STATEMENT OF

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ON

"MEDICAID PROGRAM INTEGRITY: SCREENING OUT ERRORS, FRAUD AND ABUSE"

BEFORE THE
UNITED STATES HOUSE COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

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Chairman Murphy, Ranking Member DeGette, and members of the Subcommittee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) efforts to strengthen Medicaid. Enhancing program integrity is a top priority for the administration and an agency-wide effort at CMS. We share this Subcommittee's commitment to protecting beneficiaries and ensuring taxpayer dollars are spent on legitimate items and services, both of which are at the forefront of our program integrity mission. CMS is coordinating a variety of efforts with Federal and State partners, as well as the private sector to better share information to combat fraud and to verify provider and beneficiary eligibility.

Ultimately States and the Federal Government share mutual obligations and accountability for the integrity of the Medicaid program and the development, application and improvement of program safeguards necessary to ensure proper and appropriate use of both Federal and State dollars. This Federal-State partnership is central to the success of the Medicaid program, and it depends on clear lines of responsibility and shared expectations. CMS takes seriously our role in overseeing the financing of States' Medicaid programs, and we continue to look for ways to refine and further improve our processes.

Medicaid Background

Medicaid is the primary source of medical assistance for millions of low-income and disabled Americans, providing health coverage to many of those who would otherwise be unable to obtain health insurance. As of FY 2015, nearly 69 million people were enrolled to receive their health care coverage through Medicaid.

Although the Federal Government establishes general guidelines for the program, States design, implement, and administer their own Medicaid programs. The Federal Government matches State expenditures on medical assistance based on the Federal medical assistance percentage (FMAP), which can be no lower than 50 percent.

Medicaid is currently undergoing significant change as CMS and States implement reforms to modernize and strengthen the program and its services. While focused on implementation of the Affordable Care Act, CMS has been working closely with States to implement delivery system and payment reforms. CMS has encouraged State efforts with new tools and strategies to improve the quality of care and health outcomes for beneficiaries and to promote efficiency and cost effectiveness in Medicaid. And, as always, CMS works to make sure appropriate financial management mechanisms are in place so that dollars are spent appropriately.

Enhancing Provider Eligibility Safeguards

A critical component to preventing waste, fraud and abuse is to ensure that only legitimate providers have the ability to bill Medicaid in the first place. States bear the primary responsibility for provider screening, credentialing, and enrollment for Medicaid. Provider enrollment is the gateway to billing the Medicaid program, and CMS is engaging in new efforts to work with states to make sure that only legitimate providers are enrolling in the Medicaid program.

CMS Oversight of State Medicaid Provider Enrollment

The Affordable Care Act required CMS to implement risk-based screening of providers and suppliers who want to participate in Medicare, Medicaid, and CHIP, and CMS put these additional requirements in place for newly enrolling and revalidating Medicare, Medicaid, and CHIP providers and suppliers in March 2011. This enhanced screening requires certain categories of providers and suppliers that have historically posed a higher risk of fraud to undergo greater scrutiny prior to their enrollment or revalidation in Medicare, Medicaid, and CHIP. States are also required to conduct reviews and revalidations of their Medicaid and CHIP providers by March 2016. States must repeat this process at least once every five years.

Providers in the "limited" risk category undergo verification of licensure, verification of compliance with Federal regulations and state requirements, and various database checks. Providers in the "moderate" and "high" risk categories undergo additional screening, including unannounced site visits. Additionally, as a condition of enrollment, States must require providers in the "high" risk category or persons with five-percent ownership interest in such a provider to consent to criminal background checks including fingerprinting. CMS began conducting fingerprint-based background checks for Medicare providers in August 2014.

State Medicaid agencies may rely on the screening done by CMS for dually-enrolling providers to assist them in complying with these requirements. CMS has been proactive about assisting States with provider enrollment and revalidation screening. In April 2012, we provided States with direct access to Medicare's enrollment database-the Provider Enrollment, Chain, and Ownership System (PECOS). In October 2013, in response to input from States, CMS began providing access to monthly PECOS data extracts that States could use to systematically compare state enrollment records against available PECOS information. We have also provided States with training and technical assistance on using PECOS.

