.⁵ In short, Medicaid is absolutely essential to the health and well-being of children in low-income families—especially those with disabilities and special health care needs.

The research shows that Medicaid works for children and families. More specifically, the research shows that access to Medicaid in childhood leads to longer, healthier lives, a better chance to finish high school and college, and more prosperous futures for our children.⁶ This research may help to explain why the most recent Kaiser Family Foundation Tracking Poll found that nearly three quarters of Americans have a “very favorable” or “somewhat favorable” opinion of Medicaid.⁷

There are many reasons for Medicaid’s success, but the program’s bedrock is its federal-state financing partnership. Since the enactment of Medicaid over 50 years

ago, the federal government has committed to matching state spending for health and long-term care services for low-income Americans on an open-ended basis. On average, the federal government pays between 63 and 65 percent of the costs of these services (the federal matching rate ranges from 50 percent to as much as 74 percent, depending on a state's per capita income).⁸ This commitment has enabled states to invest in the health of their low-income children and families; to address the long-term care needs of individuals with disabilities and seniors; to respond to epidemics like HIV, Zika, and opioid abuse; and to address the needs of victims of hurricanes and other natural disasters.⁹

The President's FY 2019 Budget proposes to cap federal Medicaid payments to states.¹⁰ If enacted, this proposal would effectively end the federal government's commitment to sharing in the costs of basic health and long-term care services for low-income Americans. A cap on federal Medicaid payments—whether in the form of a block grant or a “per capita cap”—will by definition limit federal Medicaid spending, both proper and improper. In doing so, it will shift the costs of health and long-term care services for low-income Americans to the states and counties. States, in turn, will be forced to choose between raising taxes, transferring state funds from other programs to Medicaid, or cutting back on eligibility, benefits, and payments to providers and managed care plans.¹¹ Beneficiaries, including children and families, will bear the brunt of these cuts.

Medicaid's 10.1 percent improper payment rate in FY 2017 is too high and needs to come down.

Medicaid is large and complicated, with many moving parts. It pays for health and long-term care services delivered by hundreds of managed care plans and tens of thousands of providers to tens of millions of beneficiaries. Medicaid is administered on a day-to-day basis by states within rules established by the federal government to ensure that federal Medicaid matching funds are spent properly to achieve their intended objective: paying for needed health and long-term care services for low-income Americans. Within these rules, states have broad discretion to determine eligibility, design benefits, choose delivery systems, and innovate. As a result, Medicaid programs vary widely from state to state.¹² Given Medicaid's sheer scale, as well as the state-to-state variation, errors will—and do—happen.

Medicaid had an improper payments rate of 10.1 percent, or \$36.7 billion, in FY 2017. Of this amount, over half (54%) is attributable to noncompliance with provider screening and enrollment requirements: 47%, or \$17.1 billion, were unknown losses due to noncompliance with provider screening and national provider identifier (NPI) requirements, and 7%, or \$2.66 billion, were known monetary losses due to the provider who received the payment not being enrolled. (Of the remaining improper payments, 9% were due to insufficient medical documentation, 31% were a proxy estimate of eligibility errors, and the remaining 6% were classified as “other”).¹³ These data present a clear path forward for

bringing down the Medicaid improper payments rate: fully implement the provider screening and enrollment requirements that are already on the books.

The Affordable Care Act (ACA) included a large number of program integrity provisions, including a requirement that providers serving program beneficiaries in Medicare, Medicaid, and CHIP enroll in the programs and that they be screened prior to enrollment and that their enrollment be periodically revalidated.¹⁴ The Secretary of HHS was directed to develop and publish regulations to implement this requirement, which she did in February of 2011.¹⁵ Among other things, these regulations require that states screen providers based on their level of risk to the program. In the case of those designated as limited risk, the state must verify licensure and check federal databases to ensure that the provider is not excluded from participation by the Office of Inspector General (OIG). Providers designated as moderate risk are also subject to an on-site visit; those designated as high risk are also required to submit fingerprints and undergo a criminal background check. The ACA also directed the Secretary to establish a national database that state Medicaid agencies can access for information about terminated Medicare providers; in 2016, Congress strengthened the ACA provisions in the 21st Century Cures Act to ensure that fraudulent providers do not move undetected from one state Medicaid program to another.¹⁶

The program integrity logic of these requirements is indisputable. The easiest way to reduce losses due to fraud is to keep fraudulent providers out of the program (experience teaches that once program funds have been stolen or otherwise diverted it is extremely difficult to recover them). The easiest way to keep fraudulent providers out is to identify them before they enroll. This is not to say that sorting providers into risk categories and screening them based on their risk to the program is easy to do or without administrative cost. (The federal government matches state administrative costs for provider screening and enrollment at 50 percent, 75 percent, or 90 percent depending on the activity).¹⁷ But it is fundamental to protecting program funds and beneficiaries, and to maintaining a level playing field for the many providers who are honest actors delivering quality care to people in need.

Fraudulent providers pose risks to program beneficiaries. One notorious example of this is the dental management company for Small Smiles Centers, a nationwide chain of pediatric dental clinics. In 2010, the management company agreed to pay \$24 million plus interest and enter into a 5-year quality-of-care corporate integrity agreement to settle allegations that it performed procedures on children that “were either medically unnecessary or performed in a manner that failed to meet professionally-recognized standards of care,” including pulpectomies (baby root canals), placing crowns, administering anesthesia, and performing extractions, in order to maximize Medicaid reimbursement.¹⁸ In 2014, the company was excluded from Medicaid and other health care programs for 5 years for “repeated and flagrant violations of its obligations under the corporate integrity agreement—violations that put quality of care and young patients’ health and safety at risk.”¹⁹

Medicaid's improper payments rate reflects the extent to which state Medicaid agencies have implemented the provider screening and enrollment provisions, at least in the fee-for-service portion of their programs. Under the Medicaid statistical sampling process, Payment Error Rate Measure (PERM), if a claim has been submitted by a provider who has not been screened and enrolled as required, the payment for that claim is considered improper. If a claim in the sample is for a service that has been ordered by a physician, and the physician's National Provider Identifier (NPI) is not on the claim as required, the payment for that claim is also considered improper, even if the physician has been screened and enrolled. (Without the NPI, it is impossible for the state Medicaid agency or CMS to know who the ordering or referring provider is, much less whether he or she has been screened and enrolled). By measuring these payment errors, PERM helps promote state agency implementation of the provider screening and enrollment requirements to the benefit of those eligible for the program and taxpayers alike.

Unlike the fee-for-service component of the Medicaid improper payments rate, the managed care component does not currently measure whether providers in Medicaid managed care organization (MCO) networks have been screened and enrolled. It looks only at capitation payments from states to MCOs, not at payments from MCOs to network providers.²⁰ Currently two-thirds of Medicaid beneficiaries, largely children and parents, are enrolled in Medicaid MCOs.²¹ These beneficiaries—and federal Medicaid dollars—deserve the same screening and enrollment protections from bad actors as those in fee-for-service. CMS managed care regulations issued in May of 2016 require that all MCO network providers be screened and enrolled, effective beginning with capitation rate period for contracts starting on or after July 1, 2018.²² In the 21st Century Cures Act, Congress reaffirmed this policy and accelerated the effective date to January 1, 2018.²³ CMS should revise the PERM methodology for reviewing improper payments in Medicaid managed care to measure compliance with this requirement.

Medicaid payments made to fraudulent providers are clearly improper, but Medicaid improper payments are not the same as fraud.

Medicaid regulations define fraud as “an intentional deception or misrepresentation made by a person with knowledge that the deception or misrepresentation could result in some unauthorized benefit to himself or some other person.”²⁴ An improper payment, in contrast, is “any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements and includes...any payment for services not received.”²⁵ In short, payments due to fraud are improper—they should not have been made because the services were fraudulently billed—but not all improper payments are due to fraud.

In fact, as the Department of Health and Human Services explains in its FY 2017 Agency Financial Report, the majority of Medicaid improper payments “were due to instances where information required for payment was missing from the claim and/or states did not follow the appropriate process for enrolling providers. However, these improper payments do not necessarily represent payments to illegitimate providers and, if the missing information had been on the claim and/or had the state complied with the enrollment requirements, then the claims may have been payable.”²⁶

Medicaid fraud can—and has been—committed by beneficiaries, by providers, by managed care plans, and by pharmaceutical manufacturers.²⁷ CMS has issued regulations to address each type of fraud, most recently the Medicaid managed care rule issued in May 2016 that is now being phased in.²⁸ This rule contains important program integrity provisions that address both fraud by providers in Medicaid MCO networks²⁹ and fraud by MCOs and/or their subcontractors.³⁰ As noted, two thirds of Medicaid beneficiaries are already enrolled in MCOs and the projections are for further increases, notably among individuals with disabilities and seniors.³¹ CBO projects that an increasing amount of federal Medicaid dollars will flow to providers through MCOs over the next 10 years.³²

Regrettably, the CMS Administrator has pledged to “rollback” the managed care rule because it is, in her view, “administratively burdensome.”³³ It is not clear what changes she will instruct her agency to make and when she will make them. What is clear is this: if the program integrity provisions in the rule are weakened, then Medicaid improper payments—i.e., payments that should not be made either to network providers or to MCOs—will in all likelihood increase. I hope the Committee will engage its oversight resources to prevent this outcome.

