WASTE, ABUSE, AND MISMANAGEMENT IN GOVERNMENT HEALTH CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH CARE, DISTRICT OF COLUMBIA, CENSUS AND THE NATIONAL ARCHIVES

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

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WASTE, ABUSE, AND MISMANAGEMENT IN GOVERNMENT HEALTH CARE

TUESDAY, APRIL 5, 2011

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH CARE, DISTRICT OF COLUMBIA, CENSUS, AND THE NATIONAL ARCHIVES,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:20 p.m., in room 2154, Rayburn House Office Building, Hon. Trey Gowdy (chairman of the subcommittee) presiding.

Present: Representatives Issa, Burton, McHenry, DesJarlais, Walsh, Gowdy, Cummings, Norton, Clay, Davis, and Murphy.

Staff present: Ali Ahmad, deputy press secretary; Robert Borden, general counsel; Molly Boyl, parliamentarian; Drew Colliatie, staff assistant; John Cuaderes, deputy staff director; Adam P. Fromm, director of Member liaison and floor operations; Tyler Grimm and Tabetha C. Mueller, professional staff members; Christopher Hixon, deputy chief counsel, oversight; Sery E. Kim, counsel; Justin LoFranco, press assistant; Mark D. Marin, senior professional staff member; Laura L. Rush, deputy chief clerk; Ronald Allen, minority staff assistant; Jill Crissman, minority professional staff member; Ashley Etienne, minority director of communications; and Dave Rapallo, minority staff director.

Mr. GOWDY. The committee will come to order. This is a hearing on waste, abuse, and mismanagement of government health care. And again, on behalf of the witnesses and other interested folks here, thank you for your indulgence for all of us as we had to go vote.

The Oversight Committee mission statement is as follows: We exist to secure two fundamental principles. First, Americans have a right to know that the money Washington takes from them is being well spent. And, second, Americans deserve an efficient, effective government that works for them.

Our duty on the Oversight and Government Reform Committee is to protect these rights. Our solemn responsibility is to hold government accountable to taxpayers, because taxpayers have a right to know what they get from their government. We will work tirelessly in partnership with citizen watchdogs to deliver the facts to the American people and bring genuine reform to the Federal bureaucracy. This is the mission of Oversight and Government Reform.

I will now recognize myself and then the gentleman from Illinois and the gentleman from Arizona for opening statements.

Again, I want to thank our distinguished eclectic group of witnesses for offering what I am sure is going to be wonderful insight and testimony.

Congress all too often deals in abstracts, issuing directives with broad scope and limited specificity. In other words, we pass big ideas and then leave the details to unelected individuals who sometimes escape the scrutiny that comes with popular elections, thereby abdicating our constitutional role.

However, this malady in the past has not been limited to our lawmaking responsibility. It has also extended into Congress' role to hold agencies accountable for glaring inefficiencies. Hopefully, we are beginning to recapture that role and in doing so rein in an overextended bureaucracy fraught with mismanagement and abuse.

Here on the Oversight Committee, it is our duty to ask fair questions and demand honest answers, answers whose validity the American people for too long have been conditioned to doubt. At a time when the approval of Congress is historically and empirically abysmal, this committee has a unique opportunity to begin the arduous process of re-inspiring trust in the institutions of government. That process begins with rooting out areas of waste, nowhere more prevalent than in government health care.

The American people expect government to be responsible stewards of taxpayer dollars and devoted practitioners of honest introspection. However, in the areas of Medicare and Medicaid, we have utterly failed in both regards. In the past, oversight has followed a basic path: We identify a broken program, seek to expose the underlying cracks in its foundation, and explore possible avenues to rectify the problems. We ask, why? What are the root causes? And what can be done to fix the problem? In this case, however, many of those questions have already been asked and answered, and yet nothing has been accomplished.

Since 1990, GAO has identified both Medicare and Medicaid as high-risk programs, highlighting a path that is fiscally unsustainable over the long term. The GAO also found pervasive internal control deficiencies that put billions of taxpayer dollars at risk of improper payments for waste. From delaying the implementation of headless accounting system to ignoring GAO recommendations designed to address improper payment vulnerabilities, CMS has repeatedly failed to properly confront these financial failures, a burden that falls not on the Federal bureaucrats tasked with enacting these reforms but on American taxpayers across the country.

Both Medicare and Medicaid are in desperate need of fundamental wholesale systemic reform. They serve as two principal drivers of our crippling burden of debt at a time when economic uncertainty threatens our Nation's fiscal security. Something simply has to be done.

However, full-scale reform is not the purpose of this hearing. We are seeking to identify areas of inefficiency and determine why commonsense recommendations calculated to decrease exorbitant costs have continuously been ignored. Trust must be earned, and addressing the mistakes of the past is an important first step in that process. The American people expect that when money is

spent, it is spent properly. And when areas of mismanagement are discovered, they are promptly and adequately corrected.

However, recent failures have left them frustrated, frustrated at the persistent waste, frustrated with the lack of remedy, consequence, and accountability, frustrated by a problem that is so illustrative of a broken, wasteful Federal bureaucracy.

Today, I hope we can begin the process of addressing that frustration and begin to rebuild citizens' trust in the institutions of government.

And with that, I would yield to the gentleman from Illinois for his opening statement.

Mr. DAVIS. Thank you, Mr. Chairman.

And I want to thank you first of all for holding this hearing, which I consider to be vitally important.

As a Chicago native, I have long focused on the problems of the inner city poor and disabled. The Seventh Congressional District in which I live is the largest medical center district in the country, with 21 hospitals, four medical schools, and 104 community health centers.

Specifically in my district, the Affordable Care Act, which I strongly supported, improved health insurance coverage for 334,000 residents and closed Medicare's prescription doughnut hole for 76,000 seniors. Additionally, it extended coverage to 52,000 uninsured residents and has reduced the cost of uncompensated care for hospitals and other health care providers by $222 million annually.

At a time when 13 million older Americans are considered economically insecure and our constituents are grappling with unemployment and the effects of the economic downturn, I am at a loss when some in Congress are pushing to reduce or eliminate basic health care services for vulnerable Americans.

Make no mistake, the repeal of the Affordable Care Act and deficit reduction proposals targeting Medicare and Medicaid will equate to an assault aimed at women, the sick, and the poor.

In 2009, over 365,000 Americans were on waiting lists in 39 States to join the 3 million aged and disabled individuals receiving long-term care services in nursing homes and in home health care settings.

I am concerned that today's hearing, reportedly focused on waste, abuse, and mismanagement in government health care is less about constructive proposals to fight fraud and is more about the House Republican leadership's campaign to cut Medicare and Medicaid.

For the record, this is the fourth hearing in a row in the House on this topic, with three identical hearings held in recent weeks by the Energy, and House Committee, the Committee on Ways and Means, and finally the Committee on Appropriations.

It is clear to this Member that the Republican leadership has given messages to rank and file Members for its campaign to slash Medicare and Medicaid. Certainly targeting waste and abuse in Medicare and in Medicaid is an important and bipartisan effort. I note that in February, a multi-agency anti-fraud effort, coordinated under the auspices of the administration's Health Care Fraud Prevention and Enforcement Action Team [HEAT], resulted in criminal charges being brought against 111 individuals who allegedly

defrauded the Medicare program out of $225 million through false billing claims and kickback operations.

As a proud supporter of the Affordable Care Act, which contained essential funding and new tools for agencies to fight health care fraud, I am especially pleased that the HEAT initiative has recently expanded to Chicago.

Again, I thank the witnesses for joining us today, and look forward to their testimony and to this hearing. I yield back the balance of my time.

Mr. GOWDY. Thank you, Mr. Davis.

Members may have 7 days to submit opening statements and extraneous material for the record.

We will now welcome our first panel of witnesses. It is my pleasure to introduce them from my left to right.

Ms. Deborah Taylor is the chief financial officer and the director of the Office of Financial Management at the Centers for Medicare and Medicaid Services.

Dr. Peter Budetti is deputy administrator for program integrity and director of the CMS Center for Program Integrity at the Centers for Medicare and Medicaid Services.

Mr. Gerald Roy is deputy inspector general for investigations in the Office of Inspector General at the U.S. Department of Health and Human Services.

And the Honorable Loretta Lynch is the U.S. attorney for the Eastern District of New York.

I will, as is customary, ask the witnesses to rise and receive the oath, and then we will hear from you.

Raise your right hands.

[Witnesses sworn.]

Mr. GOWDY. May the record reflect that all the witnesses answered in the affirmative.

Thank you.

And I am sure that you all are familiar with this process. There should be three lights that are reasonably visible to you. The yellow light is kind of a slowdown light, and the red light, particularly given the time, and in fact, we have another panel, I would ask you to adhere to that as closely as you can.

And starting with Ms. Taylor, we will have 5 minutes for opening statements. Your full statement will be made part of the record. So if you don't get to all of it, don't think for one moment that it won't be read. It will be.

So we will start with Ms. Taylor and then work our way down the table.

STATEMENTS OF DEBORAH TAYLOR, CHIEF FINANCIAL OFFICER, AND DIRECTOR OF THE OFFICE OF FINANCIAL MANAGEMENT, CENTERS FOR MEDICARE & MEDICAID SERVICES; PETER BUDETTI, M.D., DEPUTY ADMINISTRATOR FOR PROGRAM INTEGRITY, AND DIRECTOR OF THE CMS CENTER FOR PROGRAM INTEGRITY, CENTERS FOR MEDICARE & MEDICAID SERVICES; GERALD T. ROY, DEPUTY INSPECTOR GENERAL FOR INVESTIGATIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; AND LORETTA E. LYNCH, U.S. ATTORNEY FOR THE EASTERN DISTRICT OF NEW YORK

STATEMENT OF DEBORAH TAYLOR

Ms. TAYLOR. Good afternoon, Chairman Gowdy, Ranking Member Davis, and members of the subcommittee.

Thank you for the opportunity to discuss the Center for Medicare and Medicaid Services' efforts to prevent and recover improper payments.

CMS is committed to reducing waste and abuse in the Medicare program, and ensuring that our programs pay the right amount for the right service to the right person in a timely manner. It is important to remember that most errors are not fraud.

These errors generally result from the following situations: One, a provider fails to submit any documentation or submits insufficient documentation to support the services paid; second, services provided are incorrectly coded on the claim; and, third, documentation submitted by the provider shows the services were not reasonably necessary. CMS is committed to reducing improper payments, and we have developed many corrective actions to resolve and eliminate these improper payments in the future.

CMS has extensive prepayment edits and other review activities to identify some improper payments. However, with close to 5 million claims being processed each day, CMS cannot manually review every claim before it is paid, so we must rely on other techniques.

One important tool in our efforts to recover improper payments is the recovery audit program. In this program, recovery auditors work to identify overpayments and underpayments in the Medicare program. Recovery auditors are paid on a contingency fee basis, which means they are paid based on a percentage of the total amount of claims they correct.

The Medicare Modernization Act of 2003 required that we establish a recovery audit demonstration to pilot the potential usefulness of recovery auditing in the Medicare fee for service program. During the demonstration project, the recovery auditors corrected over $1 billion in improper payments, including returning and collecting overpayments in the sum of $990 million.

Congress expanded the recovery audit program in the Tax Relief and Health Care Act of 2006, directing CMS to implement a national recovery audit program by January 2010. We considered the lessons learned from the demonstration in establishing the national program. It was important that we design a national program around five key elements: Minimizing provider burden, ensuring accuracy of the auditor's determinations, establishing an efficient and effective process, tracking and correcting program

vulnerabilities, and ensuring program transparency. I would like to talk a little bit about some of the specific actions we took.

To address provider burden issues related to voluminous requests for medical records, we established limits to the number of medical records an auditor could request from a provider within a 45-day time period. We also required that every recovery auditor hire a physician medical director. This gives physicians additional assurance that the claim denial decisions are accurate. To improve program transparency, we created a recovery audit Web site. This Web site contains valuable information to providers about where errors are occurring and the reason for those errors.

And, last, we wanted to address recovery audit concerns around pervasive incentives to overidentify improper payments. So now we require that recovery auditors must refund any contingency fee related to decisions overturned on appeal.

Although the national program is relatively new, we have already seen significant benefits from it. To date, the program has collected or corrected a total of $365 million in improper payments. Of that, $313 million is related to overpayments that have been collected.

Another benefit of the program is identifying vulnerabilities where policy changes, system changes, and provider education and outreach are needed to prevent improper payments in the future. We are taking aggressive actions to address these vulnerabilities, and we have done many systems changes to stop payments from going out the door. I am confident that the national recovery program and ongoing corrective actions we have in place will continue to reduce improper payments.

Thank you. And I look forward to any questions you may have.

[The prepared statement of Ms. Taylor follows:]

STATEMENT OF

PETER BUDETTI, M.D., J.D.
DEPUTY ADMINISTRATOR AND DIRECTOR,
CENTER FOR PROGRAM INTEGRITY
CENTERS FOR MEDICARE & MEDICAID SERVICES

AND

DEBORAH TAYLOR
CHIEF FINANCIAL OFFICER AND DIRECTOR,
OFFICE OF FINANCIAL MANAGEMENT
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

"WASTE AND ABUSE IN GOVERNMENT HEALTH CARE"

BEFORE THE

UNITED STATES HOUSE COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM, SUBCOMMITTEE ON HEALTH CARE, DISTRICT OF COLUMBIA, CENSUS AND THE NATIONAL ARCHIVES

APRIL 5, 2011

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

U.S. House Committee on Oversight and Government Reform
Subcommittee on Health Care, District of Columbia, Census and the National Archives
Hearing on "Waste and Abuse in Government Health Care"
April 5, 2011

Chairman Gowdy, Ranking Member Davis, and Members of the Subcommittee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) efforts to reduce fraud, waste, and abuse in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

The Administration is committed to reducing waste and improper payments across the government. On November 20, 2009, President Obama issued Executive Order 13520 calling on all Federal agencies to reduce waste and improper payments across Federal programs and CMS is working hard to carry out the Order. In addition, the Administration announced last year that CMS will cut the Medicare FFS improper payment rate in half by 2012. CMS is making progress in meeting this goal, with a 1.9 percent point reduction in the error rate between FY 2009 and FY 2010.

In order to reduce improper payments and fight fraud within Federal health care programs, CMS is implementing a number of measures that will shift our enforcement and administrative efforts from a "pay and chase" mode to the prevention of fraudulent and other improper payments. This shift involves many different activities, which we are carrying out with ongoing corrective actions and the powerful new anti-fraud tools provided to CMS and our law enforcement partners under the Affordable Care Act.

Background on Improper Payments

Like other large and complex Federal programs, Medicare, Medicaid, and CHIP are susceptible to payment, billing and coding errors—called "improper payments." While these improper payments represent a fraction of total program spending, any level of

improper payment is unacceptable and CMS is aggressively working to reduce these claims processing, coding, and documentation errors.

When discussing improper payments, it is important to clarify what these billing anomalies are – and are not. Improper payments can result from a variety of assorted circumstances, including: 1) services with no documentation, 2) services with insufficient documentation, 3) incorrectly coded claims, or 4) services provided that were not determined "reasonable and necessary." Further, so-called improper payments do not always represent an unnecessary loss of Medicare, Medicaid, or CHIP funds. They are usually not fraudulent nor necessarily payments for inappropriate claims; rather, they tend to be an indication of errors made by the provider in filing a claim or inappropriately billing for a service. Most improper payments by providers and suppliers are classified as such because they relate to claims where the information in the medical record did not support the services billed. Examples of common payment errors made by Medicare providers include services that were performed in a medically unnecessary setting,[1] or were incorrectly coded.[2] Other payment errors result when providers or suppliers fail to submit documentation when requested, fail to submit adequate documentation to support the claim, or when Medicare pays a claim that should have been paid by a different group health plan or other liable party.

Medicare's claims payment systems have a series of automated edits to identify inappropriate claims, and the automated systems can detect and reject payment for medical services that are physically impossible, such as a hysterectomy billed for a male beneficiary. Additionally, CMS has developed "medically unlikely" payment systems edits, which catch services when the quantity billed exceeds acceptable clinical limits. Further, to help reduce medical necessity errors, which occur when documentation submitted by a provider or supplier does not sufficiently establish the beneficiary's

[1] Medically unnecessary setting: Medicare claims fall into this category when services are provided in a more intensive (and expensive) setting than is considered reasonable and necessary by Medicare. For example, if a minor surgery is done in an inpatient hospital setting on a healthy beneficiary, instead of in an outpatient setting, the entire claim is classified as an "improper payment."

[2] Incorrect coding: Claims are placed into this category when providers submit medical documentation that support a lower or higher code than the code submitted. (CMS Improper Medicare Fee-For-Service Payments Report, https://www.cms.gov/CERT/10_CERT_Reports_and_Data.asp#TopOfPage).

medical need for an item or service, CMS has developed Comparative Billing Reports, which compare a provider's billing pattern for various procedures or services to their peers on a State and national level.

Background on Program Integrity

In addition to reducing the improper payment rate, CMS recognizes the importance of having strong program integrity initiatives that will deter and end criminal activity that attempts to defraud Federal health care programs. We share Congress' 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 continuing to incorporate targeted screening and prevention activities into our claims and enrollment processes where appropriate. Our goal is to keep those individuals and companies that intend to defraud Medicare, Medicaid, and CHIP out of these programs in the first place, suspend payment on suspect claims before money goes out the door, and remove such individuals and companies from our programs if they do get in. The first step to preventing fraud in the Federal health care programs is to appropriately screen providers and suppliers who are enrolling or revalidating their enrollment to verify that only legitimate providers and suppliers who meet new stringent enrollment standards are providing care to program beneficiaries.

CMS' Enhanced Efforts to Reduce Fraud, Waste, and Abuse

Recovery Audit Program

Recovery Audit Program in Medicare FFS: The Recovery Audit program is an important tool in CMS' efforts to detect improper payments and thereby reduce waste in Federal health care programs. The Recovery Audit program began as a limited State demonstration project required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.[3] Congress expanded the Recovery Audit program in the Tax Relief and Health Care Act of 2006, directing CMS to implement a permanent national

[3] CMS began this demonstration in Florida, California, and New York in 2005, and later expanded to Massachusetts, South Carolina, and Arizona.

Recovery Audit program in Medicare FFS by January 1, 2010. Recovery Auditors work to identify overpayments and underpayments in previously submitted and paid claims; per the statute, these contractors are paid on a contingency fee basis.

The demonstration project helped CMS identify improvements to the Recovery Audit program that were made before expanding to the permanent national program. During the demonstration, providers expressed concerns that filling multiple requests for medical records for review created a burden. As a result, CMS created sliding scale limits, based on provider size, for the number of medical records that can be requested by Recovery Auditors from a provider. Additionally, every Recovery Auditor is now required to hire a physician medical director, which gives providers additional assurance that the reviews of their medical decisions are accurate and handled appropriately. Recovery Auditors must now also secure pre-approval from CMS of issues they wish to pursue for review - meaning that before a Recovery Auditor can proceed with large numbers of reviews, CMS staff, and if necessary, a third party independent reviewer, must examine and approve the proposed provider type, error type, policy violated and potential improper payment amount per claim to ensure that the review is appropriate. In addition, to provide greater incentive for accurate identification of improper payments, CMS now requires Recovery Auditors to refund contingency fees for any decision overturned on appeal. Further, CMS has also ensured accuracy by hiring an independent Recovery Audit Validation Contractor. The Recovery Audit Validation Contractor provides external validation and helps ensure the accuracy of the Recovery Auditor claim determinations by conducting independent, third-party reviews of improper payments identified by the Recovery Auditors. The Recovery Audit Validation Contractor reviews potential automated audit areas and makes suggestions for the approval or rejection of proposed automated audits. This contractor also reviews the Recovery Auditors' processes including assessing demand letters for clarity, accuracy, and completeness.

Recovery Auditors have proven successful at identifying and correcting improper payments made by CMS. In the demonstration project, Recovery Auditors corrected $1.03 billion in improper payments, including approximately $990 million in

overpayments collected. The permanent Medicare FFS Recovery Audit program, as of March 1, 2011, has corrected a total of $261.5 million in improper payments, including $43.6 million in underpayments corrected and $217.9 million in overpayments collected.

More importantly, the Recovery Auditors also help CMS identify areas where policy changes, systems changes, and provider education and outreach can help prevent future improper payments. CMS employs a robust system to identify patterns in the vulnerabilities identified by Recovery Auditors and to undertake appropriate corrective actions. During the demonstration, Recovery Auditors identified a number of improper payments in claims related to inpatient rehabilitation facilities (IRF). CMS recognized that the Agency's policy was outdated and published a regulation (CMS 1538-F) to update the policy and also conducted extensive provider education to ensure that providers bill IRF claims correctly. In the national program, Recovery Auditors have identified several areas where edits can be helpful in preventing improper payments. CMS is implementing edits to stop the payment of claims for services provided after a beneficiary's date of death, to stop payments for durable medical equipment while the beneficiary is receiving care in an inpatient setting, and to stop the payment for individual services that should have been bundled into another payment. In addition, the claim processing contractors have been able to implement local system edits to stop improper payments relating to durable medical equipment bundling (wheelchair and accessories and knee prosthetics) and drugs paid exceeding recommended dosages.

However, some vulnerabilities cannot be fixed with automated edits and may require ongoing medical review and other more resource intensive activities. As such, the President's FY 2012 Budget Request includes a legislative proposal that would allow CMS to retain a dedicated portion of the funds recovered by Recovery Auditors to implement additional corrective actions to prevent future improper payments, such as targeted prepayment review and provider education. Funding these activities to prevent future improper payments is estimated to generate net savings of $230 million over 10 years.

Recovery Audit Program in Medicare Parts C and D: The Affordable Care Act expanded the Recovery Audit program to Medicare Parts C and D and the Medicaid program, and CMS is drawing from the lessons learned from the Medicare FFS Recovery Audit program as we implement this new statutory authority. In January 2011, CMS awarded a contract to identify incorrect payments and recoup overpayments in Medicare Part D. Additionally, we are seeking public comment through a solicitation issued on December 27, 2010 in the Federal Register on innovative strategies for review of additional Medicare Parts C and D data, including the effectiveness of sponsors' anti-fraud plans.

Recovery Audit Program in Medicaid: To implement the expansion of the Recovery Audit program to Medicaid included in the Affordable Care Act, CMS issued a State Medicaid Director letter in October 2010 that offered initial guidance on the implementation of the Medicaid Recovery Audit requirements and also published a Notice of Proposed Rulemaking on November 10, 2010. To date, CMS has provided significant technical assistance to States through all-State calls and webinars and has begun the coordination with States that have Recovery Audit contracts in place, as required by the statute. Further, on February 17, 2011, CMS launched a Medicaid Recovery Audit Contractor At-A-Glance web page on the CMS website.[4] The page provides basic information to the public and interested stakeholders about each State's Recovery Audit program.

Medicare, Medicaid, and CHIP Screening and Fraud Prevention Rule (CMS-6028-FC)

On January 24, 2011, HHS and CMS announced a rule that implements new Affordable Care Act tools to fight fraud, strengthen the integrity of Medicare, Medicaid, and CHIP, and protect taxpayer dollars. This rule became effective March 25, 2011, and puts in place important prevention safeguards that will help CMS move beyond the "pay and chase" approach to fighting fraud.

[4] https://www.cms.gov/medicaidracs/home.aspx

Enhanced Screening and Enrollment Protections: The Affordable Care Act requires providers and suppliers who wish to enroll in the Medicare, Medicaid, or CHIP programs to undergo a level of screening tied to a categorical level of risk of fraud, waste, or abuse such providers and suppliers present to the programs. This new rule requires high-risk providers and suppliers, including newly enrolling suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) and newly enrolling home health agencies, to undergo a higher level of scrutiny based on CMS' and law enforcement's experience with these provider and supplier types. CMS has also established certain triggers that would move a provider or supplier into the higher screening levels.

In addition, CMS-6028-FC implements the Affordable Care Act provision that authorizes CMS to require that providers who order and refer certain items or services for Medicaid beneficiaries be enrolled in the State's Medicaid program; this is similar to the new Medicare requirement included in CMS-6010-IFC published last spring, which also requires all providers of medical or other items or services and suppliers that qualify for a National Provider Identifier (NPI) to include their NPI on all applications to enroll in Federal health care programs and to also include their NPI on all claims for payment submitted to Medicare and Medicaid.

CMS-6028-FC also implements the statutory authority for CMS to impose a temporary enrollment moratorium if the Secretary determines such a moratorium is necessary to prevent or combat fraud, waste, or abuse. We plan to assess the impact of any proposed moratorium on beneficiary access, and publish a notice including the rationale for the moratorium in the *Federal Register*. Other preventive measures include new levels of coordination between Medicare and State Medicaid agencies. For example, State Medicaid programs are now required to terminate a provider that has been terminated by Medicare or another State Medicaid agency.

Stopping Payment of Suspect Claims: CMS-6028-FC allows Medicare payments to be suspended from providers or suppliers if there is a credible allegation of fraud pending an

investigation or final action. The law also requires States to suspend payments to Medicaid providers where there is a credible allegation of fraud. This enhanced authority will help prevent taxpayer dollars from being used to pay fraudulent providers and suppliers.

New Resources to Strengthen Program Integrity: The Affordable Care Act provides an additional $350 million over 10 years, plus an inflation adjustment, to ramp up program integrity efforts in HHS' Health Care Fraud and Abuse Control program (HCFAC) account, including the Medicare Integrity Program, as well as the Medicaid Integrity Program. These dedicated Program Integrity funds provide important financial resources for government-wide health care fraud and abuse efforts for the next decade, which will be used by CMS and our law enforcement partners along with discretionary funding sought in the President's Budget to pursue critical new prevention-focused activities, place more "feet on the street" by hiring more law enforcement agents, and facilitate other efforts to address emerging fraud schemes in the Federal health care system.

Guidance on Self-Disclosure of Actual or Potential Violations of Physician Self-Referral Statute

In September 2010, CMS published the Voluntary Self-Referral Disclosure Protocol (SRDP) on its website to enable providers and suppliers to disclose actual or potential violations of the physician self-referral statute (Section 1877 of the Social Security Act). The SRDP contains instructions for providers and suppliers who make self-disclosures, and advises that the Affordable Care Act gives the Secretary the discretion to reduce the amount due and owing for a violation of the physician self-referral statute. The SRDP states the factors CMS may consider in reducing the amounts due and owing, including: (1) the nature and extent of the improper or illegal practice; (2) the timeliness of the self-disclosure; (3) the cooperation in providing additional information related to the disclosure; (4) the litigation risk associated with the matter disclosed; and (5) the financial position of the disclosing party.

Fiscal Year 2012 Budget Request

To continue the Administration's focus on fraud and improper payment prevention and to build on the new authorities and resources provided by the Affordable Care Act, the President's Fiscal Year 2012 Budget Request includes a package of program integrity legislative proposals across Medicare, Medicaid, and CHIP that will save $32.3 billion over 10 years. These proposals, if enacted, would provide CMS with additional tools to reduce and prevent improper payments and ensure that those committing fraud are held responsible and cannot easily discharge their debts or reenter our programs to commit additional offenses.

In addition, the FY 2012 Budget Request also includes a little over $1.85 billion for the HCFAC account, including mandatory and discretionary sources, divided between CMS' programs and our law enforcement partners at the HHS Office of Inspector General and the Department of Justice. The FY 2012 discretionary HCFAC request is $581 million, a $270 million increase over the FY 2010 enacted level. Described in more detail below, these new HCFAC resources would support and advance the goals of the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative, a joint Cabinet-level effort established by the President and led by Secretary Sebelius and Attorney General Holder. The Budget Request is necessary to continue expanding the Medicare Fraud Strike Forces—an integral part of HEAT, as well as expanding civil health care fraud enforcement activities. Further, if provided by Congress, this discretionary HCFAC funding will allow us to expand prevention and detection activities and work to reduce improper payments with aggressive pre-payment review, increased provider education, and the development of a national pre-payment edit module.

HCFAC Program Successes

HCFAC has been steadily growing since it began in 1997 and, as shown in the recently released FY 2010 HCFAC report, this investment in fraud fighting resources is paying dividends. The HCFAC report demonstrates the value of this program; in FY 2010 alone, the program resulted in a record $4 billion in recoveries. The HCFAC return-on-

investment (ROI) is currently the highest it has ever been; the 3 year rolling ROI (FY 2008- FY 2010) averaging all HCFAC activities is $6.8 to $1; this is $1.9 more than the historical average. Additionally, the ROI for the Medicare Integrity Program's activities is 14 to 1.

HCFAC funds support HEAT and many complementary anti-fraud initiatives, including:

- **DOJ-FBI-HHS-OIG-Medicare Strike Forces:** This coordinated effort is needed in order to focus enforcement resources in geographic areas at high risk for fraud. Strike Force cases are data driven, using technology to pinpoint fraud hot spots through the identification of unusual billing patterns as they occur.
- **Increased Prevention and Detection:** CMS is committed to working with law enforcement to efficiently use existing systems and collaborate on future improvements, and has provided numerous training sessions for law enforcement personnel on CMS data analytic systems.
- **Expanded Law Enforcement Strategies:** HCFAC will further expand existing criminal and civil health care fraud investigations and prosecutions, particularly related to fraud schemes in areas such as pharmaceutical services, medical devices, and durable medical equipment, as well as newly emerging schemes. It will allow the use of cutting-edge technology in the analysis of electronic evidence to better target and accelerate enforcement actions. Finally, the increase will expand Medicare and Medicaid audits and OIG's enforcement, investigative, and oversight activities.
- **Oversight:** HCFAC will help to further strengthen oversight in Medicare, Medicaid, and CHIP.

We are excited about the tools and resources available to CMS through HCFAC. In particular, because of changes in the Affordable Care Act, we will now have flexibility to utilize HCFAC funds to enhance our own expertise for pursuing fraud, waste, and abuse in Medicare.

Engaging Our Beneficiaries and Partners to Reduce Fraud, Waste, and Abuse

Meanwhile, HHS and CMS continue to work with and rely on our beneficiaries and collaborate with our partners to reduce fraud and catch overpayments in Medicare, Medicaid, and CHIP. The Senior Medicare Patrol (SMP) program, led by the Administration on Aging (AoA), empowers seniors to identify and fight fraud through increased awareness and understanding of Federal health care programs. This knowledge helps seniors protect themselves from the economic and health-related consequences of Medicare and Medicaid fraud, waste, and abuse. In partnership with State and national fraud control/consumer protection entities, including Medicare contractors, State Medicaid Fraud Control Units, State Attorneys General, the HHS OIG, and CMS, SMP projects also work to resolve beneficiary complaints of potential fraud. Since the program's inception, the program has educated over 3.84 million beneficiaries in group or one-on-one counseling sessions and has reached almost 24 million people through community education outreach events. CMS is partnering with AoA to expand the size of the SMP program and put more people in the community to assist in the fight against fraud.

In addition to working with AoA on expanding the SMPs, CMS is implementing a number of new mechanisms to better engage beneficiaries in identifying and preventing fraud. As part of that effort, CMS encourages our beneficiaries to check their Medicare claims thoroughly. Medicare Summary Notices (MSNs) are sent to Medicare beneficiaries every 90 days; CMS is working with beneficiaries to redesign the MSNs to make them easier to understand so beneficiaries can spot mistakes, potential fraud, or overpayments on claims submitted for their care. Additionally, some 10 million beneficiaries are enrolled into www.mymedicare.gov, a secure website, and can now check their claims within 24 hours of the processing date. This information is also available through the 1-800-MEDICARE automated phone system. A fact sheet and informational card have been developed to educate and encourage beneficiaries or caregivers to check their claims frequently and to report any suspicious claims activity to Medicare. These materials are being used at the regional fraud prevention summits (described below) and have been shared with senior advocates at State Health Insurance Plans (SHIPs) and SMPs.

Another of these fraud, waste, and abuse detection improvements involves modifications to the 1-800-MEDICARE call center procedures. In the past, if a caller reported that they did not recognize a provider or did not receive the service documented on their Medicare Summary Notice form, they were asked to follow up with the provider prior to filing a fraud complaint. However, now 1-800-MEDICARE will review the beneficiary's claims records with them and if the discrepancy is not resolved, CMS takes action and files a complaint immediately, regardless of whether the caller has attempted to contact the provider. Also, CMS is using the information from beneficiaries' complaints in new ways. For instance, CMS is generating weekly "fraud complaint frequency analysis reports" that compile provider-specific complaints and flag providers who have been the subject of multiple fraud or abuse complaints for a closer review. This is just one example of CMS using our available data in more proactive ways.

Further, CMS is implementing a number of new educational and awareness initiatives in identifying and preventing fraud among those Americans who receive services under the Medicaid program.

Collaborating with Law Enforcement Partners and the Private Sector

CMS is committed to working with our law enforcement partners, who take a lead role in investigating and prosecuting alleged fraud. CMS provides support and resources to the Strike Forces, which investigate and track down individuals and entities defrauding Medicare and other government health care programs. Strike Force prosecutions are "data driven" and target individuals and groups actively involved in ongoing fraud schemes. These efforts started in Miami in 2007 and expanded to Los Angeles in 2008. In 2009 and 2010 under the HEAT initiative, we continued expanding the Strike Force concept to Detroit, Houston, Brooklyn, Tampa and Baton Rouge using the additional discretionary funding that Congress provided in response to the President's budget requests. On February 17, 2011, we announced further expansion of Medicare Fraud Strike Force operations to Dallas and Chicago. HEAT has enhanced coordination of anti-fraud efforts across DOJ's Civil and Criminal Divisions and U.S. Attorneys' Offices,

FBI, HHS/OIG and CMS. The HEAT task force is working to identify new enforcement initiatives and areas for increased oversight and prevention, including how to increase efficiency in pharmaceutical and medical device investigations.

The Strike Force model has been very successful. Since its inception, Strike Force operations in nine cities have charged more than 1000 individuals who collectively have falsely billed the Medicare program for more than $2.3 billion. This figure includes the Medicare Strike Force's latest successes, announced on February 17, 2011, charging 114 individuals with more than $225 million in false Medicare billing.

Sharing information and performance metrics broadly and engaging internal and external stakeholders requires establishing new partnerships with government and private sector groups. Because the public and private sectors have common challenges in fighting fraud and keeping fraudulent providers at bay, it makes sense that we should work together to develop common solutions. In addition to the HEAT initiative, agencies including HHS, CMS, OIG, and DOJ have co-hosted a series of regional summits on health care fraud prevention.

