

ONE HUNDRED ELEVENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115

Majority (202) 225-2927
Minority (202) 225-3641

MEMORANDUM

September 20, 2010

To: Members of the Subcommittee on Health

Fr: Health Subcommittee Staff

Re: Subcommittee hearing: “Cutting Waste, Fraud, and Abuse in Medicare and Medicaid”

On Wednesday, September 22, at 10:00 a.m., in room 2322 of the Rayburn House Office Building, the Subcommittee on Health will hold a hearing entitled “Cutting Waste, Fraud, and Abuse in Medicare and Medicaid.” The hearing will examine how the Department of Health and Human Services is using available statutory tools to reduce waste, fraud, and abuse in the Medicare and Medicaid programs.

I. HEALTH CARE FRAUD AND ITS IMPACT ON MEDICARE AND MEDICAID

Health care fraud impacts private health care providers and government health care programs such as Medicare and Medicaid, costing taxpayers and citizens tens of billions dollars per year and potentially affecting the health care treatment received by millions of patients. While estimates of the total cost of health care fraud are difficult to obtain, the National Health Care Anti-Fraud Association has estimated that all health care fraud -- affecting private health insurers, Medicare, Medicaid, and other government programs – cost patients, taxpayers, and health care providers billions of dollars annually.¹

While there are no precise measures of the cost of health care fraud to the Medicare and Medicaid programs specifically, these programs are frequent fraud targets, in part because “consumers are more susceptible to fraud if they are older and/or poor.”² Health care fraud

¹ See, e.g., National Health Care Anti-Fraud Association, *The Problem of Health Care Fraud* (2010) (online at http://www.nhcaa.org/eweb/DynamicPage.aspx?webcode=anti_fraud_resource_centra&wpscode=TheProblemOfHCFraud)

² Sara Rosenbaum, et al., *Health Care Fraud* (Oct. 27, 2009)

enforcement efforts by HHS and the Department of Justice have, since 1997, recovered \$15.6 billion for the federal treasury as a result of fraud schemes uncovered in the Medicare and Medicaid programs.³ Much more fraud is prevented through the “sentinel effect” -- fraud that is never committed because potential perpetrators know that law enforcement officials are watching closely.

Health care fraud schemes can take a variety of different forms: billing for services that were never provided; misreporting costs in order to increase payments; stealing providers or beneficiaries’ identities; paying kickbacks to physicians or other health care providers. Perpetrators of fraud run the gamut from street corner criminals trafficking in illegally obtained drugs to large health care providers and multinational drug manufacturers that have been found guilty of misrepresenting costs or paying illegal kickbacks to health care providers. In recent years, CMS has identified durable medical equipment and home health care as areas “highly vulnerable to waste, fraud, and abuse.”⁴

Examples of fraud schemes uncovered by HHS and DOJ enforcement activities in recent years include:⁵

- The “largest federal health care fraud takedown” in history, in July 2010, as the HHS and DOJ combined to arrest 94 defendants in Brooklyn, Baton Rouge, Detroit, and Miami for false billing for AIDS treatment, DME, physical and occupational therapy, and home health care.⁶
- A \$2.3 billion settlement with the drug manufacturer Pfizer for the company’s illegal promotion of several drugs, including the anti-inflammatory drug Bextra. This illegal promotion resulted in false claims submitted to Medicare and Medicaid for non-medically accepted uses of the drugs.
- A Florida physician paid \$17 million to settle allegations that he billed the Medicare program for higher levels of services than were actually provided, and for services that were never provided.
- A Kentucky pharmacist was sentenced to six months of home incarceration and fined almost \$1 million for falsely billing Medicare and Medicaid for drug samples that he received for free and provided to patients.

³ Department of Health and Human Services and Department of Justice, *Health Care Fraud and Abuse Control Program, Annual Report for Fiscal Year 2009* (May 2010)

⁴ Statement of Kimberly L. Brandt, CMS, Testimony before the U.S. House Committee on Ways and Means, Subcommittee on Health and Subcommittee on Oversight (June 15, 2010).

⁵ *Id.*

⁶ Washington Post, Justice Department Charges 94 People with Health Care Fraud (July 16, 2010).

- A Maryland psychiatrist was sentenced to 36 months in prison and fined \$390,000 for falsely billing Medicare and Medicaid for hundreds of occasions, including billing the programs for face to face psychotherapy services on dates when she was on vacation or otherwise not in town.
- A Texas hospital paid \$9.9 million to resolve allegations that for more than two years, the hospital inflated charges for patient care in order to receive higher Medicare reimbursements.
- A Texas DME supplier was sentenced to 60 months in prison and paid a fine of \$1.6 million following his guilty plea for overbilling Medicare for motorized wheelchairs.
- Six Nevada physicians were fined between \$54,440 and \$212,575 each for providing kickbacks to a nurse practitioner in exchange for patient referrals.

