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EXAMINING HOW IMPROPER PAYMENTS COST TAXPAYERS BILLIONS AND WEAKEN MEDICARE AND MEDICAID

TUESDAY, APRIL 16, 2024

House of Representatives,

Subcommittee on Oversight and Investigations,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 10:30 a.m. in Room 2322, Rayburn House Office Building, Hon. Morgan Griffith [chairman of the subcommittee] presiding.

Present: Representatives Griffith, Burgess, Duncan, Guthrie, Palmer, Lesko, Rodgers (ex officio); Castor, DeGette, Schakowsky, Tonko, Ruiz, Peters, and Pallone (ex officio).

Also present: Representatives Joyce and Miller-Meeks.

Staff Present: Corey Ensslin, Senior Policy Advisor; Lauren Kennedy, Clerk; Seth Gold, Professional Staff Member; Sydney Greene, Director of Operations; Emily King, Member Services Director; Chris Krepich, Press Secretary; Gavin

Proffitt, Professional Staff Member; John Strom, Counsel; Austin Flack, Minority Junior Professional Staff Member; Tiffany Guarascio, Minority Staff Director; Mary Koenen, Minority GAO Detailee; Will McAuliffe, Minority Chief Counsel, Oversight and Investigations; Constance O'Connor, Minority Senior Counsel; Christina Parisi, Minority Professional Staff Member; Harry Samuels, Minority Oversight Counsel; and Caroline Wood, Minority Research Analyst.

*Mr. Griffith. The Subcommittee on Oversight and Investigation will now come to order. The Chair will recognize himself for a five-minute opening statement. But he ought to turn on his microphone _ but I probably ought to turn the mike on first.

[Laughter.]

*Mr. Griffith. I recognize myself for a five-minute opening statement.

Today's hearing is an opportunity to examine improper payments within the Medicare and Medicaid programs. Economic outlooks forecast the deficit in this country will balloon to $1.8 trillion, equating to 6.8 percent of the GDP, by 2024. Given these fiscal realities, financial mismanagement cannot be tolerated.

Improper payments, whether because of deliberate fraud, mistake, or an inaccurate amount is a pervasive problem across the Federal Government. Since fiscal year 2003

Federal agencies have reported an estimated $2.7 trillion in total improper payments. A recent Government Accountability Office report disclosed that in fiscal year 2023 alone government-wide improper payments amounted to $236 billion. That underscores the scale of the problem and just how bad the Federal Government's internal controls are, a concern that the GAO has been raising since 1997.

Furthermore, in a separate GAO report published in February of this year, the Comptroller General stated, "Congress and the Administration must act to move the nation off the untenable long-term fiscal course on which it is currently operating.'' GAO also stated, "The Federal debt level is growing at a rate that threatens the vitality of our nation's economy and the safety and well-being of the American people.'' I could not agree more with that sentiment.

For fiscal year 2023 GAO reports Medicare reported _ or reporting approximately 51.1 billion _ let me repeat that, billion _ dollars in improper payments, and Medicaid reporting 50.3 billion in improper payments. These staggering figures not only highlight the magnitude of the problem, but also signal deep-rooted systemic issues at the Centers for Medicare and Medicaid Services, or CMS. Amidst the highest inflation in decades, and facing increased costs across all fronts, the government's fiscal irresponsibility

here is unacceptable. The American people deserve better.

Today we aim to identify measures that can enhance oversight and address the longstanding problems of improper payments plaguing CMS. Ensuring the integrity of our health care system is paramount. Every dollar lost to an improper payment is a dollar not spent on lifesaving care, innovative treatment, or essential services for our citizens.

Recent audits by the HHS OIG underscore the severity of the issue, revealing that Medicare incorrectly compensated acute care hospitals for inpatient claims that should have been subject to the post-acute care transfer policy, resulting in 41.4 million in overpayments because of the misuse of discharge status codes.

Furthermore, investigations found that in just 2 years California and New York alone were responsible for 1.7 billion in Medicaid payments to approximately 1.6 million ineligible recipients, with an additional estimated 4.3 billion directed toward nearly 4 million potentially ineligible enrollees. Our duty is to ensure that not only are these funds recovered, but that stringent preventative measures are put in place. It is critical that we implement rigorous oversight and accountability mechanisms.

This hearing will also address challenges posed by Medicaid state financing mechanisms. Insights from HHS Inspector General suggest that diligent oversight can

mitigate and even reduce improper payments. By embracing modern solutions and fostering innovation and monitoring and compliance, the Federal Government can significantly deter fraud, waste, and abuse.

It is clear that, as health care evolves, our strategies for safeguarding its resources must do so, as well. Combating improper payments will require a multi-faceted strategy, including improved data sharing, enhanced provider education, and stronger audit mechanisms. Each of these actions has to work together to be effective. In our Federal system, where states play such an important role, leveraging technology and fostering collaboration between Federal and state agencies and health care providers will be crucial for fraud prevention and program integrity.

I hope that all of my colleagues here today will agree on the importance of ensuring Medicare and Medicaid's program integrity. As Congress, it is our job to ensure that Federal dollars are spent effectively and appropriately, ultimately leading to improved access and quality of care. It is time to increase our use of transparency and innovative data tracking to reduce the amounts of improper payments in CMS and ensure that every taxpayer's dollar is allocated correctly and with precision and purpose.

[The prepared statement of Mr. Griffith follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. With that I yield back and now recognize the ranking member of the subcommittee, Ms. Castor, for her five-minute opening statement.

*Ms. Castor. Well, thank you, Mr. Chairman. Good morning.

Good morning to our witnesses. Thank you very much for your very strong recommendations on how we keep Medicare and Medicaid strong for years to come. Your perspectives on the vulnerabilities related to Medicare and Medicaid fraud and improper payments and your recommendations on what Congress can do to ensure that tax dollars are spent appropriately are appreciated and valued.

Improper payments cover a wide range of payment irregularities, including overpayments that are sometimes the result of fraud, but are often – more often errors; underpayments; payments that cannot be verified due to insufficient documentation; duplicative payments; and payments made in connection with ineligible services, providers, or patients. So strong oversight is necessary to identify and curtail improper payments, and this provides a financial benefit, and it strengthens program integrity so Medicare and Medicaid can better serve our neighbors.

This requires a coordinated effort between CMS, state agencies, the GAO, and the Inspector General. Increasing visibility for all responsible parties into the occurrence

and causes of improper payments will allow resources to be directed where they are needed most.

During the pandemic, Congress enacted continuous coverage protections for Medicaid beneficiaries to prevent lapses in coverage. That law was a lifeline for folks who needed access to consistent, high-quality health care during a crisis. Committee Democrats have been closely monitoring how states are making Medicaid re-determinations, the unwinding after the public health emergency ended.

In my home state I am seriously concerned about the unnecessary and improper loss of health coverage for hundreds of thousands of Floridians, especially children. Of the over 1.35 million Floridians who have lost their coverage during the unwinding, an estimated 70 percent were stripped of vital coverage due to procedural reasons, not because they are no longer eligible for care. And just a few weeks ago thousands of parents with seriously ill children, many with complex medical conditions, were notified that their children were losing coverage. This is a serious program integrity problem, even though it does not fall under the definition of improper payments. It is denying coverage to people who remain eligible for care.

I am certainly glad to see that the Inspector General's office is studying state procedures during the re-determination, because the -- of the overly aggressive or

inept approaches we are seeing in some states. It is causing undue hardship for vulnerable families.

And in Medicare, I have been concerned about the significant upward trend in Medicare Advantage costs and the negative impact on Medicare beneficiaries more broadly. Medicare Advantage plans have been sharply increasing diagnostic coding intensity for their enrollees because it results in higher payments. MedPAC notes that this practice alone could cost Medicare $50 billion in higher spending in 2024.

CMS has begun implementing policies to increase accountability for Medicare Advantage plans, but we need more transparency to understand the scope of the problem. Oversight and a deeper understanding of the root causes of improper payments is necessary to ensure that resources are directed towards empowering Medicare and Medicaid to carry out their central missions of providing consistent health care to vulnerable patients and to all of our neighbors.

[The prepared statement of Ms. Castor follows:]

**********COMMITTEE INSERT**********

*Ms. Castor. So Mr. Chairman, I appreciate the opportunity for bipartisan oversight here, and I thank you and yield back.

*Mr. Griffith. The gentlelady yields back. I now recognize the chair of the full committee, Mrs. Rodgers, for her five minutes of an opening statement.

*The Chair. Thank you, Chair Griffith. I appreciate you convening this critical hearing today on the rampant problem of improper payments in Medicare and Medicaid. Today's hearing gets to the heart of a dire concern: the fiscal health of this nation. Each dollar misappropriated, spent improperly, or diverted from its intended use only further burdens our already staggering national debt.

In the case of improper payments in Medicare and Medicaid, it also is a threat to the long-term ability of these programs to provide quality care for our nation's vulnerable populations. For Medicare, especially, this cuts into the solvency of the program, which is currently slated to run out of money in 2031.

House Republicans have been raising the alarm on the need to address improper payments for years. This committee has sent multiple letters to Inspector General Grimm's office on issues such as payments to deceased beneficiaries and those enrolled across multiple states. We are probing options for how states might strengthen their systems for

beneficiary verification and eligibility detection. It is appalling to see the government's disregard for taxpayer funds.

Since 2005 the Federal Government has recorded a staggering $2.7 trillion in improper payments, a clear and unacceptable systematic failure. This mismanagement indicates not only a lack of internal control, but also a severe deficiency in program integrity that undermines public trust in government. Federal-state cooperation is vital in health care delivery, and I hope our hearing today will inform ideas to strengthen that partnership.

However, my frustration mounts with an Administration that seems to prioritize spending sprees over meaningful stewardship of taxpayers' hard-earned money. For instance, the Administration significantly altered the budget neutrality policy within Medicaid's Section 1115 demonstrations. Despite these changes, they have not updated the guidance outlined in an August 2018 letter to state Medicaid directors which still listed _ which is still listed today on the CMS website as current policy. This letter originally set forth the rules for calculating budget neutrality in Medicaid demonstrations, ensuring that these initiatives do not result in increased Federal spending.

The failure to update this guidance leaves states and the public relying on outdated information, potentially

leading to misunderstandings and misalignments with the actual fiscal policy being implemented. Budget neutrality ensures that any new health care initiative under these demonstrations won't cost the Federal Government more money than existing programs.

These unexpected changes have profoundly changed policy frameworks that dictate the allocation of billions in taxpayer dollars. This approach to policy-making, which implicates significant taxpayer funds, is concerning. I extend my gratitude to the Comptroller General for addressing this critical matter in his written statement underlying the pressing need for transparency and fiscal responsibility in managing these significant policy shifts.

Despite our committee's efforts, most notably through an October 2023 inquiry of CMS, our questions have been met with disappointing silence. This lack of communication is just another example of the Administration's reluctance to engage in good faith with congressional oversight and uphold a standard of transparency that is critical for public trust and the responsible management of taxpayer dollars.

