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4 MEDICAID PROGRAM INTEGRITY: SCREENING OUT ERRORS, FRAUD, AND
5 ABUSE
6 TUESDAY, JUNE 2, 2015
7 House of Representatives,
8 Subcommittee on Oversight and Investigations
9 Committee on Energy and Commerce
10 Washington, D.C.

11 The Subcommittee met, pursuant to call, at 10:16 a.m.,
12 in Room 2322 of the Rayburn House Office Building, Hon. Tim
13 Murphy [Chairman of the Subcommittee] presiding.
14 Members present: Representatives Murphy, McKinley,
15 Burgess, Blackburn, Bucshon, Brooks, Mullin, Collins,
16 DeGette, Schakowsky, Castor, Yarmuth, Clarke, Kennedy, Green,

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17 Welch, and Pallone (ex officio).

18 Staff present: Noelle Clemente, Press Secretary; Jessica
19 Donlon, Counsel, Oversight and Investigations; Brittany
20 Havens, Oversight Associate, Oversight and Investigations;
21 Charles Ingebretson, Chief Counsel, Oversight and
22 Investigations; Michelle Rosenberg, GAO Detailee, Health;
23 Chris Santini, Policy Coordinator, Oversight and
24 Investigations; Alan Slobodin, Deputy Chief Counsel,
25 Oversight; Jessica Wilkerson, Oversight Associate, Oversight
26 and Investigations; Jeff Carroll, Democratic Staff Director;
27 Ryan Gottschall, Democratic GAO Detailee; Ashley Jones,
28 Democratic Director, Outreach and Member Services; Chris
29 Knauer, Democratic Oversight Staff Director; Una Lee,
30 Democratic Chief Oversight Counsel; Elizabeth Letter,
31 Democratic Professional Staff Member; and Tim Robinson,
32 Democratic Chief Counsel.

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

41 Last year the Medicaid program provided medical services
42 for approximately 60 million people at a cost of $310
43 billion. But during that same year, the Centers for Medicare
44 and Medicaid Services estimate that the improper payment rate
45 was 6.7 percent, or $17.5 billion. This is an increase of
46 almost one percent, or over three billion, from the previous
47 year. It is a troubling trend, especially as the program
48 continues to expand.

49 Unfortunately, the Medicaid program is far too
50 accustomed to fraud. In fact, the Government Accountability
51 Office has designated the Medicaid program as a high risk for
52 fraud and abuse since 2003, and it has been the subject of

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53 multiple GAO and Department of Health and Human Services
54 Office of Inspector General Reports over the past several
55 years, including a GAO report being highlighted today.
56 In 2012 the Committee requested GAO identify and analyze
57 indicators of improper and potentially fraudulent payments to
58 Medicaid beneficiaries and providers. In a trustworthy
59 study, another in a longtime examining Medicaid fraud, GAO
60 has reported that CMS needs to take additional actions to
61 improve provider and beneficiary fraud controls. GAO found
62 that thousands and Medicaid beneficiaries and hundreds of
63 providers in just four states, Arizona, Florida, Michigan and
64 New York--excuse me, New Jersey, were involved in possible
65 improper or fraudulent payments during fiscal year 2011. For
66 example, almost 200 deceased beneficiaries received at least
67 9.6 million in Medicaid benefits. About 8,600 beneficiaries
68 received payments by two or more states, totaling at least
69 18.3 million.
70 The Social Security numbers for about 199,000
71 beneficiaries did not match the Social Security
72 Administration databases. About 90 medical providers had
73 their medical license revoked or suspended in the state in

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74 which they received Medicaid payments. At least 47 providers
75 had foreign addresses as their location of services,
76 including Canada, China, India, and Saudi Arabia. About 50
77 providers who received Medicaid payments were excluded from
78 the Federal program for a variety of reasons, including
79 patient abuse, or neglect, fraud, theft, bribery, and tax
80 evasion.

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

93 The report included disturbing stories, such as a
94 Georgia optometrist who claimed he conducted 177 eye exams in

95 one day, yet remained on South Carolina's Medicaid rolls for
96 after a year after he pleaded guilty in Georgia. In another
97 instance, an Ohio psychiatrist routinely over-reported the
98 time he spent with patients, and even billed for no-show
99 patients. CMS revoked his billing privileges after he was
100 convicted of felony Workers' Compensation fraud, yet he
101 continued to work in the Illinois Medicaid program, getting
102 paid $560,000 for services or prescriptions he wrote after
103 his Medicare provider revocation. Shockingly, on the day he
104 was being sentenced in Columbus, Ohio, he also claimed that
105 he saw 131 group therapy patients at his Illinois practice.
106 Now, these stories, we know, are unacceptable. Medicaid
107 fraud undermines the integrity of the program, denies our
108 most vulnerable the services they deserve, and waste
109 taxpayers' and--hard earned dollars. I hope we will hear
110 today about the steps that can be taken to further combat
111 fraud in the Medicaid program. That is what we want to focus
112 on. And GAO has recommended some common sense steps that
113 would reduce fraud, such as issuing guidance to states,
114 better identifying beneficiaries who are deceased, and the
115 availability of automated information through Medicare's

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116 enrollment database.

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

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

127 [The prepared statement of Mr. Murphy follows:]

128 *************** COMMITTEE INSERT ***************

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|

129 Mr. {Murphy.} And I now recognize the Ranking Member,
130 Ms. DeGette of Colorado, for 5 minutes.
131 Ms. {DeGette.} Thank you, Mr. Chairman. Good news on a
132 bipartisan basis, we are against waste, fraud, and abuse, as
133 usual, in the Medicaid program, and everyplace else. I have
134 been on this Subcommittee now 19 years, and we have had a
135 whole series of hearings over the years. And as you
136 accurately point out, Mr. Chairman, it goes from
137 administration to administration, Medicaid seems to
138 particularly vulnerable to issues like fraud, and we have to
139 continue our oversight. So when you say will we be here
140 again in 2 years? Probably. We will probably be here in 10
141 years, because this kind of a problem takes ever vigilance by
142 this Committee.
143 The GAO report we are talking about today tells us that
144 the Medicaid program, like many other large programs, like
145 Medicare, defense contracts, and private insurance plans,
146 experience thousands of improper, and possibly fraudulent,
147 payments every year. Last year CMS found an estimated
148 improper payment rate of 6.7 percent, which amounted to about

149 $17.5 billion for the Medicaid program in 2014.

150 Now, as I said, and you said, like many other programs,
151 Medicaid is not--fraud is not unique to this Committee. In
152 our report, which was published in 2003, which was 12 years
153 ago, we said, ``Committee hearings last year revealed that
154 the cost of the Medicaid fraud program could exceed $17
155 billion every year. This year, 2003, the Committee will
156 examine ways in which states could adopt more rigorous
157 enrollment controls to keep unscrupulous providers out of
158 their programs, and improve their program integrity
159 standards.'' And we had laudable efforts since that time.
160 Truly, $17 billion in 2003, and about $17 billion now, even
161 with the Medicaid expansion, that is not something to be
162 proud about, although I guess we should be glad it doesn't
163 seem to be getting a lot worse. Nonetheless, Congress, and
164 the Administration, and the governors all across the country
165 need to focus on improper payments.

166 There is something exciting, though, that I think may
167 actually make a major difference going forward. Under the
168 Affordable Care Act, a number of important measures were
169 enacted to prevent or reduce improper payments in the

170 Medicaid and Medicare programs. For example, the ACA
171 provided nearly $350 million in new funds for anti-fraud
172 efforts. It provided new authorities to the Secretary of HHS
173 to help shift from a traditional pay and chase model to a
174 preventative approach, by keeping fraudulent suppliers and
175 providers out of the program before they commit fraud. And
176 now we have in place a host of new and enhanced anti-fraud
177 penalties to deter those attempting to improperly bill
178 Medicaid or Medicare. These are important new tools, and I
179 think they can help safeguard the program. I am looking
180 forward to hearing from CMS and GAO on how these efforts are
181 working, and how they expect to build upon efforts to
182 strengthen Medicaid at both the Federal and State levels.
183 I think it is important to put this discussion of
184 improper payment rates in contacts--in context with large
185 scale financing of other public and private sector programs.
186 For example, I can cite endless examples of major defense
187 contractors receiving improper payments from the Pentagon.
188 Last year the Washington Post revealed that one company
189 improperly charged the government more than $100 million for
190 services. DOD alone reported it had made $1.1 billion in

191 improper payments for fiscal year 2011.

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

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

208 So, as I say, I really want to thank the agencies for
209 coming in and helping us. Anything we can do to strengthen
210 the controls to prevent overpayment and fraud is great with
211 me, because the hard working Americans in all 50 states rely

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212 on these Medicaid services, and they also rely on the fact
213 that their tax dollars are going to best serve this country.
214 Thank you, Mr. Chairman.
215 [The prepared statement of Ms. DeGette follows:]

216 *************** COMMITTEE INSERT ***************

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|

217 Mr. {Murphy.} Thank you. Now I will recognize Dr.
218 Burgess for 5 minutes.
219 Mr. {Burgess.} Thank you, Mr. Chairman. This is an
220 important hearing we are having today. Medicaid, a program
221 that is entirely under our jurisdiction in the Energy and
222 Commerce Committee, is a vital program that covers and
223 provides care for some of the nation's most vulnerable
224 populations. This Committee does have exclusive legislative
225 jurisdiction over Medicaid, and it is our responsibility to
226 ensure that the long term sustainability of Medicaid is
227 assured through proper oversight.
228 Inefficient and misdirected payments within the Medicaid
229 program have substantive budgetary, access, and provider
230 impacts that ultimately infect--affect patients. If states
231 do not have the proper tools available for monitoring
232 enforcement, there can be lasting effects on the nation's
233 Medicaid recipients, and the providers of their care. CMS
234 has report improper payments well over $17 billion for fiscal
235 year 2014 for the Medicaid program, an increase of nearly $3
236 billion from the prior year. That is a trend that should

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237 concern all of us. Each of those dollars that is spent
238 inappropriately is a dollar not spent on a patient, and is,
239 in fact, a wasted taxpayer dollar.
240 I do want to point out that the recently passed H.R. 2,
241 that this Committee had a great hand in getting started, and
242 shepherding through the legislative process, and ultimately
243 it was signed by the President, but it did have a number of
244 anti-fraud provisions contained within. Most of those
245 pertained to the Medicare system, but I do wonder if some of
246 those examples may not also be extrapolated to the Medicaid
247 system. Specifically, Mr. Chairman, Section 502, preventing
248 wrongful Medicare payments for items and services furnished
249 to incarcerated individuals, individuals not lawfully
250 present, and deceased individuals. That may be something
251 worthy of study that the CMS may want to consider for the
252 Medicaid system as well.
253 I am also concerned about allowing entities engaging in
254 fraud to continue to receive Federal funds. We want to
255 ensure provider participation in Medicaid, and patients
256 should never be faced with a choice of no care or low quality
257 care from those providers. The Office of Inspector General

258 has the authority to exclude entities that employ deceptive
259 businesses practices within the Medicaid program. In 2014
260 Ranking Member DeGette and I looked into the practices of
261 certain dental management service companies within the
262 Medicaid program which not only provide managerial services
263 to dental clinics, but also, in fact, own these clinics, and
264 have direct control over the operations and finances of the
265 clinics. We became very concerned because this corporate
266 structure was resulting in failure to meet basic quality and
267 compliance standards.
268 Unfortunately, many of these practices have continued,
269 despite Federal Government intervention. The Office of
270 Inspector General may initiate a corporate integrity
271 agreement, but these deceptive entities may dissolve under
272 bankruptcy, only to re-emerge under new management. The
273 Office of Inspector General has the authority to exclude
274 individuals and entities that have engaged in fraud and abuse
275 related to Federal health programs, including Medicaid.
276 Following our investigation, we sent a letter to the Office
277 of Inspector General recommending that OIG consider excluding
278 any corporate entity that employs deceptive practices that

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279 result in substandard care.

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

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

290 [The prepared statement of Mr. Burgess follows:]

291 *************** COMMITTEE INSERT ***************

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|

292 Mr. {Murphy.} Gentleman yields back, and--if there is
293 anybody else on our side who wants the remaining 50 seconds?
294 And, if not, we will move over to the Ranking Member, Mr.
295 Pallone, for 5 minutes.
296 Mr. {Pallone.} Thank you, Mr. Chairman. For decades
297 Medicaid has been a lifeline for tens of millions of hard
298 working Americans across the country. That is why we must
299 make sure that the resources we devote to this program are
300 administered efficiently and effectively. Every dollar lost
301 to misuse or fraud of our Federal health programs is one less
302 dollar available to fund essential lifesaving medical
303 services for Americans. Cutting down on waste, fraud, and
304 abuse is, and must remain, a priority for CMS, state Medicaid
305 programs, and this Committee.
306 Some of my colleagues on the other side of the aisle
307 have expressed concerns that expansion of Medicaid will put
308 state budgets in an untenable position and increase fraud,
309 and that is simply not true. Beneficiary access and program
310 integrity efforts are not competing goals. Smart, effective
311 regulation reinforces both goals simultaneously.

312 In the short time since states have had the option to
313 expand Medicaid, those states have already realized
314 significant qualitative and economic benefits, as
315 uncompensated care rates drop, and states are able to collect
316 more revenue. Expansion makes good economic sense, and good
317 moral sense. For instance, in my home state of New Jersey,
318 projects a nearly $150 million decline in charity care in
319 fiscal year 2016, with savings from the Medicare expansion
320 totaling nearly $3 billion through 2020. Let us also not
321 forget that Medicaid coverage lowers financial barriers to
322 access, increases use of preventative care, and improves
323 health outcomes. Making the program available to more
324 vulnerable Americans is a great achievement, and one that I
325 am very proud of having played a part in.
326 But, of course, it is now more important than ever that
327 we act as good stewards of Medicaid dollars, and ensure that
328 the benefits of this program are available for generations to
329 come. That is why, when we passed the Affordable Care Act in
330 2010, we included a number of measures to strengthen program
331 integrity and reduce fraud in the Medicaid program. In 2011,
332 for example, CMS established procedures to screen providers

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333 and suppliers based on their risk levels so we can prevent
334 fraud before it occurs. This has changed the traditional pay
335 and chase model towards a preventative approach by keeping
336 fraudulent suppliers out of the program before they can
337 commit fraud.

