

CHAIRMAN'S STATEMENT

Hearing: "*Bolstering the Safety Net: Eliminating Medicaid Fraud*"

Senator Tom Coburn, M.D.

*Subcommittee on Federal Financial Management, Government Information, and
International Security*

March 28, 2006

THE PROBLEM

One in five Americans is on Medicaid. That's around 57 - 60 million people. The program costs taxpayers \$330 billion each year, and that figure is growing, at more than twice the rate of inflation. Between 2004 and 2005, the last two years for which we have data, the program grew by 12%! Medicaid growth is outpacing even that of Medicare. What's more, the Federal investment in Medicaid is only growing – and by 2016, it is estimated that Medicaid and Medicare alone will make up almost half the federal budget for mandatory spending.

That unchecked spending growth would be troublesome enough. However, that's not the end of the story - unfortunately, fraud is a huge problem in this program. We don't know how huge because nobody is measuring the problem in any sort of systematic way. As a result, the estimates of the scope of Medicaid fraud are all over the map, but are likely to be no lower than 10%, and could be, in some states such as New York, during some years, as high as the 30-40% range. In just one year, New York was defrauded by, some have estimated, as much as \$18 billion. If true, that would represent a fraud rate of 42% for that year in New York alone – more than every third dollar that should have helped the poor was wasted to fraud and abuse. If we used the CBO's current baseline estimates for the *federal share alone* of Medicaid by 2016, and we assume what is probably a low estimate of error – 10% – that totals \$39 billion taxpayers' dollars diverted from care for those who need it.

THE REASONS

The reasons for this problem are mostly structural. We simply have not put into place the necessary systems to detect and control fraud and other improper payments. However, Congress did pass the Improper Payments Information Act of 2002, and to date, Medicaid is still out of compliance with that law, and CMS admits that the program will likely stay out of compliance until 2008. We've had three hearings already on improper payments in this subcommittee and we will continue until every agency is not only in compliance with *reporting* their payment errors, but has reduced those errors to more reasonable levels.

Apart from flagrant violations of the law, let's talk about some of the institutional reasons for the fraud problem.

1) First, there is a responsibility problem. The Federal government has chosen to abdicate on fraud control at the level where most fraud happens – individuals, providers and facilities. Instead, CMS focuses oversight efforts on how State governments behave, leaving the bulk of fraud control to States. However, this ceding of responsibility is not mandated by law and ignores the significant Federal *interest* in controlling fraud.

2) So CMS monitors State behavior primarily. But even this state monitoring by CMS is weak. Under current CMS procedure, each state gets monitored for fraud control by CMS, at best, only about once every 7-8 years. This means that at any given time, CMS has no accurate picture of fraud control efforts in even a majority of states.

3) Third, States, who have, by default, become the primary fraud overseers, have typically diluted their fraud control activities by housing them under the same roof as their “program integrity” operation – that is, the unit responsible for ensuring that the State pays every claim, and gets its full Federal match. The somewhat mutually exclusive missions between the program integrity function and a fraud control unit’s function leads to fraud control getting short shrift.

4) Fourth, our incentive structure is out of whack. States face the perverse incentive that for every additional dollar they spend on Medicaid, even if it’s fraudulently paid, they receive *more* than that dollar back from the Federal government in the Federal Medicaid match. CMS rightly is tracking inappropriate and unlawful cost-shifting games that States play by artificially inflating their costs in order to maximize their Federal match, only to then place the surplus back into their supposed State contribution, which then pluses up their Federal match again.

Another scam along similar lines is the provider tax, whereby States charge providers a tax, which increases the provider charge to the State. That increased charge, the State uses to get a bigger Federal match, and then it reimburses the providers for the tax and pockets the Federal cash. CMS has got to put an end to these schemes based on Medicaid’s perverse incentive structures.

5) Finally there is simply no strategic plan for getting this problem under control. There is no data collection to even measure the problem or track its progress over time.

THE SOLUTION

With the Federal investment in Medicaid growing at exponential rates each year, CMS needs to take responsibility for fraud control, both by increasing its efforts at the Federal level and providing some standardization, monitoring and coordination at the State level.

An effective strategic plan would have the following elements:

- Clearly delineate roles and responsibilities for fraud control and standardize those roles across States.
- Put CMS on record for measurable targets for fraud reduction and timelines for meeting those targets.
- Apply consequences with real teeth for failing to meet those targets on time.
- Provide support and assistance to States who create sound organizational structures for separating fraud control activities from programmatic financial management. Texas, who is here today, is a model of how to provide both *independence* for its fraud control activities, as well as *integration* of those activities with all the other players in government necessary to ensure that those activities are effective. For example, Texas’ Inspector General has subpoena power, whereas New York’s does not.

- Measure the problem in a systematic and reliable way, standardized across States. CMS officials themselves have estimated that appropriate info-sharing and data collection would not be expensive to support, perhaps as low as \$100,000 annually.

CONCLUSION

Finally, I want to thank our witnesses for being here today and I want to emphasize that their efforts to control fraud are not going unnoticed. Many individuals at both the State and Federal levels are working hard to combat fraud, and I commend them for their work. Some States have implemented creative solutions to prevent and control fraud. Texas just undertook a massive reorganization of its health and finance infrastructure in order to prevent and control fraud, and provides a good model for other states to emulate.

I go home on weekends to Oklahoma and practice medicine. Many of my patients are Medicaid beneficiaries who are pregnant with the next generation of Americans. Every time I deliver a new baby into the world, I'm reminded of why I spend the rest of my week in Washington. I do not want us to become the first generation of Americans to leave our children a country in worse financial shape than we found it. I know you all share that goal and I look forward to working with you.