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The Health Wonk Shop: Understanding Fraud and Abuse in Medicaid

Larry Levitt: Hello, I'm Larry Levitt from KFF. Welcome to the latest episode of The Health Wonk Shop. About once a month we dive into timely and complex health policy topics with experts from a variety of perspectives. The biggest health policy issue on Capitol Hill right now is the push for reductions in federal Medicaid spending to help pay for tax cuts. President Trump has said he will love and cherish Medicaid and protect it from cuts that affect people. He has also said he is open to spending reductions that target fraud, waste, and abuse. Republicans in Congress are targeting cuts to Medicaid of about $880 billion or more over a decade. By most accounts, fraud, waste, and abuse in Medicaid doesn't add up to anything close to $880 billion.

Of course, that depends on your definitions of fraud, waste, and abuse, and how cuts are labeled or spun. That said, it would be hard to find anyone opposed to addressing true fraud and abuse in Medicaid except maybe the fraudsters themselves. Today, that's what we're going to dig into. What types of Medicaid fraud we know about, what's being done to root it out, and what investments could be effective in reducing fraud and abuse. We have three incredibly knowledgeable and experienced experts to make sense of this, Christi Grimm is the former Inspector General at HHS. Tim Hill is Senior Vice President at the American Institutes for Research, a MACPAC Commissioner, and served in several senior positions within CMS.

Cheryl Roberts is Virginia's Medicaid Director. A little bit of housekeeping before we jump in. If you have questions, submit them at any time through the Q&A button in Zoom. We'll get to as many of them as we can. Also, note that this session is being recorded and an archived version should be available later today. We have ASL interpretation available. To access it, click on the globe icon in the Zoom control panel. Now, let's jump in. Tim, let me start with you. In the political debate, many policy changes in Medicaid being discussed are framed as addressing fraud, waste, and abuse. In the operations of the program these terms have very specific definitions though. Can you explain what are the definitions of these terms and how they differ from each other?

Tim Hill: Yeah, thanks, Larry. First, let me just say it's great to be here. Really important topic and glad to be part of the conversation. The terms are easily and regularly conflated, particularly in the healthcare context, and it can get really confusing

and I think of it very colloquially. Fraud is all about intent. It's when someone knowingly takes a false action or creates a deception to gain an unauthorized benefit. Something like taking medical records to support build services that are never going to be provided but are going to be billed to the program anyway. It's fairly clear cut. Typically, a lawyer is involved in helping you to make that determination.

I think of abuse as on the road to fraud. It's not as clear cut. There's no intent. It's someone taking advantage of perhaps unclear billing rules or confusing guidance to maximize payment or revenue. Up coding on fee-for-service claims or maybe delivering services that might not be precisely medically necessary but otherwise delivered, can fall into that abuse category. Finally, waste, I think of almost as a policy issue as opposed to an issue that affects individual transactions. It's about the misuse of resources at a program level. We're setting payment rates at a level that don't really reflect the economy or efficiency of the services.

We're creating incentives for providers, for example, to overuse certain services by the way we construct our regulations or how we make payments. It's not criminal, it's not intentional, but it does cause unnecessary expenses in the program.

Larry Levitt: Yeah, that kind of waste. Well, none of these things are limited to Medicaid, obviously, and certainly that kind of waste we see throughout the healthcare system. We've all spent a lot of our time dealing with that. Christi, let me bring you in. Focusing in on fraud. Paint a picture of what does fraud look like in the Medicaid program, at least the fraud that we know about. Who perpetrates it, what are some examples of what you've seen that are fraudulent in the program?

Christi Grimm: Okay, thank you, Larry. Thank you for the invitation to be here. I agree, we have a terrific panel today. I appreciated Tim's definitions of fraud, waste, and abuse. I generally agree with all of those definitions. The one thing that I will say about fraud is it's often thought that it doesn't have harm, particularly in healthcare, and it certainly does have harm, and I'll get to that in just a second. What does it look like? It's billing for services that aren't provided, charging for medical services or equipment that's never delivered. In the early 2000s we saw in hotspots in Los Angeles and Miami, you would go to a DME storefront and they would, in some instances, it would be a PO box.