“Rolling back” the managed care rule will not reduce the Medicaid improper payments rate. Neither will capping federal Medicaid payments to states. Shifting the costs of health and long-term care from the federal government to the states will harm program beneficiaries and the legitimate providers that serve them; it will not reduce the improper payments rate. States simply can’t protect themselves against a federal cost-shift by reducing improper payments. That’s because Medicaid costs are not driven by improper payments; they are driven by program enrollment—Medicaid does not exclude based on pre-existing conditions—the use of the services that the program covers, and the prices it pays for those services.³⁴ Even if states were somehow able to eliminate every last improper payment, they will not be able to avoid the demographic wave of aging Baby Boomers or stop general inflation in health care prices or avoid epidemics or prevent natural disasters.³⁵ Their only effective response to a cap on federal Medicaid payments will be to cut eligibility, cut benefits, and/or cut payment rates to MCOs and to providers.

CMS and states need to continue to work together to reduce fraud and other improper payments in Medicaid. And this Committee needs to continue to oversee that work and insist on results. But capping federal Medicaid payments to states to

reduce improper payments is not the solution; it will only shift costs to states, throwing out the Medicaid baby with the improper payments bathwater.

¹ One example of progress is the development of the Medicaid Provider Enrollment Compendium (MPEC), last updated 6/23/2017, <https://www.medicaid.gov/affordable-care-act/downloads/program-integrity/mpec-6232017.pdf>

² For more information on children's enrollment, see: <https://www.medicaid.gov/chip/downloads/fy-2016-childrens-enrollment-report.pdf>. For more information on parents' enrollment, see: <https://www.urban.org/sites/default/files/publication/83976/2000915-A-Look-at-Early-ACA-Implementation-State-and-National-Medicaid-Patterns-for-Adults-in-2014.pdf>.

³ <https://www.medicaid.gov/chip/downloads/fy-2016-childrens-enrollment-report.pdf>

⁴ https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_16_1YR_S2704&prodType=table

⁵ Brooks and Whitener, "At Risk: Medicaid's Child-Focused Benefit Structure Known as EPSDT," Center for Children and Families (June 2017), <https://ccf.georgetown.edu/wp-content/uploads/2017/06/EPSDT-At-Risk-Final.pdf>

⁶ Wagnerman, Alker, and Chester, "Medicaid is a Smart Investment in Children," Center for Children and Families (March 2017), <https://ccf.georgetown.edu/wp-content/uploads/2017/03/MedicaidSmartInvestment.pdf>

⁷ Kirzinger, Wu, and Brody, "Kaiser Health Tracking Poll: February 2018," Figure 5, <https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-february-2018-health-care-2018-midterms-proposed-changes-to-medicaid/>

⁸ Congressional Budget Office, "Detail of Spending and Enrollment for Medicaid for CBO's January 2017 Baseline," footnote a, <https://www.cbo.gov/sites/default/files/recurringdata/51301-2017-01-medicaid.pdf>

⁹ Centers for Medicare & Medicaid Services, "Medicaid & CHIP: Strengthening Coverage, Improving Health," (January 2017), <https://www.medicaid.gov/medicaid/program-information/downloads/accomplishments-report.pdf>

¹⁰ "HHS FY 2019 Budget in Brief," pp. 52-53, <https://www.hhs.gov/sites/default/files/fy-2019-budget-in-brief.pdf>

¹¹ "Under [cap] proposals that led to significant reductions in federal funding, many states would find it difficult to offset the reduced federal payments solely through improvements in program efficiency. Those states would have three potential approaches available to them: Raise additional revenues; cut other state programs to transfer resources to Medicaid; or change the program through some combination of reducing payments to providers and health plans, curtailing covered services, and decreasing enrollment. If reductions in federal revenues were large enough, states would probably resort to a combination of all such approaches." Congressional Budget Office, "Options for Reducing the Deficit: 2017 to 2026," p. 225 <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/52142-budgetoptions2.pdf>

¹² Medicaid and CHIP Payment and Access Commission (MACPAC), "Medicaid 101," <https://www.macpac.gov/medicaid-101/>

¹³ <https://paymentaccuracy.gov/program/medicaid/>

¹⁴ Section 6401 of the Patient Protection and Affordable Care Act, P.L. 111-148.

¹⁵ 42 CFR Part 455, Subpart E—Provider Screening and Enrollment, 455.400-455.470.

¹⁶ Section 5005 of the 21st Century Cures Act, P.L. 114-255.

¹⁷ 42 CFR 433.15(b)(3), (4), and (7).

¹⁸ Department of Justice, "National Dental Management Company Pays \$24 Million to Resolve Fraud Allegations," (January 20, 2010) <https://www.justice.gov/opa/pr/national-dental-management-company-pays-24-million-resolve-fraud-allegations>

¹⁹ Office of Inspector General, "OIGF Excludes Pediatric Dental Management Chain from Participation in Federal Health Care Programs," (April 3, 2014),

<https://oig.hhs.gov/newsroom/news-releases/2014/cshm.asp>

²⁰ Centers for Medicare & Medicaid Services, "Payment Error Rate Measurement Manual," Version 1.7, p. 26 (January 2018)

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Downloads/FY17PERMManual.pdf>

²¹ Rudowitz and Garfield, "Ten Things to Know About Medicaid: Setting the Facts Straight," Figure 6, Kaiser Family Foundation (March 12, 2018), <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/>

²² 42 CFR 438.608(b); Center for Medicaid and CHIP Services, "Medicaid and CHIP Managed Care Final Rule (CMS 2390-F) Implementation Dates," (April 25, 2016)

<https://www.medicaid.gov/medicaid/managed-care/downloads/implementation-dates.pdf>

²³ Section 1932(d)(6) of the Social Security Act, as enacted in section 5005 of the 21st Century Cures Act, P.L. 114-255.

²⁴ 42 CFR 455.3

²⁵ 42 CFR 431.958

²⁶ Department of Health and Human Services, "Agency Financial Report FY 2017," p. 202,

<https://www.hhs.gov/sites/default/files/fy-2017-hhs-agency-financial-report.pdf>

²⁷ See Department of Health and Human Services and the Department of Justice, "Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2016," pp. 12-29 (January 2017), for examples of Medicaid fraud by a mental and behavioral health clinic (p. 12), a home care agency (p. 20), a nurse (pp. 22-23), a hospital (p. 23), a managed care plan (p. 18), and drug manufacturers (pp. 15-16). <https://www.oig.hhs.gov/publications/docs/hcfac/FY2016-hcfac.pdf>

²⁸ Regulations addressing beneficiary and provider fraud are found at 42 CFR 455.13 – 455.23. Regulations addressing fraud in Medicaid managed care were published at 81 Fed. Reg. 27498 (May 6, 2016), <https://www.medicaid.gov/medicaid/managed-care/guidance/final-rule/index.html>

²⁹ 42 CFR 438.608(a)(5), (a)(8), (b).

³⁰ 42 CFR 438.608(c), 438.610.

³¹ Kaiser Family Foundation and National Association of Medicaid Directors, "Medicaid Moving Ahead in Uncertain Times: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018," pp. 17-18 (October 2017), <https://www.kff.org/medicaid/report/medicaid-moving-ahead-in-uncertain-times-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2017-and-2018/>

³² Congressional Budget Office, "Detail of Spending and Enrollment for Medicaid for CBO's January 2017 Baseline," <https://www.cbo.gov/sites/default/files/recurringdata/51301-2017-01-medicaid.pdf>

³³ "Remarks by Administrator Seema Verma at the National Association of Medicaid Directors (NAMD) 2017 Fall Conference (November 7, 2017) <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-07.html>

³⁴ Medicaid and CHIP Payment and Access Commission (MACPAC), "Addressing Growth in Medicaid Spending: State Options," (June 2016) <https://www.macpac.gov/wp-content/uploads/2016/06/Addressing-Growth-in-Medicaid-Spending-State-Options.pdf>

³⁵ Park, "New National Health Expenditure Projections Contain Several Key Findings Relevant to Medicaid," (March 13, 2018) <https://ccf.georgetown.edu/2018/03/13/new-national-health-expenditure-projections-contain-several-key-findings-relevant-to-medicaid/>

Mr. MEADOWS. Thank you, Mr. Schneider. Thank you all for your insightful testimony. And as I mentioned earlier, your entire written testimony, if you did not cover it orally, will be made part of the record. I will now recognize my good friend and the gentleman from Virginia, the ranking member, Mr. Connolly, for his opening statement.

Mr. CONNOLLY. I thank the chair, and in the interest of time, I am going to forego my formal opening statement. I echo some of what we just heard from the panelists, particularly Mr. Schneider. A, Medicaid works. It does its job: 76 million Americans, 43 percent of them children, benefit from Medicaid, and it looks like we are going to expand those numbers.

In my home State of Virginia, we are on the brink of a bipartisan agreement to finally expand Medicaid pursuant to the Affordable Care Act, which will now bring healthcare to 400,000 people in Virginia, and by the way, bring \$400 million net to the coffers of the State of Virginia, allowing to reinvest in healthcare and other needed investments. So, that is a good thing, and we will become, I believe, the 33rd State to expand Medicaid, States led by both Republicans and Democrats.

But secondly, the point Mr. Schneider just made, and I know echoed by our panelists. But the improper payment part of Medicaid is too high. Ten percent is not tolerable, and we have got to work to get that number down. And that will include actually implementing the regulations and screenings already on the books, but it also means law enforcement has got to get more involved. We need U.S. attorneys involved. We need attorneys general to be involved. We need to beef up Medicaid's own self-policing to bring that number down because every dollar that is an improper payment is a dollar foregone. It is a dollar not invested in healthcare. It is a dollar that detracts from the important core mission of Medicaid.

