

**Opening Statement of the Honorable Tim Murphy**  
**Subcommittee on Oversight and Investigations**  
**Hearing on “Medicaid Program Integrity: Screening Out Errors, Fraud, and Abuse”**  
**June 2, 2015**

*(As Prepared for Delivery)*

We are here today to discuss a continuing and increasingly expensive problem: waste, fraud, and abuse in the Medicaid program.

Last year the Medicaid program provided medical services for approximately 60 million people at a cost of \$310 billion. But during that same year, the Centers for Medicare and Medicaid Services estimated that the improper-payment rate was 6.7 percent or \$17.5 billion. This is an increase of almost 1 percent or over \$3 billion from the previous year. This is a troubling trend, especially as the program continues to expand.

Unfortunately, the Medicaid program is far too accustomed to fraud. In fact, the Government Accountability Office has designated the Medicaid program as a high risk for fraud and abuse since 2003. And it has been the subject of multiple GAO and Department of Health and Human Services Office of Inspector General reports over the past several years, including a GAO report being highlighted today.

In 2012, the Committee requested GAO identify and analyze indicators of improper or potentially fraudulent payments to Medicaid beneficiaries and providers. In a just-released study—another in a long line examining Medicaid fraud—GAO has reported that CMS needs to take additional actions to improve provider and beneficiary fraud controls.

GAO found that thousands of Medicaid beneficiaries and hundreds of providers in just four states—Arizona, Florida, Michigan, and New Jersey—were involved in possible improper or fraudulent payments during Fiscal Year 2011. For example, almost 200 deceased beneficiaries received at least \$9.6 million in Medicaid benefits. About 8,600 beneficiaries received payments by two or more states totaling at least \$18.3 million. The Social Security Numbers for about 199,000 beneficiaries did not match the Social Security Administration databases. About 90 medical providers had their medical licenses revoked or suspended in the state in which they received Medicaid payments. At least 47 providers had foreign addresses as their location of service, including in Canada, China, India, and Saudi Arabia. About 50 providers who received Medicaid payments were excluded from the federal program for a variety of reasons including patient abuse or neglect, fraud, theft, bribery, and tax evasion.

GAO acknowledged that regulations issued in response to the Affordable Care Act may have addressed some of the improper-payment indicators found in GAO’s analysis. For example, CMS created a tool called the Data Services Hub (hub) to help verify beneficiary applicant information. But questions remain whether this tool has been properly implemented and if the states have been able to effectively use this tool to combat waste and fraud.

In fact, just a few weeks ago, a Reuters report found that “more than one in five of the thousands of doctors and other health care providers in the U.S. prohibited from billing Medicare are still able to bill state Medicaid programs.” The report included disturbing stories such as a Georgia optometrist, who claimed he conducted 177 eye exams in one day, yet remained on South Carolina’s Medicaid rolls for almost a year after he pleaded guilty in Georgia. In another instance, an Ohio psychiatrist routinely over-reported the time he spent with patients and even billed for no-show patients. CMS revoked his billing privileges after he was convicted of felony workers’ compensation fraud. Yet, he continued to work in the Illinois Medicaid program, getting paid \$560,000 for services or prescriptions he wrote after his Medicare provider revocation. Shockingly, on the day he was being sentenced in Columbus, Ohio, he also claimed that he saw 131 group therapy patients at his Illinois practice.

These stories are unacceptable. Medicaid fraud undermines the integrity of the program, denies our most vulnerable the services they deserve, and wastes American taxpayers' hard-earned dollars.

I hope we will hear today about the steps that can be taken to further combat fraud in the Medicaid program. GAO has recommended some common sense steps that would reduce fraud, such as issuing guidance to state to better identify beneficiaries who are deceased and the availability of automated information through Medicare's enrollment database. In light of the history of fraud in the Medicaid program and its growing size, however, will these steps be enough? Will we be here again in another two years discussing the same thing? With the Medicaid program continuing to expand, the Committee is concerned that the opportunity and motivation to defraud the program will only increase.

I would like to thank our witnesses joining us today—you all have the ability to save the American taxpayer a massive amount of money, and we hope to hear from you today on how you plan to do that.

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