Policies have changed to curb that. In some instances it would be a storefront with nothing on the inside, but the billing for DME continued. Up coding claims for more expensive services than was actually performed, kickbacks, offering incentives for patient referrals or services. One example might be a laboratory

offering a financial incentive like money or gifts for referring patients to their lab for testing. These types of frauds, particularly in the lab space, it encourages unnecessary testing and billing, and ultimately, it inflates the cost of the government program. Identity theft is a big issue too. Sometimes when there is fraud that's happening, during the course of that fraud, if they get ahold of beneficiary numbers, that can be misused.

Beneficiaries can suffer harms not just to their identity being stolen, but also information potentially being introduced into their medical records. Who commits fraud? That's such a great question I think particularly now. It can range from an entirely false front provider, like the one that I described, in Los Angeles and Miami, a fictitious enterprise that's run by pop-up entities. It can be healthcare providers, physicians, home health agencies, hospitals who are engaging in fraudulent billing. Pharmaceutical entities involved in off-label marketing or kickbacks, and beneficiaries can be involved as well. They can be, in some instances, complicit in participating in fraud schemes.

I think there's a lot of discussion around misusing information to gain access to the program. I think more often you see beneficiaries potentially being complicit in fraud schemes, but not necessarily in some instances making a lot of money doing that. It can be they might get a couple hundred dollars or a TV or something. Sometimes even though they're participating in that fraud scheme, they claim to not know it. The financial impact of fraud, I think that I want to point out that it is challenging to detect because it is an act of deception. It can be hidden within complex billing systems, misrepresented services, falsified records.

In terms of the amount each year, we don't have a terrific estimate, but we know from our Medicaid fraud control units that operate in each state and some territories, it is at least a billion dollars annually. That's a thumbnail sketch of healthcare of Medicaid fraud.

Larry Levitt: Yeah, that's helpful. I have to ask, you mentioned Miami and Los Angeles in particular as being hotspots. Why is that? What is it about Los Angeles and Miami that seems to attract this?

Christi Grimm: I wish I had an answer so that I could offer it to policy folks, but there's a lot of business to be made, we see, in those two areas and some of the clues that stand out as, for instance, seeing one hospice for 10 beneficiaries in a certain area. But the whys, it's a great question.

Larry Levitt: Yeah, interesting. Cheryl, let me bring you in. One of the distinctive features of Medicaid is that it is a federal state partnership. Financing is shared by the federal government and states. The program is operated at the state level by

people like you. I'm sure you wake up every morning hoping not to deal with a case of fraud. What are the things you do in running a Medicaid program to prevent fraud from happening and to ensure the integrity of the program generally?

Cheryl Roberts: First, thank you for having me, and I'm glad. Christi, I remember the DME. When you said that, I said, "Oh, my gosh, I forgot about that." But thank you for bringing it to my memory. Medicaid is a real interesting program to balance. On one hand, you're trying to provide services to a group of people that is different than commercial. You have populations that are going from infants to nursing homes, across the board and difference, and different services that are unique. At the same time, you have a large financial interest, so you're also trying to make sure you're accountable. What happens new, and this is probably the new over the last five to 10 years, program integrity is no longer a back-end issue.

Before it used to be a back-end got you issue. That's what Christi said, that we found out at the end. Now, as Medicaid, we braided it. It's braided from the beginning to the end. You're starting to see more issues when we're using technology. But as was even building our services and our programs, we have built-in program integrity. It's not just the side business, it's actually part of our data and our data analysis. In Virginia, by the way, what we do is we have a strong program integrity relationship with our Medicaid control fraud unit. We really do, we meet with them monthly, but what we're doing is, is that we're doing a lot of data analysis, a lot of trending, working with our health plans, health plans were big for us.

