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COMBATING WASTE, FRAUD, AND ABUSE IN MEDICAID'S PERSONAL CARE SERVICES PROGRAM

TUESDAY, MAY 2, 2017

House of Representatives

Subcommittee on Oversight and Investigations

Committee on Energy and Commerce

Washington, D.C.

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

Members present: Representatives Murphy, Griffith, Brooks, Collins, Walberg, Walters, Costello, Carter, Walden (ex officio), DeGette, Schakowsky, Tonko, Clarke, Ruiz, and Pallone (ex officio).

Staff present: Jennifer Barblan, Chief Counsel, Oversight

and Investigations; Ray Baum, Staff Director; Elena Brennan, Legislative Clerk, Oversight and Investigations; Lamar Echols, Oversight and Investigations; Blair Ellis, Digital Coordinator/Press Secretary; Emily Felder (Martin), Counsel, Oversight and Investigations; Jennifer Sherman, Press Secretary; Julie Babayan, Minority Counsel; Jeff Carroll, Minority Staff Director; Chris Knauer, Minority Oversight Staff Director; Miles Lichtman, Minority Policy Analyst; Kevin McAloon, Minority Professional Staff Member; Jon Monger, Minority Counsel; Dino Papanastasiou, Minority GAO Detailee; and C.J. Young, Minority Press Secretary.

Mr. Murphy. Good morning. The subcommittee convenes this hearing today to examine Medicaid Personal Care Services, a critical lifeline for our nation's most vulnerable populations.

Medicaid is the largest provider of long-term care services for disabled and elderly individuals. Lately, long-term care has shifted from nursing homes and institutional settings to services provided to beneficiaries in their homes.

Personal care services, or PCS, provides essential services to Medicaid beneficiaries with significant needs so that they can stay in their homes. As they enter this ever more vulnerable stage of life, most elderly persons prefer to live in familiar surroundings.

These are not health services, but rather they assist beneficiaries with daily activities they can no longer do without assistance such as meal preparation, laundry, and transportation so that they can continue to live in their communities.

PCS now makes up a large component of home- and community-based care and continues to grow rapidly. In 2015, federal and state expenditures for PCS amounted to $15 billion, up from $12.7 billion in 2011. The actual figure is probably significantly higher because this number only reflects fee-for-service claims, and does not include managed care.

The U.S. Department of Labor projected that employment of personal and home health aides will grow by 46 percent between

2008 and 2018, which far exceeds the average growth of 10 percent for all occupations.

While the move toward home care has undoubtedly improved the lives of Medicaid beneficiaries by allowing them to stay at home and saves money for taxpayers, we cannot turn a blind eye to waste, fraud, and abuse in the Personal Care Services program.

More than 29 reports by the HHS Office of Inspector General have uncovered systemic fraud in PCS. The OIG has uncovered schemes between PCS attendants and Medicaid beneficiaries to submit claims for services that were not provided. This type of fraud is difficult to detect because attendants can often be a beneficiary's spouse, child or friend.

Even more troubling is the abuse that HHS OIG's investigations found. Stories like that of a beneficiary in my home state of Pennsylvania dying of exposure to the cold while under the care of a PCS attendant. This beneficiary had autism and a history of running away, but the attendant left her alone in a crowded shopping mall and waited an hour to call authorities.

In Maryland, a disabled woman was left alone in a locked car on a hot and sunny day, while her attendant went shopping with a friend. This woman was unable to open the car door. A concerned citizen noticed her in distress and called the police.

In Vermont, an attendant stole the opioid painkillers prescribed for the beneficiary, even though the beneficiary was

in significant discomfort and pain. This same attendant was on probation for drug possession at the time.

These are just some of the many stories of abuse uncovered by the OIG and other authorities. We will discuss them more today.

We talk about program integrity and high improper payments a lot on this subcommittee. We are used to getting into the weeds on error rates, methodology, and data collection.

To help curb fraud in PCS and protect vulnerable beneficiaries, Congress acted in the Helping Families in Mental Health Crisis Act of 2016 to require the use of an electronic visit verification system for Medicaid-provided PCS and home health services. This became law as part of 21st Century Cures, and when implemented, will help ensure that information regarding the services provided are verified.

Having verified data that will help identify waste, fraud, and abuse is important because there are real people at risk. Those who use the PCS program include our friends and neighbors, who may not have the resources or ability to speak up when they encounter abuse. This subcommittee and this Congress will not tolerate these abuses.

While it is undoubtedly good policy to keep beneficiaries in their homes, it also raises difficult questions which must be addressed.

How do we protect vulnerable people from abuse in their

homes, when no one else is around to assess an attendant's performance?

What changes can we make, by both Congress and CMS, to improve the program while maintaining access for Medicaid beneficiaries who need these services?

Both the HHS OIG and the Government Accountability Office have done excellent work to highlight the problems within PCS. These offices have also suggested ways to solve these problems, such as additional beneficiary safeguards, higher standards for attendants, and pre-payment controls.

I am grateful for your work and look forward to hearing more about your findings.

I understand that CMS has already acted to address some of these, but not all, these findings, and we will discuss what CMS is doing to address our concerns.

So thank you to all of our witnesses today for your dedication and great work to protect Medicaid beneficiaries and root out waste, fraud and abuse. I look forward to a productive discussion today.

I'll recognize Ms. DeGette for 5 minutes. Our main clock is not working, so as a reminder, I will just tap this when you reach 5 minutes. Thank you.

Ms. DeGette. Thanks, Mr. Chairman. Today, thanks to Medicaid, 74 million vulnerable Americans including seniors, children, adults, and people with disabilities have access to

quality healthcare. And despite what we often hear from our colleagues on the other side of the aisle, the Medicaid program delivers this care efficiently and effectively. In fact, not only are Medicaid's costs for beneficiaries substantially lower than that of private insurance, but they have also been growing more slowly per beneficiary. What is more, we know that the Medicaid program literally saves lives.

Last year, more than 12 million low-income adults had healthcare coverage because of the Affordable Care Act Medicaid expansion, something I think is an astonishing achievement. Coupled with other important provisions of the ACA, the Medicaid expansion has helped drive the uninsured rate to the lowest level in our nation's history.

One of the key components of Medicaid is the Personal Care Services program. Personal care services which include assistance with activities like bathing, dressing, and meal preparation are an important part of long-term care that Medicaid offers to beneficiaries. This allows beneficiaries to hold on to their independence longer and to stay in their homes with dignity. Furthermore, personal care services can save the Government money because they can be cheaper than enrolling patients in a nursing home, a lot cheaper.

However, just like other home healthcare services, personal care services can be susceptible to improper payment or even to fraud. Fraud, abuse, and mismanagement happen wherever large

amounts of money are spent, both in the public sector and in the private sector and we need to always look for ways to address this. But that doesn't mean the program is ill-conceived or should be drastically cut. Instead what it means is we need to focus our efforts on ensuring that the program receives more effective oversight and that we prevent and address these issues.

As I pointed out before, the ACA provided the Department of Health and Human Services and its Office of Inspector General with a wide range of new tools and authorities to fight fraud. For example, the ACA provided nearly $350 million in new funds for fraud control efforts, as well as new means for screening potential providers and suppliers. It also provided the HHS and OIG with new authorities to impose stronger penalties on those who commit fraud and gave the Centers for Medicare and Medicaid Services the ability to temporarily halt payments to those suspected of fraud. These new tools allow program administrators to better protect tax dollars and to move away from the pay-and-chase model by preventing bad providers from ever entering the program. These are positive developments.

But today, we are going to hear from the agencies that there are still vulnerabilities related to the PCS program, as well as additional actions that CMS should better take to oversee this program. For example, an October 2016 investigative advisory from HSS OIG detailed some disturbing cases of PCS fraud and beneficiary neglect. These bad actors not only defraud the

program, they harmed the patients they were supposed to serve. That advisory follows other HHS OIG reports highlighting PCS program vulnerabilities that contributed to questionable care services and improper payments. The OIG continues to recommend that CMS use its authorities more effectively to oversee PCS programs across all states to improve program integrity and help the risk of beneficiary harm.

Similarly, GAO has also found areas for improvement in the PCS program. Specifically, the state-reported data that CMS relies on for oversight lacks key investigation and there are variations in the program requirements across different states. This is an important point because states are ultimately responsible for overseeing their programs.

Along these lines, the GAO is also going to testify that some states continue to provide inaccurate or untimely data to CMS. We need to explore the challenges that states are facing in collecting this data and determine why states don't have additional resources to better oversee the program. We need to make sure the program is fully resourced and that includes sufficient money to collect and analyze data. Given that the states are on the front lines of running this important program, I think we need to hear from the states about what they are doing.

And finally, Mr. Chairman, as we talk about waste, fraud, and abuse, we should be mindful that the President's budget blueprint threatens agencies like HHS OIG to oversee these

programs. The OIG said on average it has one full-time employee to oversee more than $680 million a year. So I think we need to remedy that if we want to stop waste, fraud, and abuse.

So anyway, in conclusion, thanks for having this hearing. I think we are all against waste, fraud, and abuse and we all need to work together to make sure that it ends. I yield back.

Mr. Murphy. I thank the gentlelady. She yields back. I now recognize the chairman of the full committee.

The Chairman. I thank the gentleman for holding this hearing and for our witnesses' good work and good testimony. We are here today to talk about this program which serves our nation's most vulnerable individuals. Through Medicaid, personal care services provide essential care to millions of elderly people, disabled children and adults, and those who need long-term care to cope with crippling diseases. It used to be that many of these people ended up having to be institutionalized or cared for in a nursing home. Instead, personal care services provide an attendant to help people do the things like shop for groceries, do the laundry, make sure that they are taking their medications right on the schedule.

Without personal care services and home healthcare at large, these folks would not be able to live at home in their communities. Personal care services are quite literally a life saver for many.

I truly believe in programs like personal home services and home healthcare. Oregon experimented in these types of programs

a long time ago. The vast majority of personal care workers are really solid people who work hard and take care of people and they care, especially they care for these vulnerable populations. They make their lives better, healthier, brighter, and easier.

That is why it is so disturbing when the Office of Inspector General reported these instances of fraud, abuse, and mismanagement in this very essential program. Stories of attendants stealing pain meds, abandoning mentally ill beneficiaries in public places, leaving elderly folks alone for weeks at a time. This is outrageous and it is unacceptable.