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

349 So I want to hear today about how all these measures
350 have worked, and about how CMS is implementing regulations to
351 better protect patients and legitimate providers. Although
352 the ACA made significant steps to reduce fraud and abuse in
353 the Medicaid program, I know there is always room for

354 improvement, and I am glad the GAO is here today to share
355 their findings and provide constructive advice about how can
356 we make the Medicaid program even stronger.
357 But I want to caution against applying GAO's findings
358 too broadly. First, the analysis focused on four states,
359 Arizona, Florida, Michigan, and New Jersey, and its findings
360 are not generalizable across the country. Second, the report
361 looked at data from fiscal year 2011, before many of the ACA
362 anti-fraud provisions went into effect. GAO acknowledges
363 several times in a report that CMS has since made changes to
364 address improper payment issues. Third, I want to make the
365 point that many of the potentially improper payments listed
366 in this report are likely examples of provider fraud, not
367 beneficiary fraud. The GAO report lists examples such as
368 billing under deceased beneficiaries' identities, or billing
369 on behalf of currently incarcerated beneficiaries. Given
370 that these beneficiaries are hardly in a position to defraud
371 the government, I think it is likely that many of these are
372 examples of provider fraud.
373 So, Mr. Chairman, good program integrity helps to ensure
374 that beneficiaries receive the care they need, so I look

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375 forward to hearing from CMS and GAO how these latest efforts
376 are being implemented by the states. I guess--I don't know
377 if anybody wants my 30 seconds, but--otherwise I will yield
378 back. Thank you.

379 [The prepared statement of Mr. Pallone follows:]

380 *************** COMMITTEE INSERT ***************

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381 Mr. {Murphy.} Thank you, I appreciate that. We will
382 proceed onward. It is good to see we are all on the same
383 team today, focused on this, and our witnesses are part of
384 this too, so I would like to introduce the witnesses for
385 today's panel, make sure I get the names right. It is Seto
386 Bagdoyan, did I get that right? Good, thank you. The
387 Director of Audit Services in the U.S. Government
388 Accountability Office Forensic Audits and Investigative
389 Services Missions Team. Welcome here.
390 And Dr.--I know this, Shantanu Agrawal--you have been
391 here before, welcome back--is the Deputy Administrator and
392 Director of the Center for Program Integrity at the Centers
393 for Medicare and Medicaid Services.
394 I will now swear in the witnesses. As you are aware, it
395 is the Committees holding investigative hearing to--when
396 doing so, has the practice of taking testimony under oath.
397 Do either of you have any objections to testifying under
398 oath? Neither of you do, thank you.
399 So, as the Chair, I would advise you that you--under the
400 rules of the House and rules of the Committee you are

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401 entitled to be advised by counsels. Do either of you desire
402 to be advised by counsel during your testimony today? And
403 both of you say no to that, so, in that case, if you would
404 please rise, raise your right hand, I will swear you in.
405 [Witnesses sworn.]
406 Mr. {Murphy.} Thank you. You are now under oath, and
407 subject to the penalties set forth in Title 18, Section 1001
408 of the United States Code. You may now give a 5 minute
409 summary of your written statement. You know how to watch the
410 red light in front of you. Stick with that, and we will--I
411 guess we will start off with Mr. Bagdoyan.

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|

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

|

418 ^TESTIMONY OF SETO J. BAGDOYAN

419 } Mr. {Bagdoyan.} Chairman Murphy, Ranking Member
420 DeGette, and members of the Subcommittee, I am pleased to be
421 here today to discuss results of GAO's recent report on
422 Medicaid beneficiary and provider fraud controls. As you
423 know, and as you mentioned, Mr. Chairman, Medicaid is a
424 significant expenditure for the Federal Government and the
425 states, with combined outlays of about $516 billion in fiscal
426 year 2014, involving millions of beneficiaries and providers.
427 These numbers, as members mentioned, are all expected to
428 grow as a result of the expansion of Medicaid under the
429 Affordable Care Act. A program of this scope and scale is

430 inherently susceptible to error, including improper payments,
431 as well as fraudulent activity. In fact, as mentioned again,
432 CMS reported an estimated improper payment rate of 6.7
433 percent, or $17.5 billion, for Medicaid in fiscal year 2014,
434 compared to 5.8 percent, or 14.4 billion respectively, in FY
435 2013. Also, earlier this year we reported that Medicaid
436 remains on GAO's high risk list in part because of concerns
437 about the adequacy of fiscal oversight of the program,
438 including improper payments.
439 With this backdrop, I will now discuss our report's key
440 findings. Overall we found thousands of Medicaid
441 beneficiaries and hundreds of providers were involved in
442 potentially improper or fraudulent payments during fiscal
443 year 2011, the most recent year for which reliable and
444 comparable data were available in the four selected states we
445 reviewed, namely Arizona, Florida, Michigan, and New Jersey.
446 These states accounted for about 9.2 million beneficiaries,
447 and about 13 percent of all fiscal year 2011 Medicaid
448 payments.
449 More specifically, examples of potentially improper or
450 fraudulent payments include about 8,600 beneficiaries had

451 payments made on their behalf concurrently by two or more of
452 the selected states, totaling at least $18.3 million. The
453 identities of roughly 200 deceased beneficiaries received
454 about 9.6 million in Medicaid benefits subsequent to the
455 beneficiary's death. Some 3,600 individuals received about
456 4.2 million worth of Medicaid services while incarcerated in
457 State prison facilities. 90 providers had suspended or
458 revoked licenses in at least one state in which they received
459 payment. Associated Medicaid claims totaled at least $2.8
460 million.

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

471 However, CMS regulations do not require states to review

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

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

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493 Mr. Chairman, members of the Subcommittee, this
494 concludes my statement. I look forward to your questions.
495 Thank you.
496 [The prepared statement of Mr. Bagdoyan follows:]

497 *************** INSERT 1 ***************

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|

498 Mr. {Murphy.} Thank you. Dr. Agrawal, you are

499 recognized for 5 minutes.

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500 ^TESTIMONY OF SHANTANU AGRAWAL

501 } Dr. {Agrawal.} Thank you. Chairman Murphy, Ranking
502 Member DeGette, and members of the Subcommittee, thank you
503 for the invitation to discuss CMS's efforts to strengthen
504 Medicaid. We share the--enhancing program integrity is a top
505 priority for the Administration, and an agency-wide effort at
506 CMS. We share the Subcommittee's commitment to protecting
507 beneficiaries and ensuring taxpayer dollars are spent on
508 legitimate items and services, both of which are at the
509 forefront of our program integrity mission.
510 I would like to make three major points in my testimony
511 today. First, Medicaid program integrity is a shared
512 state/Federal responsibility, and I feel strongly that states
513 and the Federal Government share the goal that the Medicaid
514 program be as secure as possible to ensure beneficiaries are
515 protected, and the right payments are being made. Second, we
516 have made important progress in addressing beneficiary
517 eligibility and provider enrollment issues through advanced
518 data systems and improved collaboration. And third, it is

519 clear that more work remains, that we can build on our
520 accomplishments with improved guidance, building more
521 capabilities, and enhanced oversight.
522 States and the Federal Government share mutual
523 obligations and accountability for the integrity of the
524 Medicaid program, and the development, application, and
525 improvement of program safeguards necessary to ensure proper
526 and appropriate use of both Federal and state dollars. This
527 Federal/state partnership is central to the success of the
528 Medicaid program, and it depends on clear lines of
529 responsibility and shared goals. Although the Federal
530 Government establishes general guidelines for the program,
531 states design, implement, and administer their own Medicaid
532 programs. Medicaid is currently undergoing significant
533 changes as CMS and states implement reforms to modernize and
534 strengthen the program and its services.
535 While focused on implementation of the Affordable Care
536 Act, CMS has been working closely with states to implement
537 new, more modern delivery system and payment reforms. In the
538 last few years CMS and states have made important progress in
539 improving the systems and processes that determine a

540 beneficiary's eligibility for Medicaid, and that ensure only
541 legitimate providers enroll in and build a program. We have
542 made great strides. The error rate in beneficiary
543 eligibility, for example, has been cut in half since 2011.
544 We recognize, however, that more remains to be done, and
545 continue to work collaboratively with states to further
546 improve Medicaid program integrity.
547 A critical component to preventing waste, abuse, and
548 fraud is ensuring that only legitimate providers have the
549 ability to bill Medicaid in the first place. While states
550 bear the primary responsibility for provider screening and
551 enrollment for Medicaid, CMS is engaging in new efforts to
552 work with states to make sure that only legitimate providers
553 are enrolling in the Medicaid program. The ACA required CMS
554 to implement risk-based screening of providers and suppliers
555 who want to participate in Medicaid. This enhanced screening
556 requires certain categories of providers and suppliers that
557 have historically posed a higher risk of fraud to undergo
558 greater scrutiny prior to their enrollment or re-validation
559 in Medicare, Medicaid, or CHIP.
560 To enroll providers more efficiently, CMS has provided

561 states with direct access to Medicare's enrollment database,
562 the Provider Enrollment Chain and Ownership System, or PECOS,
563 and in response to input from states, began providing access
564 to monthly PECOS data extracts that states could use to
565 systematically compare state enrollment records against
566 available PECOS information.
567 CMS also provides guidance, education through the
568 Medicaid Integrity Institute, which has reached over 4,200
569 state employees on enrollment and other topics, and oversight
570 through state program integrity reviews. Additionally, the
571 ACA, and accompanying Federal regulations, have enhanced
572 beneficiary eligibility safeguards by establishing a
573 modernized, data-driven approach to verification of financial
574 and non-financial information needed to determine Medicaid
575 eligibility. States now rely on available electronic data
576 sources, including the Federal data hub and PARIS system, to
577 confirm information included on the application and promote
578 program integrity, while minimizing the amount of paper
579 documentation that consumers need to provide.
580 CMS has also developed its most recent comprehensive
581 Medicare--Medicaid integrity plan, in collaboration with our

582 partners, including the National Association of Medicaid
583 Directors, and is working to implement this plan. This work
584 includes providing Medicare data to states for program
585 integrity purposes, expanding support and training of state
586 program integrity staff in vulnerable areas, such as program
587 integrity oversight of managed care and evolving integrated
588 care models, and facilitating development of state capacity
589 and access to cost-effective analytics technology.

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

602 [The prepared statement of Dr. Agrawal follows:]

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603 *************** INSERT 2 ***************

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604 Mr. {Murphy.} Thank you very much. Let me recognize
605 myself for 5 minutes and keep this moving. We appreciate
606 your input on this, and some ideas here.
607 Dr. Agrawal, the improper payment rate for Medicaid
608 program was 6.7 percent in fiscal year 2014. That was an
609 increase over fiscal year 2013, where it was just 5.8
610 percent. Now, CMS set the target rate for Medicaid payments
611 at 5.6 percent, so CMS failed to meet the target rate for
612 2014, is that correct?
613 Dr. {Agrawal.} That is correct.
614 Mr. {Murphy.} So what was the--why was the target rate
615 not met?
616 Dr. {Agrawal.} Yeah, there are three major components
617 of the PERM rate of the Medicaid improper payment rate. It
618 is--there is a fee for service component, a Medicaid managed
619 care component, and then a beneficiary eligibility component,
620 and what I think you see in the error rate is a bit of a
621 mixed picture. So on one hand, the beneficiary eligibility
622 rate, which was a central topic in the GAO report, did
623 actually decrease, from 3.3 percent to 3.1. Where we saw the

624 biggest rise was in the provider screening and enrollment
625 standards in the fee for service component. What I think the
626 increase shows is that states are in various places of
627 implementing those screening standards, which has led to an
628 increase in the error rate in that part of perm.

629 Mr. {Murphy.} Now--but for 2015 they have set this
630 improper payment rate target at 6.7 percent, and that is the
631 same rate it was in 2014. It is actually higher than the
632 improper payment rate for 2013 and 2014. So why is CMS
633 actually raising that improper payment rate, that error rate,
634 in--for Medicaid instead of lowering it, and setting a target
635 for reduction of errors?

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

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645 I think there are a lot of tools that we have to help
646 states make progress, including oversight, education,
647 guidance, giving access to more data systems. But I think we
648 want to set realistic targets and, you know, work on that to
649 make sure states can meet them.
650 Mr. {Murphy.} And we want to help you with this. We
651 just want to make sure that the information that this
652 Subcommittee gets, this Committee gets, can help facilitate
653 that process. But if we have--raise our tolerance level for
654 errors, and then we say, well, it is all within what we
655 accept, that's not acceptable, so I really want to caution
656 you on that. I am--what I am hoping, that we can not have
657 that goal, but really work towards of a goal of how to lower
658 it, and then identify those outliers. And, I mean, you heard
659 the opening statements. This Subcommittee is with you on
660 trying to identify mechanisms for this.
661 Now, the Office of Management and Budget has designated
662 Medicaid as one of 13 programs as higher, with Medicaid
663 ranking third, with 17.5 billion in improper payment amounts.
664 Though does--so does CMS know why Medicaid has been
665 designated by OMB as a high error agency, Dr. Agrawal?