Section 6501 of the Affordable Care Act requires state Medicaid programs to terminate a provider that has been terminated by Medicare, another state Medicaid program, or the Children's Health Insurance Program (CHIP) "for cause" which is defined at 42 CFR 455.101 to include reasons based on fraud, integrity or quality. CMS clarified in May 2011 guidance[1] that termination "for cause" does not include terminations for reasons such as a provider's failure to submit claims due to inactivity. CMS further clarified its interpretation of "for cause" in 2012[2] by specifying examples of conduct that constitutes termination "for cause," and should be reported by the States. Examples of "for cause" termination that require reporting include terminations resulting from adverse licensure actions, fraudulent conduct, abuse of billing privileges, and falsification of billing records.

The Affordable Care Act did not require the Medicare program to revoke the enrollment of a provider terminated by a state Medicaid program, however CMS used its general rulemaking authority to permit CMS to revoke Medicare enrollment where a state has terminated Medicaid enrollment.[3] This cooperation prevents bad actors from jumping from program to program.

On January 1, 2011, CMS launched a shared system that States can access to upload information about providers terminated from other Medicaid and CHIP programs. States are required to report their data on terminations to CMS.[4] States use this information to terminate enrollment

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[1] CPI-CMCS Informational Bulletin, CPI-B 11-05, May 31,2011, and CPI-CMCS Informational Bulletin, CPI-B 12-02, January 20, 2012.

[2] Informational Bulletin (CPI-B 12-02), "Affordable Care Act Program Integrity Provisions- Guidance to States-Section 6501 -Termination of Provider Participation under Medicaid if Terminated under Medicare or other State Plan."

[3] Note: This authority was created by http://www.gpo.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf

[4] The Social Security Act§ 1902(a)(41) Provides that whenever a provider of services or any other person is

from providers terminated by other programs, and CMS uses the state data to revoke providers' Medicare billing privileges if they have been terminated for fraudulent or abusive practices. In December 2013, CMS enhanced the process for Medicaid termination notifications. States have been instructed to report all "for cause" Medicaid terminations, as defined in the 2012 guidance, for which state appeal rights have been exhausted, to CMS by submitting a copy of the original termination letter sent to the provider, along with specific provider identifiers, and the reason for Medicaid termination. CMS reviews each Medicaid termination to determine if a Medicare revocation is appropriate[5].

Enrollment Moratoria

CMS has used the authority provided to the Secretary in the Affordable Care Act to temporarily pause the enrollment of new Medicare, Medicaid, or CHIP providers and suppliers, including categories of providers and suppliers, if the Secretary determines certain geographic areas face a high risk of fraud. In July 2013, CMS announced temporary moratoria on the enrollment of new home health agencies (HHAs) and ambulance companies in Medicare, Medicaid, and CHIP in three "fraud hot spot" metropolitan areas of the country: HHAs in and around Miami and Chicago, and ground-based ambulances in and around Houston.[6] In January 2014, CMS announced new temporary moratoria on the enrollment of HHAs in four metropolitan areas: Fort Lauderdale, Detroit, Dallas, and Houston, and on ground ambulances in the metropolitan Philadelphia area.[7] CMS also extended for six months the existing moratoria for HHAs in and around Chicago and Miami, and ground ambulance suppliers in the Houston area. CMS is required to re-evaluate the need for such moratoria every six months, and, as a result, CMS extended the moratoria in July 2014 and January 2015. CMS has worked closely with each of the affected states to evaluate patient access to care, and these states reported that Medicaid and CHIP beneficiaries will continue to have access to services. During the moratoria period, CMS and the affected states will continue to monitor access to care to ensure that Medicare, Medicaid, and CHIP beneficiaries are receiving the services they need.

terminated, suspended, or otherwise sanctioned or prohibited from participating under the State plan, the State agency shall promptly notify the Secretary and, in the case of a physician and notwithstanding paragraph (7), the State medical licensing board of such action.

[5] As defined in 42 CFR 424.535
[6] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-07-26.html
[7] http://cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-01-30-2.html

Enhancing Beneficiary Eligibility safeguards

The Affordable Care Act and accompanying Federal regulations have established a modernized, data driven approach to verification of financial and non-financial information needed to determine Medicaid and CHIP and Marketplace eligibility. States now rely on available electronic data sources to confirm information included on the application, and promote program integrity, while minimizing the amount of paper documentation that consumers need to provide.