What's worse is that OIG has made clear that these are not just some isolated individual bad actors. The OIG investigations have uncovered more than 200 cases of fraud and abuse in the program just since 2012. And as we learned from witnesses earlier this year, the Government Accountability Office has Medicaid designated as a high-risk program since 2003. So we have an obligation to get to the bottom of this for the taxpayers and for patients alike.

Late last year, GAO released a report on the need to harmonize requirements for personal care services across various states. GAO reviewed the policies and procedures in my home State of Oregon and three other states while performing this work. While I was heartened to learn that the safeguards Oregon has in place to prevent this fraud, the audit made clear there is more work to be done.

More recently, GAO released a second report on the need for better data on PCS. The most recent data at the time of the audit released in 2017 was from 2012. That was 5 years ago. And the data GAO did release was incomplete. Without complete and up-to-date data, those who are tasked with rooting out waste, fraud, and abuse in this program are frankly hamstrung.

So both the OIG and GAO sounded the alarm for years. This fraud and abuse is happening because the states and the federal government failed to put in safeguards to protect these beneficiaries. It is sickening to see hard-earned tax dollars going to people who take advantage and mistreat the elderly and disabled in their own homes. And these beneficiaries are particularly suspect to harm because they are often lack the physical or mental ability to speak up. Many times a personal care worker is the only person a beneficiary may see for weeks at a time, so they go along with the fraud or abuse because they are so dependent on that person for help.

We can do better for them. Our citizens deserve to know the attendant they allow into their home, the attendant paid by state and federal tax payers, will take good care of them and have their best interests at heart. And while most do, and most do, it is clear we have a serious problem in the program.

Today, we are here to talk about the steps we're going to take to correct the problems identified for us by the good work by the Office of Inspector General and the GAO.

I would like to thank Ms. Grimm from the OIG, and Ms. Iritani from the GAO, for your extraordinary work that exposed this fraud, abuse, and mismanagement in the program. You have done a good job. Your decades of work culminated in some common-sense recommendations for CMS that will better protect beneficiaries and taxpayers. So I look forward to discussing those recommendations today and also learning about how Congress can do its part to solve these problems.

Mr. Hill, I especially appreciate your testimony today, too. I understand CMS has taken steps to implement some of the recommendations and is working to make other improvements in the program. That is encouraging. I look forward to hearing more about your work as well.

With that, Mr. Chairman, and with apologies to our witnesses, we have a couple of subcommittees going on at the same time and my duties as Full Committee Chairman drag me between the two. So thank you for your good work. I have your testimony. It is most helpful. And I return the balance of my time.

Mr. Murphy. The Chairman returns the balance of his time and yields back. I now recognize the gentleman from New Jersey, Mr. Pallone, for 5 minutes.

Mr. Pallone. Thank you, Mr. Chairman. This committee has a long-standing history of examining fraud and abuse in Medicaid and we should continue to find ways to improve the vital programs, including the Personal Care Services program. But it is

important to keep these issues in context. Medicaid is a critical program that provides essential healthcare to more than 74 million Americans, including seniors, children, pregnant women, and people with disabilities. Now with the expansion of Medicaid under the Affordable Care Act, more than 12 million people gained health insurance coverage last year. Additional achievements under the ACA have helped improve the quality, accessibility, and affordability of healthcare for millions of Americans.

We have made historic gains and we must not roll back this progress by cutting essential health programs such as Medicaid. The Republican Trumpcare bill which the Republican leadership is still trying to convince members to support, drastically cuts and caps the Medicaid program. It rations care for millions in order to give giant tax breaks to the wealthy and corporations. By allowing a state to arbitrarily cap coverage or provide a block grant for certain enrollees, Trumpcare would result in mass rationing of care for seniors in nursing homes, pregnant women, working parents, and people living with disabilities.

Instead, it is imperative that we make every effort to ensure federal and state dollars are spent effectively. While Medicaid is already an incredibly lean program that has among the lowest improper payment rates of any federal health program, we should always be looking at ways to prevent any fraud, waste, or abuse in any federal program. The HHS Office of Inspector General has reported on improper payments, questionable care quality, and

fraud in the PCS program and I am particularly concerned by OIG's investigative advisory that highlighted stories of vulnerable patients who were neglected and even harmed by the PCS providers entrusted with their care.

So I am committed to working with my colleagues to address these issues and the root causes of fraud, waste, and abuse. However, any solution we consider to address the problems in the PCS program should be designed primarily to serve one constituency, and that is vulnerable Medicaid patients. We must root out fraud and abuse, but we should not use potential fraud and abuse as an excuse to harm the people these programs are intended to serve. In other words, the answer to Medicaid fraud is not to cut coverage or reduce benefits. The answer to beneficiary harm and neglect is not to institute work requirements and the answer to abusive providers is not to drug test low-income beneficiaries. Instead, we should be strengthening oversight so that bad actors are not allowed into the program, all beneficiaries get the care they need, and the American tax dollars are protected.

The PCS program is a great example of the type of crucial services that we should be protecting and strengthening. PCS attendants help patients with daily activities such as bathing and dressing which gives Medicaid patients more freedom and dignity by allowing them to stay in their homes. Medicaid is the majority payer of long term care services and supports for seniors

and individuals with disabilities and personal care services are a critical benefit for these populations.

The HHS OIG has done important work on this issue that has benefitted the committee's past bipartisan work and no doubt will continue to benefit this committee if given the proper resources and that is one of the many reasons why I'm so concerned about President Trump's budget blueprint which threatens to undermine the important work of agencies like the HHS OIG.

We will also hear from GAO about the challenges posed by various PCS program requirements across different states and how the states have not provided accurate data on the PCS program. Because Medicaid is a federal-state partnership, we need both CMS and the states to do their part in conducting oversight.

And finally, Mr. Chairman, I would like to thank the witnesses today for their commitment to strengthening the Medicaid program and serving its beneficiaries. Instead of rolling back the progress we've made, we must continue to find ways to improve oversight of these vital programs and I don't think anybody else wants my time, so I will yield back, Mr. Chairman.

Mr. Murphy. The gentleman yields back. So let's begin. I ask unanimous consent that the members' written opening statements be introduced into the record and without objection, the documents will be entered into the record.

I now would look to introduce our panel of federal witnesses for today's hearing. First, we welcome Ms. Christi Grimm, Chief

of Staff of the Department of Health and Human Services, Office of Inspector General. With nearly 2 decades of leadership and expertise in HHS programs, Ms. Grimm manages the operation and resources of the immediate Office of Inspector General and is responsible for effective execution of OIG priority initiatives advising on a wide variety of policy and operational matters.

Next, we welcome Ms. Katherine Iritani. Have I said that right? Good. Director of Healthcare Issues at the U.S. Government Accountability Office. In her 36-year career with GAO, Ms. Iritani has helped lead a wide variety of programs and evaluation assignments for Congress. In recent years, she has overseen Medicaid financing, payment, access, and long term care issues including program oversight issues contributing to Medicaid being designated as a high-risk program.

And last, we would like to welcome Mr. Timothy Hill, Deputy Director, for the Center for Medicaid and CHIP Services, CMCS, and then the Centers for Medicaid and Medicare Services at HHS. As Deputy Director at CMCS, Mr. Hill leads activities related to national Medicaid and CHIP policy and program operations and works closely with states in the implementation of their Medicaid and CHIP programs.

So I thank all the witnesses for being here today and providing testimony. We look forward to productive discussion on how we can strengthen and combat waste, fraud, and abuse reform in the PCS program.

As you are aware, the committee is holding an investigative hearing and when doing so has the practice has the practice of taking testimony under oath. Do any of you have objection to testifying under oath?

Seeing no objections, the chair then advises you that under the rules of the House and the rules of the committee, you are entitled to be advised by counsel. Do any of you desire to be advised by counsel during testimony today? And seeing none there, then will you please rise and raise your right hand. I will swear you in.

Do you swear the testimony you are about the give is the truth, the whole truth, and nothing but the truth?

[Witnesses sworn.]

Thank you, all of you are now sworn in under oath and subject to the penalties set forth in Title 18 Section 1001 of the United States Code.

We will have you each give a 5-minute summary of your written statement and we'll begin with Ms. Grimm, you are recognized.

STATEMENT OF CHRISTI GRIMM, CHIEF OF STAFF, OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES; KATHERINE IRITANI, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE; AND TIMOTHY HILL, DEPUTY DIRECTOR, MEDICAID AND CHIP SERVICES, CENTERS FOR MEDICARE AND MEDICAID SERVICES

STATEMENT OF CHRISTI GRIMM

Ms. Grimm. Good morning, Chairman Murphy, Ranking Member DeGette, and other distinguished members of the subcommittee. I am Christi Grimm, Chief of Staff of the Office of Inspector General for the U.S. Department of Health and Human Services.

Thank you for the opportunity to appear before you to discuss the importance of protecting Medicaid personal care services from fraud, waste, and abuse and protecting beneficiaries from abuse and neglect. The Personal Care program has been one of OIG's top management concerns for the past 8 years. My testimony today will highlight our work overseeing the Personal Care program and progress the Department has made in implementing our recommendations.

In the last 5 years, often with our state partners, OIG has opened more than 200 investigations involving fraud and patient harm in the Personal Care program. For example, as the chairman pointed out in his opening, in Pennsylvania, a personal care attendant who was hired to provide close supervision to a beneficiary lost her while shopping in a department store. The

attendant waited an hour before notifying the authorities. The beneficiary was found the next day dead from exposure to the cold. This harm is something no one should ever have to experience. Systemic problems must be rectified so that the federal and state governments can prevent similar tragedies.

In the past decade, OIG has issued more than 30 reports pertaining the Personal Care which recommended the recovery of almost $700 million. OIG's November 2012 Personal Care portfolio summarized the findings of OIG's body of work which found that Personal Care payments were often improper because the services did not comply with basic requirements.

OIG's October 2016 Investigative Advisory documented common fraud schemes including payments for services that were unnecessary or not provided and resulted in death, hospitalization, and less degrees of beneficiary harm. Collectively, our work demonstrates the persistent vulnerabilities in personal care that contribute to high improper payments, significant fraud, and that place vulnerable beneficiaries at risk. Bad actors are exploiting policy vulnerabilities and diverting Personal Care resources.

OIG's long history of oversight and enforcement has consistently demonstrated that basic pillars of program integrity prevention, detection, and enforcement are lacking in the Personal Care program. We must prevent bad actors from participating in our program; detect potential fraud, waste, and

abuse and beneficiary harm; and enforce the laws through federal and state investigations and prosecutions.