Building on the momentum generated by the National Health Care Fraud Summit in January 2010, regional health care fraud prevention summits have been held across the country. These summits, held to date in Miami, Los Angeles, New York, Boston, and Detroit with plans for additional cities, have brought together Federal and State officials, law enforcement experts, private insurers, beneficiaries, caregivers, and health care providers to discuss innovative ways to eliminate fraud within the nation's health care system. These summits have also featured educational panels that discussed best practices for providers, beneficiaries, and law enforcement in preventing health care fraud. The panels included law enforcement officials, consumer experts, providers and representatives of key government agencies. CMS looks forward to continuing these summits in 2011 as well as more opportunities to bring these stakeholder communities together in other cities to continue this important dialogue and strengthen our cooperative efforts across the Federal government and with the private sector.

CMS has hosted well-attended Provider Interaction Sessions at these regional health care fraud prevention summits, as well as multiple Open Door Forums and other professional outreach activities to discuss the impact of new Affordable Care Act requirements with physicians and other medical professionals. This communication has demonstrated physicians' and other practitioners' strong interest in working with CMS and HHS in eliminating fraud, waste and abuse in the federal health care programs. CMS has demonstrated its commitment to continuing and improving these conversations; a Medical Officer was recently hired to be a liaison for providers on program integrity issues and activities.

Improving CMS' Data Analytic Capabilities

The Affordable Care Act also requires increased data sharing between Federal entities to monitor and assess high risk program areas and better identify patterns of improper payments and potential sources of fraud. CMS is expanding its Integrated Data Repository (IDR) which is currently populated with five years of historical Part A, Part B, and Part D paid claims, to include near real time pre-payment stage claims data; this additional data will provide the opportunity to analyze previously undetected indicators of aberrant activity throughout the claims processing cycle. CMS intends to develop shared data models and is pursuing data sharing and matching agreements with the Department of Veterans Affairs, the Department of Defense, the Social Security Administration, and the Indian Health Service to identify potential fraud, waste, and abuse throughout Federal health care programs. Also, the Affordable Care Act requirement that States report an expanded set of data elements from their Medicaid Management Information System (MMIS) will strengthen CMS' program integrity work both within State Medicaid programs and across CMS. This robust State data set will be harmonized with Medicare claims data in the IDR to detect potential fraud, waste and abuse across multiple payers.

CMS will implement an innovative risk scoring technology that applies effective predictive models to Medicare. Innovative risk scoring technology applies a combination of behavioral analyses, network analyses, and predictive analyses that are proven to effectively identify complex patterns of fraud and improper claims and billing schemes. CMS is integrating the advanced technology as part of an end-to-end solution that may trigger effective, timely administrative actions by CMS as well as referrals to law enforcement when appropriate. Prior to applying predictive models to claims prepayment, CMS will rigorously test the algorithms to ensure a low rate of false positives, allowing payment of claims to legitimate providers without disruption or additional costs to honest providers; confirm that the algorithms do not diminish access to care for legitimate beneficiaries; and identify the most efficient analytics in order to appropriately target resources to the highest risk claims or providers. Given the changing landscape of health care fraud, any successful technology will need to be nimble and flexible, identifying and adjusting to new schemes as they appear.

As we pursue and test new technology, CMS is working to involve the private sector and State partners to incorporate strategies that have already proven successful. As the first phase of partnership building with private sector entities, CMS held an industry day in October 2010 that was attended by approximately 300 industry representatives. This event highlighted CMS' strategic goals, priorities, and objectives in the use of information technology solutions for fraud prevention in our programs and provided an opportunity for attendees to determine whether their firm's services, methods and products fit with CMS' mission and vision. In December 2010, the CMS Center for Program Integrity (CPI) issued a Request for Information asking vendors to identify their capabilities in the areas of provider screening/enrollment and data integration. CMS is in the process of reviewing the responses and will incorporate innovative ideas into a strategy for integrated, automated, providers screening and data integration.

Further, the Small Business Jobs Act of 2010 provided $100 million, beginning in FY 2011 to phase-in the implementation of predictive analytics in Medicare FFS, Medicaid, and CHIP over four years. The new predictive modeling technology will incorporate

lessons learned through pilot projects. For example, in one pilot, CMS partnered with the Federal Recovery Accountability and Transparency Board (RATB) to investigate a group of high-risk providers. By linking public data found on the Internet with other information, like fraud alerts from other payers and court records, we uncovered a potentially fraudulent scheme. The scheme involved opening multiple companies at the same location on the same day using provider numbers of physicians in other states. The data confirmed several suspect providers who were already under investigation and, through linkage analysis, identified affiliated providers who are now also under investigation.

Delivery System Reforms

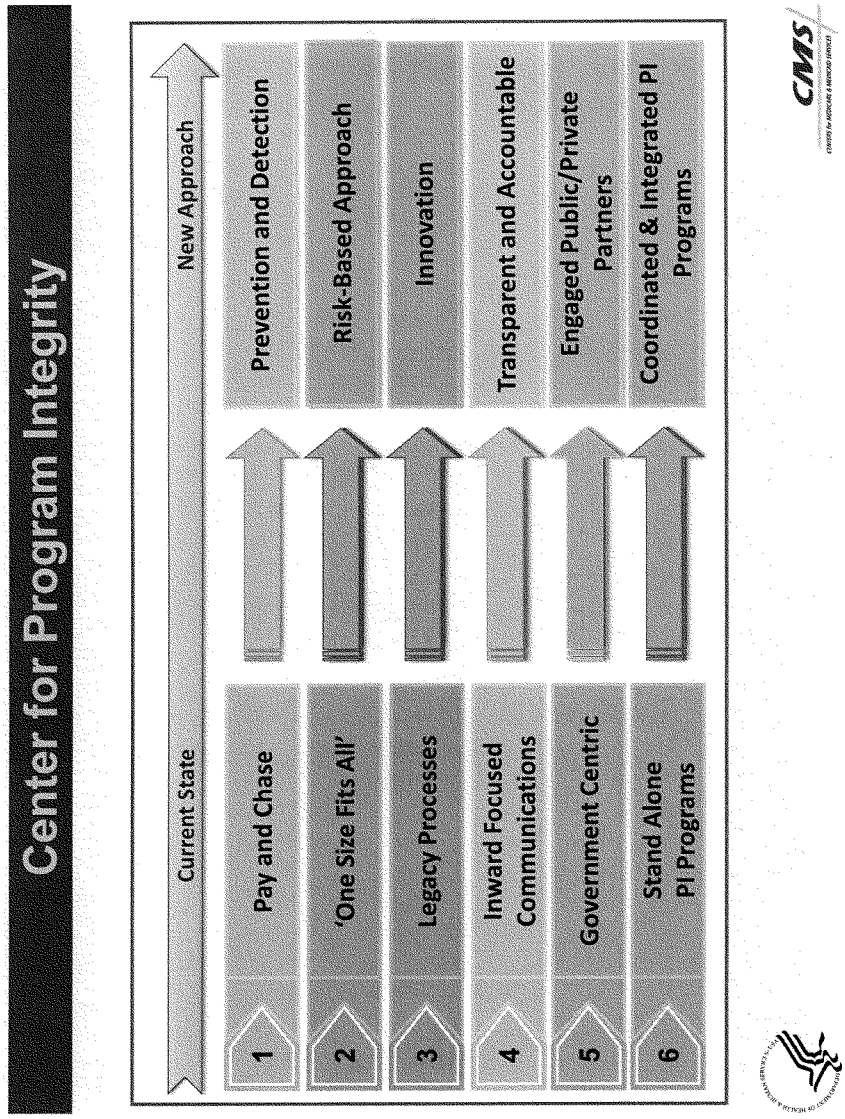
Beyond the traditional program integrity initiatives, delivery system reforms, including those created by the Affordable Care Act, will further help to deter and prevent fraudulent activities within Medicare. When there are large disparities between the cost of goods and services, as compared to the allowed reimbursement, we know that these excessive payments often make Medicare a more attractive and lucrative target for those attempting to commit fraud. For instance, OIG, the Government Accountability Office (GAO), and other independent analysts have repeatedly highlighted that the fee schedule prices paid by Medicare for many DMEPOS items are excessive, as much as three or four times the retail prices and amounts paid by commercial insurers or cash customers. These inflated prices in turn increase the potential profits of those intending to defraud the Medicare program. To that end, CMS implemented supplier contracts and new payment rates based on the Round 1 rebid of DMEPOS competitive bidding on January 1, 2011 in nine Metropolitan Statistical Areas. The Office of the Actuary estimates that once fully implemented this program is projected to save more than $17 billion in Medicare expenditures over ten years. Outside of DMEPOS, CMS is working to redesign our Medicare payment systems and institute delivery system reforms that will realign Medicare payments with market prices and thereby reduce the incentive for "bad-actors" to target Medicare.

All of these new authorities and analytical tools will help move CMS beyond its historical "pay and chase" mode to a prevention-oriented approach with strong fraud deterrents and increased enrollment screenings, new disclosure and transparency guidelines, and early identification of high-risk providers and suppliers.

Conclusion

Health care fraud and improper payments undermine the integrity of Federal health care programs. Taxpayer dollars lost to fraud, waste, and abuse harm multiple parties, particularly some of our most vulnerable seniors, not just the Federal government. Eliminating the problem requires a long-term, sustainable approach that brings together beneficiaries, health care providers, the private sector, and Federal, State, and local governments and law enforcement agencies, in a collaborative partnership to develop and implement long-term solutions. New authorities in the Affordable Care Act offer additional front-end protections to keep those who intend to commit fraud out of Federal health care programs, as well as new tools for deterring wasteful and fiscally abusive practices, and promptly identifying and addressing fraudulent payment issues, which will ensure the integrity of Medicare, Medicaid, and CHIP.

This Administration has made a firm commitment to rein in fraud and wasteful spending, and with the Affordable Care Act, we have more tools than ever before to implement important and strategic changes. CMS thanks the Congress for providing us with these new authorities and resources, and looks forward to working with you in the future as we continue to make improvements in protecting the integrity of Federal health care programs and safeguarding taxpayer resources.


Center for Program Integrity
Current State
New Approach
1
Pay and Chase
Prevention and Detection
2
'One Size Fits All'
Risk-Based Approach
3
Legacy Processes
Innovation
4
Inward Focused Communications
Transparent and Accountable
5
Government Centric
Engaged Public/Private Partners
6
Stand Alone PI Programs
Coordinated & Integrated PI Programs
CMS

Mr. DOWDY. I thank you.
Dr. Budetti.

STATEMENT OF PETER BUDETTI, M.D.

Dr. BUDETTI. Chairman Gowdy, Ranking Member Davis, members of the subcommittee, thank you for this opportunity to discuss our work at the Centers of Medicare and Medicaid Services to reduce fraud, waste, and abuse in our programs. I am delighted to be here accompanied by my colleague Deborah Taylor from the CMS, Deputy Inspector General Roy, and U.S. Attorney Lynch, who are very close colleagues in the fight against fraud, waste, and abuse.

From the first day that I had the privilege to take this job a little over a year ago, I have been asked two questions: Why do we let crooks into our programs? And why do we keep paying them after they get into the program when we think their claims are fraudulent?

I am pleased to tell you that with the new authorities that have been provided in recent laws and the commitment of this administration to fight fraud in our programs, we will be keeping the people who don't belong there out of our programs, and we will be rejecting fraudulent claims before they are paid. We now have the flexibility to tailor our resources to the most serious problems and to quickly initiate activities that will be transformative in bringing about the results that I mentioned.

Under the leadership of Secretary Sebelius, Centers for Medicare and Medicaid Services have taken several administrative steps to better meet emerging needs and challenges in fighting fraud and abuse. CMS consolidated the Medicare and the Medicaid program integrity groups under a unified Center for Program Integrity, which I have the privilege to direct. This allows us to pursue a more coordinated and integrated set of program integrity activities across both programs. This has served both our program integrity activities well, this reorganization, as well as our ability to collaborate with our law enforcement colleagues in the Office of Inspector General and the Department of Justice.

The Affordable Care Act greatly enhanced this organizational change by providing us with the opportunity to jointly develop Medicare, Medicaid, and CHIP policies on these new authorities. Affordable Care Act provisions, such as enhanced screening requirements apply across the programs, and this ensures better consistency in CMS's approach to fraud prevention.

Some might believe that an organizational change is of questionable value, but I can tell you that creating a Center for Program Integrity that is on par with other major operational units within the Centers for Medicare and Medicaid Services sends a powerful message about our serious commitment to fighting fraud and also puts the bad actors on notice.

We have made sure that our sights are fixed on the goals that we want to accomplish, and I would draw your attention to the chart that illustrates our new approach that we are pursuing.

No. 1, we are embarking on a number of changes that will allow us to move beyond our traditional way of fighting fraud, which is

known as pay and chase, to prevent problems in the first place and to avoid them from occurring.

Second, we will not take a monolithic approach to dealing with fraud. We are focusing on the bad actors who pose an elevated risk of fraud.

Third, we are taking advantage of innovation and sophisticated new technology as we focus on prevention.

Fourth, consistent with this administration's commitment to being transparent and accountable, we are developing performance measures that will specify our targets for improvement.

Five, we are actively engaging public and private partners because there is much to learn from others who are engaged in the same endeavor of fighting fraud in health care programs.

And, sixth, we are committed to coordination and integration among all of the CMS programs, drawing on best practices and lessons learned.

We are concentrating our actions so that we are doing a better job of preventing bad actors from enrolling in the first place, avoiding fraudulent or other improper payments, and working to achieve the President's goal of cutting the error rate in Medicare parts A and B by 50 percent by 2012. We are taking advantage of today's cutting-edge tools and technologies to help us at the front end and throughout the implementation of our programs.

In doing this, one point bears stressing. We are mindful of the necessity to be fair to health care providers and suppliers who are our partners in caring for beneficiaries, and to protect beneficiary access to necessary health care services. We will always respect the fact that the vast majority of health care providers are honest people who provide critical health care services to millions of CMS beneficiaries every day.

Mr. Chairman, I welcome this opportunity to appear before the subcommittee, and I look forward to your questions. Thank you very much.

Mr. GOWDY. Thank you, Doctor.

Mr. Roy.

STATEMENT OF GERALD T. ROY

Mr. ROY. Good afternoon, Chairman Gowdy, Ranking Member Davis, and distinguished members of the subcommittee. I am Gerald Roy, Deputy Inspector General for Investigations at the U.S. Department of Health and Human Services Office of Inspector General. Thank you for the opportunity to discuss fraud within the Medicare and Medicaid programs.

OIG is committed to protecting the integrity of more than 300 programs administered by HHS. The Office of Investigations employs over 450 highly skilled special agents who utilize state-of-the-art investigative technologies and a wide range of law enforcement actions. We are the Nation's premier health care fraud law enforcement agency.

Over the past 16 years, I have served in every capacity from field agent to the special agent in charge of the Los Angeles region to agency head. It is from this perspective that I will share my observations and experiences.

As a new OIG agent in 1996, I investigated a case that took me from Southern California to Miami. I gathered evidence on a father and daughter team that had worked for several years to steal almost $1 million. The investigation and the prosecution took more than 3 years. The father, a former drug dealer, told us he found stealing from Medicare far safer and more lucrative than trafficking.

Their scheme was simple. They used handwritten lists of beneficiary numbers to submit paper claims for durable medical equipment they never provided. Both ultimately pled guilty to health care fraud and conspiracy charges.

Sixteen years later, I see this same general scheme on a grander, more sophisticated scale. Today, such schemes go viral. That is, they replicate, spread quickly, with national implications.

Perhaps the most challenging and disturbing trend is the infiltration of Medicare by sophisticated organized criminal networks and violent criminals, who have little fear of law enforcement and view prison time as a badge of honor.

In Los Angeles, Eurasian organized criminals rely on stolen physician identities and compromised beneficiary numbers to perpetrate fraud. In 2003, we had nearly 2,500 compromised beneficiary numbers shared electronically around Southern California. By 2007, that number was well in excess of 100,000.

With these compromised numbers, criminals can steal well over $1 million in 90 days without ever filing a single sheet of paper or providing a single service. In one case, they had ties to employees at a Medicare provider enrollment.

These pictures you see here show weapons seized during a health care fraud search warrant. When I joined OIG, this criminal element and their tactics were unheard of. Throughout my tenure at OIG, major corporations and institutions have committed health care fraud on a grand scale.

Today, what is most troubling is the possibility that some unethical health care corporations build civil fines and penalties into their cost of doing business. They may believe they are too big to be fired, as to do so may compromise the welfare of our beneficiaries. As long as the profit from fraud outweighs punitive costs, abusive behavior is likely to continue.

Built on trust, Medicare has allowed enrollment of any willing provider and fraud perpetrators have exploited this. OIG has long advocated strengthening enrollment standards, making participation a privilege, not a right.

Also, those who steal from Medicare often perceive a low risk of detection and minimal penalties compared to street-level crimes. However, reinvigorated partnerships and an emphasis on this issue by our stakeholders, including DOJ and CMS, reinforce my belief that a sustained effort will make significant strides toward eradicating fraud. Together, we are utilizing new techniques to combat fraud. We now catch criminals in the act, conduct investigations and prosecute offenders in a fraction of the time.

At OIG, we protect the Nation's most vulnerable citizens and the Federal health care programs they depend on. OIG special agents diligently and effectively investigated health care fraud long before

this issue hit the national spotlight. We will be here for the American taxpayers, even if that spotlight fades.

However, from my perspective, we cannot afford to let up. Sustained efforts and continued interest by law enforcement, prosecutors, CMS, Capitol Hill, and the American taxpayers is paramount to our future success.

Thank you.

[The prepared statement of Mr. Roy follows:]

Testimony before the United States House of Representatives

Committee on Oversight and Government Reform

Subcommittee on Health Care, DC, Census and the National Archives

Hearing on:
"Waste, Abuse and Mismanagement in Government Health Care"

Testimony of:

Gerald T. Roy
Deputy Inspector General for Investigations
Office of Inspector General
U.S. Department of Health & Human Services

April 5, 2011
1:30PM
2154 Rayburn House Office Building

Testimony of:
Gerald T. Roy
Deputy Inspector General for Investigations
Office of Inspector General, U.S. Department of Health & Human Services

A PERSPECTIVE ON FRAUD, WASTE, AND ABUSE WITHIN THE MEDICARE AND MEDICAID PROGRAMS

Good afternoon Chairman Gowdy, Ranking Member Davis, and distinguished Members of the Subcommittee. I am Gerald Roy, Deputy Inspector General for Investigations at the U.S. Department of Health & Human Services' (HHS) Office of Inspector General (OIG). I thank you for the opportunity to discuss fraud, waste, and abuse within the Medicare and Medicaid programs. Today, I will discuss this issue from the perspective of a law enforcement officer with over 20 years of law enforcement experience, including 16 years of working health care fraud violations.

OIG's Role and Partners in Protecting the Integrity of Medicare and Medicaid

OIG's mission is to protect the integrity of the more than 300 programs administered by HHS. Approximately 80 percent of OIG's resources are dedicated to promoting the efficiency and effectiveness of federally funded health care programs and protecting these programs and our beneficiaries from fraud, waste, and abuse.

OIG employs more than 1,700 dedicated professionals, including a cadre of over 450 highly skilled criminal investigators trained to conduct criminal, civil, and administrative investigations of fraud and abuse related to HHS programs and operations. Our special agents have full law enforcement authority to effectuate the broad range of available law enforcement actions, including the execution of search and arrest warrants. We use state-of-the-art technologies and a wide range of law enforcement tools in carrying out these important responsibilities. We are the Nation's premiere health care fraud law enforcement agency.

Our constituents are the American tax payers, and we work hard to ensure that their money is not stolen or misspent. Thanks to the work of our dedicated professionals, over the past fiscal year, OIG opened over 1,700 health care investigations and obtained over 900 criminal convictions and civil actions. OIG investigations also have resulted in over $3.7 billion in expected criminal and civil recoveries during that time period.

Background

On May 3, 1995, President Clinton announced Operation Restore Trust, a 2-year partnership of Federal and State agencies tasked with protecting the Medicare and Medicaid programs through shared intelligence, coordinated law enforcement, and enhanced quality of care for our program beneficiaries. Under this program, I joined OIG in October of 1995 in the San Diego Field Office after serving for nearly 5 years as a Special Agent with the U.S. Treasury Department. As an OIG Special Agent, I successfully investigated a wide variety of health care fraud matters, including cases

involving durable medical equipment (DME) schemes, ambulance transportation fraud, and corporate fraud.

Once promoted to the position of Assistant Special Agent in Charge (ASAC) in the Los Angeles Region, I began to see organized criminal enterprises entering into the lucrative field of Medicare fraud. The sophisticated nature of organized criminal enterprises in the Los Angeles area facilitated unprecedented levels of fraud, and in a span of 3 to 4 years, their concentrated efforts would have a nationwide adverse impact on Medicare.

I was promoted to Special Agent in Charge in the Los Angeles Region in October 2006. I cultivated a law enforcement environment and worked to increase public awareness of OIG agents as law enforcement officers. During this time, for example, I recognized that OIG was ill equipped to unilaterally deal with the burgeoning organized crime issue. We lacked the historical knowledge of these criminal elements and experience in fighting the street-level tactics they incorporated into health care fraud. For the first time in OIG history, I assigned agents to organized crime task forces, and we combined our expertise to tackle the problem head on. In addition to taking such innovative approaches to investigations, I laid the foundation to establish the Medicare Fraud Strike Force teams in Los Angeles before my departure to OIG Headquarters.

Since December of 2007, I have held executive-level positions in the Office of Investigations (OI), OIG Headquarters in Washington, DC. I have spearheaded OIG's collaboration and coalition building with HHS, Congress, the Department of Justice (DOJ), and Medicaid Fraud Control Units, among other stakeholders, and solidified OIG agents' role as the Federal health care fraud law enforcement experts.

Today, I hold the position of Deputy Inspector General of Investigations. I am the senior official responsible for supervising the functions of OI. I manage, direct, and coordinate the operations and resources of OI, which includes a workforce of over 630 employees composed of criminal investigators, analysts and administrative staff. I have investigative oversight of nearly 900 billion dollars in departmental expenditures.

Over the past 16 years, I have served in every capacity available to a criminal investigator in OIG, and it is from this perspective that I will share with you my observations and experiences related to the prevalence of fraud, waste, and abuse within the Medicare and Medicaid programs.

Has Fraud Changed Within the Programs?

Some of the health care fraud schemes of 16 years ago are still used by today's criminals. These schemes include billing for services that were not provided or were not medically necessary, purposely billing for a higher level of service than what was provided, misreporting costs or other data to increase payments, paying illegal kickbacks, and/or stealing providers' or beneficiaries' identities. While many of today's health care fraud schemes continue to exploit vulnerabilities in the health care system, we are uncovering more and more fraud.

In early 1996, HHS Secretary Donna Shalala observed that many sectors of the Federal Government were experiencing a "frustrating time...amid the constraints imposed by the budget impasse and two consequent furloughs..." (Shalala, *Semi-Annual Report to Congress*, 1996). It was during this time that I opened an investigation into a San Diego-based company that was engaged in durable medical equipment (DME) fraud. The case took me from Southern California to Miami, Florida, as I gathered evidence on a father-daughter team that was perpetrating fraud on both coasts. The father-daughter team worked for several years to steal almost $1 million before the case was ultimately referred to OIG. Combined, the investigative and prosecution processes took in excess of 3 years. The father, a former drug dealer, told us he found stealing from Medicare far safer and more lucrative than his former occupation. Their scheme was simple: they used beneficiary lists that were photocopied or faxed amongst nursing homes and other fraud perpetrators to submit paper claims for DME they never provided. Both pled guilty to health care fraud and conspiracy charges. The father was sentenced to 5 months in prison and 2 years of probation. His daughter was sentenced to 3 years of probation.

Today, we see the same general scheme on a grander, more sophisticated scale. For example, when I moved to the Los Angeles Regional Office in 2003, the shared beneficiary list used in DME fraud circulating around Los Angeles was composed of approximately 2,500 Medicare beneficiary numbers. The numbers were often handwritten and traded on the streets of Los Angeles. When I departed Los Angeles in 2007 for Washington, DC, that list contained the names and numbers of well over 100,000 beneficiaries, and it was shared electronically among countless fraud perpetrators. With that list, Medicare fraud perpetrators can steal well over a million dollars in 90 days without ever filing a single sheet of paper. Today, we estimate that 270,000 Medicare beneficiary numbers have been compromised and may be employed by criminals as part of national fraud schemes.

Although there is no precise measure of health care fraud, we know that it is a serious problem that demands an aggressive and sustained response. Although the majority of health care providers are honest and well intentioned, a minority of providers who are intent on abusing the system can cost taxpayers billions of dollars. The perpetrators of these schemes range from street criminals, who believe it is safer and more profitable to steal from Medicare than trafficking in illegal drugs, to Fortune 500 companies that pay illegal kickbacks to physicians in return for Medicare referrals.

Organized Crime

Perhaps the most challenging and disturbing trend I have witnessed in my tenure at OIG is the rise of criminal enterprises in health care fraud. Medicare has been increasingly infiltrated by sophisticated, organized criminal networks and violent criminals.

For example, in Southern California, OIG special agents investigated an individual who set out to defraud the Medicare program by establishing multiple fraudulent DME companies. The owner used members of a street gang as nominee owners of his DME

companies, consistent with the organized crime model in which the crime boss uses foot soldiers as a front for his operations. He paid the gang members approximately $5,000 each to establish bank accounts and fill out Medicare enrollment paperwork. The nominee owners submitted claims for reimbursement to Medicare for power wheelchairs and orthotic devices that were not medically necessary or legitimately prescribed by a physician. The criminal records for the gang members involved in this fraud ranged from assault on a peace officer to drug trafficking. Nine of the gang members and associates were indicted for charges including health care fraud and providing false statements to government agents. Of the nine defendants, eight have pled guilty and are currently serving or have completed serving jail time for their crimes. Not only is this investigation an example of one of the more prevalent fraud schemes that we are seeing, but also it highlights multitiered schemes and sophisticated criminals entering the health care fraud arena.

Health care fraud criminals are acutely aware of the time it has historically taken Medicare program integrity contractors to discover something is amiss and inform OIG of their findings. They know they have 90 days to establish a provider number, open a bank account, and bill as much money as they can using the shared beneficiary lists. When 90 days are up, after billing Medicare for millions of dollars, they drop the provider number and empty the bank account to the best of their ability. Simultaneously, they work on establishing the next provider number and bank account. To assist in their efforts, many gang members have had insiders working at the banks to ensure that identification of account holders was difficult if not impossible. One of my agents and the Department of Justice also successfully investigated and prosecuted several individuals who worked at the Medicare provider enrollment unit in Los Angeles, who were paid to facilitate provider numbers for organized criminals. So well executed were their schemes that it was difficult identifying who these criminals actually were.

The emergence of organized crime has brought new investigative challenges and raised the level of violence. In Los Angeles, we found that Eurasian organized crime family members have little to no fear of law enforcement or our judiciary system. To them, a prison sentence is a badge of honor that is expected from each gang member at some point during a life of criminal activity. We have learned that once inside prison, Eurasian gang members can pay for personal safety using their ill-gotten gains from Medicare and recruit prisoners to act as nominee clinic and DME store owners upon their release.

The new criminal is also violent. As an ASAC in Southern California, I was once asked to assist an agent in a meeting with a criminal informant to whom we had given $10,000 to lure an elusive subject out in the open. We met at midnight at a predetermined location and waited for hours as the informant never showed. Three days later, I traveled with my agent to a community hospital 90 miles outside Los Angeles, where we had located our informant. He had been severely beaten and was so scared that he refused to cooperate further, citing not only his own safety, but that of his family. He chose to return to jail over cooperating with law enforcement.

If and when a fraud perpetrator goes outside the realm of the shared beneficiary list, we have increasingly witnessed the targeting of vulnerable beneficiaries within ethnic communities to facilitate the fraudulent actions. Our investigations have shown that fraud perpetrators are paying individuals within specific ethnic communities nominal amounts of money to secure the use of their Medicare or Medicaid identification numbers. Even worse, beneficiaries are being loaded into vans, taken to facilities and put through invasive procedures that are medically unnecessary; all for the purpose of fraudulently billing Federal health care programs. Often, language and cultural barriers impede fraud-fighting efforts in these communities.

Corporate Fraud

OIG established itself as the lead in corporate health care fraud investigations with the successful conclusion of the National Health Laboratory (NHL) investigation in 1992. The corporate entity settled civil false claims allegations for a then record-breaking $110 million. The company's chief executive also pled guilty to health care fraud. NHL billed Medicare for additional blood tests that were marketed to customers as part of a basic blood series. The deterrent effect associated with this case resonated throughout the corporate world. The message was sent and received: engage in corporate fraud activity and OIG will hold you accountable, both financially and criminally. Unfortunately, this message did not resonate for long, even in the wake of "Operation LabScam," the Government's concentrated effort to address clinical laboratory fraud nationwide. More than $800 million in recoveries later, corporate fraud continued.

How these cases are investigated has remained consistent over the years. Investigations of large corporations are often initiated after a "whistleblower" files a lawsuit on behalf of the Government, known as a "*qui tam*," alleging wrongdoing by the company. The allegations include information that the companies engaged in illegal activities that violated the False Claims Act. In doing so, the companies cause false claims to be submitted to Federal health care programs for payment. The investigations involve coordination among many Federal Government departments and agencies whose programs are alleged to have been harmed.

OIG often negotiates compliance obligations, known as corporate integrity agreements or CIAs, with health care providers and other corporate entities as part of the settlement of Federal health care program investigations arising under a variety of civil and administrative false claims statutes. Like the evolution of health care fraud, CIAs have also evolved to address specific aspects of corporate conduct. Current CIAs are much more tailored to address the deficiencies of the particular organization. For instance, there are CIA increased requirements that pertain to transparency; internal audits; and in the case of quality of care violations, very specific compliance measures that the entity must undertake.

The typical term of a comprehensive CIA is 5 years. These compliance measures seek to ensure the integrity of corporate activities and the Federal health care program claims

submitted by providers. Although many CIAs have common elements, each agreement addresses, in part, the specific facts of the conduct at issue.

To address large-scale corporate fraud, OIG has the authority to use one of the most powerful tools in our arsenal: exclusion from participating in Federal health care programs. Once we determine that an individual or entity is engaged in fraud or the provision of substandard care, program exclusion can be implemented. This tool bolsters our fraud-fighting efforts by removing from the Federal health care programs those who pose the greatest risk to programs and beneficiaries. I will discuss the impact of the exclusion process later in my testimony.

Today, what is most troubling to OIG is the possibility that some unethical health care corporations build in the cost of paying civil fines and penalties and implementing CIAs into their cost of doing business. Some hospital systems, pharmaceutical manufacturers, and other providers play such a critical role in the care delivery system that they may believe that they are "too big to fire" and thus OIG would never exclude them and thereby risk compromising the welfare of our beneficiaries. As long as the profit from fraud outweighs those costs, abusive corporate behavior is likely to continue.

Why Significant Health Care Fraud, Waste, and Abuse Continue

While our efforts have made a major impact on health care fraud, there is indeed a significant amount of fraud in our Federal health care programs. There are many reasons for this trend, including the pitfalls associated with a trust-based Federal health care system, low barriers to entry, lucrative targets, and the perception of low risk of detection and penalty.

Low Barriers to Entry Facilitate Fraud

Throughout my tenure at OIG, those who wish to steal from our program have enjoyed unfettered access to Federal health care programs. Since its inception, Medicare has been a program that allows "any willing provider" to provide services for beneficiaries. In other words, we have treated participation in our programs as a right, instead of a privilege. The Department has faced challenges in ensuring the integrity of the program's provider and supplier enrollment processes. While the majority of providers are innocent and provide invaluable services to beneficiaries, a small percentage of providers and suppliers intent on defrauding these programs have continuously exploited weaknesses in the enrollment process. Many of the criminals prosecuted in our Strike Force investigations have been able to defraud the program of millions of dollars because of these low barriers of entry. Without enhanced enrollment standards, such as proper background checks, these fraudulent providers and suppliers drain resources that should be spent on providing care to beneficiaries.

We have long advocated strengthening enrollment standards and making participation in Federal health care programs as a provider or supplier a privilege. Recently, the

Department has made strides in strengthening enrollment standards; and we will continue to work with the Department as it makes improvements in this area. It is more efficient and effective to protect the programs and beneficiaries from unqualified, fraudulent, or abusive providers and suppliers upfront than to try to recover payments or redress fraud or abuse after it occurs. Ensuring adequate and appropriate provider and supplier enrollment standards and screening is an essential first step to strengthening the integrity of the Medicare and Medicaid programs.

Low Risk of Detection and Lesser Penalties

Amongst the criminals who steal from Medicare, there is the perception of a low risk of detection. While organized crime figures use their 90-day window of opportunity to avoid being identified, other more brazen criminals discuss Medicare fraud openly on the streets as a safe and easy way to get rich quick.

We must make defrauding Federal health care programs less attractive by increasing the risk of swift detection and the certainty of punishment. As part of this strategy, law enforcement must accelerate the Government's response to fraud schemes. The Strike Force model has proved highly successful in this regard. The Medicare Fraud Strike Force is a critical component of the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative. Strike Forces are collaborative efforts, combining OIG's law enforcement skills and resources with those of our partners in the Federal Bureau of Investigation, Medicaid Fraud Control Units, and other State and local law enforcement agencies. Strike Force cases focus on the development and implementation of a technologically sophisticated and collaborative approach to combat fraud. Using this streamlined investigative approach, not only have Strike Force investigations enabled us to identify perpetrators of health care fraud earlier in their fraud schemes, but also we have significantly cut down the amount of time to fully adjudicate a case.

Additionally, there is the perception amongst criminals that if the fraud scheme is uncovered, the penalties are far less severe than imposed for other crimes. And while this may have been true in the recent past, this perception, however, is no longer reality.

