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4 ``FOSTERING INNOVATION TO FIGHT WASTE, FRAUD AND ABUSE IN

5 HEALTH CARE''

6 WEDNESDAY, FEBRUARY 27, 2013

7 House of Representatives,

8 Subcommittee on Health

9 Committee on Energy and Commerce

10 Washington, D.C.

11 The subcommittee met, pursuant to call, at 10:15 a.m.,  
12 in Room 2123 of the Rayburn House Office Building, Hon. Joe  
13 Pitts [Chairman of the Subcommittee] presiding.

14 Members present: Representatives Pitts, Burgess, Hall,  
15 Shimkus, Murphy, Lance, Cassidy, Guthrie, Griffith,  
16 Bilirakis, Ellmers, McKinley, Pallone, Capps, Schakowsky,

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17 Matheson, Green, Butterfield, Barrow, Christensen, Castor,  
18 Sarbanes and Waxman (ex officio).

19 Staff present: Clay Alspach, Chief Counsel, Health;  
20 Matt Bravo, Professional Staff Member; Paul Edattel,  
21 Professional Staff Member, Health; Steve Ferrara, Health  
22 Fellow; Sydne Harwick, Staff Assistant; Robert Horne,  
23 Professional Staff Member, Health; Carly McWilliams,  
24 Legislative Clerk; John O'Shea, Professional Staff Member,  
25 Health; Monica Popp, Professional Staff Member, Health;  
26 Andrew Powaleny, Deputy Press Secretary; Chris Sarley, Policy  
27 Coordinator, Environment and Economy; Alli Corr, Democratic  
28 Policy Analyst; Amy Hall, Democratic Senior Professional  
29 Staff Member; Elizabeth Letter, Democratic Assistant Press  
30 Secretary; and Karen Nelson, Democratic Deputy Committee  
31 Staff Director for Health.

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32 Mr. {Pitts.} The subcommittee will come to order. The  
33 Chair will recognize himself for an opening statement.

34 According to data from the Centers for Medicare and  
35 Medicaid Services, in 2011, Medicare spending accounted for  
36 21 percent of total national health expenditures. Medicaid  
37 makes up another 15 percent of total NHE.

38 Medicare has been on the Government Accountability  
39 Office's high-risk list continuously since GAO began  
40 designating programs as high risk in 1990, and it remains  
41 there in GAO's February 2013 report entitled ``High Risk  
42 Series: An Update.''

43 In 2012, Medicare spent approximately \$555 billion  
44 caring for more than 49 million beneficiaries. CMS estimates  
45 that out of that \$555 billion, \$44 billion--nearly 8 percent--  
46 --were improper payments. The report noted that while  
47 Medicare has made progress toward addressing some of GAO's  
48 previous concerns and the program's known deficiencies, not  
49 enough had been done to warrant its removal from the list.

50 Medicaid entered the high-risk list in 2003 and has also  
51 remained there. With total expenditures of \$436 billion in

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52 2011 for its approximately 70 million low-income  
53 beneficiaries, the Department of Health and Human Services  
54 estimates that Medicaid's national improper payment rate is  
55 7.1 percent. These improper payment figures represent only  
56 those payments that CMS knows were improper. Estimates of  
57 the real cost of waste, fraud and abuse in these programs are  
58 much higher.

59 In an April 2012 study, former CMS Administrator Donald  
60 Berwick and RAND Corporation analyst Andrew Hackbarth  
61 estimated that fraud and abuse added as much as \$98 billion  
62 to Medicare and Medicaid spending in 2011. And, without any  
63 significant program integrity changes, the Affordable Care  
64 Act will add an additional 7 million people to the Medicaid  
65 rolls in 2014. By 2022, that number will grow to 11 million  
66 new enrollees.

67 The ACA also contains perverse incentives for private  
68 insurance companies to ignore waste and fraud, which drives  
69 up premiums and copayments for consumers. The ACA's Medical  
70 Loss Ratio provision requires health plans to spend 80  
71 percent for plans in the individual and group market and 85  
72 percent for large group plans of premium revenue on medical

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73 care. Supporters of the MLR claim it was designed to protect  
74 consumers from unscrupulous insurance companies. However,  
75 under the regulation, investments in fraud detection, and  
76 even quality improvement and care coordination, fall under  
77 administrative expenses, which can only make up 20 percent of  
78 a plan's spending. Plans struggling to make the 80 or 85  
79 percent threshold for medical costs often can't risk these  
80 activities, which could save consumers money and provide them  
81 with a higher quality of care, for fear of being penalized  
82 and having to pay rebates. Even worse, if a plan does  
83 identify fraud, cutting those fraudulent payments and  
84 activities actually reduces their amount of spending on  
85 medical costs, making it even harder for them to reach the 80  
86 or 85 percent threshold. We are actually exporting the  
87 inefficiencies of federal health programs into the private  
88 sector.

89 While some here today may champion MLR, it is apparent  
90 to me that MLR will not reduce the tens of billions of  
91 taxpayer dollars lost each year to improper payments, but  
92 rather add to it, and that is a problem. Simply eliminating  
93 waste, fraud, and abuse is not going to put Medicare and

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94 Medicaid on solid financial ground, but the threat it poses  
95 to sick Americans cannot be ignored any longer. We have an  
96 obligation to use taxpayer funds in the most responsible and  
97 efficient ways possible, an obligation we are not currently  
98 meeting.

99 I thank all of our witnesses for being here today. I  
100 look forward to hearing from our GAO witnesses what areas in  
101 the Medicare and Medicaid programs are most vulnerable to  
102 fraud and their recommendations to combat improper payments.  
103 I also look forward to hearing from our private sector  
104 witnesses about the tools and innovations they use to fight  
105 waste, fraud and abuse on a daily basis.

106 Thank you, and I yield back.

107 [The prepared statement of Mr. Pitts follows:]

108 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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|  
109           Mr. {Pitts.} The Chair now recognizes the ranking  
110 member of the Subcommittee on Health, Mr. Pallone, for 5  
111 minutes for an opening statement.

112           Mr. {Pallone.} Thank you, Chairman Pitts, and good  
113 morning to everyone.

114           Fighting fraud across all health care settings is  
115 critical. I think we can all agree on that. In fact, this  
116 committee has an important role in ensuring that the  
117 government is aggressive in addressing long-term solutions to  
118 an ongoing threat, and I am committed to working with my  
119 colleagues now and in the future to help support the constant  
120 work that must be done to cut waste, fraud and abuse.

121           But I am not entirely sure that another hearing on this  
122 topic, since one was held less than three months ago, is  
123 necessary so soon. Instead, I think we should be examining  
124 the impact of the looming sequestration, which is just 2 days  
125 away. Mr. Waxman and I along with other senior members of  
126 this committee requested that we look at how sequestration  
127 will affect the programs and agencies we oversee. For  
128 example, in New Jersey, nearly 4,000 fewer children will

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129 receive vaccines for disease such as measles, mumps, rubella,  
130 tetanus, whooping cough, influenza and hepatitis B due to  
131 reduced funding for vaccinations, and the New Jersey State  
132 Department of Public Health will lose about \$752,000,  
133 resulting in around 18,800 fewer HIV tests. These spending  
134 cuts not only threaten our economy but also a range of vital  
135 services that I think our time today would be better spent  
136 examining.

137         Fraud schemes come in all shapes and sizes and affect  
138 all kinds of insurance, public and private alike. Whether it  
139 is a sham storefront posing as a legitimate provider or  
140 legitimate businesses billing for services that were never  
141 provided, it all has the same result: undermining the  
142 integrity of our public health system and driving up health  
143 care costs. So for every dollar put into the pockets of  
144 criminals or program abusers, a dollar is taken out of the  
145 system to provide much-needed care to millions of people  
146 including Medicare seniors.

147         I think we can all agree that a strong commitment to  
148 combat health care fraud and abuse was included within the  
149 Affordable Care Act. The law contains over 30 antifraud

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150 provisions to assist CMS, the OIG and the Justice Department  
151 in identifying abusive suppliers and fraudulent billing  
152 practices. The most important provisions change the way we  
153 fight fraud by heading off the bad actors before they strike  
154 and thwarting their enrollment into their federal programs in  
155 the first place. In this way, we aren't left chasing a  
156 payment once the money is already out the door. And we also  
157 made important improvements in the ACA to the False Claims  
158 Act, which is another useful tool that can help address fraud  
159 and abuse.

160 Today we will hear from CMS about the great work already  
161 being done. Over the past 4 years, enforcement efforts have  
162 recovered \$14.9 billion, and I think that is considerable  
163 progress. In fact, return on investment for each dollar  
164 spent on health care-related fraud and abuse investigations  
165 in the last 3 years has been \$7.90. So we will also hear  
166 from the GAO about their high-risk report released this  
167 month. That report notes that while making positive steps,  
168 there is still a lot of areas or a number of areas that  
169 continue to need improvement.

170 So I know we are going to hear from the panel. I think

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171 we must continue to innovate. Bad actors are always going to  
172 find loopholes, and it is our job to keep one step ahead of  
173 them.

174 Thank you again, Mr. Chairman.

175 [The prepared statement of Mr. Pallone follows:]

176 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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|  
177           Mr. {Pitts.} The Chair thanks the gentleman and now  
178 recognizes the vice chairman of the subcommittee, Dr.  
179 Burgess, for 5 minutes for an opening statement.

180           Dr. {Burgess.} Thank you, Mr. Chairman, and I will  
181 acknowledge that members on both sides of the dais have a  
182 fundamental sense of fairness about this and they want to  
183 preserve, protect and defend the program that is there to  
184 serve the most vulnerable seniors in our population.

185           I agree with the ranking member that it does seem like  
186 we have a lot of hearings about this. I will agree that it  
187 doesn't seem that there has been a lot of movement in the  
188 right direction. I would disagree that this hearing is not  
189 important and we should be focusing on something else  
190 because, after all, the sequester would not even be necessary  
191 if Congress was doing its job in oversight, if the  
192 Administration was doing its job and the agencies were doing  
193 their job and didn't allow these dollars to be delivered hand  
194 over fist to felons and organized crime in the first place.

195           I do feel that the Federal Government has not done  
196 enough to address this issue. Sure, we had a hearing right

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197 at the end of the last Congress, the Oversight and  
198 Investigations Subcommittee. In fact, we have some of the  
199 same witnesses here today. But I got to tell you, it bothers  
200 me that we keep having to have these hearings and we don't  
201 seem to ever move the needle.

202 I took the liberty of doing a little Google search last  
203 night, and Googled the name Janet Reno and Medicare fraud,  
204 and it turns out in February of 1998, 15 years ago this  
205 month, Janet Reno stood in front of the American Hospital  
206 Association and said fraud in the Medicare and Medicaid  
207 system is the number one priority for her Justice Department,  
208 and it was going to end with her. Well, here we are 15 years  
209 later and we are having the same discussion.

210 The analysts, the law enforcement officials estimate  
211 that 10 percent of total health care expenditures are lost to  
212 fraud on an annual basis, and guess what? That 10 percent is  
213 not equally distributed between the public and private parts  
214 of our health care system. No, the loss falls  
215 disproportionately on the part that is under the jurisdiction  
216 and control of the Federal Government. The Government  
217 Accountability Office, who we have here with us this morning,

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218 and others have said these characteristics are unsustainable.  
219 Eliminating waste, fraud and abuse that hemorrhages billions  
220 of dollars from our country's government-run health care  
221 program should be the foremost priority of this committee.  
222 And again, I will say it one more time: How can we protect  
223 the most vulnerable in our society if we don't protect the  
224 integrity of the system that was intended to serve them?

225 If we are serious about bringing down the cost of health  
226 care, if we are serious about protecting the patient, if we  
227 are serious about avoiding another sequester, if we are  
228 serious about fixing the inequities in the payment system for  
229 physicians in Medicare, we ought to be all about eliminating  
230 this problem and eliminating it in this Congress, not waiting  
231 for another Congress, not waiting for another President. The  
232 time is now.

233 The private sector has developed ways to combat fraud  
234 that really doesn't burden providers or patients. They are  
235 able to catch far more incidents of fraudulent activity. The  
236 Centers for Medicare and Medicaid Services has attempted to  
237 develop new efforts to recover funds but the current system  
238 to prevent improper payments is just simply not working, and

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239 I know we have some of the same witnesses we had here in  
240 December. I will use the Visa example again. I gave my  
241 credit card to my staff to go out and by lunch for our staff  
242 at Chick-fil-A last December. I am calling on my cell phone  
243 on the House Floor, hey, somebody is trying to charge \$100  
244 worth of Chick-fil-A on your credit card, is that okay, and I  
245 affirmed that it was. Why do we not have the same system of  
246 safeguards when we spend so many billions of dollars in our  
247 health care system?

248 Now, in fairness, one of our witnesses, Dr. Budetti,  
249 thank you very much for being here this morning and thank you  
250 for coming in to brief my staff and myself earlier in the  
251 last Congress. I appreciate the efforts that you have  
252 underway. The Government Accountability Office has made  
253 recommendations, some dating back years and years, and they  
254 failed to be implemented. Well, it begs the question: Why  
255 is this acceptable?

256 So if we are going to be developing new and innovative  
257 approaches to fight fraud, and it is becoming increasingly  
258 important that we do so, I do look forward to hearing the  
259 testimony from the witnesses today but let us hear that

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260 testimony with in mind the fact that we are going to solve  
261 this problem.

262 Thank you, Mr. Chairman, for the indulgence and I will  
263 yield back the balance of my time.

264 [The prepared statement of Dr. Burgess follows:]

265 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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|  
266           Mr. {Pitts.} The Chair thanks the gentleman and now  
267 recognizes the ranking member of the full committee, Mr.  
268 Waxman, for 5 minutes for an opening statement.

269           Mr. {Waxman.} Thank you, Mr. Chairman. I appreciate  
270 your holding this hearing today and for focusing on the  
271 important topic of health care waste, fraud and abuse.  
272 Improving our health care system, both private and public,  
273 requires pursuing dollars that are wasted or diverted,  
274 dollars that add to our costs, but don't improve health.

275           I have dedicated much of my career in Congress to  
276 improving the quality and efficiency of both the Medicare and  
277 Medicaid programs. Fighting fraud is critical to both of  
278 these and critical to being responsible stewards of  
279 taxpayers' dollars, an issue where we should be able to  
280 achieve bipartisan consensus.

281           I am very pleased by the recent reports that have  
282 highlighted our progress fighting fraud and abuse. According  
283 to the Administration's most recent report on the Health Care  
284 Fraud and Abuse Control Program, health care fraud prevention  
285 and enforcement efforts recovered a record \$4.2 billion in

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286 fiscal year 2012. For each dollar spent on health care-  
287 related fraud and abuse investigations in the last three  
288 years, we recovered \$7.90, the highest return on investment  
289 in the 16-year history of the program.

290 We are now seeing the impact of provisions in the  
291 Affordable Care Act that help us move away from the  
292 traditional ``pay and chase'' approach to a more proactive  
293 approach designed to prevent fraud before it occurs. Other  
294 Administration initiatives, such as implementing the Command  
295 Center, which brings together the Centers for Medicare and  
296 Medicaid Services, the Office of the Inspector General and  
297 the Federal Bureau of Investigation, and the Health Care  
298 Fraud Prevention and Enforcement Action Team, which is taking  
299 action against Medicare fraud in fraud hot spots across the  
300 country, are bringing more tools and resources in the fight  
301 against fraud.

302 We also need to ensure that the public and private  
303 sectors are collaborating, because we know that schemes that  
304 affect programs like Medicare and Medicaid often are also  
305 perpetrated against private payers as well. The  
306 Administration has initiated the Health Care Fraud Prevention

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307 Partnership that is bringing together federal and state  
308 officials with private insurers and health care antifraud  
309 groups to do just that. The value of these new prevention-  
310 oriented approaches is that they target fraud and abuse  
311 before it occurs and leverage partnerships across government  
312 and the private sector to support this important work.

313 Another tool in the health care fraud-fighting arsenal,  
314 which also is a form of public-private partnership, is the  
315 False Claims Act. This law incentivizes private parties to  
316 bring suit on behalf of the government to recover fraudulent  
317 payments and has been effective in helping get the federal  
318 and State governments reimbursed for a number of high-profile  
319 fraud schemes.

320 We cannot rest on our laurels and be satisfied with the  
321 current successes in fraud fighting. The data clearly shows  
322 that we are moving in the right direction. But just as the  
323 fraudsters are constantly looking for the next new scheme, we  
324 too must continue our work, and I look forward to hearing  
325 from our panels of experts about the opportunities and  
326 challenges moving forward, and I want to yield the balance of  
327 my time to Ms. Schakowsky.

