

**Testimony to the
U.S. House of Representatives
Committee on Oversight and
Government Reform**

**“Waste and Abuse:
The Refuse of the Federal Spending Binge”**

**Chairman Darrell Issa (R-CA)
Ranking Member Elijah Cummings (D-MD)**

By

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Introduction

Chairman Issa, Ranking Member Cummings, and Members of the Committee, thank you for holding this hearing today and for inviting me to participate and lend my thoughts on such a vitally important topic to our nation's future. I applaud your focus on government waste and the search for meaningful answers that will help reduce our federal deficit. Decreasing and hopefully eliminating waste, fraud, and abuse in our healthcare system represents a necessary and bipartisan means by which to achieve this goal. The Center for Health Transformation has worked extensively on these issues and with many of its members to find solutions, from technology providers to insurers, and more.

Please allow me to begin by stating that my oral and written remarks today are uniquely my own. They do not necessarily represent the views and opinions of my employer, the Center for Health Transformation, or those of its staff or members.

The Bipartisan Problem of Medicare and Medicaid Fraud

The problem of fraud and abuse in America's healthcare system represents a massive burden on the government, and consequently American taxpayers. Healthcare fraud occurs in many different ways, from simple upcoding and excessive testing to the more complex type of provider referral rings that send patients to scheme providers. Medicare and Medicaid fraud, in particular, contribute significantly to overall expenditures for the Centers for Medicare and Medicaid Services (CMS). President Barack Obama noted in an address to a joint session of Congress on September 9, 2009 that there are "hundreds of billions of dollars of waste and fraud" within our healthcare system.¹ This is not an insignificant number as we stare down massive government budget deficits and contemplate ways to reduce them.

On Monday, President Obama released his budget for the upcoming year, and Congress will reply with its own version. In his budget, the President noted that the gross federal debt will exceed \$15 trillion, equal to the size of the entire U.S. economy.² This is unsustainable. As a result, a primary goal of upcoming budget discussions will be to secure a significant reduction in wasteful government spending. Fraudulent and wasteful spending in the healthcare industry represents low-hanging fruit that can, and should, contribute to such a reduction.

There is broad bipartisan consensus that fraud and abuse within Medicare and Medicaid represents a problem that must be addressed and can make a significant dent in our nation's wasteful government spending. During the White House Health Summit on February 25, 2010, Senator Tom Coburn noted, "Twenty percent of the cost of government healthcare is fraud," a

¹ "Full Remarks of the President's Address to Congress on His Healthcare Reform Plans." September 9, 2009, at <http://www.cbsnews.com/stories/2009/09/09/politics/main5299229.shtml>.

² Dinan, Stephen. "Debt Now Equals Total U.S. Economy." *The Washington Times*. February 14, 2011, at <http://www.washingtontimes.com/news/2011/feb/14/debt-now-equals-total-us-economy/>.

statement which Senator Charles Schumer lauded. Unfortunately, to date, efforts to curb these harmful practices promulgated by criminals across the country have accomplished very little. The time to undertake the proper reforms and reduce wasteful government spending in the area of healthcare fraud is now.

Outright criminality imposes a huge burden on the system. Crooks have figured out how to game the system and must be stopped. Take for example an Orange County, California cancer doctor who was charged in April of last year with fraudulently billing Medicare and health insurance companies close to \$1 million for administering injectable cancer medications that were never provided.³ Or further look to the Miami area clinic consultant who was convicted in May of last year for healthcare fraud, conspiracy to commit money laundering, and money laundering in connection with a \$5.8 million Medicare fraud scheme in which the clinic was falsely claiming to administer HIV injection and infusion treatments.⁴

Countless examples of these types of fraud exist and their practice must be eliminated. Doing so could save the government and American taxpayers hundreds of billions of dollars. There are numerous ways this could be achieved, but the government must be flexible and think outside its traditional box in order to do so. Criminals pivot and adapt to stay ahead of their victim, and CMS and government authorities must learn to be similarly nimble.