666 Dr. {Agrawal.} Yeah. You know, I--there are clearly
667 important factors in the size and scope of the program. The
668 fact that the program is administered in numerous, you know,
669 different state Medicaid agencies, and require a great deal
670 of collaboration. I am sure it does also reflect, you know,
671 the--our historical error rate. So I think the designation
672 of it being, you know, a high risk program certainly makes
673 sense.
674 I would also add just--Chairman, to your last question
675 that part of, you know, what we see as the dynamic in program
676 integrity, which is, I think, important to think about, is
677 that as requirements increase, as the stringency of the
678 program increase--increases, oftentimes we also see an
679 increase in the error rate as a result, because providers, or
680 other stakeholders, such as states, need time to catch up to
681 requirements. I think that is a common underlying element to
682 many factors in the error rate, but specifically the provider
683 enrollment standards that the ACA created.
684 Mr. {Murphy.} Well, let me move on to something else
685 here. Director Bagdoyan, the GAO has also designated
686 Medicaid as a high risk program since 2003. All right. What

687 are the criteria that land the Federal program into that kind
688 of category, and it has been that way for a long time?
689 Mr. {Bagdoyan.} Yeah. For Medicaid, Mr. Chairman, the
690 specific factor that we cited in our report is the fact that
691 its fiscal oversight over the years has been not where it
692 should be, and within that, the--
693 Mr. {Murphy.} Fiscal oversight at the Federal level, or
694 state, or both?
695 Mr. {Bagdoyan.} That would be at both levels, since it
696 is--
697 Mr. {Murphy.} Okay.
698 Mr. {Bagdoyan.} --a joint program. And then, further
699 within that context, of course, the risk of improper payments
700 and/or fraudulent activity contributes to that designation.
701 Mr. {Murphy.} And part of this too is--we see that you
702 are collecting data. You couldn't even get data from some of
703 the states because it just isn't there. Is there things we
704 need to do with--you can recommend as well that--what we need
705 to make sure that states have been presenting data so we can
706 analyze it and identify the problem, either one of you?
707 Mr. {Bagdoyan.} I would go first. Obviously data

708 analytics is the growing field, and it would be incumbent
709 upon both the Federal Government and the states to really pay
710 attention to the quality of their data, the collection, the
711 analysis, the reliability to make cross-comparisons and other
712 analyses.

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

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

722 Dr. {Agrawal.} Yes, that is correct.

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

727 Dr. {Agrawal.} That is correct.

728 Ms. {DeGette.} And, briefly, how does CMS determine

729 which risk category an individual provider or supplier will
730 be put into?
731 Dr. {Agrawal.} Sure. So these risk categories are done
732 at the provider sort of group level, or provider type level.
733 So it isn't an individual provider that we would be placing
734 in these various categories, it would be a whole class, such
735 as--newly enrolling home health agencies are considered high
736 risk.
737 Ms. {DeGette.} I see.
738 Dr. {Agrawal.} And we designated these risk levels
739 based on input from multiple sources, including the HHS OIG,
740 based on historical levels of fraud or--
741 Ms. {DeGette.} Fraud.
742 Dr. {Agrawal.} --issues with those specific provider
743 types.
744 Ms. {DeGette.} Okay. And do the states also have to
745 implement screening requirements before they enroll a
746 provider in the Medicaid program?
747 Dr. {Agrawal.} They do. Those requirements are largely
748 identical to Medicare's.
749 Ms. {DeGette.} And those go into effect March 2016, 5

750 years after the regulation first went into effect, is that
751 right?
752 Dr. {Agrawal.} Many of the requirements have had to be
753 implemented by now already.
754 Ms. {DeGette.} Okay.
755 Dr. {Agrawal.} There were already deadlines. I think
756 what you are referencing is a re-validation deadline--
757 Ms. {DeGette.} Right.
758 Dr. {Agrawal.} --yes, is March of 2016.
759 Ms. {DeGette.} Okay. And then, after everything is
760 either validated or re-validated, it has to go--be re-
761 validated again every 5 years, is that right?
762 Dr. {Agrawal.} That is correct.
763 Ms. {DeGette.} Now, is CMS working with the states to
764 implement these new requirements?
765 Dr. {Agrawal.} We are, across the board. So we have
766 largely the same requirements in Medicare, and therefore are
767 undertaking the same work in the Medicare program. Where
768 possible, we have made data assets available to states so
769 that they can utilize the results of our screening. For
770 example, I referenced PECOS, where we have done a site visit,

771 or fingerprint-based background check. States have access to
772 that data so that they don't have to duplicate those--
773 Ms. {DeGette.} Okay.
774 Dr. {Agrawal.} --initiatives.
775 Ms. {DeGette.} And are they--the states generally on
776 track with their implementation?
777 Dr. {Agrawal.} You know, states are in really different
778 places, what we--
779 Ms. {DeGette.} Okay.
780 Dr. {Agrawal.} --find. So when we do the PERM rate
781 measurement every year, or do state program integrity
782 reviews, there are certain states that are well advanced in
783 the--in their implementation of these requirements, and other
784 states that are lagging quite far behind.
785 Ms. {DeGette.} And so I assume those are the states you
786 are focusing on, trying to get them--
787 Dr. {Agrawal.} Correct. We can increase the number of-
788 -amount of oversight, we can offer more technical assistance,
789 education efforts, things like that.
790 Ms. {DeGette.} Now, these efforts were not included in
791 the data of the GAO report, which went for 2011 data, is that

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792 right?

793 Dr. {Agrawal.} That is right.

794 Ms. {DeGette.} Yes or no will work.

795 Dr. {Agrawal.} Yes.

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

802 Mr. {Bagdoyan.} Right.

803 Ms. {DeGette.} --Dr. Agrawal is--

804 Mr. {Bagdoyan.} Yeah.

805 Ms. {DeGette.} --talking about.

806 Mr. {Bagdoyan.} That is correct.

807 Ms. {DeGette.} Do you think that these steps will help
808 close some of the gaps GAO identified in the report with
809 regard to potentially improper fraudulent payments?

810 Mr. {Bagdoyan.} Sure. As I mentioned in my closing,
811 those steps will definitely add to the toolbox that CMS and
812 the states have, and narrow the opportunities for potential

813 improper payments and fraudulent activity. They will
814 probably play out over time. As Dr. Agrawal said, some
815 states are in different places than others, so--
816 Ms. {DeGette.} And we have to focus on the ones who
817 are--
818 Mr. {Bagdoyan.} That is correct.
819 Ms. {DeGette.} Yeah.
820 Mr. {Bagdoyan.} Long term implementation success and
821 sustainability will be key in these areas.
822 Ms. {DeGette.} And--now, since 2011, do you agree that
823 CMS has taken measures to address some of these real concerns
824 that you raise in your report, like the deceased providers
825 billing Medicaid, providers with suspended or revoked
826 licenses, and people inappropriately using virtual addresses?
827 Are they working on that now?
828 Mr. {Bagdoyan.} I think they are taking steps. They
829 are in the right direction, we believe, but execution and
830 sustainability will be, again, key for both--
831 Ms. {DeGette.} I agree.
832 Mr. {Bagdoyan.} --Federal Government and the states.
833 Ms. {DeGette.} Yeah. I appreciate GAO's sustained work

834 on this issue. Excuse me, that is my child. I programmed my
835 phone to bark when--
836 Mr. {Bagdoyan.} Distinct voice that your child has.
837 Ms. {DeGette.} Yeah. That is my other one. But I am
838 glad that you both agree that the Affordable Care Act has
839 changed the way we prevent and address Medicaid fraud, and I
840 am--I look forward to it. As we said, Mr. Chairman, we are
841 going to be back here in a couple of years, making sure that
842 these ACA requirements have been implemented. Thank you.
843 Mr. {Murphy.} Thank you. I now recognize Mr. McKinley
844 for 5 minutes.
845 Mr. {McKinley.} Two quick questions. One is--the CMS
846 has raised its proper payment rate target from fiscal year
847 2015 to 6.7 percent, from the 5.6 target rate in 2014. Is
848 that a good internal control practice, to raise the target
849 rate?
850 Dr. {Agrawal.} Sir, are you asking me?
851 Mr. {McKinley.} Yes.
852 Dr. {Agrawal.} No. I do appreciate the question, and,
853 again, I think it is important to set realistic targets and
854 goals that do push us to improvement, but at the same time

855 recognize that Medicaid is a state and Federal program that
856 states are in various places of implementing. Things like
857 the provider enrollment standards, which are the major driver
858 of the improper payment rate at this point.
859 Mr. {McKinley.} Okay. Let me get to the real--the
860 question I had from West Virginia, and it is more of a
861 question, I think, of--perhaps abuse and errors. Let me
862 frame the argument. In West Virginia, 1/3 of the hospitals
863 we have in West Virginia are critical access hospitals. We
864 are a very rural state. And for nearly 30 years, since the
865 early '80s, West Virginia's critical access hospitals have
866 been using a provider tax to supplement and provide resources
867 for them.
868 In 2012 CMS hired a different auditor from all of these
869 past 30 years, and this new auditor stepped in and said that
870 is--process isn't approved anymore, and we are going to go
871 back and--we are auditing you back until 2009, and--trying to
872 recover the money that you previously were working under the
873 idea that this was the appropriate way to go about getting
874 the provider tax revenue coming in. This is going to be an
875 incredible hindrance for these hospitals to provide medical

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876 care in rural areas of West Virginia, when we go backwards on
877 them after they were working under the idea that they thought
878 they were working properly.
879 So we have talked about--can we go forward from here,
880 not go back and try to penalize them for following someone
881 else's advice, that was also with CMS? Now we go forward.
882 We are not--we have written letters. We have had
883 conversations with--until recently, but CMS really was
884 disengaged with us. Now these hospitals are all getting
885 invoices based--3 years after the--2012, when they were told,
886 we are not going to allow that anymore, now in 2015 they are
887 getting invoices that they say they have to pay them within
888 15 days, or they are going to have the funds withheld.
889 I--first, I don't know of any private sector--coming
890 from the private sector--I have got 50 years in the private
891 sector. I have never heard of someone saying, if you don't
892 pay within 15 days, we are taking it out of your hide. How
893 are they--that just doesn't work. These--there are no
894 details on the--on these invoices. And when they have asked,
895 can we get a detail of what this invoice includes, and they
896 are saying that they can't have it. They are being denied

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897 access as to what the invoice reflects.

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

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

916 Mr. {McKinley.} If you would, please. We have been
917 given the runaround. Everyone--the fingers--I have never

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918 seen so many fingers pointing in different directions. It is
919 not my problem, it is someone else, and we have been trying
920 to pursue that. So if you can help us on that, we will put
921 you on record. Okay. You are under oath that you said you
922 were going to help, so--
923 Dr. {Agrawal.} Thank you, Congressman, I appreciate
924 that. I will--
925 Mr. {McKinley.} I will remind you--
926 Dr. {Agrawal.} I will think of that.
927 Mr. {McKinley.} --of that in the future. But thank
928 you, because we need to get this resolved. Remember, a third
929 of the hospitals could very well go under if they have to
930 make these payments. Thank you.
931 Dr. {Agrawal.} Thank you.
932 Mr. {McKinley.} Yield back the--
933 Mr. {Murphy.} Gentleman yields back. Now recognize the
934 Ranking Member, Mr. Pallone, for 5 minutes.
935 Mr. {Pallone.} Thank you. GAO reports that CMS has
936 made several changes since 2011 to help limit improper
937 payments, and these steps may address many of the potential
938 improper payments GAO found in their analysis of 2011 claims.

939 In addition, to note in their progress already made, GAO made
940 two recommendations to further improve efforts to limit
941 improper payments by increasing information and data sharing
942 efforts between the Federal Government and the state Medicaid
943 programs, and GAO first recommended that CMS help states
944 better identify deceased beneficiaries.
945 I want to ask a question of each of you, but I have got
946 three sets here, so we have got to go fairly quickly. Mr.
947 Bagdoyan, can you comment on GAO's findings that led to this
948 recommendation?
949 Mr. {Bagdoyan.} Well, we did matching of deceased rolls
950 form the death master file. That is the complete file that
951 has about 98 million records, and we matched those against
952 claims data, and we discovered those beneficiaries who had
953 been deceased after their--or before their services were
954 billed for, so--
955 Mr. {Pallone.} Okay. And, Dr. Agrawal, what steps is
956 CMS taking to implement this recommendation?
957 Dr. {Agrawal.} Yeah. We take the recommendations very
958 seriously, and, as I mentioned, I--we do appreciate the
959 report. Specifically for the dead beneficiaries issue, you

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960 know, there are clearly things that we have done, like
961 implement the Federal data hub that allows states to check
962 for death and other issues on the front end. We are also
963 looking to work with our technical advisory groups with the
964 states and recommend more guidelines for the states both--to
965 both access the right data, and then access it frequently
966 enough.

967 Mr. {Pallone.} Okay. The GAO next recommended that CMS
968 apply more complete data for screening Medicaid providers by
969 providing states with full access to the Provider Enrollment
970 Chain and Ownership System, or PECOS, database. So, again,
971 Mr. Bagdoyan, can you describe the PECOS system? Can you
972 comment on how states are using PECOS, and why GAO issued a
973 recommendation for CMS to provide additional guidance to
974 states?

