

Amendment 3560 (Coburn) – To implement bipartisan provisions in the President’s Proposal to reduce waste, fraud, and abuse in the Medicare and Medicaid programs.

This amendment attempts to help the President keep his promises to crack down on waste, fraud, and abuse in Medicare and Medicaid.

On September 9, 2009 President Obama said “..[my] plan would eliminate the hundreds of billions of dollars in waste and fraud”

On February 22 of this year, President Obama unveiled his detailed proposal for health reform and highlighted nine Republican ideas to combat waste, fraud, and abuse. This amendment includes each of those policy provisions which has been endorsed by President Obama.

Certainly Washington politicians should be serious about stemming the hemorrhaging of taxpayer dollars lost to waste, fraud, and abuse. Senators will have an opportunity to vote on proposals which have garnished bipartisan support, and which the President has endorsed.

There is an estimated \$100 billion in Medicaid and Medicare waste, fraud, and abuse each year. Technologies exist which would capture these taxpayer dollars before they go out and payment. Implementing these technologies could increase Medicare and Medicaid’s financial sustainability and improve return on investment for taxpayers. This amendment uses same kinds of technologies companies use in the private sector to prevent credit card fraud.

Fraud, waste, and abuse is a dramatically serious problem which threatens Medicare’s solvency, but is not effectively addressed in the new health care bill President Obama just signed.

Fraud constitutes at least ten percent (\$100 billion) of the nearly one trillion in taxpayer dollars that Medicare and Medicaid will spend this year. Harvard's Dr. Malcolm Sparrow, author of the seminal book "License to Steal," estimates that the losses could easily be in the 20 percent or 30 percent range, even as high as 35 percent, but he insists that we ought not to have to guess. He believes the government should measure the losses and report them accurately.

Even CBS’ *60 Minutes* says there is \$60 billion in annual Medicare fraud which would be \$600 billion over ten years. Senator Reid’s fails to capture even 1 percent of that amount. Senator Reid would obviously rather cut home health care services, reduce payments to

America's hard working doctors thereby limiting access to life-saving treatments for seniors, and raise taxes, instead of stand up to the criminals.

The American people firmly support anti-fraud efforts. Eighty-eight percent in a July 2009 poll by Zogby identified, "eliminate fraud" as their preferred way to pay for modernizing our health care system. " Moreover, an Insider Advantage poll also from July found that by a margin of 61-27 Americans believe the issues of fraud and waste in Medicare and Medicaid should be addressed prior to the creation of a new government-run health program.

For years, Congress has known that the problem of health care fraud, particularly in Medicare and Medicaid, is massive. Yet, instead of targeting the crooks who are stealing from poor and elderly Americans dependent on Medicaid and Medicare, Congress routinely deals with runaway Medicare and Medicaid outlays by slashing payments to honest doctors and hospitals. That is a long term recipe for total collapse of our health care system.

Fraud, waste, and abuse in Medicare are endemic and must be stopped. American taxpayers and our country's seniors deserve better.

The story of convicted murderer Guillermo Denis Gonzalez illustrates the vulnerability of government run health programs to fraud. Gonzalez was released from prison in 2004 after serving a twelve year sentence for a murder conviction. Two years later he bought a Medicare-licensed equipment supply company and duly notified Medicare authorities that he was the new owner. In 2007 he submitted \$586,953 in false claims to Medicare and got paid for some of them. In 2008 he is alleged to have killed and dismembered a man.

The fact that a convicted murderer with a seventh grade education could so easily become a supplier to our largest health program and begin defrauding it illustrates how pervasive fraud is in America's government-run health care programs. If only the Gonzalez case were an isolated incident.

Miami Dade County in Florida is notorious for health care fraud. There are more licensed home health agencies in Miami Dade County than the entire state of California. In 2005, billing submissions from Miami Dade to Medicare for HIV infusion therapy were 22 times higher than the rest of the country combined. New York also has a serious problem with fraud.

Medicaid faces similar problems to Medicaid.

A private study of New York's Medicaid in 2006 found that one-quarter of that then-\$44 billion program cannot be explained.

The Government Accountability Office reported in January 2009 that 10 percent of Medicaid payments made in 2007, or \$32.7 billion, were improper.

In August 2009, Medicaid's internal inspector said Medicaid's current data gathering capabilities are not timely, accurate or comprehensive for detecting waste, fraud and abuse. Essentially, one the largest government-run health programs admits that they have no idea how much fraud occurs as a result of their antiquated computer systems and collection methods.

But there are solutions we can utilize to stop fraud. Medicaid's internal inspector also said that “results indicate opportunities for States and [the federal government] to reduce the timeframes for file submission and validation.... Further, there are opportunities for [the federal government] to improve the documentation and disclosure of error tolerance adjustments and expand current State Medicaid data collection and reporting to further assist in fraud, waste, and abuse detection...”

This amendment implements 9 Republican ideas which President Obama endorsed. Surely one area for bipartisan agreement in Congress is in the need to reduce fraud and abuse.

