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SAVING TAXPAYER DOLLARS BY CURBING WASTE AND FRAUD IN MEDICAID

HEARING

BEFORE THE

FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT INFORMATION, FEDERAL SERVICES, AND INTERNATIONAL SECURITY SUBCOMMITTEE

OF THE

COMMITTEE ON
HOMELAND SECURITY AND
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

ONE HUNDRED TWELFTH CONGRESS

SECOND SESSION

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SAVING TAXPAYER DOLLARS BY CURBING WASTE AND FRAUD IN MEDICAID

THURSDAY, JUNE 14, 2012

U.S. SENATE,
SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT,
GOVERNMENT INFORMATION, FEDERAL SERVICES,
AND INTERNATIONAL SECURITY,
OF THE COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:04 a.m., in Room SD–342, Dirksen Senate Office Building, Hon. Thomas R. Carper, Chairman of the Subcommittee, presiding.

Present: Senators Carper, Brown, and Coburn.

OPENING STATEMENT OF SENATOR CARPER

Senator CARPER. Good morning, everyone. The hearing will come to order. Actually, the hearing is in order. This is the quietest group I have seen or heard in quite a while. In fact, I hear nothing out there. If I closed my eyes, I would think I was here by myself. But we are glad you are all here; especially I want to welcome our witnesses.

As you know, today's hearing will focus on one of our Nation's critical safety net programs, and that is Medicaid—the partnership between our States and the Federal Government—and the steps that must be taken to help further reduce waste and fraud and improve efficiency and effectiveness as well.

A combination of Federal and State funding, as we all know, pays for Medicaid, though States take the lead in administering the program. Over the last year, State governments paid approximately $404 billion to care for some 70 million beneficiaries. These numbers are expected to grow in the coming years as the Affordable Care Act expands access to Medicaid for millions of additional Americans. And as we all know, both the Federal and State governments have struggled with record budget deficits in recent years. Today our national debt stands at just a bit over $15 trillion, well over double what it was just a decade ago.

The last time that our Nation's debt was this high, I think, as a percentage of the gross domestic product (GDP) was at the end of World War II. That level of debt was not sustainable then, and we all know that it is not sustainable today.

In order to address the burden this debt places on our country, we need to look, as my colleagues have heard me say again and again, in every nook and cranny of the Federal Government, all

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programs of Federal spending, large and small, and make certain the resources that we are investing are being spent efficiently and effectively. We need to demand results and focus the scarce resources that taxpayers entrust us with on what works. We need to find out what works and do more of that. And across the Federal Government, program managers need to sharpen their pencils, and stop making the kinds of expensive, avoidable mistakes that lead to improper payments.

The bad news is that the Government Accountability Office (GAO) tells us that last year improper payments were $115 billion. That is the bad news. The good news is that a year earlier it was $119 billion, and even with more programs covered, by the estimate it is coming down, so that is positive. But it is still way too high. With Medicaid, a significant amount of taxpayer dollars are unfortunately lost to waste and to fraud. Those resources could and should instead be used to help States provide quality health care to some of the most vulnerable citizens among us.

According to GAO, Medicaid made an estimated $21.9 billion in improper payments in 2011. I think we have a chart[1] over here. What does it say? It is hard to read over here. No, it is easy to read: $21.9 billion. I think if you add that to Medicare improper payments of about $40 billion, and that is with the Medicare prescription drug program added in for the first time—and the Medicare number is actually coming down a little bit despite the addition of the Part D. But that is still way too much. We can do better than that, and we have to do better than that.

I think the Administration has indicated that their goal in, I know, Medicare—not in Medicaid as well, but their goal in Medicare is to bring almost down by half I think by the end of next year the improper payments in Medicare. We need to make great progress as well in Medicaid. And to the extent that we do in reducing improper payments in Medicaid, we help not just the Federal Government and the Federal deficit but we, frankly, help the States as well, because almost half the money that is involved there is theirs.

Medicaid continues to be on GAO's list of Government programs at a high risk for waste, fraud, and abuse, as it has been for many years. Now more than ever, it is urgent for us to step up our efforts to eliminate the problems that lead to waste and fraud across the government. Success in doing so will help us as we work to curb our debt, and in the case of Medicaid, as I said earlier, to help States, one of which I used to be Governor. But ultimately all of us—Congress, the Administration, and the States—want to improve program integrity in Medicaid to ensure that the program has the resources that are necessary to provide critical services to those in need, to the least among us.

That is why I was encouraged to learn that in 2011 we saw a decline in the level of improper payments in Medicaid compared to more than $22 billion estimated that we saw there in 2010. So you may recall Dr. Coburn, Senator Coburn and I authored legislation signed by President Obama in 2010 that said, Federal agencies, not only do you have to figure out what your improper payments are,

[1] The chart referenced by Senator Carper appears in the appendix on page 85.

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you have to stop making them, you have to go out and recover them, and we are going to evaluate supervisors within the Federal agencies in part on how well they comply with that law. And the next year, 2011, we saw some drop in the overall improper payments from $119 billion to $115 billion, and even in Medicaid, this number has dropped from a little over $22 billion to $21.9 billion. Is that enough? No. Can we do better? Sure. But it is progress, and for that we are grateful.

But the Centers for Medicare & Medicaid Services (CMS) and State governments are clearly beginning to make some progress. However, as I said, more work remains in our efforts to curb improper payments and reduce the amount of taxpayer dollars lost to errors, waste, and fraud. I want to encourage CMS to continue to partner closely with the States to take advantage of every opportunity to prevent, identify, and recover improper payments. We cannot afford not to.

Fortunately, Congress and the Administration have made reducing Medicaid waste and fraud a high priority and are taking important steps to improve its management of this critical program. And the Affordable Care Act, enacted in 2010, includes a number of provisions, as some of us know, aimed at enhancing our efforts to fight waste, fraud, and abuse in Medicaid and Medicare. These provisions aim to eliminate avoidable mistakes and crack down on criminals. They are critical to our broader efforts of achieving better healthcare results and improving access to affordable, quality healthcare. We are also looking at additional steps that the Federal Government should take.

Senator Coburn—and there is his name again—Dr. Coburn, who is not only a doctor and Senator, but he is also, it turns out, an accountant. What do they say in baseball, that you are a five-tool player? He is at least a three-tool player here in the U.S. Senate. But Dr. Coburn and I along with dozens of our Senate and House colleagues, including the fellow to my right here, have put forward legislation to fight fraud, waste, and abuse in Medicare and Medicaid programs a couple of times, but most recently in something called the Medicare and Medicaid Fighting Fraud and Abuse to Save Taxpayer Dollars Act (FAST). That is what we call it, but it is Medicare and Medicaid Fighting Fraud and Abuse to Save Taxpayer Dollars Act. I do not know how you get FAST out of that, but someone has figured it out.

It takes some of what we already know works to decrease waste and fraud in the private sector or what we have seen beginning to work elsewhere in government. We apply those lessons and those ideas to Medicare and Medicaid. Our bill includes a wide range of initiatives. Among other things, the legislation would increase antifraud coordination between Federal and State government. That is good. It would increase criminal penalties for fraud. That is good. It encourages seniors to report possible fraud and abuse in Medicare through the Senior Medicare Patrol. That is good. We have also changed the language, the way the messaging goes to seniors, and they want to actually see copies of the bills that are being paid for them for Medicare services. Actually, it is now being written in ways they can actually read and understand so they can actually be a better partner with the Senior Medicare Patrol. That is good.

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And deploy cutting-edge data analysis and technology, some of which we are actually borrowing from the credit card industry where they do a better job of combating fraud than we do in Medicare and Medicaid.

Our legislation addresses loopholes in fraud prevention efforts that have been exploited to an alarming degree over the years. For example, there are the glaring problems of dead doctors who still manage to charge us for care they provide to patients live and dead—obviously a form of fraud. This is disturbing; it is also unacceptable. And our bill would require that the Federal Government and law enforcement take steps to curb the theft of physician identities.

I often say there is no silver bullet for fighting waste and fraud, but this bipartisan bill provides—I think we have over 35 cosponsors. That is good, too. I would like to have a few more. But this bipartisan bill provides a lot of smaller proven, common sense solutions, and it builds on recommendations by the Office of the Inspector General (OIG), by GAO, and other smart people to improve on our current work, Program Integrity at CMS, which, as I have mentioned, already has made some important progress in reducing waste and fraud in these programs.

All right. I am almost done. One more chart.[1] Even as we look ahead to implementing additional tools to help improve efficiencies and effectiveness in Medicare and Medicaid, we also need to evaluate the effectiveness of the current tools at our disposal and identify what is working and where we need to improve our efforts.

Today our witnesses from GAO and the Office of Inspector General will help us in that effort by describing weaknesses in the two primary Medicaid anti-waste and fraud systems now utilized by the Federal Government. According to GAO, one program that relies on Medicaid integrity contractors only identified about $20 million in overpayments since 2008. Yet we spent $102 million to operate the program during the same period.

I actually read that twice to make sure I had that right, and I am going to read that again. It says: According to GAO, one program that relies on Medicaid integrity contractors only identified about $20 million in overpayments since 2008. Yet we spent $102 million to operate the program during that same period of time.

We clearly need to identify ways to improve our return on investment here. And what do they say? A picture is worth a thousand words. There is a picture: cost, $102 million; return, about $20 million. So instead of saving money for the taxpayers, it looks like we lost about $80 million, and that is not good.

Finally, there are similar problems with the second Federal anti-waste and fraud programs. It is called Medicare-Medicaid Data Match Program, where Medicare and Medicaid data are compared with each other to spot duplication and other problems. Over a 2-year period of time, the program received some $60 million in funding but only prevented or recouped about $58 million in improper payments. That is better than what we see in this chart[2] to my left, we lost money there as well rather than reducing costs.

[1] The chart referenced by Senator Carper appears in the appendix on page 86.
[2] The chart referenced by Senator Carper appears in the appendix on page 87.

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But there have also been some successes, to be fair, and earlier this year, the Administration announced another record-breaking year in joint Federal and State efforts to identify and prosecute health care fraud, with more than $4 billion in recoveries from Medicare, Medicaid, and other Federal health care programs. I think that might be a record. I think it was maybe a record 2 years in a row, and we applaud that there is still a lot of fraud out there, so we need to continue those efforts and strengthen them.

In addition, stronger steps have been taken to screen physicians and other providers in order to avoid physician identity theft and other fraudulent activities that can lead to drug diversion and fraud. In fact, CMS announced last week this new automated screening process has already purged the provider database of more than 20,000 providers that were ineligible to participate in Medicare and Medicaid due to death, licensing, and other problems. That is an important step forward, and we applaud that.

I look forward today, we look forward today to hearing from Dr. Budetti, head of CMS' program integrity efforts in both Medicaid and Medicare, about how he and his team intend to build on what has worked so far and improve the performance of those initiatives that have not worked as well as any of us would like. And I also look forward to hearing from the State agency representatives we have with us today about their experiences in curbing Medicaid waste and fraud. And we are here in large part today because we have a moral imperative to ensure that both present and future Medicaid beneficiaries continue to have access to quality care. At the same time, we must also ensure that scarce taxpayer resources we invest in the program are being spent as effectively as possible.

Now I would like to turn to Senator Brown, welcome him here, to make any comments that he would care to make. Senator Brown, good to see you.

OPENING STATEMENT OF SENATOR BROWN

Senator BROWN. Good to see you, too, Mr. Chairman. Thank you.

I am not sure about you, but I am tired of seeing these numbers. Every time we come to one of these hearings, we see more numbers. I would note that it cost $6 billion to extend the student loan interest rate at the level that we have it, yet according to the chart you just had, I thought it was—I do not want to misspeak, but I thought it said $21.9 billion in improper payments were made in the fiscal year. I have a bill, as you know, Mr. Chairman, that will take some of those savings to pay for that interest staying the same and using that money that is already within the system instead of taxing our Subchapter S job creators, not only in Massachusetts, but throughout the country.

As we all know, the Supreme Court will decide the fate of the Patient Protection and Affordable Care Act (PPACA), and it is expected any day now, as we know and you referenced. I think it is more important now than at any time since I have been here, certainly, to start to find a bipartisan solution to address our Nation's most pressing problems like health care. I believe a crucial step in maintaining the viability of health care programs like Medicaid and Medicare is to ensure that these programs are not weakened by the waste, fraud, and abuse. As you referenced, there is going

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to be a lot more folks coming onto the system, and as a result of that, there is even more of an opportunity for that fraud, waste, and abuse that we have already seen.

As our Nation ages, and the economic stagnation continues, these health care programs continue to put pressure on our Nation's tough fiscal situation. We are not going to be able to tax our way out of this mess into prosperity. That is why this morning's hearing on curbing the billions of dollars, potentially, of waste, I just find mind-boggling, and we cannot afford this business as usual approach.

I have been honored to be on this Subcommittee this past year, and I know we are getting toward the end of the legislative session. However, the things we have done and brought to the attention of folks who are basically driving the trains I think has been a good thing. We brought this up. Some of them have tried to do yeoman's work to fix it. However, I do not think others give much credence to what we have said and how they are addressing these problems.

We are going to turn our attention to the Medicaid program, which is timely, as you know, because the PPACA will expand potentially Medicaid coverage by an estimated 16 million people by 2019. That is a 32-percent increase. The cost of the expansion is going to exceed $430 billion over the next 10 years, and the government is responsible for paying over 90 percent of these increased costs. I do not know where the money is coming from, but this is on top of the $404 billion in Medicaid costs for Fiscal Year (FY) 2010, of which the government's share was $271 billion.

So we will explore what the Center for Medicare & Medicaid Services is doing to confront the menace of fraud in Medicaid. Measuring, obviously, fraud in Medicaid is difficult, but CMS estimates, as we referenced, almost $22 billion in improper payments in Medicaid in Fiscal Year 2011. Once again, I believe the Congress has been complicit for far too long in this business as usual. This kind of go-along/get-along mentality where it really does not matter, a billion here, a billion there. It is mind-boggling, as I have said.

I look forward to continuing to play a role in finding ways to improve the coordination between the Federal Government and the States and improve coordination across States. I believe we need to do a better job in leveraging the IT to prevent the fraud. It seems to be, once again, a no-brainer. We need to know if a doctor is dead and you should report if a doctor is dead. There should be a central database, and immediately tied into a lot of the prescription pharmacy outlets, and it should be a red flag. It should be immediately stopped. The person should be arrested for perpetrating a crime, and we need to really do it better.

I came to Washington to work in a bipartisan manner as many of you know, and I am going to continue to do that, and I look forward to hearing the testimony. Thank you.

Senator CARPER. Thank you, Senator Brown.

Dr. Coburn, before you arrived, there was some mention of your name with respect to improper payments and the notion that we are actually making a little progress since our 2010 law was signed into law. I described you as a "three-tool player"; in baseball parlance, you are a five-tool player. As you know, you are exceptional.

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I said, "He is not just a Senator, he is not just a physician, he is not just"—"Now I know he is an accountant, but he is also a husband, and this weekend I think a father on Father's Day. So that is five tools. That is not bad. So thanks for all your work on this stuff, and you are recognized, please.

Senator COBURN. I will pass on an opening statement so we can hear our witnesses.

Senator CARPER. OK, fair enough.

Some other breaking news. Dr. Budetti, I am told by Peter Tyler, who sits over my left shoulder, that in an interview last night, you indicated taking some strong, decisive measures to get the Medicaid Integrity Contractor (MIC) Program on a more positive track, and I do not want to steal your thunder, but I would characterize those moves as positive and an encouraging example of the Administration trying to ensure that curbing waste and fraud in Medicaid continues to be a priority, and we look forward to hearing more about that in the course of your testimony. Just very brief introductions. I am just going to make this real brief.

Peter Budetti, M.D., J.D., Deputy Administrator and Director for Program Integrity, Center for Medicare & Medicaid Services, a visitor here and witness before us previously. We are delighted that you are back here today.

One of two Douglases, the first is Douglas Porter, the State of Washington Health Care Authority. Who is your Governor now? Is Christine Gregoire still the Governor?

Mr. PORTER. Yes, sir.

Senator CARPER. For another 6 months or so?

Mr. PORTER. She has another 6 months to sprint to the finish.

Senator CARPER. All right. If you ever see her, give her my best.

Our second witness is Douglas Porter, Director of the Health Care Authority for Washington State, which is their Medicaid agency. He spent almost 10 years working for the State of Washington as well as previous work with Medicaid agencies in California and Maine. We thank you for joining us today.

The second Douglas here is Douglas Wilson, and Mr. Wilson is the Inspector General for Health and Human Services Commission in the State of Texas. Most of those jobs down there are elected. Are you elected?

Mr. WILSON. No, sir, I am not.

Senator CARPER. OK. All right. Mr. Wilson has over 25 years' experience in State government with expertise in auditing, accounting, grants and contracting, investigations, licensing, compliance and enforcement. You are a five-tool player as well, I would say, with that introduction. Before his appointment, Mr. Wilson served as the Deputy Director of the Texas Attorney General's Medicaid Fraud Control Unit (MFCU). We want to thank you for being with us today all the way from Texas.

Next, Carolyn Yocom, Director of the Health Care team for GAO. Ms. Yocom has worked on a variety of issues related to health care, particularly Medicaid and State Children's Health Insurance Program (SCHIP). She has been at GAO for 20 years and has testified numerous times before Congress. We thank you for testifying here today and for the good work that you and your colleagues at GAO do.

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And, finally, last but not least, Ann Maxwell, who is the Regional Inspector General with the Office of Evaluation and Inspections at the Department of Health and Human Services. Ms. Maxwell has worked for 15 years for the Inspector General. She has directed national studies in Medicare and Medicaid and public health and in child welfare. We thank you for your work. Thank you for being with us today.

Dr. Budetti, you are recognized. Everyone, your whole statements will be made part of the record, so if you want to summarize, you are welcome to do that. Try to stay as close to 5 minutes if you can. If you get way beyond that, we will have to rein you in. Thank you so much. Dr. Budetti, you are recognized. Welcome.

TESTIMONY OF PETER BUDETTI,[1] M.D., J.D., DEPUTY ADMINISTRATOR AND DIRECTOR FOR PROGRAM INTEGRITY, CENTERS FOR MEDICARE & MEDICAID SERVICES

Dr. BUDETTI. Thank you, Chairman Carper, Ranking Member Brown, Dr. Coburn. Thank you for this opportunity to discuss the Centers for Medicare & Medicaid Services' program integrity efforts for the Medicaid program.

As you know, the Administration has made important strides in reducing fraud, waste, and improper payments across the government. We have implemented powerful new anti-fraud tools provided by Congress that are enabling us to move beyond "pay and chase" to preventing fraud. Simultaneously, we are building on the many accomplishments of the Medicaid Integrity Program by making substantial improvements to certain parts of the program, in particular the National Medicaid Audit Program (NMAP).

Just a little background on the Medicaid Integrity Program. It was established under the Deficit Reduction Act (DRA) of 2005, and it is the first comprehensive Federal strategy to prevent and reduce provider fraud, waste, and abuse in the Medicaid program. Our Center for Program Integrity (CPI) in the Centers for Medicare & Medicaid Services became responsible for the operation of the Medicaid Integrity Program in April 2010.

CMS has two broad statutory responsibilities under the Medicaid Integrity Program. The first is the one that is the main topic of our discussion today, the National Medicaid Audit Program, in which the CMS contracts with private sector entities to review Medicaid provider activities, audit claims, identify overpayments, and educate providers and others on Medicaid program integrity issues.

The second statutory responsibility is providing technical assistance and support to the States in their efforts to combat Medicaid provider fraud and abuse. I think you are well aware—and it is in detail in my written testimony—that the Medicaid Integrity Program has had a number of clear successes. I think you are very familiar with the Medicaid Integrity Institute (MII) that now has had over 3,000 students from State government pass through and has repeatedly been praised as making a substantial contribution to State efforts to combat fraud and improper payments.

We have also provided boots on the ground for specific projects in a number of States to carry out targeted anti-fraud action.

[1] The prepared statement of Mr. Budetti appears in the appendix on page 45.

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We have special contractors who are engaged in educating providers and beneficiaries on program integrity efforts. We also conduct triennial comprehensive reviews of each State's program integrity activities and disseminate best practices across the States. Further, we conduct annual State program integrity assessments to collect standardized national data on the State Medicaid program integrity activities. So all of these are very strong accomplishments of the Medicaid Integrity Program.

One major area has not been as successful as anticipated, and that is the National Medicaid Audit Program. CMS has identified redundant, ineffective, and inefficient practices in the existing program. As a result, over the course of the past 2 years, we have made changes in the National Medicaid Audit Program and initiated a redesign of the program that involves developing new approaches with States to provide for more effective and less burdensome audits of Medicaid providers, including expanding collaborative audits, and also at the same time we are working on modifying the Medi-Medi program, better identifying audit targets, and overhauling our contracting structure.

The original approach implemented shortly after the start of the Medicaid Integrity Program in 2007 created two types of Medicaid integrity contractors for the National Medicaid Audit Program: review contractors analyzed Medicaid data to assist with the identification of audit targets, and audit contractors went out and conducted audits of the providers. During the test phase, the review contractors relied on data from the States' full Medicaid Management Information Systems (MMIS), and that led to positive findings. With full implementation, however, the review contractors conducted their analyses based on a more limited data source because it was the only nationwide Medicaid claims and beneficiary information source reported to the Federal Government.

The first audits were assigned in September 2008 based on these analyses. By mid-2010, the full impact of the limitations of the data available for selecting audit targets became available. At that time CMS began to explore options to a different approach to auditing providers and began a State collaborative audit concept with a small number of States beginning in January 2010. As of February 2011, CMS discontinued assigning new targets through the traditional audit process based solely on reviews of the national data set and focused the audit processes instead on expanding additional collaborative audits with States and other direct interaction with the States. So the first audit targets went out in 2008, in September, and as of February 2011, we discontinued that specific model and moved toward a more collaborative model and much greater interaction with the States.

We are fundamentally changing the design and operation of the program to improve its overall effectiveness. We are incorporating lessons that we have learned from our early implementation efforts and from our initial success with collaborative audits. We are paying close attention to recommendations such as the ones you will hear today from the Office of Inspector General, the Government Accountability Office, and also from the National Association of Medicaid Directors (NAMD) and the Medicaid and CHIP Payment and Access Commission (MACPAC). And we are pleased to see that

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many of these recommendations complement the efforts we already have underway.

There are two main prongs of our new approach: working with States on expanding collaborative audits and developing more viable options for sharing data at the State and Federal level. Since the first collaborative audits were begun in 2010, we have worked with States to—we now have 137 collaborative audits in 15 States representing approximately 53 percent of all Medicaid expenditures. CMS is currently in discussion with 15 additional States to expand the use of collaborative audits.

As we change our approach, we are also determining options for the existing Medicaid program integrity contractors going forward. And as you noted, Mr. Chairman, we have had five active task orders for reviewing Medicaid providers for anomalies for billing. We intend now not to exercise the renewal option on three of those five task orders because the original focus of the work is no longer consistent with our redesign efforts. We are currently reassessing our approach, and we have redesigned the review contractors' work away from the focus of identifying audit targets based solely on the national data set.

In addition to building the collaborative audit program, we are also committed to pursuing alternative sources for audit quality data. We are working very closely with States to identify the data elements that would be satisfactory for multiple Federal purposes. A pilot of the new data reporting system began in May 2011, and since then, test data has been received, and the proof of concept is targeted for completion this summer.

I will summarize very quickly by identifying our plan of action in engaging the States to work with us, that even as we reconfigure the National Medicaid Audit Program in a State and Federal partnership and enhanced Medi-Medi, we will also expand our efforts to work with States in other areas that are of importance to the States and also to expand the Medicaid Integrity Institute.

I would like to let you know that we have identified five action items.

One is discontinuing the assignment of new audit space solely on the earlier data set and analysis. As I said, that began in February 2011. We have been realigning the tasks of the contractors, and we have now chosen not to exercise the option years on three of the five review contractors' task orders.

The second point is to develop and expand our collaborative audits to go beyond the 137 we have now. We are looking to expand to an additional 15 States by the end of 2013 and continue the expansion in particular with high Medicaid expenditure States by the end of 2013.

No. 3, to develop and implement enhanced data reporting by the States to fill gaps in the data set that had been reported to the Federal Government, and we intend to continue that through 2012 and finish that initial stage this year.

No. 4, we are reconfiguring the Medi-Medi program that will serve as a complement to the collaborative audit program.

And, finally, we will continue to monitor the return on investment of both the old and the new approach to the National Medicaid Audit Program.

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I appreciate the opportunity and your indulgence in going a little over my time limits, Mr. Chairman, to describe the major changes that we are undertaking, and I will be happy to answer any questions. Thank you.

Senator CARPER. Well, you have a lot to say, and we are pleased that you have had the chance to say that, and we look forward to asking some questions.

Mr. Porter, welcome. Thanks for joining us.

TESTIMONY OF DOUGLAS PORTER,[1] DIRECTOR, WASHINGTON STATE HEALTH CARE AUTHORITY

Mr. PORTER. Thank you, Mr. Chairman, members of the Committee, for this opportunity to testify. For the record, my name is Doug Porter, director of the Washington State Health Care Authority, and I am here to discuss the State and Federal efforts to reduce fraud, waste, and abuse in the Medicaid program, and specifically I will speak to the State's perspective on what is working, what is not working, and where we see room for improvement.

What is working? I am happy to report that the partnership between the State and Federal officials in program integrity is a good one. Our interests and incentives to be good stewards of the taxpayers' money are closely aligned. I will cite just a few examples of this solid working partnership.

I have been associated with the Medicaid program for about 20 years or so and served on various technical advisory groups. In my opinion, the Fraud and Abuse Detection Technical Advisory Group is one of the most productive and the best functioning TAGs in recent memory and a solid collaboration between State and Federal officials.