And finally, I would say, Mr. Chairman, working with you and others over the years on this committee, you know, there are two things this committee needs to focus on or can focus on that I think would make a material difference in reducing the debt, neither of which involve new taxes, neither of which involve, you know, cutting critical investments. And one is improper payments, about \$142 billion a year. Multiply that times 10, and you get \$1.4 trillion. Now we are talking real money. And the other is uncollected taxes, which have now grown, by starving the IRS over the years, to over \$450 billion a year. You combine those two, we are at almost \$6 trillion over 10 years, and I for one would be willing to commit that every one of those dollars we, in fact, recover I would devote to debt reduction because they are dollars we do not have now. And that would be a good down payment on the national debt over a 10-year period.

And it seems to me there is some potential bipartisan common ground. You know, we would have to make some investments, but these are two things we can do something about, and there is no downside to addressing them. And so, I thank you, Mr. Chairman, for having a hearing on the Medicaid piece today, and I look forward to having the opportunity to hear more from our expert panelists. And, again, thank you for your leadership, Mr. Chairman.

Mr. MEADOWS. I thank the gentleman for his comments, and I would like to stress obviously today we are looking at Medicaid, but there is a huge improper payment issue with the Department of Defense as well. And so, at times where sometimes one program looks ideologically to be aligned more with one side than the other, I can assure you in a bipartisan manner, we are willing to tackle those. And I thank the spirit in which the ranking member offered that.

The chair is going to recognize the chairman of the subcommittee, Mr. Palmer, for a series of questions at this time. So, he is recognized for 5 minutes.

Mr. PALMER. Thank you, Mr. Chairman. Mr. Hill, Medicaid payments are made to States based on the number of people eligible in each State and the State maintenance of effort match. In other words, CMS has a reasonable estimate of how much funding to request from Congress on an annual basis. Given that for the last 2 years Medicaid improper payments have exceeded \$36 billion, does CMS inflate its funding request to include improper payments? Is that just part of your overhead?

Mr. HILL. I would not say that we directly, that the measure of improper payments goes into the formula to say what we are going to ask for. It is much more of an actuarial analysis of the trends over time and what we think we are going to need in the next year given economic and other forecasts. So, I think it is baked there, and I think that is the point that folks have made across the board here, that because improper payments are in the baseline it is inflated, and to the extent that we could reduce improper payments, we would recoup some savings.

Mr. PALMER. Well, you had a number of recommendations for correcting this. Ms. Tinker, thank you for being here. Welcome to OGR. How many recommendations has HHS inspector general made to CMS to establish a deadline for complete and accurate TMS data?

Ms. TINKER. We have one recommendation that —

Mr. PALMER. Yeah, please turn that on.

Ms. TINKER. We have one recommendation —

Mr. MEADOWS. You better hit that button or—no.

[Laughter.]

Ms. TINKER. We have one recommendation that is currently still on the books for CMS to set a deadline for the completion the TMSIS system.

Mr. PALMER. How about GAO, Ms. Yocom?

Ms. YOCOM. We also have a recommendation. It is a little more detailed in terms of establishing some steps and some dates along the way. We think taking a step-by-step approach would be helpful rather than saying we are going to get this all done by X date.

Mr. PALMER. Yeah, I agree with that. I think it is a process, and I think it is multifaceted. It is reading the GAO's last report that I got on it that indicates, and this would be true across the Federal government, but I think it would be applicable to CMS, is about 20 percent of the improper payments is a result of antiquated data systems. And one of the things that concerns me is the antiquated data systems is an issue that we can resolve. Obviously, we will have to spend some additional funding.

But, Mr. Purpera, in dealing with this between the State and Federal level, is that an issue, because one of the things we are saying is that State systems do not always match up with Federal systems. You have a communication issue with that. Is that a problem?

Mr. PURPERA. Mr. Chairman, data is a problem. It is a considerable problem because are not dealing with finding a needle in a haystack here. We are dealing with finding needles in fields of haystacks. So, we have to have good data from the State level on up, and it extremely hard for my office to get data sometimes from the managed care operators.

For example, we keep talking about the improper payment rate being 10 percent, but that number I would tell you is considerably understated because it includes managed care at .03 percent, which clearly we are not looking at the full spectrum there.

Mr. PALMER. Well, Ms. Yocom, in the last GAO report that I saw, there were 18 Federal programs that were reported. Among those were the managed care side of Medicaid. So, and I agree, in talking with Mr. Dudero about this, he thinks the \$141 billion is understated because of the failure of programs such as the managed care side of Medicaid report.

Ms. YOCOM. Yeah, the estimation of managed care is focused on a very narrow piece of information. It is focused on what did the contract say that you would pay on a per capita basis and was the person who you paid for eligible for Medicaid. It does not look at whether or not the services were provided at all or whether they were necessary or anything else.

Mr. PALMER. Well, that is an administrative issue —

Ms. YOCOM. It is.

Mr. PALMER.—because the report also showed that you had failure to verify eligibility, failure to do proper documentation. That was about 52 percent of the improper payments.

Ms. YOCOM. Yes.

Mr. PALMER. And one other question in the last few seconds I have is on the fraud. Is fraud more an issue at the Federal level, people fraudulently billing the Federal government for Medicaid payments, or is it more at the State level? Where is the fraud most likely to occur? And, Ms. Tinker, if you know the answer to that, you can respond as well.

Ms. TINKER. We see fraud at both the Federal and the State level in the Medicaid Program because it is a shared program between both the Federal government and the State.

Mr. PALMER. So, when someone files a fraudulent claim, they file it at the State level, which when the State makes a payment it includes Federal dollars, or is it possible that they file it directly with the Federal government?

Ms. TINKER. Directly with the State government.

Mr. PALMER. Directly with the State. Thank you very much. I yield back.

Mr. MEADOWS. I thank the gentleman from Alabama. The chair recognizes Ranking Member Raskin for 5 minutes.

Mr. RASKIN. Mr. Chairman, thank you very much. Let me follow up on Mr. Palmer's question. Ms. Yocom, your testimony includes a statement that between May of 2015 and December of 2017, 11

different recommendations were made by the GAO to CMS about improvements that could be made in terms of ferreting out fraud, but your testimony also says that these recommendations have not been adopted yet by CMS. And I am wondering, I do not know, Mr. Hill, if you could speak to that, why were they not adopted, and what is the hold up there?

Mr. HILL. So, I would need to go back, and unfortunately, I do not know specifically the 11 recommendations. I know as a general matter, sometimes the recommendations that are offered require a change in regulation. Not often, but sometimes in statute. And the other issue in Medicaid unlike in Medicare because it is a shared partnership with the State, many of the recommendations that we have to implement, we have to do in partnership with our State partners. And so, we have talked a lot, for example, about provider enrollment and screening.

We can require States to do that initial guidance and tell States they need to be doing a better job, but the actual on-the-ground implementation of screening, for example, takes place at the State. So, the shared partnership, I think, does introduce some level of slowness to our response.

Mr. RASKIN. Okay. Well, I would be interested in following those recommendations because, you know, lots of times we have great hearings, and then recommendations come out, and then we do not see anything happen. So, I would love to see the follow through on that.

So, I wonder if somebody would dig down deeper into this whole question of fraud. Is most of the fraud provider-based fraud, or is it actually people who are impersonating beneficiaries, or fabricating information on applications? I mean, what is the nature of the fraud component of the problem? And I do not know, Mr. Schneider, Mr. Purpera, yeah.

Mr. SCHNEIDER. So, I do not know that I am the most qualified person to speak to this.

Mr. RASKIN. Okay.

Mr. SCHNEIDER. You already have some experts on this who have the data, right?

Mr. RASKIN. Okay, let us take Mr. Purpera and Mr. Hill.

Mr. PURPERA. Thank you, sir. I think I can approach it from the State level. At the State level, our attorney general offices, they have the Medicaid fraud control units, so they are looking at fraud. But the funds that flow from the Federal government to operate those units are strictly for provider fraud. My attorney general, if he were sitting here today, would tell you he would very much like to work in the area of recipient fraud, but right now he is prevented from doing so. Now, my office focuses not just on fraud, but we focus on fraud, waste, abuse, the whole gamut. And, you know, strategically, what we want to do is make recommendations to improve the process going forward.

But I can tell you this. In the past, and as I heard about other recommendations, there have been times when I have written findings on my department of health that says, "for the 8th consecutive year," and then the finding. And that seems to me where there is part of the problem is holding the agencies accountable and some-

how forcing the changes that are needed to prevent the waste and abuse.

Mr. RASKIN. Thanks. Mr. Hill?

Mr. HILL. I would say that in terms of the type of fraud that we see, and I have worked in Medicaid and I have worked in Medicaid, the key to the kingdom is a card, is an eligibility card. So, we do not see a lot of fraud of an individual beneficiary saying I am going to lie on my taxes to get Medicaid. They will get eligible, and then typically what we will see is they will then be in cahoots. There will be some sort of scheme with a Medicaid beneficiary or Medicare beneficiary and a group of providers to generate fictitious billings or fraudulent billings, and it is much more of a —

Mr. RASKIN. A collective activity. It is more than a conspiracy.

Mr. HILL. Yeah, they are smarter than we are many times, and they have found ways to ping and game our systems. And typically, once somebody gets eligibility, they are able to, if they are so inclined, defraud us using nefarious providers to bill and get paid.

Mr. RASKIN. Okay, yes, Ms. Yocom.

Ms. YOCOM. I would just add that if you can screen and enroll and ensure that your providers act in good faith, you have managed most of the fraud. A beneficiary alone trying to commit fraud needs a complicit provider, so focusing attention on ensuring good screening and enrollment processes is critical.

