Testimony to the House of Representatives Committee on the Judiciary

Subcommittee on Crime, Terrorism and Homeland Security

"The Enforcement of Criminal Laws Against Medicare and Medicaid Fraud"

Chairman Bobby Scott (D-VA)
Ranking Member Louie Gohmert (R-TX)

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Chairman Scott, Ranking Member Gohmert and Members of the Subcommittee, thank you for holding this hearing today and inviting me to share a few thoughts. This is a topic of great importance that affects access to healthcare services for every American. I want to emphasize my willingness to work with all of you following this hearing to develop and implement policies that will ensure our precious healthcare dollars do not end up in the hands of criminals.

I must begin by emphasizing that my oral and written remarks are solely my own. They do not necessarily reflect the views of my employer the Center for Health Transformation or any of its staff or members.

The problem of healthcare fraud is far bigger than most Americans can imagine. But fortunately leaders from both political parties have started speaking up on this critical topic. That is the first step toward creating a climate where real solutions can be offered and implemented.

During his address to a joint session of Congress on September 9, 2009, President Barack Obama accurately spoke of the "hundreds of billions of dollars of waste and fraud" in our healthcare system. This was surprising news to a lot of people.

Health and Human Services Secretary Kathleen Sebelius said at the "National Summit on Health Care Fraud" on January 28, 2010, "We believe the problem of healthcare fraud is bigger than government, law enforcement or private industry can handle alone." She was correct about that. Later in her speech she said, "Today, Medicare, Medicaid and private insurance companies pay out billions of dollars in fraudulent claims, and charge taxpayers higher premiums for it."

Congressman Ron Klein of South Florida, a hot spot for healthcare fraud, also spoke at the "National Summit on Health Care Fraud." He said, "Constituents come to me repeatedly with fake billings and stories of solicitations for their Medicare ID number."

Senator Tom Coburn suggested that, "Twenty percent of the cost of government healthcare is fraud," at the White House Health Summit on February 25, 2010. Senator Charles Schumer later associated himself with those comments, "I was glad to hear my friend Tom Coburn's remarks. I think we agree with most of them, and particularly the point that about a third of all of the spending that's done in Medicare and Medicaid, I would imagine a lot of it's in the private sector as well, doesn't go to really good health care, goes to other things."

Across the political spectrum there is emerging consensus that the amount of fraud in our healthcare system is very significant and totally unacceptable. Yet efforts thus far have failed to make a major dent in the problem.

The Government Accountability Office (GAO) has produced literally hundreds of reports over the last 30 years outlining waste, fraud and abuse in Medicare and Medicaid. A simple visit to GAO.gov and use of their search engine confirms this fact.

GAO designated Medicare a "high-risk" program in 1990 and Medicaid in 2003. The two programs combined will total $1 trillion in 2010 and their "high risk" status perseveres. An April 2009 report on the "High-Risk Series" estimated that the improper payment rate in Medicaid in 2008 was 10.5 percent with home health care administration and durable medical equipment being disproportionate contributors.[1] By contrast, the improper payment rate for non-health government agencies in 2008 was 3.9 percent.[2]

Secretary Sebelius sent a letter to Senator John Cornyn last week that outlined the first ever state-by-state breakdowns of improper payment rates. There were two notable takeaways – the improper payments are indeed excessive across a sampling of over half the states, but they are heavily concentrated in fee-for-service Medicaid and not in managed care.[3]

The Office of the Inspector General at the Department of Health and Human Services is equally dire in its reports and warnings. In just one example, on August 26, 2009 they sent a letter to CMS Director of State Operations Cindy Mann essentially saying that the Medicaid's data collection is so poor they cannot even accurately measure how bad the fraud is.[4]

Thomson Reuters released a comprehensive study in October 2009 showing that between $600 and $850 billion of what we spend on healthcare each year is wasted. That is approximately one-third of our entire national health spending. The report suggested that between $125 and $175 billion of that is pure fraud, with the remainder mostly made up of administrative waste, provider errors and waste largely characterized by unnecessary and duplicative diagnostic testing.[5]

The CBS news magazine show *60 Minutes* had a segment hosted by Steve Kroft on October 25, 2009 on Medicare fraud. It started with Kroft warning viewers that the following piece, "might make your blood boil." He asserted that $60 billion a year is stolen from Medicare by criminals like one they profiled.[6] Other news outlets confirm that organized crime in particular is rapidly moving into Medicare fraud because the risk is so low and the payoff so high.[7]

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[1] Government Accountability Office, "Progress Made but Challenges Remain in Estimating and Reducing Improper Payments," April 22, 2009. http://www.gao.gov/highlights/d09628thigh.pdf.