We are at a crossroads where continued inaction is not just irresponsible, it threatens the future of these critical benefits. Today we seek answers to shortcomings in transparency, accountability, and fiscal prudence. Today not only will we continue to highlight these issues, we will talk

about what we are doing to address them through robust oversight and smart policy solutions.

[The prepared statement of The Chair follows:]

**********COMMITTEE INSERT**********

*The Chair. I look forward to the conversation and I yield back.

*Mr. Griffith. The gentlelady yields back. I now recognize the ranking member of the full committee, Mr. Pallone, for his five-minute opening statement.

*Mr. Pallone. Thank you, Mr. Chairman.

Today's hearing builds on past committee hearings about how we maintain the integrity of the Medicare and Medicaid programs, and I appreciate the continued oversight of these vital programs.

Medicare and Medicaid are two pillars of the nation's health system, providing coverage to more than 100 million Americans, particularly seniors, children, disabled Americans, and those living on low incomes. And the Centers for Medicare and Medicaid Services, CMS, annually reports improper payments in traditional Medicare, Medicare Advantage, Medicare Part D, Medicaid, and the Children's Health Insurance Program, or CHIP. And the agency has implemented numerous policies and guidance to identify, prevent, and recover improper payments. And CMS is continuing to improve its systems.

While not all improper payments are evidence of wrongdoing, it is important to be vigilant about rooting out waste, fraud, and abuse. Program integrity for Medicare and Medicaid have been included on the Government Accountability

Office's high risk list for many years, indicating the need for efficient monitoring of payment systems on an ongoing basis.

And addressing improper payments should include constructive oversight that protects both the taxpayer and the programs. Unfortunately, too often, the existence of improper payments has been used by some as justification to undermine Medicaid and harm patients who depend on this vital program.

And these rates most commonly represent procedural and documentation-related errors, and improper payments do not capture the rates that people are inappropriately denied or kicked off of coverage in the Medicaid program, a problem we know is plaguing American families. So undermining this important program is a callous response to a problem that we can handle in a much more efficient way that prioritizes the health and well-being of beneficiaries and contributes to reducing improper payments. So I hope, as we continue our important oversight work of these programs, we keep both patients and taxpayers in mind.

There is specific components in each program that GAO, the HHS Inspector General, MACPAC, and MedPAC have studied closely, and recommended for further attention from CMS and Congress. It is helpful that we have all of these perspectives represented today.

Medicare Advantage, for instance, is growing rapidly, and Medicare spending is expected to double over the next 10 years. The Medicare Payment Advisory Commission has consistently found that providing care under Medicare Advantage has cost more than under traditional Medicare. Overpayments to Medicare Advantage insurance companies were projected to be $27 billion in 2023 alone.

A deeply concerning report from the Office of the Inspector General last year showed that one out of every eight prior authorization requests to Medicaid managed care plans were denied. While prior authorization denials are not considered improper payments, it is an area of Medicaid payment policy deserving of further study to make sure that patients are not being unfairly denied health care services.

In other words, we need to pay attention to both the preventing payments to ineligible recipients and protecting benefits of those who are eligible for coverage. And that is why Senate Finance Committee Chairman Wyden and I are leading an investigation into denial rates across these plans that can cut off access to medically-necessary services. Patients deserve access to health care they need without having to jump through unfair bureaucratic hurdles.

The Inspector General has also previously reported on similar patterns in Medicare Advantage prior authorization denials that deserve additional oversight.

Now, last Congress, President Biden and congressional Democrats championed the Inflation Reduction Act and the American Rescue Plan to rein in health care costs and expand coverage for millions of Americans. These advancements are also strengthening Medicare and Medicaid so they work better for beneficiaries. Empowering Medicare to negotiate prescription drug prices and cap out of costs -- out-of-pocket costs, I should say, of insulin, for instance, will produce savings for the government and for patients.

And so I look forward to hearing from our witnesses today about what other steps this committee and Congress can take to help CMS ensure that taxpayer dollars are being spent effectively in both Medicare and Medicaid.

[The prepared statement of Mr. Pallone follows:]

**********COMMITTEE INSERT**********

*Mr. Pallone. And with that I yield back the balance of my time, Mr. Chairman, thank you.

*Mr. Griffith. I thank the gentleman. That concludes members' opening statements.

The chair would remind members that, pursuant to the committee rules, all members' written opening statements will be made a part of the record, but we do request that you provide those to the clerk promptly.

I want to thank our witnesses for being here today and taking the time to testify before the subcommittee.

You will have an opportunity to give an opening statement of five minutes, followed by a round of questions from members.

Our witnesses today are the Honorable Gene Dodaro, comptroller general of the Accountability Office; the Honorable Christi Grimm, inspector general, Health and Human Services; Timothy Hill, MACPAC Commission member; and Dr. Michael Chernew, chair of the MedPAC Commission.

Thank you all for being here. We appreciate you being here today, and I look forward, as I know the other members of the committee do, to hearing from you.

You all are aware this subcommittee is holding an oversight hearing, and when doing so we have the practice of taking our testimony under oath. Do you have any objection to testifying under oath?

All right. Seeing no objection, we will proceed. The chair would further advise you you are entitled to be advised by counsel, pursuant to House rules.

Do you desire to be advised by counsel today during your testimony?

Seeing that none have requested counsel, if you would, if you can, please rise and raise your right hand.

[Witnesses sworn.]

*Mr. Griffith. Seeing that the witnesses have answered in the affirmative, you all may be seated. You are now sworn in and under oath, subject to the penalties set forth in title 18, section 1001 of the United States Code.

With that we will now recognize Mr. Dodaro for five minutes to give his opening statement.

TESTIMONY OF THE HON. GENE DODARO, COMPTROLLER GENERAL, GOVERNMENT ACCOUNTABILITY OFFICE; THE HON. CHRISTI GRIMM, INSPECTOR GENERAL, HEALTH AND HUMAN SERVICES; TIMOTHY HILL, MPA, MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION MEMBER; AND MICHAEL CHERNEW, PH.D. MEDICARE PAYMENT ADVISORY COMMISSION CHAIR

TESTIMONY OF GENE DODARO

*Mr. Dodaro. Thank you very much, Mr. Chairman, Ranking Member Castor, members of the subcommittee. I'm very pleased

to be here today to talk about better safeguarding these vital programs that provide essential services to vulnerable populations.

These are the two largest programs in the Federal Government, both collectively representing more than 25 percent of total Federal program spending. They are also among the fastest-growing programs. CBO estimates that, Medicare, which is estimated to be $1 trillion in spending in fiscal 2023, will double by 2034, up to $2 trillion.

Also, as mentioned this morning, the Medicare Trust Fund will be depleted by 2031, according to the most recent estimates, and therefore there'll only be $0.89 on the dollar for available payments.

Now, these factors, all point toward better managing these programs and bringing down improper payments, in addition to making sure that there is fiscal stewardship and accountability that should be there in those programs.

Now, it was mentioned this morning a couple of times that since 2003 Federal agencies have reported almost $2.3 trillion in improper payments. Of that amount, $1.5 trillion were in the Medicaid and the Medicare programs. So this is a very significant issue.

I'm pleased CMS has taken some measures to make improvements. They've instituted some automated prepayment edits to screen out inappropriate services and providers,

they've implemented some very selective prior authorization efforts which helps control the costs. They're trying to institute more audits of the managed care providers, particularly under the Medicaid program.

I believe that the Medicaid improper payment estimates are understated, as high as they are, because there needs to be more attention in the managed care area.

423 Now, we've made a number of recommendations to make
424 further improvements in these areas.
425 In the Medicare area we think that there needs to be
426 revalidation of over 230,000 providers that were enrolled
427 during the period where waivers were given due to
428 enrollment requirements that were relaxed during the pandemic. We've
429 recommended that CMS seek legislative authority from the
430 Congress to use recovery auditors for prepayment reviews to
431 ensure improper payments aren't made, in addition to using recovery auditors in a post-
432 payment environment. And we've recommended that
433 Medicare complete more timely audits of Medicare Advantage
434 contracts. They've been languishing for a long time, and

435 therefore the government does not get timely repayment of improper payments.
436 Now, in the Medicaid area they also need to do re-
437 validations of providers as screening and
438 enrollment requirements were also waived during the COVID period.
439 We are also encouraging CMS to consider requiring and
440 doing a cost effectiveness study of using recovery auditors
441 for the managed care portion of Medicaid, which is now over
442 half of the spending for Medicaid. Some states have been
443 doing this voluntarily, they've seen some benefits. I
444 think that it should be studied further. I don't think
445 there is enough audit coverage of Medicaid managed care
446 providers, and more needs to be done in that regard.
447 We also think and have encouraged the greater use
448 of state auditors. You know, the Medicaid programs are all
449 individually tailored for individual states. CMS
450 does the improper payment estimates, but they do them in

rounds of 17 states over a 3-year period. So they don't really get to all the states until a three-year cycle. Well, if you use the state auditors more, you can have more annual coverage and people who understand the tailored programs in the individual states in those areas.

So I think this is a very important hearing. I commend you for holding this hearing. It's very, very important to the long-term solvency of these programs, and also for making sure that they're carried out with proper integrity.

You know, the current estimate of expenditures for the Medicare program over the next 75 years over revenues that are expected is $53 trillion. And with alternative estimates, it could get up to as high as $65 trillion. So greater integrity is required and much needed in these

programs.

Thank you very much. I'd be happy to answer questions at the appropriate time. [The prepared statement of Mr. Dodaro follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. I appreciate your testimony. I now look to Ms. Grimm for her five minutes of opening statement.

TESTIMONY OF CHRISTI GRIMM

*Ms. Grimm. Good morning, Chairman Griffith, Ranking Member Castor, and distinguished members of the subcommittee. I am Christi Grimm, inspector general of the U.S. Department of Health and Human Services. Thank you for inviting me to address how improper payments cost taxpayers billions of dollars, the steps that can be taken to reduce those improper payments in Medicare and Medicaid, and how greater investment in enforcement and oversight will better protect these programs.

OIG protects Medicare and Medicaid from improper payments, and these programs cover about 40 percent of the U.S. population and combined cost more than $1.7 trillion. This morning I will focus on managed care in Medicare and Medicaid because it has grown so dramatically over the last decade. As it has _ as it's grown, so too have the risks for improper payment and fraud.

Operating as intended, managed care offers the promise of cost effective, coordinated, high-quality care. However, our work shows concerning gaps between the promise of managed care and how it operates in practice.

First, risks of improper payments. One major source of

improper payments is when Medicare pays managed care plans more for covering sicker enrollees, with the idea that more resources would be needed to treat sicker patients. The sicker enrollees are, the more money plans receive. However, this creates an incentive for managed care plans to make patients appear sicker simply to claim payments to which they are not entitled.