During my tenure at OIG, I have seen significant changes to the sentencing guidelines, and prison sentences for health care fraud have increased significantly. And for these changes, I would like to thank the Committee and the Congress for being our strong ally in fighting health care fraud. In just the last 15 years, the Congress has enacted a number of Federal offenses that specifically target health care, including fraud[7][1] false statements,[2] theft or embezzlement,[3] money laundering,[4] and obstruction.[5] These

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[1] 18 U.S.C. § 1347
[2] 18 U.S.C. § 1035
[3] 18 U.S.C. § 669
[4] 18 U.S.C. § 1956
[5] 18 U.S.C. § 1518

offenses are all important tools for law enforcement in prosecuting a Federal health care case. Thanks to you and your colleagues, wrongdoers also can now be required to forfeit property derived from the commission of health care fraud.[6] And just last year, the Affordable Care Act directed the U.S. Sentencing Commission to dramatically increase the Federal sentencing guidelines for health care fraud offenses, especially those that involve large losses.[7] The Commission issued draft amendments for comment early this year. In addition to enacting these strong criminal enhancements, the Congress strengthened the Government's civil remedies by amending the Federal False Claims Act in 2009 and 2010. All of these changes improved the Government's ability to pursue fraud, waste, and abuse in the Federal health care programs. These laws make clear that the Congress and the Federal executive branch are joined in an effort to identify and stop fraudulent practices, punish the wrongdoers, and recapture the funds lost to fraud.

Through the Strike Force, we are seeing the positive effects of these more stringent guidelines with more and longer sentences mandating time in prison. According to DOJ, in fiscal year 2010, more than 94 percent of Strike Force defendants were convicted; of which 86 percent received prison terms. The average prison term for Strike Force defendants was over 40 months. This is more than double the 1995 average prison term for health care fraud violations investigated by OIG.

Sustained Law Enforcement Efforts Are Critical to Success

Operation Restore Trust, the Government's first national antifraud effort, is one of many examples of OIG's efforts to hold perpetrators of health care fraud accountable. Operation Restore Trust was responsible for $187 million in recoveries, 74 criminal convictions, 58 civil settlements, and 218 exclusions from Federal health care programs. The lessons learned during Operation Restore Trust, including the importance of collaboration, have been critical to our ongoing antifraud initiatives. Its stated goals are similar to those of today's HEAT initiative. The HEAT initiative, established by Secretary Kathleen Sebelius and Attorney General Eric Holder in May 2009, is an unprecedented partnership that brings together senior officials from both Departments with the stated goals of sharing information, spotting fraud trends, coordinating prevention and enforcement strategies, and developing new fraud prevention tools.

Operation Restore Trust produced many important results. In addition to resulting in enforcement actions and recoveries, the Operation built and strengthened relationships among law enforcement agencies and within HHS. It also provided a foundation for the creation of the Health Care Fraud and Abuse Control (HCFAC) Program, which continues to be the main source of funding for OIG's fraud-fighting efforts.

However, after Operation Restore Trust concluded, external attention to health care fraud waned and some of the same fraud problems reemerged. This "pilot program" was never

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[6] 18 U.S.C. § 982
[7] ACA, § 10606

expanded beyond the original five States of California, Texas, Florida, Illinois, and New York. Data from the Centers for Medicare & Medicaid Services reveal that Operation Restore Trust reduced expenditures in fraud hotspots on which it focused -- home health and DME. However, as interest waned from those outside OIG, expenditures in those two arenas began a steady climb. In the years that followed, the fraud problem was burgeoning, with modifications to old schemes going "viral" and organized criminals discovering new ways to exploit the programs.

Making an Impact on Fraud

While I consider the state of health care fraud to be at a critical level, reinvigorated partnerships and an emphasis on this issue by various stakeholders reinforces my belief that a concerted, sustained effort will make significant strides towards eradicating health care fraud, waste, and abuse. Together, with our law enforcement partners, we are using new techniques to combat fraud. For example, the Medicare Fraud Strike Forces under HEAT are concentrating antifraud efforts in geographic areas at high risk for Medicare fraud and implemented new processes regarding the identification of health care fraud cases and the manner in which they are investigated and prosecuted. Coincidentally, we find ourselves running Strike Forces in the same five Operation Restore Trust States: California, Texas, Florida, Illinois, and New York. We have also added Michigan and Louisiana to the list. Strike Force cases focus on the development and implementation of a technologically sophisticated and collaborative approach. By using Medicare data early in the investigative process, we can spot fraud as it is occurring and catch those criminals who, for years, operated in anonymity. If my DME fraud case from 1996 were to be investigated using the Strike Force model, the combined investigative and prosecution processes associated with the father-daughter team would be less than a year. Most likely, their prison sentences would have been significantly increased.

From a law enforcement perspective, we are making a substantial impact on fraud. In February, HEAT Strike Forces engaged in the largest Federal health care fraud takedown in history. Teams across the country arrested over 100 defendants in 9 cities, including doctors, nurses, health care company owners and executives, and others, for their alleged participation in Medicare fraud schemes involving more than $225 million in false billing. More than 300 special agents from OIG participated in partnership with other Federal and State agencies. The defendants charged as a part of the operation are accused of various health-care-related crimes ranging from violating the anti-kickback statute to money laundering, to aggravated identity theft.

As of March 31, 2011, our Strike Force efforts nationwide have charged over 840 defendants; obtained over 420 convictions; and secured over $380 million in court-ordered restitutions, fines, and penalties.

We are focusing on corporate fraud as well. One way to address the "too big to fire" issue discussed above is to alter the cost-benefit calculus of the corporate executives who run these companies. By excluding the individuals who are responsible for the fraud, either directly or because of their positions of responsibility in the company that engaged

in fraud, we can influence corporate behavior without putting patient access to care at risk. For example, in 2008, we excluded three former executive officers of the pharmaceutical company Purdue Frederick based on their convictions for misbranding of the painkiller OxyContin. Each of the executives was convicted based on his status as a responsible corporate officer.

As I mentioned earlier, OIG also has the discretionary authority to exclude certain owners, officers, and managing employees of a sanctioned entity (i.e., an entity that has been convicted of certain offenses or excluded from participation in the Federal health care programs) even if the executive has not been convicted of a crime. This authority, section 1128(b)(15) of the Social Security Act, allows OIG to hold responsible individuals accountable for corporate misconduct. OIG has used this exclusion authority in over 30 cases since it was added to the statute in 1996. But until recently, we had typically applied this exclusion authority to individuals who controlled smaller companies, such as pharmacies, billing services, and DME companies and not to executives of large complex organizations like a drug or device manufacturer.

We intend to use this essential fraud-fighting tool in a broader range of circumstances. For example, in addition to excluding the Purdue Frederick executives, we recently excluded an owner (and former executive) of Ethex Corporation under our section (b)(15) exclusion authority. Ethex operated manufacturing facilities in St. Louis. In March of last year, Ethex pled guilty to felony criminal charges after it failed to inform the Food and Drug Administration about manufacturing problems that led to the production of oversized tablets of two prescription drugs. The owner was excluded for 20 years.

We are mindful of our obligation to exercise this authority judiciously, and we do not propose to exclude all officers and managing employees of a company that is convicted of a health-care-related offense. However, when there is evidence that an executive knew or should have known of the underlying criminal misconduct of the organization, OIG will operate with a presumption in favor of exclusion of that executive. We have published guidance on our Web site that sets out factors we will consider when determining whether a section (b)(15) exclusion should be imposed in a particular case.[8] This guidance alerts health care providers and executives to the standards of ethical conduct and responsibility to which they will be held accountable by OIG. Even if we decide exclusion of a major health care entity is not in the best interests of Federal health care programs and their beneficiaries, we may decide that executives in positions of responsibility at the time of the fraud should no longer hold such positions with entities that do business with the programs.

Conclusion

From a law enforcement perspective, Medicare and Medicaid are under siege by fraud perpetrators from all walks of life. And as some 70 million "baby boomers" near

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[8] Available online at http://oig.hhs.gov/fraud/exclusions/files/permissive_excl_under_1128b15_10192010.pdf.

retirement, the Medicare rolls will grow and the workforce that supports the program with taxes will shrink. In years to come, controlling fraud, waste, and abuse will play a considerable role in ensuring the solvency of our Federal health care programs that were put in place to ensure that our children, senior citizens, the disabled, and low income citizens have adequate health care.

In my tenure at OIG, I have never seen a more focused spotlight on this important issue. The partnerships between OIG, DOJ, and the Centers for Medicare & Medicaid Services are strong. The potential to make a lasting impact on fraud, waste, and abuse has never been better.

Our motto in the Office of Investigations is simple and powerful: Mission Focus. We understand that we protect the Nation's most vulnerable citizens and the Federal health care programs on which they depend. OIG Special Agents diligently and effectively investigated health care fraud long before the issue hit the national spotlight. We will be here for the American taxpayers if the spotlight is no longer focused on this important issue. But I submit that it is not in this Nation's best interest to let our attention wane.

From my perspective, we cannot afford to let up on our efforts. Sustained funding sources and continued interest from Congress and American taxpayers are paramount to our future success.

Mr. GOWDY. Thank you, Mr. Roy.
We will now recognize Madam U.S. attorney, Ms. Lynch.

STATEMENT OF LORETTA E. LYNCH

Ms. LYNCH. Thank you.
And good afternoon, Chairman Gowdy, Ranking Member Davis, and distinguished members of the subcommittee.
Thank you for inviting me to speak with you today about the Department of Justice efforts to combat health care fraud. I am honored to appear before you on behalf of the Department of Justice along with my colleagues from HHS, OIG, and CMS.
As you know, the U.S. attorneys and their assistant U.S. attorneys are the principle prosecutors of Federal crimes, including health care fraud. We represent the Department of Justice and the interests of the American taxpayer in both criminal and civil cases in the Federal courts in the 94 judicial districts across the country.
The Department's civil attorneys, both in the U.S. Attorneys Offices and the Department's Civil Division, aggressively pursue civil enforcement actions to root out fraud and recover funds stolen in health care fraud schemes.
Since the year 2000, the U.S. Attorneys Offices working with our civil division colleagues, as well as with the FBI, HHS, OIG, and other Federal, State, and local law enforcement agencies, have recovered over $1 billion every year on behalf of defrauded Federal health care programs. And in fiscal year 2010, the Department secured approximately $2½ billion in civil health care fraud recoveries, more than in any other previous year.
Working with our colleagues in the Criminal Division, our criminal health care fraud efforts have also been a tremendous success. In fiscal year 2010, this departmentwide coordination led to the largest number of criminal health care fraud convictions since the inception of the HCFAC program. Today, our criminal enforcement efforts are at an all-time high. In fiscal year 2010, the Department brought criminal charges against 931 defendants and secured 726 criminal health care fraud convictions.
The Medicare Fraud Strike Force is a supplement to the Department's successful criminal health care fraud enforcement efforts and is currently operating in nine districts, including my own district of Brooklyn. Each district has allocated several AUSAs and support personnel to this important initiative, and partners with the Criminal Division attorneys as well as with agents from the FBI, HHS, and State law enforcement.
The strike force teams use data analysis techniques to identify aberrational billing patterns in strike force cities, permitting law enforcement to target emerging or migrating schemes, along with chronic fraud by criminals operating as health care providers or suppliers.
This model is working. The strike force initiative has been an unqualified success. In fiscal year 2010, the strike forces secured 240 convictions, more than in any other year of strike force operations.
EDNY strike force criminal prosecutions cover a variety of health care fraud schemes, including kickbacks to patients. The principle focus of the Medicare Fraud Strike Force in Brooklyn has been to shut down medical clinics that pay cash kickbacks to dual Medicare

and Medicaid beneficiaries to lure these beneficiaries to the clinics through the illegal use of transportation services reimbursed by Medicaid and then illegally bill Medicare for services either medically unnecessary or never provided. I have included three of those major cases in my written testimony.

Coordination of our health care fraud enforcement resources works. AUSAs and the U.S. Attorneys Offices, trial attorneys in the Civil and Criminal Divisions, FBI and HHS agents, as well as other Federal, State, and local law enforcement partners are working together across the country with great success.

Since the HCFAC program was established, working together, the two departments have returned over $18 billion to the Medicare trust fund. Over the life of the HCFAC program, the average return on investment [ROI], has been $4.90 for every dollar expended. Very good. But through our enhanced efforts over the past 3 years, the average ROI has been even higher. As reported in the HCFAC program's annual report for fiscal year 2010, the average ROI for 2008 through 2010 was actually $6.80 for every dollar expended, nearly $2 higher than the historical average.

We are poised to continue these successes in the months and years ahead, and we look forward to working with our Federal, State, and local partners to that end.

Mr. Chairman, thank you for this opportunity to provide this overview of the Department's health care fraud enforcement efforts.

[The prepared statement of Ms. Lynch follows:]

Department of Justice

STATEMENT

OF

LORETTA E. LYNCH
UNITED STATES ATTORNEY
EASTERN DISTRICT OF NEW YORK

BEFORE THE

SUBCOMMITTEE ON HEALTH CARE, DISTRICT OF COLUMBIA,
CENSUS AND THE NATIONAL ARCHIVES
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
UNITED STATES HOUSE OF REPRESENTATIVES

ENTITLED

"WASTE, ABUSE, AND MISMANAGEMENT IN GOVERNMENT HEALTH CARE"

PRESENTED ON

APRIL 5, 2011

Statement of
Loretta E. Lynch
United States Attorney
Eastern District of New York

Before the
Subcommittee on Health Care, District of Columbia, Census and National Archives
Committee on Oversight and Government Reform
United States House of Representatives

Entitled
"Waste, Abuse, and Mismanagement in Government Health Care"

Presented on
April 5, 2011

INTRODUCTION

Chairman Gowdy, Ranking Member Davis, and distinguished Members of the Subcommittee: Thank you for inviting me to speak with you today about the Department of Justice's efforts to combat health care fraud. I am honored to appear before you on behalf of the Department of Justice, along with my colleagues, Deborah Taylor, Peter Budetti, and Gerald Roy. The Department appreciates the opportunity to testify here today.

Health care fraud is a serious problem facing our country. It threatens the long term health of Medicare, as well as all federal, state and private health care programs. Every year the federal government spends hundreds of billions of dollars to provide health care to the most vulnerable of our society - our seniors, children, disabled individuals, and low-income individuals. We have a duty to ensure that these funds are spent on providing proper medical treatment to our citizens, and while most medical providers and health care companies are doing the right thing, there are some health care providers, as well as criminals, that target Medicare and other government and private health care programs for their own financial benefit. With the rising cost of medical care, every dollar stolen from our health care programs is one dollar too

many. Medicare and Medicaid fraud can also corrupt the medical decisions health care providers make with respect to their patients, placing them at risk of harm from unnecessary or unapproved treatments. For these reasons, fighting health care fraud is a priority of the Department of Justice. Through its United States Attorneys' Offices, Civil, Criminal and Civil Rights divisions and the Federal Bureau of Investigation (FBI) – the entities responsible for enforcing laws against all forms of health care fraud – the Department has enhanced its efforts to protect the public fisc from health care fraud and to help ensure the integrity of patient care.

FIGHTING MEDICARE AND MEDICAID FRAUD IS A PRIORITY OF THE DEPARTMENT OF JUSTICE

Because coordination across agencies is an integral part of preventing and prosecuting health care fraud, Attorney General Holder and Secretary Sebelius together have pledged to strengthen our fight against waste, fraud and abuse in Medicare and Medicaid. As you know, to improve that coordination, in May 2009, they announced the creation of the Health Care Fraud Prevention and Enforcement Action Team (HEAT) a senior level, joint task force, designed to marshal the combined resources of both agencies in new ways to combat all facets of the health care fraud problem. With the creation of HEAT, we re-committed to fighting health care fraud as a Cabinet- level priority for both DOJ and HHS, and our efforts have been extremely successful.

The Justice Department has a multi-faceted litigation approach to fighting health care fraud, with the U.S. Attorneys' Offices, FBI, Criminal, Civil, and Civil Rights Division, all contributing substantial resources to the effort. As you know, the United States Attorneys and their assistants, or AUSAs, are the principal prosecutors of federal crimes, including health care

fraud, representing the Department of Justice and the interests of the American taxpayer in both criminal and civil cases in the federal courts in the 94 judicial districts across the country.

U. S. ATTORNEYS' OFFICES' WORK WITH THE CIVIL DIVISION

The Department's civil attorneys – both in the United States Attorneys' Offices and the Department's Civil Division – aggressively pursue civil enforcement actions to root out fraud and recover funds stolen in health care fraud schemes, often through the use of the False Claims Act, 31 U.S.C. §§ 3729-3733, one of the Department's most powerful civil tools. Through its Office of Consumer Protection Litigation ("OCPL"), the Civil Division also invokes the Federal Food, Drug, and Cosmetic Act ("FDCA"), which authorizes both civil and criminal actions. OCPL pursues the unlawful marketing of drugs and medical devices, fraud on the Food andDrug Administration, and the distribution of adulterated products, among other violations. In FY 2010, OCPL's efforts yielded more than $1.8 billion in criminal fines, forfeitures, restitution, and disgorgement, the largest health care-related one-year recovery under the FDCA in Department history. Since 2000, the U.S. Attorneys' Offices, working with our colleagues in the Civil Division, as well as with the FBI, HHS-OIG, and other federal, state and local law enforcement agencies, have recovered over $1 billion every year on behalf of defrauded federal health care programs; in FY 2010 the Department secured approximately $2.5 billion in civil health care fraud recoveries, more than in any other previous year.

The attorneys in my own district, the Eastern District of New York (EDNY), with our colleagues in the Civil Division, have handled a wide variety of health care matters, including false billings by doctors, and other providers of medical services, overcharges by hospitals, Medicaid fraud, kickbacks to induce referrals of Medicare and Medicaid patients, fraud by pharmaceutical and medical device companies, and failure of care allegations against nursing

home owners. The following are two significant EDNY civil/criminal global settlements that were national in scope:

- **Quest Diagnostics Inc ("Quest")/Nichols Institute Diagnostics ("Nichols")**

  In April 2009, Quest and its subsidiary, Nichols, entered into a global settlement with the United States to resolve criminal and civil claims concerning various diagnostic test kits that Nichols manufactured, marketed and sold to laboratories throughout the country until 2006. The total payment of $302 million to the United States represented one of the largest amounts ever recovered in a case involving a medical device.

  As part of the criminal resolution, Nichols pled guilty to a felony misbranding charge in violation of the Federal Food, Drug and Cosmetic Act, 21 U.S.C. §§ 301 et seq. The charge related to the Nichols Advantage Chemiluminescence Intact Parathyroid Hormone Immunoassay (the "Intact PTH Assay"), which was used by laboratories throughout the country to measure parathyroid hormone levels ("PTH") in patients. In particular, this test was widely used by medical practitioners to determine if patients suffering from conditions such as End State Renal Disease were also suffering from hyperparathyroidism, a condition which involves the overactivity of the parathyroid glands and the release of excessive amounts of PTH. Common treatments for hyperparathyroidism include calcium and Vitamin D supplementation, and, under certain circumstances, the surgical removal of the parathyroid glands. As alleged in the Information that was filed in the criminal cases, there were periods of time in which the Intact PTH Assay provided elevated results of which the company was aware, but did not disclose or correct. As part of the criminal plea, Nichols paid a criminal fine of $40 million.

Quest and Nichols also entered into a civil settlement agreement with the United States pursuant to which Quest paid $262 million to resolve federal False Claims Act allegations relating to the Intact PTH assay and four other assays manufactured by Nichols. All of the assays allegedly provided inaccurate and unreliable results, thereby causing some clinical laboratories that purchased and used the Intact PTH and Bio-Intact PTH test kits to submit false claims for reimbursement to federal health programs, and some medical providers to submit false claims for reimbursement to federal health programs for unnecessary treatments.

- **Jazz Pharmaceutical, Inc. ("Jazz")/Orphan Medical, Inc. ("Orphan")**

  In July 2007, Jazz and its subsidiary, Orphan, entered into a $20 million global settlement with the United States to resolve criminal and civil claims concerning Orphan's allegedly illegal "off-label" marketing of the drug Xyrem for uses not approved by the FDA. The scheme allegedly induced physicians throughout the country to write prescriptions for Xyrem that were not reimbursable by private health insurers or public insurance programs like Medicare and Medicaid, and caused millions of dollars of losses to those insurers.

  As part of the criminal resolution, Orphan pled guilty to felony misbranding in violation of the Federal Food, Drug and Cosmetic Act, 21, U.S.C. §§ 331(a) and 333(a)(2), and paid restitution as well as a criminal fine. Jazz and Orphan also entered into a civil settlement agreement resolving the United States' civil False Claims Act allegations stemming from the allegedly illegal marketing scheme.

I also want to highlight a significant EDNY civil settlement involving one of our local hospitals:

- **Staten Island University Hospital ("SIUH")**

  In September 2008, the United States entered into a civil settlement with SIUH in which it paid the United States approximately $74 million to settle allegations that it defrauded federally funded insurance programs such as Medicare. SIUH also agreed to pay the State of New York approximately $14 million, representing damages sustained by the state's Medicaid program. The total recovery of over $88 million is one of the largest civil fraud recoveries ever against a single U.S. hospital. The civil settlement resolved allegations of fraudulent billing for inpatient alcohol and substance abuse detoxification treatment, as well as the hospital's use of incorrect billing codes to obtain reimbursement for cancer treatment that was not covered by Medicare.

U.S. ATTORNEYS' OFFICES' WORK WITH THE CRIMINAL DIVISION

Working with our colleagues in the Criminal Division, our criminal health care fraud efforts have also been a tremendous success. In FY 2010, this Department wide coordination led to the largest number of criminal health care fraud convictions since the inception of the Health Care Fraud and Abuse Control Program (HCFAC) program. Today our criminal enforcement efforts are at an all time high. In FY 2010, the Department brought criminal charges against 931 defendants, 16 percent more than in FY 2009. Moreover, we secured 726 criminal health care fraud convictions, approximately 24 percent more than in FY 2009. In total, last fiscal year the Justice Department opened 1,116 new criminal health care fraud investigations involving 2,095 potential defendants.

The Medicare Fraud Strike Force, a supplement to the Department's criminal health care fraud enforcement efforts, is currently operating in nine districts - Miami, Los Angeles,

Houston, Detroit, Tampa, Baton Rouge, Chicago, Dallas, and my own district, Brooklyn. Each district has allocated several AUSAs and support personnel to this important initiative and partner with the Criminal Division attorneys, as well as agents from FBI, HHS, and state law enforcement. The Strike Force teams use data analysis techniques to identify aberrational billing patterns in Strike Force cities, permitting law enforcement to target emerging or migrating schemes, along with chronic fraud by criminals operating as health care providers or suppliers. Federal agents and analysts review Medicare data and other intelligence information to identify potential targets that may be billing for fictitious or medically unnecessary services.

The Strike Force initiative has been an unqualified success. In FY 2010, the Strike Forces secured 240 convictions (217 guilty pleas and 23 trial convictions), more than in any other year of Strike Force operations. One goal of the Strike Forces is to identify targets using the "data-driven" approach described above, and then bring those cases as expeditiously as possible. This model is working. Cases are initiated and brought to conclusion quickly, and defendants are going to prison. In FY 2010, the average amount of time from indictment to sentencing in Strike Force cases was approximately 9 months; more than 94 percent of Strike Force defendants were convicted; and over 86 percent were sentenced to prison terms. Since HEAT's inception, the average prison term for Strike Force defendants is over 40 months.

Just last month, Attorney General Holder and Secretary Sebelius announced that charges had recently been brought in all nine Strike Force cities against more than 110 defendants - including doctors, nurses, health care company owners and executives. Just this one group of cases reflected over $225 million in fraudulent billings to the Medicare program. Typical Strike Force cases include schemes to submit claims to Medicare for treatments that were medically unnecessary or never provided; or allegations that patient recruiters, Medicare beneficiaries, and

other co-conspirators were paid cash kickbacks in return for supplying beneficiary information to providers so that those providers could submit false Medicare claims using the names of beneficiaries.

EDNY Strike Force criminal prosecutions cover a variety of health care fraud schemes, including kickbacks to patients. The principal focus of the Medicare Fraud Strike Force in Brooklyn has been to shut down medical clinics that pay cash kickbacks to dual Medicare-Medicaid beneficiaries to lure the beneficiaries to the clinics through the illegal use of transportation services reimbursed by Medicaid, and then illegally bill Medicare for services that were either medically unnecessary services or never provided. Three of the major prosecutions are:

- **Bay Medical**

  Nine individuals, including two physicians, were indicted for participating in a $72 million conspiracy to defraud the Medicare program by submitting fraudulent claims for physical therapy and other medical services that were medically unnecessary or were not provided to beneficiaries at all. The government's investigation included the use of a court-ordered camera and microphone hidden in a room at the clinic, identified as the "Kickback Room," in which the conspirators paid cash kickbacks to corrupt Medicare beneficiaries. The camera recorded the conspirators' payment of approximately one thousand bribes totaling more than $500,000 during a period of approximately six weeks from April to June 2010. The Kickback Room was marked "PRIVATE" and featured a poster depicting a woman with a finger to her lips and the words "Don't Gossip" in Russian. The purpose of the kickbacks was to induce the beneficiaries to receive unnecessary medical services or to remain silent when services not provided to the

patients were billed to Medicare. The conspirators obtained the money for the kickbacks by cashing checks drawn on clinic accounts that had been made payable to shell corporations.

- **Prime Care**

  Seven individuals, including a physician, several medical clinic owners, and three ambulette drivers, were charged with conspiracy to commit health care fraud, health care fraud, and conspiracy to pay health care kickbacks in connection with a $56.9 million scheme to defraud Medicare and Medicaid by submitting false and fraudulent claims for purported physical therapy services and diagnostic testing. Similar to the Bay Medical case, patients were paid kickbacks, but this time the payments were made in the ambulettes, as opposed to a dedicated room within the clinic.

- **Solstice**

  Four individuals were charged with a health care fraud conspiracy that operated out of the Solstice Wellness Center, a Queens clinic that purported to specialize in providing physical therapy and various diagnostic tests. Executives of the clinic recruited Medicare beneficiaries by paying cash kickbacks to induce those beneficiaries to be transported to and from Solstice, and to purportedly receive physicians' services, physical therapy and diagnostic tests. Fraudulent claims were then submitted to Medicare for services that were not actually rendered and that were not medically necessary.

A second criminal scheme that has been a focus of EDNY Strike Force prosecutions involves the submission of fraudulent claims to Medicare or private insurance companies for durable medical equipment. Major cases include:

- **Best Equipment**

  In July 2010, four individuals were arrested for their roles in a health care fraud conspiracy involving Best Equipment Medical Supply, Inc. in Brooklyn. Between 2006 and 2010, Best Equipment submitted to Medicare thousands of claims for orthopedic shoe inserts which patients were not eligible to receive. The investigation also revealed that the patients often did not receive the inserts at all and instead received ordinary shoes such as sneakers and sandals.

- **O2 Home Services**

  Three individuals were charged for their involvement in a $3.5 million scheme to defraud the Medicare and Medicaid programs by submitting fraudulent claims for durable medical equipment. One was the owner of an oxygen equipment services company, and the other two served as patient recruiters, who targeted local churches to find Medicare and Medicaid beneficiaries whose personal information the defendants would use for their fraudulent billings.

Finally, EDNY Strike Force investigations have focused on single doctor clinic fraud cases, including:

- **Dr. Boris Sachakov**

  Sachakov, a proctologist, practiced at Colon and Rectal Care of New York, P.C. in Brooklyn. Sachakov was charged with health care fraud in connection with a two-year scheme from January 2008 through January 2010 to defraud Medicare and numerous private health care benefit programs of approximately $22.5 million. Sachakov accomplished his fraudulent scheme in two ways. First, he billed for surgeries and other procedures that he never performed. Second, he improperly billed for various surgical

procedures separately that should have been billed together as part of the same surgical package. For the two-year period charged in the indictment, his total billings amounted to approximately $22.5 million: approximately $6,578,346 in claims to Medicare (approximately $4,465,003 of which were paid); and $16,008,850 in claims to private benefit programs (approximately $5,883,171 of which were paid.)

CIVIL RIGHTS DIVISION

The Civil Rights Division also plays an important role in the Department's efforts to protect the nation's health care system. The Special Litigation Section of the Civil Rights Division is responsible for enforcing the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997, *et seq*. CRIPA authorizes the investigation of conditions of confinement at state and local residential institutions and the initiation of civil actions for injunctive relief to remedy a pattern or practice of Constitutional or federal statutory violations at such institutions. The Affordable Care Act confers new subpoena power on the Attorney General to demand records and access to institutions when investigating claims under CRIPA, greatly assisting the Department in these important investigations of conditions that jeopardize the safety and welfare of some of our most vulnerable citizens.

FEDERAL BUREAU OF INVESTIGATION

The Justice Department's primary investigative and enforcement arm is the Federal Bureau of Investigation (FBI). Working closely with U.S. Attorneys' Offices and DOJ litigating components throughout the United States, the FBI serves to identify, investigate, and aid in the prosecution of health care fraud. With its large presence and extensive investigative authority, the FBI is uniquely positioned to investigate a broad spectrum of health care fraud activity.

First, by leveraging its 750 FBI personnel dedicated solely to health care fraud investigations, the FBI is able to aggressively address fraud not only in Strike Force locations, but also in any of the more than 450 locations where the FBI has investigative personnel stationed. Second, the FBI is the primary investigative agency involved in the fight against health care fraud that has jurisdiction over both the federal and private health care programs. The FBI not only collaborates with HHS-OIG investigative personnel and other government agencies, but has built established partnerships with Special Investigative Units from all of the country's major private insurance companies. Third, the FBI leverages its intelligence across its multiple investigative programs to identify and attack criminal enterprises that are turning to health care fraud as a mechanism to fund additional criminal activity.

Some of the FBI's recent successes include:

- In October 2010, in response to the growing threat posed to the health care system by organized crime groups, the FBI and HHS-OIG indicted 73 subjects, who operated over 160 clinics throughout the U.S. Fraudulent billings attributed to these groups exceeded $168 million.
- In January 2011, the FBI and the United States Attorney's Office for the District of Puerto Rico indicted 533 individuals in a scheme which defrauded a major private insurance company out millions of dollars.
- In February 2011, the Medicare Fraud Strike Force in Miami charged more than 20 employees of American Therapeutic Corporation (ATC) in a scheme involving more than $200 million in fraudulent billings to Medicare. This indictment was a precursor to the more than 110 health care fraud subjects that were indicted as part of Nationwide Strike Force Takedown two days after the ATC announcement.

The FBI is a key component of the Justice Department's efforts against health care fraud and is a vital piece in the increasing return on investment to the Medicare Trust Fund.

CONCLUSION

Coordination of our health care fraud enforcement resources works. AUSAs in the U.S. Attorneys' Offices, trial attorneys in the Civil and Criminal Divisions, FBI and HHS agents, as well as other federal, state and local law enforcement partners are working together across the country with great success. With the passage of the Health Insurance Portability and Accountability Act of 1996, Congress created the HCFAC Program under the joint direction of the Justice Department and HHS to coordinate federal, state, and local law enforcement activities with respect to health care fraud and abuse. Since the HCFAC Program was established, working together, the two Departments have returned more than $21.3 billion to the federal government, of which over $18 billion has been returned to the Medicare Trust Funds. Over the life of the HCFAC Program, this amounts to an average return on investment ("ROI") of $4.90 for every $1.00 expended. Through our enhanced efforts over the past three years, the average ROI has been even higher. As reported in the HCFAC Program's annual report for FY 2010, the average ROI for the period 2008-2010 was $6.80 for every $1.00 expended, nearly $2.00 higher than the historical average. We are poised to continue these successes in the months and years ahead, and look forward to working with our federal, state and local partners to that end.

Thank you for the opportunity to provide this overview of the Department's health care fraud enforcement efforts.

Mr. GOWDY. Thank you, ma'am.

I would at this point recognize the distinguished gentleman from Illinois, Mr. Davis, for 5 minutes of questions.

Mr. DAVIS. Thank you very much, Mr. Chairman.

And I want to thank each of the witnesses for their testimony.

Dr. Budetti, it seems to me that since the organization of CMS, that one of its primary focuses has been on cost containment, that there has been much conversation over an extended period of time about reducing the cost of health care and containing the cost. It has been difficult to do. What would you consider to be the primary elements of fraud in the Medicare, Medicaid programs?

Dr. BUDETTI. Thank you, Mr. Davis.

I think, as Mr. Roy alluded to, we have seen the evolution of a new generation of fraudsters in these programs. We have had problems with major health care entities, companies and delivery systems and so forth for many years, of course, but more recently what we have seen is the criminal element coming into the programs and taking advantage of the fact that Medicare and Medicaid really were open for providers and suppliers to join in order to take care of our beneficiaries as necessary. So we have seen a shift.

And I think that is a very troubling but important thing for us to recognize that now we are not just dealing with the kinds of problems that we faced in the past where somebody is going to be in business a few years down the road and we have a few years to track after them and audit them and try to recover or prosecute them, but where there are criminals who are going to disappear very quickly. So we need to be able to deal with both kinds of fraud these days and be nimble and stay ahead of the ones who just don't belong in the programs at all.

Mr. DAVIS. Are there loopholes in our system that not only attract but kind of give individuals the idea that there are ways to defraud the system?

Dr. BUDETTI. Well, I think one of the loopholes was not a loophole, but it was a deliberate part of the program which, as I mentioned, was a relative ease of getting providers and suppliers into the program so that they could take care of beneficiaries.

I think in terms of the way that programs are organized and structured and funded, however they are structured, somebody is going to look for vulnerabilities, and it has to be our job to stay ahead of them and to figure out where the vulnerabilities are. No matter how we organize and pay for health care, there are going to be people, unfortunately, who will try to steal from us, and they will look at however the money is flowing and try to figure out a way to go after that money. So I think we need to be aware of all of these incentives, the financial incentives, the organizational structures, every aspect of the program, but I think it is not unique to any aspect of it.

Mr. DAVIS. Attorney Lynch, let me ask you. There used to be a time, and I guess there still is, when there were what was called Medicaid mills, where practitioners just kind of had running streams of individuals coming through their clinics, and they were just seriously ripping off the public. Are we still finding those?

Ms. LYNCH. I think we are seeing attempts to recreate them. I think the benefits of the Department's recent efforts have been

partnering with CMS and HHS, we have been able to use techniques that get us quicker data so that we can and we hope to intercept these Medicaid and Medicare mills as they are operating and move in to shut them down quickly.