As Dr. Budetti just mentioned, the Medicaid Integrity Institute is a huge new asset for State program integrity staff to develop skills and share best practices, and we welcome the openness on the part of CMS to make available Medicare data to States. We think this is a big opportunity not only for program integrity enhancements, but also to improve care coordination for those clients who are eligible for both Medicare and Medicaid.

What is not working? Three major challenges on that front: The erosion recently of State resources, the layers of outmoded or ineffective programs that we have had to contend with, and bad data.

On the erosion of State resources, I will give you my own personal story. Over the last 4 years, since 2008, I have lost 20 percent of my workforce due to budget cuts. Our State legislature much prefers to eliminate administrative costs rather than program costs. I now have only 40 staff assigned to program integrity efforts to oversee over $5 billion a year of health care expenditures, and that is just not enough of a resource to do the job right.

On the continuance of ineffective programs, I would list, as you have already heard, the Medicaid integrity contractors, and the Medicaid Eligibility Quality Control (MEQC), the Payment Error Rate Measurement Program (PERM), and the Medicare-Medicaid Data Match Project. These programs all draw resources away from activities that in our State would yield a better return on investment and detract from our ability to generate even more savings than we have to date.

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On the data front, there is a lot of data, very little good information, as Dr. Budetti just indicated. Poorly collected and organized data is what is giving us a problem. The Medicaid Statistical Information System is not uniformly reported on by all States, making apples-to-apples comparisons very difficult. And the Medicare data that we are getting access to date has been difficult as it comes—Medicare Part A, B, and C comes in six different file formats for both ongoing and historical data and makes it very difficult if not impossible to merge with our existing Medicaid database.

Opportunities for improvement, let us build on what works. I would like to suggest that State efforts be supported and reform that a 75–25 matching fund be available to State program integrity staff such as is currently available to Medicaid fraud control units around the country.

Also, if we could do one thing I think would take a big burden off States, it is to create a national level provider enrollment capacity that would screen out bad providers on the front end. In the process of getting a national provider identification number, that would be the start and then have them re-enroll every 3 years. That way a central observation could be made on the databases that currently exist as to who the bad actors are out there.

I think the Medicare database, as I said, could be improved by having a single documented file format and one single set of confidentiality and privacy requirements. And we should use a return on investment analysis to evaluate the effectiveness of programs and fund them accordingly.

I would make a pitch finally to further enhance the Medicaid Integrity Institute by using distance education and involving Webinars to reach more State staff around the country. And I would suggest the establishment of a national certification process to credential State program integrity staff.

That concludes my prepared remarks, and I thank you very much for the opportunity to be here today, and I would be glad to answer any of your questions.

Senator CARPER. Good. That is a real interesting to-do list. Thank you.

Mr. Wilson, welcome. Please proceed.

TESTIMONY OF DOUGLAS WILSON,[1] INSPECTOR GENERAL, HEALTH AND HUMAN SERVICES COMMISSION, STATE OF TEXAS

Mr. WILSON. Good morning, Chairman Carper, Ranking Member Brown, and Dr. Coburn. For the record, my name is Douglas Wilson, and I serve as the Inspector General for the Texas Health and Human Services Commission. I appreciate the opportunity to be with you today to offer testimony from the Texas perspective regarding program integrity challenges, opportunities, and successes.

Over the past year, we have worked in Texas to reform and refocus the Office of Inspector General. We have shifted resources internally to target our efforts to the cases with the greatest potential for recovery, increased the number of case investigations,

[1] The prepared statement of Mr. Wilson appears in the appendix on page 58.

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shortened our investigative timeframes, and we are on track to increase the identification of potentially recoupable dollars.

We recognize the importance of positive relationships between the States and CMS, and our experience with CMS has been positive. We primarily work with the Medicaid Integrity Group, and we have experienced cooperation at all levels. Through our attendance at the Medicaid Integrity Institute, we have greatly benefited from the ability to work through current and emerging issues and to discuss challenges and opportunities faced by other States with similar responsibilities.

The ability to share information and knowledge at the Federal, State, and local level is very important to our collective success. In our experience, more data is better. Whether the data comes from Medicaid, Medicare, the Supplemental Nutrition Assistance Program (SNAP), the Women, Infants and Children's Program (WIC), the Temporary Assistance for Needy Families (TANF), Craig's List, county property lists, or nearly any other source, all of this data can help us to identify patterns of behavior and billings which may lead to the faster identification of intentional or inadvertent overbilling and overpayments. Usable access to the Medicare claims and payment data would be greatly beneficial to us.

Texas OIG has spent a lot of time meeting with companies to discuss information technology solutions designed to improve the probability of detecting schemes and patterns sooner. We believe we have identified pattern recognition technology that identifies patterns and connections between seemingly unrelated events and individuals. Thus, data queries that might normally take hours or even days to run can be completed in minutes or even seconds. The ability to partner with the Federal Government to assist with the cost of this type of software is important to our anticipated success.

Today, interdiction and recoupment efforts are a two-edged sword. States work to identify potential overpayments, and after due process steps we have to worry about potentially having to repay CMS more than we can ever hope to collect.

Unfortunately, this process builds in disincentives to the States to be active in identifying and publicizing anti-fraud, anti-overpayment activities. In Texas, we are currently in the midst of investigating a small number of orthodontists who collectively have overbilled the State potentially hundreds of millions of dollars over the past 5 years. We find ourselves making tough decisions regarding aggressively pursuing overpayments while at the same time working with the Medicaid program to ensure we do not create access to care issues and leave Texas children at risk.

In summary, we believe there is a solid foundation for the CMS-State relationship but also that the environment in which that relationship exists needs to change to improve. An attitude of cooperation and assistance is already evident but needs to extend further, to data access and resource development.

I appreciate the efforts of CMS, and in particular I am grateful for the efforts this Subcommittee and the efforts that you continue to make. The Texas OIG looks forward to partnering with CMS and other Federal, State, and local agencies involved in the fight to rid our programs of fraud, waste, and abuse.

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I am happy to answer any questions you may have. Thank you for inviting me.

Senator CARPER. Thanks so much. Thanks for joining us from Texas and for your testimony.

Now we will turn to Ms. Yocom. Ms. Yocom, welcome. Good to see you.

TESTIMONY OF CAROLYN L. YOCOM,[1] DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Ms. YOCOM. Chairman Carper, Ranking Member Brown, and Members of the Subcommittee, I am pleased to be here to discuss the National Medicaid Audit Program. My statement will highlight key findings from a report prepared at your request which focuses on the effectiveness of the MIG's implementation and subsequent redesign of the National Medicaid Audit Program.

In brief, our work found that the majority of the audits that the MIG conducted were less effective than its initial test audits and the more recent collaborative audits, primarily because they use Medicaid Statistical Information System (MSIS) data. MSIS data are an extract of States' claims data, and they are missing key elements such as provider identifiers that are important for identifying appropriate targets.

Since Fiscal Year 2008, just 59 of the 1,550 MSIS audits identified $7.4 million in potential overpayment. Of the remaining MSIS audits, over two-thirds did not identify overpayments, and the remaining audits, 27 percent, were ongoing. In contrast, the 26 test audits and the 6 collaborative audits which used States' more robust claims data and allowed States to select audit targets together identified more than $12 million in potential overpayments. Moreover, the typical amount of the potential overpayments for MSIS audits was smaller than the amounts identified through other audit approaches. Our review found that MSIS audits averaged $16,000 in potential overpayments compared with $140,000 for test audits and $600,000 for collaborative audits.

The MIG has reported it is redesigning the National Medicaid Audit Program, but it has not provided the Congress with key details about the changes that it is making. In particular, CMS has not provided details or information on why it changed to collaborative audits, the new analytical roles for the contractors, and plans for monitoring and evaluating the performance of this redesign.

In looking at CMS' redesign, our work suggests that collaborative audits are more likely to result in increased findings and will allow States to leverage the MIG's resources to augment their own program integrity capacity. It is less clear, however, whether the new analytical role for its contractors, some of which are just underway, will ultimately improve the selection of audit targets.

Finally, the lack of a published plan detailing how the MIG will monitor and evaluate the National Medicaid Audit Program is a concern. Without appropriate tools in place to evaluate progress and assess adjustments that need to be made, CMS risks wasting

[1] The prepared statement of Ms. Yocom appears in the appendix on page 68.

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Federal dollars and missing potential findings of improper payments.

Given that the National Medicaid Audit Program has accounted for more than 40 percent of MIG expenditures, transparent communications and a strategy to monitor and continuously improve the program are essential components of any plan seeking to demonstrate the MIG's effective stewardship of the resources provided by the Congress. As a result, we are recommending that the Acting Administrator of CMS ensure: First, that the MIG's planned update of its comprehensive plan provide key details about its redesign of the National Medicaid Audit Program; second, that the MIG's future annual reports to Congress clearly address the strengths and weaknesses of the audit program and its effectiveness; and, third, that the MIG's use of program contractors supports and expands States' own program integrity efforts through collaborative audits.

In conclusion, we look forward to working with the committees, with CMS, and with others to continue to improve efforts to ensure program integrity in Medicaid.

This concludes my prepared remarks. I would be happy to answer any questions you may have.

Senator CARPER. Good. Thanks, Ms. Yocom.

Ms. Maxwell, please proceed.

TESTIMONY OF ANN MAXWELL,[1] REGIONAL INSPECTOR GENERAL FOR EVALUATION AND INSPECTIONS, OFFICE OF THE INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. MAXWELL. Good morning, Chairman Carper, Dr. Coburn. Thank you for the opportunity to discuss the Office of Inspector General's recent evaluations of two national program integrity efforts: The National Medicaid Audit Program and the Medicare-Medicaid Data Match Program.

Our evaluations reveal that these national integrity efforts in many ways resemble a funnel: Significant Federal and State resources are being poured in, but only limited results are trickling out.

Both national efforts are required to identify improper Medicaid payments for recovery. The National Medicaid Audit Program strives to do this within States and across States. The Medicare-Medicaid Data Match Program attempts to detect overpayments in Medicaid and in Medicare by matching data across these programs to identify suspicious billing patterns. Both programs had limited success in achieving the goal of identifying Medicaid overpayments. As a result, both programs yielded a negative return on investment.

In 2010, the National Medicaid Audit Program paid contractors approximately $32 million to identify Medicaid overpayments of just half that amount. In fact, we discovered that 81 percent of the audits assigned in the first half of that year did not or are unlikely to discover any overpayments at all.

[1] The prepared statement of Ms. Maxwell appears in the appendix on page 74.

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The Medicare-Medicaid Data Match Program also had a negative return on investment. This program, as you know, was appropriated $60 million over a 2-year period, during which time it saved $58 million. Of that amount, only one-quarter, $11 million, was saved on behalf of five States.

There are a variety of challenges that limited the potential of these programs to detect Medicaid overpayments. The most fundamental of these is the data. National Medicaid data are not current, they are not complete, and they are not accurate. In fact, the National Medicaid——

Senator CARPER. Would you just repeat that last sentence again, please?

Ms. MAXWELL. The National Medicaid data are not current, they are not complete, and they are not accurate. In fact, the National Medicaid data does not capture all the elements necessary for the detection of fraud, waste, and abuse. Missing data include elements as basic as beneficiary name and address and as technical as very specific billing information.

Now, more current and accurate Medicaid data does exist, but it is captured in systems maintained by the States, and these systems are not standardized across States. For example, data elements that might be captured by one State might not even exist in another State's data system.

Due to these data problems, the National Medicaid Audit Program wasted resources, auditing potential overpayments that were not real. They were simply mirages created by the data. Due to these data problems, the Medicare-Medicaid Data Match Program does not provide electronic access to matched Medicare and Medicaid data.

For these programs to be successful, they need better access to better data. In the short term, we recommend that they rely on the more timely and accurate State-specific Medicaid data, but it is not enough to stop there. We believe more must be done to overcome the significant shortcomings in the National Medicaid data. A recently launched pilot project to improve this data certainly holds promise, but it will require sustained focus and resources at the Federal and State level to deliver on that promise. Past initiatives to improve National Medicaid data have not delivered.

We recommend that the Centers for Medicare & Medicaid Services devote the resources necessary to transform the National Medicaid data into a resource that helps protect the Medicaid program.

In conclusion, without timely, complete, accurate, and standardized Medicaid data, it is impossible to effectively detect systemic vulnerabilities that cross State lines and cross Federal health care programs.

We appreciate and share your interest in protecting the Medicaid program. I am happy to be of assistance if you have any questions. Thank you.

Senator CARPER. Dr. Coburn, do you want to go first?

Senator COBURN. No. I will wait.

Senator CARPER. OK. There is some good news here, and there is some really troubling news here. What I would like to do with a hearing of this nature is to look for consensus to figure out how we can do a better job. I want to commend the efforts that are un-

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derway, that have been underway that are producing some results. But as I said, everything we do, I know we can do better. We have to do better here. The amount of money that is being misspent is still way too much.

Ms. Maxwell, if you were ever here and you were wearing Dr. Budetti's hat—not that he would ever give it up or that you would want it, but if you were wearing his hat, what would you do? What would you do about this stuff?

And the second question is: If you were wearing the hat of Dr. Coburn, Senator Brown, or myself, what would you do if you were sitting in our seats? What would you do about this to make it better?

Ms. MAXWELL. Our findings that indicate negative return on investment necessitate a serious reassessment of these programs, and that is precisely what we recommend in these reports. We recommend that CMS take stock of both these programs to determine what elements, if any, of these programs should be part of a national strategy to protect the Medicaid program.

I think the goal that they embody, the goal of having a national presence in Medicaid program integrity is a goal that is important, and it is important to get right.

So as I said in my oral statement, I would focus in the short term on using the data that is available which is more accurate at the State level, but I would not stop there. I would continue to push for more timely, accurate, and complete Medicaid data at the national level to support a national strategy.

Senator CARPER. Dr. Budetti, would you react to that? And I want Ms. Yocom to react to that as well, please.

Dr. BUDETTI. I think if you are looking for a consensus, Mr. Chairman, I think you are going to find quite a bit on this side of the table this morning. We have recognized the problems with these programs, and we are looking to solutions.

As far as the availability of data, we absolutely agree. There are two ways to go about doing these—carrying out the Federal responsibility for oversight. One is for Federal entities to do the audits. The other is for Federal entities to work very closely with the States in doing the audits. The second is our current mode of emphasis. We are working toward a collaborative approach in which we are all satisfied about what the audited targets are and what the data are for doing that and how to go about conducting the audits and using Federal resources to assist the States in that way. We still have a ways to go before we have a full menu of all of the collaborative audits that we hope to have in place across the States.

The other approach of the Federal entities doing audits and other kinds of oversight based upon adequate data is also a goal, and that involves also working very closely with the States so that we can identify precisely what the useful data elements would be and how the States would go about reporting them. That is the core emphasis of our current pilots, to work with the States, to identify that, to see what elements they can report and what elements they would need to create the capacity to report and to have a uniform set of data that would then be available for us to see the spectrum of activities at the right level of detail.

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So I agree with what Inspector General Maxwell just mentioned, and I think that those are the directions that we are moving in.

Senator CARPER. Ms. Yocom, I would like to hear your reaction as well, please.

Ms. YOCOM. I do agree there is a lot of agreement. Focusing on the collaborative audits——

Senator CARPER. A lot of agreement and some progress, but not nearly enough.

Ms. YOCOM. That is right. There is more to be done, and the collaborative audits are promising, but I believe that one of the key things that needs to happen is more effective and frequent communications.

Senator CARPER. Among whom?

Ms. YOCOM. Among CMS in terms of reporting findings and what is going on in the program. Dr. Budetti mentioned that the MSIS audits were discontinued in February 2011. It is June 2012, and we are just now finding information and data about those results. So communicating specifically what is happening and what needs to be different I think is very important.

Holding hearings I think is one way of getting to this information. Reporting out in its annual reporting requirements are another.

Senator CARPER. All right. Thank you.

When I was Governor of our State and involved in the National Governors Association (NGA), we always used to say States are laboratories of democracy, let us use them in that capacity. And this is a great opportunity because of the unique partnership in Medicaid between State and Federal Government. What can we learn from our States? You have already spoken to this in part, but I want you to reiterate some of what you think the most important points are in terms of what can we learn from our 50 laboratories of democracy. And I asked my staff, I said, "Why do we have the folks here from Washington State and the State of Texas?" And they tell me because you guys are good at this and that is why you are here. So let us hear your thoughts further. Go ahead.

Mr. PORTER. We are very encouraged by the direction Dr. Budetti is talking about with these collaborative audits. We in the State of Washington are looking forward to the first time being able to audit hospitals once every 3 years. We have not been able to do that to date. That is where a lot of the expenditures sit. And this capacity——

Senator CARPER. Why haven't you been able to audit hospitals?

Mr. PORTER. Lack of resources, Senator. As I said earlier, whenever we have a budget problem at the State level, law makers are loath to go in and deprive vulnerable citizens of services or programs or benefits and are more likely to take a harsher budget ax to State employees.

Senator CARPER. OK.

Mr. PORTER. And that hurts.

Senator CARPER. All right. Proceed. I interrupted your thought.

Mr. PORTER. That is quite all right. I was talking to our staff about how the Medicaid Integrity Institute could be improved, and as you heard in my remarks, they were suggesting that you make

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that resource available—that CMS make that resource available to more State staff.

I come from the State of California, where they had 800 auditors and investigators in their shop for the Medi-Cal program. It would be virtually impossible for them all to get to South Carolina to go through the excellent course work that is being offered there. The extent to which distance education could be made available, I think it would be very helpful. I cannot underscore enough that if I have somebody who is funded 75 percent by the Federal Government, as the Medicaid fraud control units do, I am much less likely to put their positions on the table because the State legislature is only interested in saving State general funds, and by cutting one FTE that if funded at 75–25, you only save 25 cents on the State dollar. It is a means of protecting a valuable asset.

Senator CARPER. My time has expired, and, Mr. Wilson, I am going to come back to you with the same question when we go for a second round. But let me yield to Senator Brown. Thanks.

Senator BROWN. Thank you, Mr. Chairman. I am bouncing back and forth between meetings, and I did catch it on TV.

Dr. Budetti, you see the chart[1] over there. It costs $102 million to get back a little under $20 million, so we lost $82.1 million. I understand you fired the contractors. I would think you would do so based on that type of performance. Did you fire them as a result of the hearing today? I mean, weren't they just fired like yesterday or something?

Dr. BUDETTI. Senator, I do not want to necessarily impugn the contractors. I think it is the data that we asked the contractors to analyze that was the cause of the problem. They were analyzing data that were absolutely not appropriate for the task. They produced some leads that looked extremely promising, but in the course of actually going out and conducting the audits by the other contractors, they proved to be not nearly as promising—in fact, in many cases zero.

So we just simply do not need those contractors doing that work anymore because we are shifting to a new approach, and we have spent a number of months working on the redesign of our program. I think it is clear——

Senator BROWN. So when did you fire them? When did you let them go?

Dr. BUDETTI. We are in the process of doing that. Under Federal acquisition rules and regulations, we have certain procedures that we have to go through. We have to figure out what the best way to go about this is so that we do not lose more money in terminating a contract than we otherwise——

Senator BROWN. Did you actually spend $82.1 million? Is that what the taxpayer money was actually spent to collect that?

Dr. BUDETTI. I have no reason to doubt that those are the correct numbers. But I would point out, Senator, that, as I said in my statement, the first audits went out—were assigned in 2008, in September, and by February 2011, we recognized the problem and we shifted.

[1] The chart referenced by Dr. Budetti appears in the appendix on page 86.

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Senator BROWN. OK. So 2008, 2009, 2010, 2011, you basically—at some point, I would think you would say, oh, my goodness, we are not getting a good value for our dollar, not getting a good return——

Dr. BUDETTI. Absolutely, and that——

Senator BROWN [continuing]. And it has taken like 4 years, 5 years.

Dr. BUDETTI. Well, it took from September 2008 until——

Senator BROWN. Well, those numbers are from June 2007 to February 2012, those numbers right now.

Dr. BUDETTI. Right, overall.

Senator BROWN. You just said in your earlier testimony that those were accurate. So I am just presuming——

Dr. BUDETTI. Right. I believe they are.

Senator BROWN [continuing]. That the GAO is accurate.

Dr. BUDETTI. I am not challenging those numbers at all, and I am saying that we did——

Senator BROWN. Well, I am challenging them because it just makes no sense. I am challenging the whole concept that we spent $82 million to get back 20. Only in the U.S. Government do we do that.

Dr. BUDETTI. Sir, I am not disagreeing——

Senator BROWN. I mean, it is $102 million.

Dr. BUDETTI. I am not disagreeing with you. That is why we are——

Senator BROWN. It is 102.

Dr. BUDETTI. That is exactly——

Senator BROWN. We lost $82 million.

Dr. BUDETTI. That is exactly why we are changing direction.

Senator BROWN. It only took, what, 3 or 4 years. It is unbelievable. And that being said, as we are approaching the 50th anniversary of Medicare and Medicaid with both programs on GAO's high-risk list as a result of some of the things we are hearing and the fraud, waste, and abuse, we are also facing PPACA expansion in Medicaid, as I said in my earlier opening statement, in 2014, a 32-percent increase over the current enrollment. Based on CMS' prior success in eradicating waste, fraud, and abuse, or lack thereof, how can you assure the American people that CMS will be ready for the expansion in Medicaid?

Dr. BUDETTI. I believe that we are ready for that——

Senator BROWN. Based on what?

Dr. BUDETTI. Based on the program integrity arena, based upon our assessments, our open and candid assessments of the lack of results from our oversight—from this particular program.

Senator BROWN. See, I look at that and I say, well, we are down $82 million right now, so we are already in the hole $82 million. So you basically—in my mind, we have to find $82 million and then find some more.

Dr. BUDETTI. Senator, if I could just say something about the broader Medicaid integrity program, you have heard very positive comments, for example, about the Medicaid Integrity Institute. We do not measure the financial impact. We do not measure the return on investment in dollars of all of the work that——

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Senator BROWN. Because it is not your money. It is not your money. It is the taxpayers' money.

Dr. BUDETTI. Yes, sir.

Senator BROWN. We need people to actually measure those. It is all about dollars and cents. When we are talking about $6 billion to pay for keeping student loan interest rates low we could use that money. We could use that $82.1 million. We could use other—it is all about the money. That is all we are talking about up here, is money, money, money. How are we going to pay for A, B, C, and D? Dr. Coburn is legendary in identifying a lot of these things, and I commend him for that.

Let me just shift gears. What are your savings goals for this year and next so we can ultimately track your progress? And would we have statements or some type of way to measure that success or lack thereof?

Dr. BUDETTI. I believe you heard from both the GAO and the IG about our need to specify what our targets are, what our goals are, but also to report on our progress. Our goals are, of course, always to have a positive return on investment of the taxpayers' dollars. We believe that there is a sufficient problem in fraud and overpayments, that is the least that we can expect. We believe we are moving in that direction certainly with the Medi-Medi program and also with the redesign of the Medicaid Audit Program to the collaborative models that we have talked about. So we do believe that we have every reason to expect a positive return on investment.

Senator BROWN. And, Mr. Porter, you actually withdrew from the Medi-Medi program. Why was that?

Mr. PORTER. We had some frustration with the contractor that was assigned to our State. We felt that they did not understand Medicaid data, although they were pretty—they were very conversant with Medicare data and were trying to treat our Medicaid data the same way. They also took very much a criminal justice approach and a fraud-oriented approach to the program where we saw much more opportunity in the waste and abuse portions of our expenditures.

The bottom line, with the 40 staff that I have and the other opportunities we saw to save our program money at the local level, we opted to withdraw from the program and redirect our resources in a more productive venue.

Senator BROWN. So how helpful would it be for you to have access to real-time provider screening data from the Medicare provider screening contractors? Would it also be helpful to expand access to Medicare data for your State's program integrity efforts?

Mr. PORTER. We think Medicare data could be extraordinarily valuable. As I said in my earlier remarks, our problem is the format in which the data is made available. It is very difficult to manage the merging of that with our Medicaid data, and also there appear to be a number of barriers on the confidentiality and privacy front that restrict how we can use it and with whom we can share that data. We would very much like to work with CMS to reduce some of those barriers.

Senator BROWN. Yes, we would like to know what those are so we can provide guidance and effectuate that streamlining.

Thank you, Mr. Chairman.

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Senator CARPER. You bet. Dr. Coburn.

Senator COBURN. The one question I have for Dr. Budetti is not about that you let that contractor go. Did you let the person or people who made the decision to contract that go? In other words, what we are seeing is the Pentagon all over again. One system does not talk to another system. There is no communication. We have had testimony, we have six different sources of information, and each one in a different format, and you have to go buy somebody to program it to where you can be able to utilize the information. Correct? And each one of those are six different types of data. So the right hand is not talking to the left hand.

We also had testimony on MSIS audits that they do not include provider identification. These audits are worthless if you cannot source data to the provider, because that is where it starts. That is where the fraud or the overpayment or the abuse, or whatever it is, starts.

So what I see is the same thing. If you go back, the Deficit Reduction Act passed in 2005, 2006 to 2008 to get the audit started, 2008 to 2010 to see there was a problem, and from 2010 to now to redesign the program. So we are 6 years out, and we really have not accomplished anything in terms of savings. And that is the problem. I have a lot of questions that I think I will submit for the record because they are pretty detailed.

I think what Senator Brown touched on is important, if Texas and Washington could get easily accessible data without all the rules and regulations that mean nothing in terms of true results—in other words, clean it up to where you have limited common sense regulations controlling the security of the data. If you could get that data and merge it, is there any question in your mind that you could do a much better job in terms of overpayments, fraud, and abuse on Medicaid payments? Whether it is provider data or trend data or whatever it is, is there any doubt in your mind that you could save a lot of money for Texas and Washington State?