In 2012, CMS issued regulations to require States to use the Data Services Hub (Hub) to verify applicant eligibility upon enrollment and at least annually thereafter. States are able to use this to identify applicants and beneficiaries who may be incarcerated, deceased, or do not meet Medicaid eligibility requirements. States can also validate applicants' Social Security Numbers (SSNs) using the Hub. CMS also required every state to submit a verification plan describing their verification policies and procedures including confirmation that the state verifies SSNs.

States are also required to use the Public Assistance Reporting Information System (PARIS) to identify individuals who are enrolled in Medicaid in more than one state.

 PARIS is a system for matching data from certain public assistance programs, including State Medicaid programs, with selected Federal and State data for purposes of facilitating appropriate enrollment and retention in public programs. In certain circumstances, PARIS may also be used as a tool to identify individuals who have not applied for Medicaid coverage, but who may be eligible based on their income. We plan to provide additional guidance to help States participate in the PARIS match over the coming months.

Revision of the Payment Error Rate Measurement to Align with Program Changes

The Payment Error Rate Measurement (PERM) program measures improper payments in Medicaid and CHIP and produces error rates for each program. The error rates are based on reviews of the FFS, managed care, and eligibility components of Medicaid and CHIP in the FY under review.

In light of the changes to the way States adjudicate eligibility for applicants for Medicaid and CHIP implemented by the Affordable Care Act, the State Health Official Letter 13-005, issued on August 15, 2013, directs States to implement Medicaid and CHIP Eligibility Review Pilots in

place of the PERM and Medicaid Eligibility Quality Control (MEQC) eligibility review requirements for FYs 2014-2016. The Medicaid and CHIP Eligibility Review Pilots will provide more targeted, detailed information on the accuracy of eligibility determinations using the Affordable Care Act's rules, and provide States and CMS with critical feedback during initial implementation.

The eligibility review pilots will provide a testing ground for different approaches and methodologies for producing reliable results and help inform CMS' approach to future rulemaking.

Working with States to Improve Medicaid Program Integrity

Medicaid is a Federal-state partnership, and that partnership is central to the program's success. CMS provides States with interpretive guidance to use in applying statutory and regulatory requirements, technical assistance including tools and data, Federal match for their expenditures, and other resources. The following efforts will expand the capacity of CMS to protect the integrity of the Medicaid program:

Comprehensive Medicaid Integrity Plan

Section 1936(d) of the Social Security Act directs the Secretary of Health and Human Services (HHS) to establish, on a recurring 5-fiscal year basis, a comprehensive plan for ensuring the integrity of the Medicaid program by combatting fraud, waste, and abuse. The current Comprehensive Medicaid Integrity Plan (CMIP) provides a strategy for CMS to improve Medicaid program integrity for the FY 2014-2018 period.[8] The current CMIP was shaped by six broad considerations: (1) the transformation of the Medicaid program over the next five years; (2) the actual harm from fraud, waste and abuse on the entire Medicaid program beyond the risk to State and Federal funds; (3) the importance of the Federal-state partnership in Medicaid program integrity efforts; (4) the shift within program integrity strategies from "pay and chase" to prevention efforts; (5) the coordination across CMS to safeguard the integrity of the Medicaid program; and (6) the coordination of program integrity efforts across the Medicare and Medicaid programs.

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[8] http://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/Downloads/cmip2014.pdf

To increase the ability of state Medicaid agencies and CMS to leverage program data to protect Medicaid from fraud, waste, and abuse, CMS will:

- Improve the quality and consistency of Medicaid data reported to CMS;

- Increase state Medicaid agency access to Medicare program integrity data; and

- Improve the analysis of Medicaid program data to identify potential fraud, waste, and abuse.

To build the capacity of state Medicaid agencies to prevent and detect fraud, waste, and abuse against the Medicaid program, CMS will:

- Streamline CMS assessment of state Medicaid program integrity activities;

- Support state oversight of program integrity in Medicaid managed care;

- Provide technical assistance to state Medicaid agencies with respect to data analysis; and

- Expand training of state staff through the Medicaid Integrity Institute.