975 Mr. {Bagdoyan.} Sure. Thank you for your question.
976 With PECOS it is a situation where states would need access
977 to the system electronically so they can be able to run batch
978 searches, if you will. I know it is a little technical term,
979 but right now they have to do a manual search on a case by
980 case basis each name, each time in order to get a result,

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981 whether there is an issue or not. So that is the essence of
982 our recommendation, is to get them the automated access that
983 would allow them to do bigger and wider searches at once.
984 Mr. {Pallone.} Thanks. Dr. Agrawal, what training and
985 guidance has been provided to states on using the PECOS
986 system, and what additional efforts will you be undertaking?
987 Dr. {Agrawal.} Sure. So we have two different kinds of
988 access to PECOS, one that is the sort of provider by provider
989 real time access to the system, but since this analysis was
990 done, we have also been making data extracts available to
991 states so that they can use those extracts and compare them
992 against their entire enrollment file. We are looking--we
993 have already made changes to those extracts based on state
994 input, and are looking to expand them as we go on.
995 With respect to guidance, we do offer education in using
996 CMS data assets to states through things like the Medicaid
997 Integrity Institute. We also offer other technical guidance,
998 and sort of case by case help as needed, and states can
999 contact us for that.
1000 Mr. {Pallone.} All right. Let me see if I get my third
1001 question in. Given that Medicaid is a joint state/Federal

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1002 program, states have a very important role to play in
1003 preventing improper payments. It sounds like there is a fair
1004 amount of Federal information available to states, but that
1005 not all states are taking full advantage of what is
1006 available. So I will start with Dr. Agrawal. How can states
1007 be encouraged to use the data available to them?
1008 Dr. {Agrawal.} Yeah, I think that is a great question.
1009 So there are data assets like PECOS and Paris, where we know
1010 that all states have access. And I think part of getting
1011 them to use it offering the guidance, offering the technical
1012 input to make sure that they are using the data in the right
1013 way, and using it as frequently as they can. With something
1014 like Paris, for example, we were able to release guidance,
1015 and ask all states to not only input their data every
1016 quarter, but also to use that data in their enrollment
1017 efforts every quarter.
1018 Mr. {Pallone.} Okay. And, Mr. Bagdoyan, based on GAO's
1019 findings, how can the states more effectively use the data
1020 available to them?
1021 Mr. {Bagdoyan.} I think I would echo Dr. Agrawal's
1022 comments. I think, if they are available, once they are

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1023 available, they would be encouraged through guidance, they
1024 would be held to account to make sure that this works as
1025 intended. I mean, again, it is a partnership. It is a
1026 common model, if you will, to make this work.

1027 Mr. {Pallone.} All right. Just want to thank both of
1028 you. In addition to the important tools already added by the
1029 Affordable Care Act, I am encouraged that CMS implementation
1030 of GAO's recommendations will further help state Medicaid
1031 programs in their efforts to address this persistent issue.
1032 So thanks again. Thanks, Mr. Chairman.

1033 Mr. {Murphy.} Thank you. Now recognize Dr. Burgess for
1034 5 minutes.

1035 Mr. {Burgess.} Thank you, Mr. Chairman. You know, one
1036 of the hazards of having been on this Committee for a number
1037 of years is you see themes repeating themselves. And,
1038 Chairman Murphy, I remember very well a morning in late
1039 September 2008, when we held a Health Subcommittee hearing
1040 downstairs, and we had some, I don't know, eight, 10, 12
1041 witnesses. It was a pretty varied panel. Karen Davis from
1042 Commonwealth, Steve Parenti from the McCain campaign, the
1043 late Elizabeth Edwards was one of the panel members, and it

1044 was all a panel to discuss what is it going to cost to
1045 provide health care to everyone who lacks health insurance in
1046 this country. And the estimates were quite varied, and they
1047 ran from $60 billion a year to $800 billion a year.
1048 Chairman Murphy, I remember you asking the question, how
1049 could it be--how could there be so much variation? And Steve
1050 Parenti, on the panel, was the only one willing to take it
1051 on, and said, well, if you provide Medicaid to everyone, and
1052 that is how you expand your coverage, that is the lower
1053 number. If you provide Federal employee health benefit plan
1054 to everyone, which was being talked about by some of the
1055 candidates at the time, that is the higher number.
1056 So I guess my point is, everyone knew going into
1057 everything that became the Affordable Care Act that the way
1058 to expand coverage without blowing up the cost was Medicaid
1059 expansion. Why wouldn't you fix some of these problems
1060 before you undertook to expand a program that, if I
1061 understand correctly, Mr. Bagdoyan, it was already on a watch
1062 list in 2008, and certainly on a watch list in 2009, when the
1063 law was written in 2010, or the law was signed. But really,
1064 why not put the effort on the front end? The way we are

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1065 going to expand coverage is through Medicaid, maybe we could
1066 deal with some of these problems. What about the fact we
1067 have got dead people that we are paying money for? What
1068 about the fact we have got people who are receiving benefits
1069 in two states simultaneously? That is not supposed to
1070 happen, is it, Dr. Agrawal?

1071 Dr. {Agrawal.} That is correct.

1072 Mr. {Burgess.} Then the whole issue--GAO in 2005 or
1073 2006 put out a report about the third party liability--
1074 Medicaid will pay a claim when a person has private health
1075 insurance. And, really, Medicaid is supposed to be the payer
1076 of last resort, not the payer of first resort. And we have
1077 never really satisfactorily dealt with that problem, have we?

1078 Mr. {Bagdoyan.} I am not familiar with the report.

1079 Mr. {Burgess.} Well, I will tell you, no, we have not.
1080 So here we have it here, three very basic steps, don't pay
1081 the dead people, don't pay people twice, and, hey, if Aetna,
1082 United, Cigna is supposed to be paying the bill, you get them
1083 to pay first, before the state reimburses on their Medicaid
1084 system. Relatively simple steps that could have been done
1085 before expanding a program massively. And now we are in a

1086 situation where not every state has expanded their Medicaid.

1087 And, Dr. Agrawal, let me just ask you, when states come
1088 in with their proposals, if a state is considering expanding
1089 Medicaid in their state, and some states are, whether I think
1090 that is correct or not, some states are, when they come in
1091 with those proposals, are you talking to them about the fact
1092 that there are some inherent problems in the Medicaid system,
1093 and we would like to see those fixed before you double your
1094 number?

1095 Dr. {Agrawal.} Yeah, thank you for the question, Dr.
1096 Burgess. So I think our relationship with the states is such
1097 that we are talking to them regardless of whether or not they
1098 are seeking to expand their Medicaid programs. There are
1099 current program integrity challenges and vulnerabilities, as
1100 the GAO has pointed out. They exist in the current Medicaid
1101 program. Our state oversight efforts, whether it is the PERM
1102 rate, or state program integrity reviews, include all states,
1103 not just those that are expanding.

1104 I think, you know, to your larger point, what we are
1105 trying to do is balance real program integrity interests and
1106 needs against the needs of socioeconomically disadvantage

1107 population that needs access to health care and health--

1108 Mr. {Burgess.} Let me stop you there, because time is
1109 going to become critical. I--in my opening statement I
1110 reference a problem that was related to dental care in the
1111 State of Texas. You have got a real problem. People who
1112 should be barred from ever participating in the program again
1113 simply dissolve into bankruptcy, and re-emerge in--someplace
1114 else. What are you doing to keep that from happening?

1115 Dr. {Agrawal.} There are clearly efforts that we have.
1116 You know, we do conduct collaborative audits and
1117 investigations with states and, where appropriate, encourage
1118 states to take termination actions in their programs. I
1119 think you referenced the exclusion authority by the HHS OIG.
1120 We obviously, you know, agree that that is a very powerful
1121 authority. We encourage OIG to implement it where
1122 appropriate. And where they do, we can take revocation
1123 action quickly behind it.

1124 Mr. {Burgess.} Let me just, before time expires, Dallas
1125 Morning News over the weekend, series of--or an article that
1126 I think is part of a series of articles about how private
1127 nursing homes are drawing down dollars by combining with a

1128 public entity, and some of these are fairly low ratings on
1129 the star rating on the nursing homes. Are you working with
1130 the states to address this problem?
1131 Dr. {Agrawal.} Yes. I am not aware of the specific
1132 nursing homes, but, you know, we do have survey, and
1133 certification, and other rating functions to CMS that can
1134 work with states on these issues.
1135 Mr. {Burgess.} Well, $69 million just to these nursing
1136 homes identified last year, so it is a place where we need to
1137 put some effort. Thank you, Mr. Chairman, I will yield back.
1138 Mr. {Murphy.} Gentleman yields back. Now recognize Mr.
1139 Kennedy for 5 minutes.
1140 Mr. {Kennedy.} Thank you very much, Mr. Chairman.
1141 Thank you for--to our witnesses for coming today, and for
1142 your testimony at an important hearing. I want to touch base
1143 a little bit on the improper payment rate, and put that in
1144 context. Medicaid program provides about 70 million low
1145 income and disabled Americans with vital health care
1146 services, and we must do everything we can to strengthen it
1147 and protect it. No one--as you have heard from my colleagues
1148 here this morning, no one, Democrat or Republican, is in

1149 favor of fraud. We clearly want to make sure this program is
1150 as lean as it possibly can be, and that the people that need
1151 help and need the services are getting them.
1152 So, to that end, Mr. Bagdoyan, I would like to begin
1153 with you. Since its peak of 9.4 percent in 2010, the
1154 improper payments rate for the Medicaid program has steadily
1155 decreased, reaching a low of 5.8 percent in 2013, or 14.4
1156 billion. That number rose to 6.7 percent in 2014, or 17.5
1157 billion. Is that right?
1158 Mr. {Bagdoyan.} That is correct, sir.
1159 Mr. {Kennedy.} So I want to dig into that number a
1160 little bit deeper and see if I can better understand the
1161 dynamics that are, in fact, driving that improper payment
1162 rate. The ACA provided CMS with a number of new tools to
1163 strengthen program integrity in the Medicaid program. In
1164 2011 CMS established a new risk-based screening procedure for
1165 Medicare, Medicaid, and CHIP providers. CMS also promulgated
1166 new regulations, requiring the states to use electronic data
1167 maintained by the Federal Government to verity and re-
1168 validate beneficiary eligibility through the data services
1169 hub.

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1170 So, Dr. Agrawal, let us break down that payment rate a
1171 little bit into its relevant components. I know you touched
1172 on this a little bit earlier. If I understand this
1173 correctly, Payment Rate Measurement Program, or PRM, measures
1174 error rates both overall for the Medicaid program, as well as
1175 for certain subcategories, fee for service, managed care, and
1176 beneficiary eligibility. Is that right?
1177 Dr. {Agrawal.} That is correct.
1178 Mr. {Kennedy.} So what has happened to that beneficiary
1179 eligibility error rate since 2011?
1180 Dr. {Agrawal.} I think that is an important point, and
1181 it does highlight some of the intricacy in the rate. The
1182 beneficiary eligibility error rate has actually been cut in
1183 half since 2011.
1184 Mr. {Kennedy.} So the error rate for--beneficiary
1185 eligibility rate cut in half, declined by three percent. Is
1186 that a substantial improvement, major improvement, small
1187 improvement? How do you characterize it?
1188 Dr. {Agrawal.} I think, given the issues that GAO has
1189 highlighted, that is obviously a substantial improvement.
1190 More work remains to be done, which we are focusing on, but

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1191 it does indicate good progress.

1192 Mr. {Kennedy.} And so what is driving that improvement,
1193 then? Is it the--like the result of, in your opinion, the
1194 work CMS has been doing to implement the new program
1195 integrity tools in the ACA? Is it something else? What is
1196 behind the success?

1197 Dr. {Agrawal.} I think it is work that--being done at
1198 both the Federal and state levels between increased
1199 collaboration, more education and technical guidance going to
1200 states, better data assets that have been highlighted by Mr.
1201 Bagdoyan.

1202 Mr. {Kennedy.} And if--given that large drop in the
1203 error rate for beneficiary eligibility, what factors are
1204 driving the increase in the overall PERM rate? And I realize
1205 you touched on this a little while ago, but if you could
1206 flesh that out a little bit for me?

1207 Dr. {Agrawal.} Sure, no problem. The biggest driver of
1208 the increase in the rate are provider enrollment and
1209 screening standards. And, again, as with other PI aspects of
1210 program integrity, whenever there is a new requirement,
1211 certain stakeholders, in this case states, do--can experience

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1212 some difficulty in keeping up. So what we have found, that,
1213 while some states are quite far along, other states are
1214 lagging behind, and generally that is causing the error rate
1215 to rise.
1216 Mr. {Kennedy.} And how do we get those other states to
1217 pick up the pace?
1218 Dr. {Agrawal.} Well, we are--we exercise oversight in a
1219 variety of ways, so I think it is both what can we offer them
1220 in terms of collaboration that will help, like technical
1221 assistance, data assets like PECOS, and then where can we
1222 exercise real oversight? We do that through the PERM rate.
1223 We require states to submit corrective actions to improve the
1224 error rate going forward, and also conduct state program
1225 integrity reviews, with associated corrective action plans
1226 where states fail to meet requirements. So I think it is a
1227 mix of both of those things.
1228 You know, I think the error rate increase in that
1229 particular aspect is the reflection of more stringent policy,
1230 which in and of itself is a good thing. We need that policy.
1231 Mr. {Kennedy.} What, if anything, can this Committee do
1232 to help you with that?

