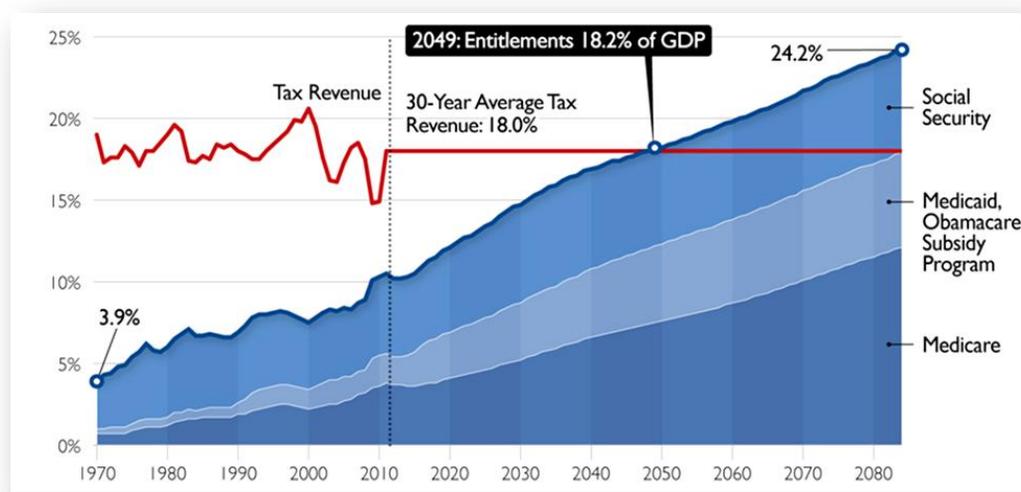


## MEDICARE AND MEDICAID

Medicare and Medicaid provide health insurance coverage to approximately 90 million Americans. Of this, Medicare provides health insurance coverage for 45 million Americans, most of whom are senior citizens,<sup>1</sup> while Medicaid covers more than 55 million low-income Americans.<sup>2</sup> Nine million Americans are enrolled in both programs.<sup>3</sup> Together, they provide health care coverage for approximately one in five Americans and, along with Social Security, make up the backbone of the federal safety net.

The costs of health-entitlement programs are increasing so dramatically, however, the non-partisan Congressional Budget Office (CBO) concludes “the single greatest threat to budget stability is the growth of federal spending on health care.”<sup>4</sup>

Medicare and Medicaid will cost taxpayers roughly \$1 trillion this year alone. Unless reforms are enacted, entitlements are on track to consume *all tax revenues* before today’s 25 year-olds are eligible for Medicare. The status quo is empirically unsustainable.



Based on data from the Congressional Budget Office, this chart from the Heritage Foundation demonstrates how entitlements are set to consume the entire U.S. budget. As The Heritage Foundation notes, “If the average historical level of tax revenue is extended, spending on Medicare, Medicaid and the [Patient Protection and Affordable Care Act] subsidy program, and Social

<sup>1</sup> “Medicare,” The Kaiser Family Foundation website, accessed July 17, 2011; <http://www.kff.org/medicare/index.cfm> .

<sup>2</sup> “Medicaid/CHIP,” The Kaiser Family Foundation website, accessed July 17, 2011; <http://www.kff.org/medicaid/index.cfm> .

<sup>3</sup> “HHS offers new tools to help states lower Medicaid costs, provide better care,” Department of Health and Human Services website, May 11, 2011; <http://www.hhs.gov/news/press/2011pres/05/20110511a.html> .

<sup>4</sup> Congressional Budget Office, “The Budget and Economic Outlook, Fiscal Years 2010-2020,” January 2010, <http://www.cbo.gov/ftpdocs/108xx/doc10871/01-26-Outlook.pdf>

Security will consume all revenues by 2049. Because entitlement spending is funded on autopilot, no revenue will be left to pay for other government spending, including constitutional functions such as defense.”<sup>5</sup>

The Government Accountability Office (GAO) estimates the federal 75-year funding gap – the difference between anticipated tax receipts and government spending – is a staggering \$76.4 trillion. This is more than five times our current national debt. Entitlement spending alone accounts for more than 80 percent of that debt.<sup>6</sup>

Given this grim projection, broad health-entitlement reform is a necessity, not a choice.

The reason for this straightforward: the programs’ costs are higher than the money available for them. CBO estimates Medicare’s Hospital Insurance Trust Fund will be financially insolvent in 2020, less than nine years from today. According to the 2011 Medicare Trustees’ Report’s worst-case scenario, the trust fund could be insolvent as early as 2016. The Trustees’ report also notes the trust fund is expected to pay out more in benefits than it receives into its accounts from revenue in *all* future years.

Medicare and Medicaid consume one in five federal tax dollars. Unfortunately, not every dollar is spent on health care. Taxpayers lose an estimated \$100 billion *a year* to waste, fraud and abuse in the two programs, which is the combined annual budget of three entire federal departments—Transportation, Homeland Security, and Housing and Urban Development.