Our health plans are able to nationally see trends that we don't just see for us and then be able to drill down. Then, from there we're able to do those types of analysis and that type of audits. Those audits then get eventually referred to the [inaudible 00:13:24]. But I do want to say one last thing is though, I was glad Tim brought this up, is that Medicaid is really not the home of fraud. If you look at everything in here, most of the things that we are dealing with is improper payments that have to do with documentation. When people usually say to us, what's the big issues are, if you look at all what we call our PERM audits, more than 80% of our PERM audits are just documentation.

It doesn't mean that there's not bad actors, and it doesn't mean that we're not focused on bad actors, but I feel glad that he was able to distinguish the difference, so we don't start off with believing that we are the home of fraud. Actually, if you look at it, we are about the same as commercials. But thank God, like what Christi had to say was, is you want those bad actors, those bad actors can cause a lot of harm to your program, and more importantly, your trust that people have into the program. We'll talk I guess a little more about some of the

things the plans have done and some of the things Virginia has done that I think has been successful.

Larry Levitt: Definitely. Thanks for that. We're starting to throw some acronyms around, just want to make sure people understand them. Cheryl, you touched on this idea of improper payments. Tim, let me come back to you. There have been a lot of numbers bending about, one of those is the improper payment rate, which is found through these PERM audits that Cheryl talked about. Give us a sense, so what are improper payments? What is that rate? How's it been trending, and is it a measure of fraud?

Tim Hill: First, I'll also say, it's not a measure of fraud, but we'll get bottom line up front, it's not a measure of fraud, but it is an important compliance measure, the improper payments calculations. They're done for all programs in the federal government, really to assess how well the payments that are made in the program are made in accordance with the rules that are established for that program. Whether they're documentation requirements for physicians or enrollment requirements, for example, for providers to come into the program. It's a calculation of whether or not the agency and the folks who administer the program are compliant. For Medicaid, over time it's been about 5% of total Medicaid payments can be found in error.

It's a big number. Medicaid is a lot of money, and so the improper payment number is going to be a big number, but the vast majority of the improper payments, 74%, 75% across the country and consistently year to year, are around documentation issues. Whether a physician didn't appropriately document why they coded something, or a home health agency didn't appropriately document how long they were in there for a visit. It doesn't mean a service wasn't provided, it doesn't mean that somebody didn't get care. What it does mean is that the rules that the agencies established for getting payment weren't followed. All those errors could be corrected. The total outlay of the program could still be the same, but they would be in compliance as opposed to be counted as an error.

Larry Levitt: Christi, let me ask you. Actually, let's back up a little bit. Several of you have mentioned the Medicaid fraud control units. Just give us a lay of the land. Who is involved in these fraud investigations? There's federal agencies, there's state agencies, multiple state agencies, who does what in all of this?

Christi Grimm: Medicaid fraud control units, there are 53 of them, again, operating in states and a few territories. The program is generally funded by states and federal government, but if I can use this word, generously funded on the federal side, because new units, they're newer units, 90% of costs are paid for from the federal perspective. Then, for established units, it's 75%. They identify and

prosecute healthcare fraud. Sometimes working in partnership with the federal government, with offices of Inspector General, my office or my old office, and working with the Department of Justice. But they're critically important in the fight against healthcare fraud.

If you are looking at the federal Office of Inspector General for fighting Medicare fraud, think of really the Medicaid fraud control units as the primary fighters of Medicaid fraud in states. Typically, they're located in the attorney general's office. Generally speaking, they're not the same office as the policy shop. The one thing that I think did keep me up at night, still keeps me up at night, is making sure that Medicaid fraud control units are appropriately resourced to do the work that they do because they make a huge difference. They returned a billion dollars in 2023. Depending on where things go from a policy perspective with Medicaid, the work that they do may become ever more important.