[2] Garret Hatch & Virginia McMurtry, "Improper Payments Information Act of 2002: Background, Implementation, and Assessment," Congressional Research Service, October 8, 2009. http://assets.opencrs.com/rpts/RL34164_20091008.pdf.

[3] Letter from Secretary Kathleen Sebelius to Senator John Cornyn, February 25, 2009.

[4] Stuart Wright, "Memorandum Report: 'MSIS Data Usefulness for Detecting Fraud, Waste, and Abuse,' OEI-04-07-00240," Office of Inspector General, Department of Health & Human Services, August 26, 2009. http://oig.hhs.gov/oei/reports/oei-04-07-00240.pdf.

[5] Thomson Reuters, "Healthcare Reform Starts with the Facts," October 27, 2009. http://thomsonreuters.com/content/corporate/articles/healthcare_reform.

[6] 60 Minutes, "The $60 Billion Fraud," October 25, 2009. http://www.cbsnews.com/video/watch/?id=5419844n.

[7] Kelli Kennedy, "Mafia, violent criminals turn to Medicare fraud," Newsvine.com, October 6, 2009. http://www.newsvine.com/_news/2009/10/06/3354515-mafia-violent-criminals-turn-to-medicare-fraud.

The American people are becoming aware of how bad the problem is. In a poll conducted last summer by Insider Advantage, the American people by a margin of 61-27 said Congress should eliminate fraud in existing public programs before creating another one.[8] A Zogby poll from around the same time asked Americans what is their preferred way to pay for modernizing our healthcare system. Eighty-eight percent said "eliminate fraud" placing well ahead of the second place finished "standardize administrative forms" at 77 percent and "reduce medical errors" at 72 percent.[9] In other words, Americans prefer going after criminals before ensuring their own personal safety from medical mistakes!

More broadly speaking, Americans believe that 50 cents of every dollar spent by the federal government is wasted according to a September 2009 Gallup poll. Democrats pegged it at 41 cents, Republicans at 54 cents and independents at 55 cents.[10] This is a startling lack of faith in the ability of the federal government to spend tax dollars efficiently.

Prior to getting into specific, workable solutions however, it is important to mention third-party payer as the root cause of excessive waste, fraud and abuse in our healthcare sector. I appreciate that this is well beyond the scope of today's hearing. But it must be acknowledged that third-party payer arrangements dominate all of Medicare and Medicaid and nearly all of what we call "private insurance." They encourage patients and healthcare providers to be less than vigilant about dollars being spent and billed. Consumers of health care services are simply more mindful of their spending when they have skin in the game as shown by the classic Rand Health Insurance Experiment[11] and more recently by the experience of Indiana state employees.[12]

Absent confronting the inherent perverse incentives of third-party payer, the next best solutions are exponentially better use of available information technology, better data sharing, metrics-based management and more transparency. Fortunately, these cost relatively little, should have few partisan boundaries and done properly would have a massively positive effect on rooting out waste, fraud and abuse.

Consider the example of the credit card industry. There are over $2 trillion in credit card transactions annually in the United States which makes it more than twice as large as Medicare and Medicaid combined. There are roughly 800 million cards in circulation,

[8] Insider Advantage poll of 636 registered voters, July 15, 2009. http://www.healthtransformation.net/cs/IAPollJul09.
[9] Zogby International/University of Texas Health Science Center poll of 3,862 adults, June 2009. http://www.zogby.com/news/ReadNews.cfm?ID=1722.
[10] Gallup, "Americans: Uncle Sam Wastes 50 Cents on the Dollar," September 15, 2009. http://www.gallup.com/poll/122951/Americans-Uncle-Sam-Wastes-50-Cents-Dollar.aspx.
[11] RAND Health Insurance Experiment. http://www.rand.org/health/projects/hie
[12] Mitch Daniels, "Hoosiers and Health Savings Accounts," Wall Street Journal, March 1, 2010. http://online.wsj.com/article/SB10001424052748704231304575091600470293066.html?mod=WSJ_Opinion_LEFTTopOpinion.

millions of vendors and countless products available for purchase. Yet, fraud in the credit card industry is less than one-tenth of one percent. It is perhaps 100 times worse in Medicare and Medicaid.

Why is this true? For one, the credit card industry does a much better job at screening out bad vendors in the first place. Medicare fee-for-service consistently fails at that. The *60 Minutes* segment referenced earlier gives a flavor for that.

Second, the credit card industry uses advanced information technology that flags suspicious purchases in real time. All of us know that if we traveled to Fargo, North Dakota, tomorrow and tried to buy three plasma televisions, our credit card company would signal the store clerk to ask for us for identification in the space of seconds. Most of us have had similar experiences with seemingly more routine purchases. Medicare fee-for-service is light years behind the credit card industry in its ability to identify criminals and deny their payments.