GAO designated Medicare as a “high-risk” program in 1990, a designation reserved for a select group of programs particularly vulnerable to fraud, waste, abuse, and mismanagement. Medicaid was added in 2003. Medicare’s improper payment rate for fiscal year 2010 was \$48 billion, while Medicaid’s was nearly \$36 billion. The inefficiency of the management of these programs is costing taxpayers tens of billions every year and, as a result, siphoning dollars away from the care of needy patients.

Medicaid is a particular burden on states, consuming on average 22 percent of state budgets, according to a Fiscal Survey of the States. The National Governors’ Association estimates that states are already facing a collective \$175 billion budget shortfall in 2010 – the worst state budget crisis since the Great Depression. According to the CBO, states will be forced to spend another \$60 billion on Medicaid through 2021, while another tally estimates the costs to state could reach at least \$118 billion through 2023.



<sup>5</sup> Heritage Foundation 2011 Budget Chart Book, “Entitlements Will Consume All Tax Revenues by 2049,” <http://www.heritage.org/budgetchartbook/entitlements-historical-tax-levels>, accessed July 14, 2011.

<sup>6</sup> Government Accountability Office, “Fiscal Pressures Could Have Implications for Future Delivery of Intergovernmental Programs,” July 2010. <http://www.gao.gov/new.items/d10899.pdf>

## **Medicare And Medicaid Should Be Improved**

The problems facing Medicare and Medicaid are not just about numbers and budgets, but also the quality of care delivered to the patients who depend upon the program. The right reforms will address both for the better.

Unfortunately, these troubled programs often deliver substandard care for patients. Nearly half of physicians do not accept Medicaid patients because the program's reimbursement rates are so low. Not surprisingly, patients on Medicaid have poorer health outcomes, higher rates of infant mortality and more complications after major surgery than individuals with no health insurance at all. Under current law, states do not have the necessary flexibility to make basic improvements to their programs. As a result, they are often forced to make drastic cuts to provider reimbursements, further limiting patients' access to care.

Millions of seniors have care delayed or denied because they cannot access a physician. The government-run Medicare payment process creates perverse incentives through a dizzying array of billing codes that often overpay for certain types of tests, but underpay for primary care. By default, the complexity of this government-run process puts politicians and bureaucrats in charge of deciding how much doctors get paid for their services and what services are covered.

## **Transfer Program Management of the Medicaid Program to the States**

This proposal repeals the Medicaid expansion in Congress' wrong-headed health law and strengthens Medicaid's safety net for the poorest patients by transferring program management authority to the states. After decades of ineffective management of the program out of Washington, D.C., the proposal continues the federal partnership in the Medicaid program, but modernizes Medicaid's federal-state shared financing, saving federal taxpayers an estimated \$770 billion over 10 years. States are freed from red tape and cumbersome, bureaucratic restrictions, thereby empowering them to provide care in a more efficient and cost-effective manner. States would be required to provide care for certain populations, but are given flexibility to negotiate with provider networks, design benefit packages, and coordinate care for the individuals and families in their state.

## **Reform Medicaid Payment for Transportation**

The Department of Health and Human Services Office of the Inspector General (HHS OIG) "identified significant vulnerabilities to fraud and abuse in State nonemergency medical transportation programs."<sup>7</sup>

The *Associated Press* reported a "federal audit estimates taxpayers paid between \$700,000 and \$1.6 million in 2005 alone for improper transportation of Medicaid patients in Milwaukee County. The payments went to Milwaukee-based American United Taxicab, which transports

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<sup>7</sup>Office of Inspector General, U.S. Department of Health and Human Services OIG: OEI-06-07-00320, "Memorandum Report: 'Fraud and Abuse Safeguards for State Medicaid Nonemergency Medical Transportation Services May 28<sup>th</sup> 2009,'" <http://oig.hhs.gov/oei/reports/oei-06-07-00320.pdf>, Page 4, accessed July 14, 2011.

Medicaid recipients to doctor's appointments as required under the program."<sup>8</sup> Wisconsin was forced to repay \$347,000 to the federal government for improper payments in the Medicaid program.<sup>9</sup>

Another report revealed a New York a "woman took a daily \$300 taxi ride to visit her son in Albany for three years -- and taxpayers picked up the tab."<sup>10</sup>

This proposal would eliminate such blatant waste of scarce federal resources by strengthening program integrity provisions and making changes to the payment of transportation.



Medicaid is improperly spending millions of dollars every year for cab rides. A New York woman, for example, took a \$300 taxi ride to visit her son every day for three years

### **Reforms Payment Processes for Medicaid Personal Care Services**

Personal care services are generally furnished to individuals residing in their homes rather than institutional care settings, such as hospitals or nursing facilities. Medicaid beneficiaries are authorized for personal care services by a physician in accordance with a plan of treatment or with a service plan approved by the individual State.

The HHS OIG found "eighteen percent of paid claims for Medicaid personal care services (PCS) in our universe totaling approximately \$724 million were inappropriate because attendants'

<sup>8</sup>Associated Press, "AP Newsbreak: Medicaid Patients Received Free Rides for Errands, November 21, 2008," <http://www.wkwtv.com/Global/story.asp?S=9393850&nav=menu1362,Page2>.

<sup>9</sup>Associated Press, "AP Newsbreak: Medicaid Patients Received Free Rides for Errands, November 21, 2008," <http://www.wkwtv.com/Global/story.asp?S=9393850&nav=menu1362,Page2>.