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328 [The prepared statement of Mr. Waxman follows:]

329 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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|  
330 Ms. {Schakowsky.} I thank the gentleman so much, and I  
331 appreciate his decades of work to make Medicare, Medicaid,  
332 the programs our citizens rely on, more efficient.

333 But I have to say, the passion that I heard from Dr.  
334 Burgess, it is as if we don't share that, and I want to set  
335 the record straight, that we want to and have been cutting  
336 the waste, fraud and abuse and we need to build on our  
337 successes, the \$4.2 billion in fiscal year 2012. I think we  
338 can start with that and go further.

339 And I also want to say that it is as if the election  
340 didn't happen. As I recall, the \$716 billion that Democrats  
341 were able to save through Obamacare that reduced the cost of  
342 Medicare without cutting benefits was used as a sledgehammer  
343 accusing Democrats of cutting Medicare and in fact we did  
344 reduce the cost. Rather than being applauded for that at the  
345 time, it was used to say that we are the ones that are really  
346 taking away something from Medicare beneficiaries when of  
347 course we weren't.

348 So let us get on the same page here. We agree, we all  
349 agree that waste, fraud and abuse is a problem. We have

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350 begun and let us continue to do something serious about it.

351 Thank you. I yield back.

352 [The prepared statement of Ms. Schakowsky follows:]

353 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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354           |           Mr. {Pitts.} The Chair thanks the gentlelady.

355           We have two panels for today's hearing. On our first  
356 panel, we have Dr. Peter Budetti, Deputy Administrator and  
357 Director at the Center for Program Integrity at CMS, and Ms.  
358 Kathleen King and Ms. Carolyn Yocom, who are both Directors  
359 of Health Care at the Government Accountability Office.

360 Thank you for coming this morning. Your written testimony  
361 will be entered into the record. I will recognize each of  
362 you for 5 minutes to summarize your testimony.

363           Dr. Budetti, you are recognized for 5 minutes for your  
364 opening statement.

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|  
365 ^STATEMENTS OF PETER BUDETTI, DEPUTY ADMINISTRATOR AND  
366 DIRECTOR, CENTER FOR PROGRAM INTEGRITY, CENTERS FOR MEDICARE  
367 AND MEDICAID SERVICES; KATHLEEN M. KING, DIRECTOR, HEALTH  
368 CARE, GOVERNMENT ACCOUNTABILITY OFFICE; AND CAROLYN L. YOCOM,  
369 DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE

|  
370 ^STATEMENT OF PETER BUDETTI

371 } Dr. {Budetti.} Good morning, and thank you, Chairman  
372 Pitts and Ranking Member Pallone and members of the  
373 subcommittee for this invitation to appear before you today.

374 As the Deputy Administrator of the Centers for Medicare  
375 and Medicaid Services for Program Integrity and Director of  
376 the Center for Program Integrity, I am now into my third year  
377 of having the privilege of overseeing program integrity  
378 efforts for the Medicare and Medicaid programs, which is a  
379 top priority for this Administration and for CMS, and it is  
380 an area where I am very pleased to say that new tools and a  
381 collaborative approach are indeed helping us move beyond pay  
382 and chase to preventing fraud before it happens.

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383           A key component of our fraud-fighting approach is what  
384 we call the Fraud Prevention System, or FPS. This system,  
385 this high-tech system, highly sophisticated system that we  
386 put into place in the middle of 2011, analyzes all Medicare  
387 fee-for-service claims using risk-based algorithms and  
388 generates alerts. CMS and our program integrity contractors  
389 can then stop, prevent and identify improper payments using a  
390 variety of administrative tools and actions including  
391 prepayment review, claims denials, payment suspensions,  
392 revocation of Medicare billing privileges, and referrals to  
393 law enforcement.

394           We have a poster for you here today that demonstrates  
395 the initial results from the first year of implementation of  
396 the Fraud Prevention System. Our numbers show that we did  
397 achieve a positive return on investment, saving an estimated  
398 \$3 for every \$1 we spent in the first year and that we have  
399 prevented or identified an estimated \$115.4 million in  
400 improper payments. In addition, and very importantly, this  
401 system generated leads for over 500 new fraud investigations  
402 and provided new information for over 500 existing fraud  
403 investigations.

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404           To further enhance our program integrity efforts, we  
405 have implemented a risk-based screening process for newly  
406 enrolling and revalidating Medicare providers and suppliers.  
407 This system is designed to both make it easier for the  
408 legitimate providers and suppliers, some 20,000 of whom  
409 applied to be able to bill in the Medicare program every  
410 month, to make it easier on the enrollment side for them to  
411 get into the program while making it much harder for the bad  
412 guys to get in and makes it easier for us to find the bad  
413 guys if they do get in and kick them out.

414           We have implemented the terms of the Affordable Care Act  
415 that required us to put into place risk-based screening so  
416 that people in the higher-risk categories are subject to  
417 greater scrutiny prior to their enrollment or revalidation in  
418 Medicare. Since March of 2011, our processes have validated  
419 or revalidated enrollment for nearly 410,000 Medicare  
420 providers, and because of this, we have deactivated some  
421 136,000 enrollments and revoked over 12,000 enrollments that  
422 were not appropriate or not timely in the program.

423           We have also made major progress in engaging other  
424 federal partners to improve the collaboration in fighting

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425 fraud. Thanks to a variety of efforts, federal, State and  
426 local law enforcement health care fraud activities are being  
427 coordinated more and more and, as you have heard, and as I  
428 will talk about in a second, we are also engaging with our  
429 fraud-fighting partners in the private sector to improve the  
430 integrity of Medicare and Medicaid.

431 We are working with our State partners to improve and  
432 enhance our program integrity activities in the Medicaid  
433 program and we have taken steps to ensure that someone who is  
434 caught defrauding the program in one State cannot simply move  
435 to another State. We have implemented the Recovery Auditor  
436 program in Medicaid, and the States are already reporting  
437 some \$95 million in recovered payments in the first phase of  
438 implementation of that program.

439 We have been working more closely with law enforcement,  
440 both through our new command center, which provides a  
441 collaborative environment so that we can work together and  
442 not just talk to each other one after the other, and we have  
443 had a string of successes in terms of building new models and  
444 engaging in new approaches to fighting fraud coming out of  
445 our collaboration in the command center.

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446 Medicare and Medicaid and health care fraud anywhere  
447 affects every American by draining critical resources from  
448 our health care system. The Administration has made stopping  
449 fraud and improper payments a top priority, and today new  
450 tools and a collaborative approach are moving us beyond pay  
451 and chase to preventing fraud before it happens. I look  
452 forward to continuing to work with you to make Medicare and  
453 Medicaid stronger, more effective programs by protecting  
454 their integrity and safeguarding taxpayer resources, and I  
455 thank you for this opportunity to appear before you, and I  
456 will be happy to answer questions later. Thank you, Mr.  
457 Chairman.

458 [The prepared statement of Dr. Budetti follows:]

459 \*\*\*\*\* INSERT 1 \*\*\*\*\*

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|  
460           Mr. {Pitts.} The Chair thanks the gentleman and now  
461 recognizes Ms. King for 5 minutes for opening statement.

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|

462 ^STATEMENT OF KATHLEEN M. KING

463 } Ms. {King.} Chairman Pitts, Ranking Member Pallone and  
464 members of the subcommittee, I am pleased to be here today to  
465 discuss our recent high-risk report on Medicare and Medicaid.  
466 I am joined by my colleagues, Carolyn Yocom and James  
467 Cosgrove.

468 For many years, we have designated these programs as  
469 high risk because of their size, complexity and  
470 susceptibility to improper payments. Together, these two  
471 programs finance vital health care services for nearly 120  
472 million Americans. Ensuring that they function effectively  
473 and efficiently should be a high priority.

474 CMS has taken a number of important steps in Medicare to  
475 improve payment systems in traditional fee-for-service and  
476 Medicare Advantage. For example, CMS has implemented a  
477 competitive bidding program for durable medical equipment  
478 that pays selected providers at competitively determined  
479 prices. To date, it has produced savings while beneficiary  
480 access and satisfaction appeared stable in early assessments.

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481           However, we have also identified a number of  
482 opportunities for CMS to improve and refine payments to  
483 encourage appropriate use of services such as improving the  
484 accuracy of payments for Medicare Advantage.

485           With respect to program integrity, CMS has made reducing  
486 improper payments one of their key priorities and has made  
487 progress in error rate measurement. CMS has also implemented  
488 provisions of the Patient Protection and Affordable Care Act  
489 to enhance its ability to screen providers before allowing  
490 them to enroll in Medicare. This should have prevented  
491 providers intent on defrauding the program from gaining  
492 entry. It has also implemented a fraud prevention system  
493 which uses analytic methods to screen provider billing and  
494 beneficiary utilization data before claims are paid to  
495 identify those that are potentially fraudulent. While these  
496 are important steps, we have made recommendations to CMS to  
497 enhance program integrity such as identifying measurable  
498 performance metrics and goals for the Fraud Prevention  
499 System.

500           With respect to Medicaid, both Congress and the  
501 Administration have demonstrated commitment and leadership to

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502 making Medicaid fiscal and program integrity a priority. I  
503 would like to highlight two areas where there has been some  
504 progress but concerns remain. First, with regard to improper  
505 payments to providers, some positive steps toward improving  
506 transparency and reducing improper payments have been taken  
507 in recent years such as increased guidance to States  
508 regarding oversight of providers. However, key challenges  
509 remain including eliminating duplication between CMS and  
510 State program integrity efforts and refocusing national  
511 audits on cost-effective approaches. Also, our work has  
512 identified areas where CMS could streamline and improve its  
513 oversight of States' improper payments.

514       Second, supplemental payments, that is, payments above  
515 and beyond regular Medicaid payments for services, continue  
516 to be a large and growing problem. In fiscal year 2011,  
517 States reported spending at least \$43 billion on supplemental  
518 payments up from \$32 billion in fiscal year 2010. While a  
519 variety of actions have helped curb supplemental payment  
520 arrangements, gaps in oversight remain. In 2010, CMS  
521 implemented new transparency and accountability requirements  
522 for certain Medicaid supplemental payments known as

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523 disproportionate share, or DSH payments. However, similar  
524 standards for calculating, reporting and auditing non-DSH  
525 supplemental payments have not been established. Although  
526 Medicaid payments are not always limited to the cost of  
527 providing Medicaid services, when payments greatly exceed  
528 Medicaid costs, it raises questions about their purpose,  
529 relation to Medicaid service and whether such payments  
530 contribute to beneficiaries' access to quality care.

531 Congress, HHS and CMS have taken steps to improve the  
532 fiscal integrity of Medicaid. However, more federal  
533 oversight is needed, particularly in the areas of addressing  
534 improper payments and oversight of supplemental payments. In  
535 both cases, CMS oversight has been hampered by data systems  
536 that do not provide complete and timely data.

537 Mr. Chairman, this concludes my prepared remarks. I  
538 would be happy to answer questions.

539 [The prepared statement of Ms. King follows:]

540 \*\*\*\*\* INSERT 2 \*\*\*\*\*

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|  
541 Mr. {Pitts.} The Chair thanks the gentlelady and now  
542 recognizes Ms. Yocom for 5 minutes for an opening statement.

543 Ms. {Yocom.} Chairman Pitts and Ranking Member Pallone  
544 and members of the subcommittee, Ms. King and I combined our  
545 statements so I am available to answer any questions  
546 regarding Medicaid.

547 Mr. {Pitts.} Thank you. I will now begin questioning  
548 and recognize myself for 5 minutes for that purpose.

549 Dr. Budetti, it is often said that CMS uses a pay-and-  
550 chase model to fight fraud in our Nation's entitlement  
551 programs. That is, CMS will unknowingly process a fraudulent  
552 payment and then try to recover payment down the road. My  
553 understanding is that CMS still largely operates reactively.  
554 Are you aware of any single claim using the Fraud Prevention  
555 System that stopped a claim before it was paid?

556 Dr. {Budetti.} Mr. Pitts, the history certainly has  
557 been of a predominantly pay-and-chase approach, and that is  
558 what the Fraud Prevention System is changing, and I would  
559 like to point out something that is really quite different  
560 with the Fraud Prevention System than the way we have done

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561 things in the past because in the past, most of our screening  
562 was done on a single claim-by-claim basis, and what the Fraud  
563 Prevention System allows us to do, it is triggered by claims  
564 that into the system, but then what happens is, we are able  
565 to combine not just one claim but the pattern of claims that  
566 we are seeing and the pattern of beneficiaries being served  
567 and the pattern of services being billed as well as lots of  
568 other forms of information to produce, if you will, a picture  
569 of an entire book of business, and that book of business then  
570 is given a risk score, and based upon that risk score, we  
571 then are able to take action, and that is the basis of the  
572 \$115 million in savings, which includes many ways of stopping  
573 the payments.

574 Mr. {Pitts.} So the answer is no?

575 Dr. {Budetti.} No, the answer is yes. We have  
576 definitely been implementing systems that are stopping  
577 payments from going out the door triggered by incoming claims  
578 but looking at a broader perspective. For example, one of  
579 the ways we like to stop payments is to kick somebody out of  
580 the program once we have identified the fact that they don't  
581 belong in the program.

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582 Mr. {Pitts.} Thank you.

583 Ms. King, Dr. Budetti testified before the Health  
584 Oversight and Government Reform Committee on April 5, 2011,  
585 that most of the \$60 billion in improper payments accounted  
586 for in 2010 were not ``usually fraudulent nor necessarily  
587 payments for inappropriate claims'' but rather, indications  
588 that errors were made by the Provider in filing a claim or  
589 inappropriately billing or a service. In that same year, his  
590 former boss, Donald Berwick, put the number at \$98 billion.  
591 Frankly, I haven't seen one indication that CMS truly knows  
592 how much it loses each year much less whether a majority of  
593 these payments are not usually fraudulent. Do you agree with  
594 Dr. Budetti's assertion that most of the payments are not  
595 fraudulent but merely billing errors by providers?

596 Ms. {King.} Mr. Chairman, I would like to distinguish  
597 between improper payments and potentially fraudulent  
598 payments. Improper payments are those payments that should  
599 not have been made for any reason, and they include both  
600 overpayments and underpayments, and each year HHS measures  
601 the rate of improper payments. It is true that most of the  
602 problems related to improper payments are related to

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603 inadequate or missing documentation, so a large part of that  
604 is they have not supplied the proper documentation or the  
605 documentation is inadequate.

606 But i would like to point out the difference between  
607 improper payments and fraud. There is no measure of fraud in  
608 the Medicare program, in part because you can't determine  
609 everything that is fraudulent because a lot of fraud is  
610 committed and it doesn't hit the improper payment screens.  
611 For example, if I sell my beneficiary number to someone and  
612 they use it to obtain services, and if those services are  
613 billed correctly, they are not going to show up as an  
614 improper payment. And fraud is actually only determined by a  
615 court of law because it involves a deliberate attempt to  
616 deceive and to cheat.

617 Mr. {Pitts.} Thank you.

618 Ms. Yocom, in GAO's most recent report, you note that  
619 States have increasingly used supplemental payments through  
620 sophisticated financing arrangements such as provider taxes.  
621 Increased scrutiny of such payments has raised significant  
622 concerns from the States who believe they have limited  
623 resources to fund their already strained Medicaid programs.

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624 Given the drastic expansion of the Medicaid program in 2014,  
625 do you not see a further increase in the use of such State  
626 funding arrangements?

627 Ms. {Yocom.} Mr. Chairman, our work has shown that  
628 there has been an increase in the use of supplemental  
629 payments rising from about \$23 billion in 2006 up to about  
630 \$43 billion in 2011. We do have some outstanding  
631 recommendations for CMS involving in particular the use of  
632 non-DSH supplemental payments, which currently there is not  
633 enough reporting and transparency regarding their oversight,  
634 approval and use.

635 Mr. {Pitts.} Thank you. My time has expired. The  
636 Chair recognizes the ranking member, Mr. Pallone, 5 minutes  
637 for questions.

638 Mr. {Pallone.} Thank you, Mr. Chairman.

639 Dr. Budetti, if Congress fails to act in the next couple  
640 days, sequestration will result in a 2 percent cut in the  
641 Medicare funding, and I know that funding for fraud and abuse  
642 work is not exempt from this cut. Can you tell me yes or no,  
643 though, is the funding for your program integrity work at CMS  
644 exempt from the sequester? Just yes or no.

