

Opening Statement of the Honorable Tim Murphy
Subcommittee on Oversight and Investigations
Hearing on “Medicare and Medicaid Program Integrity: Combatting Improper Payments
and Ineligible Providers”
May 24, 2016

(As Prepared for Delivery)

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

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

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

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

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

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

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

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

For the Medicare provider database, the OIG compared three sets of owner names: (1) the names listed on Medicare enrollment records, (2) names submitted by providers directly to the

OIG for their evaluation, and (3) names listed on state Medicaid enrollment records. The OIG found that nearly all providers in the OIG's review had different names on record than the state Medicaid programs.

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

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

Today we also will examine the larger body of work conducted by HHS OIG and the GAO, over years of audits and investigations.

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

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

The Subcommittee convened a hearing in June of last year to examine a troubling GAO report that highlighted Medicaid improper payments. After auditing four states with just over 9 million Medicaid beneficiaries, GAO found that 200 deceased beneficiaries received at least \$9.6 million in Medicaid benefits. The individuals were already deceased before apparently receiving medical services covered by Medicaid. One year later, GAO's recommendation to fix this problem is still "open," indicating that CMS has not taken the necessary action.

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

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

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