<sup>10</sup>Crowley, Cathleen, "Taxpayers Finance \$196,000 ride Audit shows taxi cab bill among abuses of health care system for indigent", *Albany Times Union*, December 23<sup>rd</sup>, 2009, <http://www.timesunion.com/AspStories/story.asp?storyID=880946&category=region>.

qualifications were undocumented.”<sup>11</sup> Based on the sample results, the HHS OIG estimated a single state improperly claimed \$41.7 million for unallowable Medicaid personal care services during a two-year period. These deficiencies occurred because the state did not have sufficient resources to adequately monitor the personal care services program for compliance with certain Federal and State requirements.

The HHS OIG recommended the state implement additional procedures and controls for monitoring the providers of personal care services for compliance with Federal requirements.<sup>12</sup> This proposal strengthens program integrity provisions and makes changes to the payment of personal care services.

### **Enroll Low-Income Seniors in Medicaid Managed Care Organizations**

Under current law, approximately nine million low-income seniors and disabled individuals are eligible for and enrolled in both Medicaid (based on income or disability status) and Medicare (based on age). This group is often referred to as “dual eligibles” – men and women who are who are dually eligible for both program.



Patients enrolled in both programs must navigate two systems to access services, and usually rely on Medicaid to pay premiums and cost-sharing under Medicare.

The President’s bipartisan fiscal commission found “divided coverage for dual eligibles results in poor coordination of care for this vulnerable population and higher costs to both federal and state governments.” The commission recommended “giving Medicaid full responsibility for providing health coverage to dual eligibles and requiring that they be enrolled in Medicaid managed care programs.”

Many studies suggest better-managed care is less expensive. The Lewin Group published a report synthesizing 24 studies on the cost savings experience of states that have implemented managed care for their Medicaid populations. The report demonstrates managed care improves access and quality while at the same time yielding savings.

<sup>11</sup>Office of Inspector General U.S. Department of Health and Human Services OIG Report: OIE-07-08-00430, “Inappropriate Claims for Medicaid Personal Care Services December 13<sup>th</sup> 2010,” <http://oig.hhs.gov/oei/reports/oei-07-08-00430.asp>, accessed July 14, 2011.

<sup>12</sup>Office of Inspector General U.S. Department of Health and Human Services OIG Report: A-04-10-04003, “Review of Medicaid Personal Care Services Claims Submitted by Providers in North Carolina June 1, 2011,” <http://go.usa.gov/DEy>, accessed July 14, 2011.

Some states have utilized managed care to cover some Medicaid patients, but significant opportunities for states still exist.

All managed care exclusions in federal law should be repealed, thereby enabling states to further expand managed care availability in Medicaid programs. Under this plan, as the Commission envisioned, Medicare would continue to cover its share of expenses, effectively reimbursing the Medicaid program, and federal taxpayers would win, saving an estimated \$15 billion over 10 years.

### **Track High Prescribers and Utilizers of Prescription Drugs in Medicaid**

States currently have the capability to implement monitoring systems for prescription drugs, but are not taking full advantage of these systems' potential benefits. President Obama's FY2012 budget proposed requiring the Department of Health and Human Services to track drug claims for indications of fraud, waste, or abuse by providers or beneficiaries and to take steps to reduce wasteful or abusive prescribing practices.<sup>13</sup> Even though program authority should be transferred to states, under the continued federal-state Medicaid partnership, adopting this proposal could save taxpayers \$3.45 billion over a decade.

### **Medicare Reforms**

This proposal adopts a range of bipartisan and common-sense policy reforms to strengthen and save Medicare for current seniors and future enrollees.

### **Modernize Benefits, Protect Seniors From Financial Ruin**

President Obama's bipartisan *National Commission on Fiscal Responsibility and Reform* noted, under current law, "Medicare beneficiaries must navigate a hodge-podge of premiums, deductibles, and copays that offer neither spending predictability nor protection from catastrophic financial risk." Medicare is so complicated that the "Medicare and You" handbook for beneficiaries is more than 130 pages long.<sup>14</sup>



Because cost-sharing for most medical services is low, the benefit structure encourages over-utilization of health care. In place of the current structure, this proposal establishes a single combined annual deductible of \$550 for Part A (hospital) and Part B (medical care), along with 20 percent uniform coinsurance on health spending above the

<sup>13</sup>President's Budget for Fiscal Year 2012, "Terminations Reductions and Savings," <http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf>, Page 191, accessed July 14, 2011.

<sup>14</sup>U.S. Department of Health and Human Services Medicare 2011 Handbook, "Medicare and You," <http://www.medicare.gov/publications/pubs/pdf/10050.pdf>, accessed July 14, 2011.

deductible. This also provides catastrophic protection for seniors by reducing the coinsurance rate to 5 percent after costs exceed \$5,500 and capping total cost sharing at \$7,500.

The ability of Medicare cost-sharing to control costs – either under current law or as proposed above – is limited by the purchase of supplemental private insurance plans (often called “medigap plans”) that piggyback on Medicare. The President’s bipartisan Commission noted that “medigap plans cover much of the cost-sharing that could otherwise constrain over-utilization of care and reduce overall spending.” This proposal also prohibits medigap plans from covering the first \$500 of an enrollee’s cost-sharing liabilities and limits coverage to 50 percent of the next \$5,000 in Medicare cost-sharing. These changes improve Medicare and save \$130 billion over 10 years.