It is worth noting that there are not thousands of federal and state law enforcement officials assigned to police rampant and ongoing credit card fraud. The problem is almost entirely nipped in the bud by proper pre-screening of vendors and advanced algorithms that spot outliers instantly.

Law enforcement plays a critical role in combating healthcare fraud but it is by definition reactive. The cost in time and money of indicting, prosecuting and imprisoning a criminal is significant and unfortunately the deterrent effect appears to be minimal as organized crime continues its march into Medicare and Medicaid fraud. Keeping up with and stopping the latest scams in a third-party payer system with poor use of information technology is like the mythical character Sisyphus trying to push the rock up to the top of the hill only to have it crash to the bottom every time he seems to be making progress.

That said, the Health Care Fraud Prevention and Enforcement Action Team (HEAT) has been a successful joint effort between the Justice Department and Health and Human Services. The level of cooperation and data sharing has been extensive and they notched up several significant successes in 2009. Aggressive, innovative United States Attorneys like Luis Perez in South Florida are making important contributions.

But the fact is, these efforts simply do not have and will never have the amount of resources and manpower to try and convict all the criminals guilty of Medicare and Medicaid fraud. James Mehmet, the former chief state investigator for Medicaid fraud in New York said in 2005, "40 percent of all claims are questionable."[13] In a Medicaid program the size of New York's that is in the neighborhood of $20 billion annually in questionable claims. To re-emphasize - that is *one state's* Medicaid program in *one year*. With all due respect to the honorable and hardworking men and women in law enforcement, a number of this magnitude makes the busting of $50 million dollar fraud

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[13] Clifford J Levy and Michael Luo, "New York Medicaid Fraud May Reach Into Billions," *The New York Times*, July 18, 2005. http://www.nytimes.com/2005/07/18/nyregion/18medicaid.html?pagewanted=print

rings seem like a drop in the ocean especially when factoring in all costs associated with the investigation, prosecution and eventual jail time for those convicted. One percent of annual Medicare spending is $5 billion.

Many of the attorneys and investigators I have spoken with off the record say that prosecutions focus almost exclusively on very large cases where convictions are a virtual slam dunk. The message criminals hear is that they should just not get too greedy. So long as their theft remains in the tens of thousands of dollars, they need not fear prosecution. Those smaller activities multiplied across the country thousands of times likely add up to far more dollars than the marquee indictments, prosecutions and convictions.

So because law enforcement cannot reach these smaller and vastly more numerous crimes, we must think of innovative and low cost ways to prevent and deter fraud that utilize the all-hands-on-deck approach as suggested by Secretary Sebelius.

There is no Constitutional right to become and remain a supplier to the Medicare program. This may sound obvious. But there is a mentality among too many that simply because an application is filled out properly and various token requirements are met, everyone can supply Medicare patients. This leads to ridiculous situations where there are 897 licensed home health agencies in Miami-Dade County (as of April 2009) which was more than in the entire state of California.[14] There is simply not a need for that many home health providers in such a small geographic area. The Medicare fee-for-service program essentially accepts all eligible applicants regardless of patient need or demand. By contrast, commercial insurers don't have 40 suppliers in a region when five are sufficient.

Here are nine action items that would significantly reduce fraud and abuse:

1). Add the phrase, "under penalty of perjury" to CMS form 855 and its various subforms. These are the applications used by people wanting to become suppliers to Medicare. This very minor tweak would be a big asset to prosecutors going after bad actors because perjury is a more serious offense.

2). Medicare and Medicaid should use private sector standards for establishing the number of suppliers for a product or service in a defined area. California's Medicaid program has been doing this for the better part of a decade now in the durable medical equipment space. While there was some pushback from frustrated potential providers, there were no reports of access to care issues from beneficiaries.

In a related experiment last year, the South Carolina Medicaid program told its 48 Medicaid beneficiaries with the most number of prescriptions that they could select any pharmacy. That one pharmacy would be their sole provider of needed medications. After

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[14] Craig Smith, "South Florida: Ground Zero for Healthcare Fraud," *Stop Paying the Crooks*, ed. James Frogue (Washington, DC: Center for Health Transformation Press) 47

eight months those 48 individuals had 40 percent fewer prescriptions which translated into a savings of $320,000 for the Medicaid program.