Across 33 audits looking at these payments, OIG found that Medicare overpaid plans by more than half a billion dollars, and this amount is likely just the tip of an iceberg. In related work we found plans reported serious medical conditions for enrollees that had resulted in higher payments. These conditions included vascular disease, chronic obstructive pulmonary disorder, congestive heart failure, and serious mental illness. Yet these enrollees did not seem to be receiving any treatment. This raises concerns about whether enrollees with serious conditions might be going untreated, and the accuracy of the data that plans are reporting to Medicare.

Improper payments cost taxpayers. And while not all improper payments are fraud, all fraud is an improper payment. As managed care grows, we're seeing a migration of fraud schemes from traditional fee for service to managed care. In 1933 a reporter asked Willie Sutton, "Why do you rob banks?'' He replied, "Because that's where the money

is.'' Increasingly, health care dollars are in managed care, and so too are the criminals looking for ill gotten gains.

One clear example is the rise in durable medical equipment, or DME, fraud. DME suppliers are submitting fraudulent bills to managed care plans, driving up costs for the plans and American taxpayers too. We work closely with plans every day to find and shut down these fraud schemes. To mitigate losses we use data analytics to spot fraud early and, once spotted, we work with the Centers for Medicare and Medicaid Services to stop payments on potentially fraudulent claims so that criminals cannot walk away with large sums of money.

Second, reducing improper payments. Data and data analytics are among the most critical tools the government has to stop fraud, waste, and abuse. Many of the solutions we recommend target improving data accuracy, data collection, and data use to identify improper payments. For instance, our work looking at Medicaid managed care demonstrates that states need better, more useful data. That would ensure that states are not paying for deceased enrollees or paying for an enrollee who has moved to another state. Our work shows that reducing these types of payment mistakes could save Medicaid about a billion dollars a year.

Third, investing in oversight and enforcement. OIG delivers positive results by detecting fraud, identifying

misspent funds, and holding wrongdoers accountable. Our work pays dividends for American taxpayers, but much more can and needs to be done.

I'm committed to using our resources as efficiently and as effectively as possible to reduce improper payments and fight fraud, but we're struggling to keep up. We're unable to keep pace with the health care industry that has ballooned to one-fifth of the economy. The vast sums of money heighten the risk of improper payments and attract criminals. Unfortunately, we are declining 300 to 400 viable fraud cases per year because we don't have the agents to work them. Congress can help by supporting legislation to increase investment in the Health Care Fraud and Abuse Control Program.

Thank you for your leadership on this important topic and for inviting me to participate in this hearing. I look forward to your questions.

[The prepared statement of Ms. Grimm follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. Thank you very much. I now recognize Mr. Hill for his five-minute opening statement.

*Mr. Hill. Great.

TESTIMONY OF TIMOTHY HILL

*Mr. Hill. Good morning, Chairman Griffith, Ranking Member Castor, and members of the subcommittee. My name is Tim Hill. I'm the senior vice president for health at the American Institutes for Research, a non-partisan, not-for-profit behavioral and social science research firm. I've also served in various roles at CMS, including as the chief financial officer and director of program integrity. Today I'm here in my capacity as a MACPAC commissioner. MACPAC is a non-partisan congressional advisory body charged with analyzing and reviewing policies for Medicaid and CHIP, and making recommendations to Congress, the HHS Secretary, and to the states.

Ensuring the integrity of Medicaid is especially important, given the program's role as a key safety net for 94 million beneficiaries, and with total spending of $824 billion in 2022. Medicaid program integrity activities are meant to ensure that taxpayer dollars are spent appropriately, to deliver high-quality and necessary care, and to prevent and detect fraud, waste, and abuse. My testimony is based on MACPAC's analysis and represents the

views of the Commission. I will focus my comments this morning on a brief Medicaid program integrity overview, and then highlight key MACPAC findings and recommendations intended to improve Medicaid program integrity.

To begin, we view program integrity as grounded in concepts of fraud, waste, and abuse, which are related but also distinct in important ways. Fraud is an intentional deception made by a person for some unauthorized benefit to himself or another person. Abuse refers to provider practices that are inconsistent with sound fiscal or medical practices, and beneficiary practices that result in an unnecessary cost to the Medicaid program. Waste is the overuse of services or other practices that directly or indirectly result in unnecessary costs or burden.

Similarly, improper payments refer to payments that should not have been made or that were made in an incorrect amount. Improper payments are not necessarily caused by fraud, and may be attributable to administrative errors.

Federal and state agency program integrity efforts span a continuum of activities, from front-end claims processing controls to audit and overpayment recruitments. Some activities are required under the statute and others are optional. Examples of mandatory activities include provider screening and enrollment, implementing the Recovery Audit Contractor Program, and participating in the Payment Error

Measurement Program. Optional activities include things like data mining and analysis, and use of separate and distinct contractors to support states in their efforts.

In terms of MACPAC's work related to Medicaid program integrity, we have focused on three broad conclusions.

First, our work showed that coordination of program integrity efforts is important for mitigating duplication and administrative burden. For example, many Federal and state agencies, including CMS, state Medicaid agencies, state Medicaid fraud control units, the IG, and the GAO are involved in program integrity. Our work found that the agencies may conduct audits at the same time or in the same or similar topics, and state Medicaid agencies and providers may be subject to multiple Medicaid audits over the course of a year, and the volume of audits can place undue burden on providers.

In addition, we learned that many audits find unintentional provider errors with submitted claims due to complex billing processes and rules.

To address these concerns, MACPAC has recommended that the Secretary simplify and streamline regulatory requirements for program integrity, identify the most effective Federal program integrity activities, and eliminate programs that are redundant, outdated, or not cost effective.

Second, Macpac found that states face challenges in

assessing the effectiveness of their program integrity approaches, such as finding the return on investment for any particular intervention, and that states lack the information they need to identify efficient state practices.

In response to these findings, we've recommended that the Secretary take steps to assist states, for example, by quantifying the effectiveness of PI activities and disseminating best practices. In addition, we believe HHS should examine state program integrity activities to identify approaches associated with success, and establish pilots to test novel strategies across the states.

Finally, MACPAC found that recovery audit contractors, which conduct post-payment reviews of Medicaid claims and are paid on a contingency basis, have markedly decreased over the years, and that states are unable to find RACs willing to contract with them.

As a result, the Commission recommended that Congress make the Recovery Audit program optional to provide states greater flexibility to focus resources on the most effective PI strategies.

Building on our program-integrity-specific work, MACPAC has also been examining the need for additional data to gain better line of sight into the Medicaid program. For example, we recently recommended that Congress require comprehensive reporting of the sources of non-Federal share to improve the

transparency of Medicaid and CHIP financing.

I want to end with recognizing the work that CMS and our partners here at the HHS, IG, and GAO have done related to Commission recommendations. As always, a lot of work has been done, but more needs to be improved upon.

This concludes my statement and I'd be happy to respond to your questions.

[The prepared statement of Mr. Hill follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. Thank you very much. I now recognize Mr. Chernew for his five-minute opening statement.

TESTIMONY OF MICHAEL CHERNEW

*Dr. Chernew. Thank you, Chair Griffith, Ranking Member Castor, and distinguished committee members. My name is Michael Chernew, and I am the chair of the Medicare Payment Advisory Commission, or MedPAC. I appreciate the opportunity to speak with you today about the Commission's work on improving payment accuracy in Medicare.

Much of our work focuses on Medicare payments to providers and health plans to ensure that beneficiaries have access to high-quality care, and that Medicare is a good steward of taxpayer funds. Today I will discuss the Commission's recent work and recommendations in three areas. And a fourth, improving Medicare's ability to identify the clinicians who are providing care, is discussed in my written testimony.

First, diagnostic coding in Medicare Advantage. Medicare beneficiaries have the option to receive benefits from private health plans in the Medicare Advantage program, or MA, rather than from traditional, fee-for-service Medicare. We estimate that in 2024 Medicare will spend approximately 20 percent more for MA enrollees than it would spend if the beneficiaries were in fee-for-service. Higher

payments, some of which finance added benefits, reflect the system used to pay MA plans _ in particular, the system used to adjust payment for differences in enrollee health status.

Specifically, Medicare Advantage plans are paid a per-enrollee amount, which is adjusted based on the relative health of enrollees. Health status is based on diagnoses recorded on claims. Unlike in fee-for-service, Medicare Advantage plans have a financial incentive to ensure that all possible diagnoses are recorded because adding diagnoses raises plan payments. Plans have several mechanisms that allow them to capture more diagnoses than are captured in fee-for-service, which we estimate account for about half of the higher MA payments.

Coding differences do not necessarily imply that MA plans are coding improperly, though some may be. For example, research has shown that in fee-for-service, conditions are not consistently captured. Conditions like diabetes may drop off of fee-for-service claims in some years, suggesting that under-coding in fee-for-service accounts for some of the differential in diagnostic coding. But importantly, because MA payments are based on fee-for-service data, relatively higher diagnostic coding in MA, regardless of the reason, increases payments to plans.

We have found that coding intensity varies significantly across MA plans. For example, among the 8 largest MA

insurers, we have found a 15 percentage point variation in coding intensity, which distorts the nature of competition, a crucial feature of Medicare Advantage.

The Commission has recommended making several changes to the MA risk adjustment system outlined in my written testimony. Our recommendations would lower MA payments and improve equity across plans by reflecting that some plans capture more enrollee diagnoses than others. More broadly, when reforming Medicare's payments to MA plans, the Commission has urged Congress to balance the benefits for enrollees, payment adequacy to plans, and responsible use of taxpayer dollars.

Second, payments for post-acute care services. As part of our work we examine the adequacy of Medicare payment rates for three types of post-acute services: skilled nursing facilities, or SNFs; home health agencies; and inpatient rehab facilities, or IRFs. We estimate that in 2024 the margins of fee-for-service Medicare payments will be 16 percent for SNFs, 18 percent for home health agencies, and 14 percent for IRFs. The Commission recommended modest payment reductions in all of these settings to balance Medicare payments with the cost of care delivery.

Importantly, these providers, particularly SNFs, serve other market segments. While our focus is on Medicare, policymakers may wish to consider the broader sector context.

Third, aligning Medicare payments across settings. Medicare payments for the same service often differ across ambulatory settings. These payment differences encourage consolidation of physician practices with hospitals and shifts in care towards the settings with the highest fees, which increase total Medicare spending and beneficiary cost sharing without significantly improving patient outcomes.

For example, from 2015 to 2021 the volume of chemotherapy delivered in freestanding clinician offices, the lowest paid ambulatory setting, fell 14 percent, while the volume delivered in hospital outpatient departments, the highest paid ambulatory setting, climbed 21 percent. Based on this analysis, in 2023 the Commission recommended that Congress more closely align payment rates across ambulatory settings for services that can be safely and appropriately delivered in all settings and when doing so does not degrade access.