### **Adjust Medicare’s Eligibility Age for Increases in Longevity**

The eligibility age for Medicare benefits is 65, although certain people qualify for coverage earlier because of disability. Since the creation of the Medicare program in 1965, life expectancy and the average length of time that people are covered by Medicare has risen dramatically. According to the Centers for Disease Control, when Medicare was passed in 1965, the average lifespan for Americans was 70.2. In 2006, the average lifespan for Americans was 77.7 – an increase of 10.6 percent. While this is a wonderful development, such an increase in the length of time an enrollee may be covered by Medicare has significantly raised the costs of the overall program.

This plan would increase Medicare’s eligibility age by two months every year beginning with people who were born in 1949 (who will turn 65 in 2014) until the eligibility age reached 67 for people born in 1960 (who will turn 67 in 2027). Thereafter, the eligibility age would remain at 67. These increases are similar to those already under way for Social Security’s full retirement age.<sup>15</sup> This change saves \$124 billion over 10 years. After the eligibility age increases to 67 for those attaining age 62 in 2027 or later, it is then indexed to life expectancy—so the eligibility age increases 1 month every two years, reaching 69 in 2080.

### **Apply Funds in the Medicare Improvement Fund toward Deficit Reduction**

The Medicare Improvement Fund was created “to make improvements under the original Medicare fee-for-service program under Parts A and B for Medicare beneficiaries.”<sup>16</sup> This proposal uses these funds for deficit reduction, saving taxpayers \$275 million.

### **Reduce Subsidies to Teaching Hospitals for Graduate Medical Education<sup>17</sup>**

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<sup>15</sup>Congressional Budget Office, “Budget Options Volume 1: Health Care, December 2008,” <http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf>, Page 37, accessed July 14, 2011.

<sup>16</sup>Hinda Chaikind, Jim Hahn, Paulette C. Morgan, and Jennifer O’Sullivan, “Summary of Major Provisions in House-Passed H.R. 6331, the Medicare Improvements for Patients and Providers Act of 2008,” Congressional Research Service, June 25, 2008; <http://aging.senate.gov/crs/medicare2.pdf>.

<sup>17</sup>Congressional Budget Office, “Reducing the Deficit: Spending and Revenue Options, March 2011,” <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>, accessed July 14, 2011.

Medicare currently provides supplemental funding to hospitals with teaching programs for costs related to residents receiving graduate medical education (GME) and indirect costs (IME). Based on analysis by the Medicare Payment Advisory Commission, taxpayers are currently overpaying teaching hospitals compared to the actual costs of GME and IME. This proposal brings payments in line with the costs of medical education. The President's bipartisan Fiscal Commission also recommended similar changes.<sup>18</sup> These policy reforms save taxpayers more than \$70 billion over 10 years.

### **Target Assistance to Those Who Need It Most**

Many Americans think that payroll taxes they pay during their careers fund Medicare. However, a closer look at Medicare's financing shows general tax revenues are primarily used to foot the bill.

Only Medicare Part A (hospitals) is funded by the payroll taxes that are deducted from Americans' paychecks. Medicare Part B is supported by premiums (25 percent) and general tax revenue (75 percent). This means that seniors have their Medicare Part B coverage subsidized through general revenue tax dollars.

The Medicare drug program (Part D) was created in 2003 and began in 2006. But in 2010, 83 percent of total program costs were paid by general revenues, with just 11 percent of the program costs covered by beneficiary premiums.



Under Parts B and D, even wealthy Americans receive subsidized Medicare coverage through general revenue tax dollars. Wealthy individuals making more than \$150,000 annually (\$300,000 for couples) should pay the full cost of their Medicare Part B and D coverage. This reform saves an estimated \$21 billion over 10 years, and ensures those with the most need will have access to the assistance they need.

The proposal also increases the newly created annual maximum out-of-pocket cap to higher levels for those with significant monetary means. This policy is consistent with the principle that wealthier Americans are going to need to pay more if Medicare is to become solvent. This change saves an estimated \$5 billion.

### **Ask All Seniors to Pay a Little More To Keep Medicare Solvent**

<sup>18</sup>The National Commission on Fiscal Responsibility and Reform, "The Moment of Truth, December 2010," [http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12\\_1\\_2010.pdf](http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf), accessed July 14, 2011.

Medicare Part B allows retirees to purchase insurance coverage for physicians' services for a set monthly premium. In 2011, the majority of Medicare enrollees paid a premium of \$96.40 per month. But when the program began in 1966, the premium was intended to finance 50 percent of Part B costs per aged enrollee with the remainder funded by the federal government. Today however, general revenues still fund the remaining 75 percent of Medicare Part B, which puts enormous pressure on the federal budget year over year.

