Testimony to House Energy and Commerce Committee Subcommittee on Health

"State Fiscal Relief: Protecting Health Coverage in an Economic Downturn"

Chairman Frank Pallone (D-NJ)
Ranking Member Nathan Deal (R-GA)

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Tuesday, July 22, 2008

Chairman Pallone, Ranking Member Deal and Members of the Committee, thank you for the opportunity to testify today. My oral and written remarks reflect solely my own views and not necessarily those of the Center for Health Transformation, its staff or members.

This Committee is considering legislation that would send an additional $15 billion to the states for Medicaid costs they have incurred. There is one simple action this Committee could lead that would be low cost and go a very long way toward improving the care received by 50 million people on Medicaid while eliminating much of the waste, fraud and abuse that is largely responsible for states having chronic financial trouble with Medicaid in the first place.

Legislation should be put forward by this Committee that would require states to post their Medicaid patient encounter data on the Internet for all to see. Specifically, this is the set of claims that Medicaid providers send to the state for reimbursement for treatment of patients.

This is administratively simple, cheap, and would have a profoundly positive impact on the quality of care delivered via Medicaid. In addition, it would dramatically increase accountability for how Medicaid dollars are spent thereby decreasing the likelihood that state leaders would return to seek still more money from Congress.

How many dollars the federal government sends to each state annually is a known number. Each state's FMAP is a known number. Therefore some very simple arithmetic gives policymakers and the taxpaying public the target figure for the sum total of Medicaid claims, plus a reasonable amount for administrative overhead.

Of course it must be stated clearly and emphatically up front that this data should only be made public in a patient de-identified way. Patient privacy is sacred. Fortunately there are multiple safeguards that can and must be put in place to ensure that individual patient names, or information that would identify an individual, are not revealed to unauthorized persons or entities. Use of the right algorithms to scramble patient identities is routinely successful in similar studies of large employer groups and other public programs like Medicare.

States already collect Medicaid patient encounter data so uploading it to the Internet would require minimal cost and effort. This incredibly rich data set would then be open to policymakers, academics, clinicians and the widest possible range of people with expertise in medicine, pricing practices, technology, accounting, fraud detection and a vast array of other disciplines relevant to improving and modernizing this important program. Call it, “Open Source Medicaid.”

The data would lay bare to all whether or not Medicaid beneficiaries are getting appropriate medical care. Among the many thousands of statistics revealed by patient encounter data, for example, is what percentage of women over 50 are getting annual mammograms. The figure should be 100 percent. In one state, the data revealed that only 17 percent of women on Medicaid in this age group were getting annual mammograms. That exceedingly low figure, heretofore unknown to the public at large, means that these women are at severe risk of undetected breast cancer. It also means that the overall cost to taxpayers is likely to be much higher down the road because relatively low-cost screenings today could eliminate the need for much higher-cost interventions in the future.

The same state’s claims data showed 4,000 people who had gotten six or more Oxycontin prescriptions. Less than half of children received well child check ups. It even showed one beneficiary who had visited the emergency room 405 times in a three year span. It also appeared that the state was overpaying for the very expensive drug therapy this individual was receiving, probably to the tune of hundreds of thousands of dollars.

Obviously this person was suffering unnecessarily by getting uncoordinated, haphazard care, while costing the state millions of dollars unnecessarily.

In another claims review of a different state, a hospital was found billing Medicaid for pneumonia treatments at a rate of 80 percent bacterial and 20 percent viral. In nature, pneumonia tends to be 80 percent viral and 20 percent bacterial. So this study revealed that either there was a highly unusual and worrisome outbreak of bacterial pneumonia or there was fraud. In either situation, it is important for policymakers and the general public to know immediately. It turned out that Medicaid reimbursed treatment for bacterial pneumonia at a much higher rate in this state and this hospital had been engaged in fraud.

Claims data shows outliers, trends, adherence to evidence-based medicine, best practices, disease patterns and outbreaks, and pricing, among many other key points. It is absolutely theoretically impossible for any one state's Medicaid administration to do a better job maximizing the value of this information than would the collective wisdom of everyone else who may view it. Hence the need to put this information in the public domain to leverage the potential of mass collaboration, a concept known as "wikinomics."