These recommendations alone would not reduce Medicare spending because current law requires them to be budget neutral. However, aligning payment rates for select services would reduce incentives for providers to make site _ would reduce incentives for providers to make site decisions based on the financial rather than clinical factors, which could eventually result in lower aggregate spending.

In conclusion, the recommendations that the Commission

has made in these and other areas aim to ensure that beneficiaries have access to high-quality care while being a good steward of taxpayer dollars.

Thank you for your time, and I look forward to your questions.

[The prepared statement of Dr. Chernew follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. Thank you very much, and thank you all for your testimony. We will now move into the question and answer portion of the hearing, and I will begin questioning, and therefore recognize myself for five minutes.

Mr. Dodaro, I liked your idea of the state auditors, and my gut tells me that that could save a significant amount of money, but would also save the states money so that it would pay for itself to use their state auditors. Do you agree with that?

And give me some more of your concepts on having the state auditors look at it instead of having it once every three years by the Feds.

*Mr. Dodaro. First of all, each state designs its own program, so they're very different from state to state. The state auditors now have to arrange what's called a single audit of the Federal and state spending, say, for a state health department, for example. And there are requirements in there from CMS some compliance testing with their requirements. So they already have a base level of knowledge.

In some of the state auditors contract that out to a public accounting firm, some do it themselves. But they've also on their own done some targeted reviews, for example. They find payments going to deceased individuals, going to providers that are no longer enrolled, the same type of

issues that the HHS, IG, Ms. Grimm's office, and our people at GAO find.

But they're there all the time. Now, part of the problem is how to finance them. I coordinate a lot with not only the inspector generals, but all the state auditors and local auditors through an intergovernmental audit forum. And so they will need some payment. Now, the payments could come from the states.

In some of the states, as you point out, the Medicaid program is about a third of the state's budget. So it's a significant amount of money that goes in there. But they need to get more incentives in place.

A number of the state auditors have complained to me, too, that sometimes their findings aren't dealt with at the CMS level, so we've recommended that they follow up on this from their auditing standpoint.

Also, there have been some limitations put on them in auditing the Medicare _ excuse me,

*Mr. Griffith. Medicaid.

*Mr. Dodaro. Medicaid managed care contractors at the local level. I think they could do much more there. We've worked with CMS. CMS really wasn't using the state auditors very much before. I arranged some meetings between the state auditors and CMS to start the dialogue, and they could provide training to them.

I think they could also use some funding to the state auditors that would provide a good return on investment.

*Mr. Griffith. Well, and I wouldn't want to see us spend any more Federal money in that regard. But at the same time, if they can find Federal savings, maybe we could share some of the money they have _

*Mr. Dodaro. Right.

*Mr. Griffith. They are going to save the state some money _

*Mr. Dodaro. Right.

*Mr. Griffith. _ but they may also be able to save the Federal Government some money, and maybe we give them a percentage of what they save the Federal Government when they find something.

Ms. Grimm, we have talked about ways that _ you know, the process that is going on now. One of the questions I have always had is the private sector seems to do a better job of ferreting out _ they are not perfect, but they do seem to do a better job of ferreting out waste, fraud, and abuse. Sometimes maybe they go too far. But are there things that CMS could use that they are not using that are currently being used in the private sector?

And should we be looking at AI in the long term?

*Ms. Grimm. CMS has its Center for Program Integrity, and they have a data analytics shop. Our data analytics shop

works closely with the Center for Program Integrity. I've been around a while, it's probably one of the best working relationships that I have seen.

A common criticism is, why can't we do what credit card companies do? Why can't we just shut off the payments? They are required to have evidence of some misdeeds before they can move to institute administrative penalties such as payment suspension or a number revocation. So OIG works very closely _ when we are taking a look at claims data, we see spikes, we investigate immediately. We send investigators to take a look. If we see enough information, we provide CMS recommendations for payment suspensions or revocations. But just because they see a spike doesn't mean that they can automatically shut off the spigot immediately. They need some additional data.

*Mr. Griffith. I am running out of time, but should we be collecting that data quicker or are there some legislative changes that need to be made to make them more nimble?

*Ms. Grimm. I think what we would all need is some additional resources. The HCFAC program has not been rebased since 2010. With some additional resources we would be able to add more data analytics.

We're piloting artificial intelligence to be able to look for patterns that we can build into some of our formulas, for lack of a better term, but with additional

resources we would be able to sort of double down on what we're trying to do with data and analytics.

But data and analytics is the key, as I said in my opening.

*Mr. Griffith. The private companies seem to be doing a better job, and I see my time is up so I am going to have to yield back, but I just _ I think maybe we can learn something from private industry, where they have got their own dime on the hook, as opposed to the taxpayers.

With that I yield back and now recognize the ranking member of the subcommittee, Ms. Castor, for her five minutes of questions.

*Ms. Castor. Thank you, Mr. Chairman.

A number of you have highlighted the ways that patient information and health status can be distorted, resulting in improper payments, and how that is happening in Medicare Advantage that can't be done in traditional Medicare.

So Dr. Chernew, I would like to ask you some questions about how Medicare Advantage payments are calculated. How are enrollee risk scores determined, and how does CMS use them to calculate coverage payments?

*Dr. Chernew. CMS, as a payment model _

*Ms. Castor. I think your mike --

*Mr. Griffith. Yes, if you can, either turn it on or pull it closer to you.

*Dr. Chernew. Or just yell.

*Mr. Griffith. There you go.

*Dr. Chernew. This is a topic that should be yelled.

[Laughter.]

*Dr. Chernew. CMS as a payment _ a risk adjustment model that's based on fee-for-service claims, where they statistically estimate the relationship between patient conditions and spending in fee-for-service, that relationship is then used and applied to claims data from Medicare Advantage plans to essentially then predict, if the relationship was the same as in fee-for-service, what would you have to pay for that person in Medicare Advantage. And that's based on this risk score. So it's fee-for-service data that is then applied to Medicare Advantage data to compute a risk score. The risk score then multiplies up or down how much is paid to the plan.

And the issue that I highlighted in my testimony is that, statistically, if the Medicare Advantage plans are better able at capturing diseases through health risk assessments or chart reviews, it can inflate their payments relative to fee-for-service, and thereby they get, we estimate, approximately 20 percent more.

*Ms. Castor. And has MedPAC tried to gauge the reliability of the information that MA plans report from chart reviews and health risk assessments?

*Dr. Chernew. We don't look directly at how much of it is what we would call fraudulent or not, but we are concerned with, for example, the diseases being treated and how much of it is related to capture of disease.

*Ms. Castor. Do you see these -- this as misleading?

*Dr. Chernew. I don't think that it's necessarily misleading. I think the issue is that there's a lot of problems in fee-for-service that Medicare Advantage plans can then capture better codes, and so they end up with risk scores that are higher than they would have been if they were in fee-for-service. And so _

*Ms. Castor. Is there, though, an -- is there -- have we built a system now that is an incentive because it is pretty lucrative?

*Dr. Chernew. Oh _

*Ms. Castor. And then I think your testimony was that there is no corresponding provision of care.

*Dr. Chernew. Sometimes there is, sometimes there isn't. But more broadly to your point, there is a strong incentive for Medicare Advantage plans to invest a lot of resources in capturing disease, and they do a lot of activities that enable them to do that through the health risk assessments, the chart reviews, the way they interact with providers and the provider system. So there's a lot of activities that MA plans do to make sure that they're

capturing disease as best as possible.

*Ms. Castor. So Ms. Grimm, past reports from the inspector general's office have found deficiencies in the data submitted to CMS by Medicare Advantage plans, and question the usefulness of the data sources in portraying the actual cost of care expected for an enrollee. What action can be taken to strengthen reporting requirements so CMS can make decisions with more complete and accurate data?

*Ms. Grimm. Well, on the topic of Medicare Advantage and risk adjustment payments, we have focused on two particular techniques, tools called chart reviews and risk assessments, and these are a combination of reviewing medical records for enrollees and, you know, trolling data, and even visiting beneficiaries' homes to ask them information about their health.

We're finding that that information then is _ appears to be sort of the sole sources to result in that risk adjustment. So one of the recommendations we have made to CMS is _ and then we're not seeing, in all cases, services flow from those conditions. We have recommended decoupling risk adjustment from chart reviews and risk assessments when those are the only two assessments that have happened to feed into that diagnosis.

*Ms. Castor. Okay. Mr. Dodaro, do you have recommendations to add onto reforms that would provide

verifiable information to CMS from MA plans?

*Mr. Dodaro. Yes, I do. First, we found that the encounter data for Medicare Advantage isn't updated as appropriate.

Also, we found when doing the risk adjustment scores they weren't using the most current beneficiary data and some of the characteristics, by gender and race, et cetera. And so we made recommendations in those areas, as well, so they could use more up-to-date information in making these risk scores adjustments. And our recommendations, our findings kind of align with what's been reported by MedPAC.

*Ms. Castor. Thank you very much.

I yield back.

*Mr. Griffith. The gentlelady yields back. I now recognize the chairwoman of the full committee, Mrs. McMorris Rodgers, for her five minutes of questions.

*The Chair. Thank you, Chair Griffith, and I thank all the witnesses for being here today to address this issue of improper payments. It is really important on a number of fronts for protecting the integrity of these programs, our beneficiaries. But also, we need to address these issues or our nation is just going to continue down this path of fiscal trouble.

Ms. Grimm, in your testimony last year you had some valuable insights into issues like deceased beneficiaries

still receiving benefits and concurrent enrollments in multiple states. In correspondence with the committee you noted that CMS does not support the recommendation to fully utilize the Transformed Medicaid Statistical Information System, or TMSIS, to monitor such fraudulent payments.

Would you elaborate on why leveraging this system would help reduce instances of beneficiaries still being enrolled in Medicaid in multiple states?

*Ms. Grimm. Thank you for that question, Chair Rodgers. We have recommended to CMS to reduce instances where payments are being made in Medicaid managed care for deceased beneficiaries. And in instances where an enrollee has moved to another state, duplicate capitated payments are being made to the state where the person had moved from.

We had recommended using TMSIS data. There have been a lot of investments in TMSIS data over the years, some of it at the prompting of OIG. It has been a consistent recommendation we have had for a decade and a half to continue building TMSIS data. There is information in TMSIS that would be able to allow states to know if a beneficiary is enrolled in another state. CMS would have the ability to look at SSA's master death file and include information and allow states to know if a beneficiary had passed.

CMS did not concur with these recommendations. In one instance it said a system called PARIS would be able to

detect if a beneficiary is enrolled in two states at once. We have found quality issues with PARIS, timeliness information with PARIS. And by the way, states did have that at their disposal and we still found the overpayments that we did for deceased beneficiaries. So we continue to recommend TMSIS as a solution to better equip states to not make these payments to Medicaid MCOs.

*The Chair. Thank you.

Mr. Hill, MACPAC has made a number of recommendations over the past decades on ways to improve TMSIS. Can you comment on the state of data reporting through the system, and whether it is meeting our needs today, or whether there is more work that is needed?