This proposal increases the basic Part B premium for all enrollees by 2 percent of program costs every year for five years until the premium level enrollees paid reached a minimum level of 35 percent of the program's cost in 2019. The dollar amount of the monthly premium increase per year would be, on average, approximately \$15-20 a month. Additionally, this policy continues the "hold-harmless" policy that prevents a reduction of a beneficiary's Social Security check due to a Part B premium increase. If the Medicare Part B premium increase exceeds the Social Security recipient's cost-of-living adjustment, the total Medicare Part B increase would not be more than their total cost of living adjustment. This simple change could save Medicare more than \$241 billion over a decade.

### **Increase Savings in Home Health Industry**

CBO projects that the use of home health services, and the resulting costs to the Medicare program, will grow rapidly over the next 10 years, rising from approximately \$23 billion in 2012 to \$52 billion in 2021. This proposal accelerates some changes created by the Patient Protection and Affordable Care Act to incorporate productivity adjustments beginning in 2013 and directing the Department of Health and Human Services to phase in rebasing the home health prospective payment system by 2015 instead of 2017. Based on the recommendation of the President's bipartisan Fiscal Commission, this change saves an estimated \$9 billion over 10 years.

### **End Medicare Payments of Uncollected Debts to Hospitals**

Currently, Medicare reimburses hospitals and other providers for unpaid deductibles and copays owed by beneficiaries. In order for hospitals to be paid for unpaid deductibles and copays, the hospital must be able to establish that reasonable collection efforts were made, and there was no likelihood of recovery at any time in the future. This practice is not mirrored by the private sector, and is fiscally unsound while the Medicare program faces enormous shortfalls.

This proposal's establishment of an annual maximum-out-of-pocket coverage within Medicare should drastically reduce the need to reimburse hospitals for bad debt. Accordingly, and based on the recommendation of the President's bipartisan Fiscal Commission, this proposal phases out this subsidy for uncollected hospital debts by taxpayers, saving an estimated \$23 billion over 10 years.



### **Allow Seniors to Opt-Out of Medicare Part A**

Currently, seniors only receive their Social Security benefits if they are enrolled in Medicare Part A. Seniors should be allowed to opt out of Medicare Part A and still receive their Social Security benefits. By eliminating the link between the two programs, this proposal will restore seniors' personal liberty to maintain a health plan of their choice and allow seniors to save taxpayer dollars in the process. If just one percent of Medicare enrollees were to opt out taxpayers would save roughly \$1.5 billion per year.

### **Adjust Medicare's Eye Surgery Fees to Reflect Services Actually Provided by Physicians**

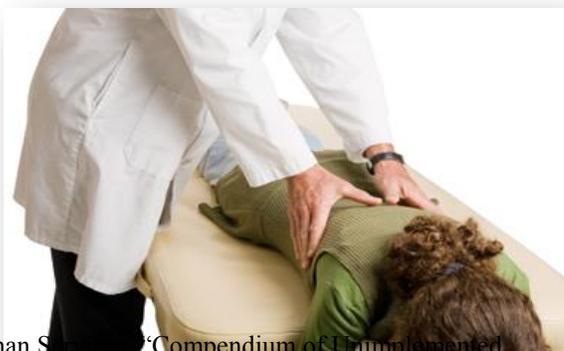
The Medicare program determines reimbursement for physicians' services based on an annual fee schedule. Various factors – such as a physicians' time, or the intensity of the work – go into a complicated payment formula in the fee schedule. The Office of the Inspector General (OIG) at the U.S. Department of Health and Human Services has found that the Medicare program is effectively overpaying for eye surgeries for seniors. The OIG concluded that Medicare paid more than \$97 million more than it should have for surgeries. Based on the results of the OIG's nationwide audit of eye surgeries, this proposal makes the adjustments recommended by the OIG, saving taxpayers \$97.6 million.<sup>19</sup>

### **Prevent Improper Payments for Chiropractic Services Medicare Does Not Cover**

Under current law, Medicare pays only for medically necessary chiropractic services, which are limited to active/corrective manual manipulations of the spine to correct subluxations. If a patient's improvement cannot be reasonably expected from ongoing care, chiropractic services are then not payable under Medicare.

The HHS OIG found “Medicare inappropriately paid \$178 million for chiropractic claims in 2006, representing 47 percent of claims meeting [their] review criteria; (2) efforts to stop payments for maintenance therapy have been largely ineffective; (3) claims data lack initial visit dates for treatment episodes, hindering the identification of maintenance therapy; and (4) chiropractors often do not comply with documentation requirements.”<sup>20</sup>

The OIG has recommended that Medicare administrators “implement and enforce policies, such as a cap on allowed chiropractic claims, to prevent payments for maintenance therapy.”



<sup>19</sup>Office of Inspector General U.S. Department of Health and Human Services, “Compendium of Unimplemented Recommendations, March 2011,” <http://oig.hhs.gov/publications/docs/compendium/2011/CMP-March2011-Final.pdf>, accessed July 14, 2011.

<sup>20</sup>Office of Inspector General U.S. Department of Health and Human Services, “Compendium of Unimplemented Recommendations, March 2011,” <http://oig.hhs.gov/publications/docs/compendium/2011/CMP-March2011-Final.pdf>, accessed July 14, 2011.

Medicare policies should be consistent and not pay for treatments not covered. This proposal implements OIG's recommendations, saving taxpayers an estimated \$1.97 billion over 10 years.