1233 Dr. {Agrawal.} You know, I appreciate the question. I
1234 think holding our feet to the fire is appropriate.
1235 Mr. {Kennedy.} You are welcome.
1236 Dr. {Agrawal.} Thank you very--I also think, you know,
1237 encouraging states to stay on the right path, take advantage
1238 of the various resources that we offer, identify improvements
1239 that we need to make so that they can make progress, would be
1240 extremely helpful.
1241 Mr. {Kennedy.} And, again, just putting this in
1242 context, if I understand Mr. Bagdoyan, the GAO report, it was
1243 four states, yes?
1244 Mr. {Bagdoyan.} Yeah.
1245 Mr. {Kennedy.} And it covered 9.2 million Medicaid
1246 beneficiaries, right?
1247 Mr. {Bagdoyan.} That is correct.
1248 Mr. {Kennedy.} And I know we talked a little bit about
1249 the 200 or so deceased beneficiaries that received payment.
1250 If we were to put that--just so I understand it, that is 200
1251 out of 9.2 million, right?
1252 Mr. {Bagdoyan.} My math is not that good.
1253 Mr. {Kennedy.} Right. If we wanted to put that in that

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1254 percentage, though, if you take my word for it that my iPhone
1255 calculator ain't so bad, that is .00002, four zeros and then
1256 a two--as far as error rates go, we are--nothing is
1257 acceptable, but we are doing okay if it is 200 out of 9.2
1258 million, right? You guys are doing your jobs?
1259 Mr. {Bagdoyan.} Well, that is we found is 200 out of
1260 the 9.2 million. That is all I am prepared to say.
1261 Mr. {Kennedy.} Well, thank you for your work on this.
1262 Thank you for your research, and being here today, and
1263 highlighting an important issue for the hearing.
1264 Mr. {Bagdoyan.} Thank you.
1265 Mr. {Murphy.} I guess this can go in the category of
1266 lies, damn lies, and statistics. We appreciate it no matter
1267 what it is, and we are all in agreement that we want to make
1268 sure we rid that--Dr. Bucshon, you are next for 5 minutes.
1269 Mr. {Bucshon.} Thank you, Mr. Chairman. First of all,
1270 I was a practicing physician for 15 years, as I had mentioned
1271 to our witnesses beforehand. I have taken care of all
1272 patients, regardless of their ability to pay, which is what
1273 we do in health care. But I just want to highlight that all
1274 is not rosy with Medicaid. And I know this hearing is about

1275 waste, and fraud, and abuse, but I am from Indiana, and I--
1276 our medical practice routinely wrote off hundreds of
1277 thousands of dollars from a neighboring state's Medicaid
1278 program in billings every year because they ran out of money
1279 before the end of the year, and this pre-dates the ACA.

1280 The other thing is is that the program within our own
1281 state has been financially challenged historically with a
1282 significant Medicare provider cut within the last 10 years
1283 just to stay afloat. That said, Medicaid is a critical
1284 program that we have to have for our citizens. What can we
1285 do? Well, Indiana has expanded our Medicaid program using an
1286 innovate plan called Healthy Indiana Plan 2.0, and I am
1287 hopeful that this state-based plan, as well as state-based
1288 plans around the country, can use--be used as a proving
1289 ground how to move forward on our Medicaid program.

1290 Some facts about the Medicaid expansion that are not
1291 surprising to me, but seem to be surprising to those who
1292 wanted expand traditional Medicaid, is that ER visits are up,
1293 in some cases dramatically up, in multiple studies across the
1294 country. And why--and the hospitals are very happy, but we
1295 have made no progress because this is the highest cost form

1296 of medical care available in the country. And so, you know,
1297 having a card in your pocket, but having no access to primary
1298 care physicians or others outside of the emergency room is
1299 not progress. And the encouragement to seek preventative
1300 care, as was mentioned earlier, may be technically true, but
1301 functionally not accurate because you can't get preventative
1302 care if no one takes your coverage.

1303 States that have expanded Medicaid are already starting
1304 to look for ways to pay for the program once the Federal
1305 money for the expansion goes down to 90 percent, and my
1306 concern is reimbursement cuts will be the way that will
1307 happen. And what does that do? Further limits access to the
1308 citizens in their states. And if anyone doesn't think that--
1309 sometime in the future that this--that the Federal Government
1310 will look for a way to pay for other things by cut--further
1311 cutting that expansion money to the states on their Medicaid
1312 program, then I don't, you know, you are not following the
1313 government very well.

1314 That said, I have a--do have a couple of questions.
1315 And, again this is a very important hearing. I saw the--I
1316 mean, we limited the study, Mr. Bagdoyan, to the four states.

1317 Why did we pick these states, and did the GAO try to include
1318 other states in your study?
1319 Mr. {Bagdoyan.} Thank you for your question, Dr.
1320 Bucshon. The way we picked our states is we began with the
1321 universe of beneficiaries per state, and then we also looked
1322 at data reliability, as well as geographic dispersion. So
1323 those were the three key factors that we used to pick these
1324 states. Now, data reliability being a very important factor,
1325 we don't have reliable data, we can't do our analysis.
1326 Mr. {Bucshon.} And that segues into Dr. Agrawal. How
1327 do you envision--well, the data we were just talking about,
1328 not accurate from states, how do you envision the progress we
1329 are making in information sharing on Medicaid between the
1330 states and the Federal Government? How can we improve on
1331 that situation so if, in the future, we want to study this
1332 situation, we can pick any one of the 50 states? How are we
1333 doing?
1334 Dr. {Agrawal.} Yeah, thank you. I think that is a
1335 really important question. Data is really central to program
1336 integrity work. What we have found is access to the right
1337 data set can really increase the sensitivity and specificity

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1338 of our leads. The agency has made some of the biggest
1339 investments we have ever made in improving Medicaid data
1340 assets in programs like T-MSIS, which is seeking to
1341 dramatically increase the amount of data and the kind of
1342 breadth of that data that we get from state programs.
1343 In addition, Congress has funded previously programs
1344 like the Medi-Medi, which is--encourages Medicare and
1345 Medicaid data sharing and integration specifically for
1346 program integrity purposes, and we have been engaged in that
1347 process for years now.
1348 Mr. {Bucshon.} Can I--is proprietariness amongst
1349 different systems a problem? I mean, what are the barriers
1350 to, you know, it seems like it would be simple, right, but
1351 there are barriers.
1352 Dr. {Agrawal.} There are, and I am not a technologist,
1353 but there are clearly differences between systems, and
1354 getting data integration to occur, that is not a trivial task
1355 at all, especially, you know, amongst 50 different states.
1356 So, yeah, there are some real technical barriers to getting
1357 the right data formatted in the right way so that it is
1358 readily accessible.

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1359 Mr. {Bucshon.} But some of it is--it is not just about
1360 money, right, where the systems don't want to communicate
1361 because of proprietary control over data?
1362 Dr. {Agrawal.} You know, I am not sure how much
1363 proprietary issues stand in the way. I think it is more
1364 technical implementation. And then, yes, resourcing is
1365 important to make sure that we can adequately make this all
1366 work together.
1367 Mr. {Bucshon.} Thank you. Mr. Chairman, I yield back.
1368 Mr. {Murphy.} Ms. Clarke, you are recognized for 5
1369 minutes.
1370 Ms. {Clarke.} Thank you, Mr. Chairman, and I thank the
1371 Ranking Member, thank our witnesses for their testimony here
1372 today. I am glad we have had the opportunity today to talk
1373 about the Medicaid program, and how many people it helps
1374 across the country. As February 2015--as of February 2015,
1375 over 70 million people were enrolled in Medicaid. The number
1376 of enrollees will continue to rise, as 30 states have
1377 expanded Medicaid, and even more states are considering doing
1378 so. We know that fraud and improper payments have long been
1379 a reality of the Medicaid system, but with the passage of the

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1380 Affordable Care Act in 2010, we have made significant steps
1381 to strengthen the Medicare, Medicaid, and CHIP programs by
1382 reducing waste, fraud, and abuse.

1383 Dr. Agrawal, I would like to ask you about the
1384 Affordable Care Act anti-fraud measures, and how they have
1385 strengthened the Medicaid program. In your testimony you
1386 noted that the Secretary of HHS can temporarily pause
1387 enrollment for new Medicaid providers and suppliers if she
1388 determines certain geographic areas face a high risk of
1389 fraud. Dr. Agrawal, how does the Secretary make that
1390 determination?

1391 Dr. {Agrawal.} Yeah, thank you. So, you are right, the
1392 moratorium authority is one of many tools granted to CMS for
1393 its program integrity efforts. We have--we currently have
1394 moratorium in place in seven different metropolitan areas in
1395 two main service categories, ambulance services and home
1396 health agencies. And we arrived at those areas, both the
1397 service types and the geographies, by doing data analysis to
1398 look at where there was clear areas of market saturation of
1399 these provider types, and in all of these metropolitan areas
1400 we see somewhere between three to five times higher the

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1401 number of providers of these categories than, you know,
1402 comparative metropolitan areas.
1403 We also conferred with our law enforcement colleagues in
1404 DOJ and OIG to assess where hot spots really are, and where
1405 billing is really concerning for fraud, and it was really a
1406 multitude of things that led us ultimately to implement these
1407 moratoria.
1408 Ms. {Clarke.} And how does the Secretary--excuse me,
1409 how have they been effective in preventing and reducing fraud
1410 in those affected areas?
1411 Dr. {Agrawal.} So what the moratoria really do is,
1412 essentially, pause enrollment. It stops new providers from
1413 coming into those areas in these specific provider
1414 categories. That affords both us and law enforcement the
1415 opportunity to step up our activities in those areas and
1416 remove bad actors that are already in those areas prior to
1417 lowering the moratorium, and allowing new providers to enroll
1418 again.
1419 Ms. {Clarke.} And has that been effective, in your
1420 estimation?
1421 Dr. {Agrawal.} You know, I think we are still doing

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1422 data analysis to look at how effective the moratorium as a
1423 singular tool is, but what we are finding is that, in those
1424 area, which clearly are hotspot areas anyway, we have been
1425 able to effectuate literally hundreds of revocations of both
1426 home health agencies and ambulance companies. So we continue
1427 to assess the moratorium. We are obviously very concerned
1428 about access to care, want to make sure that the moratoria
1429 don't interfere in access. And so there are a lot of
1430 analytics that go on, as well as collaborating with the
1431 states.

1432 Ms. {Clarke.} And how does the affected states, during
1433 the moratorium period, how does CMS work with them?

1434 Dr. {Agrawal.} So we engage--just as we do more
1435 broadly, we engage in data exchanges, we work with them on
1436 collaborative audits and investigations, and then we do those
1437 access to care analyses to make sure that the moratorium is
1438 not having an adverse consequence.

1439 Ms. {Clarke.} Yeah, and on that point, how do you make
1440 sure that Medicaid beneficiaries are continuing to receive
1441 the services they need?

1442 Dr. {Agrawal.} Right, that is of primary importance.

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1443 Again, you know, these areas in service categories were
1444 chosen in the first place because of really significant
1445 market saturation, making access not such a huge problem
1446 right at the outset. But as the moratoria have gone on, we
1447 have worked, through our regional offices at CMS, with the
1448 relevant states. We have stayed in contact with them,
1449 exchanged data to make sure that that picture has not
1450 changed, and thus far it hasn't. Access to care continues
1451 not to be a major issue.
1452 Ms. {Clarke.} And then, finally, ACA significantly
1453 increased funding to fight Medicare and Medicaid fraud. How
1454 will additional funding help CMS address program integrity
1455 vulnerabilities?
1456 Dr. {Agrawal.} Yeah. We do appreciate the work of
1457 Congress, and the leadership of this Committee, in providing
1458 more resources for us. Those additional resources will allow
1459 us to continue to invest in existing programs, to encourage,
1460 again, more data collaboration with Medicaid agencies,
1461 provide more technical guidance and education. And then,
1462 where necessary, especially to respond to recommendations
1463 like this, we will be implementing new initiatives and

1464 programs to continue the Medicaid and Medicare programs.

1465 Ms. {Clarke.} Very well. And just out of curiosity,
1466 the implementation of the data hub, have you used that
1467 collaboratively in those high concentrated metropolitan areas
1468 as you also employ the moratoria?

1469 Dr. {Agrawal.} Well, the data hub is really more of a
1470 general Federal asset for states to utilize at the time of
1471 beneficiary enrollment and eligibility determinations. It is
1472 not really specifically focused on moratoria area. Rather,
1473 we see it as a tool that should be utilized across the
1474 program, across the Medicaid program, to ensure eligibility
1475 is done correctly the first time.

1476 Ms. {Clarke.} Very well. I yield back. Thank you, Mr.
1477 Chairman.

1478 Mr. {Murphy.} Now recognize Mr. Brooks for 5 minutes.

1479 Mrs. {Brooks.} Thank you, Mr. Chairman, and thanks to
1480 our witnesses for being here. I am a former United States
1481 Attorney, and so have worked with Medicaid fraud control
1482 units in--run by our states' Attorney General, and also with
1483 HHS OIG agents, and my question is really to both of you
1484 about the staffing, and the number of people that we

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1485 dedicate--so while you are very focused on prevention, I
1486 understand, but deterrence is also a wonderful tool, and I am
1487 curious about the effectiveness of our deterrence. Because
1488 if we don't prosecute those, and--while certainly I know U.S.
1489 Attorneys' offices and Attorney Generals are prosecuting all
1490 across the country, I don't believe they have the resources
1491 that they need. These are very complex investigations. The
1492 last thing they want to do is prosecute someone wrongfully,
1493 and these are very complicated cases.
1494 So my question is to both of you about how our--whether
1495 it is our health care providers, or the beneficiaries who are
1496 receiving improper payments, what is your thoughts on how we
1497 are doing with respect to prosecutions?
1498 Dr. {Agrawal.} So I appreciate the question.
1499 Prosecution is obviously an important aspect of health care
1500 fraud control generally. What we have been doing over the
1501 last 5 years, since the creation of the Center for Program
1502 Integrity, is really investing resources in preventing these
1503 issues from arising in the first place. That includes, you
1504 know, payment edits, audits, investigations, and ultimately
1505 removing a provider from the program, if necessary, to stop

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1506 inappropriate billing.

1507 As part of that work, we are also collaborating closely
1508 with OIG and DOJ, making sure that they have data that is
1509 adequate for their cases, providing them what additional
1510 services or resources they need, even using administrative
1511 authorities that CMS has, as long as, you know, we are
1512 obviously following those authorities and implementing them
1513 in the proper way. So I think it is a balance. I think
1514 deterrence is obviously very important, and, you know, we
1515 continue to collaborate with law enforcement as needed.

1516 Mrs. {Brooks.} Mr. Bagdoyan?

1517 Mr. {Bagdoyan.} Yes, thank you, Ms. Brooks. The issue
1518 of prosecution was not within the scope of our audit,
1519 certainly, but I would see it certainly as part of the
1520 toolbox that I alluded to in my opening remarks. So, in its
1521 totality, it would have to have preventative controls, and
1522 the ability to investigate, and, if appropriate, prosecute.