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645 Dr. {Budetti.} No, sir. My understanding is it is not  
646 exempt.

647 Mr. {Pallone.} All right. Then can you tell me if your  
648 budget takes a 2 percent cut as required in the sequester, is  
649 it logical to assume that this cut will have a negative  
650 effect on the staff and activities that are currently being  
651 used to fight fraud?

652 Dr. {Budetti.} All of our activities, Mr. Pallone, to  
653 fight fraud and to reduce improper payments depend upon our  
654 resources, and anything that reduces our resources is going  
655 to mean that we will have lowered ability to carry out our  
656 mission.

657 Mr. {Pallone.} According to your own HCFAC report,  
658 fraud and abuse activities have had an eight to one return on  
659 investment over the past 3 years. Is it true a cut to  
660 program integrity as a result of the sequester could  
661 negatively affect the ability to return fraudulently obtained  
662 monies to the Medicare trust fund?

663 Dr. {Budetti.} That is a serious consideration because  
664 what we have learned over the years of the Health Care Fraud  
665 and Abuse Control program is that the more we do spend

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666 looking for fraud, the more we find, and so the return on  
667 investment has actually gone up the more we spend. So  
668 cutting back would be expected to have just the opposite  
669 effect.

670 Mr. {Pallone.} Thank you. Now, I wanted to ask you,  
671 waste, fraud and abuse are not unique to public programs. It  
672 is fair to say that many, if not all, the fraudulent  
673 practices that we are addressing in public programs at the  
674 federal and State level are also issues for private health  
675 payers and sharing information and collaboration between the  
676 public and private sector are critical to these efforts. So  
677 could you tell us about the work CMS is doing to increase  
678 collaboration and coordination both internally between  
679 Medicare and Medicaid and externally with private payers?

680 Dr. {Budetti.} We have joined with the Attorney General  
681 and the Secretary joined together to establish the Public-  
682 Private Partnership for Health Care Fraud Prevention. We  
683 have a number of health plans and antifraud associations and  
684 other private sector partners that we are working together  
685 with as well as State agencies and other law enforcement  
686 agencies to work together on a problem. This is in

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687 recognition of the fact that actually health care fraud knows  
688 no boundaries and it attacks everybody, and we have already  
689 had the first serious interactions between the parties in the  
690 public-private partnerships, health care fraud prevention  
691 partnership, and we are building on that, and the intention  
692 is that we will be sharing best practices, data, analytic  
693 tools across the public and private sector. This is a very  
694 exciting and very important step forward for us to marshal  
695 resources throughout the health care system to fight fraud.

696 Mr. {Pallone.} Thanks.

697 Let me go to Ms. Yocom and ask her about CMS. CMS  
698 through its Medicaid Integrity Institute and other programs  
699 is working to partner with States and help to build State-  
700 level antifraud capacity. Can you give us a sense of how  
701 they are doing and are their program oversight activities  
702 that CMS has taken that appear to be effective, in your  
703 opinion?

704 Ms. {Yocom.} Sir, there has been some improvements in  
705 the improper payment rate in Medicaid. It has decreased by  
706 about a percent, and in terms of dollar value, from about  
707 21.9 to about 19.2 billion.

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708           There is more to be done. Our recommendations and our  
709 outstanding work is focusing on having CMS collaborate more  
710 with States to both augment their program activities and to  
711 support their program activities. Our work has found that  
712 those collaborative audits have actually been the most  
713 successful of the efforts that have happened to date.

714           Mr. {Pallone.} Did you want to comment on what I  
715 mentioned before in terms of, you know, dealing with the  
716 private sector as well and what they are doing?

717           Ms. {Yocom.} I don't think we have work that I can  
718 respond to you on that.

719           Mr. {Pallone.} All right. Thanks so much. I yield  
720 back.

721           Mr. {Pitts.} The Chair thanks the gentleman and now  
722 recognizes the vice chairman of the committee, Dr. Burgess, 5  
723 minutes for questions.

724           Dr. {Burgess.} Thank you, Mr. Chairman.

725           Ms. King, let me ask you a quick question that deals  
726 with third-party liability payment. Congress intended that  
727 Medicaid be the payer of last resort. My staff has been in  
728 contact with you about improving Medicaid third-party

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729 liability. To what extent do you feel that it is necessary  
730 to address this?

731 Ms. {King.} Sir, Medicare or Medicaid?

732 Dr. {Burgess.} Medicaid.

733 Ms. {King.} GAO's work on third-party is pretty dated  
734 at this point. We have some studies--

735 Dr. {Burgess.} So the answer would be, you think it  
736 would be worthwhile to look into this?

737 Ms. {King.} Yes.

738 Dr. {Burgess.} As I understand, the last report was in  
739 2006.

740 Ms. {King.} Correct.

741 Dr. {Burgess.} It demonstrated a significant problem.  
742 Will you be willing to work with my staff to see if we can't  
743 move the needle on this one a little bit?

744 Ms. {King.} We certainly would.

745 Dr. {Burgess.} Thank you.

746 Dr. Budetti, at this committee's last hearing on fraud,  
747 we asked the Government Accountability Office to provide a  
748 list of recommendations to combat waste, fraud and abuse in  
749 Medicare and Medicaid that had yet to be implemented. So in

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750 a sense of fairness, maybe you can give us an update on some  
751 of these things. I am going to ask for really brief answers  
752 like yes or no answers to these questions. Have you  
753 implemented the GAO recommendation from February 2009 that  
754 CMS should expand the types of improper billing practices  
755 that are grounds for revoking a home health provider's  
756 billing privileges?

757 Dr. {Budetti.} Dr. Burgess, I don't have the specifics  
758 on the individual programs right in front of me. I can tell  
759 you that the vast majority of the GAO recommendations are in  
760 some kind of process of our responding to them, but I would  
761 be delighted to give you a specific answer--

762 Dr. {Burgess.} I wish you would.

763 Dr. {Budetti.} --for the record afterwards.

764 Dr. {Burgess.} It is a possible no but may be an  
765 incomplete. Yes or no, have you implemented the GAO  
766 recommendation from March of 2010 to require the agency to  
767 evaluate RAC audits to correct the vulnerabilities identified  
768 in the agency? Those are the recovery audits.

769 Dr. {Budetti.} Well, again, I can't speak to the  
770 individual one right offhand but we do have lists, we do

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771 track these and I will be delighted to get that to you.

772 Dr. {Burgess.} I have a list myself, happily, and I am  
773 anxious to track this with you because it is important. The  
774 GAO makes recommendations. We are here fighting the same  
775 problem we fight year after year after year. It is important  
776 that we make some progress: I will tell you what. In the  
777 interest of time, we will leave the GAO reports and maybe you  
778 can work with my office to get us answers.

779 Now, it is referenced several times under the  
780 President's Affordable Care Act under subtitle (e), Medicare  
781 and Medicaid, CHIP program integrity provisions, several  
782 provisions that were signed into law by the President. Maybe  
783 we can just briefly run through those and you can tell me if  
784 those have been implemented. The face-to-face encounter with  
785 the patient that is required before a physician may certify  
786 eligibility for durable medical equipment.

787 Dr. {Budetti.} I believe that one has been implemented.

788 Dr. {Burgess.} So that is a yes? Ding, ding, ding.  
789 Good for you. Implement criminal background checks for  
790 fingerprinting for providers and suppliers considered at  
791 risk.

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792 Dr. {Budetti.} We have not finished the implementation  
793 of that for a number of reasons, in part related to the FBI's  
794 own internal rewarding of its contracts, but we are in the  
795 process, very much in the process of putting that into place,  
796 sir.

797 Dr. {Burgess.} It has been almost 3 years since this  
798 was signed into law. It is important stuff. I would get the  
799 FBI, the Justice Department engaged because it was felt to be  
800 important by the President. He signed it into law. Let us  
801 see that it is implemented. How about implementing  
802 limitations on how much high-risk providers and suppliers can  
803 bill the Medicare program within the first year?

804 Dr. {Budetti.} We are in the process of developing--

805 Dr. {Burgess.} So that is an incomplete. How about  
806 implementing a temporary moratorium for new Medicare  
807 providers from enrolling and billing the Medicare program  
808 even though there are more than enough suppliers to furnish  
809 health care services in certain areas of the country?

810 Dr. {Budetti.} That is a very important tool. We have  
811 been looking very carefully at the places to implement it,  
812 and we have--we are in the process of moving forward with

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813 that where we think it is appropriate as an adjunct to all of  
814 the other tools.

815 Dr. {Burgess.} Well, an important tool but it is--

816 Dr. {Budetti.} We have not implemented a moratorium  
817 yet.

818 Dr. {Burgess.} It is languishing, and we are coming up  
819 on 3 years, establish a compliance program for fee-for-  
820 service providers and suppliers.

821 Dr. {Budetti.} We are still in the process of working  
822 on that, in part because the Inspector General has long since  
823 had very sound guidance for providers for voluntary  
824 compliance programs.

825 Dr. {Burgess.} Okay. I am running out of time. That  
826 is also an incomplete. Implement a surety bond on home  
827 health agencies and certain other providers of services and  
828 supplies?

829 Dr. {Budetti.} The surety bond program is in place for  
830 DME but we are still in the process of implementing it beyond  
831 that.

832 Dr. {Burgess.} For home health specifically, that is a  
833 no, and what about implementing checks to make sure that a

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834 physician actually referred a Medicare beneficiary for  
835 medical service before paying the claim?

836 Dr. {Budetti.} We do have processes in place for doing  
837 that.

838 Dr. {Burgess.} Incomplete, so one out of those seven  
839 things that were signed into law by the President that are  
840 always referenced as hey, these are important things that we  
841 want the Affordable Care Act to do to combat fraud, we are  
842 still waiting to see if they in fact will be effective.

843 Thank you, Mr. Chairman. You have been generous. I  
844 will yield back.

845 Mr. {Pitts.} The chair thanks the gentleman and now  
846 recognize the gentleman from Texas, Mr. Green, 5 minutes for  
847 questions.

848 Mr. {Green.} Thank you, Mr. Chairman, for the time, and  
849 I appreciate our panel has taken the time to be here today.

850 The rising cost of health care threatens our Nation's  
851 economy and puts more and more families at financial risk,  
852 although I have to say that I just read an interesting  
853 article in Time magazine last week that said Medicare is the  
854 ultimate cost saver in health care, but that is not part of

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855 my questions. I believe the key part of saving money is  
856 keeping people healthier longer. To achieve this, people  
857 must have the health care coverage necessary that they can be  
858 seen when they first get sick and not have to wait until it  
859 is so bad they need urgent care.

860 My question is to GAO and CMS. Can the Government  
861 Accountability Office or CMS estimate the government or  
862 private sector costs from the administrative waste associated  
863 with the phenomenon in Medicaid known as ``the churn'' where  
864 people who are eligible for Medicaid are discharged from the  
865 rolls for bureaucratic or paperwork reasons or for some  
866 temporary changes in income that do not impact their long-  
867 term eligibility for Medicaid? Is there any studies that you  
868 all have been able to do on that?

869 Ms. {Yocom.} We have not done any studies in that area.  
870 We have taken a brief look at express-lane eligibility and  
871 the extent to which that is a potential benefit. There are a  
872 few States that have reported some cost savings. From our  
873 perspective, those savings always have to be offset by  
874 ensuring that eligibility is correctly calculated.

875 Mr. {Green.} Well, and I agree, and I know a lot of

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876 States have a 6-month eligibility, and if you have a senior  
877 citizen who forgets to return the letter, you know, instead  
878 of being treated for diabetes they will end with an episode  
879 and end up even costing more. Again, to GAO and CMS: Can  
880 GAO and CMS describe the costs to the State and federal  
881 budget associated with the ongoing determinations of whether  
882 people are eligible for Medicaid? For example, my State  
883 requires people on Medicaid to be determined eligible every 6  
884 months, and despite the fact that most people who are on  
885 Medicaid are eligible for the program for much longer period  
886 of time and it requires adult Texans on Medicaid to show up  
887 in person for their redetermination, and I know we can cut  
888 our Medicaid rolls by making that happen. The problem is  
889 that that increases our costs by making someone who may be so  
890 ill or a senior citizen drop off and then get back on. Is  
891 there any quantification of that?

892 Ms. {Yocom.} We have not done any quantification of the  
893 costs and benefits associated with that.

894 Mr. {Green.} Because I know on a State level,  
895 oftentimes they can quantify that if they do this, this will  
896 cut our rolls X amount, but in the long run, those folks who

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897 are typically so ill, they will be back on and much more  
898 costly. I would sure appreciate it if there was an option on  
899 that.

900 My last question to the GAO. Where should we assign the  
901 government expenditures for the following hypothetical? A  
902 Medicaid beneficiary with diabetes eligible for and enrolled  
903 in Medicaid is removed from the rolls because he or she  
904 failed to respond to a letter sent by the State to confirm  
905 their residency at a particular address. Two months later,  
906 that person has a diabetic event because the diabetes went  
907 unmanaged and is reenrolled in Medicaid at the time and now  
908 the costs are more expensive of inpatient and emergency care  
909 is billed to Medicaid. If that person were just covered by  
910 Medicaid for those two months, it would be more likely we  
911 wouldn't have seen those episodic costs. In your opinion,  
912 should these added costs be categorized as waste, fraud and  
913 abuse, and if not, where should we categorize that excessive  
914 waste and avoid unnecessary spending?

915 Ms. {Yocom.} Sir, certainly getting care earlier is  
916 always beneficial to the patient. Our work on preventive  
917 services and taking a look at trying to balance costs and

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918 benefits, it is difficult to come up with an exact measure of  
919 cost and/or savings, and I don't believe that GAO has done  
920 that.

921       Mr. {Green.} Well, I understand, and I have a couple of  
922 seconds left. The private sector in some of the studies we  
923 have seen, both from businesses who provide the health care  
924 can show that they can save money for that continuing care,  
925 for that continuing much more reasonable maintenance of an  
926 illness instead of waiting for that episode.

927       So Mr. Chairman, I would hope we would look at that not  
928 only from the private sector but also for Medicaid and  
929 Medicare, and I appreciate the time. I will yield back.

930       Mr. {Pitts.} The Chair thanks the gentleman and now  
931 recognizes the gentleman from Louisiana, Dr. Cassidy, 5  
932 minutes for questions.

933       Dr. {Cassidy.} Thank you, sir.

934       Tagging off of what Mr. Pallone, now, in your testimony,  
935 you say that for every \$1 spent, the program saves \$7.90, and  
936 it begs the question, that if you have to take a 2 percent  
937 across-the-board cut, why are they going to cut the programs  
938 that would save you \$7.90 per dollar spent? Is the

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939 management so inconsiderate of return on investment that they  
940 are going to cut something that saves \$7.90 per dollar spent?  
941 That is the testimony you suggested.

942 Dr. {Budetti.} Dr. Cassidy, thank you for that  
943 question. As you know, the specific cuts related to the  
944 sequester have not occurred yet. There has been a lot of  
945 internal planning and preparation for the way to do any cuts  
946 if they should take effect.

947 Dr. {Cassidy.} I have limited time. So if the taxpayer  
948 is listening and the taxpayer is wondering what kind of  
949 management would cut a program which has an ROI of \$7.90 per  
950 dollar spent, and that is your testimony, what was management  
951 thinking that this would even be on the table?

952 Dr. {Budetti.} Well, what I would say, sir, is that the  
953 thinking is that our number one priority is making sure that  
954 beneficiaries get the medical care that they need, and if we  
955 have--

956 Dr. {Cassidy.} But clearly, if Mr. Pallone is right,  
957 that the money you save goes back into the trust fund in  
958 order to support that medical care, I think the taxpayer has  
959 every right to wonder what in the heck he is spending money

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960 for. If we are cutting something with an ROI of \$7.90 per  
961 dollar spent, do you see my concern?

962 Dr. {Budetti.} I do see your concern. I also know that  
963 in the immediate short term, we have to worry about our  
964 principal mission, which is making sure that beneficiaries--

965 Dr. {Cassidy.} So there is nothing else that can be cut  
966 between actually paying for medical services and something  
967 which gives you an ROI of \$7.90 per dollar spent?

968 Dr. {Budetti.} There are very few things that have been  
969 exempted under the terms of the sequester.

970 Dr. {Cassidy.} I will tell you, it calls into question  
971 the wisdom of your management.

972 Secondly, you create the impression that if we cut under  
973 the sequester all these valuable things, but then what Dr.  
974 Burgess just brought up, which I am sure is because of his  
975 staff's good homework, not his own, that only one out of  
976 seven of these things demanded by the Affordable Care Act,  
977 which passed in 2010, has been fully implemented. It doesn't  
978 seem like a sequester cut now is going to be that which is  
979 fatal to their implementation. It actually seems as if there  
980 is kind of a casual timeline anyway.