The problem of course is, as Dr. Budetti has intimated, is these organizations will spring up, close, and then reemerge under a different name. So with the increased tracking that we have been able to utilize with our partners, we think we are doing much better at finding these clinics and finding these doctors. But it is still a continual problem.

Mr. DAVIS. Quickly, Mr. Roy. Could you think of some recommendations, based upon your experiences, that might be helpful to implement as to further reduce the opportunities for fraud and abuse?

Mr. ROY. Yes, sir. Thank you for the question.

In my experience, and as I spoke to in my testimony, for me personally it all comes down to provider enrollment. It really comes down to ensuring that those people that come into our program are there to serve our Medicare beneficiaries.

It seemed to be a theme throughout my tenure at OIG that those who wish to perpetrate fraud recognize the low barrier to entry, and they exploit that to the maximum. So I would recommend a concentration on a provider enrollment to that aspect of the program.

Mr. DAVIS. Thank you very much.

Thank you, Mr. Chairman.

Mr. GOWDY. Thank you, Mr. Davis.

The chair would now recognize the gentleman from Arizona, Dr. Gosar.

Mr. GOSAR. Mr. Roy, could you agree with this description of fraud: Misusing a process to gain a financial advantage?

Mr. ROY. Yes, sir.

Mr. GOSAR. How about you, Ms. Lynch?

Ms. LYNCH. I think it is part of the description of fraud. Obviously, when it comes to criminal fraud, we would have to have intent requirements. But, yes, that is part of the description of fraud.

Mr. GOSAR. What if it was the government? Would that still qualify? In a process. Let me go a little deeper. How about that? How do we audit our federally qualified health centers? I am going to give you some personal experiences just so you know.

I am a dentist. I have been practicing 25 years until last year. Why on the WIC program would it take a single mom, most of the time, five or six visits to see the doctor, repeated entry, not on the same day? Why would we take a child with a full mouthful of decay and only allow one tooth be taken care of one at a time? Can you describe why would we do that? How about you, Doctor? You are talking about processes. What kind of process would mandate this kind of care?

Dr. BUDETTI. I am not familiar with those policies, Dr. Gosar. But——

Mr. GOSAR. Do you know what an encounter is?

Dr. BUDETTI. Yes, sir.

Mr. GOSAR. Why would that be misused?

Dr. BUDETTI. I can understand your concern if that is what you were observing.

Mr. GOSAR. I am alluding exactly to that. Why would we—what is the purpose of an encounter?

Dr. BUDETTI. The purpose of an encounter, sir, of course, is to deal with the patient and the issues the patient has and try to take care of them.

Mr. GOSAR. How about we take five different visits for a WIC woman to be able to fill out a health history? And that took 5 weeks, five different visits for an encounter. Would you not call that fraud?

Dr. BUDETTI. I am not familiar with the situation that you are describing, but that certainly doesn't strike me as the best way to go about the business of taking care of patients, sir.

Mr. GOSAR. When you look at processes, how do we review the process when we look at FQACs? You said that you are constantly are updating and looking at processes. How do we look at that process?

Dr. BUDETTI. In our area, sir, the work that we are doing focuses principally on both Medicare payments and Medicaid payments. And so we look at the way that the money flows and look for patterns of problems no matter where the money is going. So we intend to look no matter where the money is going.

I can't tell you that I am familiar with particular emphasis on the kinds of issues that you are talking about, but certainly we are looking at all of the ways that the money is flowing and the possibilities for problems like that.

Mr. GOSAR. What kind of audit do you on a federally qualified health center, or health center? And when are they done? Are they announced, or are they unannounced?

Dr. BUDETTI. I would have to get you specific information on that, sir. It is not something that I am personally familiar with at this point.

Mr. GOSAR. What if I was to tell you that it is standing procedure that what we do is we have standing patients that come in to seek services on Medicaid and they are supposed to be seen first come, first serve. And they sit all day long, and they just get transferred to a hospital. And they are isolated to one segment of the day? Wouldn't you call that fraud? It is a process. Right? An inappropriate process. Right?

Dr. BUDETTI. It sounds like a process that would need some attention to me, the way you describe it, sir, yes.

Mr. GOSAR. Mr. Roy, you said that you look and review these kind of processes. Would this be something that you have looked into before?

Mr. ROY. Sir, the Office of Investigations does not look into such processes.

Mr. GOSAR. How would you have to go back into looking at them?

Mr. ROY. I am an investigator. Our office investigates fraud and brings those cases to a criminal prosecutor either at the Federal or State level. The audit process would be from another component within our OIG.

Mr. GOSAR. And where would that come from?

Mr. ROY. Our Office of Audit. And I am more than happy to find out and get additional information for you on that process.

Mr. GOSAR. Ms. Lynch, would we persecute that individual who was the head of that health center for that kind of misuse of patients?

Ms. LYNCH. Congressman, I hope we don't persecute anyone.

Mr. GOSAR. I mean, prosecute. I am sorry. It's been a long day.

Ms. LYNCH. OK.

On the facts as you've described, I certainly don't have enough information. It certainly sounds like an inefficient process, but I would have to know more about it.

Mr. GOSAR. If we had an administrator misusing a process, fraud, that is misusing a process for a financial aspect and an upward gain, it seems to me like we have to do a much better job on that because we are seeing a lot of this. It is not just the private sector. It is also the government and the entities that it pays.

I yield back my time.

Mr. GOWDY. I thank the gentleman from Arizona.

The chair would now recognize the gentleman from Maryland, the ranking member of the full Oversight Committee, Mr. Cummings.

Mr. CUMMINGS. First, I want to thank the witnesses for your testimony. And as I listened to Mr. Gosar, I could not help but think about the young boy in Maryland, Diamonte Driver, who died 3 or 4 years ago because he could not get a doctor, Medicaid doctor to treat him; $80 worth of treatment would have saved his life, and he eventually died, and his mother was in search of somebody to treat him.

And I guess as I listened to those questions, I had to change my own line of questioning because I want to make sure that we focus where the fraud is.

Ms. Lynch, I am sorry. U.S. Attorney Lynch, I really appreciate what you said when you talked about in fiscal year 2010, the Department secured approximately $2½ billion in civil health care fraud recoveries. And I think before that, it had been, what? What was the highest before that?

Ms. LYNCH. It was roughly around $1 billion per year.

Mr. CUMMINGS. $1 million.

Ms. LYNCH. $1 billion, sir.

Mr. CUMMINGS. And I am trying to figure out what—I assume you believe—first of all, that is great. Congratulations to the Department, to all the people who work so hard to accomplish that. I assume you believe that there is more to be done?

Ms. LYNCH. I do.

Mr. CUMMINGS. And what kind of tools do you need to accomplish that? Because we on—first of all, on both sides of the aisle, we want to see this fraud, waste, and abuse addressed, and we want to see it addressed on every level. And as you answer me, I just want to just mention that the Coalition Against Insurance Fraud estimates that 80 percent of health care fraud is committed by providers and 10 percent by consumers. The remaining 10 percent is thought to be committed by others, such as insurance companies or their employees.

And so I am just wondering, what do you see—what can we do to address this issue in an even more effective and pattern—manner?

Ms. LYNCH. Thank you for the question, Mr. Cummings.

I think that the President's budget outlines several provisions that would increase the resources being brought to bear on this problem that would allow us to expand the strike force system, for one, which would be an important tool in targeting the transitory nature of this fraud, the emerging nature of this fraud, and the ever evolving nature of this fraud.

Another important initiative currently pending on the Affordable Health Care Act actually did mandate that the Sentencing Commission put forth a schedule for higher sentences for those individuals convicted of health care fraud based upon the amount of false billings, not just what they actually received. Sometimes that is less than the amount actually billed. But the Sentencing Commission was directed to in fact revise the guidelines to cover the amount billed as well as to raise the guidelines for the type of fraud that we are seeing. We think these are important resources and tools that the Department would use in fighting this battle.

Mr. CUMMINGS. Now, I assume that when you spend a certain amount of money to go after folks, there is a yield. In other words, there is a benefit that comes back in the form of prevention; hopefully, the message gets out, but also in the form of dollars. And I was just wondering, if the budget is cut substantially—say, for example, the strike force that you talked about. We actually are kind of—I mean, if that is the situation where you can actually show, I guess, where X dollars spent yields X dollars, we are kind of—I mean, if we in the Congress slash your budget, I guess we are kind of working against ourselves. Is that right?

Ms. LYNCH. Well, I think we are certainly working against the public fisc. I think it has been documented, as I mentioned, over the last 3 years, the HCFAC fund is returning almost $7 back for every dollar spent. A lot of that money has been allocated since 2008, I believe. And so if we were to reduce or eliminate certain funding streams, we would severely curtail our efforts to go after this fraud.

Of course, we would keep the focus up. We would still work these cases. But we would have fewer resources to do them, fewer people with which to do these cases, and obviously, I think the return to the American taxpayer would be significantly diminished.

Mr. CUMMINGS. I think it was you, Mr. Roy, who said that these folks who are involved in this criminal activity a lot of times see getting caught—reminds me of drug dealers, these big drug cartels. They see getting caught as a part of the tax they pay. And so they don't—they are committed to accomplishing this because they see the benefits are so great.

Mr. ROY. Absolutely, sir. Thank you for the question.

The Eurasian organized crime element in Los Angeles when I was a special agent in charge out there and an assistant special agent in charge, this criminal element had no fear of law enforcement whatsoever. And indeed, when they were caught and sentenced to jail, they considered it a badge of honor. And in fact what

they would do is they would have Mickey Mouse tattooed on their arms behind bars to signify that they had done time in a U.S. jail.

Mr. CUMMINGS. Thank you very much.

Mr. GOWDY. Thank you, Mr. Cummings.

At this point, the chair would recognize the gentleman from North Carolina, Mr. McHenry.

Mr. MCHENRY. I thank the chairman.

And thank you for your testimony.

Mr. Roy, now, the incidents of fraud in different types of Medicare programs are—fall in different rates. Is that correct?

Mr. ROY. I would say so. Yes, sir.

Mr. MCHENRY. For instance part D, Medicare part D, is there a higher level of incidents of fraud in that program compared to the rest of Medicare?

Mr. ROY. Right now, we see the emphasis in terms of fraud on durable medical equipment. Certainly part D is up there. Home health seems to be an area of Medicare where perpetrators like to prey. And I also would go back to corporate fraud element in terms of the tremendous amount of dollars in the corporate culture that goes along with that. I would say those are some of the top areas of fraud. But I think certainly part D falls within that realm.

Mr. MCHENRY. OK. Meaning you compare it to A and B, for instance, what part of Medicare actually has the highest incidence, according to your study and research?

Mr. ROY. Durable medical equipment right now.

Mr. MCHENRY. And where do those payments come from? Which component of Medicare?

Mr. ROY. They come from part B.

Mr. MCHENRY. Part B.

Mr. ROY. Yes, sir.

Mr. MCHENRY. So comparing part B to part D, which has the higher incidents of fraud?

Mr. ROY. Clearly part B overall.

Mr. MCHENRY. Now, is there something different about the construct of those two programs? Or is it, for instance, what they are paying for? Is there something different about those two that would leave a greater component of taxpayers paying more for the program?

Mr. ROY. I would say that one of the issues on why part B would be higher than part D is simply because part D is a newer program. We are looking at the prescription drug benefit, which is part D, is considerably newer than part B, and the schemes haven't developed yet as they have in our part B programs.

Mr. MCHENRY. Interesting. OK.

Ms. Taylor, is that similar to what your findings—or, your experience, I should say?

Ms. TAYLOR. I think in the part D program, we do find some issues there. But for the most part, the errors that we identify are mostly in the DME, the durable medical equipment arena, which is the part B program.

Mr. MCHENRY. Mr. Roy, is there something intrinsic about the relationship between Medicare and providers and patients, is there something intrinsic in the construct of the program that leads to greater incidents of fraud?

Mr. ROY. That is an interesting question. Not that I could put my finger on.

Mr. MCHENRY. For instance, if you are writing—if Medicare is required to stroke a check on a base amount of proof that a device has been delivered or a service has been rendered, you know, is there a way to change how that is structured?

Mr. ROY. Go back to what I said earlier about, again, keeping a better eye on who we let into our programs. We need to screen and scrutinize our providers better. That is my opinion.

Mr. MCHENRY. OK. So private sector providers of health care. Like compare CMS to one of the Blues or one of the other health care providers, do they have a similar level of incidents of fraud?

Mr. ROY. I am not familiar with what is happening in the private sector. OIG for HHS, we concentrate on Medicare. And clearly sometimes we will be partnering with those entities, law enforcement entities that have oversight and work in the private sector health care fraud arena as well. But there is nothing—I am not the person to say that those involved in Medicare fraud are exponentially more than what we see in the private sector.

Mr. MCHENRY. OK. Well, thank you, Mr. Chairman. I would be happy to yield my time to the chairman if you would like it.

Mr. GOWDY. I thank the gentleman from North Carolina. And I will keep that in mind.

I am going to go last. If there is anybody here when I go, I will keep that in mind.

I would yield to at this point to the gentleman from Connecticut, Mr. Murphy.

Mr. MURPHY. Thank you, Mr. Chairman.

Ms. Taylor, I just want to get a couple facts on the table so we have a clear understanding of the Medicaid program. Medicaid covers about 60 million at-risk Americans. Is that right?

Ms. TAYLOR. I believe it is around 40 to 50, but it is in that ballpark.

Mr. MURPHY. And covers about half of all of the long-term care expenses, half of all the nursing expenses in the country?

Ms. TAYLOR. Correct. Yes.

Mr. MURPHY. About a third of the money goes into community services, and about half of all Medicaid recipients are kids. Right?

Ms. TAYLOR. I am not a Medicaid expert, but—I am not sure about that number, but I assume it is probably a large chunk of children. Yes.

Mr. MURPHY. I ask these questions because what I see is a disconnect here today. This is an incredibly important hearing.

But there is I think a gap between a very worthy discussion that we are having here today and what happened earlier today, where my Republican friends outlined a proposal to essentially end the Medicaid program as we know it and dramatically cut Medicaid funds for kids, for seniors in nursing homes, for States, and essentially results in millions of vulnerable seniors and children losing access to our health care system. I think this is a really important conversation. But it happens on the same day that we are talking about essentially ending preventative health care services and crisis health care services for a lot of vulnerable Americans.

And to Ranking Member Cummings' question, there also seems to be a disconnect between the budget debate that we are having today, in which we are talking about potentially dramatically cutting the budgets for many of your agencies while asking you to do more with respect to fraud and abuse. And in addition to the bottom line numbers that are being cut out of your budgets, there are also riders to the continuing resolution, including the repeal of the Health Care Reform Act. And as we talked about, there are some incredibly important provisions in that act which bolster your efforts.

And so it is a frustrating hearing today, because we are talking about radical changes to Medicare and Medicaid being proposed today that will withdraw services from millions of vulnerable Americans. And we are talking about cutting your budgets at the same time that we are holding multiple hearings in the Capitol about asking you to do more.

And I guess I take—Representative Cummings hit on a couple issues here, but I guess I would pick one piece out of the Health Care Reform Act that would go away with the continuing resolution as passed originally through the House of Representatives and pose the question maybe to Mr. Roy and to Attorney Lynch. That is, the element of the Health Care Reform Act that focuses on data sharing, a really important piece of understanding fraud and trying to make sure that all agencies, whether they be at the Federal or State level, have the information that they need to try to track fraud and to address it when necessary.

So I guess I would ask both Mr. Roy and to Attorney Lynch, how important are the provisions of the Affordable Care Act with respect to increasing data sharing? And do you have worries, should that act be repealed, whether you have the resources necessary to try to track information as it moves through the system?

Ms. LYNCH. Thank you, Mr. Murphy.

I would say that, yes, repeal of those particular provisions would in effect harm our efforts to eradicate fraud. In particular, data sharing is important because as CMS and HHS are working on their processes, they are able to provide to us, the prosecutors, almost real-time data on claims that are being made. And if we can identify those fraudulent claims as they are going into the system, we have a much greater chance of stopping them before they get to the large numbers that we are seeing currently.

We also have a much greater chance of identifying the players. As I mentioned before, they do tend to shut down and move on. This would allow us to identify those players, those fraudsters much earlier.

So, for us, for the Department, the Department's perspective, the data sharing provisions of the Affordable Care Act have been extremely important.

Mr. MURPHY. Mr. Roy.

Mr. ROY. Thank you, sir.

Ultimately, I think that I would probably survive the data angle. Data—and the way you described the issues is very important to investigators. I talk about it in my testimony about how we are catching criminals in the act as opposed to finding out 90 days

later that they are stealing money from us, and by that time, they are already gone on their way to the next scheme.

What concerns me more are the funding aspects, the long-term funding for HCFAC. OIG, OI is human resources driven, and I need to ensure that I have the funding to keep bodies on the ground and engaged in the process.

Other that than that, I think Dr. Budetti and I—I think I would be OK getting the data out of Mr. Budetti.

Mr. MURPHY. Thank you, Mr. Chairman.

Mr. GOWDY. I thank the gentleman.

The chair would now recognize the gentleman from Indiana, Mr. Burton.

Mr. BURTON. Thank you, Mr. Chairman.

I just have a couple of questions.

Ms. Lynch, you said for every dollar that is spent on prosecution, you get $7 back or you recover $7?

Ms. LYNCH. Yes. Roughly, sir. Yes.

Mr. BURTON. The estimated fraud over the last several years has been $150 billion each year since 2008. I don't know how that dovetails into the results you say you are getting. If you're getting $7 back for every $1 invested, then you are saying that you actually need a lot more money in order to stop the fraud that is so prevalent. Right?

Ms. LYNCH. Well, I think that certainly funding is an important part of what we need. The other tools that we have mentioned in terms of—and I would defer to the agencies, in terms of changing their protocols, are also very important as well. But the resources that we have enable us to sharpen our focus on these particular activities, and they do bring great benefits back to the taxpayers.

Mr. BURTON. Well, the system that we have right now just if you are getting $7 back for every $1 that you get for investigations or prosecutions, this is just overwhelming you. There is just no way that you are going to be able to really make a big dent in an estimated $150 billion in fraud each year. I mean, if you are doing such a good job, which I don't disagree that you are, but if you are getting $7 back for every $1 that is being invested in you and we have $150 billion in fraud each year, my gosh, you would need $20 billion in order to keep up the 7–1 ratio if you went and got everybody.

So it just seems like to me it is almost an insurmountable task that you have before you to stop the waste, fraud, and abuse or even make a big dent in it because it is so prevalent.

Ms. LYNCH. Well, Congressman, I would prefer not to view any crime problem as insurmountable but more as a challenge to be met. And I think we have a number of tools. We have the civil enforcement as well. We have a number of options there. I would rather—certainly rather not give up on the problem.

Mr. BURTON. No. No. I don't want you to give up. Don't misunderstand. I just think that the whole system needs to be revamped, because no matter how hard you work, all of you collectively, to stop fraud, waste, and abuse in the system, it is not going to work. I mean, when you have an estimated $70 billion to $234 billion in fraud, as hard as you work with the money we give you,

you are never going to be able to make a big dent in it. The system needs to be revised.

We need to do something like—and this has nothing to do with you. But it seems to me that the government ought to provide a mechanism for people to buy insurance through private sources rather than have the bureaucracy try to contain waste, fraud, and abuse, because you can't do it. As hard as you work—and I am sure you all work very hard. If you get $7 back for every $1 in investment that you make, and we still have $150 billion a year in fraud, the system is not working. And it is not going to get any better unless we take a hard look at the system and revise the whole thing. And I think that is what we are talking about right now.

And I hope that both sides of the aisle, my colleagues on both sides of the aisle will take a hard look at that. Because if we still have $150 billion in fraud that we can't stop and we haven't been stopping, and we have people who are working so diligently like Ms. Lynch and the others, and they are getting $7 back for every $1 we give them for investigations, it is a task that is not doable. And so we have to look at a different way to deal with the problem of health care and the system needs to be revised.

Obamacare—I know you call it something else, but we call it Obamacare. Obamacare is only going to exacerbate the situation. So I think we need to as a Congress go back and take a look at the whole system and try to make this system more responsive to the individual. In other words, if they buy insurance from a health care company and we provide a mechanism for them to do that, we will be able to keep track of the losses and whether or not there is fraud, at least to a much greater degree than we are right now.

Mr. CUMMINGS. Would the gentleman yield? Just very quickly.

Mr. BURTON. Sure, I will be glad to yield.

Mr. CUMMINGS. Just very quickly. Just on this side, we were trying to figure out where you—just give us the cite for your $150 billion, since you——

Mr. BURTON. Sure. The New England Health Care Institute estimates that the United States wasted $150 billion each year since 2008. But the losses or the waste and fraud and abuse has ranged from $70 billion to $234 billion. Even if you take the lower figure, these people who are doing a good job—and I am not criticizing them. I am just saying there is not enough money that we can give them to enforce the laws that will overcome at least $70 billion. And the estimate is it is $150 billion a year. And I thank the gentleman. I yield back.

Mr. GOWDY. I thank the gentleman from Indiana. I will recognize myself now for 5 minutes.

Ms. Taylor, do agree with the President when he said there is $900 billion of waste, fraud and abuse in Medicare and Medicaid?

Ms. TAYLOR. I think that is probably a better question for Dr. Budetti.

Mr. GOWDY. I mean yes or no?

Ms. TAYLOR. I——

Mr. GOWDY. Is it a $900-billion-a-year problem?

Ms. TAYLOR. I am really not familiar with that quote or that number. I am not familiar at all.

Mr. GOWDY. All right. Let me ask you, there was a chart put up initially that had, we want to go from pay and chase to verify. And it strikes me the frustration that I have heard listening to the testimony or frustration that I have felt listening to it is that it is—the strategy seems to be pay and then pay again to investigate and then pay again to prosecute and then pay again to pretrial services to do a PSI and then pay the probation and pay to the marshals and pay to the Bureau of Prisons. What I want to know is, when are we going to invest the same amount of money in stopping the fraud before it happens? We cannot investigate and prosecute our way out of this problem.

So Mr. Roy, let me ask you this, last night I was reading and I could be wrong, let's say I am, I counted 55 different recommendations that have been made with respect to reforming Medicare and Medicaid that have not been implemented, 55. Let's say I am off by 25, let's go down to 25, or let's just take your issue, durable medical equipment. Can you give us specific things that should be done to start ferreting out fraud, waste, abuse, whichever of the three you want to call it, with respect to durable medical equipment?

Mr. ROY. I would go back to my earlier testimony, sir, and concentrate on provider enrollment. Scrutinizing——

Mr. GOWDY. Right, criminal background checks.

Mr. ROY. Absolutely.

Mr. GOWDY. What else? Make sure they are familiar with the policies and procedures so they can't claim they didn't know.

Mr. ROY. Make sure they have office and office hours. Make sure that they have products to actually provide to durable medical equipment beneficiaries.

Mr. GOWDY. OK.

Mr. ROY. Again, I also would throw in there that you have to look at the environment in which they are working. In Los Angeles, for example, we once had 25 durable medical equipment companies in a 5-mile radius serving a very, very small——

Mr. GOWDY. All of which can be done with a site visit, right? A criminal background check, an interview and a site visit? It is not high mass, so I would ask you Dr. Budetti or Ms. Taylor, why hasn't that been done?

Dr. BUDETTI. Well, thank for the question Chairman Gowdy, Chairman Gowdy, I must say I agree with you that this is exactly what needs to be done, and that is exactly what we are doing. As of Friday of March 25th, our major regulation took effect that put into place risk-based screening for applications to be new providers and suppliers.

Mr. GOWDY. I don't want to interrupt you——

Dr. BUDETTI. Putting those kind of screens into place, sir.

Mr. GOWDY. But can you appreciate the frustration——

Dr. BUDETTI. Absolutely.

Mr. GOWDY [continuing]. Of this problem not having arisen in March of this year, it has been a problem for a number of years. And I think folks question what takes us so long to deal with—that is not high math what he just suggested. We could come up with that over lunch. So what has taken so long?

Dr. BUDETTI. I can't speak to what happened before I took this job a year ago. But I can tell you that those are some of the same reasons I took the job. And those are exactly the things that we are working on everyday.

Mr. GOWDY. Mr. Roy, what about home health, give me three things that you would do if you were emperor for the day with respect to home health?

Mr. ROY. I would go back to, once again, looking at those, who is coming into our program? Who is providing those services? And then, again, I would look at the environment to see how many providers are in a certain area. Does it really make sense to have an exponential amount of providers to serve a community that probably doesn't exist? Those are the types of issues I would focus on if I was looking at it from an administrative position.

Mr. GOWDY. Dr. Budetti, do you agree with me that Ms. Lynch and her colleagues cannot ever prosecute and enforce our way out of this problem?

Dr. BUDETTI. Yes, I think we all agree that we need a teamwork approach here, that we need to keep the bad guys out in the first place, not pay them when they are submitting fraudulent claims, and also go after the ones who do get into the program and who do need to be prosecuted. We can't do away with that side of the equation by any stretch of the imagination.

Mr. GOWDY. I am not advocating—that would be one of the last things I would advocate would be doing away with prosecutors. But how are you going to change the pay-and-chase model to a verify and then pay?

Dr. BUDETTI. Through our new screening, through our new authorities to declare a moratorium on new enrollments of providers and suppliers when necessary to fight fraud, through our new ability to exclude—to keep people out of the Medicaid program. When they have been terminated for cause in one State, they will be terminated everywhere, same for Medicare.

We have a number of new authorities put into effect that will have exactly that effect. It is keeping the bad guys out and suspending payments when there is a credible allegation of fraud pending an investigation by our colleagues at the Office of the Inspector General. All of those are in place, sir.

Mr. GOWDY. My time is up, so I am going to ask one very quick question. Have those changes already been implemented, or are they yet to come?

Dr. BUDETTI. Many of them have—the regulation I referred to took effect, and we are actively implementing it as I speak.

Mr. GOWDY. And when would you expect the country to have confidence that they are fully implemented?

Dr. BUDETTI. I would expect that all of the advanced technologies and other sophisticated techniques that we are applying will be in place later this year and will be well into our payment systems fully integrated by next year. But we are implementing them bit by bit as we go forward, as we learn what we can do in the meantime. But this is something we are working on very diligently everyday now, sir.

Mr. GOWDY. All right, thank you.

Dr. BUDETTI. You are welcome, thank you.

I want to thank our panel, and we are going to take a 5-minute recess. I am going to come down there and thank you all personally for coming, and then we will set up for the next panel.

[Recess.]

Mr. GOWDY. Good afternoon, we now want to welcome our second panel of witnesses: First, David, Mr. David Botsko is the inspector general of the Arizona Health Care Cost Containment System.

Ms. Gene MacQuarrie, is that close.

Ms. MACQUARRIE. It is.

Mr. GOWDY. Is vice president for client services at Thompson Reuters; and Michael Cannon is director of health policy studies at the Cato Institute.

Pursuant to committee rules, all witnesses will be sworn in, so I am going to ask you to please rise and raise your right hands.

Ms. Klein, I can see your last name, but I don't have my information so when I get it, I will do due diligence in your introduction, too, OK.

Ms. KLEIN. Sure.

Mr. GOWDY. But we can still take the oath.

[Witnesses sworn.]

Mr. GOWDY. Let the record reflect all witnesses answered in the affirmative.

I am going to start with Mr. Botsko, and we will move from my left to right, and you will have 5 minutes. I think if you were here for the first panel, you know there are lights and what the lights mean. Ms. Klein, by the time we get to you, I will have a full introduction worthy of your distinguished background, OK?

We will start with Mr. Botsko.

STATEMENTS OF DAVID A. BOTSKO, INSPECTOR GENERAL, ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM; JEAN MACQUARRIE, VICE PRESIDENT FOR CLIENT SERVICES, THOMSON REUTERS; MICHAEL F. CANNON, DIRECTOR OF HEALTH POLICY STUDIES, CATO INSTITUTE; AND RACHEL KLEIN, DEPUTY DIRECTOR FOR HEALTH POLICY, FAMILIES USA

STATEMENT OF DAVID A. BOTSKO

Mr. BOTSKO. Good afternoon, Chairman Gowdy, Ranking Member Davis, and the other distinguished members of the subcommittee. Thank you for the invitation to speak before this committee, I am David Botsko, the inspector general of the Arizona Health Care Cost Containment System, the state Medicaid agency.

I have spent my entire career enforcing laws and protecting citizens. Prior to my 11 years with Medicaid, I was a Special Agent with the U.S. Government for 22 years conducting criminal investigations. The program I work for, AHCCCS, was established in October 1982 as a managed care agency and is a leader in controlling medical costs within the Medicaid program. The $10 billion AHCCCS budget serves 1.3 million beneficiaries. The AHCCCS OIG was created in November 2009, replacing the program integrity office.

As of February 2011, the OIG has recognized the total savings and cost avoidance of approximately $31 million during the past 8

months alone. We also have achieved 9 criminal convictions, with 11 additional individuals pending prosecution as I speak.

Even though overall staffing for the AHCCCS program is down due to budget challenges, we have actually increased OIG staffing.

My testimony will focus on three elements that impact the success or failure of Medicaid investigations, and I have some recommended solutions. The OIG utilizes a dedicated team of investigators to screen Medicaid applications that meets suspected fraud criteria. The applications are referred to the Fraud Prevention Unit, which strives to conduct the initial investigation within 24 hours of receipt.

During the State fiscal year 2010, the unit received almost 8,200 referrals, and we conducted approximately 8,000 investigations. The investigations resulted in 1,500 ineligible individuals being denied benefits. The estimated cost avoidance for these denials was in excess of $15 million. During this timeframe, the Fraud Prevention Unit saved an average of $1.9 million per investigator per year. We are working to expand this program for more offices, but the State is limited to available matching funds for additional staffing.

The OIG has two units for investigating member and provider compliance issues in addition to the Fraud Prevention Unit. The average cost per investigator is $58,000 per year per investigator. In 2010, these two units opened 450 investigations and closed 300 cases. During the State fiscal year 2010, these two units realized the total cost avoidance in recovery of $13 million with the return on investment of 9.1.

We're utilizing an analytical tool produced by EDI Watch to discover suspicious payment patterns and apply this information to other providers within the system. These tools generate additional information and potential cases that also require more State match for funds for investigations.

We have developed a successful outreach program that has dramatically increased the amount of fraud referrals received by our office. However, because of our success, we have created more back logs.

Other issues that impact our resources, such as countless staff hours working with federally mandated audit contractors, which have historically had little positive impact while draining resources. Recently imposed Affordable Care Act rules mandate additional screening requirements and accountability for receiving provider application fees, etc. These mandates will have had and will continue to impact the agency resources as they continue to strain our overburdened work force.

The ongoing efforts at the Federal and State level to reduce fraud and waste in health care programs is critically important. We are confident that we can continue to improve our oversight by focusing responsibilities and resources on those who are best equipped and most informed, which is the States.

Each State Medicaid program is unique. In Arizona, we rely significantly on managed care, and we work with our managed care partners, but as the State, we play a critical role in investigating and pursuing fraud. The State Medicaid Fraud Control Units are funded with 75 percent Federal matching dollars. Why not fund the

State Medicaid OIGs and Program Integrity Units with the same funding but require that the State document the rate of return on that investment to the Congress? Change the Federal code to allow the State OIGs or program integrity units to conduct full investigations and avoid duplication of effort and save valuable time and money.

To summarize, the State Medicaid programs are best positioned to target limited resources. We also use a program called CLEAR in investigating our members. My recommendation is to increase matching dollars that should not require additional Federal expenditures if duplicate Federal initiatives were streamlined and focused on State efforts. Medicaid is a Federal-State partnership, the States are doing everything in their power to ensure the Medicaid program that we are responsible for operates efficiently. Thank you, and I'll be happy to answer any questions.

[The prepared statement of Mr. Botsko follows:]

Statement of

David A. Botsko, Ph.D.

Inspector General

Arizona Health Care Cost

Containment System

On

Waste and Abuse in Government

Health Care

Before the

U.S. House Subcommittee on

Health Care

April 5, 2011

Good afternoon, Chairman Gowdy, Ranking Member Davis, and other distinguished Members of the Subcommittee thank you for the invitation to speak before this committee. I am David Botsko, Inspector General of the Arizona Health Care Cost Containment System (AHCCCS) the state Medicaid Agency.

AHCCCS was established in October 1982 as a managed care agency and is a leader in controlling medical costs within the Medicaid program. The AHCCCS budget is $10 billion which serve the 1.3 million beneficiaries. We are currently contracted with 19 health plans to serve the state Medicaid population.

The AHCCCS Office of Inspector General (OIG) was created in November 2009 to more accurately reflect the overall scope and enhanced mission relating to fraud and program mismanagement. Prior to formation of the OIG, the AHCCCS Office of Program Integrity accomplished the fraud and abuse investigations for the Administration. The organizational goal of the OIG is to protect and serve the Medicaid public interest by increasing awareness and improving the detection, investigation, civil and criminal prosecution and prevention of health care fraud in the state of Arizona. As of February 28, 2011 the OIG has recognized a total savings and cost avoidance of approximately $31 million during the current state fiscal year. During the same period there have been nine criminal convictions and 11 additional individuals are pending prosecution.

I am thankful for the opportunity to discuss the problems faced by the state Medicaid program in fulfilling the responsibilities entrusted to us by the American public. While a

small percentage of health care providers and consumers engage in fraudulent activities the impact can inflict serious consequences on expenditures. The state agencies are in the forefront in the fight against fraud. The AHCCCS OIG cooperates with state and federal law enforcement, regulatory agencies and state and federal prosecutors to detect prevent and prosecute Medicaid fraud. My testimony will focus on three elements that impact the success or failure of Medicaid investigations and some recommend solutions.

I. Effectiveness of pre-screening Medicaid applicants and providers

The Office of Inspector General utilizes a unique dedicated team of investigators to screen Medicaid applications that meet our criteria that may indicate the presence of fraud. The applications are referred to the OIG Fraud Prevention Unit (FPU) which strives to conduct the initial investigation with 24 hours of receipt. During the state fiscal year 2010 the unit received almost 8,200 referrals for investigation and conducted approximately 8,000 investigations. The investigations resulted in 1500 individuals being denied benefits. The estimated cost avoidance savings for these ineligible participants was $15.23 million. During this time frame the FPU operated with eight full time investigators and saved an average of $1.9 million per investigator per year, in program dollars. Again, these investigations were based upon referrals with established fraud indicators. Beginning in July 2010 the FPU inaugurated an outreach program to train and educate our eligibility entities and we increased their staffing by one full time employee. This effort has resulted in an increase in the percentage of cases investigated and a corresponding number of individuals were found ineligible and denied services. As of March 2011 we have already surpassed last year's savings and have realized a cost

avoidance of $15.6 million. There are approximately 73 offices that determine eligibility for Medicaid programs in Arizona and we currently receive fraud referrals from 27 of them. We are unable to expand this program to more offices without the requisite staff to conduct the additional investigations.