That's the thumbnail sketch of the Medicaid fraud control units. HHS, OIG provides, administers their grants and then also takes a look at performance metrics. Again, couldn't be more important, our Medicaid fraud control units.

Larry Levitt: You mentioned a billion dollars in recoveries. What's generally the payoff from a dollar invested in Medicaid fraud control units or the IG's office in terms of recoveries from fraud?

Christi Grimm: The return on investment is around $1 given to a Medicaid fraud control unit, you get $3.30 back.

Larry Levitt: Got it. Cheryl, you mentioned the managed care plans and their role in all of this. I think it's not appreciated by everyone, but most, in fact, the vast majority of Medicaid beneficiaries are now covered in managed care plans, typically private commercial managed care plans, which was not always the case. How has that changed the landscape for you in terms of credentialing providers and finding fraud, dealing with fraud, addressing program integrity?

Cheryl Roberts: The first step of that is, like you said, from procurement all the way, I can't say procurement, from acquiring health plans to actually managing health plans, one of the big things that we did was put really strong program integrity terms. It's actually a big section of the contract. We have staff that actually not only ensure that the plans are meeting those terms, but also at that point doing the analysis for it. What we expect from a plan is that they have something in the front end to deal with both the submission and the adjudication, the actual payments, to make sure that they're watching not only who the provider is and who's coming in in terms of licensing, but also watching what their claims are doing in their data.

We want them to do it on the prepayment side, because our goal is to try to see those things happen before they get paid. But then, afterwards we are looking for them to do some retroactive work and say what the trends are. I'll give an example of one. Since Christi gave one, I'll give you one too. We had good intentions, right? We were looking at, in our case, crisis stabilization, and we were trying to think of evidence-based ways to help people who were going through severe crises, behavioral health crises. We found that some providers use that opportunity to interpret that broadly. They said a crisis is homelessness. Okay, let's put it that way. What we found was is that the plans were the first to identify it.

They were the first to see the trends. They were the ones that did the site visits and they worked with us and our local police, and then together we were able to then put a case together. But it also helped us do the analysis as a state to do the guardrails we needed to do in the front end. What you're trying to do with the health plans are, is they have an incentive. You have an incentive as a state. What you're trying to do is try to align them together. You're trying to say, in places that you may know this is an issue, we may have more information that helps. For example, if a plan sees that someone is billing nine hours a day for something that seems a little unusual.

What the state can do now is look across that data and realize all five health plans have the same issue and there isn't 45 hours in a day. So that while one person may see it's a small issue, we as a state can work together with that kind of information and data. The idea of having the right data, the analytics, and then working with your plans has been successful. States that have done that has made it successful.

Larry Levitt: Tim, you spent a long time at CMS, you certainly saw changes, the rise of managed care not only in Medicaid but in Medicare through Medicare Advantage. How did that change the landscape of program integrity?

Tim Hill: It really changes the types of, as Cheryl was doing, the types of analysis you have to do, the types of people you have, and the expertise that you have. Reviewing fee-for-service claims on an ongoing basis in Medicare or in Medicaid is one set of skills and one thing you need to do. But setting payment rates, executing contracts, ensuring compliance of these large plans with the rules that have been established is a different skill set. You're monitoring not just the, as Cheryl just described, being sure that providers are billing plans appropriately and that fraud at that level is being found, but you're also having to ensure compliance as a payer now or purchaser of a plan.

Whether it's an MA plan or a Medicaid Managed Care plan, to be sure they're in compliance. Then, with Medicaid, from CMS's perspective, you now have

oversight of a state to be sure they're doing what they're supposed to be doing with each of the state. Pardon me, with each of the managed care plans in their state. Really speaks to the complexities in Medicaid, certainly relative to Medicare with that state-federal partnership, when you start introducing all the levels of delivery, from plans to providers, and the compliance mechanisms that are needed across that landscape.