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981 Dr. {Budetti.} Sir, I would point out that there are a  
982 few more pages of provisions that actually have been  
983 implemented that--

984 Dr. {Cassidy.} But I am speaking specifically about  
985 waste, fraud and abuse.

986 Dr. {Budetti.} That is exactly what I am talking about.  
987 We have implemented many provisions in the Affordable Care  
988 Act that have greatly strengthened our ability to fight  
989 waste, fraud and abuse, and in doing so, we always have to  
990 establish our priorities and allocate our resources  
991 appropriately.

992 Dr. {Cassidy.} Well, if we are going to establish  
993 priorities, then I would suggest that the taxpayer would like  
994 that you continue to spend money which gives you a \$7.90  
995 return on investment per dollar spent.

996 Now, let me move on, and I don't mean to grill but this  
997 is obviously a process. We are all familiar with the New  
998 Yorker article about McAllen, Texas, under Medicare, the  
999 hospital in McAllen spent 180 percent of a cohort, of the  
1000 amount spent on a cohort in El Paso. There is a follow-up  
1001 article on that in Health Affairs in which Blue Cross Blue

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1002 Shield patients, Texas Blue Cross Blue Shield, 7 percent less  
1003 was spent for the cohort in McAllen than in El Paso. Under  
1004 CMS, it is 180 percent more. On Blue Cross Blue Shield, it  
1005 is 7 percent less. It seems like the problem may not be the  
1006 docs, the patients or the hospital but it may be CMS's  
1007 systems, just looking at the contrast between the two payers  
1008 and the results they get. What comment would you have on  
1009 that?

1010 Dr. {Budetti.} I would say that one of the advantages  
1011 of our having established the strike forces under the joint  
1012 Department of Justice and Health and Human Service aegis has  
1013 been to look at the highest fraud areas very carefully.

1014 Dr. {Cassidy.} But why did Blue Cross Blue Shield  
1015 figure this out prospectively and we are having to do strike  
1016 forces to get it retrospectively?

1017 Dr. {Budetti.} The populations that are being served,  
1018 sir, are very different. The situations are very different.

1019 Dr. {Cassidy.} Sixty-four years old and 65 years old,  
1020 these are the same patients in the same hospital with the  
1021 same doctors. Again, this seems somewhat of an indictment  
1022 upon the system because there is not that much difference--I

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1023 am a doc--between something who is 64 and 65.

1024 Dr. {Budetti.} I don't have a specific answer for you  
1025 on that, in that area. I would be happy to look for, you  
1026 know, anything more specific, but I will say that we are  
1027 focusing on the high-fraud areas and we are making major  
1028 progress in identifying discrepancies like that and working  
1029 together with law enforcement and with the private sector to  
1030 do something about it.

1031 Dr. {Cassidy.} Thank you for your testimony. I yield  
1032 back.

1033 Dr. {Budetti.} Thank you, sir.

1034 Mr. {Pitts.} The Chair thanks the gentleman and now  
1035 recognizes the gentlelady from California, Ms. Capps, 5  
1036 minutes for questions.

1037 Mrs. {Capps.} Thank you, Mr. Chairman. I again thank  
1038 the panelists for being here today.

1039 Dr. Budetti, Dr. Burgess asked about several projects  
1040 CMS is implementing from the Affordable Care Act, and you  
1041 didn't really have time to address them. Would you like to  
1042 take a minute now to tell us what CMS has been implementing  
1043 from the ACA?

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1044 Dr. {Budetti.} There are many provisions of the  
1045 Affordable Care Act that we have implemented. Some of the  
1046 biggest ones involve the risk-based screening of providers  
1047 and suppliers, which is a new way of identifying the  
1048 suppliers and providers that are in the limited-risk group  
1049 and are subjected to very detailed background checks but not  
1050 to the same level of scrutiny as others. That is a very  
1051 extensive program. We have established a program to alert  
1052 States when someone is suspended or is terminated by one  
1053 Medicaid program or by Medicare for cause so that other  
1054 States can keep them from entering their program. That is an  
1055 important step forward. We have implemented a number of  
1056 aspects of our collaboration with law enforcement that have  
1057 really moved things forward on that front. There are many  
1058 provisions of the Affordable Care Act that have strengthened  
1059 our ability to fight fraud, waste and abuse and we have  
1060 implemented a great number of them.

1061 Mrs. {Capps.} Thank you. You know, the hearing is  
1062 about fraud, waste and abuse. We know these are significant  
1063 problems for both public and private health care payers. The  
1064 scope and complexity of health care itself as well as the

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1065 diverse payers and the systems we have to pay for it  
1066 certainly adds to the challenge. Both CMS and GAO  
1067 acknowledge that we don't really know the true scope and cost  
1068 of waste, fraud and abuse to the Federal Government.

1069 My question has to do with how we can begin to get our  
1070 hands around measuring the scope and the extent of the  
1071 problem. Unless we do, we won't really know how to tackle it  
1072 or how much to spend doing that. In that context, how do we  
1073 measure the effectiveness of the efforts being undertaken  
1074 now, just some of the problems that you just described?

1075 Dr. {Budetti.} Sure. We have taken steps towards  
1076 developing the methodology for measuring probable fraud. We  
1077 intend to implement that in one particular arena, which is  
1078 home health, and to apply that methodology. It involves a  
1079 very sophisticated approach because as Ms. King pointed out,  
1080 people don't often volunteer that they have committed fraud  
1081 so we can't do a simple survey, but we have made substantial  
1082 progress toward having a methodology in place to estimate  
1083 probable fraud. We intend to do that first in home health,  
1084 and then once we have learned how well that works to apply it  
1085 to other areas. We have done a very thorough job in the

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1086 government of measuring improper payments, and improper  
1087 payments encompass a wide range of reasons why a certain  
1088 payment should not have been made, and we would very much  
1089 like to move forward with a reliable measure of probable  
1090 fraud.

1091 Mrs. {Capps.} One sort of parallel question that hasn't  
1092 been brought up. Measuring the impact of prevention--that is  
1093 my background, public health--this is really hard to measure  
1094 in any way. Can you share some of the metrics and benchmarks  
1095 that you are using or working on in the area of preventive  
1096 health?

1097 Dr. {Budetti.} Sure, and I appreciate the question very  
1098 much. I think the best way to illustrate it is with an  
1099 example. When we put into place one of our models in the  
1100 Fraud Prevention System, we identified a pattern of behavior  
1101 that raised very strong suspicions, and we ended up  
1102 identifying a particular potential fraudster who fell into  
1103 the same pattern that others had perpetrated, others had  
1104 billed hundreds of thousands of dollars or even millions of  
1105 dollars to the program, but this particular one, I believe,  
1106 had only billed us for \$4,000 but it was the same scam and it

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1107 was clear that they were just starting up and getting going,  
1108 and so we are faced with the question of how do we take  
1109 credit for finding something that had only billed us for  
1110 \$4,000. Now, that is exactly where we want to be. I mean, I  
1111 would rather it be at \$2,000 but \$4,000 is a lot better than  
1112 \$4 million, but yet if we just say that we stopped something  
1113 that prevented that when somebody had already billed us for  
1114 \$4,000 doesn't sound very impressive. So we have to figure  
1115 out the best way to put, as the statute requires us, to put a  
1116 dollar value on prevention, and that is a challenge but we  
1117 are taking it on.

1118 Mrs. {Capps.} I appreciate that. Thank you very much,  
1119 and I yield back.

1120 Mr. {Pitts.} The Chair thanks the gentlelady and now  
1121 recognizes the gentleman from Illinois, Mr. Shimkus, 5  
1122 minutes for questions.

1123 Mr. {Shimkus.} Thank you, Mr. Chairman.

1124 I am not sure if it was Ms. Yocom or Ms. King who made  
1125 the statement of trying to define improper payments from  
1126 fraudulent payments.

1127 Ms. {King.} That would be me.

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1128           Mr. {Shimkus.} And, you know, we are almost in like  
1129   bizarro world a little bit because improper payments,  
1130   fraudulent payments, theft, abuse--Dr. Budetti, when you  
1131   mentioned this \$4,000, following this scheme of abuse, you  
1132   know, that is what credit card companies do every day. Dr.  
1133   Burgess is right.

1134           Now, I know, sir, you have done a pilot program on the  
1135   magnetic strip card, identification card, I think it was in  
1136   Indiana. Not a lot of fraud there. One, I would ask if we  
1137   could get a release of the findings of that pilot program.  
1138   Also, you know, I have also been involved in the magnetic  
1139   chip issue. There was a bill last year by Mr. Gerlach. I  
1140   would encourage all my colleagues to look at that bill from  
1141   last year, 2925. It will probably get reintroduced this  
1142   year. If major financial institutions can call someone and  
1143   ask about an improper payment that is outside their area  
1144   within 12 hours of the payment being made, for the life of  
1145   me, I don't understand why that is not a good system to help  
1146   us identify improper payments and fraudulent payments. The  
1147   billing on both ends, a statement released. Well, that is  
1148   why we have a bill because we don't think you have

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1149 effectively looked at it and we are slow, we are  
1150 bureaucratic, we are not private sector and we just can't  
1151 seem to get it done, and that hurts the payments to other  
1152 folks. So that is my statement, that there is another bill  
1153 coming to try to get us to move to a current world technology  
1154 of a payment system that will help identify improper and  
1155 fraudulent payments.

1156 A real crisis in Medicaid is the funding. That is why  
1157 these hearings are important, but in Illinois, we have  
1158 \$1,922,000,000 in backlog of unpaid bills that are sitting in  
1159 our comptroller's office. There is another \$700 million  
1160 worth of bills that are being held by the State government  
1161 before they give them to the comptroller, when then you add  
1162 those up, that is \$2.6 billion in unpaid Medicaid  
1163 reimbursements to our providers. The delay in payment is 3  
1164 to 8 months, and of course, when they do pay, they are paying  
1165 70 percent of what the private sector is paying for the  
1166 health care delivery. We are a disaster in Medicaid  
1167 reimbursement to our health care providers, some smaller ones  
1168 going broke or just saying we can't provide Medicaid anymore.  
1169 Having said that, I know that, Ms. Yocom, the biggest

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1170 challenge to the Medicaid program, through federal  
1171 initiatives is the lag in Medicaid data from the States, and  
1172 you have reviewed the discrepancy in the data from States and  
1173 reported that CMS will need more reliable data for assessing  
1174 expenditures and measuring performance in the Medicaid  
1175 program. I would encourage you to get current data on  
1176 Illinois.

1177 Can you please outline the GAO work on aligning the  
1178 States' expenditure data which in your 2012 October report  
1179 showed significant discrepancies and reported expenditures of  
1180 more than \$40 billion for fiscal year 2009? Even in  
1181 Washington, \$40 billion is a bad discrepancy of reporting on  
1182 payments.

1183 Ms. {Yocom.} Yes, sir. We did take a look at two  
1184 expenditure systems that CMS operates. The first is an  
1185 expenditure system that is the basis with which States claim  
1186 their federal match. The second is a statistical system that  
1187 takes the activities performed in the Medicaid program and  
1188 looks at them from the perspective of the beneficiary. So it  
1189 is beneficiary-specific payments. These two systems are not  
1190 measuring the same thing, so there is some acceptance that

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1191 they should be different, but we could not quantify the  
1192 source of all the differences or the reasons why those  
1193 differences occurred. At the end of the day, we ended up  
1194 with about a 90 percent national match but on the State-by-  
1195 State basis, there were significant variation across the  
1196 different--in terms of the two systems.

1197 Mr. {Shimkus.} Thank you, Mr. Chairman.

1198 Mr. {Pitts.} The Chair thanks the gentleman and now  
1199 recognizes the gentlelady from Illinois, Ms. Schakowsky, for  
1200 5 minutes for questions.

1201 Ms. {Schakowsky.} Thank you, Mr. Chairman.

1202 There was an earlier discussion about McAllen, Texas,  
1203 and CMS's antifraud activities to root out fraud and  
1204 unnecessary spending. Dr. Budetti, you mentioned the HEAT  
1205 task force as catching fraud on the back end, but isn't it  
1206 also true that many of the Affordable Care Act provisions you  
1207 are implementing are catching fraud on the front end? For  
1208 example, the Fraud Prevention System, the new provider  
1209 screening requirements, the cross-checking between bad  
1210 providers and Medicare and Medicaid. So is it not accurate  
1211 to say that--so my sense is that it is not accurate to say

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1212 that you are doing nothing in these high-fraud areas on the  
1213 front end, and I wondered if you could talk about how the  
1214 front-end prevention is paying off.

1215 Dr. {Budetti.} Thank you, Ms. Schakowsky. One of the  
1216 things that I am extremely pleased with is our growing  
1217 collaboration with law enforcement. Our law enforcement  
1218 colleagues are very fond of saying that they don't believe  
1219 that they can prosecute their way out of the current fraud  
1220 situation after the fact, and so they have been very active  
1221 partnering with us on the prevention side and on the early  
1222 detection side as well, and we have agents from both the  
1223 Office of Inspector General and the FBI who are assigned to  
1224 work directly with us and who have been very much involved in  
1225 helping us build the Fraud Prevention System and the models  
1226 in the Fraud Prevention System and how to follow up on it,  
1227 and when we do that, we are taking an across-the-board  
1228 approach which says we want to stop as much as we can before  
1229 it ever happens, and that is what we are able to do with  
1230 activities under the Fraud Prevention System. We want to  
1231 catch it early and take administrative action because if  
1232 somebody has only stolen, say, \$4,000, that may very well not

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1233 be a case of law enforcement could ever pursue because of  
1234 resources. But then we also want to work together when in  
1235 fact some people do squeeze through and we have to chase  
1236 after them after the fact. So our approach is to shift to  
1237 moving beyond pay and chase but we cannot pay and chase in  
1238 that sense.

1239 Ms. {Schakowsky.} I wanted to ask you also about the--I  
1240 feel like sometimes we overlook the importance that  
1241 beneficiaries can play in fighting fraud, and I am wondering  
1242 if you could discuss how Medicare beneficiaries can help CMS  
1243 identify fraud and what steps CMS may have taken to make it  
1244 easier for beneficiaries to spot fraud or errors.

1245 Dr. {Budetti.} So I don't know if any of the members of  
1246 the subcommittee have looked at their explanation of benefits  
1247 recently, but when I got to CMS and we were reviewing the  
1248 Medicare summary notices, we decided that we could do a  
1249 better job of communicating both what the content was and the  
1250 ability to highlight where there might be problems, and so  
1251 over a period of time working with focus groups with Medicare  
1252 beneficiaries and redesigning the Medicare summary notice, we  
1253 have now produced a new statement that is going out for the

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1254 first time this year. It has been available for people who  
1255 would get their summary notices online previously but it is  
1256 now going into the mail, and this will be much easier to read  
1257 and much easier for individuals to look to see whether or not  
1258 there is a problem with the billing that is attributed to  
1259 their having gotten services and be able to raise questions.

1260 In responding to that, we have also vastly upgraded and  
1261 made much more user friendly the 1-800-MEDICARE call system  
1262 way of dealing with calls that come in that raise questions  
1263 about possible fraud, and last year something like 50,000 of  
1264 the calls that came in led to some level of escalation of our  
1265 investigation to look behind an incoming call. So on both  
1266 the summary notices and on the changes to the 1-800-MEDICARE  
1267 call system and, on top of that, to our outreach to Medicare  
1268 beneficiaries to inform them about these changes, we are very  
1269 much engaging because our feeling is that, you know, 45  
1270 million, 50 million beneficiaries out there fighting fraud  
1271 with us is one of the--

1272 Ms. {Schakowsky.} Let me just say, I would like to see  
1273 an example or two of the savings from beneficiaries.

1274 Dr. {Budetti.} I would be happy to.

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1275 Ms. {Schakowsky.} Thank you.

1276 Mr. {Pitts.} The Chair thanks the gentlelady and now  
1277 recognizes the gentleman from Kentucky, Mr. Guthrie, 5  
1278 minutes for questions.

1279 Mr. {Guthrie.} Thank you, Mr. Chairman, and thank you  
1280 for coming and I appreciate your having this hearing on  
1281 waste, fraud and abuse within the Medicare system and hope we  
1282 continue to explore this.