*Mr. Hill. I can't comment specifically on the TMSIS issues with respect to the recommendation on deceased beneficiaries, and I know we've done a lot of work with the states and with CMS to make sure that TMSIS is meeting their needs.

We've done some work and continue to do work looking at reporting coming from states, for example, on supplemental payments, payments that are made outside of the TMSIS system, and sort of to verify and understand how they rate _ or relate to the payments being made in TMSIS. But beyond that, we'd have to do some more thinking.

*The Chair. Okay, thank you.

Mr. Dodaro, the Administration implemented significant changes to budget neutrality policies for Section 1115 waivers, as evidenced through recent waiver approvals, without issuing a formal process that outlines such budget calculation changes in a new state Medicaid directors letter or other bulletin, as previous administrations had done. Our committee has expressed concern regarding this change in policy, requested detailed explanations.

Can you explain why it is crucial for CMS to issue a state Medicaid directors letter to clarify these changes, especially when a large proportion of Medicaid spending is involved?

*Mr. Dodaro. Yeah, we found a lot of problems with these demonstration programs. And while CMS has a policy that they be budget neutral, we find in many cases they're not budget neutral. They're costing more money, there's use of hypothetical cost data in there, they're not taking full advantage of looking at what the administrative costs would be. And these demonstrations now account for over half of Medicaid spending, so they're significant.

And we think that there ought to be more guidelines out there to states and more attention to this. We believe, if CMS doesn't institute more guidance, that it would be appropriate, I think, for Congress to set some direction in this regard. These have enormous fiscal consequences and

need to be done properly.

The question is what kind of evaluations are done of the demonstrations? Are they actually producing the results that they were originally intended to do? And is it worth the cost effectiveness of it?

We found that some of the evaluations are lacking, too. So it's both on managing the cost to keep it budget neutral, but also, are we getting any benefits from these demonstrations?

*The Chair. Okay. Thank you. My time is expired, but more to come. I appreciate you being here.

*Mr. Griffith. The gentlelady yields back. I now recognize Mr. Pallone, the ranking member of the full committee, for his five minutes of questioning.

*Mr. Pallone. Thank you, Mr. Chairman.

Members of this committee have long expressed concerns that the rapidly increasing costs for Medicare Advantage plans compared to traditional Medicare, changes to billing practices could help rein in these costs and increase accountability for Medicare Advantage plans. So let me ask Dr. Chernew initially.

Your testimony says that MedPAC has estimated that Medicare will spend 20 percent more for Medicare Advantage enrollees than if those enrollees were covered under traditional Medicare. Can you explain the structural reasons

that drive overpayments to Medicare Advantage plans compared to traditional Medicare, and what effect MedPAC thinks this has to the -- you know, this means to the Medicare program in the long term, if you will?

*Dr. Chernew. So you're right. I think there's a few things I'd highlight. The ones that I highlighted in my testimony, as several others have, is the extent to which Medicare Advantage plans are better able to capture disease than in fee-for-service. Sometimes that's fraudulent, sometimes it's not. But they do it better, it raises payment.

There's another issue that we've been looking at recently, which is selection. So if you look at a group of people that have a given disease _ diabetes, for example _ some of them would spend a lot, some of them would spend a little. The ones that are systematically enrolling in Medicare Advantage tends to be the ones that would have spent less in fee-for-service. That raises payments, as well.

There's a few other structural things that matter. The way the quality bonus system is designed, for example, raises Medicare Advantage payments above fee-for-service spending. And the fundamental Medicare Advantage payment system, which is based on quartiles, in many markets pays more than fee-for-service by design.

I think the core heart of your question is, what does

this mean for the Medicare program overall? And I think there's a few problems.

One problem is, of course, it just raises Medicare program spending, and that's a core problem that people have worried about, and that's an issue for taxpayers and others.

The other issue, I think, is it creates an imbalance between Medicare Advantage and the fee-for-service system. In doing so, over time, if that were to continue, the entire Medicare Advantage program would unravel because of the way that payments in Medicare Advantage are based on fee-for-service.

So I think we're at a point in the system where really rethinking the Medicare Advantage payment model is going to be necessary both to _ for fiscal reasons, for quality reasons, and for just stability of the Medicare program.

*Mr. Pallone. Then we have heard today that payment calculations to Medicare Advantage plans require more oversight to make sure that the cost accurately reflects the quality of care being provided, so let me ask Mr. Dodaro.

What further action could Congress or CMS take to -- I know you have talked about this a little bit. If you could discuss it more, what further action could Congress or CMS take to improve the agency's auditing process that would help identify and recover overpayments?

*Mr. Dodaro. First, I think on Medicaid there needs to

be more attention to auditing the Medicare providers. Right now, in the estimate that CMS makes on the improper payments, all they do is check to see whether states are paying the capitated amount to the Medicare plans. They don't check to see whether or not the Medicare providers are actually _ how they pay beneficiaries, or whether they're overpaying beneficiaries.

Based on our recommendations, they've started auditing. Between 2016 and 2018, they only audited 16 plans between 2019 and 2021 and they've now audited 893 plans. And preliminary results show that there are overpayments in that area. So I think there needs to be continued attention at Medicaid managed care plans to make sure that they're carrying out their responsibilities in a fiscally responsible manner.

Also, as I mentioned to the chairman, the state auditors could be used more to do more timely audits and evaluations, rather than CMS taking 3 years to get through all 50 states. That's too long. The amount of money, that increased spending in that three-year period is exponential compared to their lagging accountability measures in those areas.

So I think there's a lot more that could be done in that area to be more timely in the auditing of all this spending.

*Mr. Pallone. Well, thank you. I know I'm running out of time, but I did want to ask Ms. Grimm about your focus on

process improvements that would lower costs.

What do you see as the greatest financial vulnerabilities presented by the current payment process for Medicare Advantage or Medicaid managed care?

And is there some way we can address them better?

*Ms. Grimm. Well, on the Medicare Advantage side, certainly, the risk adjustment process is a big driver for costs. In addition to what I've already talked about, we do see concentration with a few different plans. We found that out of 5 of $9 billion associated with risk adjustment payments that were only linked to chart reviews and in-home risk assessments, that 5 million were just sort of concentrated on a couple of different plans. So additional process for oversight of some of the big users of some of these risk adjustment tools could be useful.

On the Medicaid side, certainly, from a process perspective, using data that CMS has to catch some of the payments for deceased beneficiaries and for beneficiaries in two different states.

Another process improvement could be having the provider identifier, the NPI, for ordering physicians, we have found that for Medicare Advantage plans they don't have the exact same vetting process, say, for durable medical equipment suppliers. And so it's hard sometimes to tell if that DME supplier has been vetted by others. And we see that as a

program integrity gap, and something that could give rise _ if somebody was intent on committing some fraud.

So those are three suggestions.

*Mr. Pallone. Thank you.

I am sorry for going over, Mr. Chairman. Thank you.

*Mrs. Lesko. [Presiding] Thank you, and now I recognize Representative Duncan for five minutes of questioning.

*Mr. Duncan. Thank you, Madam Chair.

Mr. Dodaro, your testimony highlights serious concerns regarding states' arrangements to fund the non-Federal share of Medicaid, which could inflate Federal costs significantly. Could you elaborate on the types of arrangements that pose the greatest risk to Medicaid's financial integrity, and what GAO recommends to address these vulnerabilities?

*Mr. Dodaro. There's a couple of things.

One, on the supplemental payments that could be made over and above reimbursement for claims or capitated rates, the states can impose taxes on providers. And then they collect the revenue from the providers as a means of meeting the state requirement for the state's share of the Medicaid program. So there's no state money involved in those cases.

And then there are payments made, and the Federal Government matches on the payment. So over time, it has a couple effects. One, it kind of erodes a little bit of the joint responsibility that was envisioned in the Federal-state

responsibility for the Medicaid program, and it subtly shifts some of the costs to the Federal Government over a long period of time. So it's those provider taxes and other things that are done that are really one of the revenue sources.

We've recommended there be more transparency over this process so that there's more reporting of these supplemental payments or the state-directed payments _

*Mr. Duncan. Well, let me ask you _

*Mr. Dodaro. Yes, sure.

*Mr. Duncan. _ just ask you about the transparency. What specific actions can Congress take and the Administration undertake to enhance that transparency and accountability in how they report their financial sources for Medicaid?

*Mr. Dodaro. Well, I think Congress can impose requirements that make it clear that they're to report those requirements. Right now, the CMS has acted on our recommendation, and they're providing more reporting, but they're not reporting on where the sources of the funds are coming from for making the supplemental payments. That is information I think needs to be reported. And if CMS doesn't take full action on our recommendation, I'd recommend Congress do so.

*Mr. Duncan. Agreed.

Mr. Hill, MacPAC just voted last week to recommend that states should be required to disclose their funding sources for the non-Federal share of Medicaid. How would this added level of transparency benefit the program's fiscal management?

*Mr. Hill. I think, for the reasons that were just discussed, having a better understanding about not only the supplemental payments, sort of the payments that are being made to providers where Congress has already required reporting and CMS is collecting data, but having that combined, complementary understanding about where the source of those funds are. We assume for the moment that the _ it's a legal, appropriate source of funds. But knowing how they're financed and what they're supporting and how it is the state has viewed those arrangements in terms of driving economy and efficiency and quality for patients is important. And right now it doesn't exist. And having that data reported and elevated and made public, I think, will expose some of that and give us all a better understanding about how those arrangements are set up.

*Mr. Duncan. Yeah. As you were talking I just remembered when I was in the state legislature and we were trying to pass _ the general assembly was trying to pass cigarette tax for the intent purpose of chasing Medicaid dollars, and a three-to-one match on state dollars spent. So

it was just about increasing that spending.

Ms. Grimm, from your oversight perspective, what improvements can HHS implement to monitor and regulate state methods of reporting Medicaid funding, particularly to curtail abuses involving provider taxes and intergovernmental transfers?

So I will go to Ms. Grimm for that.

*Ms. Grimm. Our work is consistent with what has been described. We _ some of the _ we refer to it as state financing mechanisms, where states are getting money from hospitals and purportedly using that money to do things like improve quality in nursing homes, and we're not necessarily seeing those outcomes achieved. So additional oversight, additional reporting, additional assessments would be helpful.

*Mr. Duncan. My time is expiring. Mr. Chairman, it is a great, informative hearing here, and I appreciate you having it. I think it is bipartisan on our approach. And I yield back.

*Mr. Griffith. [Presiding] I thank the gentleman and now recognize the gentlelady of Colorado, Ms. DeGette, for her five minutes of questioning.

*Ms. DeGette. Thank you, Mr. Chairman, and thank you for having this hearing, because something we can all agree on is that we shouldn't be wasting money in Medicare and

Medicaid programs. This is something that we have thought about in this committee for -- in this subcommittee for many years, and so I want to make sure we are all on the same page about what we are talking about.

