

**Amendment 2966 – To reduce waste, fraud, and abuse in the Medicare and Medicaid programs and to protect Medicare benefits and services provided to America’s seniors.**

This amendment attempts to help the President keep his promises. On September 9, 2009 President Obama said “The only thing [my] plan would eliminate is the hundreds of billions of dollars in waste and fraud, as well as unwarranted subsidies in Medicare that go to insurance companies -- subsidies that do everything to pad their profits but don't improve the care of seniors..... Reducing the waste and inefficiency in Medicare and Medicaid will pay for most of [my] plan.”

The majority’s bill cuts \$464 billion from Medicare – even though the Administration’s own actuary said this level of cuts could bankrupt hospitals and threaten patient care – and only generates less than \$2 billion from reducing waste fraud and abuse in Medicare and Medicaid. <sup>i</sup>

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 replaces the draconian Medicare cuts with the same kinds of technologies companies use in the private sector to prevent credit card fraud.

**This bill uses draconian cuts to create a piggybank to pay for a new entitlement program. This breaks President Obama’s promise and will harm seniors’ care while further burdening taxpayers.**

Seniors have paid into the Medicare program and it is unconscionable that their benefits would be cut or their access to health care reduced in order to create a new budget-busting health care entitlement program.

The proposed legislation permanently cuts all annual Medicare provider payment updates by at least \$150 billion over the next 10 years. The chief actuary for the Centers for Medicare and Medicaid Services (CMS) believes these cuts could cause providers (e.g. hospitals, home health agencies and hospices) to end their participation in Medicare, threatening access to care as providers find it more financially difficult to care for Medicare beneficiaries.

On top of these cuts, the Reid bill creates a permanent Independent Medicare Advisory Board composed of unelected officials to come up with additional Medicare cuts. This board would be required to make recommendations to reduce Medicare spending growth if arbitrary targets are not met. This board's "recommendations" would automatically go into effect even absent Congressional action. CBO estimated that this board would cut Medicare by \$23 billion over the next 10 years.

**Fraud, waste, and abuse is a dramatically serious problem which threatens Medicare's solvency, but is not effectively addressed in the Reid bill.**

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. Americans 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 of this year that 10 percent of Medicaid payments made in 2007, or \$32.7 billion, were improper.

In August, 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 of 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..."<sup>1</sup>

**This amendment implements 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.”**

Members of Congress should look to the credit card industry as a 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.<sup>[iii]</sup> 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.<sup>[iv]</sup>

- This amendment requires the Secretary of Health and Human Services to change the Medicare beneficiary identifier used to identify Medicare beneficiaries to numbers like we have on credit cards, in an effort to protect beneficiaries from identity theft.
- This amendment requires data matching across federal agencies to check for social security numbers in Medicare and Medicaid of dead, imprisoned, or otherwise ineligible beneficiaries and providers.
- This amendment requires Secretary of HHS to establish procedures to identify and investigate unusual billing to prevent fraud and abuse.
- This amendment requires HHS to implement a real time data review of all Medicare claims to provide data analysis of claims for reimbursement and to help identify and investigate unusual billing or order practices. This is front-end, pre-

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<sup>1</sup> <http://oig.hhs.gov/oei/reports/oei-04-07-00240.pdf>

payment technology similar to that employed by private hedge funds, investment funds, and banks.

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<sup>i</sup> [http://www.cbo.gov/ftpdocs/107xx/doc10731/Reid\\_letter\\_11\\_18\\_09.pdf](http://www.cbo.gov/ftpdocs/107xx/doc10731/Reid_letter_11_18_09.pdf), page 15