1283 But before I begin my questions, I would just like to  
1284 bring to the committee's attention a company in Kentucky that  
1285 has a plan to bring savings to the Medicare program through  
1286 the home health program integrity measures. The industry's  
1287 2010 proposal to limit outlier payments has been successful  
1288 in saving the program roughly \$900 million per year in the  
1289 first 2 years alone. Almost Family's proposal will build on  
1290 that, and that includes episode limits for a beneficiary to  
1291 get at the bad actors who are billing for lengthy episodes of  
1292 care in excess of three or four per beneficiary. Estimates  
1293 predict this would save Medicare nearly \$1 billion per year.  
1294 We should look at this and other industry proposals for a way  
1295 to save money within the system and get the bad actors that

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1296 are fraudulently draining Medicare dollars. I found that a  
1297 lot of industries with good actors who are trying to do  
1298 service and do things correctly immediately want to point out  
1299 the bad actors immediately want to point out the bad actors  
1300 because that affects the whole Medicaid and Medicare program.

1301 I do have a question for Ms. Yocom and Dr. Budetti. I  
1302 am interested in reviewing how the States use the funds in  
1303 the health care law related to Medicaid IT payments. As you  
1304 know, States are eligible to receive a 90 percent match from  
1305 the Federal Government for the design and development of new  
1306 systems through 2015. Has GAO initiated any integrity review  
1307 of these funds and how they are expended to date?

1308 Ms. {Yocom.} We have not instituted an integrity review  
1309 of the 90/10 matching States. There has been interest in  
1310 that, and I believe we are planning to respond to that  
1311 interest.

1312 Mr. {Guthrie.} What are you doing now with CMS to  
1313 ensure--this is a significant funding stream--that funds are  
1314 being appropriately? How are you managing that? I know you  
1315 don't have a GAO study or initiative but how are you managing  
1316 that to make sure it is being spent appropriately?

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1317 Dr. {Budetti.} We are working very closely with the  
1318 States and encouraging the States to implement their advances  
1319 in data systems and technology because that is a major aspect  
1320 of oversight of the Medicaid program. If you would like more  
1321 details on that, I would be happy to get you a substantial  
1322 amount of information on just what our approach is. But yes  
1323 we do believe that having adequate and sophisticated data  
1324 systems at the State level that can both analyze data and  
1325 supply data better to the Federal Government that we need for  
1326 oversight is one of our top priorities.

1327 Mr. {Guthrie.} Thank you for that answer, and I do have  
1328 2-1/2 minutes I can yield, or yield to Dr. Burgess.

1329 Mr. {Pitts.} Dr. Burgess.

1330 Dr. {Burgess.} I appreciate the gentleman for yielding.

1331 Director Budetti, let me just ask you a couple of  
1332 questions along the lines that Ms. Schakowsky was just  
1333 asking. First off, do you have an app for that?

1334 Dr. {Budetti.} For--

1335 Dr. {Burgess.} When you talked about your new  
1336 explanation of benefits and forms that you are providing  
1337 people.

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1338 Dr. {Budetti.} Well, that is a very interesting  
1339 question, Dr. Burgess, because we have been looking into that  
1340 possibility.

1341 Dr. {Burgess.} Well, I did a little research sitting  
1342 here at the dais, and I typed the word ``Medicare'' into the  
1343 app store and you don't have one but other people do, and it  
1344 just seems, you know, knowing the way the world works, most  
1345 people who get to the age where they are signing up for  
1346 Medicare are going to be asking their 12-year-old grandson to  
1347 help them navigate the smartphone. It may be something that  
1348 is worth looking into.

1349 I thank the gentleman for yielding, and I will yield  
1350 back.

1351 Dr. {Budetti.} In my case, I will rely on my 17-year-  
1352 old grandson and my 5-year-old and my 4-year-old.

1353 Dr. {Burgess.} Great.

1354 Dr. {Budetti.} The Chair thanks the gentleman and  
1355 recognizes the gentlelady, Dr. Christensen, 5 minutes for  
1356 questions.

1357 Dr. {Christensen.} Thank you, Mr. Chairman, and welcome  
1358 to the panelists this morning.

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1359 I want to follow up also on Congresswoman Schakowsky's  
1360 question, and I am glad to know that the notices to  
1361 beneficiaries have improved. I am sure they have improved a  
1362 lot over the 16 years that I have been having to explain  
1363 them. And you pretty much answered how beneficiaries can  
1364 help detect fraud, and I know that many seniors are just as  
1365 concerned as we are with program integrity and are glad to  
1366 help in fighting fraud. My constituents participate in the  
1367 Senior Medicare Patrol program, and they seem to be very  
1368 active. How widespread is this program across the States and  
1369 territories and has it shown itself to be helpful in ensuring  
1370 or reporting and helping program integrity?

1371 Dr. {Budetti.} Dr. Christensen, when I got to my job at  
1372 CMS, I decided that one thing we should do was invent the  
1373 Senior Medicare Patrol and then I found out it already  
1374 existed, so we worked very closely to help expand the  
1375 resources available to the Senior Medicare Patrol for the  
1376 first couple of years that I was on the job. It does extend  
1377 to all States. There are programs operating, and I believe  
1378 through the territories as well. It does involve many  
1379 Medicare beneficiaries, and they receive extensive training

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1380 in how to help seniors protect their identities, how to  
1381 identify problems with potential fraud or abuse, and what to  
1382 do about it and how to report it. So we consider this a very  
1383 strong adjunct program of ours and we have taken a lot of  
1384 initiative in helping to support that program.

1385 Dr. {Christensen.} Thank you. I have a provider  
1386 question as a person who has practiced medicine for more than  
1387 20 years before coming here, and having heard from my  
1388 colleagues back then but also more so since I have been here  
1389 about sometimes overzealous investigations and sometimes  
1390 unwarranted investigations. But I am very interested, like  
1391 my colleagues are, that efforts to fraud are effective, but  
1392 also that they are fair to providers, especially those  
1393 providing care to our Nation's most underserved communities  
1394 who are sicker and where there are fewer resources, and I  
1395 just want to say for the record, of course, and I am sure you  
1396 will agree, that the vast majority of providers are honest  
1397 actors who are not causing problems.

1398 I would like to find out what CMS is doing to ensure  
1399 that providers are your partners and not necessarily  
1400 adversaries, and how effectively are you able to distinguish

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1401 between who the bad actors and the good guys are, so that  
1402 some of my colleagues or former colleagues are not feeling  
1403 that they are being treated fairly in some of these  
1404 investigations.

1405 Dr. {Budetti.} First of all, this is a very high  
1406 priority for us. I mentioned early on that we want to make  
1407 the system easier and more efficient for the legitimate and  
1408 vast majority of providers while making it much harder and  
1409 more likely to spot the ones who don't belong in the program,  
1410 and along those lines, I will give you one example, that in  
1411 developing improvements in our enrollment processes, we  
1412 worked very closely with the provider community. There is a  
1413 long list of changes that we made to the enrollment system  
1414 that came specifically out of group meetings that we had with  
1415 providers, working side by side with them to have demonstrate  
1416 to us online what the problems were that they were having  
1417 with our system so that we could implement a fix to that  
1418 problem. So that has been a big part of it. We have gotten  
1419 a lot of positive feedback from the provider community in  
1420 doing that.

1421 And in terms of the audits and the potential for

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1422 problems, one of the big advantages of moving the Medicare  
1423 and Medicaid program integrity operations together into the  
1424 Center for Program Integrity is, it is allowing us to pursue  
1425 coordination and integration of a wide range of audits  
1426 precisely for that reason, to make sure that we are doing the  
1427 job but we are doing it as respectfully and appropriately as  
1428 possible.

1429 Dr. {Christensen.} Thank you. And on the enrollment, I  
1430 understand you are transitioning away from a paper-based  
1431 system of provider enrollment. Do you feel that you are able  
1432 to capture the rural providers and some of those providers  
1433 that are in the poor, urban communities as well?

1434 Dr. {Budetti.} That is a very important consideration,  
1435 and I will--I know that we have worked with large groups but  
1436 I will be sure that we will check on what our outreach  
1437 efforts have been.

1438 Dr. {Christensen.} Thank you, Mr. Chairman. I yield  
1439 back.

1440 Mr. {Pitts.} The Chair thanks the gentlelady and now  
1441 recognizes the gentleman from Virginia, Mr. Griffith, 5  
1442 minutes for questions.

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1443           Mr. {Griffith.} Thank you very much. I would like to  
1444 pick up where Dr. Christensen left off because some of my  
1445 providers don't feel like there is much of a partnership  
1446 going on, and I would direct your attention specifically to  
1447 the RAC program where I am advised that the American Hospital  
1448 Association based on self-reported data indicates that  
1449 nationally, 74 percent of the appeals are being overturned in  
1450 favor of the hospitals when this comes up, and apparently in  
1451 my region, it is 78 percent. And it would seem to me, I  
1452 mean, one of the problems that they are having is, they feel  
1453 like these independent contractors are taking the money and  
1454 saying wait a minute, we are not going to release this unless  
1455 you go through the process, push it to the end, and then if  
1456 you win in the end, you will get your money. And so this is  
1457 a real concern for them because while we all want to get the  
1458 bad guys, the hospitals by and large in my district are not  
1459 the bad guys, they are the good guys, and I may not know of  
1460 some exception to that rule but I think they are all pretty  
1461 good providers and they are trying to do the best they can.  
1462 And 78 percent being overturned on appeal indicates there is  
1463 a problem in the system. Wouldn't you agree?

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1464 Dr. {Budetti.} So Mr. Griffith, I will say that we want  
1465 to get it right, and we want to get it right for the good  
1466 guys and we want it to be as efficient as possible. The very  
1467 high--we have heard some very high appeal successes, but it  
1468 is only a small fraction of total RAC determinations. So  
1469 when appealed, the overturn rates seems to be growing, but  
1470 still only a very small fraction of total RAC determinations  
1471 are being appealed in the first place.

1472 But having said that, we do want to get it right and so  
1473 we have put into place a number of checks to look back at  
1474 what the guidance is that is going to the recovery auditors,  
1475 what the number of documents that they are able to request.  
1476 There are a lot of things that we are doing to make sure that  
1477 the system is working.

1478 Mr. {Griffith.} Well, I would encourage you to do that.  
1479 I would say, I don't come from a medical background. I was a  
1480 country lawyer, and most of the time when people lose, if it  
1481 is close, they don't appeal, and I understand that. When  
1482 they appeal, it means that they really think they have been  
1483 treated wrongly. That being said, in my profession, if you  
1484 had a 78 percent turnover rate, you would have a judge being

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1485 removed, and that is what I am looking at is, that, you know,  
1486 in this case, if we can't get it straightened out, we may  
1487 have to look at a different system because that is not fair  
1488 to the medical providers. And so I appreciate that.

1489 Also, one of the other complaints they had that ought to  
1490 be simple to fix is that when they are denied, they get a  
1491 letter, but when they win or they get it overturned, they  
1492 don't get a letter so all of a sudden a check comes in and  
1493 then they have to track down, well, why did we get this  
1494 check. It sure would be nice if there was a tracking number  
1495 or a letter that came with that that said we have decided you  
1496 were right and here is your check. Can you fix that?

1497 Dr. {Budetti.} I will make every effort to look into  
1498 that, sir. I have initiated a number of actions to, shall we  
1499 say, improve our communications, and I will put this on the  
1500 list.

1501 Ms. {King.} Sir, and if I might add?

1502 Mr. {Griffith.} Yes, ma'am.

1503 Ms. {King.} There has been a change in the design of  
1504 the RAC program so that if the provider wins on appeal, the  
1505 RAC doesn't get to keep the contingency payment, and that is

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1506 a change from earlier. And I would also add that we have  
1507 been asked to look into--well, we have work underway now that  
1508 looks at what is happening in postpayment review and the  
1509 coordination of those contractors that are doing that and  
1510 whether there is duplication, and also to look at the  
1511 communications that they are issuing. So we will have  
1512 something to say on that later this year.

1513 Mr. {Griffith.} Well, I really appreciate that, and I  
1514 hope that you all will continue to work to make this an  
1515 easier process for the providers that are just trying to do  
1516 what they do, and that is to help heal people.

1517 That being said, let me shift gears slightly and just  
1518 ask if there isn't more you can do in the private sector. In  
1519 our area, I represent southwest Virginia, which includes a  
1520 big chunk of Appalachia, and we have had a problem with  
1521 abusive drug usage, and some of the private companies are  
1522 doing things that actually work to stop that such as they  
1523 have one they call the lock-in program where if somebody is  
1524 abusing, they don't stop giving them drugs if they need help  
1525 but they don't let them go from doctor to doctor; they are  
1526 locked in. Can we do things like that to try to look and see

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1527 what the private sector is doing like the lock-in program?

1528 And there are others that I have here but my time is running  
1529 out.

1530 Dr. {Budetti.} We have been looking at what the options  
1531 are because we agree that where there are problems such as  
1532 the ones that you mentioned, we should look to do the most we  
1533 can. I will say that the constraints that we have, certain  
1534 rules that do or do not apply in the Medicare program, we may  
1535 have different options in terms of what we can pursue. I  
1536 don't know if you have looked at this or not.

1537 Ms. {King.} We have actually looked at it and we have  
1538 made recommendations that CMS consider that, and I think  
1539 their response back to us has been that they believe there  
1540 are some legal restrictions.

1541 Mr. {Griffith.} Well, let us just say you are at the  
1542 right place to get those legal restrictions changed, and if  
1543 you need something that helps catch the bad guys but makes it  
1544 easier on the health care providers, we would be glad to  
1545 oblige.

1546 Mr. {Pitts.} The Chair thanks the gentleman. The  
1547 gentleman yields back. The Chair recognizes Ms. Ellmers, the

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1548 gentlelady from North Carolina, 5 minutes for questions.

1549 Mrs. {Ellmers.} Thank you, Mr. Chairman, and thank you  
1550 to the panel.

1551 I have a couple of questions for you, and I am probably  
1552 going to run out of time, so I would ask that I be able to  
1553 submit some of my questions to you and that you would be able  
1554 to give me a written response within a reasonable amount of  
1555 time. Would that be--

1556 Dr. {Budetti.} Absolutely. We would be delighted to do  
1557 that.

1558 Mrs. {Ellmers.} Wonderful. Well, let me start off with  
1559 one question, and Ms. Yocom, I think this question is best  
1560 suited to you, but feel free for anyone to answer.

1561 Back in 2008, when Congress passed Section 1940 as  
1562 amended to the Social Security Act, Section 1940 required  
1563 that the Department of Health and Human Services through CMS  
1564 to ensure that each of the 50 States implement an electronic  
1565 assessment verification system for their Medicaid programs to  
1566 ensure current and future beneficiaries meet the eligibility  
1567 standards to qualify for assistance. My question for you is,  
1568 since that time, being the 5 years that have passed now, how

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1569 many States have fully implemented this program?

1570 Ms. {Yocom.} I may have to provide that for the record.

1571 We did do work looking at that for long-term care

1572 eligibility, and I believe it wasn't all States yet.

1573 Mrs. {Ellmers.} Okay. Well, my understanding based on

1574 the information that I have is that there is one State out of

1575 50 that has put this in place, and that is the State of

1576 Florida. That is an incredible amount of time for this

1577 process to not have been put in place, and, you know, for me

1578 in North Carolina, this is significant. Why is it important

1579 to us? Because the costs--you know, because the system isn't

1580 put in place, you know, the losses that our State is facing

1581 is about \$275,000. At this point, obviously, 5 years in the

1582 process, this should have been put in place. So I guess I

1583 would ask, what is standing in the way of that? What

1584 possible reason could there be that only one State be fully

1585 implementing this process?

1586 Ms. {Yocom.} Again, we will provide additional for the

1587 record, but I do believe that a lot of it is around data

1588 systems and Medicaid and the need for them to be upgraded and

1589 improved.

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1590           Mrs. {Ellmers.} Okay. Well, my next question, I am  
1591 going to shift gears a little bit here, and I don't know, Dr.  
1592 Budetti, this might be a question best suited for you. In  
1593 the durable medical equipment competitive bidding process,  
1594 one of my questions is for those facilities that have the  
1595 durable medical equipment. The number of audits has  
1596 increased dramatically. I have a number of 140 in 2010, up  
1597 to 4,199 in 2012. That is a significant number of audits.  
1598 Now, the audits themselves are basically giving that facility  
1599 45 days to report all information to basically show medical  
1600 necessity, and obviously their payment or actually taking  
1601 back the payment would be based on that information. Having  
1602 been a nurse for over 20 years, I know working in a  
1603 physician's office that, you know, you are dependent upon  
1604 that particular physician's office to provide that  
1605 information and then the facility or the company that has  
1606 provided the durable medical equipment is then incumbent to  
1607 report the information to you. In the current state of  
1608 health care with fewer physicians and physicians having to  
1609 decrease their overhead, that is a big problem. What are you  
1610 doing today to help decrease this cost of administrative cost

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1611 to these not only durable medical equipment companies but  
1612 also to physicians who are also facing this burden?