Mr. Dodaro, can you please -- we always talk about fraud, waste, and abuse. Can you define each one of these terms briefly for me?

*Mr. Dodaro. Fraud is willful misrepresentation to obtain gain. An example of this would be a provider who builds for a service that's never provided.

*Ms. DeGette. That they don't --

*Mr. Dodaro. And they know about it.

*Ms. DeGette. Yes.

*Mr. Dodaro. Improper payments can include mistakes. Maybe an eligibility determination, somebody was deemed eligible, but it was a mistake, they really weren't eligible or the service could have been provided at a different level.

Waste would be more a case of a service was provided, but maybe it could have been provided at a lower level of service, or that there's funding being used that's being not a good steward of Federal money.

*Ms. DeGette. Right. So do you have a sense of each of these three buckets, what percentage of --

*Mr. Dodaro. Yeah.

*Ms. DeGette. -- what we are talking about is in them?

*Mr. Dodaro. There's not a specific estimate yet of fraud in the Medicare or Medicaid areas. I released a report today where we estimated fraud at the government-wide level, all right, of 100 _ between 2018 and 2023 we said the fraud losses were between 233 billion and $521 billion.

*Ms. DeGette. Okay.

*Mr. Dodaro. And we've recommended that OMB work with the agencies and the inspector generals to start estimating fraud.

*Ms. DeGette. And what about waste and abuse?

*Mr. Dodaro. The improper payments would be the closest thing to that.

*Ms. DeGette. Yes, yes, yes.

*Mr. Dodaro. But the estimate on improper payments isn't complete. Even though it's $236 billion if you add all the governments up, the two largest HUD rental housing programs are not making improper payment estimates, the Temporary Assistance for Needy Families is not making improper payment estimates, the Treasury Emergency Fund rental funds is not making estimates, so the problem is much bigger. It's _

*Ms. DeGette. It is a -- it is a government-wide problem.

*Mr. Dodaro. Yes.

*Ms. DeGette. And in Congress we all sit around talking

about waste, fraud, and abuse. But in fact, unless you can define and identify it within each agency, you can't figure out how you are going to remediate it. Correct?

*Mr. Dodaro. That's right.

*Ms. DeGette. Yes.

*Mr. Dodaro. That's why I did this fraud estimate.

*Ms. DeGette. Thank you.

*Mr. Dodaro. And hopefully that will help. And if you have that and improper payments, you have things to manage and measure by.

*Ms. DeGette. That is correct, and that is the only way you can fix it.

Now, inefficiently provided care is also part of this whole construct, like care provided in a high-cost setting that could be provided in a low-cost setting. You referred to that, is that right?

*Mr. Dodaro. Yes, that _

*Ms. DeGette. Also, it includes therapies that are maybe not needed. Is that right?

*Mr. Dodaro. That's correct.

*Ms. DeGette. And as you alluded to, these payments don't always come from ill intent. Is that correct?

*Mr. Dodaro. That's correct.

*Ms. DeGette. Yes. So Dr. Chernew, I want to turn to you. So as you heard, care that is provided in an

inefficient setting is really a driver of waste. Are there innovative payment models that can incentivize high-quality care and cut down on this inefficiency and waste?

*Dr. Chernew. Yes, in two ways. There are certainly payment models that are now being in the law. The accountable care organization models, for example, they shift people to more efficient sites of care. And I would be remiss if I didn't mention I think there's changes to the actual payment amounts that can be made without a new model to try and equalize payment across the sites of care.

*Ms. DeGette. Are there any current CMMI care coordination models that show overall promise?

*Dr. Chernew. Yes. I think the ACO programs, by and large, the ones that are working do show promise, particularly in the areas you're talking about in terms of shifting sites of care. Post-acute care, for example, would be the poster child for that.

*Ms. DeGette. Thank you.

Thank you, I yield back.

*Mr. Griffith. The gentlelady yields back. I now recognize _ where is my list?

*Voice. Mr. Palmer.

*Mr. Griffith. Mr. Palmer for his five minutes of questions.

*Mr. Palmer. I have been working on this issue almost

from the time I came to Congress, and there is a _ it is frustrating that we have not made more progress than we have, despite numerous recommendations from the GAO.

Mr. Dodaro, I was just looking at another report where you had made a number of recommendations, and it seems that most of the improper payments are _ fall under the category of failure to verify eligibility, administrative error, antiquated data systems. Is that still the case after _ and I have been working on this, what, eight, nine years?

*Mr. Dodaro. I'd add provider enrollment to that list, but it's _ the basic causes haven't really changed. And there's been some efforts to address these issues, as I mentioned in my opening statement, but much more needs to be done in order to be appropriate.

The concern that I've always had here is the hiding behind insufficient documentation. You know, if IRS audits somebody and they don't have documentation to support their deductions, the government takes your money. I don't know why we're spending hard-earned money without documentation requirements.

Now, we've recommended that CMS either _ look, maybe there are inconsistent documentation requirements between Medicare and Medicaid that can be rationalized. Maybe they don't need that level of documentation. But they ought to change it. Right now it's providing a smoke screen that

prevents you from really dealing with the substance of the problem.

*Mr. Palmer. Well, in Ms. Grimm's written testimony she cites a situation where a Medicaid applicant submitted two monthly pay stubs that indicated the individual's income exceeded the level for eligibility for Medicaid, yet the person responsible for verifying eligibility only accounted for one pay stub.

So Ms. Grimm, what I would wonder about that, is that incompetence or is that fraud? I mean, when you are presented with documents to indicate you are not eligible, yet you discount _ you don't even consider one of the documents, and you sign them up anyway.

And that is really a state issue, isn't it?

*Ms. Grimm. So that work is looking at Medicaid redeterminations following the public health emergency. And we are taking a look at redeterminations and whether they were accurate in allowing for continued enrollment, or whether, if they were terminated, that was accurate to do so.

In that instance we find, as the comptroller general has said, for eligibility we find paperwork mistakes all the time. We find that _

*Mr. Palmer. But this specific question is about someone who made a decision not to account for both pay stubs, and enroll them based on one pay stub. And that seems

to be someone who made up their mind to do that. So that is not _ in my mind, that is not incompetence, that is intentional.

And I think that is some of what has to be addressed because Congress _ and I give credit to my Democratic colleagues _ passed two bills, the Improper Payments Information Act and then the Improper Payments Elimination Recovery Improvement Act, but there was no enforcement in those bills. We don't really hold people accountable for incompetence or for negligence or, in this case, in _ just in my opinion _ fraud.

There is another issue, Mr. Dodaro, that I think needs to be addressed _ and this is something that came up in a previous hearing and, again, having read your some of your reports _ is hospitals billing for the same patient for Medicare and Medicaid improperly. Now, I know there is dual eligibility in some cases, but not in all cases. And I think there is some indication that even the estimates on improper payments for Medicare and Medicaid is probably low.

*Mr. Dodaro. I definitely think the Medicaid improper payment estimate is understated, and particularly in the managed care portion. I don't think _ it's not done the same way as the improper payment estimate for Medicare Advantage, and I think more needs to be done to improve that estimate to have a realistic assessment of what the problem is.

I also think you need assessments of some of these other programs, because what we found out during the pandemic _ and along with the IGs and GAO are people who are trying to defraud the government, they're not just limiting themselves to one program. You have the same organization or individual doing it across several different programs and activities. That's certainly the case between Medicare and Medicaid, where you have, you know, similar providers in those cases.

So, there's a lot more that needs to be done in this area if we're going to really be assured that there's the right type of program integrity for these large and growing programs.

*Mr. Palmer. Mr. Chairman, when we are looking at numbers like 230-plus billion, 250-plus billion _ and keep in mind, we do our budgets in 10-year windows _ that is 2.3 to $2.5 trillion plus interest because every dollar of improper payment is a borrowed dollar.

I yield back.

*Mr. Griffith. Thank you, Mr. Palmer. I appreciate you yielding back and now recognize _ who is up _ Ms. Schakowsky for her five minutes of questioning.

*Ms. Schakowsky. Thank you, Mr. Chairman. I am so glad that we are talking a lot about Medicare Advantage. I think it is so important that we look at this. There are two issues that I want to talk about. One has to do with the

denial of care that we are seeing right now, and also the upcoding.

You know, we are talking -- when we say Medicare Advantage, it is not -- it is private, for-profit insurance companies that we are talking about. And I think that greed is part. We are watching advertising that they are doing on television ad nauseam. You can't get away from it for Medicare Advantage.

Right now we are seeing lots of people, thousands and thousands of people, who are being denied care. I hear it in my office all the time. When those denials are checked, we find that 80 percent should be overturned. The problem is, doctors are so swamped with this that they can't always make the complaints that these are denials that are not right. And so a lot of people are absolutely denied the care.

We know that Medicare Advantage -- I think this has been documented -- that they are -- that Medicare Advantage is overpaid $224 billion over the last 3 years in overpayments. And if you took that money, you could actually apply that in traditional Medicare to do eyes, ears, teeth, to do the kinds of things that Medicare Advantage likes to advertise as the real hook on why you should go to Medicare Advantage.

And now we are also seeing this issue of the upcoding, where they are -- now, there may be some things that they are more adept at finding, the illnesses, but really what we are

finding is that they are going through their lists and seeing if they can find things that they could add to make more money.

I want to tell you I believe that traditional Medicare, if we could do it right, and we could make sure that people can get their supplemental insurance, that that would be the way -- the way to go. I actually have legislation that would not allow Medicare Advantage to use the word "Medicare," because it isn't really traditional Medicare.

And so I wanted to ask you, our inspector general, about what -- you have been doing some research on this. What are the things on upcoding, for example, have you recommended?

And what are the things that we can do that are going to make this more hospitable for the seniors who need the care?

*Ms. Grimm. We have been doing work looking at additions of diagnoses and care not flowing from those diagnoses.

We've also been looking at prior authorization, which I think you're talking about. We found an instance where somebody was denied care because they needed a CAT scan because they didn't have an X-ray first, and they were trying to rule out a life-threatening aneurysm, and there is no such Medicare requirement.

So we have made recommendations on prior authorizations. CMS has taken action. We've seen reductions in prior

authorizations. But as you point out, those are overturned a good chunk of the time, so we're worried about that.

*Ms. Schakowsky. If they are challenged.

*Ms. Grimm. If they're challenged. It should not require such resolve to get the access to care that one would need.

*Ms. Schakowsky. And the other issue about upcoding, you are looking at that as well, right?

*Ms. Grimm. So the upcoding, some of the diagnoses that we have looked at, we try to zero in on the most serious diagnoses, you know, colon cancer, acute stroke, COPD, very serious mental health disorders. And we look at whether service flows from those diagnoses that add to the amount of money that a Medicare Advantage plan gets. And we are finding too often that they are not flowing. In one instance, when we looked at 1 year, $9 billion associated with some of these very serious conditions where we weren't seeing services flow.