Larry Levitt: We've had a ton of questions come in from the audience that I want to get to. One, there are a whole bunch that deal with, how I frame things initially in the policy debate right now going on in Congress around reductions in federal Medicaid spending. There are a lot of things that are being called fraud, waste, and abuse. One of those, and we've had several questions about this, is provider taxes, state provider taxes used to help finance Medicaid and draw down federal matching funds. It's been called money laundering, abuse, fraud, all kinds of things. I think I'd like all of you to address this, but Tim, let me start with you. Is there fraud and abuse in provider taxes? Is it fraudulent behavior? Is it a policy issue with trade-offs and different points of view?

Tim Hill: There's absolutely a policy issue at play here, but I think we have to start from the perspective of the state-federal partnership. The statute is very clear, that the state has many mechanisms they can use to finance their share of the Medicaid program. Among them are appropriate tax situations, ways that they can set up provider taxes to pay for their benefits. Are there instances maybe where there are providers or states who are pushing the envelope on what is appropriate and what is not appropriate with respect to that financing scheme? Perhaps, there's always issues and you're always trying to stay on top of that. I don't think from my perspective that it's a hundred percent fair to say that because provider taxes are allowed in the system that it's money laundering or that it's resulting in services that shouldn't otherwise be provided.

It is certainly the case that some states have used those mechanisms to fund things that politically might not be palatable in another state. Then, that's a policy question. Should we be paying for those things that are financed under a Medicaid waiver using Medicare provider tax? That's policy debate, but I don't view it, I don't know that it's fair to call it fraud and abuse or to even call it waste, because the policy decisions been made within the constructs of the statute. It's an incredibly complex debate and it's really hard to follow, and being sure that the tax situations are set up in a way that comply with the statute. But when they're complying with the statute, I think it really is a policy conversation, not a conversation in my view about fraud and abuse.

Larry Levitt: Christi, is that something you looked at in your former job as IG?

Christi Grimm: Well, we've looked at state funding mechanisms. I want to take a step back. There's been discussion today too about seeing blips in data anomalies, deviations, and in all of those instances, it's a clue but it is not a finding of fraud, waste, or abuse. You need those boots on the ground, so to speak, to be able to follow-up on those leads. I think that's important. As an OIG, essentially what we would do is take a look at, in that instance, what the state plan articulates for the state Medicaid agency, to look at waivers if that information presents criteria, if you will. Then, we would look at whether states were following those own rules.

Certainly, we would find instances where they were tucking in things. Family planning was a big one that we had looked at, but just by seeing that something doesn't look right, you do have to look at what CMS has essentially allowed to go on and what the states had applied for and done. I think a more appropriate view for that is more along the lines of at least starting with an audit to take a look at, what are the rules, what's actually happening? Then, during the course of that, if you're seeing something that might be fraud, of course, bringing in the investigators. But I agree with Tim, just on its face to call it fraud, there are a lot of steps that need to happen to get there.

Larry Levitt: Cheryl, do you use provider taxes in Virginia to help finance Medicaid?

Cheryl Roberts: Yes, we do. I agree with Tim. As part of our federal state partnership, when we have a request, we do get it approved by CMS as well as the terms and what was needed as part of the pre-print. We are hearing that CMS is taking a harder look at them and asking more additional questions in line with what you're saying, Christi, to ask questions on whether or not quality was measured or what we had requested is there. But it sounds more of like a policy question, a clarification on policy. I don't believe it's a fraud question. I believe it's a policy question. I agree with you, Tim, particularly because in each of these cases, the state did get approval from CMS.

It's not like the state went rogue and did something on their own. That's important because I think as they're being justified, CMS will have to say, "We are clarifying versus saying the state did something wrong."