Mr. WILSON. From the Texas perspective, there is no doubt at all that we could do a much better job at identifying fraud, waste, and abuse. I think Senator Brown was very much on point in terms of saying it is all about the money. In Texas, we have been very clear about suggesting that or saying that right to our staff. It is all about the money. In these times, when Medicaid in our State is about a third of the State budget and estimates are, arguably, that as high as 10 percent or so of that or more is potentially fraud, waste, and abuse, it is all about the money. We are working diligently to stem the tide. Obviously, the great challenge is getting access to the data. But when you get the data, having the tools that can quickly look through that data and identify the patterns and trends that you want to target to go after. Today I said in my written testimony I visited with a number of companies that say they can help us. The challenge that we find is these companies have yet to do business with anybody in a large number in any other States. The hesitance is this: Every State knows we need help, but the cost to secure that type of software is there. If you make the wrong decision and do not get the right company and get the results that you need, then you are criticized. In our State, I am suggesting that we cannot sit paralyzed for fear of being successful.

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We have to identify the software that we think can help us and let us move toward it in that direction. And it is not extremely costly, but someone has to take the big plunge, and let us start identifying it sooner than later.

I mean, as I have talked about in our State, we have a number of issues right now that we are facing, and the dollars at risk are huge. It is most unfortunate. We are being aggressive in trying to collect those dollars. But when you are—it has been my experience in this business that when you see people that are taking money they are not entitled to, they are not taking it to save it or hold on to it. So when I identify it and I say that I want to get that money back, it is a process. It takes time for me to work through that.

Senator COBURN. Does Texas have a predictive analytics program?

Mr. WILSON. Texas has a system that is known as Medicaid Fraud and Abuse Detection System (MFADS), which is sort of more known for models and targeted queries that we can build and run that allows us to identify outliers, people that have maybe aberrant billing patterns or behaviors that suggest we should take a look at them.

What Texas does not have is a system that can look within the data itself and on its own identify things that are questionable, like five providers in your database of 50,000 or more providers have the same exact address or the address is within a mile of each other and they are making referrals and billings all the time and it is accounting for X percent of dollars. Those are things that take human intelligence today to get to.

In our visits with the various companies, we are learning that there is software that does that type of analysis, that can identify unknown trends or behaviors and patterns that we otherwise would not see, and that allows us to then say let us take a look at what that is and let us go identify it sooner than later.

In many cases, by the time we notice the aberrant billing pattern, it has been a little time that it has been going on.

Senator COBURN. The money is out the door. This is not reinventing the wheel.

Mr. WILSON. No, sir.

Senator COBURN. The private insurance industry has all this predictive analytics. They are using it. We contracted at the Federal Government to create a new program, which I was very much against reinventing the wheel. I saw a demonstration of the Fraud Prevention System (FPS)—and, Dr. Budetti, I thank you for giving us the time to do that. But we do not need to reinvent the wheel. It is out there. And I just think our whole approach—I mean, 6 years to get to somewhere where we are not there yet, and I will go back. Dr. Budetti, the people who made the decisions on this to go this direction, are they still with you?

Dr. BUDETTI. Senator, those decisions were made some years ago, and I am not sure whether——

Senator COBURN. I do not care which Administration. I am talking about the individual that was responsible for making those decisions, are they still with you?

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Dr. BUDETTI. I would have to go back and check and see whether they are still with us. We have completely reorganized a number of times since then, as you know, sir.

Senator COBURN. Well, I think that tells us one problem: No accountability, no responsibility, no consequence for failure. That is a principle that this Government cannot live with anymore. And it is fine to get rid of something that is not working, but the question ought to be: Who made the deductive reasoning that said this was the way to go? And why did they do it? It is not about second-guessing. It is about holding people responsible.

Ms. Yocom, CPI or CMS utilized its moratorium authority at all in areas where there are known rates of high fraud and significant market saturation of providers or suppliers?

Ms. YOCOM. I cannot answer that. I am sorry, sir. I do not know.

Senator COBURN. Does anybody know the answer to that question?

Dr. BUDETTI. Yes, sir, I do. We are very much interested in using that authority. We believe that we should combine the use of the moratorium authority with all the other appropriate tools that we have. A moratorium is just that. It just tells people they cannot get into the program. It does not do anything about the bad guys who are already in there. We have been undergoing extensive analysis to pinpoint the ways in which that moratorium authority is most appropriate for us to use it, and we will be using that tool when we believe that it is appropriate.

Senator COBURN. And how long has CMS had that authority?

Dr. BUDETTI. Since the implementation of the Affordable Care Act.

Senator COBURN. OK. And so you have Miami-Dade County, which we know is a big hotbed of fraud.

Dr. BUDETTI. Yes, sir.

Senator COBURN. And yet we still do not have a moratorium.

Dr. BUDETTI. We do not have a moratorium. We have lots of other activities that are going on, for example, revoking building privileges, getting people out of the program, stopping payments. We do want to use the moratorium authority when we believe that stopping new providers and suppliers from getting into the program is an effective part of our overall strategy. Yes, sir.

Senator COBURN. I want to ask the two State directors. You have difficulty getting access to a list of bad players on the Federal level. Is that correct? In other words, Medicare knows these are bad players, but that is not accessible to you. Is that correct?

Mr. WILSON. Senator, partially, yes. I think in the Medi-Medi program, in some cases we are made aware when there is a bad player in the Medicaid side. For us, in some cases that just means a crossover claim is being paid.

Senator COBURN. Yes.

Mr. WILSON. So, in other words, it may be 20 percent of that claim. On the Medicare side, it could be a lot of dollars at risk. For our State, it may or may not be a number of dollars at risk.

Senator COBURN. But, specifically, can you go to CMS and say we want to know the names of everybody that is on your watch list, your fraud list—in other words, all these provider numbers, can

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you go and say we want to know who to look at harder in Texas based on what CMS has discovered?

Mr. WILSON. Not to my knowledge, sir.

Senator COBURN. OK. Well, there is a big problem, and the question is: Why not? I mean, we are going to spend all this money at the Federal level to identify these bad actors, and we are spending a ton of money, and you do not have access to it, and what portion—60 percent of the portion on Medicaid in the State of Texas is funded with Federal dollars?

Mr. WILSON. Yes, sir.

Senator COBURN. Why don't they have access to everything CMS has access to in terms of providers? And if the rules are too hard, why don't we change the rules? And if there is a Federal law that limits the ability to have common sense rules, why don't we change those laws?

The point is that we are running around in a circle and the problem is getting bigger rather than smaller. And so I guess the question for Dr. Budetti or for General Maxwell is: What is the problem? Format aside, why can't the States have access to the information of the bad players in their State that Medicare has already identified?

Ms. MAXWELL. I know the Office of the Inspector General has been on the record in support of transparency to the extent that the policymakers and lawyers provide, and we consider it to be a healthy development to have more transparency in the data.

Senator COBURN. But it is still not there. I have been in the Senate almost 8 years. I was in the House 6 years. These are the same problems we were talking about 16 years ago. I mean, I can recall hearings in the Commerce Committee where we were raising this same question with CMS. There is no answer, or the answer is incompetence.

I will submit the rest of my questions for the record, Mr. Chairman. Thank you for holding this hearing. This is a big issue.

I would make one last comment. If we were to block grant Medicaid to the States, making them fully responsible—not taking away any of their dollars, making them fully responsible, take the Federal laws, let them do it, what we will see is some States very successful and some States not. And one of the things that can happen, I guarantee you, if Texas—I know Texas because they are my neighbor. We have great admiration for the things that happen in Texas in terms of their government. I guarantee you, they would save a whole lot more money. They will be a whole lot more efficient with the Federal dollars that we send because they are spending so much of their own.

I appreciate your time.

Senator CARPER. And we appreciate your dogged persistence on this issue.

I just want to say on a brighter note—you said we have been working on this forever and not making a lot of progress. One of the things that Senator Roth when he was in the Senate and when I was in the House, I think in my last year, we worked on legislation with a number of our colleagues to require that every Federal agency of any consequence have a Chief Financial Officer and also that they develop auditable finances. And it has taken a long time

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to get there, but everybody is basically doing that now, except the Department of Defense (DOD). And Leon Panetta has assured us that they will be auditable prior to their deadline of 2017, so that is good.

Ten, 15 years ago, nobody was thinking about improper payments, no discussion really of improper payments that I ever heard of. And today there is a whole lot of discussion on improper payments. We have a good law in effect thanks to your efforts, and we are making progress.

Senator COBURN. And let me differentiate between improper payments and fraud. They are cumulative. They are not the same.

Senator CARPER. So the glass is not entirely empty, at least half-full, and we have just to fill the rest of it up here. Fortunately, we have some water here so we can do that.

I want to go back to Mr. Wilson, and I said the reason why we asked you and the other Douglas, Douglas Porter, to come is because you guys do a good job at this. And my question was: What can the other States learn from you down in Texas and maybe what can we learn here from what you all are doing?

Mr. WILSON. In our State, we have become a lot more aggressive in working these cases. I think the challenge that I walked into when I assumed the responsibility of Inspector General was initially some hesitance on our part to pursue cases where it was a question of medical necessity.

On the program integrity side of the house, that is a big part of what we do, determining whether or not the client recipient actually needed the service or not. There are definitely challenges because we are dealing with medicine, a discipline where there is built-in expectations and respect for the people that we are in many cases challenging and pursuing to get dollars back from.

Our approach since I have hired my new deputy, Jake Stick, Deputy of Enforcement, has been we have a number of medical consultants on our staff now that we have contracted with to—once we see behaviors that we believe do not fit, that are not right, that look suspicious——

Senator CARPER. They are not employees that you consult with, you contract with them?

Mr. WILSON. We would love to have employees, but as my counterpart here, Douglas Porter, has indicated, there are always challenges with the budget. It is better for me at this point to contract with them to give us some of their time on a case-by-case basis, once we go pull the records and we suspect we have seen fraud, waste, or abuse, to have them come in and take a look to verify what my guys think they know. We have had great success with that, especially in the area of orthodontia for the cases——

Senator CARPER. Especially where?

Mr. WILSON. Orthodontia. The orthodontist problem we have in Texas. Great success with it. Extremely high error rates from what we are seeing from our specialists, as high as 90, 95 percent in many cases of what has been billed to our program.

The challenge—because, as you know, there is a due process right there—is once we say, "You owe us money," they are going to say, "No, we do not." And then we are having to contend with contested case hearings, the dueling medical professionals, our at-

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torneys saying, "You are guilty," their attorneys saying, "They are not." And in many cases, if we have identified a number that we believe is due back to the State, we may get some, or even all of it, but then our ability to collect once a favorable decision is rendered then becomes the next challenge, because, as I said before, no one is taking the money to hold on to it and save it. They are actually spending it. So our ability to negotiate as we deem appropriate, that is in the best interest most definitely of our State, but also the Federal Government, is tantamount to our success, to sit down with them and say—because it leaves me with a couple of choices. I can put you out of business if you cannot repay me, which means I get nothing, but it helps me because I do not have to pay anything back to CMS. Or if you can remain viable—and in some cases, we have some cases where the dentist or the perpetrator who was actually committing the fraud, waste, and abuse is no longer with the company because we are looking at a time certain, and there is no ownership, let us say, and they have made improvements, but it is still under the same name. We are pursuing them saying, "You owe us money back." "Well, a lot of dollars we are talking about. We cannot pay it all, but here is what we think we can pay." And negotiating those kinds of settlements when I identify an overpayment, as the system works today, I am on the hook for about 50 percent of what is identified, not what is collected.

It is a huge challenge for us. It forces us to make tough decisions. We are very appreciative of the changes that were made in the timeline from 60 days to 1 year. I cannot speak for other States, but in the State of Texas, there was much rejoicing around that additional time that was provided. I think the more time that is provided, that gives us the flexibility to work out repayment agreements that are viable for the States and for the Federal Government to see some return of those dollars that we are talking about on that board over there is absolutely essential.

Senator CARPER. Yes, interestingly enough, I think the idea for providing the 1-year extension that you just alluded to actually came out of a hearing right here where Ms. Yocom is sitting. I think it was the Medicaid Director from the State of New York who suggested that, and we folded that into our law.

Mr. WILSON. Awesome change. Thank you.

Senator CARPER. Good. Thank you. I will mention that to another Peter back here who worked on that for us.

Did you have something else, Mr. Porter?

Mr. PORTER. Yes, I would say, Senator, we have done three things in our State that have amped up our performance considerably. The leadership issue would be the first one. The second one would be a focus on improving our own data. And the third would be investing in the tools that help us do a better job.

When I got to the State of Washington, the culture, the organizational culture, was such that there was a reluctance to antagonize the provider community. There was a premium placed on access, and there was a fear that if you made payment review too burdensome, you would push people out of the program. So it was the Secretary of Health and Human Services, Dennis Braddock, who really brought in a new crew to focus on payment review and program in-

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tegrity and take on some of the tough constituents at the State House level, a very unpopular move with doctors and hospitals and nursing homes, but there was the political will to move forward, and that was very important.

On the data piece, we had all different silos of data, bad data, conflicting data that prevented us from moving forward and getting folks around the table to really define what you are going to use the data for, so how should you better collect and organize that data and have that drive your decisions was a key factor in success.

And then, finally, investing about 5 years ago in a new Medicaid Management Information System that had a more robust capacity for edits and audits on the front end so that you were not paying money out to fraudulent or abusive providers in the first place and then having to chase it afterwards.

The combination of those three aspects I think have made our program as successful as it is today.

Senator CARPER. OK, great. Thank you for those.

I have a couple of questions my staff has been good enough to help prepare, and I am going to go ahead, and before we close out, give you at least one of those. But while I do that—and one of the questions is for Dr. Budetti. A guy I sometimes like to quote is another doctor, Dr. Alan Blinder. He has a Ph.D. in economics. He teaches at Princeton. He used to be Vice Chairman of the Federal Reserve, and he testified before the Finance Committee last year that in terms of reining in the growth of health care costs and trying to make sure it did not eat us alive in States' Medicaid and Federal Government Medicare and really companies trying to compete with other companies around the world whose health care costs were a lot less. And he said that what we should do in order to rein in the growth of health care costs is find out what works, do more of that. And I said to him, "Do you mean find out what does not work and do less of that?" And he said, "Yes."

So before we leave, that is going to be my last question, name one thing that is working that we ought to do more of and one thing that is not working that we ought to do less of. So while all of you are thinking about that, I will pick on Dr. Budetti for a minute. I want to ask you a question about recovery audit contracting, one of our favorite subjects. As you know, recovery audit contracting is a form of post-payment auditing in which private companies are employed to review payments, supporting documents, and other information in an effort to try to identify overpayments and underpayments. We used them in the State of Delaware Division of Revenue to recover monies, tax revenues that we were not recovering, and to compensate the folks who did the actually recovering, they would retain a percentage of what they collected.

But recovery audit contracting has been used by CMS to review Medicare payments since, I think, 2005. They recouped, I am told, a little more than $2 billion during the last couple of years. In the Affordable Care Act, we expanded the use of recovery audit contractors to all of Medicare and to Medicaid as well. And I understand that as of April of this year, 26 States had operational programs. We are at about the halfway point, and that is good.

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First, let me say that we are pleased to see the program up and running, and, Dr. Budetti, when do you think we will see all 50 States participating? And when will we begin to see the numbers on the success of the program showing the amount of dollars recovered?

Dr. BUDETTI. Yes, sir. The Recovery Audit Contractor Program, as you know, expanded under the Affordable Care Act to Medicaid and also to Parts C and D of Medicare. All 50 States have submitted State plan amendments laying out their intention to proceed with putting recovery audit contractors in place. I believe the last numbers I have are that more than 30 of them now actually have signed contracts with recovery audit contractors, and they are gearing up.

Just as we did with the Medicare program under Parts A and B, we expect to see returns even in the first year of operation. So as those recovery audit contractors become operational in the States, we would expect to see some recoveries beginning this year.

Senator CARPER. Good. Thank you.

Dr. BUDETTI. Mr. Carper, I would also like to add one thing, which is that our discussion about the movement to collaborative audits really has a side benefit, which is that we believe that the collaborative audit approach with the States is also going to be a very effective tool for coordinating the audits that will be done under the Recovery Audit Contractor Program with the audits that would be done under the Medicaid Integrity Program so that they will not overlap and duplicate each other to any great extent, because if we are working with the States to select the audit targets and they are also working with their recovery audit contractors to identify the audit targets, we ought to be able to keep duplication to an absolute minimum.

Senator CARPER. That is a good point. And you may have just said this in a different way, but one of the things we have learned in Medicare where the recovery audit contractors have been working is that they are helpful in helping us move away from "pay and chase" where we pay the bills in Medicare and then have to chase the money, because we learned through the recovery audit contractors, they are like a passthrough. They come back and say to the Federal Government these are the places where we are seeing fraud occur, so rather than continue to make those mistakes, let us fix them in the front end. So there is a double benefit there. But, anyway, that is good. We have 30. That is good. We have 20 more to go, and we will not be home free, but we will be on our way.

This is a question, if I can, for Mr. Wilson and Mr. Porter dealing with the Public Assistance Reporting Information System (PARIS) and cross-State checks for beneficiaries. I would like to ask the panel about a specific challenge for Medicaid, and under Medicaid rules, a beneficiary can only be enrolled in one State's Medicaid program. Is that correct? I think that is correct.

Mr. WILSON. Yes, it is, sir.

Senator CARPER. OK. If a beneficiary is enrolled with the Delaware Medicaid program, that beneficiary cannot be enrolled in Maryland, our neighbor to the west, or Pennsylvania, our neighbor to the north, or New Jersey, our neighbor to the east. However, I understand that there is not a systematic process for cross-check-

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ing between States to try to identify duplicate enrollees. This seems to us to be a significant problem to address waste and fraud.

In March, our Subcommittee held a hearing on improper payments, and we heard about a system called the Public Assistance Reporting Information System, which, of course, has the acronym PARIS, as in France. But it is the Public Assistance Reporting Information System. It is run by the Department of Health and Human Services. The system has the ability for States to do such cross-State beneficiary checks of individual enrollees. However, we learned that Medicaid State agencies are not fully utilizing the system, nor does CMS perform these cross-checks.

I would just ask our friends from Washington and from Texas, could you comment on this specific challenge and how Congress and the States and maybe CMS can work together to ensure that beneficiary enrollments are not duplicated in other States?

Mr. WILSON. Sure. For Texas, we have actually found benefit in using——

Senator CARPER. Is there a Paris, Texas?

Mr. WILSON. There is a Paris, Texas. Yes, there is a Paris, Texas. It is not much to see, Senator, but there is a Paris, Texas.

Senator CARPER. The other one is worth seeing, the big one.

Mr. WILSON. Yes, sir, it is.

We have gotten benefit from the PARIS system. Texas has been part of that system for a while, and through that process we do identify recipients attempting to get access to Medicaid services in our State that may be receiving them in another State. We have recently been using it to identify recipients that are on the Medicaid rolls in our State but are also expending the benefits in another State, almost any of the other 49 States, to be quite candid with you.

In some respects, we have learned in working with the Federal Government that people travel, they go out of town, things happen, so we have been trying to sort of tighten down that window in Texas. If you are on the Medicaid program in Texas but you have expended your benefits on your SNAP card in Oklahoma or Maine somewhere for 6 months, that may be an indication that you have actually physically moved and you are no longer a resident of our State.

There has been hesitance to allow us to make those changes because ultimately it is a Federal program. They are eligible in Texas. They will probably be eligible in whatever State they are actually in. From our perspective, though, they are on our rolls. It looks like that person is receiving or needs Medicaid benefits in our State when they actually do not.

But those are the kinds of things that we are working through. We think that PARIS absolutely does have utility. We have had to my knowledge no issues getting that data and trying to use it in helping us work recipient cases.

Senator CARPER. All right. Thank you. Mr. Porter.

Mr. PORTER. We have had great success using the PARIS system in the State of Washington, but primarily for identifying those individuals who are on the Medicaid program who are actually entitled to veterans benefits and hooking them up with another payer, if you will, for things like longterm care and other health benefits

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that the VA offers. And that helps get people off of our rolls or at least not put as much demand on our Medicaid program when they are entitled to other benefits. So it has been quite helpful there.

We have used it to monitor what you are talking about, dual enrollment, but we have not—we actually have a specific focus on our sister State to the south, the State of Oregon. They do not have a sales tax where the State of Washington does. Washington does not have an income tax like the State of Oregon does. So we are always mindful that people might be crossing the border to try and game those two systems. And we did some driver's license checks in addition to the PARIS checks, but we find that is at least not a very big problem at all in our State, having people travel to a border State.

Senator CARPER. OK, good. Thanks.

A question for Dr. Budetti, and then I will go back to the question inspired by Dr. Alan Blinder. Last year, at about this time, our Subcommittee held a hearing that discussed the Integrated Data Repository (IDR). I have another Subcommittee I chair. We have been exploring repositories for spent nuclear fuel, so I am really focused on repositories this year. But the Integrated Data Repository refers to an existing database of all Medicare claims, including prescription drug claims, and providing access to State Medicaid agencies for program integrity purposes was one of the original ideas, I believe, for the Integrated Data Repository. I am told that no States, though, have been granted access, and I would just ask, Dr. Budetti, when do you think the States will have gained access? Are there any challenges that you can describe which prevent sharing this data with States?

Dr. BUDETTI. Senator, I think, as you know, the Integrated Data Repository is far advanced from what it was when we discussed it last year. It has a lot more data and also now has some pre-pay data in it, as we had intended all along. One of the big gaps still is getting the Medicaid data in there, and that is something we are working on.

But as far as State access to data, I think you are aware that last week CMS announced a new initiative to make data sharing a major activity of the Centers for Medicare & Medicaid Services, and we are currently looking at all of the—States can get quite a bit of the data right now, but as you have heard before, there are restrictions in the way that they can use it, and some constraints and inefficiencies in the ways that they get access to it. All of those are things that are currently under very intense discussion, and we anticipate having some major steps forward on that front very soon in terms of making the data available to the States, the appropriate data available to the States, while we continue to protect, of course, legitimate privacy and confidentiality interests. So that is something that we look forward to having major progress in the near future on.

Senator CARPER. Good. Well, we will keep following up with you. Thank you.

Ms. Maxwell, you get to be the lead-off hitter on our last question. Again, the idea is to find out what is working in the realm of issues we are discussing here today and what should we be doing more of and maybe give us one good idea. Then we will come

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back to you to ask for an example of something that is not working and we ought to do less of that. Please proceed.

Ms. MAXWELL. Based on our evaluations, we found that the partnerships with the States really were more successful than the MSIS audits. We found that——

Senator CARPER. Say that again. The partnership with the States——

Ms. MAXWELL. The collaborative audits that the——

Senator CARPER. Were more successful than?

Ms. MAXWELL. Were more successful. Ninety percent of the identified overpayments came from seven collaborative audits. An additional 35 regular audits only uncovered $700,000 in identified overpayments.

Senator CARPER. That is interesting. Why do you suppose that is?

Ms. MAXWELL. We believe that is because they were able to partner with the States from the very beginning through the whole process, so that allowed them to access State knowledge based on States' understanding of where the fraud might be most problematic. It also allowed them access State knowledge in our program policies so they can interpret the data. And, most importantly, it allowed them to access that more accurate and more timely State-specific Medicaid data.

Senator CARPER. OK. Well, good. Thank you.

Ms. Yocom? And it is OK to say the same thing that someone else has said. Repetition is not bad.

Ms. YOCOM. That is good to know because I was going to. [Laughter.]

Senator CARPER. Good. And in NASCAR, they call this "drafting" the car in front of you.

Ms. YOCOM. We had slightly different time periods, but our results were the same. The collaborative audits looked to be very promising, and as Dr. Budetti said, the cooperation and the coordination that happens with the States I think is a very effective outcome as well.

One thing that I would do more of is about transparency. The more transparent CMS is, the more transparent the States are about the issues they are facing and ways to combat them, the more we have a feedback loop in the process and we can make progress more quickly.

Senator CARPER. OK, thanks. Mr. Wilson.

Mr. WILSON. I would echo what the previous two have just said. I think that collaboration is key. It has been said that if you have seen one State Medicaid program, you have just seen one State Medicaid program. I think the collaboration works because each State knows its program best, and we can help you understand what our policies and rules mean and pursue the money much more aggressively.

I also believe that aggressively pursuing these cases from my agency, changing our mind-set about how we approach the case, was——

Senator CARPER. Sorry. Changing your mind-set about?

Mr. WILSON. How we approached our cases, giving my staff the courage to say, "I know you are the doctor, but we think you did

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something wrong. Let us go after him." Having clean data that we could utilize and then having good investigations being conducted, and then having other professionals, medical professionals, come in and verify what we think we know to be accurate for us has been very successful.

I think—and I circled what Carolyn said. I had on there for what could be improved is definitely the transparency. Texas wants to be transparent. I want to show what I think I know and what I do know, but I want to do that without fear of reprisal. I do not want to have negative consequences to my State for being aggressive and doing the right thing we believe was best for not only Texas but also for the Federal Government, who we partner with in these programs. We understand that. We are committed to that. They have commercials there that say, "Do not mess with Texas." We are serious about that when it comes to our Medicaid money. So we absolutely do want to work with everyone here.

I think the other thing that is working good now is absolutely the ability to dialog with others, both at the State and Federal level. I am listening to Mr. Porter next to me, and I am almost thinking he has moved to Texas and just has not told me. Some of the things he is talking about I echo almost verbatim. It is sort of the same experience. And I think we would find that nationally, that everybody is fighting the same types of battles and we are looking for the same kinds of solutions, and collective knowledge is priceless.

Senator CARPER. All right. Thanks so much.