When the Office of Inspector General was formed the provider registration functions were subsequently transferred to the OIG. The transfer of the provider registration function has proven to be beneficial in screening providers who may have criminal convictions or misconduct charges. Utilizing the resources and investigative capabilities of the entire OIG to examine facility ownership and relationships between provider entities has been extremely beneficial and cost effective.

II. Return on investment

The OIG also has two units for investigating member and provider compliance issues. The average cost per investigator for the Member and Provider Compliance Unit's was approximately $58,000 per year per investigator during the last state fiscal year. During that period the Office of Inspector General had an average staffing of 34 investigators and supervisors. Excluding the Fraud Prevention Unit, the Member and Provider Compliance Investigative Units opened 450 investigations and closed 300 cases. During the state fiscal year 2010 these two units realized a total cost avoidance and recovery of $13 million with an average recovery per investigator of $500,000 or approximately a 9:1 return on investment. We are utilizing an analytical tool produced by a company named EDI Watch to discover suspicious payment patterns and apply this information to other

providers within the system. This tool generates additional information and potential cases that also require more state matching funds for investigations.

III. Impact of unfunded mandates

I can not over emphasize the importance of having strong program integrity initiatives that deter entities that attempt to defraud the Medicaid program. The AHCCCS Office of Inspector General has developed fraud and awareness educational programs that are presented on the AHCCCS Website. The successful outreach program has dramatically increased the amount of fraud referrals received by the OIG. The OIG currently has a backlog of 600 fraud referrals which have not been assigned due to the lack of available resources. Other issues impact our resources such as countless staff hours working with Recovery Audit Contractors (RAC) and Medicaid Integrity Contractors (MIC) which have historically had little positive impact while draining resources. The recently imposed affordable care act rules mandate additional screening requirements, additional accountability for receiving mandated application fees, payment suspensions, and compliance plans for providers and suppliers has had and will have impacts on the Provider Registration Unit, such as:

- System changes that impact several major operating systems
  - Addition of reading new databases
  - Tracking mechanisms
  - A Mechanism to record, track and report fees collected
- Additional requirements that are outside the scope of existing processes: such as site visits, fingerprint verification, application fees, etc.

- Processing procedures that require modification to all provider types. There are currently 56,000 providers registered in the State of Arizona.
- Staffing: Resources needed to plan, implement and maintain changes

The additional requirements placed on existing resources create a strain on an already overburdened workforce. Backlogs are expected to increase as well as staff attrition. With existing budget constraints the agency is restricted from providing any type of added incentive to compensate for the additional workload.

IV. Conclusion

I have spent my entire career enforcing laws and protecting citizens. Prior to my work in Medicaid, I was a special agent with the U. S. Defense Department OIG and the U. S. State Department for 22 years conducting criminal investigations. The ongoing efforts at the federal and state level to reduce fraud and waste in health care programs are critically important. We are confident that we can continue to improve our oversight by focusing responsibilities and resources on those who are best equipped and most informed, the states. Furthermore, we are implementing a number of measures that will enhance our enforcement and administrative actions in the prevention of fraudulent and improper payments. This shift involves many different activities which we are carrying out with the new EDI Watch anti-fraud tool recently acquired by the AHCCCS Administration. We are utilizing analytical tools to search across all contracted health plans to discover suspicious payment patterns and apply this information to other providers within the system. The OIG also utilizes a sophisticated data base named CLEAR to identify

individuals who may be attempting to defraud the Medicaid system. Eliminating the problem of fraud and overpayments within the Medicaid system requires a long-term, sustainable approach. The duplication of audit efforts at the federal level requires an unnecessary amount of staff time to educate and assimilate them into a position to produce results. Additional experience has proven that the state OIG or Program Integrity Unit is in a better position to conduct the audit due to expertise and experience with the rules and contract requirements which impact the entities undergoing the audit. Each state plan is a little different and each contain nuances' that make them singular in methodology and practices. Attempting to write federal rules and guidelines for Medicaid by placing the words "and Medicaid" after the Medicare rules does not always work.

Changes and new authorities that may improve the effectiveness of the Medicaid anti-fraud activities are:

- Provide funding to permit the state to focus our limited resources on conducting effective audits at the local level.
- The state Medicaid Fraud Control Units are funded with 75% federal matching dollars. Fund the state Medicaid OIG's and Program Integrity Unit's with the same funding.
- 42 CFR 455.14 requires the Medicaid agency to conduct a preliminary investigation and when fraud is suspected refer the allegation to the Medicaid Fraud Control Unit (MFCU). In some states the Medicaid OIG or Program Integrity Unit may be equipped to conduct a full investigation and subsequently refer the case to the MFCU for prosecution, avoiding duplication of effort and

save valuable time and money. A minor change to the law by striking the words "of a preliminary investigation" to "of an investigation" would allow states with the appropriate capabilities to become a more effective partner with the MFCU.

- Add language to the existing legislation that would permit Medicaid OIG's and Program Integrity Units to issue subpoenas for records in support of Medicaid investigations. Currently some states have this authority others do not. Additionally, if the subpoena's are federally mandated it would assist the states in obtaining information across state lines.

To summarize: Each state program is unique. In Arizona we rely significantly on managed care. We work collaboratively with our managed care partners but as the state we play a critical role in investigating and pursuing fraud. The states are the best source to conduct provider audits due to program familiarity. The recommendation to increase federal matching dollars should not require additional federal expenditures if duplicative federal initiatives were streamlined and focused on state efforts. Unfunded mandates are a burden that detract from the fraud detection and recovery mission of the state agencies. Based on my many years of experience I firmly believe that the state Medicaid OIG's and Program Integrity Units are the best line of defense against fraud and we have the results to prove it..

Thank you, I would be happy to answer any question you may have.

Mr. GOWDY. Thank you, sir.

We will now recognize Ms. MacQuarrie for her 5-minute statement.

STATEMENT OF JEAN MACQUARRIE

Ms. MACQUARRIE. Chairman Gowdy, Ranking Member Davis, members of the subcommittee, my name is Jean MacQuarrie, and I am vice president for health care payment integrity for Thompson Reuters. Thompson Reuters has been engaged with our public and private sector customers to ensure payment integrity for decades.

The U.S. health care system is complex with providers treating differently for the same condition. Data mining alone is not sufficient to validate the reasonableness of services being billed. Clinical intelligence must be embedded in analytic software to allow for identification of inappropriate bills.

Additionally, most fraud investigators are not physicians or professional coders. Therefore, it takes software to accommodate the complexities of health care for the fraud investigator.

The foundation of clinically based fraud, waste and abuse detection systems are essential. Within the Thompson Reuters Advantage Suite products, we include episodes of care which aggregate inpatient, outpatient and drug claims and into disease categories with severity stages. Episode grouping enables validating submitted claims against patient's medical conditions, identifying services that might be fraudulent or abusive. Clinical intelligence is also added to the data. These clinically intense data additions save our customers hundreds and thousands of investigative hours each month by allowing rapid and clinically accurate data mining.

Congress has recognized the critical importance of predictive modeling in the fight against fraud and waste and now needs to recognize the critical importance of clinically intensive models to further advance the analytics essential to fraud, waste and abuse. As an example, it is a well-known fact that some types of fraud are pervasive, and they occur because it is hard to catch them in claims data. Your screen will have some screen shots from this system.

Having a clinically based detection system is essential to identify the issues. For example, diabetic test strips are not needed by patients without diabetes. We use our episode technology to identify patients who get test strips and then make sure that they have diabetes. The subset selection process allows me to run these reports in English without having to understand the complex coding behind disease conditions.

The report shows individual pharmacies and the number of diabetic test strips that they distribute to patients who do not have diabetes with some of these pharmacies in the 95 to 99 percent range. This could be an indication that beneficiaries are purchasing these items, which are frequently sold at flea markets, or that pharmacies billing for products that aren't delivered.

In Medicaid, the Payment Integrity Units run complex statistical analyses for specific provider types, like mental health, dentistry and therapy. These complex reports rank providers by their degree of deviation from their peer groups based on numerous statistical measures calculated over time. The comparisons to the peer group

are automatically adjusted for the severity of illness of the patients so that rankings of the providers are fair for those providers who treat really sick patients. Good providers greatly appreciate clinical intelligence.

It would take an investigator hundreds of hours to perform dynamic risk-adjusted profiling, capabilities all embedded in the Thompson Reuters Advantage Suite product. With our clinically based solution, these complex measures can be adjusted by our clients which just a few mouse clicks. To investigate the providers who ranked at the top of the report, we also go to CLEAR, the Thompson Reuters public records data access solution. It is important to use public records and other disparate data when we look for fraud and abuse.

Investigators should not use claims data alone. Public records data sets includes Federal and State sanctions from all States as an example. Those data banks can be queried automatically and as available as a standalone, searchable platform. This screen shows how easy it is to request a review of one of the ranked providers. And when we drill down, we can see this provider has four sanctions and leads us to a link analysis chart showing to providers related to 19 total providers on boards of directors of each other's companies who practice out of the strip mall you see in front of you, which does not seem to support the millions of dollars billed to Medicare by these providers.

Our Thompson Reuters clients who use this analytic software include 22 State Medicaid agencies who identify hundreds of millions of dollars in fraud, waste and abuse annually. In addition, CMS has Advantage Suite implemented and is rolling it out now.

In closing, as documented in the white papers, you will find on the table to my right, the problem of fraud, waste and abuse in health care as clearly noted today is huge. We have done a lot to help our clients combat the problem.

CMS has taken many steps to implement predictive modeling and now clinically based detection systems. With that said, there is still much to do. Thompson Reuters won't let up; we will continue to work hard and fast to deploy the best technology and subject matter experts to stay ahead of those who would defraud the government. Thank you very much.

[The prepared statement of Ms. MacQuarrie follows:]

SUBCOMMITTEE ON HEALTH CARE, DISTRICT OF COLUMBIA, CENSUS AND THE NATIONAL ARCHIVES OF THE COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

WRITTEN TESTIMONY

Part 1 Verbal Testimony

Jean MacQuarrie
VP, Healthcare Payment Integrity Practice

April 5, 2011

THOMSON REUTERS

Subcommittee on Health Care, District of Columbia, Census and the National Archives of the Committee on Oversight and Government Reform

TITLE

Good afternoon. My name is Jean MacQuarrie and I am the Vice President for Healthcare Payment Integrity for Thomson Reuters. Thomson Reuters has been engaged with our customers to ensure payment integrity for decades.

Slide 2: Agenda

In my brief time with you today I am going to talk about:

- How Thomson Reuters views the problem of Waste in the U.S. healthcare system, including fighting fraud and abuse
- The importance of having clinically-based analytics in an effective Fraud, Waste and Abuse (FWA) detection system
- The importance of leveraging external data not on claims to help validate claims accuracy, and
- The need to Gold Card good providers so we can focus our data mining and analytics on outliers

Slide 3: Documented Waste in the System

Thomson Reuters has written 2 white papers on the topic of Waste in the U.S. Healthcare System.

- "Where Can $700 Billion in Waste be Cut Annually From the U.S. Healthcare System?"; and
- "A Path to Eliminating $3.6 Trillion in Wasteful Healthcare Spending"

Each brings together cited works estimating the size of the problem in the U.S. healthcare system and offers strategies for eliminating waste in the healthcare system, including mitigating fraud and abuse.

Slide 4: Fraud, Waste and Abuse Costs

The "$700 Billion Annual Waste White Paper" is broken down into 6 categories including fraud and abuse. Our research shows that fraud and abuse amounts to 19% of the problem or $125 to $175 billion annually.

Slide 5: Clinically-based Analytics

The U.S. healthcare system is complex with providers treating patients differently, for the same condition. Data mining alone is not sufficient to validate the reasonableness of services being billed. Clinical intelligence must be imbedded in analytic software to allow for identification of inappropriate bills. Additionally, most fraud investigators are not physicians or professional claims coders. Therefore, the software needs to accommodate the complexities of healthcare for the investigator.

Slide 6: Clinically-based Analytics

The foundation of clinically-based waste and abuse detection systems like Thomson Reuters Advantage Suite includes analytic constructs including:

- Episodes of Care – Aggregates of inpatient, outpatient and drug claims into disease categories with severity stages. Episode grouping enables validating submitted claims against patients' medical conditions, identifying services that may be fraudulent or abusive.
- Admissions – Group together all costs associated with a hospital stay including the physician care.
- Clinical measures and subsets are pre-constructed on the most common and abused conditions like Diabetes and Narcotics.

- Clinical intelligence is added to the data. Fields like Drug Product Name, Therapeutic Class and Clinical Intensity help investigation.
- Clinical Methods like Benchmarks, Case-Mix and Age-Sex Adjustment are necessary to determine true outliers.

These clinically-intense data additions save our clients hundreds and thousands of investigative hours each month by allowing rapid and clinically-accurate data mining. Congress has recognized the critical importance of predictive modeling in the fight against fraud and waste and now needs to realize the critical importance of clinically-intensive models to further advance the analytics essential to fraud, waste and abuse detection and mitigation.

Slide 7: Diabetes Test Strips Without a Diabetes Episode

As an example, it is a well known fact that some types of fraud are pervasive and they occur because it is hard with claims-based data mining to identify the perpetrators. Having a clinically-based detection system is essential to identify many of these issues. Diabetic test strips aren't needed by patients without diabetes. We use our episodes technology to identify patients getting test strips and then make sure they have the clinical condition – diabetes. The subset selection process allows an investigator to query the database for test strips. The episode of care subset limits the selection to test strips not linked to diabetic episodes. Now that I've selected these two subsets (and without having to understand the complex coding around HCPCS and disease conditions), I can open the report to analyze the test strip usage.

Slide 8: Diabetes Test Strips Without a Diabetes Episode

The report shows individual pharmacies and the number of test strips that they dispense followed by the number of test strips without a diabetes condition. The first pharmacy listed depicts that 94% of the test strips purchased were not for beneficiaries with diabetes. For Alpine Valley Drugs, 99% of the test strips weren't associated with a diabetic episode. This could be an indication of either

beneficiaries who are purchasing these items which are often sold at flea markets or the pharmacy billing for supplies not delivered.

Slide 9: Medicaid FWA Surveillance

In Medicaid, the Payment Integrity SURS units run complex statistical analysis for specific provider types, like Mental Health, Dentistry and Therapy Providers.

Slide 10: Medicaid FWA Surveillance

These complex reports rank providers by their degree of deviation from their peer groups, based on numerous statistical measures calculated over time. The comparisons to the peer group are automatically adjusted for the severity of illness of the patient population so that the rankings are fair for the providers who treat really sick patients. Good providers greatly appreciate this clinical intelligence. It would take an investigator with a Business Intelligence tool hundreds of hours to figure out how to perform dynamic and risk adjusted benchmarking – all embedded in Thomson Reuters Advantage Suite fraud and abuse tool.

Slide 11: Medicaid FWA Surveillance

With our clinically-based solution, these complex measures can be fine tuned by our clients with just a few mouse clicks.

Slide 12: Linking Public Records Data to Claims for Enhanced FWA Detection

To investigate the providers who rank at the top of the report, we go to our CLEAR public records data access solution. It is important to utilize public records and other disparate data sources when we look for fraud and waste. Investigators should not use claims data alone. Public records data sets include Federal and State sanctions information for all states. Criminal history and business relationships between suspicious providers also provide keen insights to investigators. This data can be queried automatically as part of an integrated fraud and abuse detection system and also is available as a standalone searchable platform of which I will show an example next.

Slide 13: Linking Public Records Data to Claims for Enhanced FWA Detection

This screen shows how easy it is to request a review of one of the ranked providers.

Slide 14: Linking Public Records Data to Claims for Enhanced FWA Detection

And then we can see that the selected provider has 4 sanction records.

Slide 15: Ranked Provider Drill Down

This portion of CLEAR presents a Link Analysis Chart showing our provider's relationship to other corporate entities. These 2 providers were found to be linked to a total of 19 providers, many on the board of directors of the other providers – and as this shows, they work out of this strip mall which clearly doesn't seem to support the millions of dollars billed to Medicare by these providers.

Slide 16: Oxycontin Abuse

Another area where the clinical enhancement of the data is invaluable in fraud, waste and abuse detection is in the area of prescription drugs. One of the clinical enhancements of the data is to apply drug classification data to claims using our Redbook product. We add therapeutic class, whether or not the drug has a generic alternative, and the DEA class of the drug, with Schedule II meaning "narcotics". In this example, we start with a standard report and look at the Top 100 Drugs prescribed. As you can see, Oxycontin, a highly abused drug, is in the top 10. The measures include net payment per script, the number of scripts used per patient and the number of total scripts.

Slide 17: Oxycontin Abuse

To drill down, we select "DEA Schedule II" which is not a field included on the claims. Oxycontin is the top Schedule II drug prescribed.

Slide 18: Oxycontin Abuse

To investigate Oxycontin users in more detail I can select a subset for just those beneficiaries that have greater than 180 days of supply in a year. I use these English words in my query instead of the hundreds of NDC codes for Oxycontin and other Schedule II drugs.

Slide 19: Oxycontin Abuse

Opening the report shows those people who have taken over 180 days of Oxycontin. Note that many of those patients use other Schedule II drugs in addition to Oxycontin. One individual has 359 days supply of Oxycontin and also has 178 days supply of other Schedule II narcotics.

Slide 20: Oxycontin Abuse

Drilling down to this individual shows an 80-year old male, with uncomplicated diabetes (stage 1.03) who has been prescribed 42 narcotics scripts. Performing this clinical analysis for every drill down needed in a waste and abuse study would take thousands of hours if a clinically-based detection system weren't used.

Slide 21: Gold Card Low Risk Providers

The process of assigning Gold Card status to providers who routinely bill appropriately reduces the necessity to apply these advanced analytics to each and every claim submitted. Investigators can spend the majority of their time researching claims that look like outliers. Prepayment systems can edit all claims but predictive analytics can be applied to the smaller set of claims from providers who don't have Gold Card status. This is a much more efficient use of technology and investigator time.

Slide 22: Thomson Reuters Clients

Our Thomson Reuters clients who use clinically-based analytics include 22 State Medicaid agencies that are identifying hundreds of millions of dollars in fraud, waste and abuse. Additionally, CMS has Advantage Suite implemented for all 45 million beneficiaries nationwide. Two ZPICs have been trained and other users are now being trained. Many of our large employer clients are now focused on mitigating losses to fraud and abuse. Our public records search engine is used by

the Department of Justice (DOJ), Health and Human Services (HHS), the Department of Homeland Security (DHS) and numerous State Law Enforcement agencies. Perhaps the next step should be to integrate these powerful solutions to enhance each agencies effectiveness in combating fraud, waste and abuse.

Slide 23: Summary Statement

As documented in the White Papers attached to my testimony, the problem of fraud, waste and abuse in healthcare is huge. We have done a lot to help our clients combat this problem. CMS has taken many steps to implement predictive modeling and clinically-based detection systems. That said, there is still much to do. Thomson Reuters won't let up. We will continue to work hard and fast to deploy the best technologies and subject matter experts to stay ahead of those who defraud the government. Due to the complexity of these issues, all stakeholders, including the Department of Justice, state Medicaid agencies and the Office of the Inspector General should collaborate to leverage these solutions for the most effective mitigation possible.

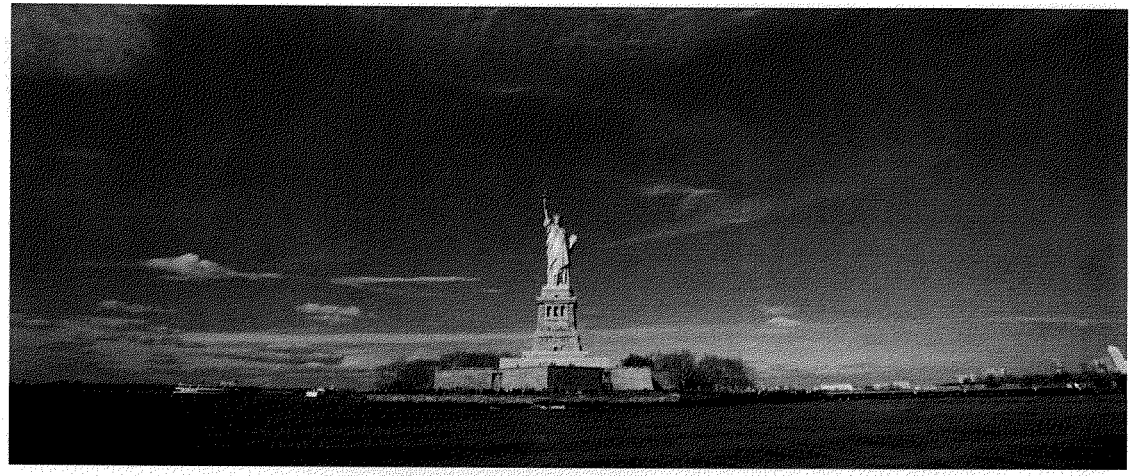
SUBCOMMITTEE ON HEALTH CARE, DISTRICT OF COLUMBIA, CENSUS AND THE NATIONAL ARCHIVES OF THE COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

WRITTEN TESTIMONY

Part 2 Slides and Demonstration

Jean MacQuarrie
VP, Healthcare Payment Integrity Practice

THOMSON REUTERS



Jean MacQuarrie

VP, Healthcare Payment Integrity Practice

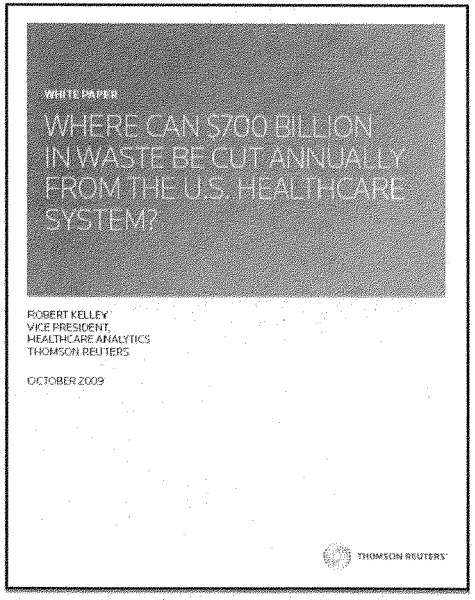
THOMSON REUTERS

TESTIMONY OUTLINE

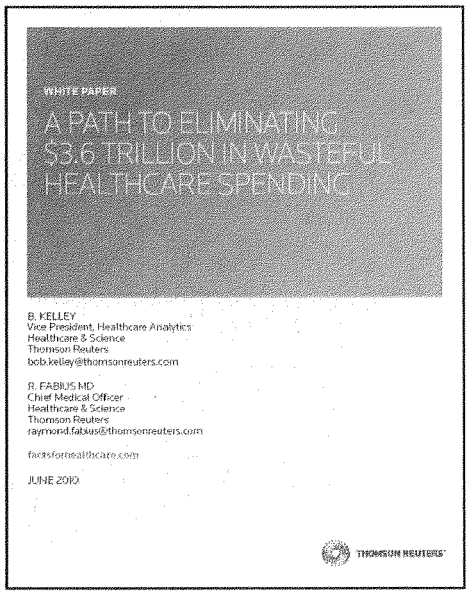
- Waste in the U.S. healthcare system, including fighting fraud and abuse
- The importance of having clinically-based analytics in an effective Fraud, Waste and Abuse (FWA) system
- The importance of leveraging external data not on claims to help validate claims accuracy
- The need to Gold Card good providers so we can focus our data mining and analytics on outliers

DOCUMENTED WASTE IN THE SYSTEM

Where Can $700 Billion in Waste be Cut Annually From the U.S. Healthcare System?

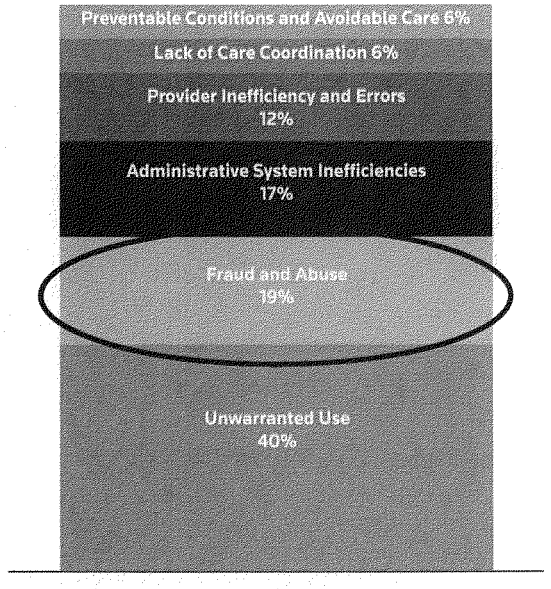


A Path to Eliminating $3.6 Trillion in Wasteful Healthcare Spending



FRAUD, WASTE, AND ABUSE COSTS

	Cost in Billions
1. Unwarranted Use	$250-325
2. **Fraud and Abuse**	**$125-175**
3. Administrative Inefficiencies	$100-150
4. Provider Inefficiency and Errors	$75-100
5. Lack of Care Coordination	$25-50
6. Preventable Conditions	$25-50
	$600-850



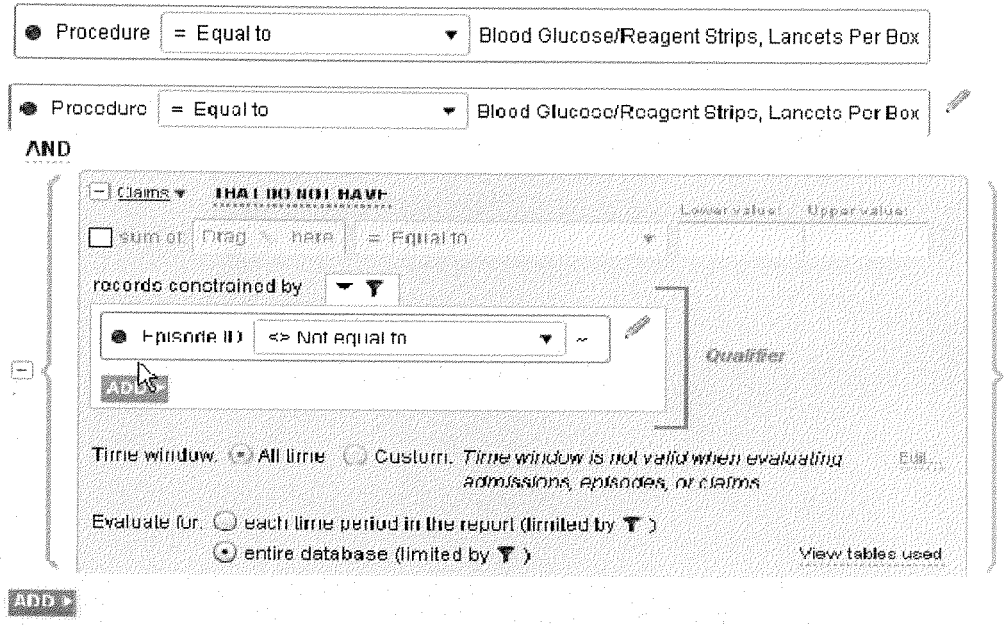
CLINICALLY-BASED ANALYTICS

- Healthcare delivery is complex
- Providers treat beneficiaries differently, for the same condition
- Claims analysis alone not sufficient to determine appropriateness of treatment
- Clinical-based analytics are essential for accurate Fraud, Waste and Abuse (FWA) detection
- Intelligence needs to be in the software to help the investigator
- Allows rapid and clinically-accurate data mining

CLINICALLY-BASED ANALYTICS

- Episodes of Care – Aggregates of inpatient, outpatient and drug claims into 550 disease categories with severity stages. Episode Grouping enables investigators to validate claims against patient conditions.
- Admissions – Group together all costs associated with a hospital stay including the physician care.
- Clinical Measures and Subsets are pre-constructed on the most common and abused conditions like Diabetes and Narcotics.
- Added clinical intelligence is added to the claims data to facilitate analysis (e.g., Drug Product Name, Therapeutic Class, and Clinical Intensity).
- Clinical Methods like Benchmarks, Case-Mix and Age-Sex Adjustment are necessary to determine true outliers.

ADVANTAGE SUITE – DIABETES TEST STRIPS WITHOUT A DIABETES EPISODE



ADVANTAGE SUITE – DIABETES TEST STRIPS WITHOUT A DIABETES EPISODE

016 Diabetic Supplies Not in an Episode

Time Period: Incurred Year	2004		
	Test Strip and Lancet Services	Test Strip and Lancet Services Not in an Episode	% Test Strip and Lancet Services Not in an Episode
Provider ID and Name			
2999313176 West Tall Maple Junction Drugs	1,925	1,808	94%
2999439351 West White River Quality Drugs	4,379	1,128	26%
2999314224 Alpine Valley Drugs	1,142	1,125	99%
2999381744 West White Bay Mall Pharmacy	1,586	953	60%
2999331866 West Tall Lake City Pharmacy	1,052	655	62%
2999318589 West Tall Pine Park Pharmacy	3,236	602	18%
2999293156 West Tall Island A-1 Pharmacy	1,032	600	58%
2999927629 Corner Mall Pharmacy	746	579	78%
2999314307 Rec Rose Pharmacy	678	556	82%
2999396403 W. White Isle Crossing Drugs	779	512	66%
2999381751 West White Bay Plaza Pharmacy	1,576	487	31%
2999292503 W. Tall Canyon Junction Drugs	883	477	54%
2999932363 White Valley City Pharmacy	560	477	85%
2999429758 West White Oak Top Rx Pharmacy	490	472	96%
2999428701 West White Oak Park Pharmacy	573	449	78%
2999293220 W. Tall Island Crossing Drugs	999	428	43%
2999293360 Beech Tree Pharmacy	1,034	418	40%
2999450134 West White Valley Pharmacy	425	400	94%

MEDICAID FWA SURVEILLANCE

Cognos > Public Folders > Medstat MktScan AS Medicaid Demo thmdtbe72-advom424_build > I
advom424 Reports > Demo > Template reports > Adhoc Reports > **SURS**

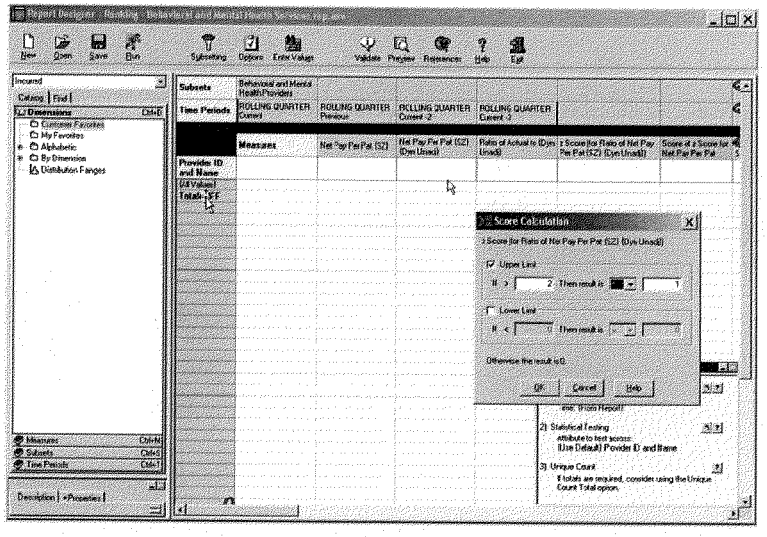
Name	Description
Ranking - Behavioral and Mental Health Services	
Ranking - Blind or Disabled Recipients	
Ranking - Clinic Services	
Ranking - Dental Services	
Ranking - Home Health Services	
Ranking - Inpatient Hospital Services	
Ranking - Laboratory and Radiology Services	
Ranking - Medical Supply Providers	
Ranking - Nursing Facility Services	
Ranking - Outpatient Hospital Services	
Ranking - Physician Services	
Ranking - Prescribed Drugs Pharmacy Services	
Ranking - Therapy Providers	
Ranking - Transportation Services	
Summary Profile - Physician Services	
Summary Profile - Prescribed Drugs Pharmacy	
Summary Profile - Recipients	

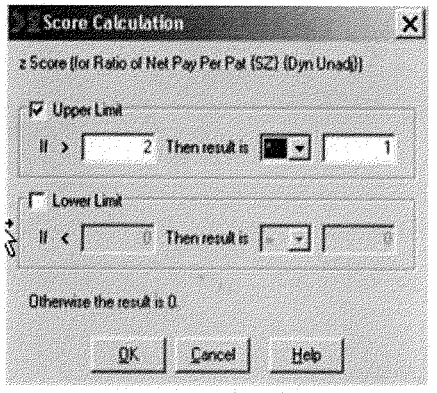
MEDICAID FWA SURVEILLANCE

Subset		Behavioral and Mental Health Providers								
Time Period		Jul 2005 - Sep 2005								
Provider ID	and Name	Net Pay Per Pat {SZ}	Net Pay Per Pat {SZ} {Dyn Unadj}	Score of z Score for Net Pay Per Pat	Net Pay Per Svc Med {SZ}	Net Pay Per Svc Med {SZ} {Dyn Unadj}	Score of z Score for Net Pay Per Svc Med	Svcs Per Pat Med {SZ}	Svcs Per Pat Med {SZ} {Dyn Unadj}	Score of z Score for Svcs Per Pat Med
2999543954	S. Blue Sky Cove Home Health	$8,974.58	$355.90	4.77	$3,167.53	$64.56	16.50	2.83	13.26	0.30
2999368634	Dr. Burnita Keno	$11,885.75	$355.90	9.09	$200.04	$64.56	4.66	59.42	13.26	2.38
2999447297	Dr. Dimitri Stripp	$10,562.15	$355.90	8.51	$183.99	$64.56	4.28	57.41	13.26	2.33
2999877535	Hillside Meadows Medical Ctr	$6,634.55	$355.90	7.61	$86.13	$64.56	0.00	76.98	13.26	6.11
2999436134	Inocencia Kileny, PhD	$284.53	$355.90	0.00	$73.87	$64.56	0.00	3.86	13.26	0.30
2999298914	Dr. Barbara M Swarts	$183.00	$355.90	0.00	$4.17	$64.56	0.00	43.83	13.26	0.30