### **Reduce the Rental Period for Home Oxygen Equipment**

The Medicare program currently pays for a wide range of durable medical equipment, including home oxygen equipment. The program will pay for stationary oxygen concentrators and portable oxygen delivery systems, but portable oxygen delivery systems are covered on a rental-only basis for 36 months. After 36 months, Medicare discontinues payments to home oxygen suppliers.

However, over the period of eligibility for reimbursement, Medicare is paying much more to *rent* the oxygen equipment than it initially costs to *buy*.

The HHS OIG examined the median amount on the 2006 fee schedule and found that Medicare paid \$7,215 for 36 months for oxygen equipment that cost, on average, \$587 to purchase.<sup>21</sup> Beneficiaries paid \$1,443 themselves in coinsurance for the same equipment, but neither Medicare nor beneficiaries need to pay as much if Medicare payments were changed to reflect actual costs. Based on the OIG's analysis, reforming payment policy could be straightforward, as "minimal servicing and maintenance for concentrators and portable equipment are necessary."<sup>22</sup>

The OIG's recommendations should be implemented limiting rental payments for oxygen concentrators to 13 months under a "rent-to-own" design, saving taxpayers an estimated \$6.2 billion over 10 years.

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<sup>21</sup>Office of Inspector General U.S. Department of Health and Human Services, "Compendium of Unimplemented Recommendations, March 2011," <http://oig.hhs.gov/publications/docs/compendium/2011/CMP-March2011-Final.pdf>, Page 47, accessed July 14, 2011.

<sup>22</sup>Office of Inspector General U.S. Department of Health and Human Services, "Compendium of Unimplemented Recommendations, March 2011," <http://oig.hhs.gov/publications/docs/compendium/2011/CMP-March2011-Final.pdf>, Page 47, accessed July 14, 2011.

## Ensuring Proper Payments For Medical Equipment During Nursing Home Stays

Medicare has several parts that are financed differently and cover different types of services. For example, Medicare Part A covers patient services for home health and care seniors receive in hospitals and skilled facilities, while Medicare Part B covers doctor office visits.

Medicare Part A covers nursing home care for up to 100 days in a skilled nursing facility. If nursing home care is needed after the 100 days or the beneficiary did not qualify for a Part A skilled nursing facility stay, Medicare Part B may cover certain medical and other health services. However, in that case, Part B does not pay for durable medical equipment *unless* the nursing home qualifies as the beneficiary's home.

Yet, the number of cases in which Part B would pay for a senior's medical equipment is relatively small, because only a small number of nursing homes or distinct parts of nursing homes may qualify as a beneficiary's home. Under current law, a nursing home cannot qualify as a beneficiary's home (for purposes of durable medical equipment payments) if the nursing home is basically only providing skilled nursing care.

In examining 2006 data, the HHS OIG has found Medicare incorrectly paid \$30 million for medical equipment seniors received while not in a skilled nursing facility.<sup>23</sup> Part of the problem is that Medicare's billing and data systems do not maintain level-of-care designations for nursing homes, and therefore cannot discern in real time under which Part services may be billed. However, according the OIG, such common-sense designations "could facilitate accurate claim submission by suppliers and proper claim adjudication by payment contractors."<sup>24</sup>

This proposal would improve data processes to identify patients entering nursing homes with rented medical equipment and determine which facilities primarily provide skilled care (which would *not* qualify as a senior's home for payment purposes). If the Medicare program saved a comparable amount each year from this policy change, Medicare could save \$300 million over a decade.



<sup>23</sup>Office of Inspector General U.S. Department of Health and Human Services, "Compendium of Unimplemented Recommendations, March 2011," <http://oig.hhs.gov/publications/docs/compendium/2011/CMP-March2011-Final.pdf>, Page 53, accessed July 14, 2011.

<sup>24</sup>Office of Inspector General U.S. Department of Health and Human Services, "Compendium of Unimplemented Recommendations, March 2011," <http://oig.hhs.gov/publications/docs/compendium/2011/CMP-March2011-Final.pdf>, Page 53, accessed July 14, 2011.

## **Increase Efforts to Reduce Medicare and Medicaid Waste, Fraud, and Abuse**

It is widely known that the Medicare program is rapidly approaching insolvency, and governors have been vocal about the increasing strain that Medicaid programs are placing on their budgets. But too often there is an untold story that waste, fraud, and abuse in these programs are undermining their effectiveness, draining away precious taxpayer dollars to enrich those who would scam the system.

No one knows with exact certainty the amount of Medicare and Medicaid dollars lost each year to waste, fraud, and abuse. The Congressional Research Services (CRS) notes, “Although a good estimate of the dollar amount lost to Medicare fraud and abuse is open to discussion, analysts agree that billions of dollars are lost” each year.<sup>25</sup>

AARP President Barry Rand and others have estimated there may be up to \$100 billion taxpayer dollars lost to waste, fraud, and abuse annually in these two programs.<sup>26</sup>



CRS notes “fraud analysts and law enforcement officials estimate between 3 percent and 10 percent of health care expenditures (for all payers, including Medicare) are lost annually to fraud.” Ten percent of our \$2.3 trillion health care system is \$230 billion annually that could be fraudulently diverted from the system.