When these basic safeguards are in place, they have a dramatic effect on our ability to identify and stop fraud, waste, and abuse. For example, Alaska implemented a requirement that all Personal Care attendants enroll with the State Medicaid Agency. Attendant enrollment data helped Alaska detect potential patterns of fraud and help strengthen cases for prosecution. In 2 short years, that data helped Alaska to investigate and obtain 108 criminal convictions and recover $5.6 million.

CMS has concurred with our top recommendations for improving the Personal Care program. In 2016, CMS issued a request for information, guidance, and provided training to states and providers resulting in improvements to the Personal Care program. Notwithstanding this progress, much remains to be done. As of today, four OIG recommendations from the 2012 portfolio remain unimplemented.

First, CMS should establish minimum federal qualifications and screening standards for all personal care attendants.

Second, CMS should require states to enroll or register all personal care attendants and assign them unique identification numbers.

Third, CMS should require that Personal Care claims identify the dates of services and who provided those services.

Finally, CMS should consider whether additional controls are needed to ensure that Personal Care Services are allowed under program rules and are provided.

OIG work has demonstrated that Personal Care is subject to persistent fraud and beneficiary harm. CMS, in partnership with states, must implement basic safeguards to protect this critical benefit that allows millions of beneficiaries to remain in their homes and communities. Combating fraud and patient harm in Personal Care not only protects beneficiaries and programs, but also elevates the many honest, professional, and dedicated care attendants that enable beneficiaries to live independently.

Again, thank you for the opportunity to testify this morning. I am happy to answer any questions you have.

[The prepared statement of Ms. Grimm follows:]

**********INSERT 1**********

Mr. Murphy. Thank you, Ms. Grimm.

Ms. Iritani, you are recognized for 5 minutes.

STATEMENT OF KATHERINE M. IRITANI

Ms. Iritani. Chairman Murphy, Ranking Member DeGette, and members of the subcommittee, I am pleased to be here to discuss GAO's work on Medicaid for self-care services. The number of people receiving these services is significant and growing. Medicaid is the nation's primary payer of long-term services and support including those provided in homes and community settings.

Personal care services are critical to helping people age in place, maintain independence, and participate in community life to the fullest extent possible. These services are not without risk, both for beneficiary safety and for improper payments. Regarding safety, beneficiaries receiving these services include older adults and individuals with disabilities, some of whom could be vulnerable.

Regarding improper payments, personal care services are among the higher types of risk of being improper. When known, concern is with Medicaid being billed for care that was never provided to the beneficiary.

My testimony today is based on two recent GAO reports that examined federal requirements for programs providing personal care services and data available for oversight.

Now typically, I would start my statement with some key facts about these services such as the federal requirements in place to protect beneficiaries from harm and to ensure that services

billed to Medicaid were actually provided, and basic facts about these important services such as the number of beneficiaries receiving them in states and at what cost.

But as you'll hear today, these key points of fact are not easily laid out.

I have three key observations from our work. First, there are multiple different program authorities under which states can provide personal care services and Medicaid. Since the program's inception in 1965, states have been required to cover institutional, but not home and community-based care. Since 1975, several different options to provide home and community services have been provided to states. All states have adopted one or more different programs to varying degrees. How states screen, train, and monitor attendants and ensure billed services are provided varies, not only between states, but even within states by program.

A second key finding in our work, the federal requirements CMS has in place for oversight of beneficiaries' safety and provision of services vary significantly between the different types of programs. Approaches for measuring quality assurance, defining and monitoring critical incidents, screening attendants to ensure they are not bad actors and then ensuring billed services are provided can and do vary significantly between programs. These differing requirements result in uneven safeguards for beneficiaries, depending on the program they are enrolled in and

even assurances regarding oversight of billed services and complexities for states and others administering and overseeing services.

A third key finding of our work relates to the data CMS needs for oversight. Our work found that data available to CMS on the provision of and spending on personal care services are not always timely, complete, consistent, or accurate. For example, data lags caused by late submissions from states and other problems can mean CMS lacks good data for years on the services states have provided.

At the time of our work conducted in 2016 largely, the best available data were for 2012 and only available for 35 states that provided these services. For those 35 states where we had data, 15 percent amounting to nearly $5 billion in claims lacked provider identification numbers; 34 percent amounting to over $5 billion in claims lacked information on the quantity of services provided; and more than 400 different procedure codes were used by states to identify personal care services.

Without good data, CMS cannot effectively perform key management functions such as ensuring state claims are appropriate, ensuring appropriate federal matching, identifying program risks, and monitoring access and spending trends.

In recent years, Congress has directed HHS to improve coordination of home and community-based programs and Medicaid. CMS has taken steps to do so and more can be done. In view of

the growth and the demand for it and the cost of Medicaid home and community-based services and the importance of these services to the beneficiaries who rely on them, federal leadership to improve data and better harmonize requirements among different types of programs is needed.

Mr. Chairman, this concludes my statement. I'm happy to answer any questions.

[The prepared statement of Ms. Iritani follows:]

**********INSERT 2**********

Mr. Murphy. Thank you, Ms. Iritani.

Mr. Hill, you're recognized for 5 minutes.

STATEMENT OF TIMOTHY HILL

Mr. Hill. Thank you. Good morning, Chairman Murphy, Ranking Member DeGette, and members of the subcommittee. Thank you for the invitation and the opportunity to discuss personal care services in Medicaid.

Speaking as a career executive with over 25 years of experience to Medicare and Medicaid service, to Medicare and Medicaid beneficiaries, I can state with confidence that CMS shares your commitment to protecting beneficiaries and ensuring the taxpayer dollars are spent on legitimate items and services. This fiduciary commitment is the forefront of all of our activities. In that regard, we greatly appreciate the ongoing work done by the IG and the GAO to highlight potential vulnerabilities in these important programs and we rely on their recommendations to inform our program improvement activities across all our programs.

As you know, states are primarily responsible for day-to-day operation of the Medicaid program and for designing programs that best serve the needs of the beneficiaries in any particular state. While we at CMS have an important role to play in terms of providing overall guidance and direction, states are in charge of administering the Medicaid programs and have significant flexibility to choose options that enable them to deliver high quality, cost effective care for their residents.

Perhaps nowhere in the Medicaid program is that flexibility more important than in designing and administering home and community-based service programs including the provision of personal care services. Personal care services provide vital, person-centered care that allows individuals to remain in their homes or community instead of a nursing facility or other institution. In Medicaid, coverage of these important services is generally optional for states. However, because states see the value in these services, nearly all 50 states provide some level of coverage.

It's hard to overstate the ways in which maintaining home and community based service programs benefits both the communities and the beneficiaries they serve. These programs cost less for both states and beneficiaries. They empower patients to have more control over their daily lives and the management of their health and they provide essential and culturally appropriate support to patients and their families.

It's precisely because of the importance of these programs to Medicaid that it's paramount that we do all we can to protect these programs from fraud, waste, and abuse. Not solely to protect against financial losses, but as we've heard this morning, but more importantly to protect against abuse or neglect of vulnerable beneficiaries, many of whom are elderly or individuals with disabilities and may have no other practical alternative to institutionalization.

Even one case of fraud, abuse or neglect is too many. In our efforts to protect these programs and the beneficiaries they serve, we pursue a balanced approach that recognizes the unique needs of every state while preserving their flexibility to design programs that will best serve their residents, while at the same time analyzing when and where to use national standards or guidance.

We take a number of actions and we'll continue to help states safeguard their Medicaid beneficiaries and program resources by providing them with the tools they need to be successful. For example, to help states better understand requirements and share best practices, we publish guidance that highlights suggested approaches to strengthening and stabilizing the Medicaid home care workforce and other options to strengthen program integrity in Medicaid Personal Care Services programs.

We've provided training for state officials and other stakeholders creating space for them to collaborate, share best practices, while staff is simultaneously staying up to date on emerging program vulnerabilities.

CMS also uses focused program integrity reviews, assessing state program integrity effectiveness related to their administration of personal care services, providing states with feedback on vulnerabilities and possible corrective actions.

This year, we plan to conduct focused reviews on PCS in five additional states.

We also use our Medicaid Integrity Resources to work collaborative with states to identify improper payments through review of claims. Using these resources, we've conducted over 40 audits on personal care services in 8 states. In one recent audit of PCS services in one state resulted in over $500,000 being returned to the Treasury.

Even as we continue to work with states to help them implement their programs, we are interested in understanding what changes need to be made at the federal level. That is why last November, we published a request for information to gather stakeholder feedback on a provision of HCBS services. We are particularly interested in the benefits and consequences of implementing standard federal requirements for personal care services and what these standards could include and how they could be developed.

We're reviewing the comments we received to inform our approach to supporting states and their program integrity efforts in a way that maximizes state flexibility while protecting personal care service programs and beneficiaries from fraud, waste, and abuse.

As we continue our efforts for PCS, we must also work to ensure that any additional oversight requirements do not create administrative burden, increase costs or impact beneficiary choice or control. The successful delivery of PCS in Medicaid ensure that both individual needs and preferences are met and that the program has adequate safeguards in place.

We look forward to continuing our work with states, our oversight partners, and other stakeholders. This concludes my statement. I'm happy to take any questions.

[The prepared statement of Mr. Hill follows:]

**********INSERT 3**********

Mr. Murphy. Thank you, Mr. Hill. I'll recognize myself for 5 minutes. First of all, Ms. Grimm, Ms. Iritani, I want to commend you and your offices. It doesn't happen a lot in Congress, but in terms of a branch of the Federal Government that do their job, we thank you for doing that. We are absolutely indebted to you for these discoveries and there's a real trust we have in this committee for the work you do. So please pass that compliment on to your other workers as well.

That being the case, it bothers us about the stories you're telling us, the fraud and abuse and how it really hurts the beneficiaries, the elderly and disabled individuals.

And there's certain elements of this, Ms. Grimm, that you talked about, the PCS that make it more susceptible to fraud for the vulnerable. You mentioned in some of your testimony some of the stories that beneficiaries often feel reliant on -- or loyal to their attendant. It sort of reminds you of the Stockholm Syndrome here. But even if that attendant is committing fraud or abuse and harm, so why is that and what is in the system inherent in that that leads to that and of course, how do we change it?