1523 Mrs. {Brooks.} Let me get--dig a bit further on the
1524 investigation, though, because you have to do--and I have
1525 seen the reports done by those units, and the analysis they
1526 do, and it is very complex. And I know that in your written

1527 testimony you talked about the medical--Medicaid Integrity
1528 Institute, Dr. Agrawal. How many employees do you know
1529 across the country deal with Medicaid, state and Federal?
1530 Any idea? Because I saw that--in the testimony--or in a
1531 Reuters report that more than 4,200 employees have been
1532 trained, but there are thousands more, I would suspect, but I
1533 have no idea.

1534 Dr. {Agrawal.} Right. So I am not sure exactly what
1535 the total number of Medicaid employees is. I think the 4,200
1536 number, what that really sort of refers to are state
1537 employees that we have been able to bring over to the
1538 Medicaid Integrity Institute to engage in an educational
1539 experience on some aspect of program integrity, whether it is
1540 working with law enforcement, or provider enrollment in
1541 screening standards, beneficiary eligibility, whatever the
1542 case may be.

1543 I think there certainly may be--there are definitely
1544 more than 4,200 out there. Right now our only constraint is
1545 the resourcing and the time to get as many employees in as
1546 possible. But the program is a strong one, I think, because
1547 it really allows us to spend Federal resources. States have

1548 to pay very little to nothing for an individual employee to
1549 be educated and have access to those courses.
1550 Mrs. {Brooks.} And are all the courses required to be
1551 done in person, or could you move to an online training
1552 program to help states who have, you know, constrained
1553 budgets have more of their Medicaid employees trained?
1554 Dr. {Agrawal.} Yeah, that is a--
1555 Mrs. {Brooks.} I think that is a challenge for a lot of
1556 states.
1557 Dr. {Agrawal.} Agreed, that is a great question. We
1558 have, up until now, done the vast majority of these--of this
1559 educational work in person because there is a value to that
1560 in-person education, being able to conduct seminars, real
1561 sort of small group trainings. However, I think your point
1562 is a good one, and we are currently looking at ways of using
1563 more virtual training, as well as potentially putting MII on
1564 the road, so that states that can't travel, or, you know, for
1565 their own policies or whatever, still have access to the
1566 education.
1567 Mrs. {Brooks.} Do you have any sense as to the success
1568 of this institute? I mean, how many folks have gone back and

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1569 have actually prevented fraud?

1570 Dr. {Agrawal.} Yeah. So measuring the impact of

1571 education, as you are probably aware, is really challenging

1572 to connect it to specific dollars and cents that are saved.

1573 What we find, in certainly post-course assessments, are--is a

1574 very high rating by state officials that indicate that they

1575 really did value the education that was given. We do also

1576 ask them to self-report where they feel the education

1577 contributed to recoveries or savings. We can give that

1578 number to you. But, again, I think, you know, it is hard to

1579 connect education to a specific dollar that is saved. I

1580 think it is often important to do these activities merely

1581 because that greater awareness at the state level is valuable

1582 onto itself.

1583 Mrs. {Brooks.} Thank you. I yield back.

1584 Mr. {Murphy.} The gentlelady yields back. Now

1585 recognize Ms. Castor for 5 minutes.

1586 Ms. {Castor.} Well, thank you, Mr. Chairman, for

1587 calling this hearing, and thank you to the witnesses. Thank

1588 you for your attention to program integrity, and rooting out

1589 fraud in Medicaid. In Medicaid, every dollar counts, because

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1590 these are dollars that go, in large part, to children and
1591 their health care needs, and our older neighbors in nursing
1592 homes, and other hard working Americans.
1593 Now, CMS has issued several new regulations and guidance
1594 just in the past month, and I would like to ask you about
1595 them today. Dr. Agrawal, as I understand it, under the
1596 proposed regulation for Medicaid managed care organizations,
1597 managed care providers would be subject to the same screening
1598 requirements as providers for the fee for service program, is
1599 that correct?
1600 Dr. {Agrawal.} That is correct.
1601 Ms. {Castor.} And that is especially important because
1602 many states are moving their Medicaid programs to managed
1603 care models, is that right?
1604 Dr. {Agrawal.} That is correct.
1605 Ms. {Castor.} In fact, do you know how many states have
1606 already shifted, and have instituted Medicaid managed care?
1607 Dr. {Agrawal.} I think the majority have. They are at
1608 various levels. States like Arizona, where it is essentially
1609 all managed care at this point, other states that are, you
1610 know, have a hybrid population between fee for service and

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1611 managed care. But that kind of enrollment requirement is a
1612 vulnerability or an issue that have been flagged by both OIB
1613 and GAO--

1614 Ms. {Castor.} Um-hum.

1615 Dr. {Agrawal.} --and so we are happy to get into a
1616 proposed rule.

1617 Ms. {Castor.} Okay. Elaborate on that. Why did CMS
1618 make that decision?

1619 Dr. {Agrawal.} Yeah. So, as you mentioned, you know,
1620 the rise of managed care is definitely occurring in all
1621 states, with some at various levels of integrating managed
1622 care. Previous OIG and GAO reports have highlighted that as
1623 an issue because, up until now, providers that provide
1624 services in managed care programs, you know, through MCOs,
1625 aren't necessarily known to the states. They don't
1626 necessarily have to go through the same enrollment standards.
1627 Some states require that. Others--most don't.

1628 We felt that this was an important vulnerability or an
1629 issue to address. Hence that was a part--sort of one piece
1630 of the program integrity provisions in that MPRM, and we
1631 think that requiring the same screening standards will ensure

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1632 beneficiary safety, regardless of whether they choose to stay
1633 in fee for service or managed care.
1634 Ms. {Castor.} Good. And, Mr. Bagdoyan, is this a
1635 policy change that the GAO supports?
1636 Mr. {Bagdoyan.} I am aware of the rule coming out, but
1637 I am not familiar with its details. I would go back to my
1638 original point that steps like this one would, over time, if
1639 executed and sustained, help narrow that window of
1640 opportunity for fraud and improper payments. So that would
1641 be my assessment at this point.
1642 Ms. {Castor.} Okay. Dr. Agrawal, my understanding is
1643 that the proposed rule also imposes new internal compliance
1644 and program integrity requirements on Medicaid and CHIP
1645 managed care plans. Can you walk us through those
1646 requirements?
1647 Dr. {Agrawal.} Sure. There are other requirements of
1648 managed care plans that include elevating issues, or
1649 informing the state about audit issues, other vulnerabilities
1650 that they have identified. It is making sure that they have
1651 compliance programs in place to ensure the integrity of
1652 payments, program integrity generally. Those are all new

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1653 elements that the majority of states don't have.

1654 In addition, there is a data sharing element, which

1655 requires language in managed care contracts to ensure states

1656 can still get access to managed care data as needed for

1657 program integrity and other purposes. So I think that--

1658 those, you know, MPRM, obviously we are in sort of the

1659 rulemaking process. But, if finalized in its form, would

1660 make really important progress in program integrity.

1661 Ms. {Castor.} And your goal is to complement what is

1662 already in place at some states? Some don't have the--

1663 similar safeguards, is that right?

1664 Dr. {Agrawal.} Correct. You know, you can sort of

1665 think of this as trying to build the safeguards in place that

1666 have been started in fee for service. So the same screening

1667 and enrollment standards, the same kind of access to data,

1668 and making sure that those go through to managed care plans.

1669 So, again, beneficiaries have the choice for, you know, which

1670 to engage in in states that have both, or states can make the

1671 transition to managed care without necessarily feeling that

1672 they have to give up program integrity along the way.

1673 Ms. {Castor.} Okay. I would also like to ask you about

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1674 the guidance CMS issued earlier this week on criminal
1675 background checks and fingerprinting of certain providers in
1676 the Medicaid program. First of all, who will be subject to
1677 the full background check and fingerprinting requirement, and
1678 how will CMS and state agencies determine if a provider
1679 represents a high risk?

1680 Dr. {Agrawal.} Sure. So you are referring to
1681 fingerprint-based criminal background checks that were one of
1682 the ACA requirements in enrollment and screening for
1683 providers. Generally fingerprint checks are utilized for
1684 provider types that are designated high risk. That would be,
1685 for example, a newly enrolling home health agency or DME
1686 company where there has been a history of kind of endemic
1687 fraud issues. If you are newly enrolling in the state in one
1688 of those categories, you would be subject to a fingerprint-
1689 based criminal background check. If CMS has already done it,
1690 states can utilize our results as their own.

1691 The only other provider types are those that have
1692 already designated--been issues of the program, and therefore
1693 are on an individual basis designated high risk if they try
1694 to re-enroll.

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1695 Ms. {Castor.} Thank you very much.

1696 Mr. {Murphy.} Mr. Mullin, you are recognized for 5
1697 minutes.

1698 Mr. {Mullin.} Thank you, Mr. Chairman. Doctor, can you
1699 walk me through the process of what happens when a state
1700 medical fraud unit identifies a provider that is committing
1701 fraud within the system?

1702 Dr. {Agrawal.} Broadly speaking I can. I will sort of
1703 tell you the steps that I know, but I will just make the
1704 point that MFCUs, or the Medicaid Fraud Control Units,
1705 actually respond to the Office of Inspector General, and they
1706 work with program integrity units at the state Medicaid
1707 agency.

1708 But I, you know, surmising that the relationship is
1709 really similar to what we have with our Office of Inspector
1710 General, we will often initiate investigations based on data
1711 assets, beneficiary complaints, a host of other inputs. And
1712 then, if there is any indication of fraud, or patient safety
1713 issues, we will send that over to the OIG, and oftentimes
1714 state Medicaid agencies with similar policies, engaging their
1715 fraud control unit.

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1716 Mr. {Mullin.} Can the state medical--or Medicaid fraud
1717 units indict providers?
1718 Dr. {Agrawal.} I believe they can, working with, you
1719 know, regional DOJ offices.
1720 Mr. {Mullin.} What--when--with our--communication with
1721 our Oklahoma fraud unit for Medicaid, they indicated that
1722 they couldn't. They had to basically turn it over to you
1723 all.
1724 Dr. {Agrawal.} Again, they might be referring to
1725 Federal law enforcement, either, again, OIG or DOJ. You
1726 know, as an administrative agency, we don't indict providers.
1727 We have various administrative authorities and actions, but
1728 the most severe is kicking somebody out of the program.
1729 Mr. {Mullin.} So they can go in and be fraudulent, and-
1730 -billing Medicaid for millions of dollars, and the worst
1731 thing that happens to them, they get kicked out of the
1732 program?
1733 Dr. {Agrawal.} Well, again, you know, we have the
1734 administrative authorities that we have. We are able to
1735 suspend payments, terminate the enrollment of providers. And
1736 then I think, you know, to the point that was made earlier,

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1737 we do work with law enforcement to bring other, you know,
1738 more criminal justice activities.
1739 Mr. {Mullin.} But we hear reports over and over again
1740 about providers that were kicked out of the program for
1741 having fraudulent claims, and then they turn back around,
1742 change their name, and are back in business the following
1743 week.
1744 Dr. {Agrawal.} So--
1745 Mr. {Mullin.} What is the indicator that you
1746 communicate with the Federal prosecutors and say, look, we
1747 want this guy to go to jail--
1748 Dr. {Agrawal.} Right.
1749 Mr. {Mullin.} --or do you guys just don't do that? You
1750 say, well, whatever. You guys--I mean, he defrauded the--or
1751 she defrauded the taxpayers millions of dollars, but it is up
1752 to you?
1753 Dr. {Agrawal.} Well, specifically with working with law
1754 enforcement, we make referrals--I think hundreds, if not
1755 thousands of referrals, and we can actually get you some
1756 numbers for the last couple of years to show you how many, to
1757 law enforcement for those cases that are most concerning for

1758 fraud, and where we believe a law enforcement action would be
1759 appropriate, at least from our determination.
1760 But I think, to your larger question about providers
1761 kind of reinventing themselves, we too have noted that as a
1762 vulnerability, and, in fact, have promulgated rules that have
1763 allowed us to close it by, for example, tracking
1764 administrative actions, and actually applying them to owners
1765 who would try to reinvent companies.
1766 Mr. {Mullin.} Well, it seems like, to me, if more of
1767 them went to jail, that might prohibit them from going
1768 through. So we--do we know how many actually end up in--
1769 doing jail time?
1770 Dr. {Agrawal.} I think that is a question for at least
1771 the OIG, or the state law enforcement officials.
1772 Mr. {Mullin.} Could--is that a number that you guys can
1773 provide?
1774 Dr. {Agrawal.} We don't track--remember, our
1775 authorities don't involve--
1776 Mr. {Mullin.} So there is a breakdown in communication
1777 is what I am saying.
1778 Dr. {Agrawal.} No, I wouldn't say that--

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1779 Mr. {Mullin.} I am asking you, because you kick them
1780 out of the program, then turn it over, then no one pays
1781 attention to them anymore. And if the Federal prosecutors
1782 aren't willing to prosecute, then they come right back into
1783 your system, no one is paying attention to them, and they end
1784 up doing the same thing over again. Because if the worst
1785 thing that happens to them is they get kicked out, then it is
1786 not there.
1787 Maybe it might be something that we might want to look
1788 at. Maybe we ought to let the states do this. If they have
1789 a unit that specifically identifies claims to Medicaid that
1790 the state is issuing, and they see fraudulent activities, and
1791 they turn it over to you, you all kick them out, they turn it
1792 over--you all turn it to the Federal prosecutors, if they end
1793 up getting lost in the chain, why don't we simplify the
1794 process and just let the state prosecute them?
1795 Dr. {Agrawal.} Just to be clear, states don't have to
1796 go through CMS in order to get to prosecutors or law
1797 enforcement. They do have Medicaid fraud control units that
1798 they can go to directly.
1799 Mr. {Mullin.} But they--

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1800 Dr. {Agrawal.} They have other--

1801 Mr. {Mullin.} --can't prosecute them, though.

1802 Dr. {Agrawal.} Right. As administrative agencies, the
1803 state Medicaid agency, CMS, we don't prosecute directly, but
1804 we don't work with law enforcement to do that. I wouldn't
1805 characterize it as a communication breakdown. I would
1806 characterize it as different lines of authority. We are
1807 happy to work with law enforcement. We provide law
1808 enforcement with data on a routine basis, work with them
1809 sometimes for years as they develop, investigate, and take
1810 action on cases.