Mr. Porter, are you thinking of moving to Texas? Is there anything to that?

Mr. PORTER. I have been to Maine, California, Washington. Texas could be next on my itinerary.

Senator CARPER. A great place.

Mr. PORTER. What works in medicine is prevention, and I am going to take this opportunity to make another pitch for a national enrollment, Level one enrollment where 50 States do not have to comb through the Federal databases, that we would oblige our providers to get enrolled in Medicaid via a centralized national screening process. States would be free to add additional criteria before they would admit providers to their Medicaid programs, but at least there would be one place where an entity could see across State lines, see where people had been, and if they were excluded in one State, they would know not to allow them to enroll in another State, and then re-enroll them every 3 years.

Senator CARPER. Could you just stop right there? Would others in the panel just briefly comment on that, about his point? Ms. Maxwell, do you have any thoughts on what he just said?

Ms. MAXWELL. That is not an issue I am particularly informed about. I could certainly have our office get back to you.

Senator CARPER. That is OK.

Ms. Yocom, any thoughts on what Mr. Porter just said?

Ms. YOCOM. We have not studied it either, but I would say that in concept it makes a lot of sense. We may have 56 programs reinventing the wheel to investigate providers.

Senator CARPER. Mr. Wilson, would you comment on that?

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Mr. WILSON. I believe in my written testimony we make comments regarding provider enrollment, and I would echo what he is saying exactly. We are enrolling a number of providers in our States, and the Affordable Care Act requires us to go out here recently and conduct actually onsite visits of all those providers, in the first year just for one provider type, which I have met up with 6,000 visits we have to conduct, many of whom are also in the Medicare program. So I think the ability to leverage that common information, that common knowledge, and share it freely helps everybody. So I totally support what Mr. Porter is saying.

Senator CARPER. Dr. Budetti, would you react to that?

Dr. BUDETTI. Thank you for asking that question, Senator Carper. Yes, we are, in fact, right now talking to States about applying the automated provide screening system that we have put into place for the Medicare enrollment of providers and suppliers and applying that to the Medicaid provider and supplier community. As you know, there is a great deal of overlap—not 100 percent overlap—between providers and suppliers in the Medicaid program. There are some that are unique to Medicaid, and the States will have to apply the screening for that separately, or we can work with them to figure out ways to use our technology. But in terms of using what we are doing for Medicare, since the States can accept the same screening for enrollment in Medicaid, we are currently developing pilots with States to do exactly that so that we could implement one-stop shopping for provider screening.

Senator CARPER. OK. Thanks very much.

See what you started here, Mr. Porter?

Mr. PORTER. I am keeping my hopes up.

Senator CARPER. Good. OK. Did you have any other point?

Mr. PORTER. On what is not working——

Senator CARPER. Hold that one and we will come back to you.

Dr. Budetti, give us one good example of what is working and we need to do more of.

Dr. BUDETTI. Well, I think you have heard very extensive comments that were very supportive for the Medicaid Integrity Institute and all of the incredible work which I wish we could quantify the results of, and we are looking for ways to quantify the results of, but at least we are gratified that the qualitative results and the testimony we get from people who have used the system and their supervisors is all very positive. We are indeed working to expand the use of it through—we are looking at ways to do remote learning, distance learning, and other approaches to expand the use of it.

I think the other thing that is——

Senator CARPER. In fact, could I interrupt for just a second?

Dr. BUDETTI. Sure.

Senator CARPER. There is a fair amount of focus on distance learning with respect to VA benefits and with respect to Department of Defense benefits, and there are concerns that in some cases some of the folks in proprietary colleges and universities are doing distance learning with folks in the VA program, the GI bill program, and tuition assistance. Some of them do a great job, a terrific job. Some of them do not. And we are trying to put a lot of pressure on those who are not doing a very good job and are taking

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advantage of the veterans and the taxpayers, and the quality of their program or lack of quality in their program, we are trying to ferret those out and get them to change their ways.

In terms of being able to take a program that—it sounds like people go to South Carolina to the institute to actually participate in it, but to be able to do that from their home States is—you may want to think about some of the distance learning colleges and universities, if you will, training under these, they are doing a really good job, and see if there might be some way to do a competition with them to help them come in and do the same kind of thing with the institute.

Dr. BUDETTI. Thank you for that. Yes, sir, I have been engaged in quite a bit of distance education in my time, and I agree that there are good ways to do it and not so good ways to do it, and we do not want to ruin something that is very good. We will continue the onsite education because the networking, the interaction, the ability to share best practices, all of that is a whole level——

Senator CARPER. I am sure it is.

Dr. BUDETTI [continuing]. That you will not get through the distance learning.

Senator CARPER. I am sure it is. OK.

Dr. BUDETTI. Do you want something else that is working?

Senator CARPER. Please.

Dr. BUDETTI. One of the things that is working, I think, I would like to mention, which does address one of Dr. Coburn's questions, which is that the technology that we have built in the fraud prevention system on the Medicare side that you are familiar with, we are required under the Small Business Jobs Act to apply that to Medicaid. And so we are very much interested in doing the kinds of things that you heard from our colleagues in both State programs about using the technology that we already have at the Federal level, that is expanding, and that is being enhanced all the time, applying that to the Medicaid program. So I think the fact that we have a collaborative relationship and we are developing pilots to do exactly that, I think that is something that is—it is a work in progress, but I believe it is working.

Senator CARPER. OK. Good things.

All right, Ms. Maxwell, back to you. Something that is not working that we need to do less of?

Ms. MAXWELL. I would say what is not working is——

Senator CARPER. Are you going to say these hearings? [Laughter.]

Ms. MAXWELL. No; that is very effective. I would say what is not working is an underinvestment in creating a National Medicaid data set. With a National Medicaid data set, we would be able to detect billing patterns that cross State lines, that cross Federal health care programs, and we would be able to do that more quickly, and we would not leave the States in the position of trying to chase dollars that are difficult to collect.

Senator CARPER. All right. Thank you.

Ms. Yocom, something that is not working that we need to do less of?

Ms. YOCOM. To go back to transparency again, the more transparency, the less duplication. We have some duplication in our sys-

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tem right now that is not serving us well, and we need to do less of it.

Senator CARPER. Any particulars you want to mention with respect to duplication?

Ms. YOCOM. Some of the algorithms run at the Federal level have been the exact same ones that the States have run. At times, States have had to take time to train the Federal Government about their systems rather than collaborating with the someone who already knows their own systems. Those are two examples.

Senator CARPER. Thanks. Mr. Wilson

Mr. WILSON. I would say what is not working is the current process for repayment where a State may be at risk for repaying dollars that there is no chance they could possibly collect. I find that to be a disincentive at this point for my State.

Senator CARPER. OK. Thank you. Mr. Porter.

Mr. PORTER. I think what has not worked in our State is adopting vendor-driven solutions to things that are kind of prepackaged.

Senator CARPER. Explain what that means in English.

Mr. PORTER. Well, I will speak to what has been mentioned earlier on predictive modeling. When we were pursuing better care coordination for chronic illnesses, we had a lot of national vendors come forward talking about their predictive modeling capacity, and when we looked under the hood, we did not see a whole lot there. A lot of marketing, not a lot of product. And we are very closely watching what is going on with the Medicare efforts under predictive modeling and trying to resist the many vendors coming into our State saying to the legislature, "You should adopt this proven technology." And we are there saying, "It is not proven yet." And we would like to see the results. We would like to not be in a position where I am defending how much money I spent on something that has no track record and has no evaluation and no proven results or return on investment before I buy into it.

Senator CARPER. Good. Thank you.

Dr. Budetti, the last word, or the next to the last word.

Dr. BUDETTI. I think the one thing that we all agree has not been working is the way that we have gone about the National Medicaid Audit Program with reliance on an inadequate database and with contractors who were not working in an interactive and collaborative way with the States. And so I am very pleased to say that we are moving away from something that is not working.

Senator CARPER. OK. Thank you.

I think that is probably it for today. I think we are making some progress here, and I think you are helping us to make some more, not just for the Federal Government but for all of our States.

Coincidentally, the next Chairman of the National Governors Association is a fellow named Jack Markell, who is the Governor of Delaware, and he will become Chairman of the National Governors Association I think sometime this summer, and I think he will be a very good one because he is a very good Governor.

I was once, a dozen or so years ago, privileged to hold that position when I was Governor of Delaware, and I think for the year that he is Chairman, there may be an even better opportunity to partner in some of these areas and to get better results for less money. And we will look forward to trying to use our personal rela-

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tionship and friendship and close working relationship in Delaware on all things Delaware and to be able to see if we cannot use that as a springboard to greater results on some of the issues we are talking about here today.

I want to thank you all for coming. Some of our colleagues who did not come missed a good hearing. A lot of them, I am sure, were glued to their televisions so they could watch it on TV, and certainly their staffs were. Some may have some questions, and what do they have, Peter, a couple weeks?

Mr. TYLER. Two weeks.

Senator CARPER. They have 2 weeks to produce those questions and provide them to you. When you get them—and you will get some from us as well—I would just ask that you promptly respond to them.

My guess is that somewhere down the line we will have another hearing. I do not know that we will trouble each of you to come, but we might, and this has been a very productive hearing, and we are grateful for your preparation and the great travel from as far away as Washington State and Texas. When I was a naval flight officer, I left Pensacola on my way to Southeast Asia, and I was stationed for a while in Corpus Christi Naval Air Station. I have just wonderful memories of being in Texas.

I would ask again, Mr. Porter, that you give my best to Governor Gregoire as she winds up her service there.

All right, everybody. That is it. With that, this hearing is adjourned. Thanks so much.

[Whereupon, at 11:56 a.m., the Subcommittee was adjourned.]

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APPENDIX

FOR RELEASE: June 14, 2012
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U.S. SENATE COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT INFORMATION, FEDERAL SERVICES, AND INTERNATIONAL SECURITY

HEARING: "Saving Taxpayer Dollars by Curbing Waste and Fraud in Medicaid"

Opening Statement of Senator Tom Carper, Chairman
As prepared for delivery

Today's hearing will focus on one of our nation's critical safety net programs, Medicaid, and the steps that must be taken to help further reduce waste and fraud and improve efficiency and effectiveness there.

A combination of federal and state funding pays for Medicaid, though states take the lead in administering the program. Over the last year, state governments paid approximately $404 billion to care for 70 million beneficiaries. These numbers are expected to grow in the coming years as the Affordable Care Act expands access to Medicaid for millions of Americans.

As everyone in this room knows, both the federal and state governments have struggled with record budget deficits in recent years. Today our national debt stands at about $15.7 trillion, well over double what it was just ten years ago. The last time our national debt was this high was at the end of World War II. That level of debt was not sustainable then, and it is not sustainable today.

In order to address the burden this debt places on our country, we need to look in every nook and cranny of federal spending – in programs large and small – and make certain that the resources we're investing are being spent efficiently and effectively. We need to demand results and focus the scarce resources taxpayers entrust us with on what works. And across the federal government, program managers need to sharpen their pencils and stop making the kind of expensive, avoidable mistakes that lead to improper payments.

With Medicaid, a significant amount of taxpayer dollars are unfortunately lost to waste and fraud. Those resources could, and should, instead be used to help states provide quality healthcare to some of our most vulnerable citizens.

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According to the Government Accountability Office, Medicaid made an estimated $21.9 billion in improper payments in 2011. And Medicaid continues to be on the Government Accountability Office's (GAO) list of government programs at "high risk" for waste, fraud and abuse — as it has been for many years.

Now more than ever, it's urgent that we step up our efforts to eliminate the problems that lead to waste and fraud across government. Success in doing so will help us as we work to curb our federal debt and, in the case of Medicaid, it will help states as they grapple with their own budget problems. Ultimately all of us -- Congress, the Administration, and the states -- want to improve program integrity at Medicaid to ensure that the program has the resources necessary to provide critical services to those in need.

That's why I was encouraged to learn that, in 2011, we saw a decline in the level of improper payments in Medicaid compared to the more than $22 billion estimate we saw in 2010. The Centers for Medicare and Medicaid Services (CMS) and state governments are clearly beginning to make progress. However, more work remains in our efforts to curb improper payments and to reduce the amount of taxpayer dollars lost to errors, waste, and fraud. I want to encourage CMS to continue to partner closely with the states to take advantage of every opportunity to prevent, identify, and recover improper payments. We can't afford not to.

Fortunately, Congress and the Administration have made reducing Medicaid waste and fraud a high priority and taken important steps to improve its management of this critical program. The Affordable Care Act, which was enacted in 2010, includes a number of provisions aimed at enhancing our efforts to fight waste, fraud, and abuse in Medicare and Medicaid. These provisions aim to eliminate avoidable mistakes and crack down on criminals. They are critical to our broader efforts of achieving better healthcare results and improving access to affordable, quality healthcare.

We are also looking at additional steps that the federal government should take. Senator Coburn and I, along with dozens of our Senate and House colleagues, have put forward legislation to fight fraud, waste, and abuse in the Medicare and Medicaid programs— "The Medicare and Medicare Fighting Fraud and Abuse to Save Taxpayers Dollars Act", or the FAST Act as we call the bill. It takes some of what we already know works to decrease waste and fraud in the private sector, or that we have already seen is beginning to work elsewhere in government, and applies these ideas to Medicare and Medicaid.

Our bill includes a wide range of initiatives. Among other things, the legislation would increase anti-fraud coordination between the federal and state governments, increase criminal penalties for fraud, encourage seniors to report possible fraud and abuse in Medicare through the Senior Medicare Patrol, and deploy cutting-edge data analysis technologies. Our legislation addresses loopholes in fraud-prevention efforts that have been exploited to an alarming degree over the years. For example, there's the glaring problem of dead doctors who still manage to charge us for care they provide their patients, obviously a form of fraud. This is both disturbing and unacceptable. Our bill

would require that the federal government and law enforcement take steps to curb the theft of physician identities.

I often say that there is no silver bullet to fighting waste and fraud. But this bipartisan bill provides a lot of smaller, proven, common-sense solutions. It builds on recommendations by the Office of the Inspector General, GAO, and other experts to improve upon the current work of the program integrity office at CMS, which, as I've mentioned, has already made important progress in reducing waste and fraud in these programs.

Even as we look ahead to implementing additional tools to help improve efficiency and effectiveness in Medicare and Medicaid, we also need to evaluate the effectiveness of the current tools at our disposal and identify what's working and where we need to improve our efforts. Today, our witnesses from the GAO and the Office of Inspector General will help us in that effort by describing weaknesses in the two primary Medicaid anti-waste and fraud systems now utilized by the federal government.

According to GAO, one program that relies on Medicaid Integrity Contractors only identified about $19.9 million in overpayments since 2008, yet we spent $102 million to operate the program during the same period. We clearly need to identify ways to improve our return on investment here.

There are similar problems with the second federal anti-waste and fraud program, called the Medicare-Medicaid Data Match program, where Medicare and Medicaid data are compared with each other to spot duplication and other problems. Over a two year time period, the program received $60 million in funding, but only prevented or recouped $57.8 million in improper payments.

But there have also been successes. Earlier this year, the Administration announced another record breaking year in joint federal and state efforts to identify and prosecute health care fraud, with more than $4 billion in recoveries from Medicare, Medicaid and other federal health care programs.

In addition, strong new steps have been taken to screen physicians and other providers in order to avoid physician identity theft and other fraudulent activity that can lead to drug diversion and fraud. In fact, CMS announced last week that this new automated screening process has already purged the provider database of more than 20 thousand providers that were ineligible to participate in Medicare and Medicaid due to death, licensing and other problems. This is a very important step forward.

I look forward to hearing today from Dr. Budetti, the head of CMS's program integrity efforts in both Medicaid and Medicare, about how he intends to build on what has

worked so far and improve the performance of those initiatives that have not worked as well. I also look forward to hearing from the state agency representatives we have with us today about their experiences curbing Medicaid waste and fraud.

We are here today in large part because we have a moral imperative to ensure that both present and future Medicaid beneficiaries continue to have access to quality care. At the same time, we must also ensure that the scarce taxpayer resources we invest in the program are being spent as effectively as possible.

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Opening Statement by Senator Scott P. Brown

June 14th, 2012

Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security

U.S. Senate Homeland Security & Governmental Affairs Committee

"Saving Taxpayer Dollars by Curbing Waste and Fraud in Medicaid"

The Supreme Court's decision on the fate of the Patient Protection and Affordable Care Act (PPACA) is expected any day now, that's why I think it is more important than ever to come together in a bipartisan manner to address our nation's most pressing problems like healthcare. I believe a crucial step in maintaining the viability of healthcare programs like Medicaid and Medicare is ensuring that these programs aren't weakened by waste, fraud and abuse. As our nation ages and the economic stagnation continues these healthcare programs continue to put pressure on our nation's already dire fiscal condition. We cannot tax our way to prosperity that is why this morning's hearing on curbing waste, fraud and abuse is so important. We simply can no longer afford the business as usual approach to this problem that has permeated Washington for so long. The reason I came to Washington was to fix these problems and ensure the vitality of these programs that so many of our nations most vulnerable depend on for their health and well being.

This morning we turn our attention to the Medicaid program, which is timely as PPACA expands Medicaid coverage by an estimated 16 million people by 2019 -- a 32 percent increase over the current enrollment in the program. The cost of Medicaid expansion is estimated to exceed $430 billion over the next 10 years. The federal

government is responsible for paying over 90 percent of these increased costs. This is on top of the estimated $404.9 billion Medicaid cost in fiscal year 2010, of which the federal government's share was estimated to be at $271 billion.

Today we will explore what the Center for Medical Services (CMS) is doing to confront the menace of fraud in the Medicaid program. Measuring fraud in Medicaid is difficult but CMS estimates that there were $21.9 billion in improper payments in Medicaid in fiscal year 2011.

I believe Congress for too long has been complicit in the Washington's business as usual culture that tolerates the continuing waste and fraud in these healthcare programs. Congress has a duty to ask when the fraudulent payments will stop and what can be done for State and Federal governments to prevent fraud. I am taking a leadership role in ensuring that Congress upholds its oversight responsibilities to provide comprehensive program integrity to Medicaid. Simply put we need to improve coordination between the federal government and states and we need improve coordination across states. We also need to do a better job of leveraging information technology to prevent fraud and which would provide a meaningful deterrent to potential fraudsters. I know the President and the States share my conviction that we must work together to stamp out fraud in Medicaid – we are all on the same team in this regard.

I came to Washington to work in bipartisan manner to solve the issues Americans care about, I believe members of Congress from both parties agree that the fraud, waste and abuse in Medicare and Medicaid must end. So I extend an invitation to members of Congress from both parties, the Administration and the States to work with me and let's end fraud in Medicare and Medicaid.

STATEMENT OF

PETER BUDETTI, M.D., J.D.

DEPUTY ADMINISTRATOR AND DIRECTOR,
CENTER FOR PROGRAM INTEGRITY
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

"SAVING TAXPAYER DOLLARS BY CURBING WASTE AND FRAUD IN MEDICAID"

BEFORE THE
UNITED STATES SENATE COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENT AFFAIRS
SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT
INFORMATION, FEDERAL SERVICES, AND INTERNATIONAL SECURITY

JUNE 14, 2012

U.S. Senate Committee on Homeland Security and Government Affairs
Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security

Hearing on "Saving Taxpayer Dollars by Curbing Waste and Fraud in Medicaid"
June 14, 2012

Chairman Carper, Ranking Member Brown, and Members of the Subcommittee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) program integrity efforts for the Medicaid program.

The Administration has made important strides in reducing fraud, waste and improper payments across the government. Over the last two years, CMS has implemented powerful new anti-fraud tools provided by Congress and implemented large-scale, innovative improvements to our program integrity strategy to shift beyond a "pay and chase" approach by focusing new attention on preventing fraud. Simultaneously, CMS is using the same innovative tools to further enhance our collaboration with our State and law enforcement partners in detecting and preventing fraud.

Preventing and Detecting Fraud in the Federal Health Care Programs

CMS directly administers Medicare through contracts with private companies that process claims for Medicare benefits. Medicaid is administered by the States within the bounds of Federal law and regulations, and CMS partners with each State Medicaid program to support program integrity efforts. In April 2010, Secretary Sebelius announced the alignment of Medicare and Medicaid program integrity functions with the creation of the Center for Program Integrity (CPI) in CMS. This newly-established Center brought together the oversight of Medicare Program Integrity and Medicaid Program Integrity to coordinate resources and best practices for overall program improvement. The Affordable Care Act (P.L. 111-148 and P.L. 111-152) and the Small Business Jobs Act of 2010 (P.L.111-240) provided additional opportunities to strategically combat fraud, waste, and abuse with a coordinated approach in Medicare and Medicaid.

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The New "Twin Pillar" Strategy

CMS has implemented a twin pillar approach to fraud prevention in Medicare that builds upon program integrity efforts focused on detecting and prosecuting fraud. The first pillar is the new Fraud Prevention System (FPS), which applies predictive analytic technology on claims prior to payment to identify aberrant and suspicious billing patterns. The second pillar is the Automated Provider Screening (APS) system, which identifies ineligible providers or suppliers prior to their enrollment or revalidation. Together, these innovative new systems, the FPS and APS, are growing in their capacity to protect patients and taxpayers from those intent on defrauding our programs. These pillars represent a comprehensive approach to program integrity – preventing fraud before payments are made, keeping bad providers and suppliers out of Medicare in the first place, and quickly removing wrongdoers from the program once they are detected.

The Medicaid Program

Medicaid is the primary source of medical assistance for 56 million low-income and disabled Americans. Although the Federal government establishes requirements for the program, States design, implement, administer, and oversee their own Medicaid programs. The Federal government and States share in the cost of the program. State governments have a great deal of programmatic flexibility within which to tailor their Medicaid programs to their unique political, budgetary, and economic environments. As a result, there is variation among the States in eligibility, services, reimbursement rates to providers and health plans, and approaches to program integrity. The Federal government reimburses a portion of State costs for medical services through a statutorily determined matching rate called the Federal Medical Assistance Percentage, or FMAP, which is based on each State's per capita income relative to the national average and normally ranges between 50 and 75 percent. The Federal government also reimburses the States a portion of their administrative costs through varying matching rates determined according to statute, ranging from 50 percent to 90 percent. The total net Federal Medicaid outlays in fiscal year (FY) 2011 are approximately $275 billion.

Preventing and Detecting Fraud in Medicaid

States have primary responsibility for policing fraud, waste, and abuse in their Medicaid programs, and they have significant financial interest in doing so as they pay, on average, 43 percent of the cost of the program. CMS plays a significant role through the provision of technical assistance,

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guidance, and oversight in the State-based efforts. Section 1936 of the Social Security Act ("the Act") provides CMS with the authorities to fight fraud and abuse by Medicaid providers by requiring CMS to contract with private sector entities to review provider claims data, audit providers, identify overpayments, and educate providers and other individuals about payment integrity and quality of care. CMS works with partner agencies at the Federal and State levels to enhance these efforts, including preventing the enrollment of individuals and organizations that would abuse or defraud the Medicaid program and removing fraudulent or abusive providers when detected.

CMS is evaluating many of the tools used in Medicare for opportunities to transfer the knowledge and lessons learned to the Medicaid program. Specifically, CMS is evaluating the use of the twin pillars, FPS and APS, on State data. CMS is also actively pursuing ways to apply advanced data analytics technology, including predictive analytics, to the Medicaid program. CMS is required, under the Small Business Jobs Act of 2010, to complete an analysis of the cost-effectiveness and feasibility of expanding predictive analytics technology to Medicaid and the Children's Health Insurance Program (CHIP) after the third implementation year of the FPS. Based on this analysis, the law requires CMS to expand predictive analytics to Medicaid and CHIP by April 1, 2015.

CMS is currently working to identify specific FPS algorithms applicable to Medicaid and will be performing an analysis of one State's Medicaid claims data using the identified algorithms. Once the analysis is complete, we will share the results with the State. We anticipate the analysis being complete before the end of the year. As another example, CMS is engaged in an additional pilot to screen all of one State's Medicaid providers using the APS. Once the analysis is complete, we will provide the results to the State for their action as appropriate. The goal of this test project is to demonstrate the utility of using an automated screening application to screen Medicaid providers, and we expect results later this year. Once we test the effectiveness of these types of solutions in Medicaid, our goal is to expand these capabilities to more States. CMS is also supporting States' use of predictive analytics through technical assistance and education.

CMS is collaborating with our State partners to ensure that those caught defrauding Medicare will not be able to defraud Medicaid, and those identified as fraudsters in one State will not be able to replicate their scams in another State's Medicaid program. Specifically, the Affordable Care Act

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and CMS' implementing regulations require States to terminate from the Medicaid program those Medicare providers or suppliers whose billing privileges have been revoked, or terminated for cause by another State's Medicaid or CHIP program. Similarly, under current authority, the Medicare program may also revoke the billing privileges of its providers or suppliers terminated by State Medicaid or CHIP agencies.

To support State efforts to share such information, CMS implemented a web-based application that allows States to share information regarding providers that have been terminated for cause and to view information on Medicare providers and suppliers that have had their billing privileges revoked for cause. We are confident this interactive tool for States is the beginning of a smarter, more efficient Federal-State partnership, integrating technology solutions to routinely share relevant program information in a collaborative effort.