Svcs Per Pat Group Counseling {SZ}	Svcs Per Pat Group Counseling {SZ} {Dyn Unadj}	Score of z Score for Svcs Per Pat Group Counseling	Svcs Per Pat Indiv Counseling {SZ}	Svcs Per Pat Indiv Counseling {SZ} {Dyn Unadj}	Score of z Score for Svcs Per Pat Indiv Counseling	Svcs Psych Testing Per Pat Med {SZ}	Svcs Psych Testing Per Pat Med {SZ} {Dyn Unadj}	Score of z Score for Svcs Psych Testing Per Pat Med	Quarter Score	Cross Quarter Total Score	Rank
#N/A	6.12	0.00	#N/A	4.65	0.00	0.00	0.13	0.00	21.27	68.43	1
#N/A	6.12	0.00	#N/A	4.65	0.00	0.00	0.13	0.00	16.62	66.19	2
#N/A	6.12	0.00	#N/A	4.65	0.00	0.00	0.13	0.00	15.72	65.38	3
#N/A	6.12	0.00	#N/A	4.65	0.00	0.00	0.13	0.00	13.72	63.33	4
#N/A	6.12	0.00	2.83	4.65	0.00	0.36	0.13	0.00	0.00	40.09	5
#N/A	6.12	0.00	2.33	4.65	0.00	0.00	0.13	0.00	0.00	37.99	6

MEDICAID FWA SURVEILLANCE

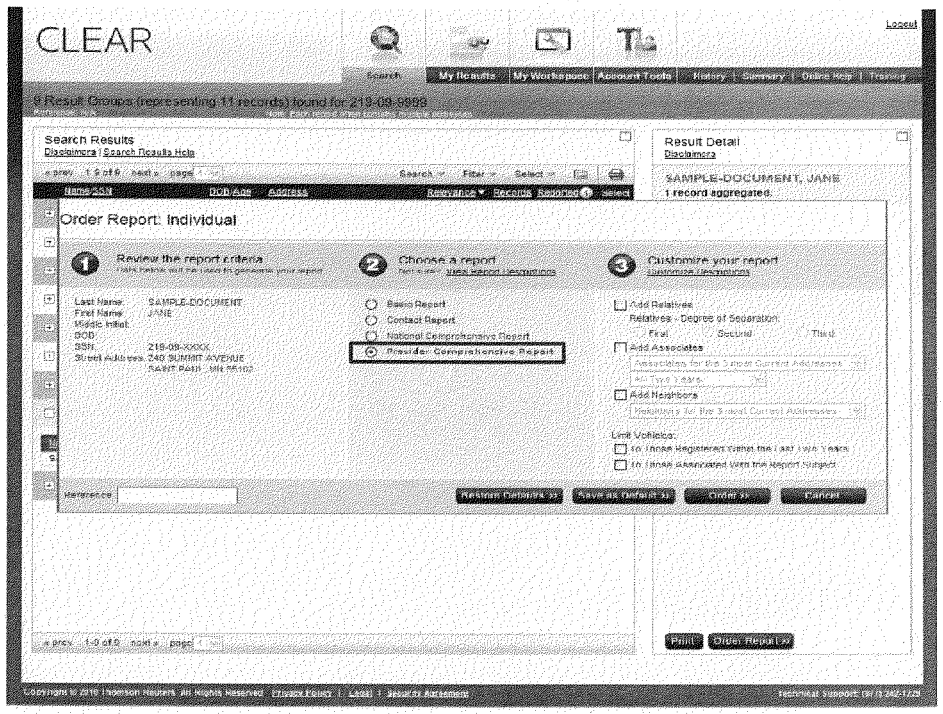




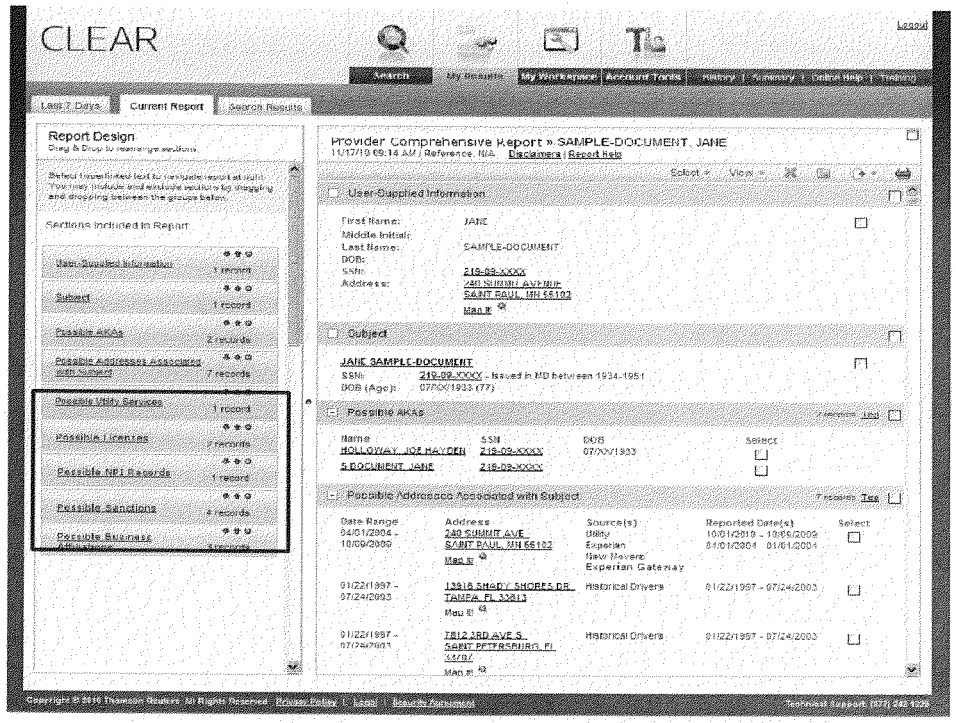
LINKING PUBLIC RECORDS DATA TO CLAIMS FOR ENHANCED FWA DETECTION

- Death Records
- Federal and State Sanctions – all States
- Criminal Records
- Liens and Judgments
- Corporate Records
- Corporate Relationships
- Motor Vehicle Records
- Names, AKAs, Other Addresses

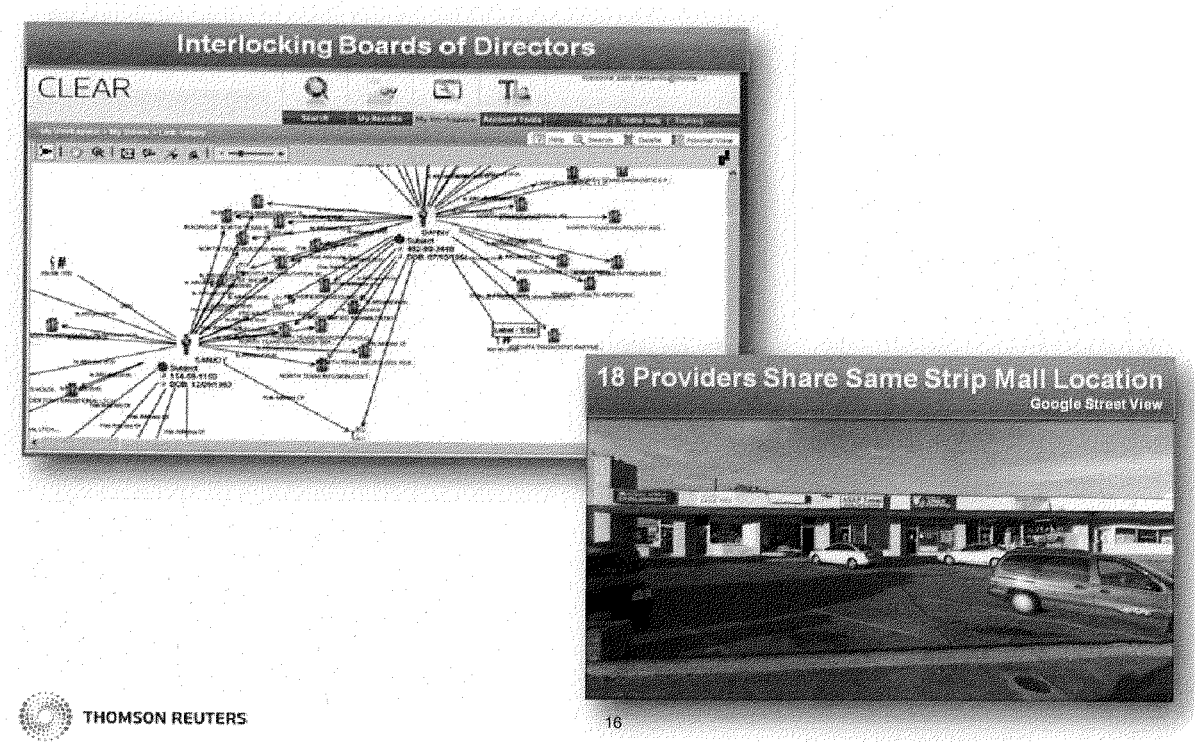
PUBLIC RECORDS SEARCH ENGINE



PUBLIC RECORDS SEARCH ENGINE



CLEAR – RANKED PROVIDER DRILL DOWN



THOMSON REUTERS

OXYCONTIN ABUSE

017 Top 100 Drugs

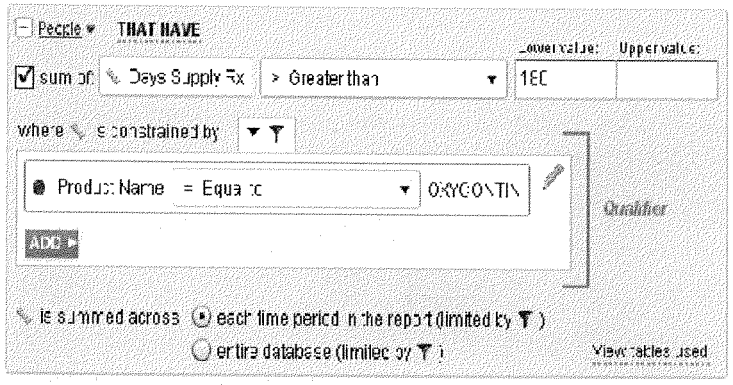
Subsets / Time Period: Incurred Rolling Year	Standard View			
	Oct 2004 - Sep 2005			
	Net Pay Rx	Net Pay Per Script Rx	Scripts Per Pat Rx	Scripts Rx
Product Name				
ZYPREXA	$8,839,153.75	$325.48	6.24	27,157
RISPERDAL	$6,465,248.08	$189.55	6.53	34,108
PREVACID	$3,302,617.72	$146.99	3.96	22,469
PRILOSEC	$3,238,546.31	$164.04	4.42	19,743
SEROQUEL	$3,134,453.93	$207.50	6.00	15,106
CELEBREX	$2,783,400.48	$107.16	3.55	25,974
LIPITOR	$2,235,173.80	$86.23	4.28	25,933
PAXIL	$2,082,874.62	$92.89	4.25	22,424
NEURONTIN	$1,982,327.17	$115.43	4.57	17,174
OXYCONTIN	$1,734,914.60	$286.76	5.60	6,050
ZOLOFT	$1,668,323.63	$73.22	4.44	22,785
NORVASC	$1,649,130.99	$56.73	4.83	29,068
DEPAKOTE	$1,569,898.24	$104.31	5.46	15,051

OXYCONTIN ABUSE

01/a Top 100 Drugs Schedule II

Subsets	Standard View			
Time Period: Incurred Rolling Year	Oct 2004 - Sep 2005			
DEA Class	Schedule II			
	Net Pay Rx	Net Pay Per Script Rx	Scripts Per Pat Rx	Scripts Rx
Product Name				
OXYCONTIN	$1,734,414.60	$286.76	5.60	6,050
DURAGESIC	$1,027,105.23	$201.91	5.02	5,087
CONCERTA	$534,552.78	$78.84	4.22	6,780
ADDERALL XR	$410,464.31	$79.79	4.07	5,144
ADDERALL	$405,487.51	$77.19	3.20	5,253
MORPHINE SULFATE	$195,337.92	$109.43	2.94	1,785
METHYLPHENIDATE HCL	$150,857.56	$32.91	3.61	4,584
MS CONTIN	$144,543.53	$102.41	4.10	890
AMPHETAMINE SALT COMBO	$141,631.07	$71.42	2.35	1,983
ACTIQ	$126,817.23	$912.35	4.21	139
ORAMORPH SR	$120,709.06	$353.99	2.64	341
PERCOCET	$79,390.87	$83.48	2.40	951
ENDOCET	$65,221.82	$26.29	2.36	2,481
METADATE CD	$56,720.50	$49.67	3.30	1,142
DILAUDID	$45,383.77	$106.79	5.82	425
APAP/OXYCODONE	$39,247.98	$11.03	1.69	3,559

OXYCONTIN ABUSE



018 Drugs taken by Heavy Oxycontin Users

Subset	017 Pats w GT 180 Days Oxycontin	
Time Period: Incurred Year	2005	
DEA Class	Schedule II	
	Patients Rx	Days Supply Rx
Product Name		
OXYCONTIN	335	92,392
OXYCODONE HCL	46	5,236
DURAGESIC	32	2,486
ROXICODONE	30	2,993
APAP/OXYCODONE	26	984
OXY IR	25	2,010
ROXICET	23	1,878
ENDOCET	21	1,464
MORPHINE SULFATE	19	1,180
PERCOCET	15	950
ACTIQ	14	925
METHADONE HCL	12	1,081
HYDROMORPHONE HCL	10	877
ENDODAN	9	924
DILAUDID	6	662
MEPERIDINE HCL	6	341
METHADOSE	5	246

OXYCONTIN ABUSE

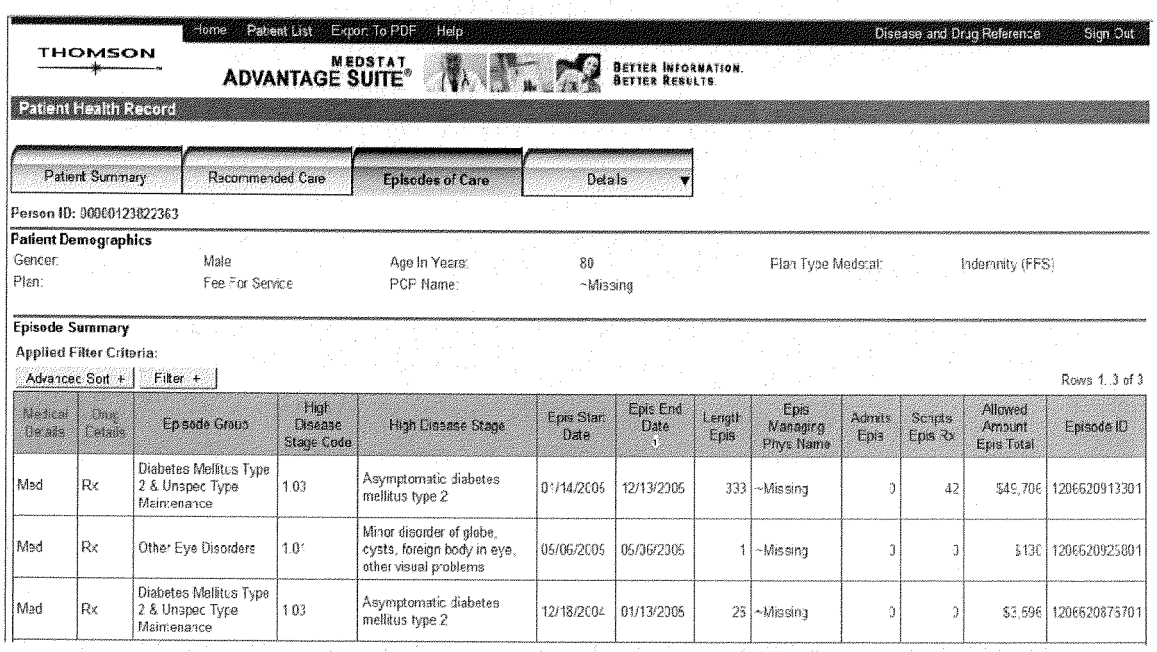
019 Top Oxycontin Users

Subsets	017 Pats w GT 180 Days Oxycontin	
Time Period: Incurred Year	2005	
DEA Class	Schedule II	
	Days Supply Rx	
Product Name	Oxycontin	All Other Values
Person ID		
00000155068220 PHR	600	
00000203895226 PHR	590	
00000103976451 PHR	540	131
00000104422842 PHR	540	
00000154387589 PHR	540	96
00000158563821 PHR	540	165
00000199917548 PHR	540	
00000143792143 PHR	510	
00000125487214 PHR	498	
00000138426643 PHR	473	87
00000170075199 PHR	460	8
00000180788698 PHR	455	
00000203906057 PHR	455	170
00000108963338 PHR	451	263
00000208829648 PHR	450	

019 Top Oxycontin Users

Subsets	017 Pats w GT 180 Days Oxycontin	
Time Period: Incurred Year	2005	
DEA Class	Schedule II	
	Days Supply Rx	
Product Name	Oxycontin	All Other Values
Person ID		
00000117537240 PHR	420	
00000134160391 PHR	413	30
00000167637375 PHR	404	41
00000207341637 PHR	400	
00000128265226 PHR	384	468
00000139569662 PHR	382	209
00000140128548 PHR	379	29
00000206497448 PHR	378	300
00000202132490 PHR	376	148
00000114896475 PHR	370	259
00000142495273 PHR	365	16
00000206498693 PHR	364	235
00000108355224 PHR	360	13
00000207794021 PHR	360	202
00000123822363 PHR	359	178

OXYCONTIN ABUSE



Home Patient List Export To PDF Help Disease and Drug Reference Sign Out

THOMSON

MEDSTAT ADVANTAGE SUITE®

BETTER INFORMATION. BETTER RESULTS.

Patient Health Record

Patient Summary | Recommended Care | Episodes of Care | Details

Person ID: 00000123822363

Patient Demographics

Gender:	Male	Age In Years:	80	Plan Type Medicat:	Indemnity (FFS)
Plan:	Fee For Service	PCP Name:	~Missing		

Episode Summary

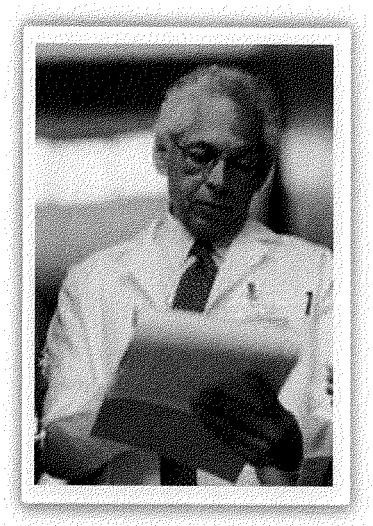
Applied Filter Criteria:

Advanced Sort + | Filter +

Rows 1..3 of 3

Medical Details	Drug Details	Episode Group	High Disease Stage Code	High Disease Stage	Epis Start Date	Epis End Date	Length Epis	Epis Managing Phys Name	Admits Epis	Scripts Epis Rx	Allowed Amount Epis Total	Episode ID
Med	Rx	Diabetes Mellitus Type 2 & Unspec Type Maintenance	1.03	Asymptomatic diabetes mellitus type 2	01/14/2005	12/13/2005	333	~Missing	0	42	$49,706	1206620913301
Med	Rx	Other Eye Disorders	1.01	Minor disorder of globe, cysts, foreign body in eye, other visual problems	05/06/2005	05/06/2005	1	~Missing	0	0	$130	1206620925801
Med	Rx	Diabetes Mellitus Type 2 & Unspec Type Maintenance	1.03	Asymptomatic diabetes mellitus type 2	12/18/2004	01/13/2005	25	~Missing	0	0	$3,596	1206620875701

RECOGNIZE PROVEN LOW RISK PROVIDERS WITH GOLD CARD STATUS



- Gold Card providers are reviewed less frequently
- Allows the majority of investigative effort to be dedicated to outliers
- Allows pre-payment algorithms to process less data
- Measure Return on Investment (ROI) consistently across stakeholders

THOMSON REUTERS ADVANTAGE SUITE CLIENTS

- 22 State Medicaid Agencies
  - Achieving hundreds of millions of dollars in savings
- Being adopted by increasing number of 200 Large Employer Clients
- CMS – One Program Integrity (One PI)

Next step might be to integrate DOJ, HHS, DHS and State Law Enforcement Agencies

SUMMARY STATEMENT

As documented in the White Papers attached to my testimony, the problem of fraud, waste and abuse in healthcare is huge. We have done a lot to help our clients combat this problem. CMS has taken many steps to implement predictive modeling and clinically-based detection systems. That said, there is still much to do. Thomson Reuters won't let up. We will continue to work hard and fast to develop and deploy the best technologies and utilize subject matter expertise to stay ahead of those who defraud the government. Due to the complexity of these issues, all stakeholders, including the Department of Justice, state Medicaid agencies and the Office of the Inspector General should collaborate to leverage these solutions for the most effective mitigation possible.

Mr. GOWDY. Yes, ma'am, thank you.
Mr. Cannon.

STATEMENT OF MICHAEL F. CANNON

Mr. CANNON. Thank you, Mr. Chairman and Ranking Member Davis, for this opportunity to address the committee on this very important issue.

My name is Michael Cannon. I am the director of health policy studies at the Cato Institute. The Cato Institute is a libertarian think tank founded in 1977 to promote the ideas of individual liberty, limited government, free markets and peace.

The best evidence that we have suggests that $1 out of every $3 that Medicare spends is pure waste; that is, it provides zero benefit to Medicare enrollees, either in terms of improved health or greater patient satisfaction.

Fraud and improper payments exceed—likely exceed 9 percent of Medicare spending and have been estimated to be as high as 40 percent in the New York State Medicaid program. Medicaid abuse is so great, entire cottage industries of consultants and lawyers have emerged to help individuals and States abuse the program.

It is difficult to convey the magnitude of waste, fraud and abuse in Medicare and Medicaid. We often hear about how private insurance companies earn excessive profits, while insurance company profits on an annual basis come to about $12 or $13 billion a year. Improper payments in Medicare, including fraud, have been clocked at $48 billion per year. So for every $1 the private insurance companies earn in profits, Medicare loses $4 to fraud and other improper payments. When we include Medicaid, the Federal Government loses nearly $6 to fraud and improper payments for every $1 that insurance companies earn in profits.

We often hear about how there is too much money in political campaigns. Well, if you look at all Federal campaigns, if you look at spending by all candidates, all parties, all independent groups seeking to influence Federal elections in both 2007 and 2008, the sum total of all that spending comes to just over $5 billion. Medicare loses roughly 25 times that amount each year to wasteful health care spending, that is health care spending that does nothing to improve the health or improve patient satisfaction for Medicare enrollees.

Medicare fraud is not confined to the behavior of criminals and a few health care providers. Elected and unelectedofficials in both the legislative and executive branches of the Federal Government routinely defraud the American public by pretending that the so-called Medicare trust funds contain actual assets that may be used to pay Medicare benefits. As the Clinton administration explained in its 2000 budget submission, the balances in the Medicare and Social Security trust funds, "Do not consist of real economic assets that can be drawn down in the future to fund benefits. The existence of large trust fund balances therefore does not by itself have any impact on the government's ability to pay benefits."

I should note that was an aberration that appeared in one of the Clinton administration's budgets. And I don't know that any statement that frank has appeared in any budget submission since.

Congress and the White House under the control of the both parties have also defrauded the American people by using budgetary gimmicks to hide the full cost of Medicare. These fraudulent gimmicks include the legislative reductions in Medicare payments to physicians under the Balanced Budget Act of 1997, passed under Republican control of Congress, and to part A providers under the Patient Protection and Affordable Care Act of 2010, passed under a Democratically controlled Congress.

Such spending reductions are so politically implausible that Congress routinely rescinds them, yet their inclusion in statute makes Medicare appear less costly than it actually will prove to be in a 10-year budget window and beyond. This type of fraud has become so routine that the Congressional Budget Office attempts to correct for it by projecting future Medicare outlays based on current policy, assuming that Congress rescinds the spending reductions as opposed to current law, which assumes the reductions will take affect.

I think this hearing is particularly timely given the budget blueprint that House Budget Committee Chairman Paul Ryan has introduced today. The Medicare and Medicaid reforms in that proposal could dramatically reduce waste, fraud and abuse in those programs, and I think that expanding those proposals would do even more to combat fraud, waste and abuse. Thank you.

[The prepared statement of Mr. Cannon follows:]

Testimony of

Michael F. Cannon
Director of Health Policy Studies
The Cato Institute[1]
Washington, D.C.

Subcommittee on Health Care, District of Columbia, Census, and the National Archives
Committee on Oversight and Government Reform
United States House of Representatives

Waste, Fraud, and Abuse in Government Health Care

April 5, 2011

Chairman Gowdy and members of the subcommittee, it is a pleasure to be present with you today to discuss waste, fraud, and abuse in government health care programs. I will focus on the two largest such programs, Medicare and Medicaid.

As it happens, the best available data on waste in the U.S. health care sector comes from the Medicare program. That body of research suggests that one third of Medicare spending offers no benefit to seniors whatsoever. Fraud is prevalent in both Medicare and Medicaid, and occurs not just at the hands of those who dispense or receive government subsidies, but also at the hands of elected and unelected officials in how they communicate the costs of those programs to the public. Abuse is most readily identifiable in Medicaid, where millions of Americans, who could obtain health or long-term care insurance on their own, instead opt to have taxpayers pay their medical and long-term care expenses, while states use various inappropriate schemes to maximize their pull-down of federal Medicaid dollars.

The acute problems of waste, fraud, and abuse in Medicare and Medicaid are not a consequence of fee-for-service payment or any other particular design feature; they are a consequence of *government*. All economic endeavors involve the risks of waste, fraud, and abuse. But these problems are endemic to government for the simple reason that government spends other people's money, and nobody spends other people's money as carefully as they spend their own. The only way to eliminate waste, fraud, and abuse in a governmental activity is to eliminate that activity.

This hearing is particularly timely given the budget blueprint that House Budget Committee chairman Paul Ryan (R-Wisc.) has introduced today. The Medicare and Medicaid

reforms in that proposal could dramatically reduce waste, fraud, and abuse in those programs. Expanding those proposals would do even more to combat waste, fraud, and abuse.

Wasteful Medicare Spending

Decades ago, researchers now affiliated with the Dartmouth Atlas stumbled across what may be the best method of detecting wasteful spending in an economic sector as complex as medicine. They noticed that patients in some areas consume a lot more medical care than patients in other areas — more office visits (to specialists in particular), more diagnostic tests, more procedures, more hospitalizations, *et cetera*. Dartmouth researchers began to question whether the patients who consume more care actually benefit from that additional care. They have therefore spent the past few decades measuring both geographic variation in medical consumption, as well as any benefits of that consumption for which they can find data. Do patients in high-spending areas start out sicker than patients in low-spending areas? Do they end up healthier? Are they more satisfied with their care? The Dartmouth researchers are scientists trying to capture the empirical reality of America's health care sector. They have been doing this for a long time, they are very good at it, and they consistently find that a lot of the medical care that Medicare purchases is wasteful. That is, it appears to provide zero value.[2]

That finding has drawn intense criticism, not least from health care providers in high-spending areas, whose efficacy and resource use it calls into question. Dartmouth researchers have tried to address those criticisms by approaching the issue from whatever angles the data will allow. It is possible, and many critics claim, that high-spending regions spend more because they treat sicker patients. The Dartmouth folks have therefore controlled for patients' health status, then measured whether patients in high-spending areas experienced better outcomes.[3] It is certain, as critics also note, that those controls are imperfect. Dartmouth researchers have therefore controlled for the ultimate outcome — death — by measuring geographic variation in Medicare enrollees' medical consumption in the last six months of life. That too is an imperfect strategy: it is possible that high-spending regions are doing things that keep some Medicare patients alive and out of that cohort. Dartmouth researchers have compared variations in spending to measures of quality other than health outcomes, including "process" measures that show whether doctors are following evidence-based treatment guidelines. To determine whether patient preferences are driving geographic variation, they have compared consumption patterns to surveys estimating patients' preferences for more- vs. less-aggressive treatment.

These various strategies consistently show that a large share of Medicare spending cannot be explained by patient characteristics, patient preferences, or better health outcomes. Indeed, Dartmouth researchers have even found that higher spending often correlates to lower-quality care.[4] These findings suggest that perhaps one-third of Medicare spending is not making patients any healthier or happier.[5]

These research strategies are not perfect, either individually or in the aggregate, because the data are imperfect and medicine is extraordinarily complex. Nevertheless, the central finding – that Medicare wastes a substantial portion of its nearly $500 billion annual budget – has held up to many different research strategies. Dartmouth researchers have produced a sizable and credible body of research that suggests as much as one third of Medicare spending is little more

than a wealth transfer from taxpayers and premium-payers to health care providers and medical suppliers.

Moving Medicare from its current structure as an open-ended entitlement to a voucher system would help reduce wasteful health care spending by giving seniors an incentive to avoid low- and zero-value services. At present, Medicare enrollees have little incentive to avoid wasteful expenditures because they do not reap the savings. A well-designed voucher system, however, would give each Medicare enrollee a fixed sum of money with which they could purchase any private health insurance plan they choose. Enrollees who choose an economical plan could keep the savings in a health savings account and pass any balances on to their heirs. Chairman Ryan's proposal takes a large step in this direction, though I do see room for improvements.[6]

Skeptics may worry that seniors will make bad decisions with their vouchers, or that the voucher amounts may prove inadequate. They should consider what the Dartmouth Atlas implies for vouchers. As President Obama's Council of Economic Advisers put it, "nearly 30 percent of Medicare's costs could be saved without adverse health consequences."[7] In other words, vouchers would come with a huge built-in margin of safety: seniors could consume one-third less care without any harming their health. At the same time, vouchers would improve the quality of care for seniors by encouraging "accountable care organizations" and other innovations.[8]

Medicare & Medicaid Fraud

Medicare and Medicaid are rife with fraud and other types of improper payments. The Centers for Medicare and Medicaid Services estimates that Medicare made at least $48 billion in improper payments in 2010.[9] That figure does not include improper payments in Part D, which auditors believe is also highly susceptible to abuse.[10] Nevertheless, $48 billion amounts to more than 9 percent of total Medicare spending and nearly four times the combined profits of private health insurance companies.[11] CMS also estimates that the federal government alone made $22.5 billion in improper Medicaid payments in 2010, making the combined total of improper payments in the two programs somewhere north of $70 billion per year.[12] In one infamous case, a New York dentist once billed that state's Medicaid program for 991 procedures in a single day. In 2005, the *New York Times* reported that New York's Medicaid program "has become so huge, so complex and so lightly policed that it is easily exploited," and that "a chief state investigator of Medicaid fraud and abuse in New York City said he and his colleagues believed that at least 10 percent of state Medicaid dollars were spent on fraudulent claims, while 20 or 30 percent more were siphoned off by what they termed abuse, meaning unnecessary spending that might not be criminal."[13] Some experts estimate that improper payments are even more prevalent in these programs. Harvard University's Malcolm Sparrow estimates that improper payments account for 20 percent of spending in federal health care programs.[14] That suggests Medicare alone makes $100 billion in improper payments annually. The Government Accountability Office has for two decades designated both Medicare and Medicaid as posing a high risk for fraud.[15] Decades of congressional efforts to combat Medicare and Medicaid fraud have proven largely fruitless and even harmful to patients, as my colleague Prof. David Hyman explains in his satirical book *Medicare Meets Mephistopheles*, an excerpt from which I have attached as an appendix.[16]

Medicare fraud is not confined to the behavior of criminals and a few health care providers.[17] Elected and unelected officials, in both legislative and executive branches of the federal government, routinely defraud the American public by pretending that the so-called Medicare trust funds contain assets that may be used to pay future Medicare benefits.[18] As the Clinton administration explained in its 2000 budget submission, the "balances" in the Medicare and Social Security trust funds "do not consist of real economic assets that can be drawn down in the future to fund benefits...The existence of large trust fund balances, therefore, does not, by itself, have any impact on the Government's ability to pay benefits."[19] Congress and the White House, under the control of both parties, have also defrauded the American people by using budgetary gimmicks that hide the full cost of Medicare. These fraudulent gimmicks include the legislated reductions in Medicare payments to physicians under the Balanced Budget Act of 1997 and Part A providers under the Patient Protection and Affordable Care Act of 2010. Such spending reductions are so politically implausible that Congress routinely rescinds them. Yet their inclusion in statute makes Medicare appear less costly than it actually will prove to be in a 10-year budget window and beyond. This type of fraud has become so routine that the Congressional Budget Office attempts to correct for it by projecting future Medicare outlays based on current *policy* (assuming that Congress rescinds the spending reductions) as opposed to current *law* (which assumes the reductions will take effect).[20]

The proposals advanced by Chairman Ryan would reduce fraud in both Medicare and Medicaid. Medicare fraud would decline because fraud would become easier to police. At present, Medicare makes more than 1 billion separate payments per year to "700,000 physicians, 6,000 hospitals and thousands of other providers and suppliers."[21] Converting Medicare to a voucher system would reduce the number of financial transactions Medicare performs to one per senior, which would dramatically reduce opportunities for fraud while increasing Medicare's ability to detect it. It would also be easier to detect and prosecute providers or insurers who attempt to defraud seniors. Under a voucher system, fraudsters would be cheating seniors out of the senior's own money, rather than the governments, which would make seniors more active partners in policing fraud.

Chairman Ryan's proposals would reduce Medicaid fraud by replacing the system of matching grants that Congress uses to fund state Medicaid programs with a system of block grants. At the margin, states pay for 43 percent of the cost of their Medicaid programs, while the federal government pays 57 percent. States therefore care about fraud less than half as much as they should, because the federal government bears most of the cost of Medicaid fraud. Under a system of block grants, states would bear 100 percent of the cost of fraud, and would therefore have a much greater incentive to detect and eliminate it.