Ms. Grimm. Thank you for your question. I think inherent to personal care services is sort of the intimate nature of those services, going into beneficiaries' homes and providing services like bathing, dressing, light housekeeping, food preparation. And in many of those instances, as you point out, the beneficiary becomes very reliant on those services and in their mind,

services, even if they're sub-optimal are better than no services and we have found apprehension on having fraud and abuse reported by beneficiaries. Often referrals come to us from families or loved ones that are witnessing neglect.

Mr. Murphy. Are there threats made, subtle threats in terms of that sometimes occurs under these circumstances?

Ms. Grimm. I'm not aware of a specific instance where the beneficiary was told they could not report, but we certainly have plenty of examples of harm that's resulted from fraud.

Mr. Murphy. And I'm wondering in these cases, too, at times maybe a family puts up a hidden camera in the home, too, and also records events. Have those occurred? Have you seen anything like that?

Ms. Grimm. Hidden cameras in beneficiaries --

Mr. Murphy. Families many times do that with their babysitters, too, that may actually record some instances where a PCS worker was causing some problems. Have you seen any instances of that yet?

Ms. Grimm. I don't have any instances of that, but we do have examples of family members that are perpetrating the harm and neglect with the beneficiary, so even in those scenarios where it's self-directed PCS, we are still seeing instances of family members committing that harm.

Mr. Murphy. So given all of these stories and the heart-breaking nature of them, if you could choose a

recommendation you think would make the biggest impact, what would it be?

Ms. Grimm. We want to know who we're doing business with at the attendant level. So the number one recommendation that I would put forward is that you enroll and register attendants and make sure that those identifiers are on claim.

Mr. Murphy. And background checks, full background checks on them, too?

Ms. Grimm. We do recommend background checks. Many of the instances that we included in our investigative advisory would have revealed a history of criminal conduct including drug diversion.

Mr. Murphy. And what other kinds of backgrounds would be in this besides drugs? Felonies, burglaries?

Ms. Grimm. We do have another example of a case in Illinois where a nurse had lost her licensure because she was stealing drugs from her employer. And in that instance, she was excluded from all federal healthcare programs and a check, like we recommend for other programs and looking at the exclusions list, would have revealed that.

Mr. Murphy. Okay, thank you. Ms. Iritani, what impact does CMS have? How is it, in fact, not getting data on time? You made references to this data. How does this affect the oversight ability for CMS on PCS workers?

Ms. Iritani. Data is critically important to really

overseeing the program. CMS needs data to ensure that payments are appropriate and to assess trends and to ensure that the federal matching is appropriate for what states are claiming from the federal government in terms of provided services.

Mr. Murphy. Thank you. And Mr. Hill, given the kind of things here, what steps do you see moving forward that you could use to improve this whole process?

Mr. Hill. So I think I would focus on two areas that have been highlighted. First, on the policy side and the recommendations with respect to standards. We've talked to the IG. We issued our RFI last year. For us, it's a balance, right, so every state is a little different. The requirements in one state may not be the requirements we want to have in every state, so we're anxious to continue our analysis there to determine whether or not we should be putting more requirements on states that internally have their own set of standards or whether we should be doing that nationally at the federal level.

Second, and I couldn't agree more, I think, with our colleague from the GAO that the dearth of data in the Medicaid program is a problem. We've done a lot over the last year to get data in in a much more timely way in a way that will let us do analysis, not only for our own selves, but also to give information back to the states about how their programs are operating and so continuing our effort to get data in to make that data timely and accurate I think is very important.

Mr. Murphy. Thank you. I'm out of time. Ms. DeGette, you're recognized for 5 minutes.

Ms. DeGette. Thank you, Mr. Chairman. I'm gratified to hear that members on both sides of the aisle recognize the importance of the Personal Care Services program to Medicaid beneficiaries and also the potential cost savings that we can get. But I do think that we can work together to address where controls need to be improved.

A little note, one of the many little known provisions in 21st Century Cures which, of course, this entire committee worked together on, required an electronic visit verification system for personal healthcare services and home healthcare services under Medicaid. What this requirement said is by 2019 all personal care visits have to be electronically verifiable and that standard background information would be collected on every claim which I think would help. That would be a help.

I just want to ask the panel some of the questions about the scope of the Personal Care Services program and what we can do.

Mr. Hill, you heard Ms. Grimm talk about some of these services, particularly to the elderly who can stay in their homes. I think we all agree this program can be very beneficial to people like that, is that right?

Mr. Hill. It's incredibly beneficial. For every example and every conversation we have with the IG about abuse and the horrible things that are going on, I think there's also as

unreported sort of hundreds of examples of folks who are now living in their home, in their community with attendants and workers who make their lives fulfilling in a way that would not be if they were in an institution, people who have suffered broken limbs, broken back or where they have intellectual disabilities or any number of medical conditions that normally keep them in an institution are keeping them in their communities.

Ms. DeGette. And not only that, but it also is more cost effective than putting them in nursing homes, is that correct?

Mr. Hill. Absolutely, even as the GAO has noted, the highest spending state for PCS is close to $30,000 per beneficiary. Nursing homes are easily three to four times that amount.

Ms. DeGette. Thank you. Now Ms. Iritani, I think you testified to this, your January 2017 audit found that the CMS data is of limited value for oversight purposes because it's often not timely and it's inconsistent across state lines and has errors. Is that correct?

Ms. Iritani. That's correct.

Ms. DeGette. And also, this is important. Although there are problems with the quality of data, it doesn't necessarily mean there's widespread fraud in the program, is that right?

Ms. Iritani. That's correct.

Ms. DeGette. And so why do you think the states are having such a hard time providing accurate and timely data to the CMS?

Ms. Iritani. There are a host of different reasons and we

didn't look at that specifically. We have on-going work actually looking at challenges that states are having with implementing T-MSIS, the utilization claims system. More work needs to be done. But some of the things that we are aware of in terms of some reasons states haven't submitted is related to new systems that they're putting in, maybe to comply with T-MSIS and other reasons.

Ms. DeGette. Don't you think it would be a good idea to work with the states so that we can get the data that we need because we can't really even begin to get our arms around the extent of the problem until we have that data?

Ms. Iritani. Yes.

Ms. DeGette. Can anybody testify what efforts we're making to standardize and to get that data? Mr. Hill?

Mr. Hill. I'll speak briefly on where we are with the data collection. As GAO has pointed out, historically, the Medicaid data that we've gotten into CMCS has not been timely. It's not been accurate. Beginning 4 years ago, we began implementing a transformed system, a new system to collect use data, utilization data, claims data from states in a much more timely and standard format. We now have requirements in terms of what data the states have to submit, how it has to be submitted and the timeliness of that.

We now have 35 states representing more than 60 percent of the beneficiaries and expenditures in the country reporting data

into that system. We're beginning to share that data with our partners to do quality assessment and be sure that it's useable and it has fixed a lot of the vulnerabilities that have been identified by the GAO and are hoping, we, CMS, will be ready to accept data from all states by the end of the summer.

Ms. DeGette. Great. Let me stop you there because I'm out of time.

Mr. Hill. Yes.

Ms. DeGette. Let me just say I think this would be a perfect hearing for the fall, Mr. Chairman, to bring the states in to talk about are they complying with that deadline of this summer and to see what else they need.

Mr. Murphy. Right, and we also had that briefing before that most states are not even getting data.

Ms. DeGette. Right.

Mr. Murphy. So we're kind of flying blind. So appreciate it.

Ms. DeGette. Okay, thanks. I yield back.

Mr. Murphy. I recognize the chairman of the committee for 5 minutes.

The Chairman. Thank you, Mr. Chairman. Ms. Iritani, in your report on PCS data, you were only able to analyze 35 states because 15 had not reported the data yet, as you all are having this discussion from 2012. So you conducted this audit from July 2015 to January of 2017 and as of then, 35 of 50 states had enough

data from 2012 to analyze, correct?

Ms. Iritani. Correct.

The Chairman. Why were the data so late? Is this a common problem? Once it gets there, it just seems like it can take several years for CMS to process it and why is that?

Ms. Iritani. And I think there are two issues. One is that states submit data late and it could be because they are largely managed care and managed care plans may submit data late or it may not submit data at all.

The other problem is that when the data comes in, it is not good and so CMS needs to go through a lengthy validation process which is part of why we only had data for 35 states several years later is that the data had not been validated for those other states.

The Chairman. Makes is it pretty hard to do appropriate oversight and reconciliation and everything else then?

Ms. Iritani. Yes.

The Chairman. Mr. Hill, GAO's January 2017 report raised concerns about these processing times. What's the average time it takes to process 1 year's worth of data if there is such a thing as an average time?

Mr. Hill. Right, so as identified, the data that the GAO looked at in the system that they were looking at was the system that is prior to the one we're using now. So for a state, for example, that's what we call live, submitting data into our

system. For the 35 that I've identified that are processing, we have up-to-date data within a month current to the year, right, so if it's March and they submitted the data on the 1st of -- from January and it's consistent, current for January.

The Chairman. All right.

Mr. Hill. Now as I said, we've built in a lot of the front-end control to be sure that we don't have to take as long as we were taking in the prior system to do the quality check. Those quality checks are built in upfront. So we're confident and hopeful, I should say, and confident that this new system will both provide data much more timely, much more consistently, and in a way that will allow us to do the analysis and the oversight in a way that we could not.

The Chairman. Okay. Ms. Iritani, a question back to your comment about the managed care plans, could the states or the Federal Government make a condition of the contract with the managed care plans that they have to submit data on a regular basis in a format that works for the expedited review and do we do that?

Ms. Iritani. Yes, they are required to. It's more a question of enforcement.

The Chairman. What's the penalty if they don't?

Ms. Iritani. I think that will depend on the contract that the states have put in place with the managed care organization.

The Chairman. And we could probably weigh in on that contract requirement since we're a partner in this process?

Ms. Iritani. That would be a policy decision.

The Chairman. Yes. Okay. Ms. Grimm, I understand a beneficiary in Pennsylvania died of exposure to the cold while under the care of a PCS attendant according to some of the reports. In another case, a hot July day, a PCS attendant in Maryland left a beneficiary with developmental disabilities in a locked car while shopping with a companion.

What's the most important thing CMS can do to prevent beneficiaries from being subject to neglect and abuse by PCS attendants?

Ms. Grimm. Move to require states to enroll or register a care attendant so that we're able to keep track of what's happening at that attendant level.