CMS Collaboration with States on Medicaid Program Integrity

To address Medicaid's structure as a Federal-State partnership, CMS has developed initiatives specifically designed to assist States in strengthening their own efforts to combat fraud, waste, and abuse. The Medicaid Integrity Institute (MII) is one of CMS' most significant achievements in Medicaid program integrity. The MII provides for the continuing education of State program integrity employees, including specific coursework focused on predictive analytics. At the MII, CMS has a unique opportunity to offer substantive training, technical assistance, and support to States in a structured learning environment. From its inception in 2008 through May 2012, CMS has continually offered MII courses and trained more than 3,000 State employees at no cost to the States. These State employees are able to learn and share information with program integrity staff from other States on topics such as emerging trends in Medicaid fraud, data collection, and fraud detection skills, along with other helpful topics. In 2012, CMS has already held several events at the MII and plans to host a Data Expert Symposium this summer to bring together State Medicaid data experts to exchange ideas about predictive analytics, including algorithm development and trend analysis.[1]

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[1] Medicaid Integrity Institute FY-12 Training Calendar: http://www.justice.gov/usao/eousa/ole/mii/mii.courses.12.pdf

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Additionally, to provide effective support and assistance to States to combat Medicaid fraud, waste, and abuse, and to gauge States' efforts in this regard, CMS conducts triennial comprehensive reviews of each State's program integrity activities. We use the State Program Integrity Reviews to identify and disseminate best practices. The review areas include provider enrollment, provider disclosures, program integrity, managed care operations, and the interaction between the State's Medicaid agency and its Medicaid Fraud Control Unit (MFCU). CMS also conducts follow-up reviews to evaluate the success of the State's corrective actions.

Through its reviews, CMS has identified 52 unduplicated program integrity "best practices" that we have publicized to all States through annual summaries of our efforts. The guidance includes specific examples of how States have created well-functioning and committed partnerships between the State Medicaid agency and its MFCU. CMS, working with State Medicaid agencies and MFCUs, issued guidance in September 2008 entitled "Performance Standard for Referrals of Suspected Fraud from a Single State Agency to a Medicaid Fraud Control Unit." CMS, State Medicaid agencies, and MFCUs developed this performance standard to provide State program integrity units with a clear understanding of how to comply with requirements for making referrals of fraud to MFCUs. In concert with the release of the performance standard, MIG issued a second guidance document, "Best Practices for Medicaid Program Integrity Units' Interactions with Medicaid Fraud Control Units." This document advises State program integrity units of the circumstances under which they should refer cases to their MFCUs, and provides guidance for interactions between State program integrity units and their MFCUs, with specific examples of actions taken by States that have created well-functioning and committed partnerships between the two entities.

CPI is taking steps to improve communication and coordination on cross-cutting issues, which will strengthen program integrity efforts in both Medicare and Medicaid while potentially saving both programs valuable resources. For example, many States require that Medicaid DME providers be enrolled in Medicare to participate in Medicaid. In these states, there are opportunities to leverage resources and share information regarding changes in enrollment status and the results of site visits and other investigations. We are partnering with three States to test strategies and develop processes for improved information sharing between programs regarding DME provider enrollment activities.

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Just recently, CMS announced another initiative to assist States in their program integrity efforts. On May 30th, we launched the "CMS Provider Screening Innovator Challenge," an innovation competition to develop a multi-State, multi-program provider screening software application which would be capable of risk scoring, credentialing validation, identity authentication, and sanction checks, while lowering burden on providers and reducing administrative and infrastructure expenses for States and Federal programs. This competition addresses our goals of improving our abilities to streamline operations, screen providers, and reduce fraud and abuse. It also complements CMS' current efforts in applying the APS to Medicaid screening. Further information about the Challenge is available at www.medicaid.gov.

CMS also provides States assistance with "boots on the ground" for targeted special investigative activities. Since October 2007, CMS has participated in 12 projects in three States, with the majority occurring in Florida. CMS assisted States in the review of 654 providers, 43 home health agencies and DMEPOS suppliers, 52 group homes, and 192 assisted living facilities. During those reviews, CMS and States interviewed 1,150 beneficiaries, and States took more than 540 actions against non-compliant providers (including, but not limited to fines, suspensions, licensing referrals, and State MFCU referrals). States reported these reviews have resulted in $40 million in savings through cost avoidance.

CMS Redesign of the National Medicaid Audit Program

CMS has learned important lessons during the initial years of the Medicaid Integrity Program. Beginning in early 2010, CMS determined through internal analysis, environmental assessments, parallel discussions with stakeholders, and reviews of contractor performance that the initial auditing model of the Medicaid Integrity Program required fundamental changes to effectively support States in their efforts to combat fraud, waste, and abuse in their Medicaid programs. In short, we recognized that audits based solely on a subset of post-payment data provided to the Federal government (the Medicaid Statistical Information System (MSIS)) [2] and carried out with little input from States had mixed results, at best. The Department of Health and Human Services' Office of Inspector General (HHS-OIG) and the Government Accountability Office (GAO) have

[2] MSIS data is the primary data source for Medicaid statistical data, and is a subset of Medicaid eligibility and claims data from all 50 States and the District of Columbia.

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reported findings consistent with those identified by our internal assessments. CMS' 2010 Annual Report to Congress[3] on the Medicaid Integrity Program contained a section entitled "Redesign of the National Audit Program" that described how CMS was approaching improvements to Medicaid program integrity. Since February 2011, CMS stopped initiating audits by our contractors based on the results of algorithms developed solely using MSIS data. CMS instead has focused on developing collaborative auditing projects with the States.

The collaborative approach allows CMS to work alongside States in identifying areas that warrant further investigation and to develop the audit targets. Through this process CMS can more effectively support a State's program integrity efforts. In addition, the corresponding data for the collaborative audits is in many cases provided or supplemented by the States, making the data more complete and thus increasing the accuracy of any audit findings. The number of collaborative audits has progressively increased.

Since the earliest collaborative audits were assigned to Medicaid Integrity Contractors (MICs) in January 2010, CMS has worked with States to develop and assign 137 collaborative audits in 15 States that collectively represent approximately 53 percent of all Medicaid expenditures in FY 2011. CMS is committed to expanding collaborative audit projects to a broader number of States, and is in discussions with 15 additional States that make up approximately 26 percent of FY 2011 Medicaid expenditures.

CMS has continued to identify additional opportunities for program changes and improvement. CMS' redesign plan for the National Medicaid Audit Program recognizes the significant increase in Medicaid managed care penetration, anticipated growth in enrollment in the Medicaid program, the influence of new State Medicaid recovery audit contractors, as well as the need to eliminate certain redundant, ineffective, and inefficient practices. We are working within CMS and with our State partners to develop and test best practice approaches to managed care program integrity oversight that considers both the growth in enrollment and alternative funding arrangements.

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[3] http://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/Downloads/fy10rtc.pdf; page 24.

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As noted earlier, others came to many of the same conclusions for the need for changes to strengthen Medicaid program integrity that resulted from our own internal analysis. Recently, the HHS OIG,[4] the Medicaid and CHIP Payment and Access Commission (MACPAC),[5] the National Association of Medicaid Directors (NAMD),[6] and GAO[7] have identified many of these same factors and have made recommendations for changes to the Medicaid Integrity Program that parallel CMS' plans for restructuring the program. We appreciate the work of our oversight partners and have taken their recommendations into consideration as we make ongoing changes to improve the program integrity efforts in the Medicaid program.

Both the OIG and GAO reports primarily focused on early results of the National Medicaid Audit Program and noted CMS' efforts to improve its program and expand collaborative audits with States appear to enhance results. In CMS' review of the relevant reports, including those from MACPAC and NAMD, we note there were similar recommendations, and we are pleased to note the Medicaid Integrity Program improvements CMS has initiated address many recommendations in those reports. Beyond the expansion of collaborative audits, examples include improving alignment of State and Federal audit activities, expanding support and training of State program integrity staff in vulnerable areas such as program integrity oversight of managed care and evolving integrated care models, facilitating development of State capacity and access to cost effective analytics technology, and providing guidance for better quantifying the effectiveness of program integrity activities to demonstrate impact of cost avoidance from prevention.

CMS is implementing the program redesign in a phased approach which involves piloting new concepts and sharing best practices with States, as well as collaborating with States to use State data directly for the National Medicaid Audit Program. These improvements include expanding reviews to managed care entities, refining the identification of audit targets like high-risk providers serving

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[4] HHS OIG, "Early Assessment of Audit Medicaid Integrity Contractors." March 2012. http://oig.hhs.gov/oei/reports/oei-05-10-00210.pdf

[5] MACPAC, "Report to the Congress on Medicaid and CHIP." March 2012. http://www.macpac.gov/reports/2012-03-15_MACPAC_Report.pdf?attredirects=0&d=1

[6] NAMD, "Rethinking Medicaid Program Integrity: Eliminating Duplication and Investing in Effective, High-Value Tools." March 2012. http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/namd_medicaid_pi_position_paper_final_120319.pdf

[7] GAO. "Medicare and Medicaid Fraud, Waste, and Abuse: Effective Implementation of Recent Laws and Agency Actions Could Health Reduce Improper Payments." March 2011. http://www.gao.gov/assets/130/125646.pdf

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both Medicare and Medicaid beneficiaries, examining areas where greater efficiency can be obtained, and enhancing support to States in their recovery of overpayments.

CMS is constructing an analytical approach that will assist States with their assessment of managed care rate setting. In addition, we intend to assess industry practices, share State best practices, and exchange ideas through the educational courses CMS sponsors at the Medicaid Integrity Institute.

Improving Data to Fight Fraud in Medicaid

CMS has made significant improvements to our databases and analytical systems in recent years. However, we acknowledge that more can be done. CMS is committed to enhancing the quality and availability of our data to States. CMS is keenly aware that States' appropriate access to Medicare data and analytic tools could strengthen the State agency's ability to prevent and mitigate improper Medicaid payments. CMS is working toward solutions to provide States with sufficient access to CMS data for program integrity purposes. There are privacy, contractual, operational and potential regulatory constraints that need to be resolved in order to implement an efficient and effective process for sharing Medicare data with States for program integrity. However, the agency does release Medicare data to states for research purposes, which could include some data analysis for program integrity; we are looking into what flexibilities may be within existing research protocols to allow States, for example, to use predictive analytic models to identify fraudulent activity worth scrutiny. We anticipate solutions will need to be implemented in stages based on current constraints and technology.

Additionally, CMS recently launched an initiative to transform the agency's approach to data and analytics. The Office of Information Products and Data Analysis (OIPDA) was established in May 2012 to make development, management, use, and dissemination of data and information resources a core function of CMS. [8] Over time, the initiative will modernize CMS' intricate data systems and policies, and help the agency to achieve the greatest improvements in health care delivery.

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8 http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4371&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&

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Integrated Data Repository (IDR)

CMS has made great progress in building the Integrated Data Repository (IDR) to provide a comprehensive view of Medicare and Medicaid data including claims, beneficiary data, and drug information, and continues to address the remaining issues. The IDR provides broader and easier access to data and enhanced data integration while strengthening and supporting CMS' analytical capabilities. The IDR is currently populated with seven years of historical Medicare Parts A, B, and D paid claims, and CMS has recently integrated Part B and DME pre-payment claims. Part A pre-payment claims data will be integrated later this summer.

The IDR continues to be an integral part of CMS' data strategy. The IDR ensures a consistent, reliable, secure, enterprise-wide view of data supporting CMS and its partners in more effective delivery of quality health care at lower cost to CMS' beneficiaries through state-of-the-art health informatics.

CMS is also working to incorporate State Medicaid data into the IDR, while also working with States to improve the quality and consistency of the data reported to the Federal government from each State. MSIS data has been the primary data source for Medicaid statistical data. It is a subset of Medicaid eligibility and claims data from all 50 States and the District of Columbia. To improve the quality of the MSIS data, and Medicaid data in general, CMS established the Medicaid and CHIP Business Information Solution (MACBIS) Council. This Council provides leadership and guidance in support of efforts to create a more robust and comprehensive information management strategy for Medicaid and CHIP. The Council's strategy includes:

- Promoting consistent leadership on key challenges facing State health programs;
- Improving the efficiency and effectiveness of the Federal-State partnership;
- Making data on Medicaid, CHIP, and State health programs more widely available to stakeholders; and
- Reducing duplicative efforts within CMS and minimizing the burden on States.

The Council has initiated several efforts including the Transformed MSIS (T-MSIS) pilot project in 11 States, which together represent 40 percent of the nation's Medicaid expenditures. The heart of this pilot is to create a consolidated format from a variety of State information sources to satisfy multiple Medicaid and CHIP Federal information reporting requirements. CMS will use the results and lessons learned from these 11 States as the basis for national implementation by 2014. The

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MACBIS projects will lead to the development and deployment of improvements in data quality and availability for Medicaid program administration, oversight, and program integrity.

One Program Integrity (One PI)

Improved data and analytical tools will allow CMS and its partners to analyze information from throughout the claims process to identify previously undetected indicators of aberrant activity. Used with the IDR, CMS' One PI web-based portal, and analytic tools helps CMS share data with our integrity contractors and law enforcement and enhances their use of the data. CMS has been working closely with our law enforcement colleagues to provide One PI training and support. Since October of 2010, CMS has provided training at CMS's Baltimore Training Facility to a total of 622 program integrity contractors and CMS staff, including 82 law enforcement personnel, on the portal and tools on One PI.

The Medicare-Medicaid Data Match Program

The Medicare-Medicaid Data Match Program (Medi-Medi) is another CMS initiative to improve the use and availability of better quality Medicaid data. The Medi-Medi program began as a pilot project with the State of California in 2001; nine other states joined the Medi-Medi program between 2003 and 2005, followed by further expansions. The Medi-Medi program enables participating State and Federal Government agencies to collaboratively analyze billing trends across the Medicare and Medicaid programs to identify potential fraud, waste, and abuse. Currently, CMS is partnering with States that account for most of the expenditures in Medicaid; the 16 States that now participate in the Medi-Medi program account for more than half of total Medicaid expenditures. Participating States include: New York, New Jersey, Pennsylvania, North Carolina, Georgia, Florida, California, Texas, Colorado, Oklahoma, Utah, Iowa, Ohio, Mississippi, Missouri, and Arkansas.

CMS is working to identify ways the Medi-Medi program can be improved and made more beneficial to States. We are also exploring additional opportunities to collaborate with States as well as working directly with States to match Medicare and Medicaid data for specific collaborative projects. The APS and FPS pilots with State Medicaid data will also provide more collaboration between Medicare and Medicaid. In addition, we will be providing more opportunities for sharing

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lessons learned from States that have made successful referrals and recouped Medicaid expenditures.

Looking Forward

As these efforts mature, we expect to be able to more easily transfer the lessons learned from Medicare program integrity analytics and algorithms, including predictive analytics, to the Medicaid Integrity Program. As in Medicare, CMS' ultimate goal is to use predictive modeling and other sophisticated analytics to enhance our capabilities, as well as increase information-sharing and collaboration among State Medicaid agencies to detect and deter aberrant billing and servicing patterns at the State level and on a regional or national scale.

Medicare and Medicaid fraud affects every American by draining critical resources from our health care system and contributing to the rising cost of health care for all. The Administration has made a firm commitment to rein in fraud, waste, and improper payments. Today, we have more tools than ever before to move beyond "pay and chase" and implement strategic changes in pursuing and detecting fraud, waste, and abuse. I look forward to continuing to work with you as we make improvements in protecting the integrity of our health care programs and safeguarding taxpayer resources.

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Testimony of Douglas Wilson

Inspector General

Texas Health and Human Services Commission

before the

Senate Committee on Homeland Security & Governmental Affairs
Subcommittee on Federal Financial Management, Government Information, Federal Services, & International Security
June 14, 2012

Good morning Chairman Carper, Ranking Member Brown, and distinguished members of the Committee. My name is Douglas Wilson and I serve as the Inspector General for the Texas Health and Human Services Commission. I appreciate the opportunity to be with you today to offer testimony from the Texas perspective regarding program integrity challenges, opportunities and successes.

Over the past year since I assumed the position of Inspector General, Texas has reformed and reenergized its Medicaid program integrity efforts. Our Medicaid program has a budget of $19.6 billion annually and my office has about 615 employees. Although completed case investigations are a long way from recouped dollars (and in fact the two are only marginally related), our reinvigorated Office of Inspector General has significantly increased the number of case investigations in the last fiscal year, and we are on track to increase the identification of potentially recoupable dollars by more than eighteen times. However, much like high pressure water through a leaky hose, the efforts we have made have identified some holes in the system requiring attention.

State-CMS Coordination and Cooperation

Although some bemoan the inflexibility of federal agencies that has not been our experience with CMS. Our relationships primarily are with the Medicaid Integrity Group, where we have experienced significant and meaningful cooperation at all levels. In particular, we have regular, positive and useful contact with Robb Miller, Director of the Division of Field Operations, Lyn Killman, the Deputy Director, and Angela Brice-Smith, Director of the Medicaid Integrity Group. They have repeatedly sought to assist and encourage us in our innovative efforts, and we view them as active, cooperative team members. Our joint challenge is to work through policies and regulations that were designed to create certainty in process but which actually have hampered our efforts.

A specific example of the assistance CMS recently provided to Texas in the area of program integrity is an innovative, but common sense effort we have launched to reduce fraud involving durable medical equipment. Our experience tells us DME vendors are more likely than other providers to overbill the Medicaid program. As difficult as it may be to believe, one relatively easy method to steal from Medicaid is to obtain a Medicare and Medicaid provider number and simply start billing for DME – no supplies delivered. Our solution to this problem is to sweep all the DME vendors in the State of Texas – nearly 6,000 of them – with onsite visits. Simply physically visiting each vendor to identify which of them do not have a physical location, or have a location that is inadequate for the volume they bill, will likely reduce the number of DME vendors (and concomitantly, the fraud exposure those vendors create) by a third or more. Yet the Affordable Care Act requires each of these vendors receive two visits – once immediately before

re-enrollment, once after re-enrollment – and Texas is not yet ready to begin the re-enrollment process. Obviously, traveling to and conducting site visits on all of these vendors will take tens of thousands of hours and will be a significant cost to the Office of Inspector General. So we called CMS, starting with Robb Miller. We explained what we wanted and he engaged Lyn Killman. Together they cleared obstacles for us and facilitated an arrangement that permits Texas to pilot this type of statewide fraud sweep while still permitting us a year's grace period to count the fraud site visits as re-enrollment site visits under the Affordable Care Act. Although it may sound simple, this type of cooperation is exactly what we need to combat fraud jointly. CMS will provide us with up to date Medicare site visit data, thereby reducing the overall number of vendors interviews we must conduct. In return, Texas will comply with the Medicare site visit requirements, including photographing or making a video record of the site visits. We will then provide the results of our visits to CMS for use in the Medicare program, thus eliminating the needs for Medicare's contractor to repeat our efforts.

In addition, no comment on CMS assistance to the states would be complete without a reference to the Medicaid Integrity Institute in South Carolina. Texas has taken advantage of the support the Medicaid Integrity Group has provided to the Medicaid Integrity Institute and we regularly send the maximum number of students to the Medicaid Integrity Institute's training programs. My office's senior executive management takes advantage of every opportunity the Institute provides to meet with executive management from other states, and we have found nothing to compare to that experience for the knowledge, ideas and innovation that occurs simply by putting like-positioned people together to talk about ideas and experiences.

Data Access

The Texas experience is that more data is better. Whether the data comes from Medicaid, Medicare, SNAP, WIC, TANF, Craig's List, county property lists, banking records, arrest records, employment records or nearly any other source you can imagine, all of this data can help to identify patterns of behavior and billing which lead to identifying intentional or inadvertent overbilling and the accompanying overpayment. Although I will discuss pattern recognition more later, the single largest source of non-Medicaid data and cooperation is Medicare. Unfortunately, our interaction with Medicare is limited to the unsuccessful Medi-Medi program. In Texas, as in most places, Medi-Medi is unsuccessful because of its focus on specific cases, invariably Medicare, rather than upon the *purpose* of the program, which is enhanced cooperation between the two federally-supported health insurances. Thus, we receive few referrals and the ones we do receive are limited to small, dual-eligible overpayments. What we want and need is usable access to the Medicare claims and payment data. We know providers who defraud one program are overwhelmingly likely to defraud the other, or the Children's Health Insurance Program. Yet while we all know that, we still encounter federal institutional opposition to sharing Medicare data with us. The reality is that additional data would enable us to see and identify overpayments in a far broader context – overpayments which might otherwise fly below the radar and escape our notice.

Pattern Recognition Technology

Many argue that data analytics and approaches among the states and federal government on Medicaid expenditures should be standardized to facilitate the transfer and analysis of data. Yet

the old adage is that if you have seen one state's Medicaid program, you have seen one state's Medicaid program. Because each state assigns different levels of effort and funding to priorities within the Medicaid program, a universal approach to data analysis would likely prove counterproductive. Even if it were possible to run the same analytics on every state or territory's program, the results quickly would grow stagnant. Ranchers and farmers know the value of hybrid vigor – cross breeding different strains of livestock or crops – to enhance the strength and viability of the animal or plant. A similar concept applies in investigations. Too many people running the same queries or investigations stifle creativity, innovation and adaptability. We would end up with every investigator in the country aware of and investigating the same schemes, while those bent on stealing money from the Medicaid program would stay up late plotting ways to avoid detection. In our judgment, CMS should encourage each state to use whatever method of data analysis is effective for that state. To some degree, trial and error will help reveal the most effective methods of approaching large quantities of data and extracting useful information from it. Yet the more programs that are looking at data and trends from more perspectives, the greater the probability that schemes and patterns will become visible to everyone sooner.

In Texas, we have identified pattern recognition technology that traverses gigantic quantities of data in remarkably short times to identify patterns and connections between seemingly unrelated events and individuals. Thus, data queries that might normally take hours or even days to run can be completed in minutes, seconds or even sub-seconds, and a physical graph of the results can be displayed on a desktop computer for an investigator to see. Recognizing that fraud is fundamentally a behavior rather than simply an act, we can begin to compile databases of

Medicaid transactional history, other social service program history and additional data from widespread other resources to track relationships between people and specific acts in time. In this way, we can see how events, times, locations and actions are related to each other. Importantly, we can begin to understand not only the actions individuals commit, but also the behavioral indicators and relationships that are suggestive of fraud The end result will be a remarkable abbreviation of the time it currently takes us to see aberrant billings or expenditures. Although much is said about pre-payment review of claims, the reality is that investigators still must know trends and patterns to know whether a creeping upward expenditure line is an aberration or expectation, and whether physicians referring to certain pharmacies or therapy clinics are doing so for professional or fraudulent reasons.

This technology is not without cost, and states need federal assistance in obtaining it. Yet equally as important is access to federally-maintained data, such as that in the Medicare databases. There are organized groups of people in the United States today who are, this very moment, conspiring to defraud the government and our taxpayers. Until the states and the federal government reach the point where there is no "our data" and "your data," we will continue to play catch me if you can with criminals who skip from state to state and scheme to scheme as easily as other people change socks.

Federal – State Recoupment Cooperation

Currently, interdiction and recoupment efforts are a two-edged sword. States identify potential overpayments and, after the proper due process steps are observed, CMS is entitled to 50% of the

identified overpayment. States have 60 days to repay the overpayment to CMS in non-fraud cases, one year to do so in cases where the state has established fraud.

Unfortunately, this process builds in disincentives to the states to be active in identifying and publicizing anti-fraud, anti-overpayment activities. In Texas we currently have a number of large cases where the potential overpayment could easily involve tens of millions of dollars. Historically, our options for cases where we identify a potential overpayment of that size are limited. Providers with large overpayments generally go out of business or bankrupt, either of which relieves them (and consequently the state) of the burden of repaying any portion of the overpayment they obtained.

In Texas, we are currently in the midst of investigating a relatively small number of orthodontists who collectively have overbilled the State in the neighborhood of hundreds of millions of dollars over the past five years. Although the pattern recognition software I mentioned earlier would have identified the creeping upward trends and identified this problem much earlier, we are confronted with a situation now where a few providers are providing care to an enormous number of Medicaid recipients. One provider alone has roughly $27 million in orthodontic overpayments in addition to general dentistry overpayments that may far exceed that amount. The easiest thing for a provider in that situation to do is close, leaving the state scrambling to identify substitute providers for the patients affected. For larger providers, the number of affected children easily reaches the tens of thousands. Although Texas could absorb that type of disruption once or twice, perhaps even three or four times, we simply do not have enough

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professionals to care for all the children who would be affected if their orthodontist went out of business.

Thus, we are confronted with two dilemmas. First, we have providers overbilling the Medicaid program. At the same time, we need their services to complete the treatment they began or, in some cases, simply provide care in areas where there are no other providers. Second, we have little ability and few tools to recoup money from those individuals. Recognizing that over-billers rarely save their ill-gotten gains in liquid accounts, we see provides buying jets, expensive cars and building enormous houses. If we pursue them for repayment, we find few easily collectible assets. Worse, we can only pursue them once we have established a definite overpayment amount – which means the clock starts running for the state to repay CMS one half of the identified overpayment. In the case of my state, our program integrity efforts could perversely cost the state hundreds of millions of dollars in identified overpayment money CMS is obligated to claw back.

However, given enough time and flexibility it is possible for us to recoup some lost money. Long term repayment arrangements and litigation to pursue assets are two readily identifiable methods for recovering money the program paid improperly. Yet neither option is possible under current rules and strictures, leading to a Hobson's choice: we can either finally and formally identify an overpayment amount, and enter into a relatively short repayment arrangement (thereby triggering state repayment obligations to CMS), or we can put the provider out of business (thereby eliminating the specter of CMS withholding millions of dollars from the State's Medicaid payments). In the first case we either significantly restrict the total amount of

recovery available to that which the provider can repay within 60 days (or one year for fraud cases), or the state shoulders the burden of paying the CMS portion up front and recouping from the provider as time goes by. In the second case, the provider often escapes with no liability whatsoever.

When the federal government pursues a provider for an overpayment, it rarely, if ever, seeks settlement approval from the State. The converse is not true. Perhaps there was a time when this was appropriate, when the federal government took a greater portion of any recovery. Today, the State and the federal government share the recoupment amount equally. If we had the authority to negotiate cases directly with providers to establish long-term payment plans, or had the flexibility to pursue assets in court for as long as that took and could repay 50% of the recovery – whatever it was – upon actual recovery, it is my belief we would unquestionably see our recovery rates and absolute dollars skyrocket.