A simple sampling of news stories in recent years highlights more than 100 charges, arrests, convictions, or sentences issued related to Medicare and Medicaid fraud that appear to total more than \$1 trillion.<sup>27</sup>

The amount of money lost from Medicare and Medicaid is so significant, in part, because the size of the programs themselves is colossal. Medicare and Medicaid cost federal taxpayers approximately \$1 trillion this year alone and provided coverage for approximately one in five Americans. CRS reported that “since 1990, the Government Accountability Office (GAO) has identified the Medicare program as at risk for improper payments and fraud, and, since 2004, has issued 12 products documenting various program vulnerabilities.” GAO points to the program’s size, complexity, and administration as factors that increase its susceptibility to being defrauded

<sup>25</sup>Senator Coburn Website, “Medicare Program Integrity: Activities to Protect Medicare from Payment Errors, Fraud, and Abuse,” [http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File\\_id=48425bf8-4c57-4b95-b2e7-83ff1f4fb694](http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=48425bf8-4c57-4b95-b2e7-83ff1f4fb694), accessed July 14, 2011.

<sup>26</sup>Orlando Sentinel Website, “Stop Paying Crooks: Get Tough on Health Care Fraud,” [http://articles.orlandosentinel.com/2010-09-29/news/os-ed-medicare-fraud-gingrich-093010-20100929\\_1\\_health-care-fraud-home-health-medicare-and-medicaid](http://articles.orlandosentinel.com/2010-09-29/news/os-ed-medicare-fraud-gingrich-093010-20100929_1_health-care-fraud-home-health-medicare-and-medicaid), accessed July 14, 2011.

<sup>27</sup>Congressional Research Service, “Medicare Program Integrity: Activities to Protect Medicare from Payment Errors, Fraud, and Abuse: June 23, 2011,” [http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File\\_id=48425bf8-4c57-4b95-b2e7-83ff1f4fb694](http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=48425bf8-4c57-4b95-b2e7-83ff1f4fb694), accessed July 14, 2011.

and abused. Medicare's improper payment errors for the fee-for-service program last year alone resulted in \$34.3 billion in overpayments.<sup>28</sup>

Fraud and abuse in these programs is not only a financial problem, it often results in the degrading or denial of care to patients who depend on these programs. CRS echoed this, saying “not only do fraud and abuse contribute to rising health care costs, they also can harm patients, particularly when medically necessary services are withheld, or when medically unnecessary services are provided.”

At a recent hearing before the House Committee on Oversight and Government Reform, the Deputy Inspector General of the Department of Health and Human Services said that fraud in public health care programs is attractive to organized crime because the penalties –if they are apprehended – are lower than penalties for many other criminal offenses, historically there have been relatively low barriers to participation in the programs, fraud schemes are easily replicated, and weak, untimely data analysis limits detection efforts.

Certainly, at a time when organized crime rings are defrauding Medicare and thieves can pilfer stolen provider billing numbers on the black market, Americans expect strong policy reforms to fight fraud and abuse, and save taxpayer dollars. Fortunately, for taxpayers, there is good news. Opportunities exist both for preventing fraud before it occurs, and for prosecuting it after it happens.

While the digital age has increased the number of billing vulnerabilities for both Medicare and Medicaid, the advance of a range of technological tools and intelligent data analysis holds great promise to stem the tide of dollars flowing out of the programs through fraudulent activities.

To help prevent waste, fraud, and abuse in Medicare and Medicaid, more resources need to be focused in an aggressive timeline to:

- replace outdated technology systems with cutting-edge technologies;
- build a cooperative culture of data-sharing and timely analysis;
- encourage the widespread adoption of industry standards;



<sup>28</sup>Congressional Research Service, “Medicare Program Integrity: Activities to Protect Medicare from Payment Errors, Fraud, and Abuse: June 23, 2011,” [http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File\\_id=48425bf8-4c57-4b95-b2e7-83ff1f4fb694](http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=48425bf8-4c57-4b95-b2e7-83ff1f4fb694), accessed July 14, 2011.

- incentivize the identification and prosecution of waste, fraud, and abuse;
- leverage a range of technologies to examine payments and billing patterns, and;
- adopt transformative coverage and payment models with proven records of lower costs, better care, and reduced levels of abuse and fraud.

Even after fraud or abuse occurs, there is still an opportunity for taxpayers to see their hard-earned dollars recouped through targeted efforts to punish those who defrauded the system. While the ultimate focus for increasing program integrity must be preventative in nature – to eliminate the “pay and chase” culture that too often typifies these efforts – it still is a worthwhile investment to enhance funding for law enforcement and other entities like the Inspector General’s office. In fact, according to government figures, the average return-on-investment for the Health Care Fraud and Abuse Control program run by the HHS OIG is significant, recouping \$6.8 for every \$1 of program funding.<sup>29</sup>

By making the reduction of waste, fraud, and abuse in Medicare and Medicaid a top national priority and smartly investing more in proven technologies and methods, it may be possible to stem the hemorrhaging of taxpayer dollars due to fraud, reclaiming billions of dollars a year. Adopting such a comprehensive, aggressive plan could save taxpayers \$10 billion on average each year, or \$100 billion over a decade.