The Chairman. Okay, and what reaction, if you get any, from the states when this is suggested?

Ms. Grimm. We have a report coming out at the end of the summer that provides survey data from the Medicaid Fraud Control Unit Directors on the recommendations that we have put forward, also fraud trends related to personal care. We know that that group very much endorses the recommendation that we've put forward related to enrollment and registry. And the report will also have some other solutions states have explored.

The Chairman. Okay, perfect. How do you investigate fraud when it involves beneficiaries' family members because we understand that's a problem, too?

Ms. Grimm. One thing that I think this committee could also do is to give our Medicaid Fraud Control Units the authority to investigate stand-alone harm in patients' homes. They currently only have the authority to investigate when it's associated with billing fraud. So it does become challenging to investigate harm when it is not linked to some of those other billing issues.

The Chairman. My time has expired. Thank you again for the good work that you are doing and your counsel to us. We appreciate it.

Mr. Chairman, I yield back.

Mr. Murphy. All right, I now recognize Mr. Tonko for 5 minutes.

Ms. Iritani.

Mr. Tonko. Thank you, Mr. Chair. It's good to see CMS here today to talk about improvements that CMS can make and should make to this program. But let's not forget that the Medicaid program and PCS, in particular, is a partnership between the Federal Government and the states. States are given flexibility to design their given programs to fit the needs of their populations, but in exchange they have to do their part to ensure the integrity of the programs.

States are the first line of defense in protecting federal and state Medicaid dollars. So with that being said, Mr. Hill, in your testimony you stated and I quote, "Both the Federal Government and states have key roles as stewards of the program."

So is it accurate to state that CMS cannot perform effective oversight without cooperative state partnerships?

Mr. Hill. I think oversight is always more effective when there's cooperation between us and the states. We have our role. The state has their role. Sometimes there will be tension, right, between what we view as a direction the state needs to be or whether or not they're in compliance with federal rules. But we always prefer to be working particularly on issues beneficiary harm and abuse, working hand in glove to make sure that we mitigate those.

Mr. Tonko. So what does CMS need from the states to improve this whole outcome?

Mr. Hill. As I've indicated earlier I think in any oversight context, the more data we have and the better data we have with states and states being up to date with submitting that data is going to give everybody a leg up in terms of understanding what our problems are and how we meet those gaps. Beyond that, I think states as identified by the IG, each have their own requirements for how they oversee and maintain the integrity, in particular, of personal care attendants and how those services are being delivered. And we need to make sure that states are following through and enforcing those individual state compliance, right?

We don't have the resources, nor is it our job, to on a day-to-day basis be monitoring claims and understanding how the benefits are being delivered in any particular state. So the state really needs to be in a position to step up and be doing

that work on behalf of those beneficiaries.

Mr. Tonko. Thank you. And Ms. Iritani, would you agree that the responsibility for program integrity falls on both CMS and the state Medicaid programs?

Ms. Iritani. Yes.

Mr. Tonko. So the OIG has done a lot of excellent work looking at different state programs and pointing out vulnerabilities and short comings. I understand that OIG's audits of some states have found problems with PCS claims such as providers claiming more hours than were recorded. And again, that being said, Ms. Grimm, it seems clear that states need to make improvements. Do you believe that the provision passed by the last Congress which does require states to ensure PCS visits are electronically verified will help address some of the issues that have been raised by the OIG?

Ms. Grimm. Thank you for that question. We very much appreciate some of the protections and collection of data that's offered by that provision in 21st Century Cures. We know that that does not currently include managed care and with the high percentage of services in Medicaid being provided through a managed care model it definitely does not serve, wrap around those services, but it is a terrific step forward and it does collect some of the information that would allow our criminal investigators to detect potential patterns of fraud. Yes.

Mr. Tonko. Thank you. And what additional resources do

states need in order to conduct better oversight of the PCS programs?

Ms. Grimm. I think having uniformity in the kinds of standards that are required, the qualifications, some for requirements for the care attendants upon which states can build and customize according to the special needs of those states. I think that would better put states in a good position to make sure care being rendered to their beneficiaries is of a high quality.

Mr. Tonko. Thank you. And Mr. Hill, what steps is CMS taking to encourage or require states to do more in this area?

Mr. Hill. So we've taken a number of steps in terms of working with states on education, giving them best practices and feedback about program integrity, methods and standards, be it through review of claims, how to put edits in place to review claims for high dollar or unsubstantiated services, helping them think about putting together registries or enrollments for PCS attendants. But beyond that, we're also working with states to provide direct training. We have a facility where we can bring states in and bring our law enforcement partners in to do hands-on work to understand better how to do investigations around PCS types of work and what kind of policies to put in place to prevent those types of abuses from occurring.

And finally, we're doing our own work to understand whether or not more federal requirements are needed beyond just requiring states to have their own internal policies, particularly around

enrollment of attendants should there be a federal standard, should we have nationwide standards for how these attendants ought to be monitored and overseen.

Mr. Tonko. And that training is up and running now?

Mr. Hill. Yes, we had training back in February. We had 36 states, a number of our partners from law enforcement and the oversight community, and we'll continue to do that.

Mr. Tonko. Thank you very much, Mr. Chair. I yield back.

Mr. Murphy. Thank you, Vice Chairman, Mr. Griffith is recognized for 5 minutes.

Mr. Griffith. Thank you very much. Ms. Iritani, it's my understanding that states can receive more federal money in the form of a higher match for some activities related to collection and compliance with federal reporting requirements. Am I correct in that?

Ms. Iritani. Yes, that's correct.

Mr. Griffith. And so you're having difficulty getting states to get some of the reporting and so forth. And I'm going to switch gears in a minute on that. But do you have a stick? You've got the carrot. Do you have a stick that they might receive a lower match if you they're not collecting some of the data that you want?

Ms. Iritani. CMS does have authority to reduce the federal matching for system areas that are experiencing problems from a 75 match to a 50 percent match.

Mr. Griffith. Now let me switch gears a little bit because I am worried about the states and I think that some of the resistance from the states may come from a fear that they'll chase some folks out of this industry, particularly when you're dealing with family members and we all want to stop the abuse, but when you're talking about family members I heard, I believe it was you who earlier said that some state had 400 different codes and so it was hard to get the coding straight. And I can see a family member who is trying to take care of their loved one is receiving some monies for bathing or doing some daily activity where the mom or the dad of theirs needs help and then they're faced with having to learn 400 codes. So I think if we're going to do something, we have to make it simple. Would you not agree?

Ms. Iritani. Yes, we would agree with the harmonization of requirements. The 400 codes was actually at the federal level in terms of how PCS was coming in in terms of the coding.

Mr. Griffith. So if we're going to require electronic verification which I think is fine as long as it can be done on the phone because most people will have their electronic phones with them, their little gaskets, and this is where tele stuff can be of great help, technology can be of great help to us, but it needs to be simplified because you're going to have a hard time -- if you're just a 50 some or 60 some year old child trying to do the best you can for your parents because Mr. Hill, you did point out earlier, we see in the news all the horror cases. What

we don't see are the thousands of people, whether they be the professionals who are coming in or the agencies that are sending people in or whether it's a family member, where that person's life is greatly enhanced by having a PCS individual helping them out through one of these programs and I get that.

It also raises some concerns for me that not only do we have to simplify it, but we have to be careful because there's a difference between somebody who's working for an agency that sends in folks and that family member. Because while we want family members monitored to a certain degree, I'm not sure we want to create a whole new bureaucracy to monitor them. We have the Department of Social Services, at least in the Commonwealth of Virginia that already is aware of that and if something is going on a neighbor can report and they go out just like they would with a child, for child abuse, and look for that.

Then we also have this whole thing where everybody is like let's do background checks. The question is if we're going to do background checks and I'm not against that, but we need to make sure that we're not throwing the baby out with the bath water. Because absolutely, if you've got a history of child abuse or spousal abuse or abuse of a parent, even if you're a family member, you ought not be involved. But a theft -- I was a criminal defense attorney, by the way, for 28 years -- so a theft of four tires off of an automobile when you're 18, it's a theft, Mr. Chairman raised that issue and he was right to do so. It's a theft. It

may want to be something that you take a look at, but I'd had to see a son who's now in his 40s or 50s being precluded because he came back with a felony conviction 20 some years ago on stealing tires or doing something that when you look at the facts it's a whole different case than just running it through.

And the problem is when government gets a hold of a criminal background check, oftentimes they come up with hard and fast rules. If you've been convicted of X, you can't be involved. And I think we need to set that bar fairly high. I'm not sure it shouldn't be our responsibility. What do you all have to say about that?

Go ahead, Ms. Grimm. I think you're the right person to start on that.

Ms. Grimm. Okay, I very much appreciate the question and that context absolutely matters. We believe that those background checks can reveal information that consumers can use and their family members can use to make informed decisions about the care that's provided.

Mr. Griffith. Okay, so you would look for if we were going to craft some language along those lines to say have the background check done, but then it would be the family members who would decide or it would be forwarded to Department of Social Services, something along those lines? Would that be your proposal?

Ms. Grimm. I think we would want there to be guidance to be accompanying the types of convictions and histories that are

revealed through those background checks, but we have not gone forward with a recommendation that says this specific kind of crime should preclude them from providing personal care. CMS can provide some exemptions and we've had those conversations with CMS.

Mr. Griffith. And if you all decide to go with guidance, I'm happy to assist in any way I can to have you come up with ways that you may be able to ferret out the bad actors without throwing out the folks who might have made a mistake at one point in time. Likewise, maybe you all can help us come up with the proper guidelines to put into the legislation that would give you that authority.

With that, Mr. Chairman, I yield back.

Mr. Murphy. I recognize the gentleman from California, Dr. Ruiz, for 5 minutes.

Mr. Ruiz. Thank you very much, Mr. Chairman. I think everyone can agree that we must do all that we can to maintain program integrity in the Medicaid Personal Care Services program and continue to work to eliminate fraud and abuse and we must continue to identify common sense improvements to this program such as better data collection and federal baseline standards, but we must do so by maintaining patient access to this critical program that allows individuals to remain at home and live independently when they might otherwise be forced to move to a nursing home or assistive living facility.

Data collection is integral in evidence-based policy development. And I think many of you had mentioned that there are some exciting opportunities here and if we don't use data, then we're at the whims of ideological partisanship that then kind of makes the wrong decision, contrary to what's best for the patient and for the American people.