*Ms. Schakowsky. It seems to me that Medicare Advantage now is getting so much extra money. We have identified the funding that they -- that they get, and it seems to me we have to do something about this, the money and the care. Thank you.

And I yield back.

*Ms. Grimm. Thank you.

*Mr. Griffith. The gentlelady yields back. I now recognize the gentlelady from Arizona, Mrs. Lesko, who is vice chair of this subcommittee.

*Mrs. Lesko. Thank you, Mr. Chair.

My question I am going to ask each of you is, if you were king or queen for one day and you had one item that you could reform, what would it be?

Let's start over here.

*Mr. Dodaro. Medicare Advantage, Medicaid Advantage.

*Mrs. Lesko. What would you do with it?

*Mr. Dodaro. I'd make it more accountable. I mean, as I recall, the whole efforts started in order to save money. It's clearly not saving money. The question is, how much more is it costing us?

And I'm very concerned _ we've done work, too _ if somebody is under Medicare Advantage in the last year of life, when the costs are really high, they shift to fee-for-service. And so I don't think it's serving its purposes. So I'd really want to reform both of those efforts to make sure that they are cost effective, that they've met their original intention, and they're getting the care that people need to be provided.

*Mrs. Lesko. Thank you.

Ms. Grimm?

*Ms. Grimm. Reforming the risk adjustment process.

Plans should be paid more when they're caring for sicker enrollees. That's what it was designed to do. We have found so many concerns and overpayments and misuse that we've recommended additional oversight and delinking the Medicare adjustment payment when you're only finding that diagnosis stemming from a chart review or risk assessment because we're seeing so many concerns.

But I just want to make clear that it's there for a reason. It's currently allowed. It's driving up costs, and we have quality of care concerns because we're not seeing services flow from those diagnoses. So reforming that is important.

*Mrs. Lesko. Mr. Hill?

*Mr. Hill. I think, from the Commission's perspective, understanding and being sure we all understand the flow of payments and what payments are going for, particularly when we're talking about supplemental payments and how they're financed at the state level, to be sure that they're actually driving increased quality, driving access for beneficiaries, and being used in an efficient way.

*Mrs. Lesko. Dr. Chernew?

*Dr. Chernew. So I'll plus-one on the risk adjustment comment broadly. I think the health risk assessments and the chart reviews are two areas that we've made recommendations on.

I think the quality bonus program in Medicare Advantage needs _ MedPAC has discussed paying it below the line as opposed to above the line, for example.

And more generally, I think things like using two years of fee-for-service claims is another recommendation we'd have. And leveraging some of the existing tools that CMS has to ultimately balance average risk payments between MA and fee-for-service would be valuable.

*Mrs. Lesko. And I thank all of you for being here and for the work that you do.

And I yield back.

*Mr. Griffith. The gentlelady yields back. I now recognize Mr. Peters of California for his five minutes of questioning.

*Mr. Peters. Thank you, Mr. Chairman. Thanks for having this hearing. I was myself a little surprised by the quantity of these amounts, and so I think it is really important that we get programs like Medicare and Medicaid to work the way they were intended, and that we get beneficiaries the access to care that they need.

Just with respect to the comments I have heard about the budget in general, again, I would call your attention to the bill that Bill Huizenga and I have put together for a fiscal commission on the Federal debt and deficit. It would facilitate a discussion of these and other issues that are

looming before us in a way that I think we are just, obviously, not having right now, and this is part of it.

Medicaid provides health care coverage to millions of Americans, including almost a million people in San Diego County alone. So collaboration and data sharing between the Federal Government and state agencies are necessary to ensure that payments to providers and participate plans are timely, but also proper.

Ms. Grimm, in your testimony you state that one risk area for overpayments is Medicaid payments to managed care organizations, or MCOs. Some of these overpayments reportedly occur when a person is enrolled in more than one state's Medicaid program and there are duplicate payments. How would improve data sharing help CMS reduce these managed care overpayments?

*Ms. Grimm. Improved data sharing by allowing states to see what CMS has in its TMSIS system in terms of an enrollee being enrolled in two different states could help states know that they've got a duplicate enrollee on their rolls.

*Mr. Peters. What is the barrier to doing that now?

*Ms. Grimm. CMS did not concur with that recommendation. Its argument was that it has a system called PARIS, and that _

*Mr. Peters. Right.

*Ms. Grimm. _ it would be duplicative. We find

inadequacies with the PARIS system.

*Mr. Peters. So I think it is on Congress, maybe call for that. Is that your understanding?

*Ms. Grimm. I do think that there would be an administrative way for CMS to do that. But sure, if Congress wanted to take action, sure.

*Mr. Peters. Mr. Dodaro, in your written testimony you recommend enhancing collaboration between CMS and state auditors. Can you tell me, like, a little bit more about what you think the benefits of that partnership would be, and how do you -- how do you make sure that states' auditors are doing the right thing? Are they self-incentivized to do that already?

*Mr. Dodaro. All state auditors or any auditors, whether it's Federal, state, or local that audit Federal funds have to follow the auditing standards sent by myself and the GAO for generally accepted auditing standards. So they're held to a standard.

Now, the reason I think that it's effective to do this in Medicaid is each state has a different system. And right now CMS only gets to all 50 states over a 3-year period in order to do the improper payment estimate, and that prevents timely action in regards. The state auditors already have to do the annual single audit of the health funds in Medicare. Usually it's the health department and the agency. So

they're already there, they know the systems. And I think if they're incentivized further to do some more work, then there would be benefits to the Federal Government.

*Mr. Peters. Mr. Griffith had a sort of a profit sharing idea. What do you think would be the way we could make sure that states are participating in the way you think would be most constructive?

*Mr. Dodaro. I've tried to engage CMS with the state auditors, and now that's underway a little bit more. Ms. Grimm's office does a lot of work with the state auditors too. I think we could pull them together and find out from them what they think would be the best incentives, and we will provide that information to the committee.

I deal with state auditors all the time, and just like there's 50 of them, they've got 50 different opinions. And what might work in one state might not work in another. So we have to figure out what's the best way to incentivize them.

But I know some way we have to get them money, either through a profit sharing arrangement or by maybe a matching program, where the Federal Government will put in, the state has some incentive to do more auditing, as well. Maybe there's a way to do some matching up front to pay for it, and then have a cost sharing approach.

*Mr. Peters. The coordination can happen within the

administration, but I assume that the sharing, the cost sharing and the revenue sharing, would have to happen from Congress.

*Mr. Dodaro. It may or may not. There may be some flexibilities. The Federal Government reimburses the states for these single audits that are done, so there's already a reimbursement approach. And this is a joint Federal-state program. We ought to be able to figure out a way _

*Mr. Peters. Is there --

*Mr. Dodaro. _ but maybe Congress may need to do something _

*Mr. Peters. I was going to say, is there anything Congress could do right now to facilitate this kind of cooperation?

*Mr. Dodaro. I think you could ask for CMS to come up with a proposal, and we could come up with one, too.

*Mr. Peters. Great. I'll ask you to do that, then. That's fantastic.

*Mr. Dodaro. Absolutely.

*Mr. Peters. The ideas that come from the outside are often the ones that are most effective. So --

*Mr. Dodaro. Sure, happy to do so.

*Mr. Peters. Thank you very much, Mr. Chairman, for the hearing, and I yield back.

*Mr. Griffith. Thank you very much, and I appreciate

that. And now we will go to Mr. Tonko for his five minutes of questioning.

*Mr. Tonko. Thank you, Mr. Chair.

The Medicaid program provides health care to about 77 million people, including individuals with disabilities and low-income Americans. Today most Medicaid enrollees receive at least some coverage through managed care arrangements with managed care organizations, or MCOs. Though these managed care programs can help states reduce costs if used correctly, there are also increased risks of duplicate payments or payments for ineligible patients.

So Mr. Dodaro, in 2018 GAO identified 6 types of payment risks in the Medicaid managed care program. What types of improper payment risks arise specifically in Medicaid's managed care program?

*Mr. Dodaro. In that area, some of the same risks you mentioned, but it depends on the reviews of the claims. There is a risk of overpayment in those areas, depending upon the documentation that's provided in those areas. And so some of the same risks that occur in the fee-for-service area, it just happens in a managed care environment.

Now, you have some risk, as we've talked about, with these risk adjustment scores when the CMS goes to, you know, sort of queue up the Medicaid Advantage portion with the fee-for-service portion. So there's adjustments in some of those

areas. So that _ it's pretty much _ they're not necessarily unique to managed care, but they're a similar type of risk.

*Mr. Tonko. Okay, thank you. And GAO offered three recommendations for CMS to conduct greater oversight over the managed care program, including expediting guidance on programs -- the program's integrity, addressing impediments to audits, and ensuring that states address overpayments, and setting future program payment rates. So, Mr. Dodaro, again, how has greater oversight into the managed care program helped CMS identify overpayments made by plans to providers?

*Mr. Dodaro. Well, the first thing is they've begun to eliminate the impediments to the audits. Between 2016 and 2018 there were only 16 managed care providers audited. Between 2019 and 2021, 893 have been audited, managed care providers. So that is a good step.

And preliminary results that we've seen indicates overpayments in some cases as a result of these audits. So as they've eliminated that, they need to continue to do that and have more regular assessments over time. So they haven't _ they've started to implement our recommendation. They haven't fully implemented it. They need to have additional guidance out and follow up on a regular basis to make sure that these efforts are underway and that the states good oversight, as well.

*Mr. Tonko. Thank you.

And Ms. Grimm, in your testimony you outlined two major risk areas for improper payment involving Medicaid MCOs: payments for people enrolled in more than one state Medicaid program, and payments to MCOs for people who are deceased. What kind of coordinated action from CMS could help bring consistency to oversight of MCOs and reduce the risks of improper payments?

*Ms. Grimm. CMS could leverage the data that it has in its TMSIS system to provide states with the information it needs to be able to identify whether they're paying for deceased beneficiaries or _ and/or whether a beneficiary is enrolled in another state.

We've also suggested a broad enrollment database as a possible solution.

*Mr. Tonko. Thank you. And as the co-chair of the Addiction Treatment and Recovery Caucus, and the long-time champion for mental health and behavioral health parity, I noticed that your office also recently published a report finding some states were non-compliant with Medicaid managed care mental health and substance use parity requirements.

Ms. Grimm, could you briefly describe what the IG recommended in that report to maintain access to these critical services for patients covered under Medicaid?

*Ms. Grimm. Yes, I can. We did do a report where we looked at whether MCOs were following parity requirements to

ensure that beneficiaries were getting the same kind of access for behavioral health services as one would get for physical surgical health needs.

I'm having trouble finding that, I'm sorry. We recommended that CMS increase its oversight of MCOs to make sure that they're compliant with parity rules. And we recommended additional reporting requirements. And I'm happy to get back to you with the very specific recommendations. CMS concurred with them.

*Mr. Tonko. Okay. And has any action been taken?

*Ms. Grimm. The report is very new.