The Government Accounting Office (GAO) has designated both Medicare and Medicaid as “high-risk” programs. In fact, a 2009 GAO report on the “High-Risk Series” that includes both programs estimated that the improper payment rate for Medicaid in 2008 was 10.5 percent.⁵ This exists in sharp contrast to the 3.9 percent improper payment rate for non-health government agencies during 2008.⁶ This amounts to up to \$200 billion annually in Medicare fraud⁷ and

³ “Orange County Cancer Doctor Charged with Defrauding Medicare and Other Health Insurers in \$1 Million Scam (U.S. Attorney for the Central District of California).” April 10, 2010, at <http://stopmedicarefraud.gov/innews/california.html#apr-15-2010>.

⁴ “Miami Clinic Consultant Convicted in \$5.8 Million Fraudulent HIV Infusion Scheme (U.S. Attorney for the Southern District of Florida).” May 4, 2010, at <http://www.stopmedicarefraud.gov/innews/florida.html#may-04-2010>.

⁵ Government Accountability Office. “Progress Made, but Challenges Remain in Estimating and Reducing Improper Payments.” April 22, 2009, at <http://www.gao.gov/highlights/d09628thigh.pdf>.

⁶ Hatch, Garret and McMurtry, Virginia. “Improper Payments Information Act of 2002: Background, Implementation, and Assessment.” Congressional Research Service. October 8, 2009, at http://assets.opencrs.com/rpts/RL34164_20091008.pdf.

⁷ Fox, Maggie. “Healthcare System Wastes Up to \$800 billion a Year.” Reuters. October 26, 2009, at <http://www.reuters.com/article/2009/10/26/us-usa-healthcare-waste-idUSTRE59POL320091026>.

around \$32 billion per year in Medicaid fraud.⁸ With the estimated 18-20 million additional Medicaid beneficiaries likely to join the rolls in states across the country as a result of changes in last year's health reform law, this number could very easily increase without additional funding for monitoring fraudulent behavior.

The Example of the Credit Card Industry's Success in Curtailing Fraudulent Spending as a Lesson for Medicare and Medicaid

The fraud and abuse rate within Medicare and Medicaid exists in sharp contrast to that of the private sector credit card industry. There are more than \$2 trillion in credit card transactions annually and nearly 1 billion cards in circulation. Yet, for this incredibly high level of activity, the fraud rate in the credit card industry is less than one tenth of one percent, according to experts at Visa and American Express.

There are several reasons for these successful figures that save the credit card industry hundreds of billions of dollars each year. First, the industry uses technological innovation to their advantage by immediately flagging suspicious purchases and even placing holds on accounts when a perceived instance of fraud exists. Meanwhile, Medicare fee-for-service utilizes a "pay and chase" model that fails to identify fraud upfront and tries to track down criminals after the fact and by the time they are long gone. This inability to stop fraud and abuse before it happens contributes significantly to the massive Medicare price tag, and represents an area that can be attacked to reduce government costs.

The credit card industry also does a much better job than Medicare and Medicaid in terms of screening its vendors. Dedicating resources on the front end to determine the legitimacy of a prospective vendor would certainly save vast amounts on the back end in terms of fewer instances of fraud and abuse. Further, CMS must acknowledge that not every supplier who applies to provide services to beneficiaries has a right to be approved. A more rigorous approval process would cut down on the number of fraudulent suppliers thereby produce savings in the system.

Wasteful Government Spending Apart from Fraud and Abuse

A thorough examination of healthcare waste released in 2009 by Thomson Reuters determined that between \$600 billion and \$850 billion of healthcare spending annually is wasted. While the study found \$125 billion to \$175 billion of this is attributed purely to fraud, the remainder is made up of administrative waste, provider errors, and other costs associated with unnecessary

⁸ Rehnquist, Janet and Javitt, Jonathan. "Creative Approaches to Combating Fraud in State Medicaid Programs." *Stop Paying the Crooks: Solutions to End the Fraud that Threatens Your Healthcare*, ed. James Frogue (Washington, D.C. Center for Health Transformation Press), at 161.

and duplicative diagnostic testing.⁹ Further, a recent Gallup poll conducted for Jackson Health Care and the Center for Health Transformation found that nearly 25 percent of all medical services ordered by physicians are done so unnecessarily.¹⁰ Based on the survey, Jackson Health Care estimates that \$650 billion of the nearly \$2.5 trillion that CMS estimates is spent annually on healthcare in America is spent on unnecessary tests and treatments. Not only do we need to aggressively attack the roots of fraud and abuse in the system, but we also need to address the causes of waste and implement reforms that will also help reduce wasteful spending.