Mr. RASKIN. Great. Okay. My final question is about data. Everybody seems to agree that a much more comprehensive data system is going to be essential lower than 10 percent rate. Are there legislative changes that need to be made, or can all of this be done through regulatory action? Mr. Hill.

Mr. HILL. In terms of collecting data from States and us aggregating the data, we do not see it as a statutory problem. If you want to write a check and give us more money, we are always happy to sort of have more infrastructure. But the issue really is compliance with States and us working with States to get the data in at the Federal level that they already have at the State level, so it is not really a statutory issue from our perspective.

Mr. RASKIN. Thank you. Yield back, Mr. Chair.

Mr. MEADOWS. I thank the gentleman. The chair recognizes himself for 5 minutes for a series of questions. Ms. Tinker, let me come to you. As we look at this transformed medical statistical information system, or, I guess, "T-MSIS," as they would say, how significant are your concerns about the quality of the information in there?

Ms. TINKER. We have significant concerns about the quality of the data.

Mr. MEADOWS. Okay. Let me give it to you in a different way. On a scale of 1 to 10, with 10 being the most highest, most concern, what number would you give it?

Ms. TINKER. That is a pretty difficult question to answer as the

Mr. MEADOWS. And that is why I am here, so —

[Laughter.]

Ms. TINKER. How I would answer is while we are very pleased that States are reporting and data now, and almost all are there, that that really means that we are really at the starting line and

not at the finish line in terms of building T-MSIS. We are still looking to see that the data has the quality necessary to perform program integrity efforts, specifically that all States report all data, and secondly, that when States are reporting that data, that it is actually uniform, that all States interpret the data pieces the same way.

Mr. MEADOWS. Right, yeah. Ms. Tinker, you have been well coached, and so I am going to give you another piece of advice. When I ask a question on 1 to 10, you might as go ahead and answer it because I am not going to stop until you answer. So, on a scale of 1 to 10 with "10" being most concern, what number would you give it?

Mr. HILL. I would give it a 7.

Mr. MEADOWS. Thank you, Ms. Tinker. Mr. Hill, in your statement I think you said that 98 percent of those that should be reporting are reporting. Is that correct?

Mr. HILL. That is correct.

Mr. MEADOWS. And so, would you say 98 percent is a good percentage?

Mr. HILL. It is.

Mr. MEADOWS. Oaky. Out of the 98 percent based on the statement that Ms. Tinker gave me with a 7 being a concern, how much of the 98 percent data can you actually use?

Mr. HILL. Right. I mean, I share Ms. Tinker's concern. I would not say we are necessarily at the starting line. We are probably midfield. But it is absolutely the case that the first thing that we had to accomplish was get the States to report. We now have them to report. The next challenge for us is being sure that, as described, the data is uniform, that we can use it, that States are reporting

Mr. MEADOWS. So, can you use it today?

Mr. HILL. We are using it today. We were —

Mr. MEADOWS. Can you use it accurately today?

Mr. MEADOWS. I would not want to rely a whole lot of policy analysis on the data that we have because we have just started

Mr. MEADOWS. So, that means that we got 98 percent compliance of un-useful data.

Mr. HILL. Right, and the —

Mr. MEADOWS. Do you not see a problem with that?

Mr. HILL. I see a program that we had to continue —

Mr. MEADOWS. I see your staff behind you. They are nodding that there is a real problem with that. And so, as we look at that, how do you fix that, I mean, because for you to come and say, well, we got a 98 percent compliance rate, we really do not have a 98 percent compliance rate because Ms. Yocom and Ms. Tinker both in their testimony have shown the quality of the data is worthless. So, if the quality of data is worthless, why are we focusing on a compliance rate of 98 percent?

Mr. HILL. I would not characterize the data as worthless first. And as I said —

Mr. MEADOWS. But you just said you cannot use it.

Mr. HILL. Well, I think it is important to understand how we build data systems, right? So, this is not an information system

that we are using to process and pay claims like the States are. We are asking States to aggregate their claims data and give it to us to put in a database that we can use to do analytics. The first step in that process is for them to build that interface, to give us that data, and to put it into T-MSIS, and that is where we have it. Until we —

Mr. MEADOWS. But the ranking member—hold on.

Mr. HILL. Yeah.

Mr. MEADOWS. I am running out of time. The ranking member and I have the Data Act. We have a number of other systems when we look at that. We have a dashboard on FITARA, which, you know, is the Connolly-Issa bill. Is that correct? So, when we look at that, bad data going in makes those systems worthless, and you say that it is not worthless, but at the same time, asking them to comply is a real problem.

So, let me shoot real quickly to another area. It appears that \$1.2 billion worth of improper payments actually come from three States. Is that correct, Ms. Tinker, \$1.2 billion in estimated improper payments came from three different States?

Ms. TINKER. We did find beneficiary eligibility errors in three States—California, New York, and Kentucky—totaling \$1.2 billion.

Mr. MEADOWS. All right. So, what can we do to fix this? I mean, if it is three States, I would say that was a target rich environment, that we can focus on those three States.

Ms. TINKER. The main causes of the errors we found were human errors and eligibility system inability to actually perform the functions it needed to. The recommendations that we made to States were three: one that where we found errors they do the redeterminations necessary; two, that they put policies and procedures in place to properly train people so that we could decrease the human errors; and third, that they update their systems so that they could better talk to other data systems to get the correct information to make those determinations.

Mr. MEADOWS. So, Mr. Hill, are you going after the \$1.2 billion?

Mr. MEADOWS. The \$1.2 is identified as potential overpayment. There was not a recommendation to collect it because —

Mr. MEADOWS. Well, let me give you a recommendation. Collect it. I mean, it is the American taxpayers' dollars. I mean, is it your sworn testimony here today is because you did not get a recommendation to collect —

Mr. HILL. No.

Mr. MEADOWS.—\$1.2 billion in improper payments, you are not going after it?

Mr. HILL. No, the recommendations were to fix the system in California —

Mr. MEADOWS. So, are you going after it or not?

Mr. HILL. We are not issuing a disallowance to California —

Mr. MEADOWS. Okay. I want you to report back to this committee in 30 days on why you decided to ignore \$1.2 billion in improper payments and decided not to collect it.

Mr. HILL. Yep.

Mr. MEADOWS. All right.

Mr. MEADOWS. All right. The chair recognizes the ranking member, Mr. Connolly, for a generous 6 minutes.

Mr. CONNOLLY. I thank the chair, and let me echo what the chairman just said, Mr. Hill. I mean, on a bipartisan basis, we simply cannot say that, well, we have lost that if for no other reason besides the fact that this is taxpayer money, but also if we are going to get serious about improper payments, we got to get serious about improper payments. How about we start now? And people have to know they cannot get away with it, that mistakes will be corrected, and fraud or abuse will be pursued vigorously. And we are prepared to back you up on a bipartisan basis, but we need you to do it. So, I strongly support the chairman's recommendation that we review, if not rescind, the decision not to pursue that \$1.2 billion.

Let me ask a question about how much we know about the data. Ms. Yocom, Ms. Tinker, Mr. Hill, how much of Medicaid improper payments is fraud? How much of it is fraud because in Medicare, for example, Mr. Hill, we know it is about \$50 billion a year in fraud in Medicare. And correct me if I am wrong, most of it is provider fraud as you pointed out. It is not individual beneficiaries committing fraud, though some may be involved, but it is actually, and this is always hard for the public to believe, that doctors cheat. They lie. They steal. Not all doctors of course, but a handful of bad actors, but it adds up to a lot of money. A lot of money.

So, in Medicaid, how much of the total improper payment we are looking at is fraud, because one has to disaggregate the kinds of improper payments because there are different strategies. You know, if it is overpayment because we messed it up, you know, we thought you were eligible and you were not, we thought you qualified for this additional benefit, but you did not or you did, that can be addressed through management, personnel, and technology.

Fraud is different. That has a law enforcement element to it which I am going to get to. But in order to know how we marshal our resources to get at the improper payments, we got to be able to accurately say this much is fraud. So, what percentage of total Medicaid improper payments is fraud?

Mr. HILL. My understanding in the way we measure improper payments now, you cannot disaggregate it. It does not measure fraud for a variety of reasons. As you just described, it measures compliance errors, it measures where documentation is missing. Sometimes when you look at a fraudulent claim, it is going to look perfect, right? It would not show up as an error because a fraudulent provider is going to make sure that they get it through the system in a way that it will get paid. And so, it is a much more complicated analysis to make the determination on whether it is fraud involving law enforcement partners and others.

So, it is my understanding we do not have a measure, you know, a rigorous measure as we do with the Payment Error Rate Measurement Program for fraud in Medicaid, which is why we spend time with our law enforcement partners and in partnership with our States to identify it in an investigatory way. But it is not something that we can use the PERM Program to address.

Mr. CONNOLLY. It is distressing to hear you say that because I do not how you have a coherent, let alone effective, countermeasure to improper payments. I mean, ideally want to bring improper payment to zero.

Mr. HILL. Right.

Mr. CONNOLLY. Now, we know that we are never going to quite reach zero, but we certainly can do better than \$142 billion a year. But I cannot devise a strategy that is efficacious if I cannot disaggregate fraud from administrative errors or technical error in the computer. Ms. Yocom, help us. Can GAO help Mr. Hill disaggregate that global number so that we are dealing with its component parts and developing efficacious strategies?

Ms. YOCOM. Yeah, I do not have good news in terms of a percentage. However —

Mr. CONNOLLY. Oh, Ms. Yocom, come on. If there was one person in this room I thought would bring me good news, it was you.