*Mr. Tonko. Okay.

*Ms. Grimm. It's been out for one month.

*Mr. Tonko. But you could provide us with the specifics, the committee -- subcommittee with it?

*Ms. Grimm. We can provide you with an update.

*Mr. Tonko. Thank you. I would appreciate that. So appreciate the work.

And with that, Mr. Chair, I yield back.

*Mr. Griffith. The gentleman yields back. I now recognize Mrs. Miller-Meeks for five minutes of questioning.

*Mrs. Miller-Meeks. Thank you, Mr. Chairman, for allowing me to waive on to the Oversight and Investigations Subcommittee, and thank you to the witnesses for testifying before the subcommittee today.

Whether you are a Democrat or Republican or something else, the rates of Medicare and Medicaid improper payments should concern you. And as a physician, they tremendously concern me even when physicians are the bad actors. According to the Centers for Medicare and Medicaid Services, the Medicare fee-for-service improper payment rate in fiscal year 2023 was 7.8 percent, which equates to $31.2 billion. While CMS seemed proud of this figure, highlighting in the fact sheet that fiscal year 2023 was the seventh consecutive year in which the improper payment rate was below 10 percent, wasting tens of billions of dollars of taxpayer dollars is highly disconcerting.

I am drafting legislation to implement AI and machine learning at CMS to reduce improper and fraudulent payments. While there may be upfront costs to implementing these technologies, it is important to recognize the long-term cost-saving potential. According to the studies, a one percent reduction in fraud results in one million savings per month.

Ms. Grimm, earlier this year several intermittent catheter companies were found to have engaged in fraudulent activities, deceiving both Medicare and patients. Durable medical equipment industry research identified _ the industry identified _ this was paper-based fraud, meaning the companies did not contact the patients and therefore did not

deliver any products.

I do not believe this is a DME industry issue, but rather an enrollment and claims processing issue. Can you please highlight what CMS is doing to ensure fraudulent players are identified early and prevented from participating in the program?

*Ms. Grimm. Representative, I can tell you what OIG is doing. I cannot comment on any specific investigation. I can't confirm whether it exists or does not exist.

Catheters are a type of durable medical equipment. OIG has a long history with _ of combating DME fraud. I can tell you that we monitor claims data. When we see a spike in billing, we immediately move to investigate. That requires boots-on-the-ground kinds of investigative techniques.

There are a lot of tools that exist if we're seeing that it might be fraud that CMS has at its disposal, things like payment suspension and number revocation. A lot of this happens behind the scenes. One example is a case called Operation Brace Yourself. It was a $2 billion DME fraud scheme that we were able to shut down. In that instance bad actors were buying DME companies, not reporting the sale, billing huge amounts, and then getting out. The proliferation of technology is making this easier to do.

*Mrs. Miller-Meeks. So my understanding is you have made recommendations. I am hoping that CMS takes up some of

your recommendations.

And you have seen firsthand the challenges and opportunities in modernizing data collection, as you have mentioned, within the Federal health programs. Can you elaborate on how the implementation of advanced data technologies could reduce human error and improve accuracy in tracking and reporting on improper payments?

*Ms. Grimm. We are piloting different AI techniques, where we're taking a look at large blocks of text to try to identify patterns, learning from prior fraud schemes, applying that to models.

Without going into specific details about specific cases, we are monitoring how AI is being used in industry and other government areas, of course, within OIG. And we work with CMS on some technological solutions.

*Mrs. Miller-Meeks. So you led to my next question and, I think to build upon that, you see artificial intelligence as playing a role in transforming the detection and prevention of fraud. And are there specific tools or initiatives currently being developed or implemented that you find promising?

*Ms. Grimm. I don't have a specific AI model that I can point to. We are piloting a number of different AI uses to see if we can better detect so that we can quickly respond.

*Mrs. Miller-Meeks. I would look forward to hearing

from them.

And with that, Mr. Chair, I yield my time.

*Mr. Griffith. The gentlelady yields back, and now we are going to have a few questions from Ms. Castor and myself.

Ms. Castor, did you want to go first?

*Ms. Castor. Sure. Thank you, Mr. Chairman. These relate to some of the items I have submitted for the record relating to Florida's disastrous Medicaid redetermination.

And I understand, Ms. Grimm, that the IG's office -- you are conducting oversight of a few different -- I was just handed the report that just came out on Ohio. Do you -- do you have Florida in your sights for one of these oversight reports?

*Ms. Grimm. Thank you for this question. We have Massachusetts, Utah, and I'm forgetting the fourth state, but we do not have Florida in our model currently. We would like to be able to do more states if we had the resources to do it. Right now we have four states in our plan, and Ohio is the first.

*Ms. Castor. And I imagine Utah would be substantially different from a state like Florida.

But I note that one of the items I am submitting for the record is a letter to the governor of Florida from Secretary Becerra also raising very, very significant concerns about how it is conducted and what -- it really looks like most of

the people who have been disenrolled, it is largely because of procedural errors, and just heart-wrenching stories of people with complex medical conditions having to go through rigmarole because they were -- they were discontinued and they don't understand why, in addition to a number of -- just a high proportion of children showing up in the doctor's office and they have been discontinued, and there is no reason, and then the state not helping move them to other options.

So I -- what guidance can you give us? As you go in and you are looking at Medicaid unwinding overall, what can we take back to our state to shine the light on what's happening?

*Ms. Grimm. Thank you for that question.

The fourth state is California.

*Ms. Castor. Okay, so that is a big one.

*Ms. Grimm. That's a big one.

We would point out in the Ohio report that Ohio is using a lot of different electronic systems to be able to do this non-touch step with enrollees so that they are looking at what already exists and they don't have to send out a form to the enrollee. I think that is a more efficient means. In that report we did find that they were generally following guidelines from CMS. And I _

*Ms. Castor. There, you know, it also raises -- I think

there were only two states -- and Florida was one of them -- that refused to accept any help and guidance that was offered by CMS for the -- from HHS for the unwinding. Most states said, yes, we could use your -- this collaboration, and they didn't. So I would highlight that to you. That might be a reason for the IG to say, okay, this state that didn't accept any help and has such a high proportion of folks disenrolled, maybe that would help raise it on your to-do list.

*Ms. Grimm. We would like to come talk to you a little bit more about that matter.

*Ms. Castor. Okay.

*Ms. Grimm. Okay.

*Ms. Castor. Thank you very much.

*Mr. Griffith. The gentlelady yields back, and I appreciate her giving us a few extra questions so that we could _

*Ms. Castor. Thank you.

*Mr. Griffith. _ get Mr. Joyce here. Dr. Joyce would _ is now recognized for his five minutes of questions.

*Mr. Joyce. Thank you for allowing me to waive on to this important hearing, Chairman Griffith, and thank you, Representative Castor, for your assistance here today.

Given the current fiscal state of the Federal budget, now, more than ever, robust oversight and financial controls over existing mandatory spending is necessary to ensure that

the Federal funding is used properly, and spending is done according to the law.

In fiscal year 2023 alone, we have seen Medicare and Medicaid report improper payments of over $100 billion. This underscores why this hearing is necessary. Ms. Grimm, in regard to fraud charges in the prescription drug space, can you discuss specific initiatives that have been recently implemented to combat these issues?

*Ms. Grimm. With respect to opioids?

*Mr. Joyce. Specifically regarding opioids.

*Ms. Grimm. Okay. We have something called a fraud task force. It's called heat task forces. We typically would include, if we're finding physicians that are over-prescribing and doing it illegally, they might be part of those investigative efforts.

Frankly, we have seen a decline in physicians that are prescribing opioids at a concerning amount and at-risk beneficiaries, according to the data that we see. So we have moved over to access for substance use disorder.

*Mr. Joyce. Additionally, can you provide any examples with measures that have been utilized to address issues of counterfeit drugs like Ozempic, which is currently very popular?

*Ms. Grimm. I'm not sure I understand the question about Ozempic. I'm sorry, can you repeat it?

*Mr. Joyce. Are there issues that you are seeing counterfeit measures _ counterfeit drugs coming into the arena as far as utilizing these new drugs like Ozempic, which are commonly prescribed?

*Ms. Grimm. I'm not aware of any work in this space. That doesn't mean that we haven't received a hotline complaint and we might be working on something.

*Mr. Joyce. Thank you. Could you specify the tools or resources, Ms. Grimm, that would further enhance your office's ability to detect and protect against fraud in Medicare and Medicaid?

*Ms. Grimm. Congressman, thank you for that question. Frankly, resources in general for the Health Care Fraud and Abuse Control Program are very much needed. Those resources have not been rebased since 2010. We are currently turning down 300 to 400 viable cases, cases involving nursing home residents being forced to take antipsychotic drugs, hospice fraud involving people who are enrolled in hospice and being told they have a fatal condition and they do not, opioid misuse where physicians are trading for cash or worse.

We are having to turn down some serious cases. That's not to say that we aren't prioritizing to deal with the worst of the worst, but the most important thing that can be done is for Congress to take a look at that legislative proposal that would rebase our HCFAC program, which would provide an

immediate infusion. We would be able to, in the first year, hire 100 agents to get to some of the back load and some of the serious cases that I have described.

*Mr. Joyce. So please clarify for me. Just minutes ago you said there are fewer cases of opioid problems, but then you said there are cases that are not being investigated. Reconcile that for me, please.

*Ms. Grimm. There are fewer _ from our data analysis there are fewer providers that are prescribing _

*Mr. Joyce. Is that because you don't have the opportunity to investigate?

*Ms. Grimm. No, that's just from some of the enforcement that we've taken, we have seen a decrease. But we don't have some of the resources to tackle some of the cases that are coming to us.

*Mr. Joyce. Thank you.

Mr. Dodaro, based on the GAO's evaluations, which aspects of Medicare and Medicaid are most susceptible to fraud?

*Mr. Dodaro. Well, I think the programs overall have been susceptible to fraud, and it can be in any of the areas. I mean, I don't think there's any one in particular.

I think there have been some areas that have been pointed out, durable medical equipment being one of them; home health services being another one that are higher-risk

areas that are susceptible to fraud. But it can occur in any part of the programs. And that's why I think you need better program integrity efforts.

*Mr. Joyce. Thank you for your answers. My time has expired. And I agree with you, I think we definitely need better integrity managers.

Chairman Griffith, thank you again for allowing me to waive on.

*Mr. Griffith. Thank you very much.

And seeing there are no further members wishing to ask questions, I would like to thank our witnesses again for being here today. Thank you.

I ask unanimous consent to insert into the record the documents included on the staff hearing documents list, including the ones that Ms. Castor mentioned earlier.

Without objection, that will be the order.

[The information follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. Pursuant to committee rules, I remind members they have 10 business days in which to submit additional questions for the record, and I ask the witnesses to please submit their responses within 10 business days upon their receipt of the questions.

Without objection, the committee is adjourned.

[Whereupon, at 12:25 p.m., the subcommittee was adjourned.]