One of the problems we've seen regarding this program integrity in the Personal Care Services program is inadequate data. A GAO report stated that CMS is developing an enhanced Medicaid claims data system known as the Transformed Medicaid Statistical Information System pronounced as T-MSIS, right? Under T-MSIS, states will be expected to report claims data that are more timely and more complete.

Mr. Hill, it's clear that T-MSIS is a critical tool to ensure timely, accurate, and complete data from states and it is my understanding states have been working for years to implement the new system. What steps has CMS taken to complete T-MSIS this year?

Mr. Hill. So this year, we've actually had a good year this year. As I mentioned earlier, we've now got 35 states reporting and I think most of them are current with their data reporting. We're working with the remainder of the states to meet them where they are, to make sure that they have everything they need in place to begin reporting and will be ready to take their data by the end of the summer. Whether they can meet that deadline or not

is something we'll continue to work with them on.

Mr. Ruiz. How many states? What's the percentage? And what year do you think we'll have everybody on board?

Mr. Hill. I'm hopeful that by the end of this year we can have all states in. Now again, that all depends on whether states are going to be able to internally meet their own deadlines. As you know, Medicaid is incredibly complex at the state level and they're integrating state data from many state systems. And so it's a challenge for them to be able to put it into a common core.

Mr. Ruiz. So what additional claims information will be included under T-MSIS and how will this improve the integrity of the Medicaid claims data?

Mr. Hill. I think the single biggest piece of information that we'll have out of -- and this is where -- it's hard to know when you're supposed to correct a congressman, but it's T-MSIS.

Mr. Ruiz. T-MSIS.

Mr. Hill. When we have the T-MSIS data in, particularly data around providers, right, so there's just a statutory requirement now to be providing, referring, and ordering information on a claim so we'll know who referred, who ordered a service and we'll know more information about the providers that are submitting claims. Under the old prior information, we didn't have that enrollment information and we didn't have the ordering and referring information from providers.

Mr. Ruiz. Ms. Iritani, how will any further delay impact

the integrity of the Medicaid claims data in the near future?

Ms. Iritani. Significantly. Reliable data is really important for overseeing improper payments and other functions and we have recommendations to CMS on personal care services in particular that CMS should issue guidance that is standard on reporting of personal care services.

And with regard to T-MSIS, should really prioritize the data that CMS needs for oversight.

Mr. Ruiz. So I understand that while there are reported benefits of implementing T-MSIS, it is not a cure all, correct?

Ms. Iritani. Correct.

Mr. Ruiz. For example, in your report, you stated that CMS will need to develop plans for how it can be used for oversight. Can you give me some examples of how that can be used for oversight?

Ms. Iritani. Well, ensuring, for example, that the federal matching for what states are claiming as expenditures is appropriate. Our work found, for example, that 17 percent of the expenditure line reporting for personal care services was incorrect.

Mr. Ruiz. Would you say this is the number one most impactful way to start providing oversight for potential fraud and abuse is if we were to focus on one thing would it be the data collection system, Mr. Hill?

Mr. Hill. For me, I mean we are focusing on it now and it continues to be a priority. You can't run a program of the size

and scope of Medicaid without good, accurate data.

Mr. Ruiz. So what do you need to finish this in a timely manner?

Mr. Hill. We need the continued cooperation of states to get their data in and to do the work they need to do to get the data in a timely way and we have that and we'll continue to work with them.

Mr. Ruiz. Thank you very much.

Mr. Murphy. Mr. Collins, you're recognized for 5 minutes.

Mr. Collins. Thank you, Mr. Chairman. I want to thank the witnesses also.

Now I'm a private-sector guy. I spent 30 years in the private sector and at one point I also was the county executive of the largest upstate county in New York. It was bankrupt. I'm a Lean Six Sigma guy. I brought Lean Six Sigma into a large municipal government for the first time in the United States about 8 years ago. And it worked. But we also had a program called Just Do It. We would put together a team of a lot of different commissioners and we'd deep dive some issue that touched on a lot of different departments and it would take us 6 months. And then every once in a while we'd come up with what we'd called the Just Do It. It was so obvious, so direct. We knew the problem. We really knew 90 percent of the solution. We said why are we going to waste our time with this 6 months' program. Let's just do it.

And kind of sort of what I'm hearing today is a lot of just

do it. So what am I missing here? The Federal Government sends money out to the states. In the case of New York, our program is $60 billion a year. So with 6 percent of the nation's population, we spend 12 percent of the nation's Medicaid money and it just keeps flowing.

In the private sector, if I have a vendor and he sends me an invoice and he doesn't have the proper numbers on it, I don't pay it. If he sends me an invoice and whatever requirements that I've had aren't there, I don't pay it. So here's my just do it.

Now no disrespect intended, but why are we wasting our time analyzing 2012 data? It's worthless. Completely, utterly worthless. There's nothing to compare 2012 to 2017. If we've got a bunch of people crunching 2012 data, if I'm Tom Price or Seema Verma, I'd go what? Are you joking me?

So if we've got the power of the purse strings, why don't we just stop paying people, sending money to states who don't adhere by our responsibilities? The requirements. Why don't we? Why don't we?

Okay, there's my just do it. I call you and I say we're just going to do it. No money goes out without the data in a timely fashion. Thirty-five states, well, 15 states just wouldn't be getting any more money. If you start cutting off the flow of cash, you will get their attention and you will get your data. You'll get your data in a timely fashion. And if you have -- I'm just somewhat dumbfounded by this. The solution is staring us

in the face and we're sitting here talking about something. I don't get it. What am I missing?

Ms. Iritani. Well, we agree that CMS needs to take immediate steps to --

Mr. Collins. So why don't we do it? Do it today. Is there a reason? We can do it today.

Ms. Iritani. To improve the data, yes.

Mr. Collins. Today.

Ms. Iritani. And to issue guidance to states on standard elements that they should be reporting.

Mr. Collins. Require that the attendants register. And if there's not a number, they don't get their money.

Ms. Iritani. There has been a longstanding and also interest in making sure that there is access to services.

Mr. Collins. We do. But money talks.

Ms. Iritani. Yes.

Mr. Collins. The minute you cut off the funds, I mean that's what I find. When we talk about waste, fraud, and abuse and we find that the Federal Government is sending this money out and then we're finding out after the fact through data that's 5 years old when in the case of 15 states they don't submit data, you know where the problem lies, in CMS, for sending the money out, for approving the voucher. Don't we have to approve payments?

Mr. Hill. So a couple of issues to unpack there and I think it's a fair comment and it's a true comment that the money speaks.

Right? And if we withhold funds, states are definitely going to get somebody's attention much quicker than other corrective actions. I think for us to consider, as we talk to states and try to -- particularly on their compliance issues, not so much now talking about program abuse of providers, billing inappropriate.

Let's talk about states meeting our requirements, for example, for submitting data. We try very hard, recognizing it's a complex system to get states to get into compliance in a way short of having to withhold the funds. It's sort of nuclear, right, to say we're immediately going to go to withholding funds from the State of New York or any other particular state without first going through as much as we can with the state to be sure they've got all the TA, all the information they need, all the help they can get from us to get into compliance. If after that, they still are unwilling or unable to come into compliance, then the purse strings is definitely the place that we go to sort of make sure that we have their attention.

Mr. Collins. And I do agree. You want to give somebody at least a glide path, 3 months, even 6 months, but to hear that we're analyzing 2012 data, I mean what a tragic waste of time. 2012 doesn't tell you anything about 2016, '17. I mean truly not to be insulting here, I think we could get there very quickly. I'm certainly hoping that Tom Price and Seema Verma get there quickly and this has been kind of eye opening again in a frustrating way.

Thank you, Mr. Chairman. I yield back.

Mr. Murphy. Thank you. I now recognize the gentlewoman from Illinois, Ms. Schakowsky from Illinois.

Ms. Schakowsky. I want to thank all of our witnesses. First of all, care services are incredibly important and I really want to emphasize that, even as we try and make it better, I hope all of us are really committed to making sure that those services are provided.

In Illinois, we have the Community Care program which is one of the home and community-based care services provided by the Medicaid benefit, to Medicaid beneficiaries and provides services to about 84,000 individuals.

We also know that these are the very programs that often are slated for huge cuts. In Illinois, unfortunately, we haven't had a budget for 2 years and Governor Bruce Rauner proposed cutting $200 million from the Community Care Program in his budget proposal which is one of the many reasons Illinois hasn't had a budget.

In addition to funding for those programs, a high quality personal care workforce is absolutely critical to ensuring that beneficiaries have access to the services they need. As GAO has reported, many of the personal care service programs differ from state to state. We know that. And that includes the training or lack thereof that service agencies provide to the workforce. In some states, training is offered or required, either for new

entrants into the workforce or for continuing education of existing workers. In other states, there's actually little or no guidance on training or continuing education for those workers.

Mr. Hill, let me ask you, have you investigated what percentage of agencies providing personal care services in Medicaid have orientation or training programs that are in place?

Mr. Hill. So as I sit here, I couldn't give you statistics by state where those requirements lie, which states require that and which particular agency.

Ms. Schakowsky. Let me ask Ms. Iritani, do you know that or either one of you know that?

Ms. Iritani. We know that it varies, yes.

Ms. Schakowsky. Okay. But you don't know.

Ms. Iritani. No.

Ms. Grimm. An analysis that we did in 2010, we did find 301 sets of qualifications across states.

Ms. Schakowsky. Okay, and that would include the kind of orientation and training programs?

Ms. Grimm. It would include that in the qualifications.

Ms. Schakowsky. Back to Mr. Hill. Do you know what percentage, or any of you, know what percentage of those specifically educate their employees and what constitutes waste, fraud, or program abuse?

Mr. Hill. What we -- as I indicated earlier in response to a question, we have issued guidance to states on best practices.

While I can't say which states require it as I sit here, I could not tell you which states require that level of training. We have identified for states that training particularly around compliance issues is the best practice for attendees. And we would expect that states would require that of particularly the attendant agencies to be sure that the folks that are coming into those agencies are properly trained, not just for patient safeguards, but also on the compliance side.

Ms. Schakowsky. Well, what it seems to me is that the word has gone out that this would be important, but nothing has been done really to enforce that or to even survey that to find out who's doing exactly what when it comes to worker training.

Finally, I just want to note that when a worker comes forward to report cases of waste, fraud, or neglect on behalf of the personal care agency they work for, I really think that it's critical that they are provided whistleblower protections.