[Laughter.]

Ms. YOCOM. However, we do have a fraud risk framework that we have put together and have looked at CMS' practices to prevent fraud, and we have found that those are lacking. There are things that CMS could be doing to better look strategically across its programs and to coordinate within its program in order to better prevent fraud.

Mr. CONNOLLY. Well, let me make an informal request of GAO, and I am sure my colleagues, Mr. Meadows, Mr. Palmer, and Mr. Raskin, as respective chairman and ranking member would join in the request. We need you to get back to us in developing methodologies in disaggregating the improper payment global number so that we can better devise strategies.

Mr. MEADOWS. I concur with the ranking member, and so I would ask within 60 days if you can come back to this committee with a plan to do that, Ms. Yocom, once you check with your colleagues.

Mr. CONNOLLY. Because I do not know how we do it rationally, frankly, if we cannot have that kind of analytical tool.

Mr. CONNOLLY. My final question because I do not want to impose on my good friend and brilliant thespian, who makes Shakespeare happy every time she appears on stage, Eleanor Holmes Norton. But before that, I mean, Mr. Purpera is here from Louisiana and doing his job at the State level. But an observation: I do not think we are using U.S. attorneys all that well for fraud, and I will give you an example. I know of one example personally, but a few years ago the U.S. attorney in Boston decided to make Medicaid fraud a very high priority, and guess what happened? Her office alone identified and mostly recovered \$3 billion. One office because she made it a priority.

There are 99 U.S. attorneys, and my sense it is kind of up to the individual U.S. attorney whether this is a priority or, you know, we will look for it if we see it and find it, maybe we will do something about it, as opposed to saying, no, one of our top five this year or top three or whatever it might be is going to be fraud, Medicare fraud, Medicaid fraud. Any of you want to comment on that, I mean, because I think that is an underutilized tool as well that could really make a difference in reducing improper payments. Ms. Tinker.

Ms. TINKER. We believe that obviously working closely with our partners in the U.S. attorneys office is extremely important. And, in fact, when you look at the return on investment in 2017, there

were \$4.7 billion in expected recoveries, over 881 criminal actions, and 826 civil actions. But an additional important part in Medicaid is our work with the Medicaid Fraud Control Units.

In 2017 in our Medicaid Fraud Control Unit annual report, we found that \$1.8 billion had been recovered as a result of the efforts of Medicaid fraud control units across the country, including 1,500 convictions, 1,100 exclusions, meaning providers who no longer able to participate in Federal healthcare programs, and over 961 civil settlements and judgments. We are very proactive in working to prevent fraud and to bring bad actors —

Mr. CONNOLLY. So, my time is up, but what you are saying to us is you are happy with the cooperation you are getting from U.S. attorneys.

Ms. TINKER. There is always more we can be doing without a doubt.

Mr. MEADOWS. So, Ms. Tinker, I want to follow up on that. If you will help us identify perhaps those U.S. attorney districts where you get more help, it would help us, you know, to the ranking member's concern. If you could help us do that. I mean, that is not a formal request, but if you will get that as part of the report back. And I see your staff nodding behind. So, I feel we are in good shape.

The gentleman from Ohio is recognized for 5 minutes.

Mr. JORDAN. Mr. Hill, how many Americans are on the Medicaid Program?

Mr. HILL. I think we have 70 million roughly.

Mr. JORDAN. Seventy million?

Mr. HILL. Yep.

Mr. JORDAN. And what has happened to that number since Obamacare and the Medicaid expansion?

Mr. HILL. Under the Medicaid expansion, we added about roughly 11 million people to Medicaid.

Mr. JORDAN. So, it increased, you know, fairly significantly.

Mr. HILL. Mm-hmm.

Mr. JORDAN. All right. So, of the 70 million, how many of those 70 million are able-bodied adults?

Mr. HILL. Well, in general, the expansion was expanded to adults, childless adults, and so I would venture to guess that the majority of the folks in the Medicaid expansion are folks who otherwise would not have been covered either as a —

Mr. JORDAN. So, it is safe to say the 11 million is probably all in that category.

Mr. HILL. Right.

Mr. JORDAN. And some of the previous 59 million were probably in that category as well, even though Medicaid initially started off for disabled kids and different things.

Mr. HILL. Right.

Mr. JORDAN. Those kinds of populations. It is fair to say that there was some portion of the 59 million prior to Obamacare who were able-bodied adults as well.

Mr. HILL. To the extent States have expended to that group, yes.

Mr. JORDAN. The number we have heard is 28 million able-bodied folks in the Medicaid population. Do you think that is accurate?

Mr. HILL. I am not familiar with that number.

Mr. JORDAN. Okay. All right. But it is something more than 11 million.

Mr. HILL. Presumably, yes.

Mr. JORDAN. All right. Of that 11 million, do you know how many are working? How many have a job?

Mr. HILL. I mean, the data suggests that a large proportion of the folks who are on Medicaid who can work, in other words, who are not disabled or a caretaking parent, are working. I do not have the specific number.

Mr. JORDAN. The Kaiser Foundation says 40 percent of that able-bodied adult population in the Medicaid Program are not working. Do you think that is accurate?

Mr. HILL. I would need to go back and look at the Kaiser data.

Mr. JORDAN. That is a big number, though, right.

Mr. HILL. Are not working, correct.

Mr. JORDAN. That is a darn big number. Now, the Democrats sent a letter a couple months ago that said we should not even think about work requirements for able-bodied adults getting taxpayer money in largely the Medicaid expansion program. Do you agree with that?

Mr. HILL. Well, as you know, the Administration is pursuing a number of waivers under our authority to promote community engagement. We have got a number of States that we have already approved.

Mr. JORDAN. I am asking you. Do you agree with that? Do you think we need a work requirement for the program?

Mr. HILL. Well, it is the Administration's policy that we are pursuing work request and community engagement for States who believe that that works for their Medicaid system.

Mr. JORDAN. Yeah. How about you, Ms. Yocom? Do you think we need to do that?

Mr. HILL. Well, I think we need to carry out —

Mr. JORDAN. Well, I am going to ask some other people.

Mr. HILL. Well, as others have said, right, we are here representing the Administration, and I am representing the Administration's position.

Mr. JORDAN. How many waivers have you given thus far to States to implement a work requirement for the Medicaid expansion population or for anyone on Medicaid, able-bodied?

Mr. HILL. Three. Kentucky, Indiana, and Arkansas are the first three States that we have approved waivers for.

Mr. JORDAN. Anyone else asked?

Mr. HILL. There are a number of States in the pipeline.

Mr. JORDAN. How many?

Mr. HILL. I think a total of 10 or 11 States have expressed interest, and they are all in various stages of review right now.

Mr. JORDAN. How long does it take to get the approval?

Mr. HILL. Well, you know, overcoming and sort of getting our policy squared away, once we got the first waiver approved, they can go through relatively quickly, anywhere from, you know, 3 months, 6 months, 9 months. Sometimes the waivers are packaged up with other innovations that the State wants to pursue that are not necessarily —

Mr. JORDAN. It takes 9 months for you guys to okay. The State says we want to make people who are able-bodied folks, and the State says we want to acquire a work component, maybe a work study component, maybe a training component. And you take 9 months for you to give them the thumb's up to do that?

Mr. HILL. Well, we try and do it as quickly as we can depending upon what the State is asking for and how complex their waiver is.

Mr. JORDAN. Of that 40 percent of this at least 11 million number—I think it is closer to 28 million—who are able-bodied and non-working, how many of them are younger folks? How many are under 35, under 40?

Mr. HILL. Well, I think that able-bodied or that expansion population is 19 to 65, anywhere from 19 up to 65. I do not know the distribution of how many are in what age category.

Mr. JORDAN. Again, I think most of it from what we have seen in other studies, most of them are younger folks. So, you got younger folks, able-bodied in the program. States coming to you saying we would like to impose a work requirement, and you are telling me it takes 9 months to give them the thumb's up.

Mr. HILL. I am telling you we work as fast as we can to get the waivers approved depending on how complex they are coming from the State.

Mr. JORDAN. And, again, refresh my memory. How many States have asked for the waivers thus far?

Mr. HILL. We have approved three, and I think there are 11 in the pipeline.

Mr. JORDAN. Eleven have asked. Do you know how long ago some of these States asked?

Mr. HILL. Most of them have all been since last January. Some were in the previous Administration.

Mr. JORDAN. Well, this is important. I mean, you talk to taxpayers across the 4th District of Ohio, my guess is taxpayers even in the Democrat districts who sent this letter saying do not do this, a bunch of taxpayers would say this makes so much sense particularly when so much of the population who are in Medicaid who are able-bodied are younger folks. The fact that there is not a work component just boggles people's minds. So, I would just encourage you to work a little faster and get those waivers approved, and make sure this happens.

With that, I yield back.

Mr. HILL. Thank you.

Mr. MEADOWS. Before I recognize the gentlewoman the District of Columbia, I want to make sure we clarify your testimony because I think you said it one way, and the gentleman from Ohio came back. There has been 14 States who have requested the waiver. You have granted three. Eleven are in the hopper. Is that correct?

Mr. HILL. That is correct.

Mr. MEADOWS. Okay.

Mr. HILL. The 11, I would need to go back and just be sure it is precisely 11, but roughly 11.

Mr. MEADOWS. Okay.

Mr. CONNOLLY. Mr. Chairman, could I just piggyback on your clarification? One of those pending States is Tennessee. Is that correct?

Mr. HILL. I believe so, yes.