Medicare claims data has been given to select researchers and institutions for decades and has yielded extremely valuable information about best practices while raising some red flags about facilities that have much higher costs without corresponding better health outcomes. The Dartmouth Health Atlas is just one good example. There are many others. If Medicare claims data were available to the general public, anyone could study it and

the result would be exponentially more solutions for more effective and more efficient care.

The idea to request that states release their Medicaid patient encounter data is consistent with the transparency movement that is sweeping through government. Members of Congress are familiar with the required transparency for campaign donations from the Federal Elections Commission and your staff is certainly familiar with their salaries being posted on Legistorm, as two examples.

The most conservative and most liberal United States Senators, Tom Coburn and Barack Obama respectively, successfully pushed through the Coburn-Obama Transparency Act in 2006 which requires the Office of Management and Budget to have a single web portal where citizens can get information on the recipients of all federal funds including all grants and contracts. This was an important first step. Future versions could have ever-more granularity that would allow for real time tracking of dollars. Taxpayers have the right to know how their money is being spent.

Medicaid also has a serious problem with fraud, waste and abuse. It is actually difficult to know exactly the scope of the problem because data is so scarce, but examples and vignettes we do get indicate very troublesome levels of misuse and inefficiency. The people hurt the most by this are poor Americans who see their access to health care services restricted or eliminated, providers who must deliver care at average

reimbursement rates that are well below even those in Medicare, and taxpayers who must foot the excessive bill.

The Government Accountability Office has documented questionable Medicaid financing schemes by states going well back into the 1980s. Please see the attached chart of selected studies at the end of this testimony. The most recent report in May of 2008 requested by Senator Charles Grassley was entitled, "Medicaid: CMS Needs More Information on The Billions of Dollars Spent on Supplemental Payments." That title alone is cause for serious concern. Of cause for greater concern is that this fits a decades-long pattern. There is far too little sunlight on how states spend Medicaid dollars, over half of which are from the federal government. States posting their encounter data online would be a major step toward rooting out intentional or unintentional misuse of money meant to finance health care for poor Americans.

The *New York Times* ran a series of articles in July, 2005 that uncovered breathtaking amounts of fraud and abuse in New York State's Medicaid program, which is the nation's largest both in per capita and overall spending. Consider:

- James Mehmet the former inspector general estimated that up to 40 percent of all Medicaid claims are questionable.
- Michael Zegarelli, another former top official said the system, "almost begs people to steal."
- One Buffalo school official sent 4,434 kids to speech therapy in a single day.

- A single doctor in one year prescribed $11.5 million dollars of a drug intended for AIDS patients that was likely diverted to bodybuilders.
- One Brooklyn dentist billed for 991 claims in one day in 2003 and over $5 million that same year for services that were never performed (for contrast, there is not a McDonald's franchise anywhere on the planet that sold 991 phantom cheeseburgers or a Federal Express delivery truck that invented 991 packages)
- Of 400 million Medicaid claims paid in 2004, state investigators uncovered only 37 cases of suspected fraud.

The horrific levels of fraud suggested by this *New York Times* series was confirmed by an outside study of New York's Medicaid claims that was completed in 2006 and delivered to a handful of officials in New York's health department in Albany. It found that a full one-quarter of New York's Medicaid program cannot be explained. One-quarter of the $44 billion spent on New York's Medicaid program in 2005 was $11 billion.

The Congressionally-created Medicaid Commission had its first meeting one week after this New York Times series ran. One of the Commission's principle objectives was to find $10 billion in scorable federal Medicaid savings over five years. They were literally handed the answer to their 18 month quest by the *New York Times* on day one – that all $10 billion could have been found in New York state fraud alone in a mere two years (considering New York's 50 percent federal match rate). Instead the Commission recommended a series of cuts that would have mostly impacted honest providers and reduced access to care for Medicaid beneficiaries.