One major reason that providers order unnecessary services is due to the fear of potential legal action for an unforeseen circumstance. Predatory litigators cause physicians to practice defensive medicine, which leads to an increase in the overall cost of the system. Creation of a system that is much more focused on timely resolution of legitimate claims would significantly benefit both the patient and provider while contributing to a reduction of cost in the system as extraneous testing becomes a remnant of the past. Congressmen Phil Gingrey (R-GA), Lamar Smith (R-TX), and David Scott (R-GA) recently introduced H.R. 5, the HEALTH Act that includes meaningful medical liability reforms while strengthening the doctor-patient relationship.¹¹ This type of systematic reform is necessary to reduce waste and ensure that patients, providers, and payers (be them government or private) are treated fairly.

Specific Proposals for Industry Reform

Below are several solutions that would significantly reduce waste, fraud, and abuse in the healthcare system and lead to increased savings.

- 1) As it relates to waste through the practice of defensive medicine, Congress must enact sensible medical justice reform that relieves physicians from the need to over-prescribe tests, procedures, and medications for fear of frivolous legal action while at the same time protecting the rights of patients.**

Government waste exists in healthcare outside the sphere of fraud and abuse. Frivolous lawsuits contribute to the practice of defensive medicine such as that previously mentioned in the Gallup poll and delegitimize meritorious claims of patients who have suffered real harm. Instituting reforms to the judicial system that protect patient safety, provide fair and effective compensation, provides resolution at a less overall cost, and incentivizes the best standards and protocols of health delivery are paramount to reducing waste in the system.

⁹ Thomson Reuters. "Healthcare Reform Starts with the Facts." October 27, 2009, at http://thomsonreuters.com/content/corporate/articles/healthcare_reform.

¹⁰ Gallup. "Poll: One of Four Healthcare Dollars Spent on Unnecessary Medical Care." February 22, 2010.

¹¹ H.R. 5, "Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011." Introduced January 24, 2011, at <http://thomas.loc.gov/cgi-bin/query/z?c112:H.R.5>:

2) Introduce significant changes to the current system of electronic data tracking and data sharing across jurisdictions and departments.

We now live in a world where massive information sharing can easily occur at the click of a mouse or hit of a keystroke. Unfortunately, CMS is unable to reconcile its multiple Medicare and Medicaid provider and supplier databases and any disciplinary action taken against them. Creating a single, unified depository of this information could significantly reduce wasted time and financial resources expended on cross-referencing potential crooks. This would be similar to how law enforcement and intelligence departments created a far more sophisticated information sharing system following the 9/11 attacks.

Additional programs such as the Health Care Fraud and Prevention Action Team (HEAT), which has been a successful collaboration between the Health and Human Services and Justice Departments should be initiated. Success can be achieved through cross-jurisdictional integration of information that will quickly identify fraudulent providers and suppliers. This data must be available easily and in real time to maximize effectiveness. These shared databases could identify potential red flags immediately and alert the proper authorities to investigate the individual and/or claim. Once again, investing resources to prevent fraud before it occurs will produce a significant level of savings and reduction of government waste.

Private sector companies already successfully amass millions of claims electronically every day. Many of the Center for Health Transformation's members focus all of their energy solely on such an enterprise and are experts at it. The compilation of this information allows for real-time tracking and can identify irregularities at a moment's notice across states and provider venues. There is no reason CMS and other government agencies should not be able to mirror this practice and immediately stop payment and initiate an investigation if a dubious claim is identified.

3) Conduct additional hearings such as this one that focus on investigating the ability of CMS to appropriately track fraud and abuse and determine the feasibility of incorporating private sector cooperation into identifying such activity.