Mr. CONNOLLY. And Tennessee has estimated that this work waiver requirement would actually cost \$18.5 million to implement, and they have asked permission to use TANF money, taking sort of from Peter to pay Paul, to do that. Is that correct?

Mr. HILL. I know that I have seen reports on how Tennessee wants to finance their work requirements.

Mr. CONNOLLY. Right.

Mr. HILL. I am really not in a position to get into what they have requested.

Mr. CONNOLLY. And while philosophically we may agree or disagree on this, is there any reason to believe that a work requirement has anything to do with waste, fraud, and abuse in reducing improper payments? Is there a connection?

Mr. HILL. I am not sure that I have drawn the connection myself. I mean, we believe the community engagement and getting folks into work —

Mr. CONNOLLY. Thank you.

Mr. HILL.—promote health.

Mr. CONNOLLY. Thank you, Mr. Chairman.

Mr. JORDAN. Mr. Chairman? Mr. Chairman?

Mr. MEADOWS. Yes.

Mr. JORDAN. The work requirement has everything to do with treating taxpayers with respect. Able-bodied adults. Many of these folks are young, many of them single men, and you do not have to do anything to get free healthcare from the taxpayer. So, it has everything to do with treating the people who pay for this with respect they deserve. That is why it is so critical. And, oh by the way, it might actually help the recipient. That is why we are for it.

Mr. MEADOWS. All right. The chair recognizes his allowance of a colloquy that came up without the intention of that. So, the chair is going to recognize, no intention of colloquy from the gentleman from Virginia. The chair recognizes the gentlewoman from the District of Columbia for a generous 5 minutes.

Ms. NORTON. I thank my good friend. Mr. Chairman, he is always fair to me. That was just a debate in case you wondered what was just happening there. I want to thank my good friend from Virginia, the ranking member, for mentioning our work together, making fun of members of committee with Shakespeare. Every year it is one of the highlights —

Mr. MEADOWS. Does the gentlewoman want to strike down his words?

[Laughter.]

Mr. CONNOLLY. No, she does not.

Ms. NORTON. On the contrary. I am a part of this play acting, Democrats and Republicans, and I must say it makes us understand that not all play acting occurs from this podium.

Just let me say something about a waiver in order to allow people to work right here. I would welcome a waiver for people who are not working in the District of Columbia on Medicaid, and with that waiver I would need in this knowledge economy from the

agencies who grant the waiver, help in finding jobs for people in the District of Columbia who are on Medicaid who are not working. I have not found them as I go around my district. I do not know if this happens in yours, but if you want a job here, and you do not have a high school education, then you need training. You need what the Federal government is not offering such people.

Most of the people on Medicaid are elderly, disabled, or children. So, let us understand who we are talking about. What I do not understand is the definition of terms. Once we get a term, it just begins to be used as if everybody understood what it means. "Improper payment rate" has been used over and over again. I thank you, Mr. Hill, for clarifying that that does not mean deliberate fraud.

And one of the things I would ask the chairman to do is to call for a task force of U.S. attorneys to work with the Agency. I do not think you are equipped to tell us what is fraud and what is not fraud. I state that as a member of the District of Columbia Bar that you need help, particularly since you are not even able to disaggregate. That is very, very unfortunate because we are using "improper payments" to cover all payments. And that is not very professional here, and it will not help you to uncover those improper payments. So, let us find out what we mean.

In HHS's 2017 financial report, and here I am quoting, "Improper payments are not necessarily expenses that should not have occurred." So, why do we not just start there? Can you explain how payments are categorized as improper, and how improper payments could be legitimate payments? Any of you, please help us clarify what we are talking about here.

Mr. HILL. I will start, and we can let others jump in, and we can turn back to our three-State audit in California, Kentucky, and New York where we are looking at eligibility systems failures. And it can be the case that a State has not complied with all the rules that we have established for verifications, for checking income, for determining whether or not a person was eligible. If they have not completed those system checks, we would count that eligibility decision as an error, and that would be a payment error.

Ms. NORTON. So, that is an error, not fraud.

Mr. HILL. Right, but in fact —

Ms. NORTON. Improper because it is an error.

Mr. HILL. Right, but it does not mean necessarily that all those payments should not have been made. So, for example, when a State in those instances would have gone back and done their redetermination, actually fulfilled the checks that they were supposed to have fulfilled, and found that the person was, in fact, eligible, the payment would have been made. So, it is an improper payment because the State has not complied, but it may not necessarily —

Ms. NORTON. And, of course, the State may at a later date correct the mistake.

Mr. HILL. Right, similarly with providers who —

Ms. NORTON. And we are talking about some people who do not have a high school education, some people are elderly, some people may have given the wrong data, some people may not have had the right data. Mr. Chairman, that was really my basic point, to try to clarify what we are talking about here, to understand that the

Agency itself has not, in fact, been able to decide whether we are talking about fraud or not.

Every member of this body has women, children, elderly, the majority of the people we are talking about may have committed errors. But it would be terrible to categorize them together with, as Mr. Hill says, there are very few people who set out to lie on their forms, whether they are income tax or other forms, and, therefore, commit fraud. And so, Mr. Chairman, I call upon the committee again, if you would, at least as a pilot to ask some U.S. attorneys to join with some members of the Agency so that they can begin to, in fact, go after fraud. And I would be glad to have my district be one of those, who would work with the Agency on actual fraud so then you could come back and give us a report on progress you are making.

I am outraged if there is actual fraud at a time when we are seeing cuts of all kinds in-services, and in Medicaid, and all kinds of threats to cover exactly the kind of services and benefits to women, children, the elderly, and disabled as are involved in Medicaid. So, a task force would help us clarify what we mean. I do not think we can ask the Agency, which is not a law enforcement agency, to do this on its own.

Mr. MEADOWS. Well, I think the gentlewoman's perspective on that, as she might have recalled in my opening statement, we do know that fraud is part of the problem because of —

Ms. NORTON. Granted.

Mr. MEADOWS.—what happened in Virginia and what happened in North Carolina that I highlighted in my opening statement. And so, in doing that, I think it is incumbent upon us before we get the U.S. attorneys involved, and, Ms. Tinker, I have already asked you to help us identify those. But it is incumbent on Mr. Hill, it is about quality data. And the truth is it is not as much the beneficiaries, as Ms. Yocom has pointed, as those that are actually providing that. That is where the fraud comes from, so it is not actually as much your individual constituents as maybe a constituent who is providing the service where the greatest amount of fraud happens. And so, I think if you can help us, Mr. Hill, highlight that.

I think the gentleman from Wisconsin, Mr. Grothman, is now recognized for 5 minutes.

Mr. GROTHMAN. Thank you. I am not sure how many cuts there are, but I worry about cuts to amend, too. A couple question here. First of all, for Mr. Purpera, as far as Louisiana is concerned, we talk about over time going for fee-for-service to managed care. I would like you to comment the degree to which that will, in addition to other benefits, reduce fraud.

Mr. PURPERA. Well, one thing to understand, sir, is that under managed care, our liability is 100 percent from day one. So, under fee-for-service, we enroll someone and they become a recipient, but there are no payments made until they actually go and see a physician or get a prescription.

Mr. GROTHMAN. Correct.

Mr. PURPERA. But under managed care, their liability becomes first day it is 100 percent. As to fraud, I can only speak for Louisiana at the moment and maybe 25 other States that do not use

income tax data to verify the eligibility role. But realize when you apply for Medicaid, it is very much based upon income, and the only thing that most of these States have to check is the wage data. Wage is data is very limited. It does not include all kinds of self-employment types of income.

And so, you know, I guess we have talked several times today about fraud as only on kind of on the provider side. I am not so sure about that, but I do not know that we know either because we are not really looking.

Mr. GROTHMAN. Right. Well, I guess the question is there is a feeling with regard to medical costs in general that maybe less procedures would be done on managed care than fee-for-service. And given that some of the fraud is from the provider side, there would be less opportunity for fraud there. I guess that is what I'm trying to get you to say, or do you think that is true or not?

Mr. PURPERA. Well, I do believe, I think it was the State of Washington, their auditor issued a report saying that for every dollar in improper payment that went into the system under managed care, it came back in the form of a dollar and a quarter in increased per member per month later on. So, that kind of data is out there. In other words, a bad payment today can result in increased payments later in —

Mr. GROTHMAN. So, you do not think that managed care would be necessarily a benefit is what you are telling me.

Mr. PURPERA. Would be, sir?

Mr. GROTHMAN. Would necessarily be a benefit. You do not buy into the idea that managed care would —

Mr. PURPERA. No, sir, I am not saying it would not be. I think that the data on that is still out. In my State, we are looking or continuously looking at what are the actual costs in counter costs of our managed care partners as compared to the PM/PMs that we are paying, you know, the money that we are sending them. And we are looking at that gap and trying to determine what is the extent of that gap.

The major portion of that, I am not saying this is fraud, but it is based upon the actuarial assumptions that go into developing the per month/per month. In Louisiana, for example, the normal rate for a Medicaid recipient PM/PM, let us say, \$350. It is around there. But under expansion, it is \$500.

Mr. GROTHMAN. Okay.

Mr. PURPERA. Now, I do not think we have really come to understanding why it jumped so much.

Mr. GROTHMAN. Okay. Another question kind of follow-up on what a couple people have said in the past, obviously Medicaid is a huge benefit, and unless you do not get out at all, I think you know that people are intentionally holding down their income because they want to keep their Medicaid, which is understandable. It is such a generous program. Either they are making less, or maybe just reporting less income, which is maybe what you were referring to, because you want to hold under a given amount.