To expand the capacity of CMS to protect Medicaid program integrity and to manage risk in the administration of Federal grants to States, CMS will:

- Eliminate duplication of efforts by integrating Medicare and Medicaid audits and investigations;

- Improve financial accountability for Medicaid managed care organizations;

- Improve safeguards for Medicaid fee-for-service claims;

- Expand reporting and controls for provider rate setting;

- Enhance beneficiary eligibility safeguards;

- Improve the accuracy of state claiming and grant management;

- Execute safeguard strategies for new forms of payment and new delivery systems; and

- Revise measurement of error rates to align with program changes.

The execution of the strategies in CMIP will improve the ability of state Medicaid agencies and CMS to leverage program data to detect and prevent improper payments, which will strengthen the ability of state Medicaid agencies to safeguard state and Federal Medicaid dollars from diversion into fraud, waste, and abuse. These efforts will expand the capacity of CMS to protect the integrity of the Medicaid program and to manage risk in the administration of Federal grants to States. CMS has already made progress in these areas, as described below.

Improve Financial Accountability for Medicaid Managed Care Organizations

CMS recently proposed the first major update to Medicaid and CHIP managed care regulations in more than a decade that will modernize the programs' rules to strengthen the delivery of quality care in Medicaid or CHIP.[9] These proposals would better align Medicaid and CHIP managed care rules and practices with those of other sources of health insurance coverage, improve consumer communications and access, provide new program integrity tools, and support state efforts to deliver higher quality care in a cost-effective way.

The proposed rule would require States to screen Medicaid and CHIP managed care providers consistent with the requirements for Medicaid and Medicare fee-for-service providers, which includes reviewing Federal databases to determine whether the provider is eligible to participate in public programs. This approach may result in administrative and cost efficiencies by providing the option to eliminate duplicative screening activities as part of the credentialing process for network providers and having that function performed instead by states (or, in the case of dually-participating providers, by Medicare contractors) for all providers. Every provider rendering a service to a Medicaid or CHIP beneficiary, whether in fee- for-service or managed care, would be screened utilizing the same criteria.

The proposed rule would add several components to strengthen Medicaid and CHIP managed care plans' program integrity through administrative and managerial procedures that prevent,

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[9] https://www.Federalregister.gov/articles/2015/06/01/2015-12965/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered

monitor, identify, and respond to suspected provider fraud. This would include implementation of procedures for internal monitoring, auditing, and prompt referral of potential compliance issues within the managed care plan; mandatory reporting of potential fraud, waste or abuse to the state; mandatory reporting of any potential changes in an enrollee's circumstances that may impact Medicaid eligibility as well as changes in a provider's circumstances that may impact that provider's participation in the managed care plan's network; and the suspension of payments to a network provider when the state determines a credible allegation of fraud exists.

Data Analytics and Technical Assistance

Programs with the size and scope of Medicaid and CHIP require robust, timely, and accurate data in order to ensure the highest financial and program performance, support policy analysis and ongoing improvement, identify potential fraud or waste, and enable data-driven decision making. Section 4753 of the Balanced Budget Act of 1997 included a statutory requirement for States to submit claims data, enrollee encounter data, and supporting information. Section 6504 of the Affordable Care Act strengthened this provision by requiring States to include data elements the Secretary determines necessary for program integrity, program oversight, and administration.

CMS is working with States to improve Medicaid and CHIP data and data analytic capacity through the Medicaid and CHIP Business Information Solutions (MACBIS) initiative. This initiative includes changes to the Medicaid Statistical Information System (MSIS), which will be known as Transformed-MSIS or T-MSIS. The enhanced data available from T-MSIS will support improved program integrity and financial management and more robust evaluations of demonstration programs. It will also enhance the ability to identify potential fraud and improve program efficiency.

CMS also administers the Medicare-Medicaid Data Match program in partnership with participating States to identify improper billing and utilization patterns that may not be seen in one program alone. CMS is working to make the program more customizable to State-specific needs. Additionally, in September 2014, CMS established a process for State Medicaid agencies to request timely Medicare Parts A, B and D data for Medicare-Medicaid enrollees to support

care coordination and program integrity activities to combat fraud, waste, and abuse in their Medicaid programs.