Fraud involves a knowing and willful effort to violate Medicare and Medicaid rules or laws. Medicare and Medicaid fraud is also distinct from the “improper payments” or “payment errors” made by these programs. In 2009, the Government paid approximately \$65 billion in Medicare and Medicaid payments classified as “improper”.⁷ This estimate does not represent the cost of fraud to the programs. The vast majority of payments classified as improper were classified as such because of problems such as illegible doctors’ signatures or otherwise incomplete paperwork. In the vast majority of cases, an improper payment does not appear to be a fraudulent payment. Moreover, recent increases in the reported improper payment rate appear to be artifacts of changes in reporting methodology (such as reporting payments on orders with illegible physician signatures as improper payments) rather than indicators of actual increases in fraud or improper payments.

Medicare and Medicaid anti-fraud activities are funded primarily through the Health Care Fraud and Abuse Control Program (HCFAC). HCFAC was established under the Health Insurance Portability and Accountability Act of 1996 in order to fund and coordinate federal, state, and local efforts to fight health care fraud. CMS’ Center for Program Integrity (which includes the Medicare and Medicaid Integrity Programs), the HHS Inspector General, the U.S. Department of Justice, and State Medicaid programs share responsibility for preventing and detecting fraud, conducting civil and criminal cases, and taking other actions to enforce anti-fraud provisions, and receive their budget for these activities through mandatory and discretionary HCFAC funding. Enforcement tools available against entities that defraud Medicare and Medicaid include civil monetary penalties, criminal penalties, and exclusion from participation in federal health care programs. Total HCFAC funding has increased in recent years, from \$1.13 billion in FY 2008 to \$1.36 billion in FY 2009 to an estimated \$1.49 billion in FY 2010.

⁷ OMB, *Payment Accuracy: High Error Rate Programs* (2010) (online at <http://paymentaccuracy.gov/content/high-priority-programs>)

Spending to prevent health care fraud results in a significant positive return on investment. The DOJ and HHS estimate that for every dollar spent on Medicare and Medicaid care fraud enforcement, approximately \$4 is recovered and returned to taxpayers.⁸

II. HHS INITIATIVES TO IDENTIFY AND PROSECUTE MEDICARE AND MEDICAID FRAUD AND ABUSE

HHS, in conjunction with the Department of Justice, has acted aggressively to respond to and reduce Medicare and Medicaid fraud. In May 2009, HHS and DOJ announced the creation of the Health Care Fraud Prevention and Enforcement Team (HEAT), designed to coordinate Cabinet-level agency activities to reduce fraud. In January 2010, the first “National Summit on Health Care Fraud” was held by HHS and DOJ to bring together public- and private-sector experts to identify and discuss ways to identify and eliminate health care fraud. And in April 2010 CMS established the Center for Program Integrity, consolidated the agency’s Medicare and Medicaid anti-fraud activities in an effort to improve coordination between the two programs and with other agencies at the State and local level.

Under the HEAT program, HHS and DOJ have expanded the use of dedicated strike force teams, placing law enforcement personnel in locations that are identified as health care fraud hotspots. Strike force teams are presently active in South Florida, Los Angeles, Houston, Brooklyn, Baton Rouge, and Tampa. These teams have, in the last three years, charged 465 defendants with defrauding Medicare of almost \$2 billion.⁹

In addition to standard program integrity activities, CMS took significant new actions in 2009 to reduce durable medical equipment fraud, establishing new enrollment, accreditation, and surety bond requirements for Durable Medical Equipment (DME) providers, and expanding the use of unscheduled site inspections.

In addition, the Administration requested and received discretionary funding increases for the Health Care Fraud and Abuse Control Fund in FY 2009 and FY 2010, resulting in over \$500 million in additional funding to fight health care fraud. These funds were used to expand program integrity activities at CMS, DOJ, and HHS, resulting in hundreds of millions of dollars in recovered funds. Fraud recoveries in 2009 increased by approximately \$600 million compared to fraud recoveries in 2008.¹⁰

⁸ Department of Health and Human Services and Department of Justice, *Health Care Fraud and Abuse Control Program, Annual Report for Fiscal Year 2008* (Sep. 2009)

⁹ Department of Justice, HEAT: A Year of Tackling Health Care Fraud (2010) (online at <http://blogs.usdoj.gov/blog/archives/934>)

¹⁰ Department of Health and Human Services and Department of Justice, *Health Care Fraud and Abuse Control Program, Annual Report for Fiscal Year 2009* (May 2010)¹⁰