1613 Dr. {Budetti.} As you know, Congresswoman, durable  
1614 medical equipment has been an area that has been subject to  
1615 serious fraud in the past. It is one of the highest risk  
1616 areas.

1617 Mrs. {Elmers.} But sir, if I could interject--

1618 Dr. {Budetti.} But I will say--

1619 Mrs. {Elmers.} One of the issues that we were  
1620 delineating here is between improper payments and then fraud.  
1621 A signature or a date or an order is simply not fraud. So  
1622 having really identified that already, how could a company be  
1623 required to send back reimbursement or a physician's office  
1624 be required to send back reimbursement and then have to go  
1625 into an appeal process that could take up to 14 to 24 months  
1626 for that payment? Isn't that a little excessive?

1627 Dr. {Budetti.} So if there is a specific circumstance  
1628 that you would like us to look into to get the details, I  
1629 would be delighted to do that. I can tell you that this is  
1630 an area where we do need to be sure that the durable medical  
1631 equipment has been appropriately ordered by someone who is

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1632 qualified to order within the Medicare program and that there  
1633 is documentation for that. That is the legal requirement.  
1634 If there is an individual circumstance that appears to be  
1635 somewhat of, you know, a problem, why don't you contact us  
1636 and we will be delighted to get that information from you  
1637 and--

1638 Mrs. {Ellmers.} We will definitely do that.

1639 Dr. {Budetti.} --we will let you know where things  
1640 stand.

1641 Mrs. {Ellmers.} I am over my time, so thank you very  
1642 much.

1643 Dr. {Budetti.} You are welcome.

1644 Mrs. {Ellmers.} I thank the chairman for indulging me.

1645 Mr. {Pitts.} The Chair thanks the gentlelady and now  
1646 recognizes the gentleman from Texas, Mr. Hall, 5 minutes for  
1647 questions.

1648 Mr. {Hall.} Thank you, sir.

1649 Mr. Budetti, you mentioned the Recovery Audit  
1650 Contractors, the RAC, how you are expanding that program into  
1651 Medicaid, and I appreciate the fact that you and all the  
1652 money you saved the government, all the fraud that they

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1653 detect, and I see you as necessary with the abuse that is  
1654 abound, and I have kind of a follow-up question to Dr.  
1655 Christensen and Counsel McKinley.

1656 I have a company in my district that has been accused of  
1657 owing multiple millions of dollars back to the government  
1658 because RACs claimed that some of the services they provided  
1659 were unnecessary, just some of the services. They are now  
1660 working with CMS on a payment plan that they can afford if  
1661 they ever get in front of a judge, and lawyers--and I also  
1662 note that RACs are paid on commission. Is that correct?

1663 Dr. {Budetti.} The RACs are paid on a contingent-fee  
1664 basis, yes, sir, so they only get to--

1665 Mr. {Hall.} Well, you know, that is one of the things  
1666 that kind of got lawyers in trouble and probably brought  
1667 about the tort reform, that they would file cases with little  
1668 merit but an insurance company would pay it to save money by  
1669 paying it and not having to go to court. And it has brought  
1670 a lot of criticism for lawyers. I am a lawyer but I remember  
1671 a story, if I might tell it. You know, in Orlando, if you  
1672 have gone there, you land in an airplane and then you get on  
1673 a train and you go on it to where the tickets are made there,

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1674 Orlando, and going there the doors will close on you if you  
1675 are not careful, and just before they closed one time, a guy  
1676 hollered, I want you to know that I am a lawyer and just got  
1677 my degree last Monday night, and then the doors closed and  
1678 they went on down the tracks. Somebody said, I hate lawyers,  
1679 they are all geeks, and another guy in the crowd said, I  
1680 resent that. He said well, I am sorry, I didn't mean to  
1681 offend you. He said I am not a lawyer, I am a geek.

1682           Something brought about bad things in the tort reform.  
1683 Sometimes you know we do that. So I guess what I want to  
1684 really ask you about, you acknowledge that part of your role  
1685 is to strike an important balance to protect beneficiary  
1686 access to necessary health care services and reduce the  
1687 administrative burden on legitimate providers--I like that--  
1688 while ensuring that the taxpayer dollars are not lost to  
1689 fraud, waste and abuse, and I certainly support that. But  
1690 what are some specific, concrete steps that CMS could take to  
1691 work with legitimate providers who may inadvertently find  
1692 themselves ensnared by some of these antifraud initiatives?  
1693 I think there is a huge distinction that should be made  
1694 between a provider who is committing fraud, for example,

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1695 billing for services that weren't rendered, and just plain  
1696 making a mistake, and that is the situation I have in East  
1697 Texas where they have been called upon to make payments that  
1698 they are unable to make now, and if they are not able to get  
1699 to the legal service that can't reach them for over a year,  
1700 they have nothing to do but to shut their doors, and they  
1701 provide very wonderful services to people and they might have  
1702 made a mistake but they need a way to pay their out of it or  
1703 prove that they didn't make a mistake. And since you all are  
1704 paid on commission, you are going to be filing those. I  
1705 don't say that you just file anything that comes in the door  
1706 but if you don't file, you are on a commission basis, you  
1707 don't make any money if you don't file. Do you think this is  
1708 the best way to pay these contractors?

1709 Dr. {Budetti.} Sir, the contingent-fee approach, of  
1710 course, is a statutory requirement of the program.

1711 Mr. {Hall.} I know you didn't devise it, we devised it,  
1712 but what do you think about--

1713 Dr. {Budetti.} But I will say that as I said before,  
1714 about all of our programs, we want to get it right, and I  
1715 think that one of the things that we are doing is greatly

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1716 increasing our feedback to providers about exactly what the  
1717 findings from the RAC program and what steps they can take to  
1718 assure that they have the appropriate procedures in place in  
1719 their billing and appropriate documentation and appropriate  
1720 site of service so that we are giving them feedback. We are  
1721 giving them comparative reports. We are giving them  
1722 indications of what the RACs are finding and what the  
1723 underlying data are behind what the RACs are allowed to look  
1724 at by CMS. So we agree with you. We want the outreach to be  
1725 even more successful in terms of educating the provider  
1726 community, and we also want to be responsive to any specific  
1727 problems like that and so again, sir, if there is something,  
1728 a specific issue that you would like us to look into, we will  
1729 be happy to do that, but we are building as much feedback as  
1730 we can to try to make sure the program works as well as it  
1731 can.

1732 Mr. {Hall.} But the alternative is to go to the  
1733 courthouse, and these people can't get to the courthouse for  
1734 a long time because of the loads of a particular area, the  
1735 courts. So maybe I would like to talk to you sometime about  
1736 that.

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1737 My time is over. I thank the chairman.

1738 Mr. {Pitts.} The Chair thanks the gentleman, and that  
1739 concludes the first round of questioning. We will go to one  
1740 follow-up per side. Dr. Burgess, you are recognized 5  
1741 minutes for questions.

1742 Dr. {Burgess.} Thank you, Mr. Chairman.

1743 I think anyone who has watched this hearing this morning  
1744 gets a sense of the enormous amount of time involved in all  
1745 of these things, and what people have a hard time  
1746 understanding is why it does take so much time. It takes the  
1747 Government Accountability Office a little over a year to do a  
1748 study and to deliver that back either to the legislative  
1749 branch, where then it takes us time to come up with a  
1750 legislative fix, or to the agency, and we see 3 years into  
1751 the signing of the Affordable Care Act into law one out of  
1752 seven of the antifraud provisions have actually been enacted,  
1753 not to say that you are not working on the others but 3 years  
1754 does seem like a long time frame, and I don't know what can  
1755 be done to accelerate the process. I know when GAO gets a  
1756 request from us, they want to do a good job. It does take  
1757 time but somehow we need to make this all work and work to

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1758 the extent that we are not just delivering money to organized  
1759 crime.

1760 Let me just ask one last question, Dr. Budetti. To what  
1761 extent are HHS and CMS using commercial public record  
1762 database services such as those used by banks and retailers  
1763 to verify the identity of providers and beneficiaries before  
1764 claims are paid?

1765 Dr. {Budetti.} So we have put into place and are  
1766 building a system that will be even more extensive than it  
1767 has been in the past in terms of getting access to a variety  
1768 of databases such as the ones that you refer to in order to  
1769 verify the provider and supplier information and to identify  
1770 them. That is part of the Automated Provider Screening  
1771 System capabilities that we are continuing to build out, and  
1772 it will allow us to look not just at licensure and Social  
1773 Security death files and other things but also at a wider  
1774 range of databases that we will have access to and the system  
1775 is being used in specific ways right now and it will be  
1776 phased in as the core way of enrolling providers. So on the  
1777 enrollment and on the revalidation side, we are very  
1778 definitely moving in that direction and we have already made

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1779 a great deal of progress.

1780 Dr. {Burgess.} I assume at some point in the future it  
1781 is going to be linked to payments and billing as well.

1782 Dr. {Budetti.} The Fraud Prevention System and the  
1783 Automated Provider Screening System are specifically designed  
1784 to be able to interact and talk to each other, if you will,  
1785 so that the information we get from the one side can feed  
1786 into the other side, and so yes, that is exactly the way that  
1787 this is intended to operate.

1788 Dr. {Burgess.} Again, credit card companies figured  
1789 this out 25 years ago, and it seems like we ought to be  
1790 farther along than we are now.

1791 Thank you, Mr. Chairman, for calling the witnesses. I  
1792 will yield back my time.

1793 Mr. {Pitts.} The Chair thanks the gentleman and now  
1794 recognizes the Ranking Member, Mr. Pallone, for a follow-up.

1795 Mr. {Pallone.} Thank you, Mr. Chairman.

1796 I wanted to ask Ms. King, we have heard in the past  
1797 recommendations that CMS pilot or adopt certain technologies  
1798 like smart cards, and I think Mr. Shimkus actually mentioned  
1799 this. Since much of GAO's work centers around making sure

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1800 that the government is prudently spending taxpayer dollars, I  
1801 would like to ask you from the GAO perspective, what  
1802 questions should CMS be asking before embarking on any  
1803 activity that would give tens of millions and even billions  
1804 perhaps of dollars to a handful of companies in one industry  
1805 to create this technology? What would you recommend?

1806 Ms. {King.} Mr. Pallone, we have actually been asked to  
1807 look into smart cards, and we have a request in-house that we  
1808 hope to start soon, and I think from that, we should be able  
1809 to answer some of those questions like what are the costs and  
1810 benefits, what are the risks, what are the downsides to this.  
1811 Because, you know, right now, as you know, Medicare has a  
1812 paper card that displays the Social Security number, and we  
1813 have recommended in the past that that be taken off of there,  
1814 and CMS has estimated about \$800 million to do that. We  
1815 don't think that that estimate was credible and we asked them  
1816 to do another one, but certainly any smart card effort would  
1817 cost much more than replacing a paper card. So you are  
1818 raising very legitimate questions, and we will be looking  
1819 into it and advising both CMS and the Congress, we hope later  
1820 this year.

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1821 Mr. {Pallone.} Thank you.

1822 Can I ask Dr. Budetti, is there anything else that the  
1823 committee or Congress should do to help you in your ongoing  
1824 efforts or activities, if you just wanted to comment in  
1825 general?

1826 Dr. {Budetti.} So Mr. Pallone, I appreciate the  
1827 question and I have to say that we very much appreciate the  
1828 support that the Congress has given us, and this is something  
1829 that I think everybody agrees is important and so we will be  
1830 delighted to continue to work with all the members on any  
1831 ideas or any potential improvements that might come up. But  
1832 we very much appreciate the support and the interest that is  
1833 being shown in fighting fraud, waste and abuse because we all  
1834 agree, this is a very important aspect of these programs, so  
1835 thank you, Mr. Chairman, and thank you, Mr. Pallone.

1836 Mr. {Pallone.} I thank you and the whole panel, and I  
1837 yield back, Mr. Chairman.

1838 Mr. {Pitts.} The Chair thanks the gentleman. The Chair  
1839 thanks the panel for your testimony, for answering questions.  
1840 It has been very informative. And at this time we will  
1841 dismiss panel one and call panel two to the witness table,

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1842 and I would like to thank the second panel for agreeing to  
1843 testify before the subcommittee today, and I would like to  
1844 quickly introduce our second panel as they come to the table.

1845 First, Mr. Darrell Langlois, Vice President of  
1846 Compliance, Privacy and Fraud at Blue Cross and Blue Shield  
1847 of Louisiana, and Mr. Thomas Green, Managing Partner of  
1848 Greene LLP. Again, thank you all for coming. We have your  
1849 prepared statements and they will be made a part of the  
1850 record.

1851 Mr. Langlois, we will begin with you. You are  
1852 recognized for 5 minutes to summarize your testimony.

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|  
1853 ^STATEMENTS OF DARRELL LANGLOIS, VICE PRESIDENT, COMPLIANCE,  
1854 PRIVACY AND FRAUD, BLUE CROSS AND BLUE SHIELD OF LOUISIANA;  
1855 AND THOMAS M. GREENE, MANAGING PARTNER, GREENE LLP

|  
1856 ^STATEMENT OF DARRELL LANGLOIS

1857 } Mr. {Langlois.} Thank you, Mr. Chair, Ranking Member  
1858 Pallone and subcommittee members. I am Darrell Langlois,  
1859 Vice President of Compliance and Privacy and Antifraud  
1860 Activities with Blue Cross and Blue Shield of Louisiana. It  
1861 is my pleasure to be here today to talk about a very  
1862 important issue, and as I listened to the testimony and the  
1863 conversation leading to this point, I want to tell you that  
1864 health care fraud has far more reaching implications than  
1865 simply the money and the dollars that are taken out of our  
1866 system, and I would like to emphasize my testimony today on  
1867 the fact that many times and at an alarming rate, we find  
1868 that the health care fraud that takes place is beyond the  
1869 dollar and it is impacting the patients, you know, your  
1870 family, my family in ways that are unmentionable, and that I

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1871 through the quality of care that is received that ultimately  
1872 results in patient harm.

1873 In my 20-plus years of being in this field, working both  
1874 nationally and locally, I can tell you I have been  
1875 increasingly alarmed at what I have personally seen in my own  
1876 State in cases that I have worked personally. These are not  
1877 anecdotes. These are not stories read in the Wall Street  
1878 Journal. These are stories and cases that I have worked  
1879 personally, and it alarms me and concerns me, and I hope we  
1880 talk a little bit about that today.

1881 My testimony is going to touch two broad topics: first,  
1882 what my organization has done in this regard, and second, how  
1883 the Affordable Care Act's MLR provisions are serving to limit  
1884 and hold back some of the investment that has taken place in  
1885 the past in respect to health care fraud.

1886 First, as far as my organization, we have structured a  
1887 three-point strategy. It has evolved in the 20 years that I  
1888 have been responsible for health care fraud at my  
1889 organization, and is currently in this format. First, we  
1890 believe that data is at the foremost and the forefront of  
1891 what we must do. The implications, the indications and the

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1892 analysis that must be done through data is apparent and  
1893 foremost. The technology that is needed to ensure that we  
1894 are successful in almost every turn in this regard is growing  
1895 and evolving and some of it is there and available for us but  
1896 we do need to see improvement in that area and we need to  
1897 spend money in that area and we need to increase resources in  
1898 that area to do some of the things that I think  
1899 Representative Burgess and others have talked about in  
1900 relation to other industries, how they have been more timely  
1901 in that respect.

1902 The second is public and private partnerships. I have  
1903 been fortunate to work very closely with the law enforcement  
1904 entities in my State. I could name names and go on and on.  
1905 But we have been one of two plans around this country that  
1906 has been successful and be included in the government's HEAT  
1907 cases there in the State of Louisiana, and that is a direct  
1908 result of our willingness to work hand and hand with our  
1909 public partners in this health care fraud fight, and we think  
1910 that needs to continue.

1911 Finally, prepay is an avenue in which we must continue  
1912 to follow. The pay-and-chase model has long been gone, long

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1913 deemed unsuccessful, and I am proud and appreciative of the  
1914 comments I have been hearing today, that that is something  
1915 that no one is considering to be a success and no one is  
1916 considering to be a strategy on a go-forward basis. We must  
1917 keep the dollars out of the hands of those who are willing to  
1918 defraud our system, and the best way to do that is to never  
1919 pay the dollar in the first place on a prepay basis.