And again, to any of you, I'm just wondering if whistleblower protections are built in.

Mr. Hill. I mean I would -- speaking for CMS and I'm sure the IG and others would have it, we review tips, whistleblower complaints as valuable sources of information as we conduct investigations in concert with our law enforcement partners. I think the whistleblower protections vary by state in state law and that's something that we value those sorts of activities highly and it's something that we would encourage states to

continue to support.

Ms. Schakowsky. Well, again, are they protected by law if they were to come forward?

Mr. Hill. On the whistleblower side, I think it's a state-by-state determination as to how the state whistleblower laws apply.

Ms. Schakowsky. Well, then let me just say I think we need to standardize that because one of the ways that I think that we can make the program operate effectively without waste, fraud, and abuse is to protect the out front, the upfront workers that are doing it because they are the most likely to see it.

In my experience with those home care workers is that these are really dedicated people who are doing often for very little money some of the most important work in our country and I yield back.

Mr. Murphy. Thank you. I now recognize Mr. Walberg for 5 minutes.

Mr. Walberg. Thank you, Mr. Chairman. Thanks to the panel. My wife and I were extremely concerned when a personal care worker stole a credit card from my mother and that was a deal from that point on dealing with the bank and then dealing with the court system. But I was disturbed, as I read the released investigative advisory coming from OIG, that there are significant number of instances where PCS workers steal painkillers and other medications from their beneficiaries.

In the case, Ms. Grimm, that you noted in 2016 in Vermont specifically, how did OIG discover that?

Ms. Grimm. So Vermont, that involved the husband. It was a wife, the beneficiary was a husband and the wife was splitting payments with the care attendant and as part of that scenario she would get or he would get pain pills as a form of payment. I don't know how that came into our office, but that was the scenario that was uncovered.

Again, going back to some of the recommendations that we've offered, had there been a background check in place, it would have revealed a pattern of drug abuse.

Mr. Walberg. How often is this happening? Is this a common occurrence that you're finding?

Ms. Grimm. I think fraud is very common in personal care. We've opened 200 investigations since 2012 and our Medicaid Fraud Control Units, it comprises one third of their criminal convictions and have upward of 8,000 cases that have been opened in that time frame.

Mr. Walberg. Are the painkillers that are stolen generally used by the individual themself or are they selling this?

Ms. Grimm. We've seen patterns of both of them using painkillers for themselves and then also selling those. Drug diversion is a big issue in the fraud that we see.

Mr. Walberg. Yes, and that's a concern when we see about the opioid problems, etcetera. The OIG recommended establishing

some minimum federal qualifications and screening standards for PCS workers. What kind of minimum qualifications do you have in mind?

Ms. Grimm. We have recommended minimum age requirements, background checks, and we endorse training. Just to sort of de-mystify things, all of those things right now are voluntary. They're not something that's required at the federal level, so to the extent that it's happening, it's the state sort of acting on it. It is not currently required at the federal level.

Mr. Walberg. With the screening and the background checks, it makes sense to prohibit individuals with felony convictions for drug-related crimes and social services fraud. Is that part of your recommendation?

Ms. Grimm. We have not specified, but there are guidelines in place for care workers that have direct interaction with patients in the home health context. And I think some good parameters could be taken from that context.

Mr. Walberg. Okay. It seems like that would make sense.

Mr. Hill, is CMS able to enact stricter standards?

Mr. Hill. We can certainly regulate. The question is how to regulate. As you know, we issued our request for information last fall, asking all the affected stakeholders on these very particular issues about whether or not federal standards for enrollment or background screening or any number of things that the IG has recommended should be put in place.

As you know, it's a tension between state flexibility and the flexibility of any particular program in terms of who it is and how it is they're overseeing those programs and the imposition of a federal requirement. So before we were to implement a federal requirement, we want to be sure that it's going to meet the needs of all the states, both from a program integrity standpoint and also from the service delivery standpoint as well.

Mr. Walberg. Well, I appreciate that. I guess I would echo some of Mr. Collins' statements as well that it's time to push. And as you indicated as well, the financial push is sometimes the best way to get these recommendations dealt with and the states to get on board. Because it's one thing for an elderly lady with dementia to lose her credit card. That can be fixed. When you get into in this particular area of medications, painkillers, getting out and misused, it impacts lives and maybe get a good handle on that.

Thank you. I yield back.

Mr. Murphy. Thank you. I now recognize Ms. Clarke for 5 minutes.

Ms. Clarke. Thank you, Mr. Chairman. Mr. Chairman, I'm glad that we've had the opportunity to talk about the Medicaid program and how many people it helps across the country. Roughly 74 million Americans depend on Medicaid for healthcare coverage and the program is a lifeline to these individuals.

The Affordable Care Act authorized states to expand Medicaid

for low-income adults, helping to fill a major gap in insurance coverage. As a result, more than 12 million low-income adults were able to gain coverage last year.

As Republicans are contemplating repealing the Affordable Care Act's Medicaid expansion and making sweeping changes to Medicare, I'd like to put this program in context. Mr. Hill, CMS has reported that the ACA's Medicaid expansion has helped reduce the rate of uninsured to its lowest level in our nation's history. Is that correct?

Mr. Hill. That's correct.

Ms. Clarke. And in a report this past January, CMS stated and I quote, "Medicaid is the most efficient healthcare program we have, covering people at lower costs than commercial insurance coverage or even Medicare. And at the same time Medicaid has that proven track record of enabling access to care, improving health, and helping children succeed in life."

Mr. Hill, do you agree that Medicaid is an efficient program and that is covers people at lower costs than Medicare and commercial coverage?

Mr. Hill. My judgement is that Medicaid is an important program doing a lot of good for the 74 million people that we cover.

Ms. Clarke. In CMS' January report, the Agency stated, "Research has shown that Medicaid expansion has helped improve quality, access, and affordability of care."

Mr. Hill, can you briefly explain how the Medicaid expansion

has improved the healthcare coverage of its beneficiaries?

Mr. Hill. Without speaking directly to the January report, let me just say that as a general proposition somebody who is covered, whether they're covered through the marketplace or whether they're covered by their employer, they have coverage through Medicaid. If you have health insurance coverage, you generally are going to be in a better place vis-a-vis be uninsured, particularly if you get sick.

Ms. Clarke. So in addition to expanding Medicaid coverage to millions, the ACA also created the Community First Choice program. This program encourages more states to offer personal care services by providing an additional six percent federal matching payment to these services. Unfortunately, in addition to gutting the entire Medicaid program, one provision of Trumpcare would actually repeal this option.

Ms. Iritani, I understand from your report that states have begun to participate in the Community First Choice program, is that correct?

Ms. Iritani. That's correct.

Ms. Clarke. Can you tell me more about states' participation in this program?

Ms. Iritani. Well, we know from our work that eight states, as of the time of our report, were participating in the Community First Choice program. And one of the concerns we have leading to our recommendation about harmonizing requirements is making

sure that for those people who are in that program who require institutional level of care that the safeguards are in place to ensure beneficiaries' safety are similar to other programs that have served similar
beneficiaries because many states are moving their beneficiaries from waiver programs that have really strong or stronger safeguards into the Community First Choice program.

Ms. Clarke. So you're saying that the Community First Choice program doesn't have strong safeguards?

Ms. Iritani. I think that it doesn't have the same level of safeguards as others, other programs' authorities.

Ms. Clarke. Are you saying that you believe that that may put some of its participants at risk?

Ms. Iritani. We recommend that CMS actually needs to harmonize the requirements in place between programs to ensure that common risks for beneficiaries, depending on their level of need, are addressed in common ways across the programs.

Ms. Clarke. And the Community First Choice program, do you believe that their services are less than traditional?

Ms. Iritani. No, we did not do that work, no.

Ms. Clarke. Okay. Mr. Chairman, I hope my colleagues recognize the importance of this program, how many people rely on Medicaid for their insurance. Trumpcare proposes to dismantle the Medicaid program as we know it, capping coverage for children, pregnant women, individuals with disabilities, and of course,

those who have gained coverage from the Medicaid expansion, not to mention Medicaid is the primary insurer of long term care services and support in this country.

I hope my colleagues will reflect on that point and the immense responsibility we have to strengthen Medicaid and not tear it down. And I yield back.

Mr. Murphy. Thank you. I now recognize Mr. Costello for 5 minutes.

Mr. Costello. Thank you, Mr. Chairman. Ms. Grimm, Mr. Hill, between 2014 and 2015, the improper payment for personal support services which includes PCS, as you know, nearly doubled from 6.3 percent in 2014 to 12.1 percent in 2015. That's a lot. Why did the error rate increase at such a level in your opinion?

Mr. Hill. So some of it will have to do with measurement, right. That's not necessarily a statistically significant way to measure those services. I'm not discounting the fact that there's an error rate meaning to worry about it, but just as a technical matter, it's hard to make comparisons year to year the way the PERM rate is put together.

I also think that the roll out of requirements around requiring ordering and referring physicians on claims began to get implemented over that time period. And so while in PCS that may not be an issue that category of services you had identified, there are claims in there that require ordering the referring physician to be on the claim. And I know states have had a

struggle coming into compliance with that requirement.

Ms. Grimm. I missed it, did you say Ms. Iritani or Ms. Grimm? I'm sorry.

Mr. Costello. Ms. Grimm.

Ms. Grimm. So the work that we've done so we've looked at error rates in personal care services across eight states and we have consistently found very high error rates in personal care services.

Looking at recent information, Missouri, upwards of 47.8 percent in error rate; New Jersey, 30.9 percent; New York City, 18 percent. And this is consistent across states. So I think the core point there is that we do find high error rates in personal care services, so it's unsurprising that the error rate in PERM is what it is for personal care.

Mr. Costello. Thank you. The electronic visitation verification piece of the Cures Act I think holds great promise and I would ask you to share for those watching, the EVV captures exactly time, date, location and duration of each visit.

The question, and there are several, so I'm just going to go through them and then open up to all three of you, where is CMS in the process of implementing that change and how much flexibility do states have? How much flexibility should states have in how they choose to use EVV? What enforcement mechanisms will CMS use to ensure state compliance with implementation by 2019? Have you see any success stories so far? And finally, how

can Congress be helpful?

For GAO and OIG, do you believe EVV implementation will help curb fraud and result in more complete, accurate, and timely data and do you care to elaborate on any GAO or OIG recommendations to ensure smooth EVV implementation?