Given the informational and systemic advantage Medicare and Medicaid criminals currently enjoy, government officials are treading water just to keep up, let alone make a noticeable dent in the amount of government waste that comes from fraudulent claims. Congress should hold hearings and invite as witnesses those contractors who have been involved with the claims process on the ground floor. These individuals are incredibly attuned to the voluminous claims activity that is part of the process and would provide a wonderful resource during the potential creation of a public-private partnership aimed at combating Medicare and Medicaid fraud and abuse.

One of the easiest ways to ensure that improper or fraudulent payments are not made is to identify them before they are actually paid. It is intuitive, yet many states, businesses, and insurers still cling to the pay and chase model. In California, for instance, the state pays approximately \$250 million a year in medical claims for its employees that should not be paid. This is similar to you or me simply writing a check to someone we owe money, but not looking

at the invoice to ensure that we're paying the correct amount. Once we realize we overpaid, we then have to spend time and resources tracking down the error and being reimbursed. Companies like Qmedtrix, a member of the Center, perform bill review on the front end to identify those payments that should not happen in the first place – due to fraud, waste, abuse, or error – and ensure that the proper amount is being paid to the appropriate party. Combining lessons learned at the government and private enterprise levels could help form an effective and targeted initiative (be it a demonstration project or otherwise) to significantly reduce government waste in the form of fraud and abuse.

4) Institute a comprehensive and transparent model of supplier approval and fraudulent claims administration.

Unlike private sector insurers, Medicare and CMS are not required to divulge their administrative costs, which ultimately are lost in other areas of the federal budget or simply ignored by the complex bureaucratic entanglements of the federal bureaucracy.¹² This is an example of the lack of transparency that leads to severe waste and a burden on the budget and U.S. taxpayers.

Requiring publicity of the approval process of suppliers would certainly act as a deterrent to some criminals not looking to have their names splashed across the public domain. For those bold enough to continue forward despite the risk, victims would be able to much easier identify them and create a track record of their information to use in a more expedient action by CMS at a later date.

5) Encourage the implementation of more intelligent systems and solutions to reduce waste and fraud in the system.

In order to significantly bend the cost curve and reduce waste in healthcare, we must capture and utilize the innovative spirit of many systems currently in place and expand their utilization across the industry. Numerous highly intelligent systems currently exist that are cutting into wasteful spending and fraudulent activity. These solutions can provide useful examples of how to put a major dent in wasted government money if applied at the federal and state level.

At the state level, Medicaid programs have historically been challenged with the difficult task of recovering payments when primary health insurance coverage information is not presented by the Medicaid patient at the time services are rendered. Many recipients do not share other health insurance coverage information with providers or are unaware that other coverage exists. Even when Medicaid agencies discover other health insurance coverage for Medicaid patients, they must engage in the aforementioned pay and chase strategy, which is not very effective in recovering taxpayer dollars. These traditional recovery programs are inefficient, expensive and produce recovery rates of less than 17% of the dollars actually billed to Medicaid programs. The

¹² Matthews, Merrill and Matthews, Meredith R. "Medicare Fraud: What the Government Can Learn from the Private Sector." *Stop Paying the Crooks: Solutions to End the Fraud that Threatens Your Healthcare*, ed. James Frogue (Washington, D.C. Center for Health Transformation Press), at 82.

Syrtris Solution program – ProTPL – identifies in real-time *before* a claim is submitted, if a Medicaid patient has alternative health insurance coverage and if so, re-routes the claim to the appropriate health insurer for payment. ProTPL thereby helps state Medicaid programs to totally avoid paying a claim. ProTPL has demonstrated results that help state Medicaid agencies save millions of dollars.

Another smart technological solution that assists payers in their effort to root out fraud comes from Verisk Health and provides a good model for helping control waste and abuse. Their products constantly monitor tens of thousands of medical diagnosis and procedure codes from every healthcare provider for irregularities they can pass along to third party payers, be them private or even Medicare. The Verisk system can immediately identify fraudulent claims that range from duplicate claims to more sophisticated forms of criminal activity.¹³ Encouraging these types of valuable technologies represents an easy and progressive way to significantly reduce fraudulent healthcare spending and contribute to the overall lowering of cost in the system.