Streamline CMS Assessment of State Medicaid Program Integrity Activities

Section 1936 of the Social Security Act requires CMS to provide support and assistance to State Medicaid program integrity efforts. To fulfill this requirement, CMS began conducting comprehensive state program integrity reviews in 2007 on a triennial basis, which play a critical role in how CMS provides assistance to States in their efforts to combat provider fraud and abuse. The reviews assess the operations of each State's program integrity unit, including examinations of provider enrollment and disclosure processes, managed care program integrity operations, and the interaction between the state's Medicaid agency and its Medicaid Fraud Control Unit (MFCU). Through these reviews, CMS also assesses the State's compliance with Federal statutory and regulatory program integrity requirements and identifies effective State program integrity activities that are noteworthy and then shares them with other States.

By the end of FY 2013, CMS had completed comprehensive program integrity reviews of every State, Puerto Rico, and the District of Columbia at least twice.   CMS is streamlining its process for conducting these reviews by shifting from an emphasis on regulatory compliance to a more integrative assessment of risk and program vulnerabilities that is tailored to address the distinct challenges of each state Medicaid program. As part of a process of continuous improvement, CMS began work in FY 2012 to redesign the state program integrity review guide to achieve an increased focus on program vulnerabilities and risk, reduce the burden of the reviews on the States, and identify more opportunities for technical assistance to the States.

In FY 2014, CMS conducted reviews of 10 States that have opted to expanded Medicaid, and focused on three priority areas: operations of managed care entities' special investigations units, implementation of provider enrollment and screening provisions, and personal care services. During FY 2015, CMS is conducting reviews in 10 additional States with a focus on Medicaid managed care, non-emergency medical transportation and personal care services in certain States.

As another means of providing assistance to States, CMS develops toolkits to address these findings from these reviews and other issues. Toolkits are designed to help States better

understand the requirements and improve compliance with Federal regulations. The toolkits identify common issues observed and provide practical solutions that States can implement on issues such as disclosures of ownership and control, healthcare-related criminal convictions, notifications to the HHS Office of Inspector General (OIG).

Expand Training of State Staff Through the Medicaid Integrity Institute

Since 2007, the Medicaid Integrity Institute (MII) has provided professional education to more than 4,200 Medicaid employees from every state, the District of Columbia, and Puerto Rico. The first national Medicaid integrity training program, the MII provides a unique opportunity for CMS to offer substantive training, technical assistance, and support to the States in a structured learning environment. The MII focuses on developing a comprehensive program of study addressing aspects of Medicaid program integrity to include: fraud investigation, data mining and analysis, and case development.

CMS and the MII hold an annual advisory group meeting with senior state program integrity officials comprising the Medicaid Fraud and Abuse Technical Advisory Group (TAG). The TAG provides CMS and the MII with critical input and recommendations for training topics and courses for the following year. The TAG provides state agency updates and guidance on what issues the States are facing in order to provide Subject Matter Experts (SMEs) for each course. The TAG is divided into workgroups that are charged with identifying and developing suggestions that can be shared during the monthly TAG call with States, CMS, and the MII. The success of the MII lies largely with the commitment of our state partners. The tailored courses are identified in the yearly meeting with the MII advisory group and developed by working group experts from States, CMS, and MII.

Eliminate Duplication of Efforts by Integrating Medicare and Medicaid Audits and Investigations

CMS currently relies on a network of contractors to carryout program integrity work in Medicare and Medicaid. To improve efficiency and coordination of Federal data analysis and audit and investigation work within each region, CMS is developing a Unified Program Integrity Contractor (UPIC) strategy. Under this strategy, Medicare and Medicaid program integrity audit and investigation work at the Federal level will be consolidated into a single contractor within a

defined multi-state area, which will complement audit and investigation efforts by States. This contractor will conduct Medicare, Medicaid, and joint Medicare-Medicaid investigations and audits within designated geographic jurisdictions. CMS expects to implement the UPIC strategy beginning with initial contract awards in FY 2016 with additional transitions to occur in subsequent fiscal years.