Larry Levitt: Thanks. You don't seem like a rogue Medicaid director. We've got a number of questions about Medicaid versus other parts of the healthcare system. Obviously, the focus is on Medicaid right now because there is a target for spending cuts. Many leaders, including President Trump, have said that Medicare or Social Security are off the table, which leaves Medicaid as a big target. But I have a number of questions. We're focusing on Medicaid now because of the budget debate, but is there any evidence that fraud is higher in Medicaid, fraud, abuse, waste is higher in Medicaid than in Medicare

commercial insurance? Tim, let me start with you. You looked across all these programs in your time at HHS. How would you compare and contrast them?

Tim Hill: I don't know that you could say that it's greater or less in any of the programs across commercial. It really is a function of, you asked earlier why are things focused in Miami and LA? Well, I guess the people who like to think up these schemes like to live in nice sunny climates, but they look at the vulnerabilities. They look at what's available to them to try and rip off the federal government or commercial plans, and you'll see them move in Medicaid. Then, they'll work in Medicare as loopholes open up or get closed. I don't know that the programs in and of themselves are more susceptible to fraud relative to one or another.

The one thing I would say, and maybe we can talk about this later, is unlike commercial and Medicare, I think the populations at play in Medicare, Christi talked about this with respect to abuse and the impact of fraud, the populations at play in Medicaid are so different. Some of them in particular are so different, people in long-term care settings, you've got youth, you've got folks with severe intellectual and behavioral issues that you just don't see in those other programs. The risk of financial improprieties in those populations to their health and their ability to get services just feels different than what you might see in other programs. Excuse me.

Larry Levitt: Christi, do you have a sense of that?

Christi Grimm: The populations are different. The incentives are different in these programs. Broadly, healthcare is 17% of the United States GDP. It's an attractive target for fraudsters. We certainly see on the Medicare side fraudsters gravitate to where there's a lot of money. It's critically important to be able to have mechanisms to prevent it, to detect it, and to go after it when you see it. But again, as another general estimate for Medicare, HHS, OIG in 2024 from investigations, it was around $6 billion for Medicare, Medicaid. It's a lot of money, obviously, and those are expected returns from investigations.

Larry Levitt: Christi, let me stay with you. We had a number of other questions about the role of inspector generals. You spent a long time in the IG's office, and as the inspector general at HHS, if you could give people some insight into what an Inspector General does on a day-to-day basis, what does that office do? What's their scope?

Christi Grimm: Well, their mission is to prevent and root out fraud, waste, and abuse, and to promote economy and efficiency. All of those words might really resonate with people right now because there've been a lot of discussion about various entities who have a similar mission, so to speak. Inspector general are independent from the departments that they oversee, and that's for a key

reason. We're meant to be able to look at where problems are, to recommend solutions. If you're running a program, like if I ran Medicare, I wouldn't be able to give without any potential bias a view of how that program is looking. That really matters in the conversation we might be having here around fraud, waste, and abuse, and identifying where there are gaps in how a program is running.

Because in those instances, we're making recommendations to the department, we can't ever force the department to do what we're recommending. It really matters then that there's transparency in OIGs, that there's communication with the department. We report information to Congress, and so we're independent but not untethered from the departments we oversee. We have reporting obligations, and the goal is to make those programs run as effectively as possible. That's that efficiency and effectiveness piece. Then, sometimes when we are identifying an extraordinary amount of fraud, and abuse, and waste, we will have those conversations with the policy folks over at CMS to talk about, "Okay, what can be done here to reduce the chances that somebody can gain the system?"

Larry Levitt: That's helpful, thank you. We had a number of questions about enrollees versus providers. Christi, you had mentioned enrollees may sometimes be complicit in fraud, but they're not necessarily the main beneficiaries of that. Cheryl, let me start with you. In terms of what you see in a state Medicaid program, is it individuals fraudulently enrolling in the program? How would that even happen? Or, is the focus really mostly on provider billing, fraudulent billing, and abusive billing?