Medicaid Abuse

As a means-tested program funded partly by open-ended federal matching grants, Medicaid is subject to abuse both by enrollees and by states. It is an abuse of the Medicaid program when individuals could obtain coverage on their own, but instead enroll in Medicaid so that taxpayers will cover their medical or long-term care expenses. For example, the *New York Times* recently reported, "Dr. Kim A. Hardey, an obstetrician-gynecologist in Lafayette, [La.,]

said…many of his patients have jobs with private insurance but switch to Medicaid when they become pregnant, avoiding premiums, deductibles and co-payments."[22] Medicaid has spawned a cottage industry of elder-law attorneys who offer to hide or shelter the assets of well-to-do seniors so that they will look poor on paper and thereby qualify to have Medicaid pay their long-term care expenses.[23] Such "crowd-out" of private coverage is a well-documented phenomenon in the economics literature.[24]

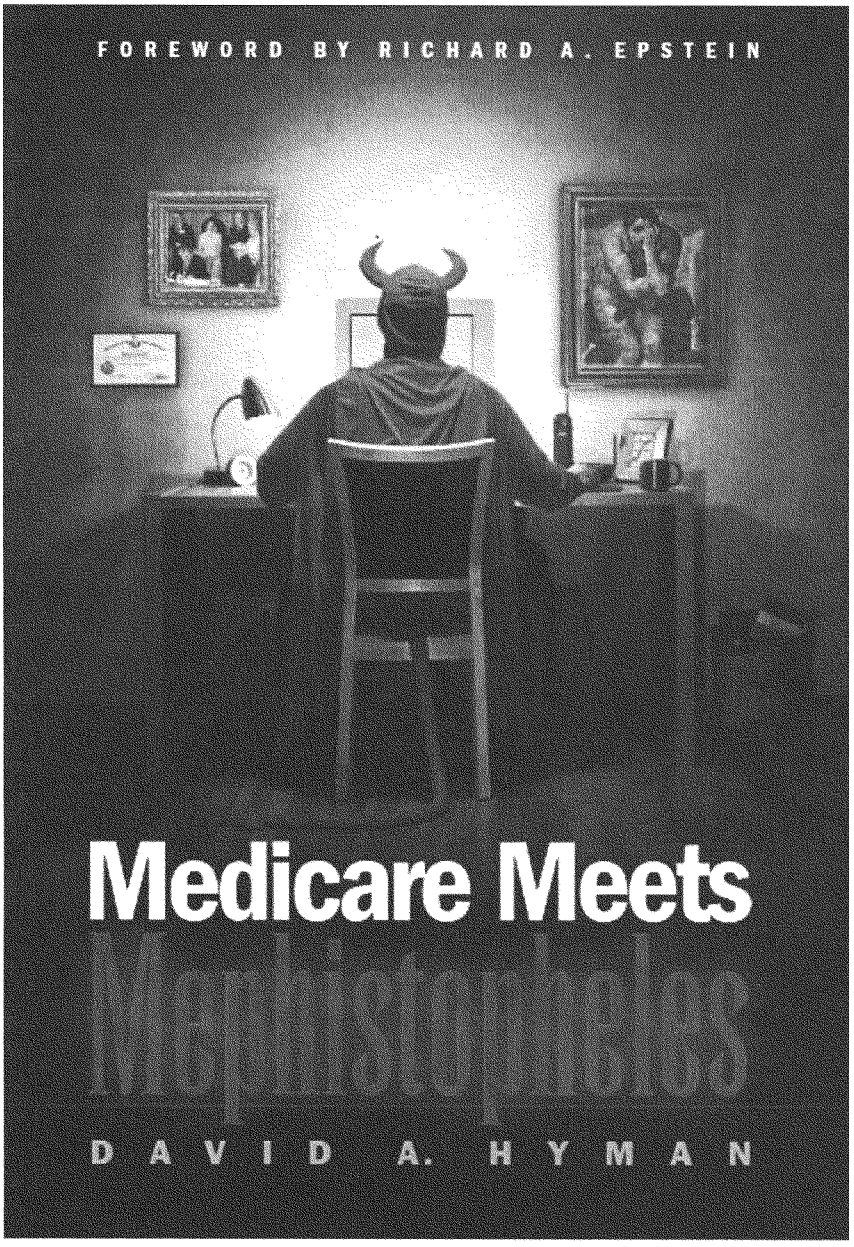
The federal government finances its share of Medicaid through a system of matching grants. The federal government will match each $1 a state spends on its Medicaid program with at least $1 and as much as $4 of federal funds. A matching-grant system creates an enormous incentive for states to *appear* to be allocating additional funds to their Medicaid programs, even if they are not. In 2007, the Government Accountability Office wrote, "GAO has reported for more than a decade on varied financing arrangements that inappropriately increase federal Medicaid matching payments. In reports issued from 1994 through 2005, GAO found that some states had received federal matching funds by paying certain government providers, such as county operated nursing homes, amounts that greatly exceeded established Medicaid rates. States would then bill CMS for the federal share of the payment. However, these large payments were often temporary, since some states required the providers to return most or all of the amount. States used the federal matching funds obtained in making these payments as they wished. Such financing arrangements had significant fiscal implications for the federal government and states. The exact amount of additional federal Medicaid funds generated through these arrangements is unknown, but was in the billions of dollars…[S]uch financing arrangements effectively increase the federal Medicaid share above what is established by law…They shift costs inappropriately from the states to the federal government, and take funding intended for covered Medicaid costs from providers, who do not under these arrangements retain the full payments."[25] In 2005, GAO reported that a cottage industry had emerged to help states abuse Medicaid's matching-grant system; the agency found that 34 states "are using consultants on a contingency-fee basis to maximize federal Medicaid reimbursements."[26]

Chairman Ryan's proposal to block-grant Medicaid would reduce both types of Medicaid abuse. Block grants would encourage states to reduce enrollments by non-needy residents because states would have bear 100 percent of the marginal cost of such abuse, rather than 50 percent or less. In addition, under a system of block grants there would be no policy levers that states could pull to increase their federal Medicaid funds.

Conclusion

I thank the committee for your attention, and I look forward to your questions.

Appendix


FOREWORD BY RICHARD A. EPSTEIN
Medicare Meets
Mephistopheles
DAVID A. HYMAN

Medicare Meets Mephistopheles

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CATO INSTITUTE
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Difficile est saturam non scribere
(It is hard not to write satire.)
Juvenal, *Satires, I*

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Medicare has resulted in extraordinary wealth for providers—not quite, as Samuel Johnson once put it, "beyond the dreams of avarice,"[3] but close. Yet, the whole point of avarice is that more than most is never quite enough, and providers ceaselessly agitate for increases in Medicare payments. As a concentrated special interest, providers have had considerable success in extracting ever-increasing sums from the federal fisc—in many instances convincing Congress to specify payment rates well in excess of those that would prevail in a free market.[4] As one former CMS administrator put it, "There are plenty of $400 toilet seats in the Medicare program because Medicare cannot deliver services to its beneficiaries without providers and because providers are major sources of campaign contributions in every congressional district in the nation."[5] Consistent with our larger goals, and as outlined in chapter 2, Medicare's compensation arrangements pay providers based on their inputs (procedures performed or time spent) and not their outputs (high-quality care actually delivered)—with predictable results on the quality and cost of care.[6]

Congress initially failed to appreciate how avarice would affect the Medicare program. When Medicare was enacted in 1965, a single provision prohibited making false statements to secure reimbursement. Matters did not remain in this pristine form for long, as the Medicare honeypot quickly attracted the more feloniously inclined members of the profession. In relatively short order, there developed a complicated interlocking array of health care-specific civil, criminal, and administrative anti-fraud laws and regulations enacted by the states and the federal government, along with multiple levels of investigative and enforcement agencies.[7] The following sidebar provides some background on how

Medicare Fraud and Abuse Laws: A Primer

Although a wide range of laws are potentially implicated by health care fraud, the three most significant provisions (anti-kickback, Stark, and false claims) are briefly outlined below.

Anti-Kickback

The anti-kickback statute was first enacted in 1972, and explicitly prohibited "kickbacks, bribes, or rebates" in connection with items or services for which payment could be made under Medicare.[8] For example, specialists and medical labs were prohibited from paying a general practitioner for sending business their way. No specific intent was required, and violation was a misdemeanor. The anti-kickback statute was substantially broadened in 1977 to include the solicitation or receipt of *any* remuneration, whether direct or indirect, overtly or covertly, in cash or in kind, in connection with items or services for which payment could be made under Medicare. Violation of the statute became a felony, subject to a maximum fine of $25,000 and imprisonment for up to five years. Various statutory and regulatory exceptions were created. Criminal prosecutions under the anti-kickback law have been relatively rare, and prosecutors have generally focused on the most egregious violations. Thus, the anti-kickback law provides fraud enforcers with a tool of tremendous power, but it is a tool that has, to date, received relatively limited use.

Self-Referral (Stark Amendments)

In 1989, Congress passed a limited prohibition on "self-referral" as part of a larger budget reconciliation act.[9] This provision, which was inserted at the insistence of Rep. Fortney (Pete) Stark, by whose name it is commonly known (Stark I), prohibits physicians from referring Medicare patients to a clinical laboratory in which they hold a financial interest, and prohibits the clinical laboratory from billing for services performed as a result of such referrals. In 1993, Congress passed Stark II, which prohibits physicians from referring Medicare patients to 10 additional categories of providers in which the referring physician or a family member has a financial interest and prohibits those providers from billing for services performed as a result of such referrals. Because Representative Stark wanted to cover every conceivable permutation imaginable, the definition of "financial interest" broadly encompasses both compensation arrangements and ownership and investment interests. The Stark Amendments contain a significant number of complicated exceptions and limitations, which variously apply to all financial relationships, compensation arrangements, and ownership and investment interests.

The Stark Amendments operate as a strict liability offense, so a physician doesn't need to be aware of the law or intend to break it for a violation to occur. Violation of the Stark Amendments is punishable by being thrown out of the Medicare program and civil penalties of up to $15,000 plus twice the amount claimed for each service that a person knows (or should have known) should not have been claimed. Although HHS has issued some regulations inter-

preting the scope of the Stark Amendments, the process has been exceedingly difficult and time-consuming. Enforcement has also been rare.

False Claims

The False Claims Act was a Civil War–era statute, enacted in response to anecdotes of procurement fraud against the Union Army.[10] The original statute included both civil and criminal sanctions, which were subsequently separated into distinct statutory provisions. The FCA creates a cause of action against individuals or entities who knowingly present a false claim to the government. No specific intent to defraud is required; it is sufficient if the defendant acted with "deliberate ignorance" or in "reckless disregard" of the falsity of the statement. Sloppy billing practices, such as failing to review claims carefully before they are submitted, will satisfy this standard. If it can be shown that a representative sample of claims is false, the court will generalize the results to all filed claims. Because of these considerations, an FCA case is much easier to investigate and prosecute than a comparable criminal case.

An FCA claim may be brought by the federal government or private plaintiffs. If a private plaintiff brings the case, the government can elect to take it over or allow the plaintiff to pursue it on his own. Private plaintiffs who sue under the FCA are known as *qui tam* relators and are entitled to a share of the eventual recovery—with the relative share affected by whether the government takes over the case. Historically, the vast majority of the cases that the government does not join have foundered.

The FCA specifies that violators are liable for a statutory penalty of $5,500 to $11,000 per claim, in addition to three times the amount of damages sustained by the government because of the false claim. Because most health care providers typically submit a large number of modest claims, this structure means that statutory penalties generally dwarf actual damages, and quickly rise to staggering levels—as much as $1.1 million for every 100 false claims, irrespective of the dollar value of the false claims. In one case, a provider accused of receiving an overpayment of $245,392 was sued for statutory penalties of $81 million.[11] The stakes in these cases are so large that most defendants are under extreme pressure to settle, and quickly do so. Indeed, virtually all of the precedents involve (generally unsuccessful) motions to dismiss. Thus, the allegations of plaintiffs are almost never tested at trial—a pattern that, I am pleased to report, creates substantial opportunities for mischief on the part of those bringing FCA claims.

These fraud and abuse provisions create a self-reinforcing dynamic that redounds to our benefit. The vast sums of money spent by Medicare create the demand for laws to restrain the avarice of providers. Provider avarice triggers a search for ways around those laws, which, in turn, results in the broadening of those laws. As the laws are broadened, they discourage organizational innovation and market entry and catch more innocent providers. This, in turn, triggers a backlash against the law and widespread violation thereof. Plus, lawyers get rich off each step. What more could we ask for?

the fraud control program works. Although Medicare's fraud control program was well intended, we have, through a variety of skillful measures, successfully redirected it to encourage our larger goals.

First, we ensured that the reach of the fraud statutes would exceed their (functionally defensible) grasp by criminalizing conduct well beyond that which was necessary to protect the program. Indeed, we even criminalized conduct that results in benefits to patients without fiscal harm to the program. That created overwhelming incentives for otherwise law-abiding lawyers and providers to simply ignore the law. Not surprisingly, the same "speakeasy" norms that we observed during Prohibition developed. Professor James Blumstein describes the issue nicely:

> In the current environment it is a truism that the fraud and abuse law is being violated routinely but that those violations are acknowledged as not threatening the public interest. Indeed, they further the public interest and are needed to improve the functioning of the health care marketplace. . . . In sum, the modern American health care industry is akin to a speakeasy—conduct that is illegal is rampant and countenanced by law enforcement officials because the law is so out of sync with the conventional norms and realities of the marketplace and because respected leaders of the industry are performing tasks that, while illegal, are desirable in improving the functioning of the market.[12]

There were predictable consequences when this speakeasy norm came into conflict with the norms of fraud control personnel. For example, in one well-known case, the government charged Columbia/HCA with Medicare fraud, asserting that its use of two sets of cost reports indicated it was intending to break the

law—even though most companies in the health care business were reported to use two sets of cost reports.[13] In another high-profile case, the government obtained a settlement of $111 million from National Health Labs, even though the U.S. attorney reportedly conceded that there wasn't a health lawyer in the United States that would have advised his clients against the practices in question.[14] The following sidebar provides details on another notorious case that demonstrates how these anti-fraud statutes serve our larger goals.

Medicare Fraud and Abuse: A Case Study

Consider the case of Dr. Swaran Jain, a psychologist who was convicted under the anti-kickback laws of soliciting and receiving remuneration from a psychiatric hospital for referring patients for admission. The patients actually required hospitalization; the facility was as good as or better than any of the alternatives and provided proper care to each of the patients; and there was no evidence that any patient suffered tangible harm or that the government suffered any adverse fiscal consequences. After a jury convicted Dr. Jain, the court of appeals affirmed the conviction, notwithstanding its observation that "all of the evidence suggests that Dr. Jain intended to provide and did provide his patients with the highest quality psychological services." Yet, he is now a convicted felon for conduct that should be unobjectionable on economic, health policy, and ethical grounds.[15]

The self-referral provisions are subject to similar criticisms, although they compound the problem with their

ambitious but highly indeterminate attempt to address any conceivable arrangement between physicians and 10 categories of ancillary services providers. When this indeterminacy is coupled with strict liability, the deleterious consequences of the fraud control regime become even clearer. The self-referral provisions certainly provide little help in differentiating fraudulent and abusive conduct from conduct that is harmless or beneficial to program beneficiaries. Indeed, when the American Health Lawyer's Public Interest Colloquium met to discuss the Medicare fraud and abuse laws, the diverse group of representatives of government, providers, academics, and other involved parties overwhelmingly believed the self-referral provisions were neither effective nor efficient.[16]

Second, we whipped up a frenzy among the public about health care fraud and created the widespread belief that fraud and abuse are pervasive. In fact, no one knows how common fraud and abuse are, but 72 percent of the American public believes that Medicare would have no financial problems if fraud and abuse were eliminated.[17] This perception is utterly uninformed by any connection with reality, but it serves our purposes nonetheless. Over time, Americans will begin to doubt the good faith and reputation for fair dealing that has hitherto prevailed among health care providers. This demoralization will ultimately redound to our benefit—as it has done in other areas.

Finally, the anti-kickback statute helped to embarrass the hospital industry, whose reputation for good deeds (principally providing charity care to those unable to pay) had become a serious

problem for us. Hospitals had reasonably interpreted the anti-kickback law as prohibiting them from offering discounts to uninsured and indigent patients because offering selective discounts induces referral—a no-no under this statute. Since hospital "list prices" (which no one ever pays) are staggeringly high, those least able to pay are faced with huge bills, consistent with Medicare regulations requiring reasonable efforts to collect unpaid bills. Various hospitals, both nonprofit and for-profit, then decided to use collection agencies to hound those patients unmercifully. Several hospitals (including Yale–New Haven Hospital) had their debtors arrested as a way of encouraging payment—shades of Dickens!

As if things weren't demonic enough, the lawyers got involved. The Yale Law School students sued Yale–New Haven Hospital on behalf of individuals who had received treatment and were the target of aggressive debt collection for unpaid bills. The Attorney General of Connecticut filed a similar lawsuit. Then, more than 50 health systems across the country were named as defendants in class-action lawsuits led by a well-known plaintiffs' attorney from the tobacco litigation—alleging hospitals had engaged in "price gouging" of the uninsured.[18] Other lawsuits were filed by other lawyers against both not-for-profit and for-profit hospitals, alleging similar concerns. Although many of these lawsuits are objectively frivolous, it's a good day for us anytime we have doctors, lawyers, and hospital administrators at one another's throats.

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[1] The Cato Institute is a nonpartisan, nonprofit, tax-exempt educational foundation organized under Section 501(c) 3 of the Internal Revenue Code. The mission of the Cato Institute is to increase the understanding of public policies based on the principles of individual liberty, limited government, free markets, and peace. In order to maintain its independence, the Cato Institute accepts no government funding. Cato receives approximately 82 percent of its funding from individuals, 10 percent from foundations, 1 percent from corporations, and the remainder the sale of publications. Cato's fiscal-year 2009 revenues were over $20 million. Cato has approximately 105 full-time employees, 75 adjunct scholars, and 23 fellows, plus interns.

[2] To access this body of research, see the Dartmouth Atlas of Health Care, http://www.dartmouthatlas.org/. For an overview of the research on unwarranted geographic variation in medical spending, see John E. Wennberg, *Tracking Medicine* (New York, NY: Oxford University Press, 2010), http://gonzo.dartmouth.edu/.

[3] Elliott S. Fisher et al., "The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care," *Annals of Internal Medicine* 138, no. 4 (February 18, 2003): 288–98.

[4] Katherine Baicker and Amitabh Chandra, "Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care," *Health Affairs* (April 7, 2004): 192.

[5] Elliott S. Fisher, "Expert Voices: More Care Is Not Better Care," National Institute for Health Care Management, no. 7, January 2005, http:// www.nihcm.org/~nihcmor/pdf/ExpertV7.pdf.

[6] See Michael F. Cannon and Chris Edwards, "Medicare Reforms," DownsizingGovernment.org (Cato Institute), September 2010, http://www.downsizinggovernment.org/hhs/medicare-reforms.

[7]Office of the President, Council of Economic Advisors, *An Economic Case for Health Care Reform*, (Washington DC: June 2009), p. 13, http://www.whitehouse.gov/assets/documents/CEA_Health_Care_Report.pdf.

[8] See generally, Michael F. Cannon, "Ryan Budget: A Huge Opportunity To Improve Health Care," *KaiserHealthNews.org*, April 4, 2011, http://www.kaiserhealthnews.org/Columns/2011/April/040411cannon.aspx .

[9] U.S. Government Accountability Office, *Medicare and Medicaid Fraud, Waste and Abuse: Effective Implementation of Recent Laws and Agency Actions Could Help Reduce Improper Payments*, GAO-11-409T, (Washington D.C.: March 9,2011) p. 3, http://www.gao.gov/new.items/d11409t.pdf.

[10] Nathan Vardi, "Rx for Fraud," *Forbes*, June 20, 2005, p. 124. See also U.S. Government Accountability Office, *Medicare Part D: Some Plan Sponsors Have Not Completely Implemented Fraud and Abuse Programs, and CMS Oversight Has Been Limited*, GAO-08-760, July 2008.

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[12] U.S. Government Accountability Office, *Medicare and Medicaid Fraud, Waste and Abuse: Effective Implementation of Recent Laws and Agency Actions Could Help Reduce Improper Payments*, GAO-11-409T, (Washington D.C.: March 9,2011), http://www.gao.gov/new.items/d11409t.pdf.

[13] Clifford J. Levy and Michael Luo, "New York Medicaid Fraud May Reach into Billions," *New York Times*, July 18, 2005, p. A1, http://www.nytimes.com/2005/07/18/nyregion/18medicaid.html?pagewanted=all.

[14] Malcolm Sparrow, "Criminal Prosecution as a Deterrent to Health Care Fraud," Testimony before the Senate Committee on the Judiciary, Subcommittee on Crime and Drugs, May 20, 2009.

[15] See U.S. Government Accountability Office, *High-Risk Series: An Update*, GAO-11-278 (Washington, D.C.: February 2011), http://www.gao.gov/highrisk/risks/insurance/medicare_program.php.

[16] See David A. Hyman, *Medicare Meets Mephistopheles* (Washington: Cato Institute, 2006). Readers should note that *Medicare Meets Mephistopheles* is a satire in the tradition of C.S. Lewis' *The Screwtape Letters*. Its device is that it is written in the voice of a junior demon who is reporting to Satan on the success of Medicare as a recruitment tool that promotes all Seven Deadly Sins. I highly recommend it.

[17] For more information on how Medicare fraudsters cheat taxpayers, see F. Cannon and Chris Edwards, "Medicare Reforms," DownsizingGovernment.org (Cato Institute), September 2010, http://www.downsizinggovernment.org/hhs/medicare-reforms.

[18] See, for example, WhiteHouse.gov, "Health Insurance Reform Reality Check: Frequently Asked Questions About Health Insurance Reform," http://www.whitehouse.gov/realitycheck/faq#s1. ("As you know, the Medicare Trust fund is projected to run out of money in about 8 years. Health insurance reform would extend the life of the fund for additional years—through at least 2022—and give it greater stability and security.")

[19] U.S. Office of Management and Budget, *Analytical Perspectives, Budget of the United States Government, Fiscal Year 2000* (Washington: Government Printing Office, 2000), p. 337, http://www.gpoaccess.gov/usbudget/fy00/pdf/spec.pdf.

[20] See, for example, U.S. Congressional Budget Office, *The Long-Term Budget Outlook*, June 2010 (revised August 2010), pp. 1-23, http://www.cbo.gov/ftpdocs/115xx/doc11579/06-30-LTBO.pdf.

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[22] Robert Pear, "Cuts Leave Patients With Medicaid Cards, but No Specialist to See," *The New York Times*, April 1, 2011, http://www.nytimes.com/2011/04/02/health/policy/02medicaid.html.

[23] See Stephen A. Moses, "Aging America's Achilles' Heel Medicaid Long-Term Care," Cato Institute Policy Analysis no. 549, September 1, 2005, http://www.cato.org/pubs/pas/pa549.pdf; and Amy Finkelstein, "The Market For Private Long-Term Care Insurance," *NBER Reporter* Research Summary no. 1, Spring 2007, http://www.nber.org/reporter/spring07/finkelstein.html.

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[26] U.S. Government Accountability Office, *Medicaid: States' Efforts to Maximize Federal Reimbursements Highlight Need for Improved Federal Oversight*, GAO-05-836T, (Washington: June 28, 2005), http://www.gao.gov/new.items/d05836t.pdf

Mr. GOWDY. Thank you.

Ms. Rachel Klein is the deputy director for health policy at Families USA.

Welcome, Ms. Klein.

STATEMENT OF RACHEL KLEIN

Ms. KLEIN. Thank you very much, Mr. Chairman, members of the subcommittee. Thank you for inviting me here today to speak to you about the important role that Medicaid plays in our Nation's health care system. As you mentioned, I am deputy director of health policy at Families USA, the national organization for health care consumers.

The Medicaid program has become the backbone of our health care for seniors, people with disabilities and children. In 2010, the program covered 68 million people nationwide. Starting in 2014, Medicaid will become the platform for an important expansion of health coverage for low-income working adults filling an unfortunate hole in our safety net.

Medicaid was designed as a partnership between the Federal Government and States, and States have a lot of flexibility in that partnership. The Federal Government provides, on average, 57 percent of the cost of the program and establishes the minimum requirements regarding who is eligible and what it covered. The States administer the program and make choices about whether to expand beyond the minimum requirements from eligibility and coverage, how to structure the delivery of health care and pay providers.

States have taken advantage of their flexibility to design very different programs. Eligibility levels vary widely across States, who is covered varies widely, what services are covered, as well delivery systems all vary widely.

Today Representative Paul Ryan, chairman of the House Budget Committee released a budget proposal that suggests radical changes to the Medicaid program that will severely restrict State flexibility. The proposal would reduce Federal Medicaid funding by 35 percent, more than one-third, over the next 10 years. It would eliminate the Medicaid expansion authorized by the Affordable Care Act enacted last year, and it would end the Federal commitment to sharing Medicaid health care costs with States by capping Federal Medicaid funding.

States are already struggling with Medicaid costs in a difficult economic climate. The Federal Medicaid cuts proposed by Chairman Ryan today will not help States with the difficult budget choices before them; rather, they will compound the difficulties facing States by shifting more costs to them. States would be forced to cut eligibility, benefits and provider payment rates or raise taxes significantly, thus shifting costs to working families. This proposal does nothing to contain or reduce health care costs, it just shifts the burden.

The proposal will make it very difficult for States to meet the needs for residents when demand for Medicaid increases sharply, such as during a recession, a hurricane or an epidemic. States are already operating very lean Medicaid programs, and there are not a lot of places for them to cut. In fact, Medicaid costs 27 percent

less than private insurance for children and 20 percent less than private insurance for adults, according to the Center on Budget and Policy Priorities. These cuts will leave Governors, as a letter from 17 Democratic Governors released yesterday attests, little choice but to eliminate health coverage for many vulnerable people.

When the Federal Government cuts Medicaid, it is important to know these cuts will particularly hurt America's senior citizens and people with disabilities. Medicaid is the largest payer of nursing home care, allowing seniors to receive the intensive care they need it as they grow more frail and aren't able to live at home. It is also the largest payer of home and community based services, allowing seniors to live in their homes or with their families longer before they need to enter a nursing home. All together, Medicaid pays for nearly half of all long-term care received in the United States.

These services are critically important, not only for seniors but for the estimated 52 million family caregivers who are able to continue working or get respite when they need it because of services. Medicaid also makes Medicare work helping seniors who have low incomes pay their Medicare premiums and copayments.

Medicaid is also an engine for State economies. Federal funding provided to States generates jobs and business activity that wouldn't otherwise be in those State economies. For example, every $1 million of additional Federal Medicaid funding in South Carolina supports 24 jobs and $2.2 million in business activity in a year. In Illinois, a million dollars of Federal funding spend on Medicaid generates 22 jobs and $2½ million in business activity in a year. Likewise, a reduction in Federal spending on Medicaid would cost jobs, wages and business activity.

Moreover, Medicaid helps working families when they lose their jobs in a recession. Despite high unemployment rates, there was no increase in the number or rate of uninsured children in 2009 during the height of the recession. Between 2008 and 2009, Medicaid enrollment increased significantly as families were able to rely on Medicaid when they lost their job-based health insurance.

A proposal such as that offered by Chairman Ryan would seriously undermine this Nation's and States' ability to meet the health care needs of our most vulnerable citizens. Seniors, people with disabilities, and children will suffer, and State economies will be strained.

Mr. Chairman, I thank you for this opportunity to speak here today.

[The prepared statement of Ms. Klein follows:]

Written Statement for the Record by

Rachel Klein, Deputy Director of Health Policy, Families USA

For the U.S. House of Representatives

Committee on Oversight and Government Reform

Subcommittee on Health Care, DC, Census and the National Archives

Hearing on Waste, Abuse and Mismanagement in Government Health Care

April 5, 2011

Mr. Chairman, Members of the Subcommittee:

Thank you for inviting Families USA to participate in today's hearing on public health care programs. Families USA is the national organization for health care consumers. Our mission is the achievement of access to high quality, affordable health care for all Americans. I am pleased to be here this morning to offer testimony on the important role that the Medicaid program plays in the lives of the senior citizens, people with disabilities, and low-income families with children who rely on it for access to necessary health care services.

Medicaid is the backbone of the health care system for the most vulnerable Americans. In 2010, it covered 68 million people, including: 6 million seniors, 11 million people with disabilities, 17 million parents and pregnant women, and 33 million children.[1] The program is specially designed to meet the unique needs of these populations, who tend to be sicker and have more intensive health care needs than the general population.[2] Moreover, it will provide the platform for a significant expansion of health care coverage in 2014, when an estimated 15 million more low-income adults are expected to get coverage because of the Affordable Care Act. The budget proposal to be released by Representative Paul Ryan, Chair of the House Budget Committee,

today will include significant reductions in federal support for Medicaid as well as a proposal to "block grant" or cap federal funding for the program. Such a plan would cause significant harm for individuals who are covered in Medicaid as well as state economies.

Medicaid is Particularly Important for Seniors and People with Disabilities

Medicaid is the largest payor of long-term supports and services, comprising 33 percent of all nursing home expenditures and 36 percent of all home health expenditures last year.[3] Medicaid helps many of the estimated 52 million people who act as informal caregivers for family members, loved ones, and friends, by providing them with support that allows them to maintain jobs or simply rest when they need to. Medicaid also makes Medicare work: in 2010, Medicaid helped 9 million seniors and people with disabilities pay their Medicare premiums and copayments.[4] Although seniors and people with disabilities make up only 25 percent of enrollees, they represent 67 percent of Medicaid costs;[5] any proposals to drastically reduce federal Medicaid spending will have a disproportionate effect on America's seniors and people with disabilities.

Medicaid Also Helps Low-Income Children and Families

For low-income families with children, Medicaid serves as a gateway to primary and preventive care, ensuring that children receive age-appropriate services to make certain that they are thriving and developing on track as they grow. And, as witnessed through the national recession in the last few years, Medicaid provides a true safety net for working families who lose their jobs and with them, their job-based health coverage. Between 2008 and 2009, the height of the most recent recession, U.S. Current Population Survey data showed an increase in 5.1 million people (more than half – 2.8 million – were children) reporting Medicaid coverage.[6] Remarkably, because children are eligible for Medicaid or the State Children's Health Insurance Program with incomes up to twice the federal poverty level in nearly every state, the number of uninsured children remained stable in 2009, despite rising unemployment rates. Without Medicaid, many millions more families would have become uninsured in these difficult economic times.

Medicaid Helps Support State Economies

Medicaid is not only an important health care delivery system; it also plays a key role in supporting state economies. The federal government pays on average 57 percent of the cost of

Medicaid, but that amount differs dramatically according to the per-capita income in a state, ranging from 50 percent of the cost of Medicaid in relatively wealthier states to 75 percent in states where the population tends to have lower incomes. These federal funds help pay doctors, nurses, hospitals, nursing homes, home care workers, lab and x-ray technicians, physical therapists, psychiatrists and psychologists, dentists and dental hygienists. These funds ensure access to emergency rooms and community clinics. In turn, these healthcare workers spend money on rent, food, cars, clothes, and other goods, spreading money throughout a state economy that generates jobs, additional wages, and business activity. For example, $1 million of federal funding spent on Medicaid in South Carolina supports 24 jobs, $2.2 million in business activity, and $798,000 in wages in a year.[7] In Illinois, $1,000,000 of federal funding spent on Medicaid generates 22 jobs, $2.5 million in business activity, and $859,000 in wages. Likewise, a reduction in federal spending will cost jobs, wages, and business activity in each state.

People in Medicaid Have Better Health Outcomes

People enrolled in Medicaid are less likely than both the uninsured *and those with private coverage* to lack a usual source of health care or to have an unmet health care need.[8] A study published by the Kaiser Commission on Medicaid and the Uninsured in May this year found that people enrolled in Medicaid were less likely than people who were uninsured and people with private insurance to lack a usual source of care, not to have had a doctor's appointment in the last year, and to have had an unmet health care need due to costs. It also found that low-income women in Medicaid are more likely to have had a Pap test in the previous two years than low-income women with private coverage or low-income women who are uninsured (16 percent had NOT had a Pap test in the past two years compared to 20 percent of those with private coverage and 41 percent of the uninsured).[9]

Among low income children, a study published in the Journal of American Dental Association found that those with Medicaid coverage are more likely to receive an annual physician's visit and dentist visit than their uninsured counterparts.[10] Among the disabled, a study in *Health Affairs* found that two-thirds of uninsured people with disabilities reported postponing or forgoing care because of cost. In comparison, those covered solely by Medicaid were significantly less likely to postpone or forgo care.[11] And lastly, among the elderly, a study in the

American Journal of Public Health found that Medicaid-insured diabetic patients in community health centers had higher quality of diabetes care than those with no insurance.[12]

Medicaid is Efficient and Effective

Some claim that the Medicaid program suffers from inefficiencies due to waste, fraud and abuse by providers and consumers. This is simply not true. Medicaid, in fact, is actually *more efficient* at covering low-income people than private coverage. After controlling for health status (since Medicaid enrollees tend to have greater health care needs), it costs at least 20 percent *less* to cover low-income people in Medicaid than it does to cover them in private health insurance.[13] In this cost-conscious climate, it only makes sense to support the most cost-effective coverage wherever possible. The most cost-effective way to provide coverage for low-income uninsured people is Medicaid.

Both the federal government and states have taken steps in the last several years to improve oversight and enhance Medicaid program integrity to ensure that all of the resources supporting the Medicaid program are used to provide high-quality, comprehensive health care. The Affordable Care Act includes additional funding to improve even further on these efforts and gives federal and state governments new tools to fight waste, fraud, and abuse.

Drastic Medicaid Cuts Will Harm Americans

The House Budget Proposal released by Chairman Ryan this week by all reports will suggest cutting $1 trillion from the federal Medicaid budget over the next 10 years. According to the Congressional Budget Office, the federal government spent $273 billion on Medicaid in 2010. Costs over the next 10 years are anticipated to grow only an average of 7 percent per year. Such a sharp reduction in federal Medicaid spending as that proposed by Chairman Ryan – as much as 22 percent of all projected federal Medicaid spending over the next 10 years – would cause significant damage to the American health care system, and to the vulnerable people who rely on Medicaid. The harm is likely to be severe:

- Seniors and people with disabilities will lose access to nursing homes and home-based care;
- children and families will lose health coverage and become uninsured;

- individuals who would have gained coverage because of the Affordable Care Act's Medicaid expansion will be unlikely to get that coverage;
- states will lose an important source of economic support and the ability to flexibly respond to crises that create increased demand for health care services and fewer people with coverage or the ability to pay for such services.