### **Make Reforms to Medicare’s Quality Improvement Organizations (QIO)**

Quality Improvement Organizations (QIOs) are private, mostly not-for-profit organizations that contract with Medicare to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries.

President Obama’s FY2012 Budget recommended a series of specific changes to QIOs. Like previous efforts in Medicare to modernize contracting by consolidating 40 fiscal intermediaries to 15 Medicare Administrative Contractors, these reforms increase competition, align procedures with the Federal Acquisitions Regulations, and strengthen the Trust Funds.

These changes should be implemented to save taxpayers more than \$3 billion over a decade:

- By requiring the Secretary to determine the geographic scope of contracts, including overlapping contracts in local, regional, or national areas when appropriate, this proposal will increase competition and eliminate overhead.
- The proposal also eliminates conflicts of interest between beneficiary protection and quality improvement activities which may arise when a single contractor is responsible for building relationships with providers to improve quality while also functioning as the entity charged by Medicare to hold providers accountable for failures in the delivery of care to beneficiaries.

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<sup>29</sup> The Department of Health and Human Services and The Department of Justice, “Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2010,” <http://oig.hhs.gov/publications/docs/hcfac/hcfacreport2010.pdf>, Page 8, accessed July 14, 2011.

- The proposal expands the pool of contractors eligible for QIO work, which will increase competition, and ensure that beneficiaries and providers are served effectively by contractors with specific skills.
- Finally, extending the QIO contract length from three years to up to five years, and aligning QIO contract terminations with Federal Acquisition Regulations will improve efficiency and increase the Secretary's flexibility in administering these contracts.<sup>30</sup>

### **Replace the Broken Medicare Physician Reimbursement Formula**

The Medicare program reimburses 96,000 physicians who provide care for roughly 40 million seniors by using a payment mechanism known as the “Sustainable Growth Rate” (SGR). Congress established the SGR in 1997 as a funding formula designed to adhere to overall spending targets. The SGR works by effectively decreasing reimbursement levels one year if Medicare reimbursements to physicians another year were higher than a set target.

Designed to rein in Medicare’s exploding costs, the SGR was a well-intentioned effort. Though cost-containment is the right goal, the SGR mechanism failed to achieve its goal. In fact, since 2004, Congress has intervened on an almost annual basis to prevent reimbursement reductions that could harm seniors’ access to care.

Now, unless Congress intervenes again at the end of the year, beginning January 1, 2012, physicians (who are paid under Part B) who accept Medicare will face an incredible 30 percent reduction in their reimbursements. This is unacceptable for physicians and patients, as allowing reimbursement cuts of over 30 percent will cause many physicians to drop their participation in the program and thus jeopardize access to medical care for seniors on Medicare. As the Chief Actuary of the Centers for Medicare and Medicaid Services warned in a memo to Congress, if reimbursement cuts are allowed to occur, many physicians “for whom Medicare constitutes a substantive portion of their business could find it difficult to remain profitable and, absent legislative intervention, might end their participation in the program possibly jeopardizing access to care for beneficiaries.”<sup>31</sup>

It is unacceptable for Congress to allow this drastic cut that could threaten seniors’ access to care to linger. In fact, the systemic flaws with the SGR mechanism have led lawmakers and leaders in the health care community to call for its redesign.

Unfortunately, too often budgets proposed by some in Washington pretend untenable reimbursement cuts scheduled under current law will occur – simply so they can ignore the real

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<sup>30</sup> President’s Budget for Fiscal Year 2012, “Terminations Reductions and Savings,” <http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf>, Page 118, accessed July 14, 2011.

<sup>31</sup> Foster, Richard, Chief Actuary for Centers for Medicare and Medicaid Services, “Estimated Financial Effects of the ‘Patient Protection and Affordable Care Act,’ As Amended,” pages 9-10, April 22, 2010, [http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File\\_id=f011f765-c229-4b33-8b95-6c30c8bfefd0](http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=f011f765-c229-4b33-8b95-6c30c8bfefd0).

costs that must be paid to ensure seniors have access to care. This proposal takes a different approach to confronting the real costs that must be addressed so millions of seniors have access to care.

This offers a fully-offset SGR replacement that is fully offset by savings within the overall proposal.<sup>32</sup> The proposal provides for a ten-year freeze on current reimbursement levels. While locking in payments at current rates is not optimal, the proposal also makes other significant Medicare reforms that may improve the delivery of health care and decrease utilization. Furthermore, during a time of dangerously high debt and spending, many Americans will have to participate in “shared sacrifice” as we put our country back on a positive path forward. This serious reform is offset and ensures stability and predictability for physicians, enabling seniors to continue to access the care they need.

**MEDICARE AND MEDICAID TEN YEAR SAVINGS**

Mandatory: \$2.64 Trillion

Total: \$2.64 Trillion

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<sup>32</sup> Congressional Budget Office, June 14, 2011. “Medicare’s Payments to Physicians: The Budgetary Impact of Alternative Policies.” [http://www.cbo.gov/ftpdocs/122xx/doc12240/SGR\\_Menu\\_2011.pdf](http://www.cbo.gov/ftpdocs/122xx/doc12240/SGR_Menu_2011.pdf)