Cheryl Roberts: The all look at Medicaid was exactly like you said, it was a beneficiary issue. That is not true. Actually, the states have now went through, as you know, what we call the unwinding, where we had to re-enroll every person in the last year and a half. That was a good exercise nationally because we were able to go through every person and see what we're seeing. Actually, ask everyone then to send their credentials in their enrollment, their finances in, and to look at it again. Now, am I going to say that there's no person that has done that? Absolutely I cannot say that. But is it vast? No, that's not what we have seen. What we have seen is otherwise then, to be honest, someone has left Virginia and moved to North Carolina and forgot to tell us they moved, which people now say that's a problem, and we do know that we have to fix it.

Or, periodically we will see that someone will claim that they're disabled periodically, but that always gets picked up because we have two levels of screenings, but that's very rare. That's not the norm. The norm of what we have seen in terms of improper payments, and we see that in all of our audits, is on the provider side. The provider is not necessarily a doctor. I do want to make that clear, because in our case Medicaid pays for services that are not standard.

As what Tim has said. We pay for the intellectually disabled group, and that's not necessarily a doctor. That is where we find both the improper payments and then some of, as Christi said, the niches and schemes. We find it in that type of service.

Larry Levitt: Tim, how about on the improper payment side, how much of that is providers billing? How much of that is eligibility improper or undocumented eligibility determinations?

Tim Hill: I think towards 2024, in my understanding, about 16% of the improper payment rate, of the 5% improper payment rate, so not of the total, was eligibility issues. Not necessarily inappropriate eligibility, but documentation issues or otherwise somebody not being re-determined timely, those sorts of things. But I agree with Cheryl, it's a long road to go for a beneficiary to try to get themselves enrolled in the program. It's not always an easy application process solely for the purpose of getting healthcare coverage. If someone's looking to make money, they're going to go try and collude with the provider to do something nefarious, not necessarily try and enroll in the program.

Larry Levitt: Christi, you had mentioned enrollees sometimes being complicit in the fraud. Just describe a little bit more of what you meant by that.

Christi Grimm: Kickback issues. If they're willingly giving their number, knowing that it's a false front provider, for the purposes of billing the program, the beneficiary potentially would be a complicit in that kind of fraud. Sometimes we see that. A person who used to work in my organization who since retired, he liked to say that the keys to the kingdom and being able to steal from federal healthcare programs are having the provider number and the beneficiary number. It used to be the case that you could trick someone into giving you that information. Now, fraudsters can potentially buy some of this information on the dark web, on social media.

But in some cases, beneficiaries do get caught up in these schemes because of something they're given, whether it be cash or a gift, something of value for them to give their information and to participate in a scheme.

Larry Levitt: Christi and Tim, so we have seen massive cutbacks in the federal workforce within HHS, roughly a quarter of the workforce through early retirements and reductions in force. Neither of you are at the department right now, and we're still piecing together information I think of where these cutbacks are happening, I'm interested in what both of you think might be some of the effects of those cutbacks on the ability of the federal government to ensure program integrity in Medicaid and other programs.

Tim Hill: I'll start, and then Christi. I think the staffing issues, let's be charitable first and say, there's a method to the madness and that there's going to be a strategic approach that allows the agencies to become more efficient. If that doesn't happen, if they've lost a lot of brain power, the ability to make policy decisions, and as Christi was describing, respond to recommendations and policy issues that are coming from the IG and other law enforcement partners is going to be really hard. Because there's just not going to be enough brain power in the building to really deal with all the issues that are coming at, in this case, in CMS's case, or at the state level.

But as important, maybe not as important, but certainly important nonetheless, is the reduction in funding to federal contractors. CMS is a relative to federal workforce. This is relatively small and most of their work is done via contract. It's the combination, the double whammy of losing resources to actually go out and do investigations, which are typically done by contractors, as well as the people internal to CMS, which I think is really going to have a detriment. We'll just have to look at the data to see what it shows over time. But I don't know, Christi, if you see things the same way.