Summary

Half of the equation in Medicaid fraud, waste and abuse detection and prevention is investigative and audit driven: getting the right technology and human resources to identify the behavior and actions that pose a risk to the program. The other half is what we do with that information once we get it.

We believe there is a solid foundation for the CMS-state relationship, but also that the environment in which that relationship exists needs to change to improve. An attitude of cooperation and assistance is already evident but needs to extend further, to data access and

resource development. We need financial assistance to obtain the best technology to identify and combat waste, fraud and abuse. Recognizing that states are equal participants in recoveries, states should have the ability – or at least CMS should have the authority to delegate it – to enter into settlement agreements designed to maximize recoveries for the state and federal governments, without fear those agreements will result in significant costs to the state's general revenue.

It is of paramount importance to both the Medicare and Medicaid programs that program integrity efforts lead to dollars being saved, not recouped, to client services being provided, not falsified and to fraudsters and inappropriate payments being stopped early, not years later.

I appreciate the efforts of CMS, and in particular am grateful for the efforts this subcommittee has made and continues to make. The Texas OIG looks forward to partnering with CMS and other federal, state, and local agencies involved in the fight to rid our programs of fraud, waste and abuse.

United States Government Accountability Office

GAO

Testimony

Before the Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security, Committee on Homeland Security and Governmental Affairs, U.S. Senate

For Release on Delivery
Expected at 10:00 a.m. EDT
June 14, 2012

NATIONAL MEDICAID AUDIT PROGRAM

CMS Should Improve Reporting and Focus on Audit Collaboration with States

Statement of Carolyn L. Yocom
Director, Health Care

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GAO-12-814T

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Chairman Carper, Ranking Member Brown, and Members of the Subcommittee:

I am pleased to be here today to discuss the National Medicaid Audit Program. Until recently, Medicaid program integrity had been primarily a state responsibility. Specifically, states have been responsible for ensuring the qualifications of the providers who bill the program, detecting improper payments, recovering overpayments, and referring suspected cases of fraud and abuse to law enforcement authorities.[1] At the federal level, however, the Deficit Reduction Act of 2005 (DRA) created the Medicaid Integrity Program to oversee and support state program integrity efforts, and, among other actions, directed the Centers for Medicare & Medicaid Services (CMS) to hire contractors to review and audit state Medicaid claims data.[2] CMS established the Medicaid Integrity Group (MIG) to implement and oversee the National Medicaid Audit Program (NMAP).[3]

My statement will highlight key findings from a report prepared at your request.[4] This report focuses on: (1) the effectiveness of the MIG's implementation of NMAP and (2) the MIG's efforts to redesign NMAP. To conduct this work, we analyzed NMAP data provided by the MIG and interviewed MIG officials. In addition, we reviewed reports submitted by the MIG's review and audit contractors and interviewed representatives of

[1]An improper payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. This definition includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except where authorized by law), and any payment that does not account for credit for applicable discounts. Improper Payments Elimination and Recovery Act of 2010, Pub. L. No. 111-204, § 2(e), 124 Stat. 2224, 2227 (codified at 31 U.S.C. § 3321 note). The Centers for Medicare & Medicaid Services estimated that $21.9 billion (8 percent) of Medicaid's federal expenditures of $270 billion in fiscal year 2011 involved improper payments, the second highest amount reported by any federal program.

[2]Pub. L. No. 109-171, § 6034, 120 Stat. 3, 74-78 (2006) (codified at 42 U.S.C. § 1396u-6). CMS is the federal agency within the Department of Health and Human Services that oversees Medicaid.

[3]See GAO, *Medicaid Program Integrity: Expanded Federal Role Presents Challenges to and Opportunities for Assisting States,* GAO-12-288T (Washington, D.C.: Dec. 7, 2011).

[4]See GAO, *National Medicaid Audit Program: CMS Should Improve Reporting and Focus on Audit Collaboration with States*, GAO-12-627 (Washington, D.C.: June 14, 2012).

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each type of contractor. We also interviewed program integrity officials in 11 states to obtain their perspectives on NMAP, and collected additional information from 8 states where the MIG has recently implemented changes to NMAP.[5] We reviewed relevant Department of Health and Human Services Office of the Inspector General (HHS-OIG) reports, and interviewed HHS-OIG officials involved in early assessments of the MIG's review and audit contractors. More information on our scope and methodology is provided in the full report. We performed our work from July 2011 to June 2012 in accordance with generally accepted government auditing standards.

We found that, compared to the initial test audits and the more recent collaborative audits, the majority of the MIG audits conducted under NMAP were less effective because they used Medicaid Statistical Information System (MSIS) data.[6] MSIS is an extract of states' claims data and is missing key elements, such as provider names, that are necessary for identifying audit targets. Since fiscal year 2008, a small fraction (4 percent) of the 1,550 MSIS audits identified $7.4 million in potential overpayments, over two-thirds did not identify overpayments, and the remaining audits (27 percent) were ongoing. In contrast, 26 test audits and 6 collaborative audits—which used states' more robust Medicaid Management Information System (MMIS) claims data and allowed states to select the audit targets—together identified more than $12 million in potential overpayments. (See fig. 1.) Furthermore, the typical amount of the potential overpayment for MSIS audits ($16,000) was smaller than the amounts identified through test and collaborative audits—$140,000 and $600,000—respectively.

[5]CMS had implemented changes to NMAP in nine states; however, eight responded to our questions on the changes to the program. We selected these 11 states because of their geographic diversity and because together they accounted for more than half of Medicaid spending and beneficiaries.

[6]For this statement, we refer to audits that used MSIS data as MSIS audits. The other two types of NMAP audits (test audits and collaborative audits) used state claims data.

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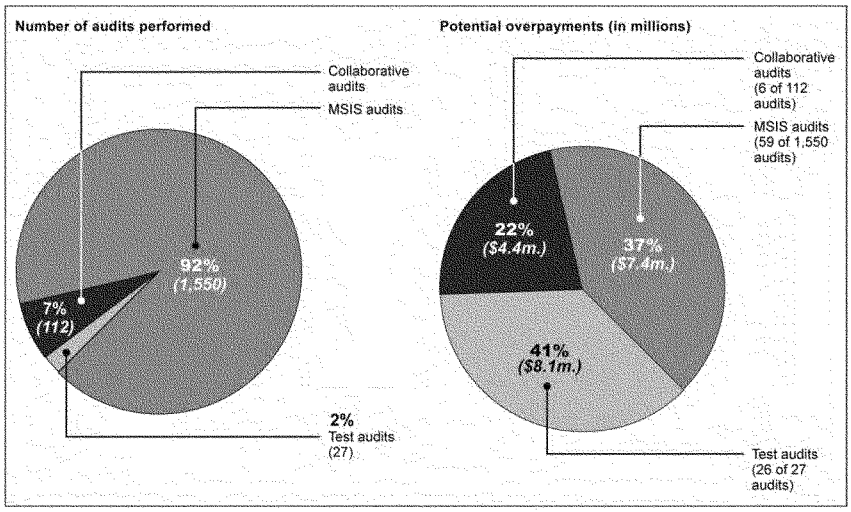
Figure 1: Number of Audits and Total Potential Overpayments Identified and Sent to States for Recoupment (in millions of dollars) by Audit Approach, through February 2012



Source: GAO analysis of CMS data.

Notes: Test audits were conducted from 2007 through 2010. MSIS audits began in 2008 and are ongoing. Collaborative audits began in 2010 as part of the redesign of the NMAP and are also ongoing. Dollar amounts shown are potential overpayments in final audit reports sent to states for recovery. They do not reflect the amounts in draft audit reports or the amounts actually recovered by the states. Percentages may not total 100 because of rounding.

The MIG reported that it is redesigning NMAP, but has not provided Congress with key details about the changes it is making to the program, including why it changed to collaborative audits, new analytical roles for its contractors, and its plans to monitor and evaluate the redesign. Early results showed that this collaborative approach may enhance state program integrity activities by allowing states to leverage the MIG's resources to augment their own program integrity capacity. However, the lack of a published plan detailing how the MIG will monitor and evaluate

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NMAP raises concerns about the MIG's ability to effectively manage the program. Given that NMAP has accounted for more than 40 percent of MIG expenditures, transparent communications and a strategy to monitor and continuously improve NMAP are essential components of any plan seeking to demonstrate the MIG's effective stewardship of the resources provided by Congress.

Our report includes recommendations that the Acting Administrator of CMS ensure that the MIG's (1) planned update of its comprehensive plan provides key details about NMAP, including its expenditures and audit outcomes, program improvements, and plans for effectively monitoring the program; (2) future annual reports to Congress clearly address the strengths and weaknesses of the audit program and its effectiveness; and (3) use of NMAP contractors supports and expands states' own program integrity efforts through collaborative audits. In commenting on a draft of our report, HHS partially concurred with our first recommendation but believed that CMS's annual report to Congress was a more appropriate vehicle for reporting NMAP results than its comprehensive plan. HHS concurred with the other two recommendations.

Chairman Carper, Ranking Member Brown, and members of the Subcommittee, this concludes my prepared remarks. I would be pleased to respond to any questions you may have at this time.

GAO Contact and Staff Acknowledgments

For questions about this statement, please contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Individuals making key contributions to this testimony include Walter Ochinko, Assistant Director; Sean DeBlieck; Leslie V. Gordon; and Drew Long.

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Testimony Before the
U.S. Senate Committee on Homeland Security
and Governmental Affairs
Subcommittee on Federal Financial Management, Government
Information, Federal Services, and International Security

Saving Taxpayer Dollars by Curbing Waste and Fraud in Medicaid

Testimony of:
Ann Maxwell
Regional Inspector General
Office of Evaluation and Inspections
Office of Inspector General
U.S. Department of Health and Human Services

June 14, 2012

10 a.m.

Location: 342 Dirksen Senate Office Building

Testimony of:
Ann Maxwell
Regional Inspector General for Evaluation and Inspections
Office of Inspector General, U.S. Department of Health and Human Services

Introduction

Good morning, Chairman Carper, Ranking Member Brown, and other distinguished Members of the Subcommittee. I am Ann Maxwell, Regional Inspector General for Evaluation and Inspections of the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG). I appreciate the opportunity to appear before you to discuss OIG's recent work focused on Medicaid program integrity.

My testimony today is based on several evaluations recently issued by OIG that focused on two national Medicaid integrity programs intended to augment States' efforts to protect Medicaid from fraud, waste, and abuse.[1] This body of work offers insights into the effectiveness of the Centers for Medicare & Medicaid's (CMS) National Medicaid Audit Program and the Medicare-Medicaid Data Match Program (Medi-Medi Program).

OIG's work reveals that these programs are not effectively accomplishing their missions. A primary objective for both programs is to identify improper payments for recovery. However, both programs had low findings of actual overpayments and, as a result, yielded negative returns on investment. These programs also delivered very few referrals of potential fraud to OIG and our law enforcement partners. In many ways, these programs resemble a funnel through which significant Federal and State resources are being poured in and limited results are trickling out.

In evaluating these programs, we found a variety of challenges that limited their potential to successfully identify Medicaid overpayments and potential fraud. Most fundamentally, there are significant shortcomings in the data available to conduct efficient, national Medicaid program integrity oversight through data analysis and data mining. In addition, variation in State Medicaid policies presented significant learning curves for integrity contractors, which had difficulty accurately applying the policies unique to each State. These problems led Medicaid Integrity Contractors (MIC) to misidentify potential overpayments and the Medi-Medi Program to identify fewer overpayments and fewer cases of potential fraud for Medicaid than it did for Medicare.

[1] OIG evaluations that serve as the basis for this testimony are: (1) *Early Assessment of Review Medicaid Integrity Contractors*, OEI-05-10-00200, February 2012; (2) *Early Assessment of Audit Medicaid Integrity Contractors*, OEI-05-10-00210, March 2012; (3) *Status of 244 Provider Audit Targets Identified Using Review Medicaid Integrity Contractor Analysis*, OEI-05-10-00201, April 2012; and *The Medicare-Medicaid (Medi-Medi) Data Match Program*, OEI-09-08-00370, April 2012.

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The potential of these programs to safeguard Medicaid may also have been diminished by the way that CMS administered them. While the National Medicaid Audit Program appeared to suffer from too much CMS involvement, the Medi-Medi Program experienced the opposite problem: a lack of involvement by all of the relevant staff at the Federal level. In addition, CMS did not always hold the contractors operating these programs accountable for performing their contracted tasks.

Federal Medicaid Integrity Programs Were Created To Augment States' Efforts

The task of ensuring Medicaid program integrity has historically fallen primarily on States; the Federal Government has provided support and oversight. States have their own program integrity or inspector general offices dedicated to Medicaid. In addition, OIG supports the Medicaid Fraud Control Units (MFCU), which handle the majority of Medicaid fraud cases.

Only recently, legislation has led to a greatly expanded role in Medicaid program integrity for CMS. The Deficit Reduction Act (DRA) of 2005 established the Medicaid Integrity Program to fight fraud, waste, and abuse. The DRA requires CMS to contract with entities to identify overpayments to Medicaid providers. CMS contracted with two types of MICs—Review MICs and Audit MICs—to identify such overpayments. Together, their efforts are known as the National Medicaid Audit Program.[2]

In general, Review MICs conduct data mining on Medicaid claims, and Audit MICs conduct audits of specific providers. More specifically, Review MICs use Medicaid claims data made nationally available through CMS's Medicaid Statistical Information System (MSIS) to identify providers that potentially received overpayments. Audit MICs then audit selected providers to determine whether they had received actual overpayments that should be recouped by the State. This is what we refer to as the "traditional process."

In addition, CMS established a "collaborative process," in which CMS assigned collaborative audits when States were willing to participate. Collaborative audit targets are selected with the involvement of Audit and Review MICs, States, and CMS. The States provide input on program areas that are vulnerable to overpayments and the State policies that apply to those program areas. MICs, CMS, and the States then jointly develop data mining models to identify potential overpayments. Instead of using MSIS, collaborative audits identify potential overpayments using data available in each State's Medicaid Management Information System (MMIS). All parties then determine which providers identified with potential overpayments should be audited.

[2] A third contractor type, Education MICs, was also created by the DRA, but they are not involved in the audit program.

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The DRA also funded an expansion of the Medi-Medi Program. The Medi-Medi Program enables CMS and participating State and Federal agencies to collaboratively analyze billing trends across the Medicare and Medicaid programs to identify potential fraud, waste, and abuse. Participation by State Medicaid agencies and other Federal agencies is optional, and States must contribute their own resources to participate. The purpose of analyzing Medicare and Medicaid claims data collectively is to detect billing patterns that indicate possible overpayments or fraud that may not be evident when analyzing the data separately.

CMS requires Medicare integrity contractors, known as Program Safeguard Contractors (PSC), to perform mandated Medi-Medi Program integrity tasks, which consist of:

- identifying program vulnerabilities by using computer algorithms to look for payment anomalies that may indicate improper payments or potential fraud;
- coordinating State and Federal actions to protect Medicare and Medicaid expenditures; and
- increasing the effectiveness and efficiency of Medicare and Medicaid prepayment denials and recovery of fraudulent, wasteful, or abusive expenditures.[3]

Federal Program Integrity Efforts Show Limited Results in Protecting Medicaid From Fraud and Abuse

As CMS took on a more active role in Medicaid program integrity at the Federal level, OIG assessed those efforts. Our evaluations assessed the results of the National Medicaid Audit Program, operated by CMS and the MICs, and the Medi-Medi Program, operated by the PSCs. These evaluations also sought to identify barriers that might be limiting the efficiency and effectiveness of these programs integrity efforts.[4]

Federal Program Integrity Efforts Were Limited in Their Ability To Identify Medicaid Overpayments

The National Medicaid Audit Program had limited results during the time of our review. Audits of providers selected using the traditional process had particularly limited results. As Chart 1 demonstrates, during our review period, Review MICs initially identified 113,378 providers with potential overpayments of $282 million, but after performing audits, the Audit MICs eventually

[3] CMS is transitioning program integrity work from PSCs to Zone Program Integrity Contractors (ZPIC). The chief difference between PSCs and ZPICs is that ZPICs cover broader geographical areas and multiple parts of the Medicare program, whereas PSCs cover more limited areas and scopes.

[4] OIG's three evaluations of the National Medicaid Audit program are an early assessment of the program. These evaluations focused on program integrity activities conducted as the result of assignments CMS made to MICs between January 1 and June 30, 2010. CMS completed the process of awarding MIC task orders to cover all regions of the country in the fall of 2009. Our evaluation of the Medi-Medi Program focused on 2007 and 2008.

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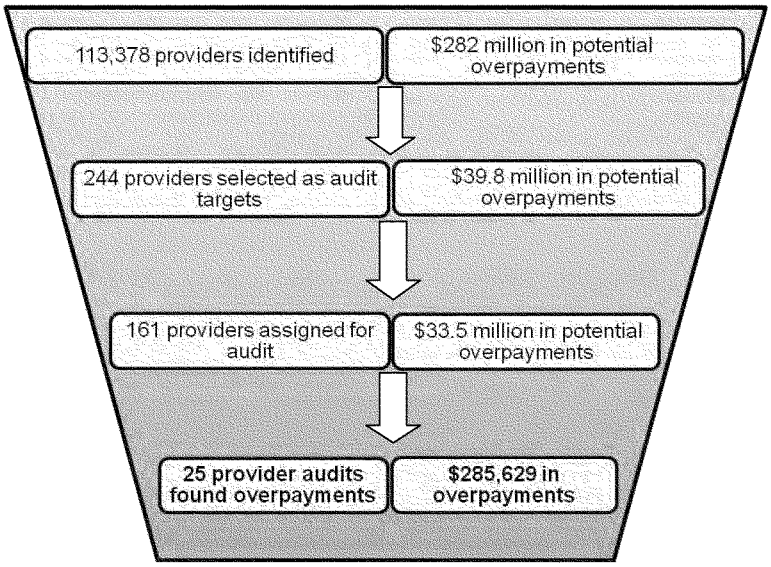
found that only 25 of these providers had overpayments, which totaled $285,629. The remaining 102 completed audits found no overpayments.

Chart 1 shows the process that resulted in the identification of $285,629 in actual overpayments.

Chart 1: Identification of Overpayments From Review MIC Analysis



A separate evaluation of audits assigned to Audit MICs also found few completed audits with findings of overpayments. OIG found that 81percent of these 370 audits either did not or are unlikely to identify overpayments. At the time of our review, only 11 percent of assigned audits were completed with findings, totaling $6.9 million in overpayments. The remaining audits had not progressed enough to draw conclusions about likely outcomes.

Most of the overpayment findings ($6.2 million) resulted from seven completed audits that used the collaborative approach. The remaining $700,000 in overpayments was identified by 35 audits that used the traditional approach.

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The Medi-Medi Program also had limited results, recovering few funds for the Medicaid program. Between 2007 and 2008, the Medi-Medi Program recovered $11.3 million for Medicaid. During the same time period, Medi-Medi recovered more than three times that amount – $34.9 million – for Medicare. While the amount recovered for Medicaid increased from $3.5 million in 2007 to $7.8 million in 2008, the total amount was still low compared to expenditures on the program.

Only 5 of the 10 participating States as of 2008 recovered Medicaid overpayments during our period of review.[5] Two of the participating States ultimately withdrew from the program, finding that it offered them minimal benefits. One of the two States that withdrew reported that it invested $250,000 of its own resources in the program, but recovered only $2,000 over a 5-year period (which included 2007 and 2008). However, during 2007 and 2008, that State also administered its own Medicaid integrity program, which recovered $28.9 million.

Identified Overpayments Yielded a Negative Return on Investment

The National Medicaid Audit Program did not identify overpayments commensurate with the investment CMS made in the program. In fiscal year (FY) 2010, CMS paid Review and Audit MICs approximately $32.1 million. Audit MICs identified $6.9 million in overpayments for assignments made in the first 6 months of calendar year 2010. Although we did not collect data for the other 6 months of the fiscal year, we have no information that would lead us to expect significantly different results. Projecting the 6-month results over a full year would yield less than $14 million, well below the annual expenditures. Further, these overpayment totals represent expected recoveries, not actual recoveries, and therefore may not all materialize as providers are given the chance to appeal the findings.

The Medi-Medi Program also had a poor return on investment. Although the Medi-Medi Program had better results for Medicare than for Medicaid, it was still not enough to achieve a positive return on investment during the time period we reviewed. In 2007 and 2008, Medicare and Medicaid expenditures recovered were $46.2 million and expenditures avoided were $11.6 million, bringing the program total to $57.8 million. However, CMS spent $60 million on the program during this same period.

Federal Program Integrity Contractors Made Few Medicaid Fraud Referrals

The National Medicaid Audit Program generated limited law enforcement referrals. During the time of our review, Review MICs did not identify any potential Medicaid fraud leads from their data mining efforts for CMS to review. CMS officials stated that they have now formalized the process for Review MICs to identify potential fraud leads. Audit MICs, however, have referred a limited number of fraud referrals to law enforcement over the course of the program.

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[5] After 2008, 7 additional States joined the Medi-Medi Program, resulting in a total of 15 participating States. As a result of the transition to ZPICs, the seven additional States joined the Medi-Medi Program as part of three geographic areas.

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The Medi-Medi Program also produced a small number of Medicaid law enforcement referrals. Over the 2 years we reviewed, the Medi-Medi Program produced 10 law enforcement referrals for Medicaid among the 10 participating States. Results for Medicare were better, although still limited, with 56 fraud referrals in this time period. Further, the vast majority of all referrals were in just 1 State, accounting for 41 percent (27 of 66) of the total referrals.

Poor Quality of Data Hindered National Medicaid Program Integrity Work

The poor quality of the Medicaid data on which these programs rely hindered their ability to efficiently detect suspicious trends in Medicaid claims for further auditing or investigation.

Review MICs use MSIS claims data to identify potential overpayments, the only national database of Medicaid claims and beneficiary eligibility information. However, OIG has found that the MSIS data are not current, available, complete, and accurate.[6] Further, MSIS does not capture all data elements that can assist in the detection of fraud, waste, and abuse.

Unlike the MICs, PSCs obtain Medicaid claims data directly from each participating State's MMIS to match them to Medicare data. These data are typically more complete and accurate. However, each State's MMIS data set is unique, rendering it difficult to match it to other States' MMIS data or to Medicare data.

The inaccuracies in and incompleteness of the MSIS data led Review MICs to misidentify providers with potential overpayments. One of the primary reasons audits resulted in no findings of overpayments was that the MSIS data used to pinpoint an audit target were inaccurate. In some instances, the reason that audits resulted in no findings of overpayments was that claims for outpatient services appeared as inpatient claims in MSIS, making the claims appear suspicious when they were, in fact, legitimate. In other cases, the State adjustments to claims were not reflected in MSIS, leading Review MICs to conclude that the State had overpaid a provider for a service when it had not.

The Medi-Medi Program faced different challenges attempting to use existing Medicaid data to fulfill its program integrity goals, mainly, efficiently matching State Medicaid data to Medicare data. The Integrated Data Repository was designed to automate the process of matching Medicaid to Medicare data. The repository contains data from Medicare Parts A, B, and D. However, as of the date of this testimony, Medicaid data are not yet included in the repository and are not projected to be available for use by the Medi-Medi Program until at least 2015.

According to CMS, Medicaid data in their current form would not be appropriate to integrate into the Integrated Data Repository. MSIS data lack many of the standardized data elements needed for program integrity work and often lack consistency across States. Similarly, States' MMISs do not

[6] *OIG, MSIS Data Usefulness for Detecting Fraud, Waste, and Abuse,* OEI-04-07-00240, August 2009.

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allow for efficient matching to Medicare data because the data are structured to meet State-specific needs, containing variables and data definitions unique to each.

Medicaid Contractors Had Difficulty Accurately Applying State Medicaid Program Policies

Both the National Medicaid Audit Program and the Medi-Medi Program encountered problems when contractors incorrectly applied State Medicaid policies in their analyses of Medicaid data. Knowledge of State Medicaid policies is critical to correctly interpreting the data.

MICs misidentified audit targets because they lacked the appropriate knowledge of each State's Medicaid program policies. Five of the seven State Medicaid oversight agencies interviewed stated that the audit targets were often inappropriate because of misinterpretation of State policy. For example, 44 audit targets were selected because of misidentified duplicate payments for services provided to dually eligible beneficiaries (i.e., beneficiaries enrolled in both Medicaid and Medicare). In these cases, Medicaid made two payments for each beneficiary's hospital stay, but in this instance, both payments were appropriate.[7, 8]

The Medi-Medi program also encountered these same issues with interpreting and analyzing Medicaid claims data. Four of the ten participating State Medicaid program integrity agencies said that the Medicare program integrity contractors administering the program do not understand Medicaid and that as a result they primarily analyze Medicare claims data.

Poor Program Administration Diminished the Potential of These Program Integrity Efforts

Our evaluations also reveal that poor administration of the National Medicaid Audit Program and the Medi-Medi Program appears to have limited their effectiveness. In addition, CMS did not always hold contractors accountable for the tasks outlined in their contracts. These are issues OIG has identified in the administration and oversight of Medicare integrity contractors for the past decade.

Basic Program Design Limited Efficiency and Effectiveness

Both the National Medicaid Audit Program and the Medi-Medi Program were constrained by elements of their program design. The National Medicaid Audit Program appears to have been constrained by the lack of communication among the contractors and States. At the time of our review, all communication, whether between Review and Audit MICs, between MICs and States,

[7] One payment covered all inpatient services, and the second payment covered the coinsurance for ancillary services billed to Medicare during the hospital stay. The State Medicaid agency is required to pay for the Medicare coinsurance for dually eligible beneficiaries.