1920         The second part of my testimony is to address the MLR  
1921 provisions of the Affordable Care Act. Today, as we  
1922 understand it, only the recovery portions of what a private  
1923 payer is able to recover are provided to us as a benefit in  
1924 that calculation. As we have just said, prepay is where the  
1925 strategy needs to be and where the focus needs to be. So to  
1926 have a calculation that focuses on an antiquated or towards a  
1927 strategy that no one wants to employ anymore seems to be  
1928 something that we ought to consider changing. In that  
1929 regard, we would offer that we broaden the perspective of  
1930 what is allowed in this fight against health care fraud to  
1931 something that is more than recoveries.

1932         Also, again, as I started my testimony, I mentioned to  
1933 you that my alarming concern that I have seen in my 20-plus

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1934 years of this has been around the quality-of-care issue. I  
1935 can tell you about cases where patients have died. I can  
1936 tell you about cases where I have spoken to family members  
1937 who have had their family members irreparably harmed  
1938 physically as a result of what physicians or other  
1939 professionals have chosen to do in the name of seeking money.  
1940 That is something that comes about through investigations and  
1941 not solely in the quality improvement area, and I would  
1942 encourage strongly that the committee and Congress consider  
1943 that those are the things that improve our system and should  
1944 be accounted for in our Medical Loss Ratio.

1945 That concludes my comments, and I will be prepared for  
1946 any questions you may have.

1947 [The prepared statement of Mr. Langlois follows:]

1948 \*\*\*\*\* INSERT 3 \*\*\*\*\*

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|  
1949           Mr. {Pitts.} The chair thanks the gentleman, and Mr.  
1950 Greene, you are recognized 5 minutes for opening statement.

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|

1951 ^STATEMENT OF THOMAS M. GREENE

1952 } Mr. {Greene.} Thank you, Chairman Pitts, Ranking Member  
1953 Pallone and members of this committee for inviting me to  
1954 testify on innovations to fight fraud, waste and abuse. My  
1955 name is Tom Greene, and my testimony today relates to my  
1956 experience representing whistleblowers under the False Claims  
1957 Act for more than 20 years. The vast majority of my False  
1958 Claims Act cases have been in the health care industry. With  
1959 respect to pharmaceutical marketing fraud litigation, I have  
1960 also represented private payers including health insurance  
1961 plans, Taft-Hartley funds and self-insured employers.

1962 I am pleased to be here today to speak about the False  
1963 Claims Act, which is an excellent model of how the United  
1964 States can foster innovation in fighting health care fraud,  
1965 waste and abuse.

1966 The False Claims Act is a dynamic fraud-fighting machine  
1967 which encourages the participation of insiders with knowledge  
1968 of fraud and the management. That is really good for  
1969 everyone. And because whistleblowers can pursue cases, even

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1970 when the United States does not intervene, the False Claims  
1971 Act can foster new ways of fighting health care fraud.

1972 When I first filed what was the first off-label  
1973 promotion False Claims Act case in 1996, the government  
1974 attorneys were not convinced of the viability of that theory  
1975 and declined to intervene. But once that case was settled in  
1976 2004, it set a precedent that kicked off \$14 billion in other  
1977 recoveries. All told, since 1986, more than \$24 billion has  
1978 been recovered by the government for health care fraud cases  
1979 under the False Claims Act, thanks largely to courageous  
1980 whistleblowers who often risk their own financial security.

1981 Today I make three recommendations to improve the  
1982 effectiveness of the False Claims Act. One is to clarify the  
1983 pleading standard for such cases because many courts have  
1984 applied the standard for common-law fraud. A second would be  
1985 to do more to encourage States to enact false claims acts.  
1986 And there is one more thing that Congress could do by  
1987 addressing one impediment to investigation and pursuit of  
1988 False Claims Act cases that attorneys in my position find  
1989 particularly troubling. Although we are working on behalf of  
1990 the United States when we pursue these cases, it is often

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1991 very difficult to gain access to data from CMS. Such data  
1992 can be critical to proving a False Claims Act case because  
1993 many whistleblowers are in marketing, sales or servicing, and  
1994 it is unusual for them to already have the data in hand when  
1995 they come to the attorney. Some of these cases fail not  
1996 because the fraud is uncertain but because we can't get CMS  
1997 data. Frankly, it is ridiculous not to facilitate our access  
1998 to CMS data when billions of taxpayer dollars hang in the  
1999 balance.

2000 Marketing fraud by pharmaceutical companies accounts for  
2001 more than half of the health care money recovered under the  
2002 False Claims Act, especially through off-label promotion of  
2003 drugs. False or fraudulent off-label promotion is a serious  
2004 problem which costs taxpayers billions of dollars through the  
2005 payment of increased health insurance premiums, and this  
2006 serious problem needs to be addressed by Congress, in part  
2007 because private payers don't have a fraud-fighting tool as  
2008 potent as the False Claims Act.

2009 Now, I believe that fraudulent pharmaceutical marketing  
2010 can be stopped before it starts in five ways. First,  
2011 fraudulent pharmaceutical marketing could be deterred by

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2012 giving private payers a right of action because currently  
2013 they are left to use ill-fitting options like RICO or  
2014 patchworks of State laws. Second, marketing fraud can be  
2015 deterred by giving teeth to the FDA Amendments Act clinical  
2016 trial registration requirement. Third, it could be deterred  
2017 by threatening the forfeiture of Hatch-Waxman Act patent  
2018 extensions for particular drugs. As you know, these  
2019 extensions are granted in part for cooperation with the FDA  
2020 approval process. When drug companies do end runs around the  
2021 FDA through off-label promotion, drug companies should  
2022 forfeit these extensions. Fourth, pharmaceutical marketing  
2023 fraud could also be deterred by making sure that  
2024 pharmaceutical executives have some skin in the game  
2025 personally. And lastly, I would like to recommend that  
2026 Congress eliminate the incentives for medical device  
2027 manufacturers to play games with the 510(k) approval process,  
2028 which could be done by amending the Social Security Act to  
2029 forbid reimbursement of off-label medical devices except in  
2030 certain circumstances.

2031 I would be happy to expand on any of these issues that I  
2032 have commented on this morning, and there is additional

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2033 detail in my written testimony.

2034 I would like to thank you, Chairman Pitts and Ranking  
2035 Member Pallone, for this opportunity to testify, and I am  
2036 glad to respond to any questions that you might have.

2037 [The prepared statement of Mr. Greene follows:]

2038 \*\*\*\*\* INSERT 4 \*\*\*\*\*

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|  
2039 Mr. {Pitts.} The chair thanks the gentleman. I will  
2040 now begin questioning and recognize myself 5 minutes for that  
2041 purpose.

2042 Mr. Langlois, your testimony describes many of the  
2043 important investment plans to prevent fraudulent payments and  
2044 improve quality so you can attract customers. I would like  
2045 to ask you to expound on this some more. If a plan expands  
2046 its provider network based on their customers' desire to  
2047 receive care from a particular doctor or physician practice,  
2048 does the MLR classify the associated cost as an  
2049 administrative expense and doesn't this penalize a plan for  
2050 expanding consumer choice in doctors and providers?

2051 Mr. {Langlois.} It is my understanding that that is an  
2052 administrative expense, and as such would have to factor into  
2053 the overall cost of our products and the overall cost of  
2054 health care, which would serve as the--as the costs go higher  
2055 would serve to limit choices for our customers and those who  
2056 participate in the program.

2057 Mr. {Pitts.} Now, plans often work to ensure that  
2058 health care practitioners are properly credentialed to

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2059 provide care. Are these quality-enhancing activities  
2060 punished by the MLR rule?

2061 Mr. {Langlois.} Again, it is my understanding that  
2062 those are considered administrative costs, which do not  
2063 benefit that calculation and would serve to discourage to the  
2064 extent it doesn't make reasonable sense to the organization,  
2065 would discourage them from participating in that activity at  
2066 some reasonable level.

2067 Mr. {Pitts.} So it would penalize a plan for ensuring  
2068 credential providers are serving their customers?

2069 Mr. {Langlois.} Yes, sir.

2070 Mr. {Pitts.} Now, these are necessary and non-  
2071 negotiable costs that we all want to encourage health plans  
2072 to incur, and clearly are not the kinds of costs that  
2073 Congress wants to curtail. Network expansion and  
2074 credentialing providers are critically important and  
2075 beneficial to customers, to consumers, and clearly enhances  
2076 value for their premium dollars. I am not sure, by why is  
2077 HHS classifying these expenses as administrative when they  
2078 are expended specifically to improve the quality of a network  
2079 that a patient can access?

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2080           Mr. {Langlois.} I am afraid I don't have the answer to  
2081 that question as I did not participate in the process.

2082           Mr. {Pitts.} Now, in your testimony, you write that  
2083 ``The MLR regulations' treatment of fraud prevention expenses  
2084 works at cross purposes with efforts by the Federal  
2085 Government to emulate successful private sector programs.''  
2086 Could you expound on these comments?

2087           Mr. {Langlois.} Sure. As an organization under the  
2088 current MLR calculation chooses to spend money or no spend  
2089 money as it works today, if they choose to spend money and  
2090 invest in this critical function, every dollar they spend  
2091 works against them in the calculation of the MLR. Therefore,  
2092 a choice has to be made according to many factors by those  
2093 who have the opportunity to spend that money and they have to  
2094 make it in spite of the fact that it is going to work against  
2095 them in the MLR calculation knowing that it could be better  
2096 for the organization and its members to go ahead in the  
2097 money. My recommendation, of course, would be to take away  
2098 that cross-purpose and make it a dual win-win. Let us not  
2099 only spend the money in a manner that is beneficial to the  
2100 system and for our customers but let us also let it work for

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2101 us during the MLR calculation, which serves to better our  
2102 system overall.

2103 Mr. {Pitts.} Now, there remains significant interest in  
2104 Congress about antifraud efforts in Medicare and Medicaid.  
2105 We just heard from the Administration that fighting fraud in  
2106 Medicare was a key goal of the Administration. Yet the MLR  
2107 regulation excludes health plan investments and initiatives  
2108 to prevent fraud from those activities that improve health  
2109 care quality. Does this create a perverse incentive in the  
2110 commercial insurance market to tackle fraud on the pay-and-  
2111 chase side rather than the prevention side just at a time  
2112 when CMS is stepping away from the pay-and-chase model?

2113 Mr. {Langlois.} It certainly seems that way. Again, as  
2114 I testified a few minutes ago, recovery processes are the old  
2115 way of doing things, and for the calculation of the MLR to  
2116 only afford a benefit in that regard does seem to be outdated  
2117 and something that should be seriously considered to be  
2118 changed. That is by far a method and an approach that my  
2119 peers and this industry are going away from as quickly as  
2120 possible for many reasons, but certainly I think that should  
2121 change in our calculation.

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2122           Mr. {Pitts.} Finally, members from both sides of the  
2123 aisle have stated that Congress should promote policies that  
2124 encourage young people to purchase health coverage. However,  
2125 doesn't the MRI penalize enrolling young and healthy  
2126 individuals in health plans since doing so makes complying  
2127 with the MLR standard more difficult?

2128           Mr. {Langlois.} If you consider from the perspective  
2129 that if the MLR calculation continues as it is and that  
2130 continued investment in fraud or the lack thereof allowing  
2131 fraud to further be perpetrated into larger extent, that will  
2132 serve only to increase the overall cost of health care fraud,  
2133 and we know that that is the primary factor for the young in  
2134 which to engage and participate in the health system. So for  
2135 those reasons, as you mentioned, I would say the answer is  
2136 yes.

2137           Mr. {Pitts.} Thank you. My time is expired. The Chair  
2138 recognizes the ranking member, Mr. Pallone, 5 minutes for  
2139 questions.

2140           Mr. {Pallone.} Thank you, Mr. Chairman.

2141           A question for Mr. Langlois. You spoke in your  
2142 testimony about concerns about the way antifraud activity is

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2143 counted as part of the Affordable Care Act provisions for  
2144 calculation of the MLR. But didn't NAIC, the National  
2145 Association of Insurance--well let me ask you this. The  
2146 Administration felt like it was taking a balanced approach in  
2147 this, giving credit for dollars recovered but not for fraud  
2148 prevention activity, and based on information on the Blue  
2149 Cross and Blue Shield of Louisiana Web site, it looks like  
2150 your return on investment for fraud-related activity is on  
2151 the order of 10 to one. So the National Association of  
2152 Insurance Commissioners, didn't they support this compromise  
2153 regarding fraud and abuse work at the MLR?

2154 Mr. {Langlois.} I am not sure I understand.

2155 Mr. {Pallone.} The NAIC, which is the National  
2156 Association of Insurance Commissioners, they supported this  
2157 compromise, the idea that--I mean, I am asking you if they  
2158 did--my understanding is that they did--that, you know, we  
2159 take this balanced approach where you give credit for dollars  
2160 recovered but not for fraud prevention activity, and my  
2161 understanding is that they supported that balanced approach.  
2162 Is that true, and is that a factor in the fact that you have  
2163 this high return on investment for fraud-related activity?

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2164           Mr. {Langlois.} I think I have two responses to the  
2165 question. First of all, I have worked somewhat with the NAIC  
2166 on an unofficial basis. We happen to be at the same  
2167 location, and a gentleman was speaking on this very issue,  
2168 and I made the same comments that I am making here today to  
2169 him and asked if there could be reconsideration. I am not  
2170 aware and did not participate in any request for it to be a  
2171 balanced approach and that this was the result of that, but I  
2172 will say that in my speaking directly to the NAIC on this  
2173 matter, I have echoed the same comments I made today. They  
2174 seemed receptive but of course indicated that there would be  
2175 have to be further evaluation before any changes could be  
2176 made.

2177           As to the dollars that you reference on our Web site  
2178 about our activities, those dollars are largely not on a  
2179 recovery basis. Those dollars are largely saved on a prepay  
2180 basis and depends from year to year times and cases and  
2181 situations will adjust to be flexible from year to year but  
2182 the recoveries are not solely represented by the number you  
2183 read. Those are a function, an aggregation of all savings  
2184 that our office works towards.

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2185           Mr. {Pallone.} Well, let me ask you this. Has Blue  
2186 Cross and Blue Shield of Louisiana had to cut back on any of  
2187 its antifraud activities as a result of the MLR requirements?  
2188 Have you had to make any cutbacks?

2189           Mr. {Langlois.} Could I ask you to ask the question one  
2190 more time? I missed the first part.

2191           Mr. {Pallone.} In other words, has Blue Cross and Blue  
2192 Shield of Louisiana had to cut back on any of its, you know,  
2193 basically reduce any of its antifraud activities as a result  
2194 of the MLR requirements?

2195           Mr. {Langlois.} You know, the word ``cutback'' would  
2196 seem to--

2197           Mr. {Pallone.} Or to reduce.

2198           Mr. {Langlois.} To reduce, and I would say that where  
2199 we are, we have held steady. The organization has recognized  
2200 since 1990 that health care fraud is a problem and as such  
2201 its investment has held steady, but as I mentioned earlier--

2202           Mr. {Pallone.} But then you haven't had to cut back or  
2203 reduce as a result of that requirement?

2204           Mr. {Langlois.} We have not been allowed to go forward.  
2205 We have not cut back but we have not been allowed to move

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2206 forward with investments that are necessary as the technology  
2207 increases, and we have been looking at technology that is  
2208 something that we believe is needed but has been unable to  
2209 move forward at this point.

2210 Mr. {Pallone.} I mean, I am just trying to point out  
2211 that the NAIC, which represents the Nation's insurance  
2212 commissioners, agrees with the current MLR calculation with  
2213 respect to fraud.

2214 Let me ask you one more thing. You know, I was excited  
2215 to learn about your participation in the Health Care Fraud  
2216 Prevention Partnership being led by the Secretary and the  
2217 Attorney General, and are there any activities being  
2218 undertaken by CMS that you think have been particularly  
2219 helpful or supportive of your efforts? Let me ask you that.