A reduction in federal funding for Medicaid does not make the health care needs of Americans who rely on Medicaid disappear; it merely shifts the costs to states and to individuals to bear on their own.

Block Granting Medicaid Would Reduce State Flexibility and Put States at Risk

Chairman Ryan's 2012 budget proposal will suggest that the financing structure for the Medicaid program be changed to a block grant or a capped allotment. Today, Medicaid is financed through a partnership of the states and the federal government, where the federal government pays a fixed *share* of Medicaid costs in each state. Under a block grant or capped allotment, the federal government would pay a fixed *dollar amount* for Medicaid in each state, regardless of the health care needs of each state's vulnerable residents.

Although proponents of block grants argue that they give states more flexibility to design programs tailored to their residents, in fact, a block grant would drastically restrict state flexibility. A block grant would:

- Lock in current variations in state Medicaid spending, preventing states with less generous eligibility levels, benefits or provider payment rates from making future improvements to reduce inequities;
- Put states at risk to bear the full amount of any cost increase above the federal cap, limiting states' ability to respond to an increase in enrollment during a recession, an increase in health care demand because of an epidemic or natural disaster like a hurricane or earthquake, or respond to an improvement in health care treatment that necessitates investment in new technology or provide coverage of new pharmaceuticals.
- Force states to either cut services, reduce the number of people covered in Medicaid, or raise taxes to compensate for increased health care costs not shared by the federal government.

Conclusion

Medicaid plays a crucial and unique role in our nation's health care system. Chairman Ryan's budget proposal will put nearly more than 80 million Americans at risk of losing access to critical health care services provided by Medicaid. It will also put state economies at risk, jeopardizing our fragile economic recovery and shifting future healthcare costs to states. Although grappling with the federal budget deficit is an important task, it should not be accomplished by passing enormous health care costs onto America's most vulnerable citizens.

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[3] Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP*, March 2011.
[4] Ibid.
[5] Kaiser Family Foundation, Stathealthfacts.org, *Distribution by Enrollment Groups FY 2007* and *Payments by Enrollment Group FY 2007*, available online at www.statehealthfacts.org, accessed on April 4, 2011.
[6] Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, U.S. Census Bureau, Current Population Reports, P60-238, *Income, Poverty, and Health Insurance Coverage in the United States: 2009*, U.S. Government Printing Office, Washington, DC 2010.
[7] Families USA calculations based on the Bureau of Economic Analysis Regional Input-Output Modeling System (RIMS II).
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Mr. GOWDY. Thank you.

At this point, I would call on the distinguished gentleman from Illinois, Mr. Davis.

Mr. DAVIS. Thank you very much, Mr. Chairman.

Medicaid is a vital program that serves the most vulnerable Americans in this country. I often have said that it was the best thing that happened to health care since Indians discovered cornflakes. But the vast majority of these individuals are either young children, senior citizens or individuals with disabilities who rely on the services that Medicaid provides.

In February, Mississippi Governor Haley Barbour told a joke about Medicaid beneficiaries driving fancy cars to get their prescription drugs while attending a National Governors Association meeting. Governor Barbour told the Washington Post, and I am quoting, "we have people pull up at the pharmacy window in a BMW, and they say they can't afford their copayment."

On March 2nd, the Washington Post fact checker gave Governor Barbour's story four Pinocchios, meaning that it was a whale of a story and it was inaccurate.

Ms. Klein, let me ask you, in your extensive analysis of Medicaid programs, do you think that the Governor's assertion is an accurate depiction of people who are seeking services through Medicaid?

Ms. KLEIN. No, I don't. There are many, many millions of vulnerable people in the United States who rely on Medicaid because they cannot afford to get health care anywhere else. Health care is extremely expensive, and when people have very low-paying jobs, they really rely on Medicaid to make sure that their kids can go to the doctor when they have an ear infection or that their parents can afford the home care or nursing care services that they need.

Mr. DAVIS. I am old enough to remember when there was no Medicaid. And I recall individuals who actually had no access to care at all. I mean, there was simply nothing that they could do. I mean, they used home remedies. They did whatever they could come up with. What do you think would happen to these individuals today if there was no Medicaid? What would they be able to do?

Ms. KLEIN. Without Medicaid, people will be uninsured. Health insurance is very expensive, and most of the people who rely on Medicaid for their primary form of health coverage cannot afford to purchase health care on a private market, so they would go uninsured.

They would miss out on a lot of health care. As we know, people who are uninsured do not get as much health care even when it is needed as people who have Medicaid coverage. And so we would see a lot of unmet needs going on, and they would delay care until they ended up in the emergency room.

Mr. DAVIS. So if they are uninsured, unemployed, over taxed emergency rooms, places where the emergency rooms may come like an old man's teeth, few and far apart. They are in serious trouble. I mean, the ultimate has to be that the only individuals who could benefit from this kind of system would be undertakers and cemeteries because there would be no way for these individuals to receive just a modicum of care. And so I—it would be a terrible way to run a health care system. And I certainly would hope that

our look at waste, fraud and abuse is not taking us in that direction, although we know that there are individuals who exploit systems in both the public and private sector.

And Ms. MacQuarrie, I would like to just ask you, how does your organization work with providers in both of those elements to try and get rid of waste, fraud and abuse?

Ms. MACQUARRIE. Thank you for your question. In both of those elements, you mean in Medicare and in Medicaid?

Mr. DAVIS. Yes.

Ms. MACQUARRIE. Yes, we provide information, independent data, data mining to our customers. As I mentioned, we have 22 State Medicaid agencies who use our data to help identify cases of fraud, waste and abuse in their programs. We support CMS in its initiatives as well.

Mr. DAVIS. Thank you very much—please go ahead.

Ms. MACQUARRIE. Yeah, I am sorry.

The important point that I was making earlier is that the software has to be smarter. We just can't aggregate numbers and crunch data and say, we are spending too much money on a particular program. We have to look at it from a clinical perspective so we have positions and clinicians who help validate the clinical intensity that we build into this data mining software.

Mr. DAVIS. Thank you very much.

Thank you, Mr. Chairman, I am going have to run out, but I am not abandoning you.

Mr. GOWDY. I do not feel abandoned.

Mr. DAVIS. I have just have to go and protect my redistricting process. Thank you.

Mr. GOWDY. The chair will recognize the gentleman from Arizona, Dr. Gosar.

Mr. GOSAR. Thank you.

Ms. Klein, why do we have so many emergency visits?

Ms. KLEIN. Um——

Mr. GOSAR. Why are we all stacked up in the emergency room?

Ms. KLEIN. I am sorry?

Mr. GOSAR. Why are we all stacked up in the emergency room? I mean, you know the facts and figures.

Ms. KLEIN. Well, there are lots of people who use emergency rooms for a lot of different reasons. Many of them have actual emergencies.

Mr. GOSAR. Oh, yes. But, I mean, we are seeing an undue thing. Let's kind of go to statistics. We can make statistics do anything we want them to, OK. Wouldn't you say the No. 1 reason we have a problem in our emergency room is we are lacking family docs?

Ms. KLEIN. You know, actually, I do not know, because I am not an expert on how the health care system is divvied up. I know they are certainly shortages of providers in certain areas of the country. That is true in—across the health care sector.

Mr. GOSAR. It is pretty much, but the No. 1 reason why we don't have family docs is because of unfunded mandates; isn't that true, Mr. Botsko?

Mr. BOTSKO. Thank you for the question. Regarding whether that is the reason, I am not really at liberty to say, that is not my specialty.

Mr. GOSAR. Uh-huh. But one of the unfunded mandates is that we are asking providers to do more and more with less, and they are not actually seeing patients. And so the only recourse patients have is to go to the emergency room.

Mr. BOTSKO. And yes, sir. We are certainly are being asked to do a lot more with a lot less.

Mr. GOSAR. Can you tell me some of the strings that are attached with the Federal money for Medicaid money?

Mr. BOTSKO. Some of the ones that we are seeing are the unfunded mandates where we are asked to go out and do site visits, and we have received no additional funding for that. We are also asked to account for the money that is to be collected for providers to register under the new act, which I believe this year is about $505. So we have to collect it, account for it and be able to do our due diligence in counting for the public's money.

Mr. GOSAR. I know, I have talked to the Governor from Arizona, being from Arizona, we have some difficult circumstances. How would you see that—could you see us working more collaboratively or more—how do I say, from a State's vantage point versus what the Federal Government's dictating?

Mr. BOTSKO. I believe the States are probably the best resource that we have right now in combating fraud, waste and mismanagement. As in my testimony, I spent 22 years with the Federal Government as a Federal Agent and a supervisory Special Agent, and 11 years currently with the State Medicaid program. We are the best equipped to fight the fraud because we are closest it; we know what is going on in our States. We work collaboratively with our health care programs. We work with the managed care system. And I believe that increasing the Federal match, such as right now the Medicaid prosecutors receive 75 percent and we, the OIG, receive 50 percent—and I believe matching that and making it at least equal with the prosecutor would be a wise solution to the program.

Mr. GOSAR. So one-size-fits-all doesn't work?

Mr. BOTSKO. Not really.

Mr. GOSAR. So we are really too big as a Federal program; it should go back to the States.

Mr. BOTSKO. That is my belief.

Mr. GOSAR. Mr. Cannon, one of the aspects of medicine is defensive medicine. Can you talk to me a little about tort reform and how we can look at tort reform as the overall cost and why we haven't had any tort reform, particularly last year and years before?

Mr. CANNON. There is a lot of belief that defensive medicine is driving wasteful health care spending. There is some evidence to suggest that it is, but I think it is important to recognize that there are two types of defensive medicine. One is efficient defensive medicine so that if the—let's take the example of back pain: Should everyone with back pain receive an MRI as a matter of course? Well, if it turns out that not giving those patients an MRI results in injuries to them, they suffer losses because we didn't detect serious spinal injuries, that would exceed the cost of providing those MRIs, then yes, we should provide those MRIs. That is efficient defensive medicine.

So there is also inefficient defensive medicine where the cost of not providing those MRIs is not that great, maybe because we don't have very good treatments for back pain, in which case the cost of providing the MRIs would exceed whatever losses they would suffer from not receiving them.

So it is very difficult, first of all, to tease out the inefficient stuff from the efficient defensive medicine, and it is important to distinguish between the two, but it is also to discern whether it is the fear of lawsuits that is driving the use of more and more services, or is it the fact that in this country as a result of mostly Federal policy, most doctors are paid on a fee-for-service basis where they make more money the more services they provide. Both the fear of lawsuits and fee-for-service payment are pushing in the same direction. So I am not sure that—first of all, it is very difficult to figure out how much defensive medicine is contributing—inefficient defensive medicine is contributing to wasteful health care spending, but I believe that it is not a significant factor.

I think that the fact that the Federal Government subsidizes health care so much through the Medicare and Medicaid programs and the Tax Code plays a much larger role.

Now why have I—with that said, I think that we do need serious medical malpractice liability reform in this country. Why have we not seen it? I think the biggest reason is that judges will not enforce contracts that allow individuals either with their health care providers or through an insurance plan as an intermediary to set their own—basically to pick their own medical malpractice liability reforms. Judges won't enforce those contracts. I think it is a much superior approach to trying out things like caps, loser pay rules and so forth because if something doesn't work, it is easier for patients to rewrite the contracts than it is for the Federal Government to State governments to rewrite the laws once they have been put in place.

Mr. GOSAR. Hold that thought. We will come back for a second round.

Mr. GOWDY. At this point, I will recognize the distinguished gentleman from Maryland, Mr. Cummings.

Mr. CUMMINGS. The—this morning, the Budget Committee Chairman Ryan unveiled his budget for fiscal year 2012, which calls for repealing the Patient Protection of Affordable Care Act, turning Medicaid into a block grant and forcing Medicare beneficiaries to spend more of their fixed income on purchasing private health insurance.

In my district, if I go to a town hall meeting, and there are 100 people and I ask them, what is their source of income, do they have more than one source, usually 90 percent, sometimes as many as 95 percent, tell me all they have is a Social Security check.

According to the Wall Street Journal article Monday, Chairman Ryan's proposal would—and this is what the Wall Street Journal said—would essentially end Medicare as the program that directly pays those bills. Instead, seniors would be forced to venture out into the private insurance marketplace to purchase insurance. The Wall Street Journal mentioned giving insurance companies approximately $15,000 toward beneficiaries' purchase of private

health insurance leaving beneficiaries to pay the remainder out of pocket.

And since my Republican friends also want to repeal the Affordable Care Act, seniors are not going have any of its protections against abuses by private insurance, by the private health insurance industry, such as prohibiting preexisting condition exclusions and charging sicker beneficiaries higher prices than younger healthy people.

I am trying to figure out, and I haven't—we just got the proposal today. Ms. Klein, help me with this, who is going to insure an elderly person? I am just curious. You know, I can't see how $15,000 is going to do that. Who is going—who is going—I—I mean, I have people that I know who are 40 years old and can't get insurance because of a preexisting condition. So now you are going put all these seniors out—not you, but the proposal—to put the seniors out there, give them a little piece of paper with $15,000. One visit in 1 day or maybe, at best, a day and a half will take care of that $15,000 quick. And we have a lot of seniors with chronic conditions. Have you gone through that? Have you figured that out?

Ms. KLEIN. No, I haven't figured that out. Thank you very much for the question. I think it is really important to take a very close look at this proposal, which is essentially removing the promise and guarantee of access to affordable health coverage that we have made to America's seniors as well as other vulnerable people.

The Medicare program and the Medicaid program work together to ensure that seniors, people with disabilities as well as children and working families have access to affordable health coverage that is comprehensive and that meets their needs. Without those programs, we will see a lot of people who are unable to get necessary health care.

Mr. CUMMINGS. I remember I was talking to my mother a few weeks ago, and she came up from South Carolina, rural South Carolina and she was telling me, we were talking about my grandparents, who died long before I was born. And they died in their 40's. And I said, "Mother, that is kind of young to die." She said, "Well, back then, there was no—we expected to die that early."

Can you see us going back to that kind of situation? And I don't like to just throw death out there, but the question becomes what are the alternatives? And it just seems to me that people—say, for example, we didn't have Social Security; we'd have seniors literally either having to depend on their relatives or begging for money. And it seems like in a country as great as ours, we can do better than that. And I think a lot of people have said to me, well, Republicans aren't going to go through with that. And I said, well, it is out there. And I think we have to be very, very careful with that.

Would you agree?

Ms. KLEIN. I would, thank you.

Mr. CUMMINGS. And does anybody else have any comments on this?

Mr. CUMMINGS. Yes, sir, Mr. Cannon.

Mr. CANNON. Thank you for the opportunity, Congressman.

I think lots—all seniors under the chairman's proposal, as I understand it, would be able to obtain health insurance coverage, and that is because the payment they receive from the Federal Govern-

ment to purchase that coverage will be adjusted for income, so that lower-income people will get larger vouchers, if you will. He doesn't call them that; I will use the V word. And they will also be risk-adjusted, so that people with severe illnesses will get larger vouchers and be able to purchase insurance coverage. That will cover a lot of people who have preexisting conditions. And another——

Mr. CUMMINGS. Which is probably about all of them, by the way.

Mr. CANNON. Well, that is true. That is why the average voucher amount, $15,000, would be more than the amount to cover—it would cost to cover someone under 65. And if you are concerned about that the not being enough money, remember the Dartmouth Atlas of Health Care has shown pretty convincingly that one-third of all Medicare spending is pure waste; it does nothing to improve the health of Medicare patients. Think of that as a huge margin of safety. So that seniors, even if they consume one-third less care than they do today, under say a very inefficient Medicare program, it would not harm their health.

Mr. CUMMINGS. I see my time is running out.

Mr. GOWDY. Thank you, Mr. Cummings.

Ms. Klein, do you disagree that we are $14 trillion in debt?

Ms. KLEIN. I am actually not an expert on the Federal budget.

Mr. GOWDY. Well, you were just very critical of our colleague Paul Ryan's budget. So do you disagree that we are $14 trillion in debt?

Ms. KLEIN. No, I do not.

Mr. GOWDY. Do you disagree that the annual deficit is $1½ trillion?

Ms. KLEIN. No, I do not.

Mr. GOWDY. Do you disagree with the President when he says there is $900 billion in waste, fraud and abuse in Medicare and Medicaid?

Ms. KLEIN. No, I don't.

Mr. GOWDY. Have you proposed a budget for 2012?

Ms. KLEIN. No, sir.

Mr. GOWDY. Has your organization proposed a budget for 2012?

Ms. KLEIN. No.

Mr. GOWDY. Well, I am struck with your willingness to criticize Representative Ryan when you have no alternative yourself.

By 2031, every single cent in revenue generated by this, the most powerful economy on the face of the earth, will only be sufficient for the entitlements. That is it, by 2031. So what is your plan to reform Medicare and Medicaid?

Ms. KLEIN. I think we need to remember that these programs provide vital services to people who, without them, would be left without access to care.

Mr. GOWDY. You don't think we know that? You don't think Representative Ryan knows that?

Ms. KLEIN. I wouldn't want to conjecture about what Representative Ryan knows. I think it is important to remember whenever we are looking at proposals to reform these programs the vital role that they play in protecting people's access to health care who would otherwise go without.

Mr. GOWDY. You would agree with—is the government the only way indigent folks can have access to health care? Is that the only model we have ever pursued in this country?

Ms. KLEIN. I don't believe it is the only model that we have ever pursued, but it has been a very successful model over the past 40-plus years. And I know that there are many folks, even within the health insurance industry, who agree that the existing programs that we have are the right way to go, particularly for people who have very high medical costs, as seniors and very low-income people tend to do.

Mr. GOWDY. Well, where—I won't say it again without contradiction. We are $14 trillion in debt. So I would beg to differ that the programs are going swimmingly, or we would not be on the precipice of a financial slew of despond that we may not get out of. With specific reference to the commerce clause, can you tell me whether or not you think the Federal Government does not have the authority to send Medicaid back to the States?

Ms. KLEIN. I am not sure I understand the question.

Mr. GOWDY. Can Congress send the Medicaid program back to the States?

Ms. KLEIN. The States already administer the——

Mr. GOWDY. I mean block grant. The very part of Representative Ryan's budget that you just criticized, the block granting of Medicaid moneys back to the State, do we have the authority to do that?

Ms. KLEIN. I haven't examined the legal authority for that.

Mr. GOWDY. So you don't challenge that we do have the authority to do that?

Ms. KLEIN. I do not challenge, I have not looked at the legal authority.

Mr. GOWDY. What plans have you put forth to eliminate waste, fraud and abuse in Medicare and Medicaid?

Ms. KLEIN. I think it is very important to make sure that both of those programs run as effectively and as efficiently as they can. I think we need to make sure and, in fact, it is our responsibility as a Nation to make sure that Federal dollars as well as State dollars spent on health care are actually going to pay for health care for the people they are designed to serve.

Mr. GOWDY. Well, you and I are in agreement on that. My question was, what specific plans have you put forth to reform Medicare or Medicaid?

Ms. KLEIN. I have not.

Mr. GOWDY. Mr. Cannon, if you could do three things with respect to Medicare, by the end of April, to cut costs, what are the first three things you would do?

Mr. CANNON. Mr. Chairman, I would give each—I would take the existing Medicare budget and convert it into a fixed voucher that each senior would receive to purchase health insurance, private health insurance plan of their choice, adjusting those vouchers for income and risk, as I mentioned before, was No. 1.

Mr. GOWDY. Now, when you say voucher, in a voucher model, the money goes to the patient?

Mr. CANNON. It would be very much like cash, but it would be restricted to health care expenses. They could use it to purchase a health insurance plan. And whatever they don't spend, they would

get to keep and even pass on to their heirs, which gives seniors an incentive to weed out waste, fraud and abuse that just doesn't exist in the program today.

Mr. GOWDY. Would you have copays for any of the patients under Medicaid, any disincentive to go to the physician whenever you want to for whatever you want to?

Mr. CANNON. In Medicaid?

Mr. GOWDY. In Medicaid.

Mr. CANNON. What I would do with Medicaid is block grant the program, and give the States maximum flexibility to spend that money on providing medical care to the needy and let them decide whether to use copayments or not. A lot of folks on Medicaid, a copayment is going to keep them away from lifesaving care. It could—it could, that is a feasible—that could happen. What I—the reason I don't want to be making those decisions is because I don't think I have the wisdom to make those decisions.

But the reason that I want block grants is because I think that the States are going to do a much better job of coming up with innovative ways of structuring those benefits so that they provide care to the people who are needy, who are truly needy. And they don't induce people to become dependent on government for their health care as the current Medicaid program does.

The way the Federal Government pays for Medicaid by matching State funds creates a pay-for-dependents incentive. If you spend another dollar, that gets someone—for every dollar a State spends they get $1, $2, $3, in some cases $4, from the Federal Government; they can quintuple their money. That encourages States to make people more dependent on the government for their health care so that is the motivation behind block grants.

It will also reduce waste, fraud and abuse in that program because the State would bear the full cost of waste, fraud and abuse, as opposed to right now where they only bear 43 percent of the cost on average.

Mr. GOWDY. Thank you, Mr. Cannon.

I will call on the gentleman from Arizona for a second round of questioning, Dr. Gosar.

Mr. GOSAR. In part of the—Mr. Cannon, part of the problem that we find is for physicians and particularly in costs associated in why we are having problems is basically cost shifting because we have so many physicians or so many services that are not compensated for and unfunded mandates, so it is constantly shifted.

How do you see—how do I want to put this? How do you see the insurance companies be a part of a problem in the tort reform aspect? Because most physicians are part of panels so there are certain things that insurance companies will tell the physician or the patient they can or cannot do, it puts physicians in harm's way.

Mr. CANNON. I am not sure I am aware of any ways that the insurance companies are creating a problem in the tort system. Medical malpractice liability insurers actually do a lot of good communicating the signals that the tort system creates into quality improvement measures to help physicians improve the quality of care that they provide.

Mr. GOSAR. I understand. But certain procedures, let's say somebody comes in, and they are going do an MRI, and the insurance company has to pre—you have to pre——

Mr. CANNON. Get pre-authorization.

Mr. GOSAR. Pre-authorization to get that done. And maybe it doesn't happen. Who is put in harm's way when that doesn't occur, and we have a litigation?

Mr. CANNON. If the insurance company requires preauthorization before necessary care, then—and they don't get that pre-authorization and the care isn't delivered, then that can put the patient in jeopardy. If it is that clear-cut a case, however, then the insurance company isn't really preventing the provider from providing those services; they are just saying, we are not going to pay for it. So there is an option for the provider to provide those services and then——

Mr. GOSAR. But hasn't that been part of the problem, particularly in hospitals and emergency rooms in some of the cost-shifting aspects within tort reform? That has been a big question mark as to who is saddled with that jurisdiction.

Mr. CANNON. I am not——

Mr. GOSAR. Who is going to get the claim? It is obviously not the insurance company; it is the doc.

Mr. CANNON. In these disputes, whenever you have an insurance company and the provider that are not part of the same entity, you are going to end up with these sorts of disputes. And I don't really know what is the best way to resolve those disputes. What I know is that we need more experimentation and competition, and we need to let people choose different ways of structuring the financing and delivering of health care, so that they can pick whatever way works best for them.

There are some health plans where the insurance plan and the providers are essentially part of the same entity. There is still friction but a lot less friction than when you just have the health insurance company paying the bills. So I don't have a magic bullet solution to that, other than choice and competition, which will let people find the solution that works best for them.

Mr. GOSAR. So an increased and competitive marketplace would definitely help us.

Mr. CANNON. And I think that Chairman Ryan's proposal is a step in that direction.

Mr. GOSAR. Would it also not have some competition within the insurance industry?

Mr. CANNON. Absolutely. That is to be desired.

Mr. GOSAR. And isn't that a problem for the States right now, in most cases?

Mr. CANNON. Too much competition?

Mr. GOSAR. Not enough competition for States and not having the jurisdiction over them now.

Mr. CANNON. I am not sure about the jurisdictional issue. However, I think that within each State, there is far less competition than there could and probably should be in health insurance, if only because each State prevents their residents from purchasing health insurance licensed by another State.

I think that is an idea that has been—that tearing down those barriers to trade is an idea that has been advanced here on Capitol Hill. Certainly we at the Cato Institute have endorsed it, and I think that would dramatically increase competition, probably even more than Chairman Ryan's proposal would.

Mr. GOSAR. So maybe even utilizing the Federal Government to actually instill that. For example, having FTC look in inclusionary monopoly type rules.

Mr. CANNON. I am more skeptical of antitrust laws—although I am not an expert in that area—I am more skeptical of them than I am of Congress' ability to use the commerce clause of the Constitution to tear down barriers to trade between the States, which was the original intent of the original meaning the commerce clause. It was intended to allow—to create a free trade zone within the United States. We don't have that in health insurance right now, and competition suffers as a result.

Mr. GOSAR. Mr. Botsko, you see competition being a problem in Arizona?

Mr. BOTSKO. Thank you for the question, sir. I don't really think that I am equipped to answer that question. The IG's Office tries to stay out of those types of things.

Mr. GOSAR. Competition would definitely help you as far as taking your dollar further, right?

Mr. BOTSKO. Yes, I believe it would.

Mr. GOSAR. Thank you.

Mr. GOWDY. Well, the chair would recognize the gentleman from Maryland, Mr. Cummings.

Mr. CUMMINGS. Mr. Cannon, help me with this, if you have 100 people, seniors, who are all sick, who all have preexisting conditions, and you are going to give them a maximum of $15,000 for an insurance policy, help me understand how that works. In other words, who is going to insure a senior who is sick? I am curious, maybe I am missing something.

Mr. CANNON. My understanding, Congressman, is that the $15,000 amount——

Mr. CUMMINGS. That is like a max, right?

Mr. CANNON. My understanding is that would be an average. Right now I think Medicare spends something like $10,000 or close to that on average per enrollee. And Mr. Ryan's proposal would take today's average amount, let that grow over time, and I think GDP plus 1 percent until 2021, at which point that would be the average voucher amount seniors would receive—I am sorry, premium assistance amount seniors would receive.

Mr. CUMMINGS. And they would go out, and they would purchase this insurance.

Mr. CANNON. Let's say that $15,000—I sort of suspect it would be more—that would then be adjusted for income so that low-income people would get more than $15,000; adjusted for illness, so that if you are low-income and sick, you would get even more.

Mr. CUMMINGS. Do you know what the max would be?

Mr. CANNON. I am not aware of what the maximum would be. That would be a result of the rules, the specific risk-adjustment rules that haven't been spelled out in his budget, but you would have sick people getting a lot more money. The key is that they

would own that money. It would be theirs. If they spent it wisely, then they would get to keep it to help pay for their out-of-pocket expenses in future years. And if they have some left over when they die, they could pass that on to their children.

Mr. CUMMINGS. Wouldn't it concern you? I know that you are concerned about the health of our seniors. Right?

Mr. CANNON. Absolutely. I am very closely related to two Medicare enrollees.

Mr. CUMMINGS. So I am trying to figure—now, let me break this down to my district, because I have to be concerned about them. A lot of people in my district are your sicker population. In other words, it would not shock me if they—if I had a room of 50 seniors, that perhaps at least out of the 50, 10 might spend some time in the hospital with dealing with maybe perhaps a chronic disease or some emergency situation, like heart problems or whatever. And those expenses could escalate very rapidly.

And I guess what I am trying to figure out is I know insurance companies are out there to make money. They make their money. They are going to find a way to make their money. And I am trying to make sure I understand, when they take that piece of paper—I know you don't want to use voucher, but that is basically what it is.

Mr. CANNON. I don't mind that term.

Mr. CUMMINGS. They take their voucher and they are shopping around for these insurance companies, they get—assuming they can get one. So you have confidence that these companies are going to insure them. And when we do away with preexisting conditions as an element that is, you know, my friends on the other side are saying they want to do away with the Affordable Care Act, one of the main things that my constituents are most concerned about is preexisting conditions. So—and as I tell my constituents, you know, some of the younger folks to say to me, well, Cummings, I am not worried about preexisting conditions. I tell them, you just keep on living; you will have some preexisting conditions.

So if I have a person who does not have the protection of preexisting conditions, got a voucher, and—I am just wondering, do you—is there a concern that they may not able to get insurance?

Mr. CANNON. Within the context of the chairman's budget—Chairman Ryan's budget—I am sorry—Medicare reforms, no. I believe that he would require insurance companies to take all-comers.

Now, the—what we call these bans on discrimination against people with preexisting conditions, they are really a government price control. A competitive marketplace would set the price for the—health insurance for someone very sick at a very high level, maybe prohibitively expensive for that individual. When the government says that you can charge them no more than you charge a healthy person, well, then that insurance company has to charge all enrollees a weighted average. The government is forcing down the price for sick people by forcing up the price for healthy——

Mr. CUMMINGS. I got that. So——

Mr. CANNON. And so the problem with government price controls is that they can change the prices that people offer in the marketplace, but they don't change the underlying economic reality that drives those market prices. And so what happens is you have in-

surance companies trying to mistreat, avoid, and dump sick people as a result of these government price controls. If a patient costs $50,000 to insure but the government says you can only charge them $10,000, well, an insurance company is going to have to get rid of those sick people by providing them lousy coverage, lousy service, or else they are going to go out of business.

And research by President Obama's—some of President Obama's economic advisers has shown that is what happens under those government price controls. I would rather do without them precisely because I think we would have better protection for people with very expensive illnesses.

Mr. CUMMINGS. I see my time has expired.

Mr. GOWDY. Mr. Botsko, the first panel talked a little bit about this pay first, verify second, third, fourth, recapture if we think we paid out incorrectly, which seems like a very inefficient model. Propose a better model to us, maybe one with verification or investigation on the front end.

Mr. Botsko. Well, I am proud to say that the State of Arizona actually does that. We have the Fraud Prevention Unit. That unit is staffed by a group of investigators who go out upon referrals that originate from hospitals due to fraud indicators that the Office of Inspector General has set forth. Once that referral is received by my office, the investigators are out on the street within 24 hours conducting interviews. So we stop the people from getting into the system, those that are ineligible and that the investigation has shown are ineligible, and we stop it right at the very beginning. And I believe last year it was about $1.9 million in cost avoidance per investigator.

Mr. GOWDY. You have a background in law enforcement?

Mr. BOTSKO. I do.

Mr. GOWDY. How many years did you serve in law enforcement?

Mr. BOTSKO. Twenty-two years in Federal law enforcement.

Mr. GOWDY. With the Bureau?

Mr. BOTSKO. I was with the U.S. Department of Defense doing contract fraud, and also with the U.S. State Department Diplomatic Security Service.

Mr. GOWDY. Did you ever run an NCIC background check?

Mr. BOTSKO. Yes, sir.

Mr. GOWDY. Those aren't hard. Are they?

Mr. BOTSKO. No, sir. A matter of seconds.

Mr. GOWDY. Is it too much to ask to run a background check or an NCIC on people who purport or want to be durable medical equipment suppliers?

Mr. BOTSKO. Absolutely not. And in fact, the Arizona Office of Inspector General, we are a criminal justice agency so we have an NCIC terminal, and we do those checks.

Mr. GOWDY. Did you ever do something as outlandish as actually go interview a target or a suspect?

Mr. BOTSKO. All the time, sir.

Mr. GOWDY. Do you think it is too much to ask that we go have a field interview with someone who aspires to be a supplier of durable medical equipment to make sure that they have an office and it is staffed and it is something other than a pizza parlor or a post office box?

Mr. BOTSKO. That would certainly be a very proper and appropriate means of attack on the program to stop those that are perpetrating fraud. However, as with everything, more money, more staff are necessary to do those things.

Mr. GOWDY. Perhaps. Or perhaps we go to Ms. MacQuarrie. And is there technology that can help? Not to eliminate any investigators' jobs, but is there technology that can help?

Mr. BOTSKO. Let me just add that we actually use one of their products.

Ms. MACQUARRIE. Thank you for the question. Regardless of how health care is paid for, there is going to be fraud in it. And it is critically important to continue the fight against fraud, first in a prepayment mode as you have just indicated, Mr. Chairman. And there are technologies available. The CLEAR product that we had in our written testimony and in my verbal testimony does a complete research check of all individuals for whom we mine the data for. And that would be all of those DME suppliers who want to get into the program.

We take that a step further, however, and we can link the risk indicators within this public record data, things like criminal records or preexisting tax liens or sanctions in one State and the providers move to another State and the State doesn't know that they were sanctioned someplace else. We can link all of that to historic claims data and do predictive modeling and actually assign a risk indicator.

This is work that we do today, assign a risk indicator on those who would be providing applications to get into the program. So if we did have some limited field investigative staff, we would have them go out against those who have the highest risk indicators, as opposed to just every 10th supplier who might submit an application for enrollment.

Mr. GOWDY. Mr. Cannon, quickly.

Ms. MacQuarrie indicated that you are going to have fraud regardless, which is probably true. Do you have any statistics or perspective on whether or not fraud is more pervasive in the private insurance market or in the government health care delivery system?

Mr. CANNON. You are going to have fraud I think wherever you have human beings. But I think you are going to have more fraud in government health care programs than you are in the private sector for the simple reason that government is people spending other people's money, and nobody spends other people's money as wisely or as carefully as they spend their own.

So we have heard some discussion about tightening provider enrollment in Medicare. We could do that. We could also insist that providers provide more documentation with the claims that they file so we can ensure that those are valid claims. But when you, Congressman, hear from people in your district, providers in your district that these measures that they have to—the legitimate providers have to comply with now are too onerous and can't we repeal them, you and other Members of Congress are going to say, maybe we should repeal these things.

They would prevent fraud, but you will roll them back. Why? Because it is not your money that is being lost to fraud. That is how

government operates. That is why waste, fraud, and abuse are endemic to government programs, because government is people spending other people's money.

Mr. GOWDY. On that happy note, we will end. I want to thank all four of our witnesses and everyone else in the audience for participating, as well as my colleagues on both sides. Thank you.

[Whereupon, at 4:40 p.m., the subcommittee was adjourned.]

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