III. THE AFFORDABLE CARE ACT'S NEW TOOLS TO REDUCE MEDICARE AND MEDICAID FRAUD AND ABUSE

The recent health reform legislation contained over 30 provisions to help CMS, the OIG, and the Justice Department reduce Medicare and Medicaid fraud.¹¹ The most important provisions involve a shift from the traditional “pay and chase” approach to fraud reduction to a preventive approach, keeping fraudulent suppliers out of the program before they can commit fraud. A proposed rule to implement many of these fraud prevention provisions was published by CMS on September 17, 2010.¹²

Key Affordable Care Act anti-fraud provisions include:

- **New tools to prevent fraudulent providers from enrolling in or taking advantage of Medicare and Medicaid.** The Affordable Care Act contains new enrollment requirements for all providers, allowing CMS to identify and eliminate fraudulent providers before they can receive payment from Medicare and Medicaid. The new enrollment process allows for enhanced background checks for providers, new disclosure requirements, and on-site visits to verify provider information. Providers must also create internal compliance programs. CMS may enact moratoria on enrolling new providers if the Secretary believes that such enrollments will increase fraud risks, may conduct enhanced oversight of new providers once they have enrolled in Medicare and Medicaid, and may suspend payments to providers in cases where there is a substantiated fraud allegation against the provider.
- **Fighting fraud in DME and home health care.** The Affordable Care Act contains several additional provisions specifically designed to fight fraud in the high-risk DME and home health programs. After July 1, 2010, physicians who order Medicare DME and home health care services are required to be enrolled in the Medicare program. Physicians are also required to maintain access to and provide upon request documentation on orders for DME and home health care services, and are required to have a face-to-face encounter with the individual prior to issuing a certification or re-certification for DME or home health services.
- **New and enhanced penalties for fraudulent providers.** Affordable Care Act provisions add new civil monetary penalties for individuals who fail to grant timely access to information required for audits or investigation, individuals who have been excluded from Federal health care programs who order or prescribe services provided by that program, individuals who make false statements on enrollment applications or bids, and individuals who know of, but do not return overpayments from Medicare and

¹¹ Sections 6401 – 6411 of P.L. 111-48.

¹² Health and Human Services, *Medicare, Medicaid, and Children's Health Insurance Programs: Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions, and Compliance Plans for Providers and Suppliers: Proposed Rule* (Sep. 17, 2010).

Medicaid. New provisions also allow the Inspector General to exclude from Medicare and Medicaid any provider that makes false statements on an application to enroll or participate in these programs, and impose new sanctions on Medicare Advantage or Part D plans that falsify information or fail to comply with marketing requirements.

- **New data sharing and data-collection provisions.** The Affordable Care Act requires the HHS Secretary to maintain a national health care fraud and abuse database to retain information on any adverse actions taken against health care providers, requires enhanced data sharing between CMS, States, and other federal health care programs, and provides additional access to new and existing databases for DOJ, the Inspector General, and States.
- **New funding to fight Medicare and Medicaid fraud.** The Affordable Care Act significantly increases funding for the HCFAC Fund, indexing the program’s mandatory baseline and funding for the Medicare and Medicaid Integrity Programs to increase at the same rate as the CPI, and providing additional mandatory HCFAC funding of \$105 million in FY 2011, \$65 million in FY 2012, \$40 million in FY 2013 and 2014, \$20 million in FY 2015 and 2016, and \$10 million in FY 2017-2020. Overall, the Affordable Care Act provides an estimated \$500 million in increased funding to fight fraud.

IV. ADDITIONAL FRAUD LEGISLATION

Reps. Klein and Roskam will be testifying on fraud legislation that they have sponsored in the 111th Congress. H.R. 5044, which is sponsored by Rep. Klein and has 57 bipartisan cosponsors, increases several civil and criminal penalties for Medicare and Medicaid fraud and includes a provision clarifying when corporate officials responsible for Medicare and Medicare fraud may be excluded from these programs. It also mandates increased data sharing to reduce fraud, a biometric technology pilot program, and a GAO study of Medicare administrative contractors. H.R. 5546, which is sponsored by Rep. Roskam, mandates that CMS implement a “comprehensive pre-payment review prevention system” for the Medicare program.

V. WITNESSES

The following witnesses have been invited to testify:

Panel 1

The Honorable Peter Roskam (R-IL)
Member of Congress

The Honorable Ron Klein (D-FL)
Member of Congress

Panel 2

The Honorable Daniel Levinson

Inspector General
Office of the Inspector General
U.S. Department of Health and Human Services

Peter Budetti

Deputy Administrator for Program Integrity
Center for Medicare and Medicaid Services