1811 Mr. {Mullin.} So do you think there is a better way--
1812 quickly, because I am running out of time, is there a better
1813 way to handle this, then?

1814 Dr. {Agrawal.} I think it depends on what the this is
1815 that you are trying to improve.

1816 Mr. {Mullin.} Well, to prosecute the individuals,
1817 rather than just kicking them out of the program, and not
1818 actually sending them to prison.

1819 Dr. {Agrawal.} Yeah. I--as a balance. So it is really
1820 important, I think, to engage in prevention, because

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1821 prosecution takes, understandably, time, and what we don't
1822 want is folks billing programs that shouldn't be billing
1823 programs. And so it is useful to actually kick them out of
1824 the program and stop dollars from going out the door. At the
1825 same time, if we can work with our law enforcement colleagues
1826 to get the prosecution, we can have the deterrence effect,
1827 and other impact that we want.

1828 Mr. {Mullin.} Appreciate it. Thank you.

1829 Mr. {Murphy.} Thank you. Mr. Green, you are recognized
1830 for 5 minutes.

1831 Mr. {Green.} Thank you, Mr. Chairman. Mr. Bagdoyan,
1832 the--Medicaid is a large program, as is Medicare, and would
1833 it be fair to say that as long as these programs existed,
1834 there have always been at least some improper payments, some
1835 people gaming the system?

1836 Mr. {Bagdoyan.} That seems to be the historical record,
1837 sir, yes.

1838 Mr. {Green.} I know it wasn't part of your audit
1839 specifically, but improper payments were not only associated
1840 with Medicare and Medicaid, but it is a challenge to our--
1841 government-wide, I assume.

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1842 Mr. {Bagdoyan.} That is correct. OMB measures that. I
1843 think maybe the Chairman or the Ranking Member earlier
1844 referred to the higher error programs that OMB tracks, so
1845 yes.
1846 Mr. {Green.} Okay. Clearly we want to lower the rate
1847 of improper payments in the programs such as Medicare and
1848 Medicaid, but it is important to put it in context. This
1849 Committee examined this issue more than a decade ago. Then,
1850 like what we are discussing today, there were improper
1851 payments associated with Medicaid and Medicare. But do we
1852 want to constantly try to eliminate improper payments--and we
1853 do want to try and eliminate improper payments and better
1854 controls.
1855 On page 14 of your report, your audit mentions that CMS
1856 is--as part of the passage of the Affordable Care Act has put
1857 in place some new tools that may help bring down improper
1858 payments. And I realize that gaps remain, but do you see
1859 this as an important step in the right direction?
1860 Mr. {Bagdoyan.} I would say they are, and they add to
1861 their toolbox that I referred to in my opening statement.
1862 Mr. {Green.} Okay. Do you see any new tools as a step-

1863 -the new tools a step in the right direction? If so, can you
1864 explain how you think they will help us reduce the improper
1865 payments moving forward?
1866 Mr. {Bagdoyan.} Well, the two recommendations we make
1867 available to states, where the action happens, so to speak,
1868 with the data they need to better screen both beneficiaries
1869 and providers.
1870 Mr. {Green.} Okay. I understand more specifically that
1871 CMS regulations established a more rigorous approach to
1872 verifying financial and non-financial information that could
1873 help determine Medicaid beneficiary eligibility. It has
1874 created a tool called the data services hub. I know that
1875 gaps will remain, and bad actors constantly try to find ways
1876 to game the system, however, does the implementation of this
1877 new tool, the data service hub, give you some encouragement
1878 that we can reduce the rate of improper payments?
1879 Mr. {Bagdoyan.} Again, by all means it is a step in the
1880 right direction. Getting the data right and reliable is a
1881 key step there, as well as having states regular and
1882 electronic access would be also useful.
1883 Mr. {Green.} I am guessing some of these new tools are

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1884 already having some positive effect. I understand the DO--
1885 GAO's audit has some limitation--mainly due to using data
1886 that is now almost 5 years old. While I applaud GAO's
1887 efforts to help strengthen Medicaid through its work, it is
1888 unfortunate we are not seeing how these new and encouraging
1889 tools are working until we can examine more recent billing
1890 data.

1891 Mr. Chairman, I hope that we continue to work with GAO
1892 and CMS and see how these new tools CMS is working on, that
1893 can help us in taking out the fraud and abuse. And, again, I
1894 want to thank GAO for the excellent work you are doing, and
1895 also CMS for responding to what we did in the Affordable Care
1896 Act to give you those tools. And I yield back my time.

1897 Mr. {Murphy.} Gentleman yields back. Now recognize Mr.
1898 Collins for 5 minutes.

1899 Mr. {Collins.} I come from the private sector. I am a
1900 Lean Six Sigma guy. I have brought Lean Six Sigma into a
1901 large municipal government. I think you all--both know where
1902 I am going. It is not a good place. This is the most
1903 disturbing hearing I have attended in 2-1/2 years. I hear
1904 you saying that making 67,000 errors per million

1905 opportunities is worth a gold star. Six Sigma says you make
1906 3.4 errors per million. 3.4, not 67,000.
1907 I will be using today's hearing in my stump speeches, in
1908 my town halls for a very long time. It is everything wrong
1909 with government. That you are setting a standard of making
1910 67,000 mistakes for every million times you try to do
1911 something, and you are going to reward and congratulate
1912 yourselves, this is disbelief, absolute, utter disbelief of
1913 what is wrong with government, to have you two individuals,
1914 with smiles on your face, and congratulating each other over
1915 trying to achieve 67,000 errors per million opportunities. I
1916 am just--my mind is blown. You know, I know if 1,000
1917 airplanes take off, and 67 of them crash, that is a 6.7
1918 percent error rate. I don't think we are going to be flying
1919 on our airplanes it is--if 67 airplanes crash for every
1920 thousand that take off.
1921 In the manufacturing world today, whether it was Toyota
1922 many years ago, whether it was General Electric, or what it
1923 is--some things I have done, we set a goal of Six Sigma, 3.4
1924 errors per million. It is achieved every single day in the
1925 private sector. And here we are in government, talking about

1926 67,000 errors per million opportunities, and how this is
1927 progress? This is disgusting. It is a waste of taxpayer
1928 dollars. It is setting the bar so low that, yeah, I guess,
1929 you know, let us--we had a goal of 5.6, we hit 6.7, so next
1930 year let us make it 6.7. Well, if it is 7.2, then the next
1931 year it is going to be 7.2, and we are going to have a
1932 hearing, and you guys are going to self-congratulate each
1933 other on achieving something like that? I don't even know
1934 that you can--you can't defend the indefensible.
1935 So, while I am carrying on here a little bit, I know you
1936 can't defend the indefensible, but maybe I will let you try.
1937 And I will also say there is a sign in my office, in God we
1938 trust, all others bring data. I am a data guy, if you can't
1939 already tell. That means you need good data. And now I am
1940 reading that the PERM program, the Payment Error Rate
1941 Measurement Program, at best, it is using a rolling sampling
1942 of 17 states, the data is not consistent, it is not gathered
1943 in a consistent way. I have one word for that data, and that
1944 is garbage. Garbage, complete garbage.
1945 So, I don't know, Mr. Bagdoyan, do you have anything to
1946 say?

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1947 Mr. {Bagdoyan.} Well, Mr. Collins, I thank you for your
1948 comments. I think our audit was thorough, by our audit
1949 standards, and our findings speak for themselves.
1950 Mr. {Collins.} You are familiar with Six Sigma, right?
1951 Mr. {Bagdoyan.} I am indeed, yeah.
1952 Mr. {Collins.} All right. So, in my world--what would
1953 you think if you are in my world, and I am used to 3.4 errors
1954 per million, and you are at 67,000? How long do you think
1955 you would work for me?
1956 Mr. {Bagdoyan.} I take your point.
1957 Mr. {Collins.} Yeah, not very long. And, Dr. Agrawal,
1958 again, you are--you seem okay with taking the 5.6 to 6.7.
1959 Can you defend that? I am going to stand up in front of my
1960 residents, and I am going to talk about this hearing, and
1961 they are going to be shaking their heads in total disbelief.
1962 You are going to be an example of everything wrong with
1963 government from this day forward in western New York when I
1964 tell them at 5.6 percent--you hit 6.7, so the next year you
1965 just changed it to 6.7. If that is not oh, my God, I am
1966 just--again, this is the most disturbing hearing I have ever
1967 taken place in. So what do you say to the third graders when

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1968 I tell them that?

1969 Dr. {Agrawal.} I think I have made it pretty clear from
1970 my opening remarks, Congressman, that we do view these
1971 findings as important, and, while we have made progress,
1972 there is more progress to be made. I don't view it as any
1973 other way. I don't view it as just sort of being happy with
1974 the results and where we are.

1975 Mr. {Collins.} Well, my time has expired, but I would
1976 suggest you set different standards for yourselves, ones that
1977 respect the B in billions. We talk in government about
1978 dollars like billions don't even matter anymore because we
1979 are trillions in debt, and I would suggest that, as somebody
1980 who has got something to do with this, next year, when they
1981 try to raise the error rate to 7.2 percent, you actually
1982 stand up and make a name for yourself and say, I am not going
1983 to stand by and let that happen. With that, I yield back.

1984 Mr. {Murphy.} Gentleman yields back. Just to clarify,
1985 Dr. Agrawal, did you set the standard at 6.7 percent?

1986 Dr. {Agrawal.} No. That is a process that involves a
1987 different part of the, you know, it is obviously kept
1988 separate from folks that are trying to make the

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1989 interventions, right, so that there is some objectivity to
1990 it.
1991 Mr. {Murphy.} And, Mr. Bagdoyan, you more or less
1992 audited this information and provided it for us, correct?
1993 Mr. {Bagdoyan.} Yeah. We use it as a point of
1994 reference, sir. We don't set the number.
1995 Mr. {Murphy.} So the follow up to Mr. Collins's
1996 question that is important for us to know, the process of how
1997 that is done? Because I think you heard unanimity of
1998 opinion, none of us want to tolerate that, but we need to
1999 know how that is happening so we can make changes on this
2000 very thing. But I thank you. I now recognize Mr. Yarmuth
2001 for 5 minutes.
2002 Mr. {Yarmuth.} Thank you, Mr. Chairman, and thank--
2003 thanks to the witnesses. I want to get some clarification on
2004 this PERM rate, because I am not sure I understand it. If
2005 you characterize these as errors, are these errors that CMS
2006 made, or are they errors that--which--just some kind of
2007 incorrect payment was made? So you would have had, for
2008 instance, a bill come in that was coded incorrectly, wrong
2009 procedure, whatever it is, and--would that have been counted

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2010 as an error?

2011 Dr. {Agrawal.} Yeah, it would be.

2012 Mr. {Yarmuth.} So you--it wasn't a mistake that you

2013 made, it was a mistake that somebody who was sending the bill

2014 in made, is that correct?

2015 Dr. {Agrawal.} Yes. I mean, I think it could be

2016 argued, and in fairness, that, you know, we need to have

2017 preventative programs in place to catch that.

2018 Mr. {Yarmuth.} I understand, but this is not

2019 necessarily an--

2020 Dr. {Agrawal.} Correct.

2021 Mr. {Yarmuth.} --indication of negligence on the part

2022 of CMS.

2023 Dr. {Agrawal.} Correct.

2024 Mr. {Yarmuth.} And, you know, I have got my problems,

2025 as everybody does, with CMS, but--so if somebody sent in a

2026 bill for--on a fee for service basis that--for $100, and they

2027 were actually only entitled to $90, that would be an error

2028 under this--

2029 Dr. {Agrawal.} That would be--

2030 Mr. {Yarmuth.} --report? Now, would that total $100 be

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2031 counted in the 14 billion? My point being that--

2032 Dr. {Agrawal.} Um-hum.

2033 Mr. {Yarmuth.} --I think there is the danger here--and

2034 I am a former generalist. There is a danger here that

2035 somebody would look at this report and say four--the mistakes

2036 cost taxpayers $14 billion in 2013, when, in fact, they

2037 didn't cost taxpayers $14 billion, they cost them some--could

2038 be a very small fraction of 14 billion. Am I analyzing that

2039 correctly?

2040 Dr. {Agrawal.} Right. I think what is really important

2041 is the measured tone that GAO and Mr. Bagdoyan have taken

2042 today, that these are all potentially improper payments, and

2043 not, you know, the data inconsistency alone doesn't

2044 absolutely establish that. It--in many of the specific

2045 claims where these improper payments have been noted, states

2046 or CMS are able to actually recover those dollars, or Federal

2047 portions are withheld. So, yeah, there is obviously

2048 complexity underlying this that you are correct to point out.

2049 Mr. {Yarmuth.} Right. I just want to make that clear,

2050 because, again, I think there is a danger in taking these

2051 numbers and blowing them out, at least with a--not a full

2052 understanding of what they represent.