2220 Mr. {Langlois.} Actually, there was one initiative that  
2221 I was a participant in with a small number of people that I  
2222 looked up very fondly and was very hopeful that the process  
2223 would carry out. As you might imagine, there are times when  
2224 CMS recognizes that a provider is engaged in an activity that  
2225 is worthy of their attention and so they will place a stop-  
2226 payment or a hold on that provider until they can better

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2227 determine what is taking place. There is a ton of Medicare  
2228 supplemental private products that are on the market which my  
2229 organization also sells. When CMS previously was stopping  
2230 these payments, we were not made aware so a payment claim  
2231 filed by a provider may not have made its way through CMS but  
2232 was being passed on to us as the private supplemental payer  
2233 and we were unaware of the activity that was taking place.  
2234 There was an initiative that was begun to where that  
2235 information could be shared, and as a result that provider  
2236 would not see payments that could potentially have been  
2237 fraudulent either from CMS or us, and I was very appreciative  
2238 and fond of that process. Unfortunately, I think at this  
2239 point the process hasn't made its way to fruition but we are  
2240 hopeful that it will, and that was one that I very much  
2241 looked forward to.

2242 Mr. {Pallone.} Thank you. Thank you, Mr. Chairman.

2243 Mr. {Pitts.} The Chair thanks the gentleman and now  
2244 recognizes the vice chair, Dr. Burgess, 5 minutes for  
2245 questions.

2246 Dr. {Burgess.} Thank you, Mr. Chairman, and Mr.  
2247 Langlois and Mr. Greene, thank you both for being here today.

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2248 I appreciate your time spent with the committee.

2249 Let me ask you as a representative of a private  
2250 insurance company. You have heard the discussion and the  
2251 size, the number of dollars that are involved at CMS in  
2252 fraudulent or inappropriate transfers of funds. Do you have  
2253 anything approaching that in the Blue Cross Blue Shield  
2254 world?

2255 Mr. {Langlois.} As to an evaluation of what those  
2256 numbers are? Unfortunately, the best measure we have at this  
2257 point is, we work very closely with the other antifraud  
2258 activities around the country, both on the private side, and  
2259 we also recognize the CMS side, and we measure our success  
2260 according to what we are seeing other payers execute in the  
2261 antifraud world. I get asked the question a lot, and I know  
2262 it is maybe not the greatest of answers but I will tell you,  
2263 do we know at any particular time how many people are  
2264 speeding down the interstate, and the answer is, we don't,  
2265 but we know it is happening and it is impossible to gauge  
2266 that. So I don't have that but I can tell you that the  
2267 returns on investments that we have been turning in the last  
2268 20 years has not slowed down, has increased, and again, I

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2269 would just emphasize the stories and the cases we are seeing  
2270 around quality have really brought an alarming sense to us.

2271 Dr. {Burgess.} Give us a sense of what you are talking  
2272 about there. Can you give us an example?

2273 Mr. {Langlois.} In the quality?

2274 Dr. {Burgess.} Yes.

2275 Mr. {Langlois.} Real quickly, there are three cases  
2276 that recently resulted in the State of Louisiana. The first  
2277 was a cardiologist who in the name of money was placing  
2278 stents in patients who had no business undergoing a knife or  
2279 any surgeries at all. We testified. This was a great  
2280 public-private collaboration. We as victims were brought in  
2281 this case. The government was brought as a victim in this  
2282 case. We both testified, and the cardiologist recently was  
2283 ordered to head to prison just before Christmas 2012. There  
2284 were millions of dollars involved, and as I spoke at a  
2285 meeting in that area, I had a family member step up and said  
2286 I just wanted to let you know that my brother was one who was  
2287 unnecessarily operated on and was now irreparably harmed.

2288 This was not identified in a quality improvement  
2289 program. This was not identified by a group of nurses who

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2290 sit in the back of a particular area and work on a diabetic  
2291 approach with someone. This was identified through hard-  
2292 nosed investigative efforts both at the public side and the  
2293 private side, and we brought it to bear. In another example,  
2294 we had--

2295 Dr. {Burgess.} Let me stop you there for just a second,  
2296 and I do want to hear your second example, but in the private  
2297 insurance world, somebody is going to call a 1-800 number  
2298 somewhere and get preauthorization for that procedure, are  
2299 they not?

2300 Mr. {Langlois.} Yes, and in this instance, the  
2301 cardiologist was willing to provide the information that  
2302 would make that appropriate yes answer on the pre  
2303 authorization. He was capable of giving the information that  
2304 made that appropriate when in fact the information was not  
2305 accurate. He owned not only the cardiology clinic but he  
2306 owned the lab in which those diagnostic-type studies were  
2307 done to justify the surgery in the first place, and he forged  
2308 that information necessary to make the surgery.

2309 Dr. {Burgess.} Well, do you feel that that is  
2310 something--I mean, was this just a one-off where one person

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2311 is performing this or do you feel that there is a larger  
2312 problem there?

2313 Mr. {Langlois.} No, you will find if you read the  
2314 literature among the government health care fraud and you  
2315 talk to others, I believe previous testimony was heard by  
2316 Alanna Lavelle at WellPoint. She spoke about cardiology and  
2317 stent procedures in her world, and she does not do business  
2318 in Louisiana, so clearly this is not a perception or a one-  
2319 off situation.

2320 Dr. {Burgess.} And what have you done as an industry to  
2321 more carefully define and refine that so that you not only  
2322 prevent the inappropriate transfer of funds but you also  
2323 prevent the inapt delivery of care? I mean, basically that  
2324 is up-selling someone who came in with a problem that was not  
2325 of cardiac origin who then got a cardiac procedure. Am I  
2326 correct?

2327 Mr. {Langlois.} Correct. The use of data analysis,  
2328 again, the three points I talked about earlier, use of data  
2329 analysis, the direct collaboration with the Federal  
2330 Government and reviewing things on a more prepayment basis in  
2331 refining those. We talked about--I was asked the question,

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2332 have we cut back. We haven't cut back but of course we  
2333 haven't extended forward the way we want to. If I were still  
2334 doing the things 20 years ago today as I was doing then, I  
2335 wouldn't be successful. We have had to evolve and move  
2336 forward, and not being able to do that is some ways hurtful.

2337 Dr. {Burgess.} Give us quickly your other example.

2338 Mr. {Langlois.} Of course, this is throughout the  
2339 country and probably throughout the world, but we had an  
2340 internal-medicine practitioner who was willing to dole out  
2341 OxyContin and various other controlled substances to patients  
2342 despite in his own practice he had newspaper articles that  
2343 articulated that his patients were distributing the same  
2344 drugs he was prescribing on the street yet he continued to  
2345 prescribe those drugs. There were at least eight deaths  
2346 associated with overdosages and other things to the point  
2347 that one of his patients actually sold the drug to another  
2348 individual, who died as a result. So it wasn't even a  
2349 patient of that doctor, yet death followed his prescription  
2350 onto another unsuspecting individual. That individual has  
2351 currently lost his license and is serving 16 years in federal  
2352 prison, again, another collaborative effort between public

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2353 and private, not identified in a quality improvement arena,  
2354 rather identified in an investigation angle, but certainly  
2355 taking a bad doctor out of the system that we all had to pay  
2356 for.

2357 Dr. {Burgess.} Thank you, Mr. Chairman. I will yield  
2358 back.

2359 Mr. {Pitts.} The Chair thanks the gentleman and now  
2360 recognizes the gentlelady, Dr. Christensen, 5 minutes for  
2361 questions.

2362 Dr. {Christensen.} Thank you, Mr. Chairman.

2363 Mr. Greene, I wanted to ask some questions around your  
2364 testimony. Since 1986, over \$35 billion, I understand, has  
2365 been recovered through the False Claims Act for the  
2366 government, and the majority of those recoveries come, as you  
2367 have stated, as a result of whistleblower-initiated cases,  
2368 health care-related recoveries from pharmaceutical companies,  
2369 hospitals and clinical laboratories. Can you give us a few  
2370 brief examples of what some of the kind of fraud involved  
2371 were involved in those cases, and what other kind of cases  
2372 other than the pharmaceutical, which you said represented the  
2373 vast majority of dollars, what other kinds of cases have

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2374 successfully returned money to the States or Federal  
2375 Government?

2376 Mr. {Greene.} I can, and I touch on this in more detail  
2377 in my written testimony but I can summarize here. First, I  
2378 would like to say that the majority of health care recoveries  
2379 under the False Claims Act come from whistleblower-initiated  
2380 qui tam cases rather than cases initiated by the government.  
2381 Qui tam cases outnumber the ones initiated by the government  
2382 by five to one. Health care cases under the False Claims Act  
2383 come in many different forms. You might have a hospital or  
2384 nursing home that up-codes claims to get higher  
2385 reimbursements or for billing services that were not actually  
2386 performed, testing labs cause billing for unnecessary lab  
2387 tests or again for tests not performed. There are cases that  
2388 are based on violation of the Anti-Kickback statute or the  
2389 Stark law where physicians are getting illicit payments or  
2390 benefits for lucrative self-referrals. Durable-equipment  
2391 companies bill for equipment that was never delivered, and  
2392 you can have medical supply companies that can be the basis  
2393 for actionable fraud. One of my cases was just recently  
2394 unsealed. It involves unnecessary delivery of oxygen

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2395 supplies. So really, there are many different types of  
2396 cases. Somebody usually sees this fraud occur and sometimes  
2397 someone will step forward and blow the whistle.

2398 Dr. {Christensen.} You know, and while the False Claims  
2399 Act specifically deals with getting money back to the  
2400 government, it seems to me that private payers, insurance  
2401 companies, employer benefit plans can be equally victimized  
2402 by these fraudulent practices, and I think we have heard some  
2403 of that already in the testimony. Can you please elaborate  
2404 on how private parties are affected and what recourse they  
2405 have at this time?

2406 Mr. {Greene.} Well, I will start off by saying private  
2407 payers don't have the potent tool, the False Claims Act, that  
2408 the Federal Government has, but yet they can be the victim of  
2409 frauds, they can be the victim of medical tests or products  
2410 that are ordered as a result of kickbacks. Really, what they  
2411 are faced with, the only thing they can rely on really are  
2412 patchwork of State laws or RICO claims, and those are  
2413 imperfect. If Congress would consider pass a private right  
2414 of action, that might give private payers like Blue Cross  
2415 sitting here at the table an opportunity to recover the costs

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2416 that they spent as a result of fraud. Like I say, it has  
2417 been difficult to try to put together a large group of health  
2418 insurance plans across the country to bring these cases in  
2419 the form of class actions. Courts are not always receptive  
2420 to that, again, because of the patchwork of State laws that  
2421 these claims are brought under or RICO. I think if we had a  
2422 private right of action for third-party payers that perhaps  
2423 offered double damages and an attorney fee-shifting  
2424 provision, that would begin to give private payers the tools  
2425 that they would need to recover some of the monies they have  
2426 lost as a result of fraud.

2427 Dr. {Christensen.} Mr. Langlois, I think you have  
2428 answered most of my questions around MLR and the public-  
2429 private partnership, so I don't know if you want to comment  
2430 on the last question around False Claims Act not, you know,  
2431 being an avenue where companies such as yours might be able  
2432 to recover.

2433 Mr. {Langlois.} It is a great question, and I  
2434 appreciate you bringing it up, and I respect Mr. Greene for  
2435 his attempt to benefit us. We identified 2 years ago in my  
2436 State, particularly myself and a State senator of Louisiana,

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2437 the need for this, and we in the last legislative session  
2438 actually passed a false claim trouble damage act provision at  
2439 the State law level that allows whenever I am a victim of a  
2440 health care fraud to bring about damages and penalties to  
2441 those who do such similar to the federal level.

2442 Now, the way it works--and I won't belabor this point--  
2443 but the way it works is, I retain the monies that I was a  
2444 victim of and lost. The second and third level of payment  
2445 from the trouble damage calculation returns to the State in  
2446 its effort to fight and better fund health care fraud  
2447 efforts. So I very much appreciate the point he made and I  
2448 do think that there are opportunities there.

2449 Mr. {Pitts.} The Chair thanks the gentlelady and now  
2450 recognizes the gentleman from Virginia, Mr. Griffith, 5  
2451 minutes for questions.

2452 Mr. {Griffith.} I guess my concern relates to the  
2453 lawsuit type, and Mr. Greene, I am going to ask you, I know  
2454 you are trying to ferret out people who are doing things that  
2455 are just fraudulent outright but don't you think it might  
2456 have a chilling effect on those folks who are using an off-  
2457 label use in cases with patients who might have severe

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2458 illnesses such as AIDS, rare diseases, cancer, etc.? Don't  
2459 you think that if you take that too far that you can actually  
2460 hurt some of the patients who may need an off-label use?

2461 Mr. {Greene.} Well, I think what you are pointing out,  
2462 and I recognize and of course courts recognize that  
2463 physicians have and will always have the right based on the  
2464 exercise of their independent medical judgment to prescribe a  
2465 drug for an off-label use. There is nothing wrong with that.

2466 Mr. {Griffith.} But here comes the question, based on  
2467 your written testimony. The question then becomes, though,  
2468 that as I understand your testimony, your written forms says  
2469 that if a company, though, has a study that says you can use  
2470 this for a rare form of cancer and that some doctors have  
2471 found it successful, that they may then open themselves up if  
2472 the pharmaceutical--because if I am treating somebody in  
2473 Abington, Virginia, I may not know that somebody in  
2474 California or New York was successfully using--another  
2475 physician was using an off-label drug to successfully treat  
2476 this particular condition or disease that may be very severe.  
2477 How am I supposed to find that out if the pharmaceutical  
2478 company is barred from sending out the information?

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2479 Mr. {Greene.} Well, they are not barred from sending  
2480 out the information, Doctor.

2481 Mr. {Griffith.} I am not a doctor; I am a lawyer.

2482 Mr. {Greene.} Sorry. There are guidances and  
2483 guidelines that allow the dissemination of scientific  
2484 articles. What I am talking about is fraudulent promotion of  
2485 off-label uses. What I am talking about is when a drug  
2486 company comes up with a marketing strategy that is signed off  
2487 by the president of the company, as was the marketing for  
2488 Neurontin, that they are going to do an end run around the  
2489 FDA approval process and they are only going to publish  
2490 positive results, not negative. So we are talking about  
2491 fraud. We are not talking about interfering with a  
2492 physician's right to prescribe off-label. We are not talking  
2493 about a drug company's right to disseminate truly scientific  
2494 articles that talk about off-label uses provided they comply  
2495 with safe harbors.

2496 Mr. {Griffith.} And I appreciate that and understand  
2497 the distinction. Now, as I was reading this and listening to  
2498 it, one of the things that I noticed was, you talked about  
2499 how much money was recovered on the Neurontin. Is that how

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2500 you say it?

2501 Mr. {Greene.} Yes, sir.

2502 Mr. {Griffith.} I am just curious how many folks were  
2503 negatively impacted. Were there deaths? Because I am not  
2504 familiar with that.

2505 Mr. {Greene.} I don't have the--

2506 Mr. {Griffith.} Were there deaths?

2507 Mr. {Greene.} --answer to that question.

2508 Mr. {Griffith.} Do you know if there were deaths?

2509 Mr. {Greene.} There were.

2510 Mr. {Griffith.} There were?

2511 Mr. {Greene.} There were. Keep in mind, with regard to  
2512 Neurontin, the FDA, it was approved for adjunctive therapy  
2513 for epilepsy in December of 1993, and the FDA told the  
2514 company back in 1992 when they looked at the clinical trial  
2515 data that it showed that the subjects were suffering from  
2516 depression, suicidal ideation, and it can lead to suicide,  
2517 and the FDA told the drug company that this drug will have a  
2518 limited widespread usefulness. But they approved it as  
2519 adjunctive therapy for epilepsy. What did the company do?  
2520 It turned around and it marketed it to bipolar patients.

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2521 That was off-label, and they never disclosed what the FDA had  
2522 pointed out to them.

2523 Mr. {Griffith.} So as you send out the positive and the  
2524 negative? You are not against pharmaceutical companies  
2525 sending out articles that highlight that this might also be  
2526 helpful in some other disease area but that, you know, here  
2527 is what we have got thus far?

2528 Mr. {Greene.} Provided they comply with the safe harbor  
2529 guidelines. They can do that. They can disseminate truly  
2530 scientific articles that describe accurately the results of  
2531 their clinical research. The FDA has given them a safe  
2532 harbor to do that. That is not fraudulent promotion.

2533 Mr. {Griffith.} All right. I thank you. I have 30  
2534 seconds if anybody wants it. I yield back.

2535 Mr. {Pitts.} The Chair thanks the gentleman. The Chair  
2536 thanks the second panel for your testimony, and I remind  
2537 members that they have 10 business days to submit questions  
2538 for the record, and I ask the witnesses to respond to the  
2539 questions promptly. Members should submit their questions by  
2540 the close of business on Wednesday, March 6.

2541 Without objection, the subcommittee is adjourned.

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2542            [Whereupon, at 12:40 p.m., the subcommittee was  
2543 adjourned.]