A model for what would happen if states posted their Medicaid claims is the Goldcorp Challenge. In March of 2000 the CEO of a Canadian mining company named Rob McEwan was frustrated by his geologists' inability to strike gold. He had recently attended a conference and learned about Linus Torvalds who founded Linux, the open-source software. Inspired, Mr. McEwan placed all of his geological data on-line and announced a global contest with $500,000 in prize money. His in-house geologists were appalled.

Goldcorp's data was downloaded 1,400 times in the next several weeks. It became clear that those people who eventually sent in their contest entries spent combined time and resources that were orders of magnitude beyond the $500,000 purse. The winners were from a small Australian company, none of whom had ever even been to Canada. Goldcorp ended up finding an astounding eight million ounces of gold and the company quickly catapulted from a $100 million sleeper into a $9 billion juggernaut.

Medicaid's chronic financial problems are well known and guaranteed to continue unabated absent real change. If Congress chooses to bailout states again as it did five years ago then at the very least it should require states to prove that they are using taxpayer dollars optimally. The best, easiest and cheapest way to do this is to require states to post their Medicaid patient encounter data on the Internet for all to see. Congress should require the same for SCHIP. State officials and providers with nothing to hide should have no objection.

Again, thank you Chairman Pallone and Ranking Member Deal for the invitation to be here today. I look forward to your questions.

Medicaid Financing Schemes Used to Inappropriately Generate Federal Payments and Federal Actions to Address Them (partial list) Source: GAO		
Financing Arrangement	**Description**	**Action Taken**
Excessive payments to state health facilities	States made excessive Medicaid payments to state-owned health facilities, which subsequently returned these funds to the state treasuries.	In 1987, the Health Care Financing Administration (HCFA) issued regulations that established payment limits specifically for inpatient and institutional facilities operated by the state.
Provided taxes and donations	Revenues from provider-specific taxes on hospitals and other providers, and from provider 'donations,' were matched with federal funds and paid to the providers. These providers could then return most of the federal payment to the states.	The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 essentially barred certain provider donations, placed a series of restrictions on provider taxes, and set other restrictions for state contributions.
Excessive disproportionate share hospital (DSH) payments	DHS payments are meant to compensate those hospitals that care for a disproportionate number of low-income patients. Unusually large DSH payments were made to certain hospitals, which then returned the bulk of the payment to the state.	The Omnibus Budget Reconciliation Act of 1993 placed limits on which hospitals could receive DSH payments and capped both the amount of DSH payments states could make and the amount individual hospitals could receive.
Excessive DSH payments to state mental hospitals	A large share of DSH payments were paid to state-operated psychiatric hospitals, where they were used to pay for services not covered by Medicaid or were returned to state treasuries.	The Balanced Budget Act of 1997 limited the proportion of a state' DSH payments that can be paid to state psychiatric hospitals.
Upper payment limit (UPL) for local government health facilities	In an effort to ensure that Medicaid payments are reasonable, federal regulations prohibit Medicaid from paying more than a reasonable estimate of the amount that would be paid under Medicare payment principles for comparable services. This UPL applies to payments aggregated across a class of facilities and not for individual facilities. As a result of the aggregate upper limit, states were able to make large supplemental payments to a few local public health facilities, such as hospitals and nursing homes. The local government health facilities then returned the bulk of the state and federal payments to the states.	The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 required HCFA to issue a final regulation that established a separate payment limit for each of several classes of local government health facilities. In 2002, CMS issued a regulation that further lowered the payment limit for local public hospitals.
Federal financial participation (FFP) rates	FFP is the funding mechanism used to reimburse agencies with federal funds for certain Medicaid activities. States would overpay governmental healthcare providers, above and beyond the costs of services provided to Medicaid beneficiaries.	In May 2007, CMS enacted a rule that would place a ceiling on payments to governmental healthcare providers, not to exceed the costs of services provided, serving as an additional check for UPLs. The rule would also prohibit states from requiring non-governmental providers (e.g., non-profit hospitals) to return part of their Medicaid payments to the State.