[8] Social Security Act, §§ 1902(a)(10)(E) and 1905(p), 42 U.S.C. §§ 1396a(a)(10)(E) and 1396d(p). States may differ in the policies that determine how Medicare and Medicaid claims for dually eligible beneficiaries are submitted and recorded.

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or between MICs and different divisions within CMS, went through a multistep process controlled by CMS. According to the MICs, this served to slow the flow of information and delayed work. Audit MICs stated that they felt compelled to duplicate Review MIC analyses because they could not easily communicate with Review MICs or States. The inability to communicate freely also meant MICs could not take full advantage of States' knowledge of State Medicaid policies.

CMS stated in response to our report that it considered its involvement to be responsible oversight in establishing a new program. Now that the program has been in existence for several years, CMS is allowing freer communication among all the parties involved in the National Medicaid Audit Program.

While the National Medicaid Audit Program appeared to suffer from too much CMS involvement, the Medi-Medi Program experienced the opposite problem: a lack of involvement by all of the appropriate CMS staff. Federal Medicaid program integrity staff were not incorporated into the administration of the program. Rather, the Medi-Medi Program was administered entirely by the Medicare Program Integrity Group. Both States and Medi-Medi contractors indicated that this resulted in a deemphasis on Medicaid program integrity within the program, leaving the majority of Medi-Medi activities focused on Medicare claims analysis. In response to our evaluation, CMS stated that it is assessing ways to increase the involvement of Medicaid program integrity staff.

CMS Did Not Hold Contractors Fully Accountable

MICs were not held accountable for completing all of their contracted tasks. Review MICs' task orders with CMS state that Review MICs are to provide or recommend audit leads, among other tasks. However, during our review period, CMS stated that it expected Review MICs only to conduct data analysis and provide lists of providers ranked by the amount of their corresponding potential overpayments and did not expect them to recommend audit leads. As a result, Review MICs did not single out any individual providers on their lists as specific audit leads. Rather, Review MICs provided lists containing a total of more than 113,000 providers to CMS for its review. CMS selected only 244 of these providers as audit targets, suggesting that CMS did a significant amount of work to screen the provider lists. Thus, it appears that CMS staff completed much of the Review MICs' contracted tasks themselves.

Similarly, CMS did not hold PSCs fully accountable for their administration of the Medi-Medi Program. Although CMS conducts annual assessments of PSCs, CMS did not formally evaluate the PSCs on each of the contracted Medi-Medi tasks. OIG found CMS's documentation of PSC performance to be insufficient for drawing conclusions about their effectiveness in completing Medi-Medi tasks.

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OIG Recommends Improvements to Medicaid Data and Program Administration

To improve the efficiency and effectiveness of these programs, we recommend that CMS:

- Devote the resources necessary to improve the quality of the Medicaid data available to conduct national Medicaid program integrity data analysis and mining;
- Improve the ability of contractors to properly analyze Medicaid data in light of State-specific policies;
- Evaluate the goals, design, and operations of both programs to determine what aspects of these programs should be part of a national Medicaid program integrity strategy. For the National Medicaid Audit Program, CMS should consider increasing the use of collaborative audits. Collaboration among Audit MICs, Review MICs, States, and CMS during audits appears to have improved the selection of audit targets and the efficiency of the audit process, leading to better results.
- Hold contractors accountable for all of the tasks outlined in their contracts by establishing clear expectations that align with the contracts and evaluating all tasks during the annual assessments.

In response, CMS stated that it has an initiative underway, called Transformed MSIS, to improve the quality of national Medicaid data. Additionally, CMS stated that it has redesigned its approach to audit assignments, instructing Audit MICs to focus on collaborative projects. In fact, CMS stated that it assigned more audits through the collaborative process than through the traditional process in 2011. CMS has also stated it has made significant strides in enhancing the effectiveness of the Medi-Medi Program. However, evidence of this has not been made available.

Conclusion: More Needs To Be Done To Protect the Integrity of Medicaid Payments

OIG's body of work raises questions about the overall effectiveness of the National Medicaid Audit Program and the Medi-Medi Program in protecting Medicaid from fraud, waste, and abuse. OIG's work reveals that neither program produced results commensurate with the investments made in them.

Given the size of current Federal and State outlays for Medicaid and the potential for increased outlays as the beneficiary population expands, a robust national approach to Medicaid program integrity is imperative.

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While we are encouraged by the changes that CMS has made, more must be done to improve these programs and ensure the economical investment of Federal and State dollars. Critically, CMS needs to improve data available to each program to enable them to efficiently and effectively identify potential overpayments and possible fraud.

Thank you for your interest in this important issue and for the opportunity to be a part of this discussion about better protecting Medicaid funds from fraud, waste, and abuse.

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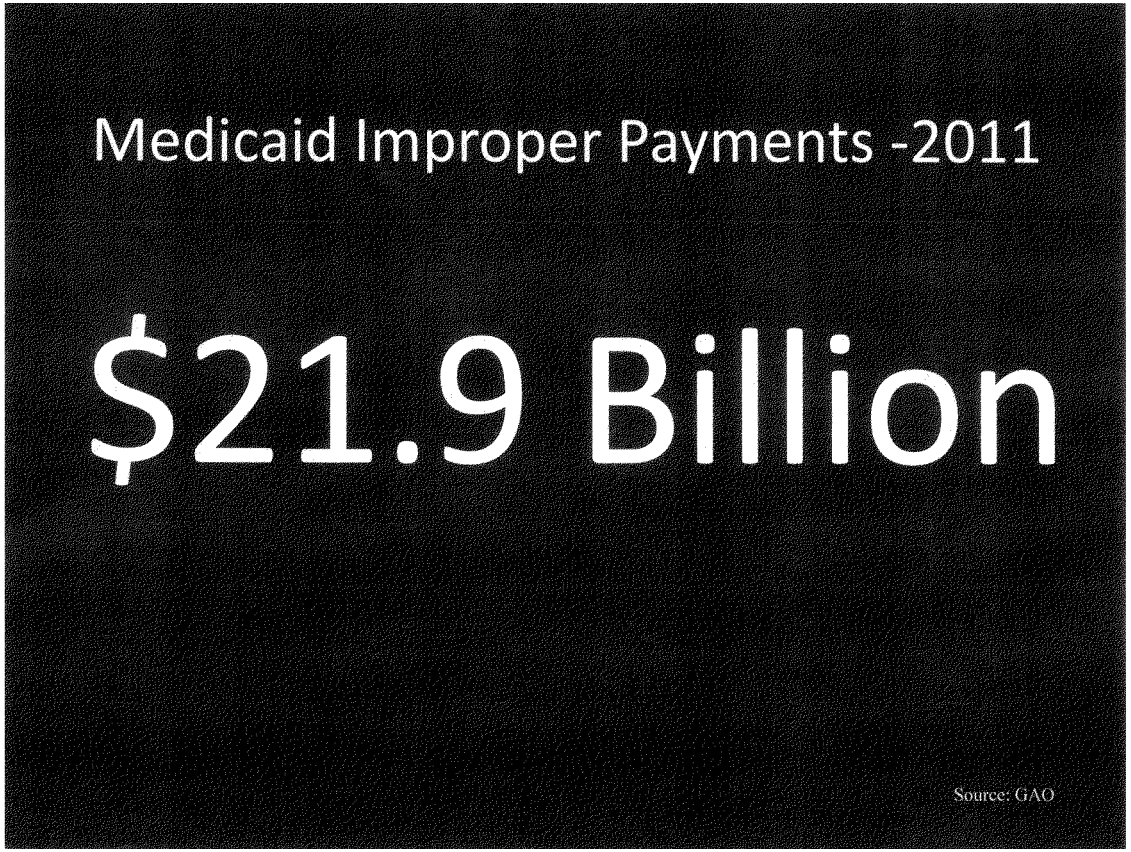

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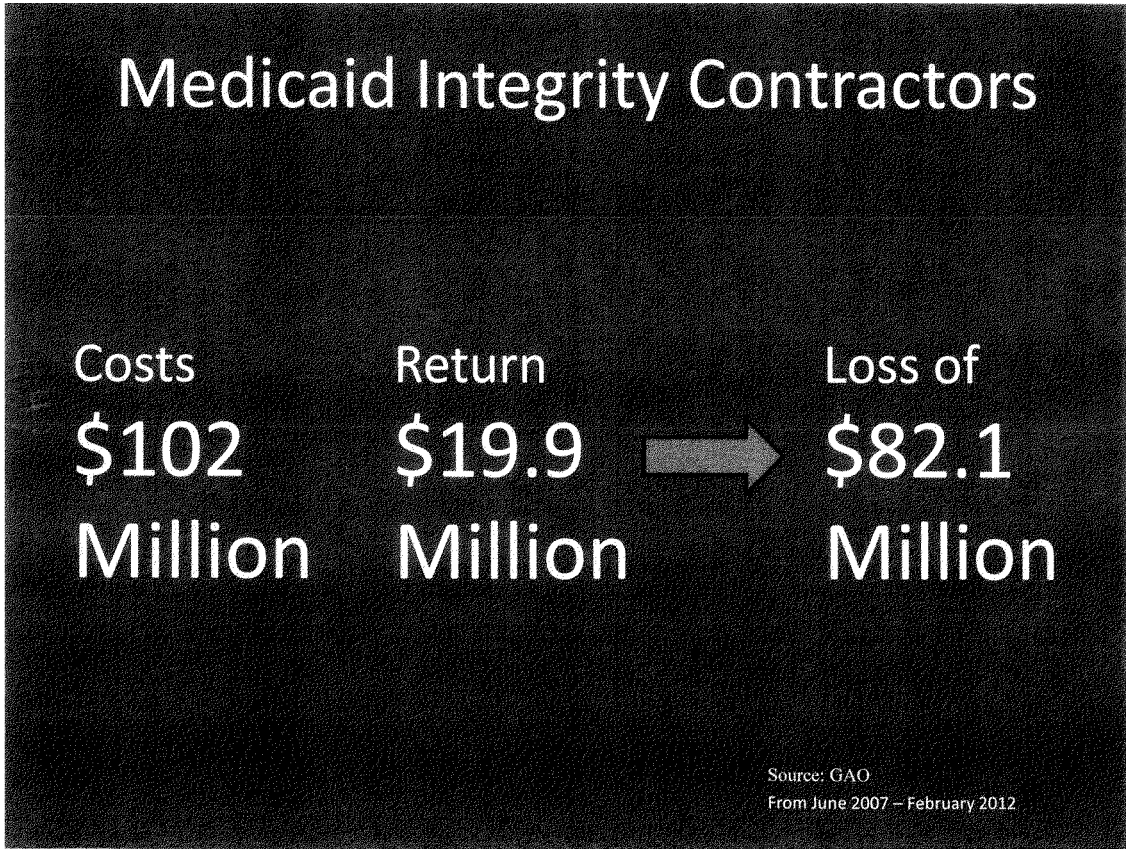

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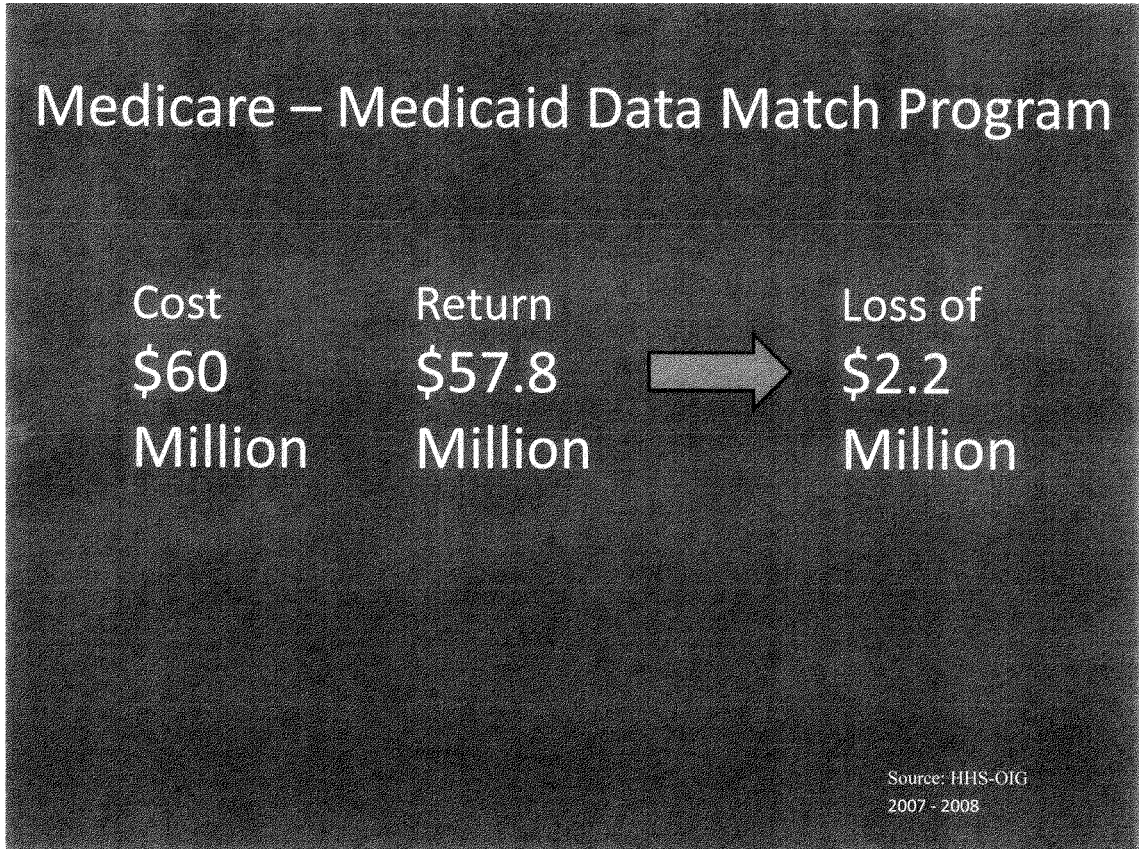

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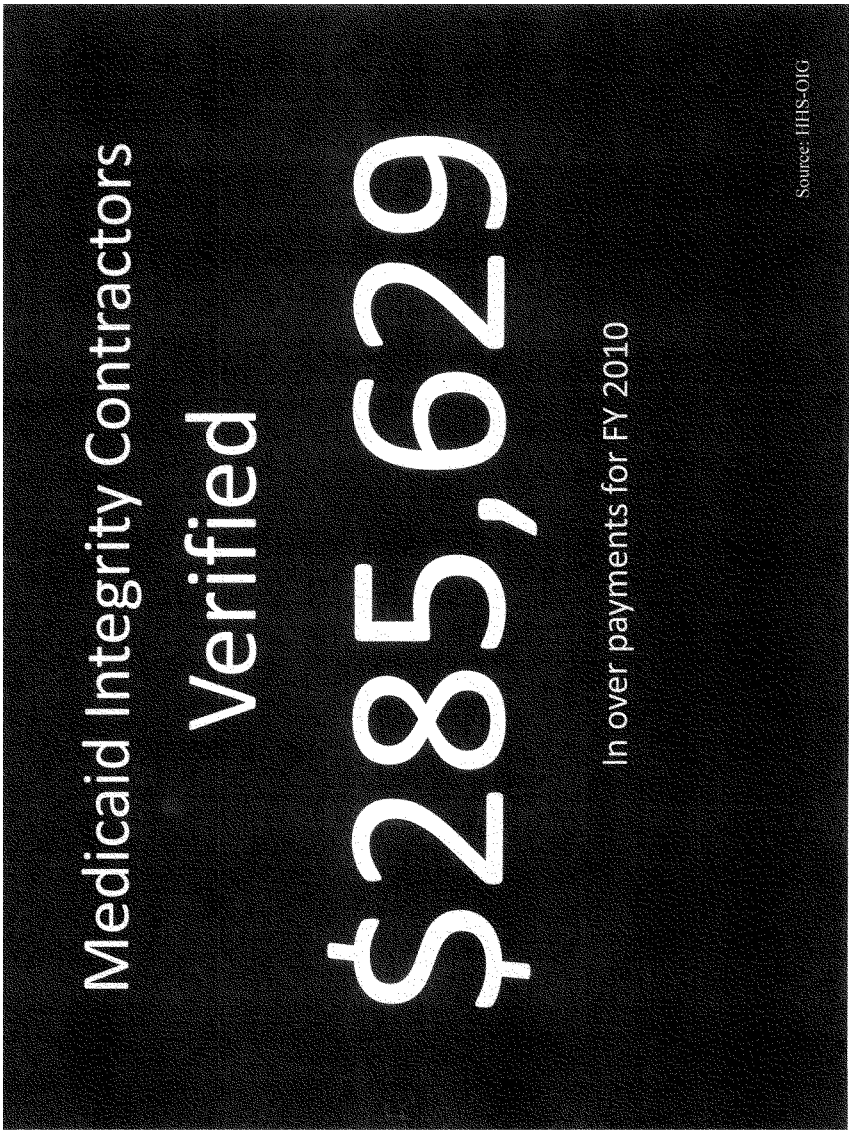
Medicaid Integrity Contractors
Verified
$285,629
In over payments for FY 2010
Source: HHS-OIG

"SAVING TAXPAYER DOLLARS BY CURBING WASTE AND FRAUD IN MEDICAID"
Questions For The Record
Chairman Tom Carper

QUESTIONS FOR DR. BUDETTI OF CMS

1) Improved Screening of Medicare and Medicaid Providers

One of the success stories highlighted during the hearing was the very recent and notable improvement in the CMS ability to verify Medicare providers (e.g. the removal of 23,000 providers lacking licenses or who had died from the CMS database). It was mentioned that CMS is exploring the same review methods for state Medicaid needs. What are the plans and timelines for this initiative new initiative for Medicaid?

Answer: We are partnering with one State to screen all of the State's Medicaid providers using the Automated Provider Screening (APS) system. Once the analysis is complete, we will provide the results back to the State for their action as appropriate. The goal of this test project is to demonstrate the utility of using an automated screening application to screen Medicaid providers, and we expect results later this year.

Just recently, CMS announced another initiative to assist States in their program integrity efforts. On May 30th, we launched the "CMS Provider Screening Innovator Challenge." This Challenge addresses our goals of improving our abilities to streamline operations, screen providers, and reduce fraud and abuse. Specifically, the Challenge is an innovation competition to develop a multi-State, multi-program provider screening software application which would be capable of risk scoring, credentialing validation, identity authentication, and sanction checks, while lowering burden on providers and reducing administrative and infrastructure expenses for States and Federal programs. Further information about the Challenge is available at www.medicaid.gov.

2) Improved Anti-Fraud Data Sharing

During the hearing, the Members of the panel and the witnesses discussed the opportunities for sharing data and information that would help identify waste and fraud. I understand that many states Medicaid agencies would like to access relevant Medicare and other relevant data that could prove useful for curbing waste and fraud within Medicaid.

Could you describe the steps that CMS is taking to facilitate or provide additional access to Medicare or other federal data to state Medicaid agencies, or state law enforcement agencies? Please comment on any timelines or plans, as well as any technical or legal challenges, for providing access to:

- **Medicare Fraud Prevention System;**

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- **Provider screening information from the Automated Provider Screening System;**
- **The full Suspension Database;**
- **Fraud Investigation Database (FID):**
- **Data from the Integrated Data Repository (IDR).**

Specifically, for the IDR, while there is the separate question of when the Medicaid state data will be included as part of the IDR, the issue is also regarding timelines and challenges for simply providing access to the states for the IDR Medicare data.

Answer: We agree that the sharing of information between the States and CMS is important to improving collaboration and avoiding duplication with respect to potential fraud, waste, and abuse. CMS is evaluating many of the tools used in Medicare for opportunities to transfer the knowledge and lessons learned to the Medicaid program. Specifically, CMS is evaluating the use of the twin pillars, the Fraud Prevention System and Automated Provider Screening, on State data. CMS is also actively pursuing ways to apply advanced data analytics technology, including predictive analytics, to the Medicaid program. CMS is currently working to identify specific FPS algorithms applicable to Medicaid and will be performing an analysis of one State's Medicaid claims data using the identified algorithms. Once the analysis is complete, we will share the results with the State. We anticipate the analysis being complete before the end of the year. As another example, CMS is engaged in an additional pilot to screen all of one State's Medicaid providers using the APS. Once the analysis is complete, we will provide the results to the State for their action as appropriate. The goal of this test project is to demonstrate the utility of using an automated screening application to screen Medicaid providers, and we expect results later this year. Once we test the effectiveness of these types of solutions in Medicaid, our goal is to expand these capabilities to more States. CMS is also supporting States' use of predictive analytics through technical assistance and education.

All States can request and gain access to the Fraud Investigation Database (FID). Fifteen States have accessed the FID since 2007. Currently, three State Medicaid Agencies (CT, KY, and OK) and one MFCU (AZ) have users actively accessing the FID. CMS plans to provide additional guidance to States on the purpose, use, and access to the FID.

At this time, there are no plans to provide direct access to the Integrated Data Repository. There are privacy, contractual, operational and potential regulatory constraints that need to be resolved in order to implement an efficient and effective process for sharing Medicare data with States for program integrity. CMS' ability to release fee-for-service Medicare data to States is limited by both the Health Insurance Portability and Accountability Act (HIPAA) and the Privacy Act. The HIPAA Privacy Rule outlines certain permitted uses and disclosures, such as research, health care operations, and health oversight activities. For each disclosure, HIPAA limits not only the actual data that can be released, but also how the entity (including States and law enforcement) receiving the data can use the data.

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However, CMS is committed to enhancing the quality and availability of our data to States. CMS is keenly aware that States' appropriate access to Medicare data and analytic tools could strengthen the State agency's ability to prevent and mitigate improper Medicaid payments. CMS is working toward solutions to provide States with sufficient access to CMS data for program integrity purposes.

The agency does release Medicare data to States for research purposes, which could include some data analysis for program integrity; we are looking into what flexibilities may be within existing research protocols to allow States, for example, to use predictive analytic models to identify fraudulent activity worth scrutiny. We anticipate solutions will need to be implemented in stages based on current constraints and technology.

Additionally, CMS recently launched an initiative to transform the agency's approach to data and analytics. The Office of Information Products and Data Analysis (OIPDA) was established in May 2012 to make development, management, use, and dissemination of data and information resources a core function of CMS. Over time, the initiative will modernize CMS' intricate data systems and policies, facilitate improved data sharing with States, and help the agency to achieve the greatest improvements in health care delivery.

3) Improvements to "Medi-Medi" Program

In April of 2012, the HHS OIG reported that the Medicare and Medicaid Data Match ("Medi-Medi") program has produced limited results and few fraud referrals. During 2007 and 2008, the voluntary program, in which 10 States had chosen to participate, received $60 million in appropriations. However, the programs only prevented and recouped $57.8 million in improper payments. Hence, Medi-Medi yielded a negative return on investment. Please describe any plans and associated timelines for improving and expanding the Medicare and Medicaid Data Match program. Specifically, what steps is CMS taking to improve upon the program's current return on investment for identifying and recovering improper payments, or for increasing fraud referrals?

Answer: The Inspector General's recent report reviewed data from 2007 and 2008. Since the period of review, CMS has made significant strides in enhancing the effectiveness of the Medicare-Medicaid (Medi-Medi) data program. The Medi-Medi program has been and continues to be a useful tool in helping to fight fraud, waste and abuse. While CMS has already implemented many of the suggestions made by the OIG, CMS is currently assessing ways the program can be improved and be more beneficial to States. CMS will share lessons learned from States that have made successful referrals and recouped Medicaid expenditures with other States to enhance program effectiveness.

Cross-State beneficiary data checks

Currently, there is no robust systematic process in use to find duplicates beneficiaries within the Medicaid program, which means that the state Medicaid agency in one state cannot easily check with the state agencies in other states to identify duplicate beneficiaries.

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However, there is at least one method that CMS and the states could engage, such as the HHS Public Assistance Reporting Information System or "PARIS."
Please describe any plans or initiatives to increase the cross checking among states for duplicate Medicaid enrollees. Also, is CMS or HHS exploring any steps to increase the effectiveness or facilitate the use of the PARIS as a method for Medicaid eligibility checks?

Answer: Per §1903(r)(3) of the Social Security Act, a State must have in operation an eligibility determination system which provides for data matching through the Public Assistance Reporting Information System (PARIS) facilitated by the Secretary (or any successor system), including matching with medical assistance programs operated by other States. Currently, CMS is exploring Public Assistance Reporting Information System (PARIS)-related webinars and other educational materials with the Medicaid Integrity Institute to help increase the cross-checking among States for duplicate Medicaid enrollees.

4) Exploring national provider enrollment for Medicaid
Currently, each state enrolls providers under its own Medicaid program. During the hearing, you described the concept of establishing a national enrollment process. Hence, a central entity, presumably CMS, would enroll providers as opposed to each individual state Medicaid agency. You mentioned that CMS is exploring the issue. Does CMS have plans for such an initiative, including potential pilot or demonstration programs? Have there been discussions with states or other entities regarding this concept?

Answer: As I mentioned during the hearing, CMS is talking to States about applying the Automated Provider Screening (APS) system that we are putting into place for Medicare providers and suppliers to States' Medicaid providers and suppliers. CMS is engaged in a pilot to screen all of one State's Medicaid providers using the APS. Once the analysis is complete, we will provide the results to the State for their action as appropriate. The goal of this test project is to demonstrate the utility of using an automated screening application to screen Medicaid providers, and we expect results later this year. Once we test the effectiveness of these types of solutions in Medicaid, our goal is to expand these capabilities to more States. CMS is also supporting States' use of predictive analytics through technical assistance and education.