Other examples of intelligent solutions exist, the types of which could be applied throughout the industry at the government and private sector level to save valuable dollars. Blue Cross Blue Shield of America and Blue Cross Blue Shield Association have instituted several anti-fraud programs that aggressively target criminals attempting to defraud their company and their patients through medical identify theft, phantom medical equipment providers, and more. All told, the Blue Plan’s intelligent initiative saved nearly \$350 million in 2008 alone and since 2000 has saved more than \$1.9 billion.¹⁴ This and other programs can provide the blueprint for moving toward large cost-saving reductions that can save tax payers billions of dollars.

Conclusion

We find ourselves on the precipice of the largest budget deficit in U.S. history. Wasteful government spending threatens to stifle growth, ingenuity, and innovation. Healthcare represents one large area where this waste can be significantly reduced if the proper reforms are put in place. Waste, fraud, and abuse run rampant in the system, but with meaningful change in how CMS uses technology, operates openly and transparently, and incorporates law enforcement and legal reform, we can save hundreds of billions of dollars over the next 10 years.

¹³ Kryder, Chris and Johnson, Barry. “The “F” Word: \$250 Billion of Easy Money.” *Stop Paying the Crooks: Solutions to End the Fraud that Threatens Your Healthcare*, ed. James Frogue (Washington, D.C. Center for Health Transformation Press), at 115-16.

¹⁴ Serota, Scott P. “Blue Plans Leading the Way: Innovative Solutions for Fighting Healthcare Fraud.” *Stop Paying the Crooks: Solutions to End the Fraud that Threatens Your Healthcare*, ed. James Frogue (Washington, D.C. Center for Health Transformation Press), at 23.

Vincent L. Frakes Curriculum Vitae

Vincent L. Frakes is the Federal Policy Director of the Center for Health Transformation. In this capacity, Vincent works closely with CHT members to analyze the impact of federal health legislation and regulation on the industry and to develop sound policy solutions that could help transform health and healthcare. He also directs the Center's Employer Project to analyze and advise how health policy affects large and small employers and helps lead CHT's Fraud Project.

Vincent works directly with Congressional members and their staff on the issue of healthcare reform and its legislative impact on all members of the industry. He also advises CHT members on the Patient Protection and Affordable Care Act and its meaning for individual companies and the industry as a whole, especially in a political context. He further works in the area of health information technology, healthcare delivery reform, healthcare fraud, employer issues and medical liability reform as they relate to the ongoing policy debate.

Vincent speaks frequently on the topic of healthcare and has appeared on dozens of television and radio programs. He has also been quoted in newspapers across the country and authored multiple articles for national online publications.

Prior to joining the Center, Vincent was a valued member of the Government Relations and Public Policy team at the DC Chamber of Commerce. He focused on legislation and policy analysis, specifically in the area of healthcare, affecting businesses operating in the Washington, D.C. metropolitan area. Additionally, Vincent has helped direct government affairs efforts for a large pharmaceutical-sponsored prescription savings program benefitting the uninsured and underinsured. His work included organizing large meetings with numerous U.S. Senators, Congressmen and congressional staff. He also focused on examining health policy directives related to pharmaceutical manufacturers. On Capitol Hill, Vincent worked for the U.S. House Committee on Ways and Means, which included work on both the Subcommittee on Trade and with the full committee.

Vincent holds a Juris Doctorate from American University's Washington College of Law , where he published an article on investor's rights and arbitration mechanisms under NAFTA, and a Masters Degree in International Affairs from the School of International Service at American University. He graduated with High Honors from the University of California at Santa Barbara with a B.A. in English and Political Science. He currently resides in Washington, D.C.

Committee on Oversight and Government Reform
Witness Disclosure Requirement - "Truth in Testimony"
Required by House Rule XI, Clause 2(g)(5)

Name:

1. Please list any federal grants or contracts (including subgrants or subcontracts) you have received since October 1, 2008. Include the source and amount of each grant or contract.

N/A

2. Please list any entity you are testifying on behalf of and briefly describe your relationship with these entities.

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3. Please list any federal grants or contracts (including subgrants or subcontracts) received since October 1, 2008, by the entity(ies) you listed above. Include the source and amount of each grant or contract.

N/A

I certify that the above information is true and correct.

Signature:

Vincent L. Frakes

Date:

2/15/2011