Christi Grimm: Certainly the drain of expertise, I know GAO has commented on this in the last decade. One of the vulnerabilities for the federal government generally is this expected exodus. With the rapidity of it, I imagine that is exacerbated. As an inspector general, I would be, as a former inspector general now, thinking about the downstream effects of these deep cuts. For instance, the work that we'd done looking at opioid abuse, improper prescribing, high-risk beneficiaries, we had seen a decrease in the providers who were prescribing at high levels. We had seen an increase in beneficiaries with substance use disorder.

Taking a look at, say, the grants that have been cut that are meant to help substance use disorder, mental health issues, these are areas of concern that I would hear about from Congress, what's happening in these spaces. Potentially, taking a look at what's going on in those downstream instances. Another area, and it's not Medicaid, but it matters to everyone. We had taken a look at infant formula. We had seen that a manufacturer had detected issues at the facility, and FDA took a long time to discover and respond to those infant formula manufacturing issues. I understand some of the cuts from news reporting were in the space where they're building teams to look at infant formula issues.

But just taking a look at where these cuts are happening, how that's affecting service delivery, where there are instances where it's reached critical mass and being able to deliver those services, even the planning that went into it is something potentially to be looked at. When I was an inspector general, if I hear that there's a 20% error rate in the amount of people that were cut, that's a pretty high error rate. I think it's important to look closely at whether critical

services in Medicare, Medicaid, in head start all sorts of areas, how that's being impacted. I don't have any answers to that. It's an observation of the questions that might be asked from an oversight perspective.

Larry Levitt: Got it. Well, we're coming to the end of our time, unfortunately, actually over time, but want to give each of you, if there was one idea you could inject into the policy debate right now that could affect, that could help prevent or root out fraud, fraud and abuse in Medicaid, what would that one idea you would offer be? Cheryl, let me start with you.

Cheryl Roberts: I only get one?

Larry Levitt: You can probably speak a couple.

Cheryl Roberts: All right. Number one is going to be CMS, actually. My hope is that with the new administration, that they will talk more about us sharing data like TMS's data and then sharing trends and information with us before the report. What I mean is that by the time we get the reports, it's usually two years out. We really want to work on that right now, quickly, get us the information, let's work together, work collaboratively. On a positive note, I do also want to say that all the Medicaid directors are very focused on program integrity. Even in our meeting in June, there's going to be a session on program integrity. I do want to show people that Medicaid directors are not just sitting and watching the concerns. We are actively working on it. I want to make sure that we are as focused as everyone else's.

Larry Levitt: Thanks. Tim?

Tim Hill: I am glad to hear Cheryl talk about data, because that's where I was going to go, and it's not an idea, more of a concept. The fact that there are so many disparate data maintenance and collection efforts in Medicaid, whether it's on fee-for-service claims through the systems they use there, or encounter data from managed care plans. All the various data systems that are used to collect information about how beneficiaries are treated under waivers and in home and community-based service settings. Very hard to pull together a really clear picture about what's going on nationally or in any particular state across those data sources.

If I had a magic wand, I would somehow figure out a way to bring that all together in a way that's much more easily analyzed and used to help us direct our efforts.

Larry Levitt: Well, as a policy researcher, that's certainly music to my ears. Christi, you get the last word.

Christi Grimm: Well, I do have to double down on the data ideas to be able to effectively use systems, to be able to detect anomalous patterns, to share that information responsibly across states. When you're seeing that in the Medicaid managed care, when there are deceased beneficiaries or beneficiaries moving from state to state, or providers that are enrolled unbeknownst to the program. That data needs to be shared so that states know who they're doing business with from a provider or from a beneficiary perspective. Nowadays, we just really, with fraud, we don't have the luxury of phone calls and just relationships. We really have to do better in having robust data systems that have accurate, timely information to be able to detect and respond appropriately.

Larry Levitt: Well, a consensus, at least among you all, so that's a good sign. Thanks to Tim, Christi, and Cheryl for being with us. That was terrific. I learned a lot. I'm sure others did as well. Thanks to the audience for joining us again on the Wonk Shop.