Just recently, CMS announced another initiative to assist States in their program integrity efforts. On May 30th, we launched the "CMS Provider Screening Innovator Challenge." This Challenge addresses our goals of improving our abilities to streamline operations, screen providers, and reduce fraud and abuse. Specifically, the Challenge is an innovation competition to develop a multi-State, multi-program provider screening software application which would be capable of risk scoring, credentialing validation, identity authentication, and sanction checks, while lowering burden on providers and reducing administrative and infrastructure expenses for States and Federal programs. Further information about the Challenge is available at www.medicaid.gov.

On January 24, 2011, CMS announced a new rule (CMS-6028-FC) implementing a number of the Affordable Care Act's powerful new fraud prevention legislative tools. Under the rule, which took effect on March 25, 2011, CMS is conducting enhanced screening of categories of providers and suppliers that have historically posed a higher risk of fraud or abuse before they

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enroll in Medicare. States are required to conduct similar risk-based screening of providers and suppliers before enrolling in Medicaid or CHIP. To avoid duplication of effort between CMS and the States, the rule provides that the States may rely upon a screening performed by the Medicare program.

CMS is also collaborating with our State partners to ensure that those caught defrauding Medicare will not be able to defraud Medicaid, and those identified as fraudsters in one State will not be able to replicate their scams in another State's Medicaid program. Specifically, the Affordable Care Act and CMS' implementing regulations require States to terminate from the Medicaid program those Medicare providers or suppliers whose billing privileges have been revoked, or terminated for cause by another State's Medicaid or CHIP program. To support State efforts to share such information, CMS implemented a web-based application that allows States to share information regarding terminated providers and to view information on Medicare providers and suppliers that have had their billing privileges revoked for cause. We are confident that this interactive tool for States is the beginning of a smarter, more efficient Federal-State partnership, integrating technology solutions to routinely share relevant program information in a collaborative effort.

5) Medicaid Integrity Contractor Program Changes

a) During the hearing, you described that some of the current Medicaid Integrity Contractor task orders will not be renewed, and that CMS is in the process of examining the program needs and expenditures. Is CMS preparing a Redesign Action Plan, or taking other steps to change the task orders, especially in order to create a more effective and more collaborative program? We request that you share the Redesign Action Plan, and any similar plans under a different name for improving the MIC program, or summaries with the Subcommittee.

Answer: CMS has continued to identify additional opportunities for improvements in the design and operation of the Medicaid Integrity Program to improve the overall effectiveness of the program and to better support States' efforts to combat Medicaid fraud, waste, and abuse. CMS is incorporating lessons learned from our early implementation efforts and initial successes with collaborative audits. We have also taken into consideration recommendations from the Office of Inspector General, the Government Accountability Office, National Association of Medicaid Directors, and the Medicaid and CHIP Payment and Access Commission. CMS is implementing the program redesign as a phased approach that involves piloting new concepts and sharing best practices with States.

CMS is reconfiguring the National Medicaid Audit Program (NMAP) to a more effective and less burdensome approach that includes collaborative audits. Over the next year, we will also enhance the Medicare-Medicaid Data Match Program (Medi-Medi), expand reviews to managed care plans, support our education efforts to promote fraud prevention with an expansion of the Medicaid Integrity Institute, and pilot the redesign of State program integrity reviews. CMS is also monitoring States' progress in their implementation of Medicaid Recovery Audit Contractors (RACs). By the Fall 2012, CMS plans to have the results of a pilot testing the

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applicability of the Medicare Automated Provider Screening application to screen one State's Medicaid providers.

CMS' plan of action for the redesign of the NMAP is outlined below.

1. Discontinued assignment of new audits based solely on Medicaid Statistical Information System (MSIS) data review and analysis with a refocus of new assignments on collaborative audits: February 2011.
    a. Initiated realignment of Review Medicaid Integrity Contractor's (MIC) tasks with the activities identified in the redesign of the NMAP: March 2011.
    b. Discontinued 3 of 5 Review MIC task orders for options years that were scheduled to be renewed in August and September, 2012.
2. Developed and expanded Collaborative audits:
    a. Initiated 3 collaborative audits in January 2010;
    b. Expanded to 137 audits in 15 States: June 2012;
3. Develop and implement enhanced data reporting by States to fill gaps in the Medicaid Statistical Information System (MSIS):
    a. Pilots initiated with 10 states April-July, 2011;
    b. Review of pilots: Summer 2012;
    c. Publish guidance for all States to provide access to expanded data set: release to State CIOs for review and comment; and,
    d. Incorporate into IDR: 2014.
4. Reconfigure Medi-Medi to complement the collaborative audit program:
    a. Review of test and future planning initiated April 2012;
    b. Implementation to start in FY 2013.
5. Monitor return on investment of old and new approach to NMAP: Ongoing.

b) You have indicated that you expect to make collaborative audits a larger part of CMS' program integrity efforts. Could you please explain the process or methodology for implementing collaborative audits, the expected number of collaborative audits to be completed, as well as any planned performance measures to be used to measure the effectiveness of completed collaborative audits?

Answer: CMS has presented the collaborative audit approach to all States through a combination of one-on-one meetings, meetings with the National Association for Medicaid Program Integrity, discussions with the Fraud and Abuse Technical Assistance Group (TAG), and through conversations between our contractors and States. Additionally, CMS has educated two State Medicaid Fraud Control Units on the possibility of using the collaborative audits to help address their needs.

During the implementation of a collaborative audit, CMS works with the State to identify areas that warrant further investigation and to develop audit targets. In many cases, the corresponding data for the collaborative audits are provided or supplemented by the States, making the data more complete and thus increasing the accuracy of any audit findings. Through this process, CMS can more effectively support a State's program integrity efforts. Since the earliest collaborative audits were assigned to the Medicaid Integrity Contractors (MICs) in January 2010, CMS has worked with States to assign a total of 137 collaborative audits in 15 States that represent approximately 53% of all Medicaid expenditures. CMS is currently in discussion with 15

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additional States, and anticipates expansion to four of those States by the Fall of 2012. CMS expects to have collaborative projects with 30 states by the end of Fiscal Year (FY) 2013. CMS is in the process of projecting the impact of a substantial shift of audits to collaborative audits including the anticipated return on investment. We are working to develop a return on investment (ROI) methodology that accounts fully for the impact of these efforts.

The advent of Medicaid Recovery Audit Contractors (RACs) will add a new component to States' audit efforts and we are working with States to anticipate and minimize any duplication with the NMAP audits. In particular, because the States manage the RAC program and work closely with CMS in developing the collaborative audits, we believe this structure will lend itself to a more efficient audit process and reduce redundancy between the Medicaid RACs and the MICs. We are working with our CMS partners as well to craft a comprehensive managed care program integrity strategy.

c) **As early as August 2009, the HHS OIG reported that Medicaid Statistical Information System (MSIS) data is often outdated, and does not contain many of the data elements needed for detecting improper payments. During your testimony, you mentioned that the new Transformed-MSIS database will include many new data elements that can assists in fraud, waste, and abuse detection efforts. Does the current T-MSIS pilot program include the full range of data elements described in the recommendations proposed in the recent HHS OIG 2009 report, "MSIS Data Usefulness for Detecting Fraud, Waste, and Abuse" (OEI-04-07-00240)?**

Answer: There are 100 data elements consolidated by the OIG from the 182 elements identified by the Medicaid Integrity Group as useful for Medicaid fraud, waste, and abuse analysis. Of those 100 elements, 93 have been incorporated into the current Transformed-Medicaid Statistical Information System (T-MSIS) release, while the remaining 7 elements are being evaluated for inclusion with the subsequent release of T-MSIS either through direct collection or through linkage to reference files.

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Post-Hearing Questions for the Record
Submitted to Dr. Budetti
From Senator Scott P. Brown

"Saving Taxpayer Dollars by Curbing Waste and Fraud in Medicaid"
June 14th, 2012

1. **Question: You have indicated that you expect to make collaborative audits a larger part of CMS' program integrity efforts. According to your testimony, you plan on expanding to 30 states by the fall of 2013. However, there was no indication of a plan or goal to extend beyond 30 states.**

   What is the timeframe for expanding these audits to all 50 states and territories? What are the challenges for expanding to the states at a faster pace? If the primary challenge is a question of resources, what are the resources necessary to expand to all 50 states and territories by the end of 2013?

Answer: CMS has presented the collaborative audit approach to all States through a combination of one-on-one meetings, meetings with the National Association for Medicaid Program Integrity, discussions with the Fraud and Abuse Technical Assistance Group (TAG), and through conversations between our contractors and States. Additionally, CMS has educated two State Medicaid Fraud Control Units on the possibility of using the collaborative audits to help address their needs.

During the implementation of a collaborative audit, CMS works with the State to identify areas that warrant further investigation and to develop audit targets. In many cases, the corresponding data for the collaborative audits is provided or supplemented by the States, making the data more complete and thus increasing the accuracy of any audit findings. Through this process, CMS can more effectively support a State's program integrity efforts. Since the earliest collaborative audits were assigned to the Medicaid Integrity Contractors (MICs) in January 2010, CMS has worked with States to assign a total of 137 collaborative audits in 15 States that represent approximately 53% of all Medicaid expenditures. CMS is currently in discussion with 15 additional States, and anticipates expansion to four of those States by the fall of 2012. CMS expects to have collaborative projects with 30 states by the end of Fiscal Year (FY) 2013. CMS is now in the process of projecting what we anticipate collaborative audits will yield over the next year which will assist us in evaluating the efficiency of the collaborative audits.

2. **Question when will the T-MSIS pilot program be completed? When will T-MSIS be fully operational? When will T-MSIS incorporate all State data? What are any barriers that Congress should be aware of that may delay the timeframes indicated above?**

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Answer: The 10-State Pilot has officially concluded on June 29, 2012 and has been approved to continue in project status. Currently, the pilot's final assessment evaluation report is being finalized.

We are evaluating what elements can be implemented at this time nationwide. Our evaluation of the pilot, and forthcoming guidance, will not only consult the pilot States but also garner input from all state Medicaid and CHIP programs. We should know more once the evaluation is complete in the coming months.

Currently, the goal is to fully expand nationwide by January 1, 2014, and States will continue working towards implementation throughout the coming months. The driving force behind this current timeframe is the Affordable Care Act's Medicaid eligibility expansion.

State resources remain a prominent risk to timely implementation. Without available resources to acquire needed hardware/software and complete mapping of required indicators for data extraction, transformation, and loading, implementation may be delayed.

When will Medicaid data be incorporated into the Integrated Data Repository? Please provide to the Subcommittee the plan and timelines for incorporating Medicaid data into the IDR, including the completion of any current pilot or demonstration programs.

Answer: Incorporating State Medicaid data into the IDR is a priority and we are working diligently to incorporate Medicaid data for all 50 States into the IDR. We are aware that States have new and competing priorities in the current fiscal environment and we are working closely with them to help streamline data requests under the agency's Medicaid and CHIP Business Information and Solutions (MACBIS) data initiative. This initiative is intended to result in the development of a national system to address the needs of Federal and State Medicaid partners. CMS intends to incorporate Medicaid data for all 50 States into IDR by the end of fiscal year 2014.

1. **Question: Is there a Comprehensive Medicaid Program Integrity ROI which aggregates all taxpayer investment in program integrity activities across State and Federal programs? Is there a Federal Medicaid Program Integrity ROI? I understand that many States publish a ROI figure. How valuable would it be to have metrics and comparable State ROI data so that taxpayers can have some feedback on how their money is being spent?**

Answer: CMS is in the process of projecting the impact of a substantial shift of audits to collaborative audits including the anticipated return on investment. We are working to develop an ROI methodology that accounts fully for the impact of these efforts. .

CMS is supporting the Medicaid Fraud and Abuse Technical Assistance Group (TAG), a national forum for regional representatives of State Medicaid program integrity directors to discuss Medicaid-related fraud and abuse control activities, in its development of a standard set of measures and assumptions to initiate a standardized method for measuring the ROI of the State Medicaid integrity programs. In May 2012, a special one-day meeting of several State

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Medicaid Program Integrity officials (ROI workgroup) was convened. The goal of the session was to construct a framework to define ROI that will allow States (and others) to more easily compare and contrast the effectiveness of program integrity efforts among States. The May meeting was precipitated by recommendations from the Medicaid Fraud and Abuse TAG meeting held in January 2012. Topics were referred for development with the objective to gather information pertaining to current Medicaid PI ROI measurements made by States, ROI measurement techniques that might be available from other sources and State-specific issues that arise when ROI measurements are made or attempted.

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Questions for the Record
Dr. Peter Budetti, Deputy Administrator and Director for Program Integrity
Centers for Medicare and Medicaid Services

Senate Committee on Homeland Security & Government Affairs
Subcommittee on Federal Financial Management, Government Information, Federal Services and International Security
"Saving Taxpayer Dollars by Curbing Waste and Fraud in Medicaid"
June 14, 2012

Senator Pryor

1. **In your testimony, you mention a number of different initiatives that CMS is implementing to strengthen Medicaid. However, there have been problems with programs, like the Medi-Medi Program and the National Medicaid Audit Program that have not provided a positive return on the investment. Has CMS developed specific metrics for evaluating the return on investment in new initiatives?**

Answer: CMS is in the process of projecting the impact of a substantial shift of audits to collaborative audits including the anticipated return on investment. We are working to develop an ROI methodology that accounts fully for the impact of these efforts. CMS is supporting the Medicaid Fraud and Abuse Technical Assistance Group (TAG), a national forum for regional representatives of State Medicaid program integrity directors to discuss Medicaid-related fraud and abuse control activities, in its development of a standard set of measures and assumptions to initiate a standardized method for measuring the ROI of the State Medicaid integrity programs. In May 2012, a workgroup of several State Medicaid PI officials was convened to construct a framework for a measure of ROI that will enable States to more easily compare and contrast the effectiveness of PI efforts among States.

Additionally, CMS has made significant strides in addressing concerns raised by the Office of the HHS Inspector General regarding the ROI of the Medicare-Medicaid (Medi-Medi) data program. The OIG's April 2012 report on Medi-Medi evaluated data from 2007 and 2008, and since the period of review, CMS has worked to enhance the effectiveness of the Medi-Medi program. The Medi-Medi program has been and continues to be a useful tool in helping to fight fraud, waste and abuse. While CMS has already implemented many of the suggestions made by the OIG, CMS is currently assessing ways the program can be improved and be more beneficial to States. CMS will share lessons learned from States that have made successful referrals and recouped Medicaid expenditures.

CMS implements the Medi-Medi program via contracts. As a measure of the extent to which the Medi-Medi program is achieving its goals, CMS evaluates the contractor's overall performance annually in the following four key areas specified in their contracts: business relations, timeliness, quality and cost control. Each key element within the four areas receives a score of unsatisfactory (0 points), marginal (1 point), satisfactory (2 points), very good (3 points) or exceptional (4 points).

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2. The Integrated Data Repository (IDR) houses a large amount of data that could be useful for states to help fight fraud. What is the status of state access to the IDR?

Answer: At this time, there are no plans to provide direct access to the Integrated Data Repository. There are privacy, contractual, operational, and potential regulatory constraints that need to be resolved in order to implement an efficient and effective process for sharing Medicare data with States for program integrity. CMS' ability to release fee-for-service Medicare data to States is governed by both the Health Insurance Portability and Accountability Act (HIPAA) and the Privacy Act. The HIPAA Privacy Rule would permit certain uses and disclosures of interest to the State Medicaid agencies, such as research, health care operations, and health oversight activities. . [CMS would have to insert here how Privacy Act restrictions could be satisfied]

However, CMS is committed to enhancing the quality and availability of our data to States. CMS is keenly aware that States' appropriate access to Medicare data and analytic tools could strengthen the State agency's ability to prevent and mitigate improper Medicaid payments. CMS is working toward solutions to provide States with sufficient access to CMS data for program integrity purposes.

The agency does release Medicare data to States for research purposes, which could include some data analysis for program integrity; we are looking into what flexibilities may be within existing research protocols to allow States, for example, to use predictive analytic models to identify fraudulent activity worth scrutiny. We anticipate solutions will need to be implemented in stages based on current constraints and technology.

Additionally, CMS recently launched an initiative to transform the agency's approach to data and analytics. The Office of Information Products and Data Analysis (OIPDA) was established in May 2012 to make development, management, use, and dissemination of data and information resources a core function of CMS. Over time, the initiative will modernize CMS' intricate data systems and policies, facilitate better data sharing with States, and help the agency to achieve the greatest improvements in health care delivery.

3. As I understand it, CMS is planning to use Medicare's Automated Provider Screening (APS) system and the Fraud Prevention System (FPS) for Medicaid. Both the APS and the FPS are fairly new programs and still need further evaluation of their effectiveness in Medicare. Has CMS established metrics for evaluating the effectiveness of the APS and FPS in Medicare?

a. How will CMS evaluate the APS and the FPS to ensure that successes from their use in Medicare will translate to the same successes in Medicaid?

Answer: CMS is required to report on the use of the Fraud Prevention System as well as certification from the Department of Health and Human Services' Office of Inspector General (OIG) on the actual and projected savings to the Medicare fee-for-service program. CMS is continually evaluating the APS as part of the IT Investment Lifecycle.

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CMS is evaluating the use of predictive analytics, advanced screening and other sophisticated analytic techniques developed for the twin pillars, the Fraud Prevention System and Automated Provider Screening, on State data through the use of pilot projects. CMS is also actively pursuing ways to apply advanced data analytics technology, including predictive analytics, to the Medicaid program. CMS is currently working to identify specific FPS algorithms applicable to Medicaid and will be performing an analysis of one State's Medicaid claims data using the identified algorithms. Once the analysis is complete, we will share the results with the State.

We anticipate the analysis being complete before the end of the year. As another example, CMS is engaged in an additional pilot to screen all of one State's Medicaid providers using the APS. Once the analysis is complete, we will provide the results to the State for their action as appropriate. The goal of this test project is to demonstrate the utility of using an automated screening application to screen Medicaid providers, and we expect results later this year. Once we test the effectiveness of these types of solutions in Medicaid, our goal is to expand these capabilities to more States. CMS is also supporting States' use of predictive analytics through technical assistance and education.

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"SAVING TAXPAYER DOLLARS BY CURBING WASTE AND FRAUD IN MEDICAID"
Questions For The Record
Chairman Tom Carper

QUESTION FOR MR. DOUGLAS WILSON– Incentivizing States for Recoveries

The Affordable Care Act included an important provision which extended the time period from 60 days to one year for states to pay the federal government its share of any identified Medicaid overpayments. During the hearing, there was some discussion about the need for further flexibility by states in recovering identified overpayments, or in repaying the federal share of identified overpayments? Are there some additional steps for incentivizing the states for improved recoveries of overpayments that Congress should consider?

Yes. Because states are prohibited from negotiating the amount of overpayment to be recouped, states are faced with one of three options: 1.) collect the overpayment in full if possible, 2.) drive the provider out of business or into bankruptcy so as to avoid liability for the federal share, or 3.) delay and minimize the identification of overpayments to avoid creating liability for federal repayments that may be uncollectible. The first option is only feasible if the overpayment amount is small enough to be borne by a solvent provider. The second option may create access to care issues. The third option results in inaccurate estimates of the extent of fraud, waste, and abuse.

If states were authorized to negotiate fair and reasonable repayment amounts, without incurring federal liability for the remaining identified overpayments, providers could afford to settle larger cases rather than exploring bankruptcy. States could resolve more cases in shorter time frames, because liquid providers would not insist upon lengthy contested case hearings. The state and federal governments would recover some money, rather than absorbing total losses. The attached document presents the historical and regulatory background, and clarifies the proposed solutions that would best work in the State of Texas.

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United States Government Accountability Office
Washington, DC 20548

August 17, 2012

The Honorable Scott P. Brown
Ranking Member
Subcommittee on Federal Financial Management,
Government Information, Federal Services, and
International Security
Committee on Homeland Security and Governmental Affairs
United States Senate

Dear Senator Brown,

It was a pleasure to appear before your Subcommittees on June 14, 2012, to discuss saving taxpayer dollars by curbing waste and fraud in Medicaid. The attached enclosure provides responses to the question for the record you posed. If you or your staff have any additional questions related to this matter, please contact me at (202) 512-7114 or yocomc@gao.gov.

Sincerely yours,

Carolyn L. Yocom
Director, Health Care

Enclosure

Post-Hearing Questions for the Record
Submitted to Carolyn Yocom
Government Accountability Office
From Senator Scott P. Brown

"Saving Taxpayer Dollars by Curbing Waste and Fraud in Medicaid"
June 14, 2012

1. Question: I understand that many States publish a ROI figure. How valuable would it be to have metrics and comparable State ROI data so that taxpayers can have some feedback on how their money is being spent?

   Having state methodologies and state reported ROI data would provide an opportunity to compare and contrast state methodologies, which could serve as a benchmark for evaluating how CMS computes an ROI for the Medicaid Integrity Program. In addition, state ROI data would provide CMS with important information to help hold states accountable for accurately reporting state Medicaid program integrity recoveries.

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Post-Hearing Questions for the Record
Submitted to Ann Maxwell
Department of Health and Human Services Inspector General
From Senator Scott P. Brown

"Saving Taxpayer Dollars by Curbing Waste and Fraud in Medicaid"
June 14th, 2012

1. Question: My understanding is that there is a HCFAC Return-On-Investment (ROI) figure, which in 2011 was $7.20 to 1 based on a 3 year rolling average for the HCFAC partners. I also understand that all discretionary Medicaid Integrity program funding is included in a separate Medicaid Integrity program ROI published in a separate report. Could you provide this Medicaid program integrity information for the past few years?

   Answer:

   The Office of Inspector General does not produce a report that contains a Medicaid Integrity Program return on investment, nor do we have such statistics that we could provide. We recommend consulting with the Centers for Medicare & Medicaid Services.

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CMS SETTLEMENT ISSUES

Background

§6506 of the Affordable Care Act provides a general rule that a state's single source Medicaid agency one year from the date of discovery of an overpayment to a provider to recover or seek to recover the overpayment before the Federal share must be refunded to CMS. The agency must refund the Federal share of overpayments at the end of the one year period following discovery whether or not the State has recovered the overpayment from the provider.

The agency is not required to refund the Federal share of an overpayment made to a provider when the State is unable to recover the overpayment amount because the provider has been determined bankrupt or out of business. 42 CFR §433.318. A partial collection of an overpayment amount by the State from a provider during the one year period following discovery does not change the recovery period for the original overpayment amount due to CMS. 42 CFR §433.316.

In the event of fraud, the state has one year to repay to CMS the amount of overpayment identified, unless a delay can be attributed to a judicial or administrative process, in which case the deadline is 30 days after the conclusion of the process.

Except for fraud, the agency must refund the Federal share of overpayments at the end of the 1-year period following discovery, whether or not the State has recovered the overpayment from the provider. 42 CFR §433.316.

Generally, a fraud overpayment is "discovered" when it is identified by any State Medicaid agency official or other State official, the Federal Government or the provider, and the overpayment is communicated to the provider in final written notice. A final written notice allows the provider to contest the determination. 42 CFR §433.304.

Non-fraud overpayments are "discovered" on the earliest of:

> (1) The date on which any Medicaid agency official or other State official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery;
>
> (2) The date on which a provider initially acknowledges a specific overpaid amount in writing to the Medicaid agency; or
>
> (3) The date on which any State official or fiscal agent of the State initiates a formal action to recoup a specific overpaid amount from a provider without having first notified the provider in writing. 42 CFR §433.316(c).

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Exceptions

- **Bankruptcy.** The agency is not required to refund to CMS the Federal share if—

  (1) The provider has filed for bankruptcy in Federal court at the time of discovery of the overpayment or the provider files a bankruptcy petition in Federal court before the end of the 1-year period following discovery; and

  (2) The State is on record with the court as a creditor of the petitioner in the amount of the Medicaid overpayment. 42 CFR §433.318(c).

  - If the State recovers any portion of an overpayment under a court-approved discharge of bankruptcy, the agency must refund to CMS the Federal share of the overpayment amount collected. 42 CFR §433.320(e).

  - If a provider's petition for bankruptcy is denied in Federal court, the agency must credit CMS with the Federal share of the overpayment. 42 CFR §433.320(f).

- **Out of Business.** The agency is not required to refund to CMS the Federal share if the provider is out of business on the date of discovery of the overpayment or if the provider goes out of business before the end of the 1-year period following discovery.

Texas Issues/Risks

- Historically, repayment was a non-issue. Investigations ranged from $25-$35 million annually spread over an average of 10 cases, while recoupments averaged 8%.

- In FY 2012, OIG investigative efforts dramatically increased with related increases in the number of cases worked (more than 100) and the amount of questioned costs.

- With the significant increase in productivity comes enhanced risk for the State: OIG success could put the State at risk for funds that will never be recovered.

- If providers cannot repay overpayments, their option is to close or declare bankruptcy, the practical effect of which is to discharge any obligation to the state or federal government.

- Providers OIG targets currently are large: 60,000 dental patients, 30,000 medical patients. Billings routinely exceed $15 million; providers with billings of $30-85 million are not rare.

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- These substantial providers can drag out litigation, hire experts to challenge everything from statistical sampling to medical conclusions, and ultimately still avoid any repayment by declaring bankruptcy.

- Many providers have indicated a willingness to negotiate, provided OIG demonstrates flexibility on 1) overall repayment amount and 2) payment terms, including length of repayment period and structure of debt retirement.

Proposed Solution

- The Texas OIG proposes a Medicare solution. Currently, based upon our meeting and understanding from CMS Medicare providers are permitted to negotiate settlement agreements with CMS and get extended repayment periods. The Texas OIG proposes that states have authority to settle all Medicaid claims on behalf of the state and federal governments, returning to CMS the federal share of what the state recovers when states receive payment.

- The solution contemplates negotiating both the overall amount of repayment and the term of repayment, and is currently in practice with Medicare.

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