So Mr. Hill and then right on down the line with those questions.

Mr. Hill. Let me take these in turn. In terms of state flexibility and what we need to do to implement the provision, as you know, the effective date is 2019 with respect to the financing of EVV. And so between now and then we'll be regulating and as part of that process we'll have to make a determination as to how much flexibility, if flexibility is given to states in terms of how we implement. So there's a lot of policy work that we need to do in terms of the state flexibility on EVV.

The enforcement here is withholding FFP. As you know, the statute articulates if the state doesn't have a program, we can reduce the federal share. In terms of success stories, we know there are two state, Missouri and Texas already who have begun rolling out EVV. We're working with them and learning all we can for how those particular states are rolling this out so that we can expand those successes and lessons learned in our oversight activity.

Ms. Iritani. I can't speak to the implementation of EVV, but what I can speak to are the benefits. We spoke to four states,

two have EVV in place. They spoke of cost savings when they implemented it, improved timekeeping, more accurate timekeeping, more accurate data, and absolving the beneficiary of the responsibility of having to record time charges.

Additionally, EVV can help ensure that there is a process for notifying the agencies if an attendant doesn't show up.

Mr. Costello. Have you offered any -- will GAO be offering any recommendations as it relates to implementation?

Ms. Iritani. We don't have current work on that.

Ms. Grimm. Implementation is going to be key. I think that we've heard that just because the requirement exists doesn't necessarily mean that the data are going to be collected and that they're going to be reported and that there are any usable time or usable way to be used. Reduction in -- so in that enforcement mechanism, the reduction in FMAP for EVVS is also going to be important. The enforcement authority, without the willingness to act on that enforcement authority I think poses a little bit of an issue. But certainly the idea that EVVs collects that verification of services will go a very long way. A lot of our fraud schemes show that they're billing for services that were never rendered.

Mr. Costello. Have you or will you be sharing your recommendations on usability with CMS to make sure that the data is in a workable manner for you to be able to audit?

Ms. Grimm. We don't have any work specifically devoted to

EVVS right now, but we do have a report looking at T-MSIS that is very close to completion that will point out -- she's related a complete list, accuracy and timeliness.

Mr. Costello. Thank you.

Mr. Murphy. Thank you. I now recognize Ms. Brooks for 5 minutes.

Ms. Brooks. Thank you, Mr. Chairman. It was actually 2012 to Mr. Collins' point earlier relying on data, but in 2012 it was when HHS Office of Inspector General released the portfolio highlighting waste, fraud, and abuse in the PCS program and to date, CMS has yet to implement four of the recommendations. And I'm not going to list all of them or read through all of them because I want to get to the questions, but they include reducing significant variation in the state PCS attendant qualifications and improving CMS' and states' ability to monitor billing and care quality.

I can go into greater detail if you don't know which four, but you know which four. So rather than spend my time on that since it's been nearly 5 years since these recommendations for improving PCS were suggested and while I appreciate that CMS has adopted some of the recommendations, there are still these four.

So Mr. Hill, why has CMS not adopted all of the HHS OIG recommendations after nearly 5 years? And do you disagree with any of the recommendations?

Mr. Hill. So obviously the controls that the

recommendations are articulating are controls we'd like to see states have in place.

The question for me is it's not -- so there are four recommendations, but overarching all of them is CMS is showing a federal standard and regulating here and requiring states and holding state accountable to those four standards. And it's that balance that we're trying to strike here as to whether or not we should regulate and create a federal standard or whether or not we should be allowing states as they are now or requiring states to have more stringent standards at the state level. So it's not a disagreement necessarily with the fact that we ought to have standards for attendant qualifications. The question is should that be a federal standard or should that be a standard that's left to the state with us ensuring that the state is following through on that and complying.

Ms. Brooks. And while I understand that that's what the differences are, it's been 5 years since the recommendation came out and so what is the problem? Is there an internal deadline at this point for CMS to adopt these recommendations?

Mr. Hill. So we issued a request for information last fall after a lot of conversation with the IG to gather more information on to the question that I just articulated in terms of federal standards are not. We're going through that information and the data that we gathered as part of that RFI and we'll be considering that as we move forward in the regulatory agenda for Medicaid

generally.

I should just be very clear, there's not an internal deadline for when we have to have a reg out or not. We're going through those comments now.

Ms. Brooks. Would you agree that a lot of people work best when there are deadlines?

Mr. Hill. I do. I understand the point, yes.

Ms. Brooks. So that might be something you might consider at this point after 5 years is setting a deadline?

Mr. Hill. I will be sure to raise that. I can't set the deadlines. I'm a deadline follower, but the folks -- I do report to the folks who set deadlines.

Ms. Brooks. And you talked about the qualification issue, what about is that a similar problem with respect to the monitoring of the billing and care quality?

Mr. Hill. The data and information on claims, all the controls that the IG has quite appropriately identified, we have to regulate if we were going to have to require a state to implement those.

Ms. Brooks. Ms. Grimm, and so Mr. Hill has talked about have there been conversations between OIG and Mr. Hill and others at CMS regarding the length of time that's passed since you've issued these recommendations and have there been any reasons as to why you believe there's been a delay that we could maybe address in implementing the recommendations?

Ms. Grimm. Se have a number of processes in place where all of our unimplemented recommendations to follow up on the status of those recommendations. We have met beginning in November 2015 with CMS leadership in person many times to talk about options and possible solutions.

Ms. Brooks. So you're following your processes for following up on recommendations. What has been the primary reason for delay in moving forward since it's been years and you've been following your process since November of '15?

Ms. Grimm. We certainly have provided a lot of technical assistance to CMS. I think that's a great question for my colleague, Mr. Hill.

Ms. Brooks. Mr. Hill, so we'll bring it back to you.

Mr. Hill. I fear I will not have a satisfactory answer for you to be able to say exactly way a reg hasn't been implemented. As you know, we sort of went through sort of a set of conversations last year. We've now had a transition. We have a new administration and we're beginning to think about what that agenda looks like.

Ms. Brooks. I'll be anxious to see with respect to those that you work with at CMS that we've set an internal deadline and move forward on many of these recommendations. With that I yield back.

Mr. Murphy. The gentlelady yields back. And I now recognize Mr. Carter for 5 minutes.

Mr. Carter. Thank you, Mr. Chairman, and I thank all of you for being here. You know, I think we've established the fact that the personal care services are extremely important. Before I became a member of Congress, I was a practicing pharmacist, so I had some experience with this, particularly in the way of medication management and drug therapy. I was also a consultant pharmacist, as well as being a community pharmacist. And one of the primary reasons that people are admitted to a nursing home or to a personal care home is medication management. It's one thing that we have to be careful of.

Representative Walberg alluded to some of the abuse and certainly I have witnessed some of the abuse that can take place with that, but I've also witnessed a lot of the benefit that it can have. And the benefit of allowing someone to stay in their home and not having to be institutionalized, it's a great benefit to them personally and it saves money for a lot of us, but obviously, there is a lot of room in that particular scenario for abuse and for fraud. And it's difficult. I get it. I understand it's difficult to identify that and hopefully our healthcare professionals such as pharmacists are helping us with that. And whenever they might see a trend or a tendency there where medication goes missing or someone is not getting their medication, maybe a physician can identify why is your blood pressure going up, you know? Are you getting your blood pressure medication or something and why is your pain level going up?

Perhaps they're not getting it like they're supposed to. But nevertheless, I agree it is a good program, but it is a program that obviously we wouldn't have you here today if we weren't looking into the fraud, the waste, and the abuse that exists in the program.

I want to start by very quickly talking just about the self-directed Medicaid service models because as I understand it a lot of the fraud that's involving the personal care services is conspiracy, if you will, between the PCS and the beneficiary.

Tell me, Mr. Hill, what has CMS done to combat that? What can you do and what's been beneficial and what's worked?

Mr. Hill. So self-direction, I think, particularly for those of us, myself included, who have sort of spent a lot of time thinking about the medical model and how we do insurance and provide services, self-direction is sort of the most out of the envelope way to think about how people are getting services. You know, having a beneficiary pick and understand and have a lot more control over who's coming into their home and how that service is being delivered is a challenge. Sometimes, as we've identified a family member or a friend, so there is a range of things that we've done to help, not just beneficiaries, but states and agencies who are sometimes involved in that model to build in practices and policies to mitigate against abuse.

We've talked about training. We've talked about compliance work with the folks who are doing the service work. Some states

and many states have requirements for enrollment and background checks, all of the things that we've talked about work in self-direction as well as they're going to work in agency. But again, because the beneficiary will be at the center of that planning, at the center of identifying who is coming into their home, the self-directed model is one that provides, presents unique challenges.

Mr. Carter. Ms. Grimm, let me ask you, it's my understanding that most of the fraud is proven through by showing -- most of the fraud is by people who have come and actually testified and through referrals from individuals who have turned them in, if you will. How can Health and Human Services do a better job with that? Is there anything? How can we incentivize people to report these types of abuse or fraud?

Ms. Grimm. I appreciate your question. I think yes, it is true that a lot of the fraud that we see is in self-directed models. They shore up a number of different requirements for self-directed so that things like the flow of cash isn't as easily sort of shared with others. So CMS has taken steps in that regard. But it would be easier, consistent with our recommendations for us to know who we're doing business with. Right now, we don't know the identities and the dates and the types of services being provided at the attendant level. So that's something that I think is critically needed for oversight.

Mr. Carter. Great. Well, my time is about up. But again,

I want to stress that I've seen the benefits of this program. The benefits are good. But I hope that we can do something to address some of the problems that we have because I've also seen the fraud that exists in there and it does exist. And trying to get those bad actors out is difficult, but we need to get them out. Thank you very much and I yield back.

Mr. Murphy. The gentleman yields back. I want to thank our panel here. This has been very enlightening for us and I want to follow up on my friend and colleague's recommendation that we bring the states in. We would look forward to hearing from you if you have suggestions of what states that might be so we can hear about what's working, what's not working. And in the meantime, please let us know if there's other things we need to pay attention to.

I thank all of the witnesses and all the members who participated in today's hearing. I will remind members they have 10 business days to submit questions for the record and I ask that the witnesses give us timely responses to those and respond promptly to those questions. And with that, this subcommittee is adjourned.

[Whereupon, at 12:04 p.m., the subcommittee was adjourned.]