CMS's goals for unifying this work are to achieve enhanced prediction, detection, and prevention of fraud, waste and abuse across the Medicare and Medicaid programs. CMS anticipates that this integrated and data-driven approach will lay the groundwork for fostering further program integrity coordination with other private and governmental payers across the entire health care industry. Ultimately, it is through partnership and increased awareness across a variety of programs that health care fraud, waste, and abuse can be reduced; therefore benefiting all beneficiaries and patients.

Working with Law Enforcement and the Private Sector to Improve Medicaid Program Integrity

CMS is engaging with the private sector in new ways to better share information to combat fraud. The Healthcare Fraud Prevention Partnership (HFPP) is a voluntary public-private partnership between the Federal Government, State officials, law enforcement, private health insurance plans and associations, and healthcare anti-fraud associations. The HFPP aims to foster a proactive approach to detect and prevent healthcare fraud through data and information sharing. The HFPP's purpose is to improve the detection and prevention of healthcare fraud by exchanging data and information between the public and private sectors, leveraging various analytic tools against data sets provided by HFPP partners, and providing a forum for public and private leaders and SMEs to share successful anti-fraud practices and effective methodologies for detecting and preventing healthcare fraud. The HFPP currently has 39 partners including 8 state agencies.[10]

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[10] State agencies include: Arizona Medicaid Office of the Inspector General, Arizona Health Care Cost Containment System; Illinois Department of Healthcare and Family Services, Office of the Inspector General; Iowa Insurance Fraud Bureau (National Association of Insurance Commissioner's representative on the Information Sharing Committee); Massachusetts Office of the State Auditor; New York Office of Medicaid Inspector General; Ohio Attorney General's Office (National Association of Medicaid Fraud Control Units (NAMFCU) representative on the

We are continuing to grow strategically by adding new partners and identifying additional overlapping fraud schemes. The HFPP has completed the following four studies to date – Misused Codes and Fraud Schemes, Non-Operational Providers (or "false store fronts"), Revoked and Terminated Providers, and Top-Billing and High Risk Pharmacies – that have enabled partners, including CMS, to take substantive actions to stop payments from being issued The HFPP is now in the process of launching three new studies based on successful identification of continuing challenges faced by current and new members.

Through the fraud, waste, and abuse prevention and enforcement efforts of the Health Care Fraud and Abuse Control (HCFAC) program, in FY 2014 the Federal Government attained legal judgments or negotiated settlement agreements with a total value of more than $2.3 billion in health care fraud cases and additionally, took administrative actions in many other health care fraud cases. As a result of these efforts, as well as those of prior years, in FY 2014, approximately $3.3 billion was returned to the Federal Government or paid to private persons. Of this $3.3 billion, the Medicare Trust Funds received transfers of approximately $1.9 billion during this period, and over $523 million in Federal Medicaid money was similarly transferred separately to the Treasury as a result of these efforts.

Additional Resources to Improve Medicaid Program Integrity

To help build on these successes, the FY 2016 President's Budget proposes to provide an additional $25 million to the inflation-adjusted base in FY 2016 for the Medicaid Integrity Program. The additional investment will grow each year until $100 million is added in FY 2025, and, thereafter, the total will be adjusted annually for inflation. Additionally, the proposal would make statutory changes to expand the authority of the program so that both contractors and Federal employees can engage in the same broad range of program integrity activities available under the authorities of the HCFAC program.

This funding will give CMS the ability to address additional program integrity vulnerabilities, including expansion of Medicaid Financial Management program reviews of state financing practices; critical updates to Medicaid claims and oversight systems needed to enhance auditing,

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Information Sharing Committee); Texas HHS Commission Office of Inspector General; and Vermont Program Integrity unit, Dept. of Vermont Health Access.

and other efforts to assist States to fight fraud, waste and abuse. Over time, the inflation adjusted investment will support initiatives that respond to emerging vulnerabilities.

Conclusion

CMS is committed to ensuring that state Medicaid programs effectively combat fraud, waste, and abuse. The past several years have brought numerous gains in these areas, but more work remains. Strengthening and improving upon programs that provide vital services like Medicaid to millions of Americans is a continuous process, and at CMS we take seriously our responsibilities to taxpayers and beneficiaries. We will continue to work with States and other stakeholders to establish new initiatives and expand upon our existing programs to fight fraud, reduce improper payments, and improve oversight. We look forward to working with this Committee to further improve Medicare and Medicaid.