Does anybody have any comments on that? Are there any people even beginning to make an estimate on the amount of income that the economy is losing as people either work less or find a way to work for cash to keep this generous benefit? Anybody given it any

thought? Mr. Purpera, that is why we like you. You are always thinking.

Mr. PURPERA. Yeah. So, let me just say this. I do not have any statistics on —

Mr. GROTHMAN. I mean, it is obvious that it is going on to a degree because you hear about it if you talk to people.

Mr. PURPERA. If you just strictly want to talk about the fraud perspective, and I am not trying to give any degree of how many people are committing fraud in this perspective. At least in Louisiana and 25 other States, they have to reduce their income because are not looking. The program is not looking, right? We are looking at their wages. So, if they are self-employed, they are a home building contractor, they can make as much money as they want to. We do not know the answer to that, and our State departments are not going to know the answer to that.

In addition to that, the way the regulations are written right now, I have got one of the applications in my briefcase back here. It says what did you make this month, and what was your income this month? Well, so if you have cyclical incomes it really gets crazy as to whether or not they are eligible or not eligible.

Mr. GROTHMAN. Yeah, and I was not aware of that. You can tell me this. If I am somebody who is working 60 hours a week from March 1st to November 30th, and I go in and apply for Medicaid on January 1st, how long do I get Medicaid for?

Mr. PURPERA. In my State, they would ask you what was your income in the previous month.

Mr. GROTHMAN. Correct.

Mr. PURPERA. And then you are going to be based upon that. And then in addition to that, you are going to be enrolled in the system primarily for a year. Now, you have a responsibility to report any time that you increase your income, but we are talking about fraud, right? So, if we are talking about fraud, then that individual is not going to report.

Mr. GROTHMAN. Okay. And in the case I said, and thank you, Mr. Chairman, for indulging me. In my example, if I am a guy, say, involved in construction and I am making a 80 grand a year every year from March 1st to November 30th, and I apply on January 1st and I am found eligible, as a practical matter, if I just let the Medicaid run and never report anything until the end of the year, am I ever going to get caught or is anything bad ever going to happen to me?

Mr. PURPERA. Unless you are honest about what you make, I do not believe you will because in 25 States, they are not using tax data. In addition to that, let me just point out, because we are basing it on modified adjusted gross income, which is a number that looks a whole bunch like tax data, then in your construction company, if you buy a new piece of equipment that year and decide to pull a 1079 deduction and write off more that year in your depreciation, then you may be living off \$100,000, but you qualify for Medicaid.

Mr. GROTHMAN. Thank you. Do you think we should require all States to use tax data?

Mr. PURPERA. I absolutely.

Mr. MEADOWS. You can answer the question, the gentleman from Wisconsin has exceeded my gracious timeframe.

Mr. GROTHMAN. That is why. It was such a good question.

Mr. MEADOWS. You can very quickly answer the question and we will close out.

Mr. PURPERA. I absolutely, sir. Absolutely do.

Mr. PURPERA. Thank you.

Mr. MEADOWS. All right. I thank the gentleman from Wisconsin. The chair recognizes the gentleman from Virginia for his closing remarks.

Mr. CONNOLLY. I thank the chair, and, again, I think this hearing is a good piece of work in trying to get at both methodology for accounting for improper payments, disaggregating them so that we can devise strategies working together to effectively reduce it. I do think it is important in listening sometimes to some of the rhetoric, you know, overwhelmingly people who take advantage of Medicaid need it. They are not gaming the system. They are not takers. They are not con men. They are families who are trying to make sure they have access to healthcare.

And what we also know is that when people have that access, society benefits. There are not free riders. People get healthier, can live more productive lives, can become taxpaying, contributing members of society. So, healthcare is an investment. We do not want anyone cheating. We do not want people stealing. We do not want people defrauding. But let us not overstate the extent of the problem. Medicaid is there for a very good reason and it has worked.

Ms. NORTON. Would the gentleman yield for a moment?

Mr. CONNOLLY. Of course.

Ms. NORTON. I just wanted to inject another bipartisan note here because my colleague who just spoke, who just asked questions indicated, and I am glad the chairman allowed him to ask the question, whether or not using tax forms would be better than having people report, for example, on a monthly basis what their income is, or even self-report.

I must say in terms of whether hearings are designed to get to remedies, unless I hear something and we need another time for this, perhaps another hearing, or perhaps they could even respond to the chairman's request for information on why tax forms would not be a better way to get at the notion of the actual income of people so that we could get at Medicaid fraud. And I yield back to my good friend.

Mr. CONNOLLY. I thank my friend for that, and I think she makes a very good point. We have heard testimony here. No one has said there is massive individual fraud going on because people are gaming the system in terms of their income, reported income. There may be examples of that, and we want to try our best to perfect the system. But I want to go at the institutional problems first because that is where the real money is, and every dollar we save at that level can be invested in the program for people in need. And so, you know, until and unless we have testimony that would corroborate the need for such a thing because of wrongdoing by large numbers of individuals, let us focus at the problem at hand that we have heard testimony from, including from the Administration.

And, again, I want to thank my friend, Mr. Meadows, for this thoughtful hearing, and I know we are going to have others on improper payments. This committee is committed to addressing this issue and working with the executive branch to do so and with our friends at GAO to develop methodologies to better capture the nature of the problem. And I thank the chair.

Mr. MEADOWS. I thank the gentleman for his remarks. A few housekeeping items and follow-ups that I would like to add. Mr. Schneider, you have been over there to my right. Normally I focus on my right. Today I did not. And in doing that, if you could actually give us a list of the top three recommendations that you either personally or in your official capacity could make to us on possibly implementing areas to address this improper payment issue. If you could do that from an intellectual standpoint. Are you willing to do that and get to the committee?

Mr. SCHNEIDER. I am, Mr. Chairman. I did provide some recommendations in my written statement. Do you want additional ones?

Mr. MEADOWS. Three additional ones above your opening written statement if you can, and I guess what I am saying is based on the testimony you have heard today, critiquing it from an intellectual standpoint, if you can do that, that would be very helpful so I can be very specific with that request.

Mr. SCHNEIDER. I would be happy to, Mr. Chairman.

Mr. MEADOWS. All right, thank you.

Mr. MEADOWS. Mr. Hill, let me come back to you one area, and it gets back to the quality of the data that we talked about with the reporting system and the data that obviously is, according to Ms. Yocom and Ms. Tinker, is less than what we would want it to be, and I think from your testimony, less than what you would want it to be. We have had a number of deadlines that seem to get extended in terms of compliance. So, what I need from you is really a plan, and I will give you, is 45 days enough to come up with a plan on how we can date specific look at how you are going to implement and improve that quality, exponentially I might add, from where it is today. Is 45 days enough to get back to this —

Mr. HILL. Yep.

Mr. MEADOWS.—with date-specific targets on when you are going to do that so it addresses that?

Mr. HILL. It is a fair question.

Mr. MEADOWS. Thank you, Mr. Hill.

Mr. MEADOWS. And so, for all of you, thank you. And thank you for the thoughtful way that you have answered these questions. Hopefully this has not been as painful as some oversight hearings that you either may have been a part of. I know from a CMS standpoint, hopefully this is better. I look back in the back and she is smiling, but there have been some that have been a little bit more contentious in the past. And thank you all.

And if there is no further business before the committees, the committees stand adjourned.

[Whereupon, at 11:46 a.m., the subcommittee was adjourned.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

Enclosure

GAO Response to Hearing Questions
Chairmen Meadows and Palmer and Ranking Members Connolly and Raskin
Subcommittee on Government Operations and Subcommittee on Intergovernmental Affairs,
Committee on the Oversight and Government Reform, House of Representatives
During the April 12, 2018, hearing entitled
“Improper Payments in State-Administered Programs: Medicaid”

Q: Would the GAO please develop a plan for disaggregating the share of improper payments in the Medicaid program that are related to potential fraud?

The proportion of fraud in improper payments cannot be calculated when such estimates are developed, since fraud can only be proven after the fact. It is well-understood that all payments made as a result of fraud are considered improper payments—but not all improper payments constitute fraud.¹ All potential fraud cases must be identified, investigated, prosecuted, and adjudicated—resulting in a conviction—before fraud can be established.

There are data on Medicaid fraud cases that have been identified and prosecuted. Medicaid Fraud Control Units (MFCU)—state entities responsible for investigating and prosecuting Medicaid fraud—have reported on Medicaid fraud convictions and recovered monies through their annual reports. For example,

- Over the past 5 years, MFCU have reported an average of 1,072 yearly Medicaid fraud convictions.²
- Over the past five years personal care service attendants/home health aides have had more fraud convictions than any other provider type.
- MFCUs reported \$681 million in recoveries related to fraud in fiscal year 2017—almost double the recoveries from fiscal year 2016.³

However, the usefulness of these data are limited for measuring total fraud. The MFCU annual report does not provide information on when the actual fraud occurred, making it difficult to provide a point in time for measuring fraud. Additionally, the bulk of the recovered monies from fraud convictions do not necessarily equate to those providers with the highest percentage of fraud convictions.

Additionally, there is no reliable way to measure fraud that goes undetected, especially since fraud can look like appropriate payments for health care services. The MFCU annual report lists a wide range of facilities, providers, and programs where fraud occurred. For example, in fiscal

¹Fraud involves taking something of value through willful misrepresentation. An improper payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments). In the Medicaid program, this can include payments made for people not eligible for Medicaid, payments for an ineligible service, duplicate payments, and payments for services not actually provided.