2053 And, Mr. Bagdoyan, looking at the numbers there, I did
2054 the same calculations that Mr. Kennedy did, and on the
2055 deceased question, looking at it another way, it was one out
2056 of every 46,000 beneficiaries. Just on the total beneficiary
2057 problems, it was one out of every 742, and on the provider
2058 problems it was one out of every 2,753. Now, I think, again,
2059 there is a danger in looking at it and saying, 8,600
2060 beneficiaries got benefits in two states, but--

2061 Mr. {Bagdoyan.} Um-hum.

2062 Mr. {Yarmuth.} --it is a relatively small number. I
2063 would be negligent if I didn't spend time talking about the
2064 Kentucky experience, because I know my colleague from Indiana
2065 talked about how states are worried about paying for the
2066 Medicaid expansion. I think everybody has some concern over
2067 what the impact will be, but--in Kentucky--and, you know, I
2068 need to congratulate Governor Beshear and his team. Under
2069 the expansion of Medicaid, more than 520,000 Kentuckians now
2070 have insurance who didn't have it before. The ACA, in my--
2071 the uninsured rate across the state has been reduced by
2072 almost half. In my district alone, the uninsured rate has

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2073 been reduced by 81 percent, which is a phenomenal occurrence,
2074 another--I think a very humane one.
2075 But more importantly, the governor just had the Deloitte
2076 Firm, highly respected accounting and business consulting
2077 firm, do an analysis and a project as to what the ACA would
2078 mean to Kentucky over the next 6 years. And, again, most of
2079 this is because of Medicaid expansion, but the vast majority
2080 of the newly insured are part of the Medicaid expansion. The
2081 Deloitte Firm concluded that over the next 6 years the ACA,
2082 in Kentucky, would create 40,000 new jobs, it would have a
2083 positive impact on the economy--additional impact on the
2084 economy positive of $30 billion, and would have a positive
2085 impact on Kentucky's budget over the next 6 years of $819
2086 million.
2087 So, you know, I think that it is easy to sit here and
2088 say, gosh, what are states going to do when they have to pay
2089 90 percent in 2021, or 95 percent in 2017 or '18? But, in
2090 fact, an analysis of our situation shows that it is going to
2091 have a positive impact well into the 2020s. So I wanted to
2092 get that on the record as part of this discussion, so--and
2093 with that, Mr. Chairman, I yield back.

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2094 Mr. {Murphy.} Gentleman yields back, and I will
2095 recognize Ms. Blackburn for 5 minutes.
2096 Ms. {Blackburn.} Thank you, Mr. Chairman, and I thank
2097 you all for being here. And, as Mr. Collins just said, this
2098 is really a frustrating hearing in so many ways for us. In
2099 2003, shortly after, I came here--we did a field hearing in
2100 Tennessee, looking at the TennCare program, which was the
2101 test case for Hillary Clinton's health care, and implemented
2102 in Tennessee, and a lot of Obamacare has been built on it.
2103 And there--one of the focuses of that hearing was the waste,
2104 fraud, and abuse, and the fact that CMS just couldn't seem to
2105 get its act together when it came to dealing with waste,
2106 fraud, and abuse.
2107 And when you isolated our state and looked at it, the
2108 payment error rate, and the eligibility issues with
2109 verification of who was and was not eligible, and then the
2110 providers, and--so to see this continue on, and your
2111 willingness to accept a failing grade in addressing this is
2112 just beyond us. Because you are not getting better, you are
2113 getting worse, and then you change the grading system to
2114 accommodate that you are not improving.

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2115 And, Dr. Agrawal, if I am understanding this right, you
2116 moved from 5.6 to 6.7 in that rate, and it--you--this was
2117 done by committee, so there is no one person in charge of
2118 this debacle, is that correct?
2119 Dr. {Agrawal.} I am sorry, ma'am, I don't understand
2120 what you are asking about.
2121 Ms. {Blackburn.} You changed your grading rate. You
2122 went from a target for--5.6, a target rate, to 6.7 in your
2123 improper payment rate. And, if I am understanding your
2124 answer to Mr. Collins, there is no one person that decided
2125 that, it was a committee, or a group, that decided that. Is
2126 that correct? Who do we hold responsible for accepting a
2127 failing grade?
2128 Dr. {Agrawal.} Well, Congresswoman, you know, clearly
2129 the target is set, but I think what is important is we
2130 actually measure our--
2131 Ms. {Blackburn.} Who sets the target? Who set it?
2132 Dr. {Agrawal.} I don't know. We would have to--
2133 Ms. {Blackburn.} Who accepts this?
2134 Dr. {Agrawal.} --go back and identify that person.
2135 Ms. {Blackburn.} Who accepts the wasting of taxpayer

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2136 money? You have got an issue that gets worse every year.
2137 Let me ask you this, we are going to get in behind this. You
2138 have got--was it 90 providers in one state that were found to
2139 be receiving erroneous payments? Did I understand that
2140 right, sir?
2141 Mr. {Bagdoyan.} It was--sorry, it was 90 in the four
2142 states we looked at.
2143 Ms. {Blackburn.} 90 in four states?
2144 Mr. {Bagdoyan.} That is correct.
2145 Ms. {Blackburn.} Okay. What would happen if we were to
2146 say there were a zero tolerance policy for improper payments,
2147 and for waste, fraud, and abuse that is taking place in CMS?
2148 What would happen? How would you all react? Because Federal
2149 agencies that deal with taxpayers, they pretty much have a
2150 zero tolerance policy.
2151 Or what if we did this, what if we were to look at these
2152 numbers--according to CMS, improper payments in the Medicaid
2153 program rose from 14.4 billion in 2013 to 17.5 in 2014. What
2154 if we were to say, CMS, we are going to charge you back with
2155 this $17.5 billion until you can get your act together? And
2156 you have got to take that out of your budget, and you have

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2157 got to find a way to deliver the services and avail
2158 yourselves of technology.
2159 Let me ask you a question too. When it comes to the
2160 data, and transferring that into information that can be
2161 used, have you looked? You say you offer guidance and
2162 support to the states. Have you told the states, we are
2163 going to hold you accountable for giving us data that can be
2164 turned into information, and we are going to cut your
2165 payments if you don't give us the data that can be used?
2166 Garbage in, garbage out. It is not going to change.
2167 And the fact that you have a secure job, and a paycheck,
2168 and think you can't be fired, and then you come in here, and
2169 what we hear is, going back to my first hearing on this in
2170 2003, the problem gets worse, the problem doesn't get better,
2171 and when it does get worse, you just change the metrics and
2172 say, well, that is okay, we are going to do better next year.
2173 No, it is not okay. The error rate is not okay. And it is
2174 something we are going to push forward, and holding you all
2175 accountable, and look for new ways of doing that. And I
2176 yield back my time.
2177 Mr. {Murphy.} Gentlelady yields back. I am going to

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2178 let Ms. DeGette take a few--2 minutes, and Mr.--

2179 Ms. {DeGette.} Yeah.

2180 Mr. {Murphy.} --Dr. Burgess, and we will proceed from

2181 there. Thank you.

2182 Ms. {DeGette.} Now, in fairness, Dr. Agrawal, were you

2183 in your job in 2003, in this job?

2184 Dr. {Agrawal.} No.

2185 Ms. {DeGette.} Mr. Bagdoyan, were you in this job in

2186 2003?

2187 Mr. {Bagdoyan.} I was not, ma'am.

2188 Ms. {DeGette.} I am going to ask you, because you are

2189 with the GAO, have they--has the agency tried to institute

2190 new metrics to try to prevent fraud since 2003?

2191 Mr. {Bagdoyan.} I think, as we reflect in our report,

2192 and in my statement, they have. Those will have to play out

2193 over the long term--

2194 Ms. {DeGette.} Right, and as--

2195 Mr. {Bagdoyan.} --at all.

2196 Ms. {DeGette.} And as we discussed when I was asking

2197 questions, unfortunately, the data that you had for those

2198 four states was from 2011, so it didn't reflect some of the

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2199 preventative efforts that have happened since--

2200 Mr. {Bagdoyan.} That is correct. That was part of the

2201 necessity of our methodology.

2202 Ms. {DeGette.} Right, exactly, because you just didn't

2203 have the data, right?

2204 Mr. {Bagdoyan.} That is correct.

2205 Ms. {DeGette.} And, Dr. Agrawal, do you think that it

2206 is a good idea to have fraud? Do you support that? Because

2207 I have been listening to these other questioners, they seem

2208 to somehow imply that either you personally, or the agency,

2209 think that it is acceptable to have fraud.

2210 Dr. {Agrawal.} Obviously I do not.

2211 Ms. {DeGette.} Why?

2212 Dr. {Agrawal.} Well, I come at it from the perspective

2213 of an ER physician. I have taken care of Medicaid and

2214 Medicare beneficiaries, and other beneficiaries, the

2215 uninsured. I do this work so that we can preserve resources

2216 for the folks who need it.

2217 Ms. {DeGette.} Thank you. I yield back.

2218 Mr. {Murphy.} Dr. Burgess?

2219 Mr. {Burgess.} Thank you, Mr. Chairman. I do thank our

2220 panel for being here, and I know it has been a long morning.
2221 Let me just ask a question, because I am trying to get a
2222 better understanding of the--of what is referred to as the
2223 PERM program. That is a 3 year rolling average of 17 states
2224 examined on a yearly basis, is that correct?
2225 Dr. {Agrawal.} That is correct.
2226 Mr. {Burgess.} And, now, what kind of statistical
2227 modeling was involved in coming up with that formula?
2228 Dr. {Agrawal.} So there is a statistical sample done in
2229 each of these states along the three major categories of the
2230 PERM program. And, again, we conduct the cycle so that every
2231 state is measured at least once in--or once at--in the 3 year
2232 period. And there is statistical analysis behind it to make
2233 sure that the results are generalizable, and can actually
2234 arrive at a national rate.
2235 Mr. {Burgess.} How do you select the 17 states to be in
2236 the particular cohort?
2237 Dr. {Agrawal.} They are--
2238 Mr. {Burgess.} --alphabetical, and then you cut it off
2239 at 17, and--
2240 Dr. {Agrawal.} That is a good question. Actually, you

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2241 know, I am not sure. I don't think it is alphabetical, but
2242 there are 17 in every cohort, and, you know, we make sure
2243 that every state is represented once in a 3 year period.
2244 Mr. {Burgess.} So the four states that Mr.--
2245 Mr. {Bagdoyan.} Bagdoyan.
2246 Mr. {Burgess.} --Bagdoyan was concerned about, are
2247 those four states all in one cohort, or are they evenly
2248 distributed between the three rolling averages?
2249 Dr. {Agrawal.} They are distributed between them.
2250 Mr. {Burgess.} Well, I guess, you know, it seems like
2251 it is--that is a difficult one. I don't understand why that
2252 model was selected. Is it just simply too difficult to
2253 assess every state on a yearly basis?
2254 Dr. {Agrawal.} I think it would be a real resource
2255 constraint to try to assess every single state every single
2256 year, and it does also pose burden issues for the states.
2257 Mr. {Burgess.} Everybody knows HHS has the best
2258 computers in the world, right? So why can't you?
2259 Dr. {Agrawal.} You know, I can take that back as a
2260 specific question if we are going to alter the methodology,
2261 but I think the methodology itself has been--it is not the--

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2262 sort of under--

2263 Mr. {Burgess.} Yeah.

2264 Dr. {Agrawal.} --your question here. It--

2265 Mr. {Burgess.} It just struck me as unusual to do it in

2266 this fashion. So, again, that is why I was wondering, is

2267 there a particular statistical methodology that has been

2268 followed, as far as the sampling, on a rotating basis, 17,

2269 17, 17 year in and year out, and how long have you been doing

2270 it this way?

2271 Dr. {Agrawal.} Since the PERM program started.

2272 Mr. {Burgess.} Which was?

2273 Dr. {Agrawal.} I believe we had the first rates in '07,

2274 but I would have to get back to you about that.

2275 Mr. {Burgess.} And do you see consistency in those

2276 numbers over those years that you go back and look at this?

2277 Dr. {Agrawal.} What we do is we report a national

2278 average rate, you know, every single year so you can actually

2279 follow the rates, as people have done in this hearing, sort

2280 of talk about the rates over time. What we don't report are

2281 rates by state, because it is very difficult to compare two

2282 different Medicaid programs that might have two very

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2283 different approaches to eligibility and other things.

2284 Mr. {Burgess.} All right, thank you. Mr. Chairman, I
2285 am going to submit a question in writing about the Dallas
2286 Morning News article that I referenced earlier in the
2287 hearing, and I would appreciate a response on that.

2288 Dr. {Agrawal.} Sure. Thank you.

2289 Mr. {Burgess.} Thank you.

2290 Mr. {Murphy.} Thank you. Let me just say this, I mean,
2291 you heard a number of--first of all, we are grateful you came
2292 to us in a candid way. But I think you hear among us, we
2293 want to facilitate this. None of us are going to tolerate
2294 any kind of acceptance of this. And there was a concern
2295 about whoever made the decision to just raise the level, it
2296 is not really acceptable. What we want to know is the
2297 methodology, and work with you, and see what next steps we
2298 need to take to deal with fraud and abuse.

2299 Granted, this data is from 2011. Some changes, as Ms.
2300 DeGette pointed out, may have already been put in place, to
2301 whatever extent you can tell us about that. We want to move
2302 a trajectory towards this, because, goodness knows, Federal
2303 dollars are limited, and anybody who is out there being a

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2304 crook needs to be handled appropriately so the money can go
2305 to those who need it. That is where our compassion should
2306 be. It is sort of in the category of those who can, those
2307 who can't, and those who won't. And those who won't play by
2308 the rules, they need to face the consequences.
2309 So we will be passing on other questions to you, and, to
2310 that extent, I want to thank the members for participating,
2311 and when the questions are submitted for the record, we would
2312 appreciate it if you could get back to us with prompt
2313 responses. So, to that extent, I now adjourn this hearing.
2314 Thank you.
2315 [Whereupon, at 12:11 p.m., the Subcommittee was
2316 adjourned.]