1. **Comprehensive Sanctions Database.** Establishes a comprehensive Medicare and Medicaid sanctions database, overseen by the HHS Inspector General. This database will provide a central storage location, allowing for law enforcement access to information related to past sanctions on health care providers, suppliers and related entities. (Source: H.R. 3400, “Empowering Patients First Act” (Republican Study Committee bill))
2. **Registration and Background Checks of Billing Agencies and Individuals.** In an effort to decrease dishonest billing practices in the Medicare program, this provision will assist in reducing the number of individuals and agencies with a history of fraudulent activities participating in Federal health care programs. It ensures that entities that bill for Medicare on behalf of providers are in good standing. It also strengthens the Secretary’s ability to exclude from Medicare individuals who knowingly submit false or fraudulent claims. (Source: H.R. 3970, “Medical Rights & Reform Act” (Kirk bill))

3. **Expanded Access to the Healthcare Integrity and Protection Data Bank.** Increasing access to the health care integrity data bank will improve coordination and information sharing in anti-fraud efforts. This provision broadens access to the data bank to quality control and peer review organizations and private plans that are involved in furnishing items or services reimbursed by Federal health care program. It includes criminal penalties for misuse. (Source: H.R. 3970, “Medical Rights & Reform Act” (Kirk bill))
4. **Liability of Medicare Administrative Contractors for Claims Submitted by Excluded Providers.** In attacking fraud, it is critical to ensure the contractors that are paying claims are doing their utmost to ensure excluded providers do not receive Medicare payments. Therefore, this provision holds Medicare Administrative Contractors accountable for Federal payment for individuals or entities excluded from the Federal programs or items or services for which payment is denied. (Source: H.R. 3970, “Medical Rights & Reform Act” (Kirk bill))
5. **Community Mental Health Centers.** This provision ensures that individuals have access to comprehensive mental health services in the community setting, but strengthens standards for facilities that seek reimbursement as community mental health centers by ensuring these facilities are not taking advantage of Medicare patients or the taxpayers. (Source: H.R. 3970, “Medical Rights & Reform Act” (Kirk bill))
6. **Limiting Debt Discharge in Bankruptcies of Fraudulent Health Care Providers or Suppliers.** This provision will assist in recovering overpayments made to providers and suppliers and return such funds to the Medicare Trust Fund. It prevents fraudulent health care providers from discharging through bankruptcy amounts due to the Secretary from overpayments. (Source: H.R. 3970, “Medical Rights & Reform Act” (Kirk bill))
7. **Use of Technology for Real-Time Data Review.** This provision speeds access to claims data to identify potentially fraudulent payments more quickly. It establishes a system for using technology to provide real-time data analysis of claim and payments under public programs to identify and stop waste, fraud and abuse. (Source: Roskam Amendment offered in House Ways & Means Committee markup)
8. **Illegal Distribution of a Medicare or Medicaid Beneficiary Identification or Billing Privileges.** Fraudulent billing to Medicare and Medicaid programs costs taxpayers millions of dollars each year. Individuals looking to gain access to a beneficiary’s personal information approach Medicare and Medicaid beneficiaries with false incentives. Many beneficiaries unwittingly give over this personal information

without ever receiving promised services. This provision adds strong sanctions, including jail time, for individuals who purchase, sell or distribute Medicare beneficiary identification numbers or billing privileges under Medicare or Medicaid – if done knowingly, intentionally, and with intent to defraud. (Source: H.R. 3970, “Medical Rights & Reform Act” (Kirk bill))

9. **Study of Universal Product Numbers Claims Forms for Selected Items and Services under the Medicare Program.** This provision requires HHS to study and issue a report to Congress that examines the costs and benefits of assigning universal product numbers (UPNs) to selected items and services reimbursed under Medicare. The report must examine whether UPNs could help improve the efficient operation of Medicare and its ability to detect fraud and abuse. (Source: H.R. 3970, “Medical Rights & Reform Act” (Kirk bill), Roskam Amendment offered in House Ways & Means Committee markup)

One of the most interesting changes in this proposal is to use smart technologies similar to those in the credit card industry. By catching improper payments before they go out, these technologies change the “pay and chase” culture to one of “verify, then pay.”

The credit card industry is a compelling model of fraud containment. It processes over \$2 trillion in payments every year from 700 million credit cards being used at millions of vendors to buy countless products. Fraud in that industry is about one percent.

The average health insurer’s anti-fraud investigative unit has an annual budget of slightly more than \$1.9 million and 19 fulltime employees. More than seven of 10 insurer investigative units use fraud-detection software.

Of course, there’s a cost for monitoring those claims, roughly 3.3 percent of claims paid. But claims processing won’t go away under government-run health insurance.

Properly adjudicating claims is money well spent on the front end, because it saves billions of dollars in fraudulent claims on the back end. For example, the National Health Care Anti-Fraud Association says that every \$2 invested in fighting fraud produces returns of \$17.3 in recoveries and court-ordered judgments, plus there are the claims that are not paid.