²Nearly all states have Medicaid Fraud Control Units (MFCU) responsible for investigating and prosecuting Medicaid fraud. MFCUs are funded jointly by the federal government and the states and the Department of Health and Human Service's Office of the Inspector General provides oversight.

³See HHS-OIG, *Medicaid Fraud Control Units Fiscal Year 2017 Annual Report*, OEI-09-18-00180 (Washington, D.C.: March 2018).

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year 2017 there were fraud convictions against facility-based Medicaid providers (hospitals, hospice, assisted living), licensed practitioners (social workers, dentists, psychologists), medical services (ambulances, laboratories, pharmacies) and physicians, among others.⁴ Thus, measuring health care fraud in Medicaid is a challenging task that would be extremely difficult to execute with any reliability. In 2016, GAO reported that the extent of fraud in federal health care programs is unknown as there are no reliable estimates of the magnitude of fraud within these programs or across the health care industry generally.⁵ Additionally, the Congressional Budget Office has not estimated the amount of fraud—either detected or undetected—in Medicare, Medicaid or the Children's Health Insurance Program.⁶

Oversight of fraud, however, is critical, and we appreciate the subcommittees' interest in ensuring that fraud investigations are part of our arsenal against improper payments. Medicaid presents opportunities for fraud because the size, expenditures, and complexities—including the variation in states' design and implementation—of the program make oversight difficult. GAO has prior work that discussed approaches to managing fraud risks, and developed the Fraud Risk Framework, which provides a comprehensive set of key components and leading practices that serve as a guide for agency managers to use when developing efforts to combat fraud in a strategic, risk-based manner.⁷ The Fraud Reduction and Data Analytics Act of 2015, enacted in June 2016, recognized this framework.⁸ The Act required the Office of Management and Budget (OMB) to establish guidelines for federal agencies to create controls to identify and assess fraud risks and design and implement antifraud control activities. These guidelines also had to incorporate the leading practices from the Fraud Risk Framework— such as a senior-level commitment to combating fraud. OMB published these guidelines in July 2016 and noted that managers should adhere to the leading practices in the Fraud Risk Framework as part of their efforts to effectively design, implement and operate an internal control system that addresses fraud risks.⁹ We have applied this Framework to Medicare and Medicaid and identified areas

⁴See HHS-OIG, OEI-09-18-00180

⁵See GAO, *Health Care Fraud: Information on Most Common Schemes and the Likely Effect of Smart Cards*, GAO-16-216 (Washington, D.C.: January 22, 2016).

⁶See Congressional Budget Office, *How Initiatives to Reduce Fraud in Federal Health Care Programs Affect the Budget*, 49460 (October 2014).

⁷See GAO, *Highlights of a Forum: Data Analytics to Address Fraud and Improper Payments*, GAO-17-339SP, (Washington, D.C.: March 3, 2017; and GAO, *A Framework for Managing Fraud Risks in Federal Programs*, GAO-15-593SP (Washington, D.C.: July 2015).

⁸ Pub. L. No. 114-186, 130 Stat. 546 (2016).

⁹ Office of Management and Budget, *Management's Responsibility for Enterprise Risk Management and Internal Control*, Circular No. A-123 (Washington, D.C.: July 15, 2016).

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where additional CMS actions could help improve oversight of fraud.¹⁰ GAO has also conducted investigations aimed at provider and beneficiary fraud.¹¹

¹⁰GAO, *Medicare and Medicaid: CMS Needs to Fully Align Its Antifraud Efforts with the Fraud Risk Framework*, GAO-18-88 (Washington, D.C.: Dec. 5, 2017).

¹¹See, for example, GAO, *Patient Protection and Affordable Care Act: CMS Should Act to Strengthen Enrollment Controls and Manage Fraud Risk* GAO-16-506T (Washington, D.C.: Mar 17, 2016; GAO, *Medicaid: Additional Reporting May Help CMS Oversee Prescription-Drug Fraud Controls* GAO-15-390 (Washington, D.C.: Jul 8, 2015), and GAO, *Medicaid: CMS Could Take Additional Actions to Help Improve Provider and Beneficiary Fraud Controls* GAO-15-665T (Washington, D.C.: Jun 2, 2015).



May 10, 2018

The Honorable Mark Meadows, Chairman
 Subcommittee on Government Operations
 House Committee on Oversight & Government Reform
 2157 Rayburn House Office Building
 Washington, DC 20515

RE: Improper Payments in State-
 Administered Programs: Medicaid

Mr. Chairman,

Thank you again for the opportunity to testify at the April 12 hearing on Medicaid improper payments held by the Subcommittees on Government Operations and Intergovernmental Affairs. At the hearing, you requested that I provide my top 3 recommendations for addressing improper payments in Medicaid based on the testimony presented by the witnesses. This is in response to your request. As in the case of my prepared statement, these recommendations do not necessarily represent the views of Georgetown University.

1.) Require CMS to conduct a state-specific analysis of compliance with provider screening and enrollment requirements in fee-for-service Medicaid.

As noted in the CMS testimony, noncompliance with provider screening and enrollment requirements is “the driver of the Medicaid improper payment rate” (Hill, p. 8), even though it has been over seven years since the provider screening and enrollment requirements took effect (March 25, 2011). The importance of compliance was underscored by both OIG (Tinker, p. 3-5) and GAO. In response to a question from Mr. Raskin concerning the source of fraud in Medicaid, Ms. Yocum from GAO answered: “If you can screen and enroll, and ensure your providers act in good faith, you’ve managed most of the fraud. A beneficiary alone trying to commit fraud needs a complicit provider. So focusing attention on ensuring good screening and enrollment processes is critical.”

There is, in all likelihood, variation from state to state in the extent of noncompliance. States with higher rates of noncompliance are driving up the national improper payment rate for the federal government and all other states. My recommendation is that the Subcommittees require CMS to report on the status of each state’s compliance with provider screening and enrollment requirements in fee-for-service Medicaid. Specifically, CMS should report for each state, by risk

category ("limited"/"moderate"/"high"), the number of providers enrolled in fee-for-service Medicaid and, of those, the number that have been properly screened and timely revalidated. These totals should be broken down by rendering providers and by ordering or referring providers (ORPs).

2.) Require CMS to conduct a state- and MCO-specific analysis of compliance with provider screening and enrollment requirements. In many states, fee-for-service Medicaid covers fewer beneficiaries and affects fewer dollars than managed care Medicaid. As of July 1, 2017, twelve states had enrolled 90% or more of their entire Medicaid population in managed care organizations (MCOs). One of those states is Louisiana. As the Louisiana Legislative Auditor noted in his testimony, the measurement of improper payments in Medicaid managed care currently focuses only on whether an enrollee is eligible and whether the capitation payment to the MCO is correct (Purpera, p. 5). Yet the program's interest in ensuring that providers are screened and enrolled is just as compelling in managed care as it is in fee-for-service—especially in states with high MCO penetration.

The Congress spoke directly to this concern in enacting the 21st Century Cures Act, P.L. 114-255, in December 2016. Section 5005(b)(2) of the Act requires that all Medicaid MCO network providers, including ORPs, be screened and enrolled by January 1, 2018. As noted, the improper payments rate does not tell us anything about the extent of state compliance with this requirement. My recommendation is that the Subcommittees fill this gap by requiring CMS to report on the compliance by each state as of January 1, 2018, broken down by MCO. As in the case of the fee-for-service analysis, this managed care analysis should present information by risk category ("limited"/"moderate"/"high"), the number of network providers in each MCO, and that number of those that have been properly screened and timely revalidated. These totals should also be broken down by rendering providers and by ORPs.

3.) Hear from the State Medicaid agencies. The 10.1% Medicaid improper payment rate for FY 2017 is a three-year national average (Hill, p. 8). During this three-year cycle, some states had rates higher than 10.1 percent, and some had rates that were lower. (Because the managed care component of the error rate is so low—0.30 percent compared to 12.87 percent for fee-for-service—it is likely that states with high managed care penetration had relatively low improper payment rates). The Subcommittees and the public would benefit from a better understanding of this state variation, especially any variation in compliance with provider screening and enrollment requirements. Medicaid is, after all, a federal-state program; the national average cannot, by definition, tell the whole story.

My recommendation is that the Subcommittees invite a number of state Medicaid agencies to a follow-up hearing to discuss how to reduce improper payments. The agencies should be representative of high fee-for-service and high managed care states as well as states with high improper payment rates and states with low rates. States should have the opportunity to respond on the record to the testimony of

CMS, OIG, and GAO, as well as to explain their individual performance with respect to provider screening and enrollment in both fee-for-service and managed care. This state testimony, combined with the testimony of federal witnesses from the April 12 hearing, would give the Subcommittees a comprehensive understanding of the types and causes of improper payments in Medicaid and inform future oversight work to improve the program.

As I indicated in my testimony, Medicaid is the health insurer for some 37 million children and over 9 million parents. It is absolutely essential that Medicaid work as well as possible for these low-income Americans. I hope the Subcommittees will continue the oversight that they have initiated with this hearing, stressing the importance of compliance with provider screening and enrollment requirements in reducing improper payments in Medicaid. If you or your staffs need additional information, please don't hesitate to contact me.

Andy Schneider
Research Professor of the Practice
Center for Children and Families

cc: The Honorable Gary J. Palmer, Chairman
Subcommittee on Intergovernmental Affairs

The Honorable Gerald E. Connolly, Ranking Member
Subcommittee on Government Operations

The Honorable Jamie Raskin, Ranking Member
Subcommittee on Intergovernmental Affairs