3). Reduce the administrative red tape and lengthy appeals that suppliers too often exploit. Currently, suppliers can drag out the process for months and usually get reinstated. In 2007 and 2008 the OIG conducted 1,581 unannounced site visits of durable medical equipment providers in South Florida and found 491 either didn't have an actual facility or were not staffed accordingly. All 491 billing privileges were revoked. 243 of them appealed and 222 (or 91 percent) of those were reinstated. Of the 222 reinstated, 111 had their billing privileges revoked again.[15]

The Florida Medicaid program requires suppliers to sign contracts that the state has the right to terminate a supplier at any time, "without cause." This has been effective in Florida without harming access to care. Any public or private purchaser of a service should retain the right to stop buying that service whenever they see fit.

4). Authorize demonstration projects whereby the authentication of new suppliers to Medicare fee-for-service is outsourced by and to an entity *not* CMS. Congress could identify a handful of counties with a history of Medicare fraud and designate an agency that is not CMS to conduct the bidding. Perhaps the Office of Personnel Management could run a small handful of these initial experiments as OPM has experience in this area. Entities such as credit card companies, financial institutions or health insurers among others would be free to bid.

5). Data sharing across departmental jurisdictions and with state and local governments should be done with the same seriousness as in national security. Prior to 9/11 the CIA and FBI rarely communicated. Now they compare intelligence frequently. There are multiple databases of Medicare and Medicaid providers and suppliers along with their disciplinary records.[16] But these databases are not as universally comprehensive or as accessible as say the National Instant Criminal Background Check System (NICS) used to keep guns out of the hands of people with criminal records. The National Crime Information Center is another law enforcement tool that allows a local officer to have instant access to a suspect criminal background across the country. These systems are not perfect, but they represent good examples of how individuals with criminal records and/or disciplinary actions in the healthcare field can at least be flagged early. This concept was part of President Obama's revised health proposal unveiled on February 22nd and based on legislation introduced by Congressman Mark Kirk so it has bipartisan support. Utilize data from the Social Security Administration and IRS as well.

6). Open up Medicare claims data to audits conducted by contingency-fee based companies beyond the standard four recovery audit collection companies. The status quo is not working. Higher contingency fees of perhaps 20 percent and new eyes would

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[15] Ibid

[16] The National Supplier Clearinghouse, the Healthcare Integrity and Protection Data Bank, the OIG Exclusion List, and CMS's Medicare Exclusion Database, etc

introduce more powerful incentives, fresh ideas and modern research techniques to the fraud hunt. The same could be done by governors with their Medicaid programs to stir up new lines of inquiry beyond what is produced by the Medicaid Fraud Control Units.

7). Create a website where payments to Medicare providers and suppliers are posted for public access. This would allow for better identification of outlier billing practices, particularly among providers with similar geography and patient demographics.

The South Carolina Medicaid program has three years of claims data available broken out by provider name, county, number of patients treated, number of patient visits, total payments for billed claims, and average cost per billed claim.[17] Future iterations could have increasing granularity around specific treatments per patient, outcomes and how those compare with peer providers around the state. A version for Medicare would be most useful if complete patient data were posted and not made available only in Part A, Part B and Part D silos (with Medicaid data for the very expensive "dual eligibles" in still another silo). It must be clearly emphasized that all "patient data" be devoid of any individual identifiers that could compromise patient privacy. Fortunately, Medicare has successfully shared its claims data with academic institutions for decades without breaching patient privacy.

8). Consider the feasibility of having all Medicare suppliers and providers publicly post their requests for payment *before* they are reimbursed by taxpayers. Again, it would have to be scrambled appropriately to guarantee patient privacy. The volume of that raw data would no doubt be massive and few people would comprehend it initially. But eventually sense would be made of the seeming chaos and patterns would emerge, some of them unflattering. This need not interfere with Medicare's existing requirement for prompt payment. President Obama spoke of the need to post legislation on the Internet for 72 hours before it is voted on by Congress. This suggestion is in that spirit of transparency.

9). Hold hearings about the governance of CMS and its ability to be truly effective in fighting fraud and abuse. But instead of having CMS political appointees and senior bureaucrats as witnesses as is nearly always the case, invite current and former Medicare contractors for example and others who could testify about how impactful CMS policies really are at the street level. Those witnesses would be most effective if they were not in positions where they feared retribution from CMS. Some of their ideas would shock.

The fraud, waste and abuse in Medicare and Medicaid are vast but it is possible to fix the problems. Law enforcement will always play a key role in prosecution and deterrence. But our best hope for solving the problem is far more aggressive use of technology, better management of the programs and more transparency. Taxpayers have the right to know where and how their dollars are being spent.

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[17] South Carolina Department of Health and Human Services, Transparency Reporting of Medicaid. http://www.scdhhs.gov/Transparency.asp