Statement of Timothy M. Westmoreland, J.D.

To the Subcommittee on Oversight and Investigations

Committee on Energy and Commerce

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Mr. Murphy, Ms. DeGette, and Members of the Subcommittee, thank you for the invitation to speak to you today.

My name is Tim Westmoreland. I am a professor from practice at Georgetown University Law Center, where I teach health law, among other topics. I do want to be clear, however, that I am testifying in my personal capacity today and that the views I present are my own. I believe that the reason I was invited today is not because of my academic work but because I was the director of the Medicaid and CHIP programs during the last years of the Clinton Administration.

Because of that work, I take a backseat to no one on program integrity issues in the Medicaid program. When I took the Medicaid director job, combatting fraud and abuse was one of my top priorities. I worked closely with both the GAO and the OIG at that time and, in fact, have testified several times with them before the Congress. Ensuring program integrity is often a thankless task, but people who care about Federal programs have to work to ensure that Federal funds are well used.

Program integrity problems are, however, not new. Military contractors cheated the Union Army during the Civil War.[1] This gave rise to the False Claims Act of 1863,[2] sometimes known as "Lincoln's Law."[3] This law is still actively used to protect the Federal fisc, including on some occasions, the Medicaid program.[4] From at least 1863 onward, it is a truth universally acknowledged that any place where money is being spent—whether it be private, State, or Federal, and no matter how good the cause—there are bad actors trying to steal some of it.

Program integrity efforts are especially important in Medicaid. This is because billions of dollars are at stake as are the health and well-being of the most vulnerable people in America. Those bad actors who steal from this program are not engaged in a heist of luxury goods; they are stealing the very means of survival from people who have nowhere else to turn and from the honest doctors and hospitals who furnish needed services to them. This importance is well illustrated by the fact that at the same time the

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[1] See L. Lahman, "Bad Mules: A Primer on the False Claims Act" (Oklahoma Bar Journal, April 9, 2005), available at http://www.okbar.org/members/BarJournal/archive2005/Aprarchive05/obj7612fal.aspx ("The Federal False Claims Act (FCA) was enacted in part because of bad mules. During the Civil War, unscrupulous early day defense contractors sold the Union Army decrepit horses and mules in ill health, faulty rifles and ammunition, and rancid rations and provisions among other unscrupulous actions." [Citations omitted.])

[2] Now codified at 31 U.S.C. 3729 et seq., available at https://www.law.cornell.edu/uscode/text/31/3729

[3] See, e.g., "Celebrating the 150th Birthday of Lincoln's Law" (Forbes, March 6, 2013), available at http://www.forbes.com/sites/realspin/2013/03/06/celebreating-the-150th-birthday-of-lincolns-law-privatized-fraud-fighting/#3135614a47da

[4] See, e.g., Department of Justice, "Justice Department Recovers over $3.5 Billion from False Claims Act Cases in Fiscal Year 2015" (Press release, December 3, 2015), available at https://www.justice.gov/opa/pr/justice-department-recovers-over-35-billion-false-claims-act-cases-fiscal-year-2015

Affordable Care Act (ACA) expanded Medicaid coverage, it also made significant improvements in program integrity efforts (as the GAO and OIG each observe).

But, as important as combatting fraud and abuse in Medicaid is, policymakers should keep it in perspective. No statistic makes sense if you do not consider the denominator as well as the numerator. As big as they are, the numbers must be viewed as what they are and as a whole.

First, we should all be careful about our terms. Not all of what is labeled "improper payments" are fraud or even mistaken; many are appropriate but simply badly documented (and may even be underpayments), and the actual loss to the government is much smaller than it may appear.[5]

But, even so, the worst of the worst estimates using the broad term "improper payments" in Medicaid (including underpayments, overpayments, errors, and insufficient documentation) is 10%.[6] That is a bad number that should be dramatically reduced. But,

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[5] See PaymentAccuracy.gov at https://paymentaccuracy.gov/faq/; also "Medicaid and CHIP 2015 Improper Payments Report" (HHS, November 2015) available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/Downloads/2015MedicaidandCHIPImproperPaymentsReport.pdf , saying "[T]hese errors do not necessarily represent payment to illegitimate providers who should have not been enrolled in Medicaid or CHIP and do not necessarily represent examples of abuse or fraud. Rather the majority of erroneous payments represented situations where information required for payment was missing from the claims or states did not follow the appropriate process for enrolling providers. Had such information been on the claims and/or had the state followed the correct enrollment process, the claims may have been payable."

[6] See CMS, "Medicaid and CHIP 2015 Improper Payments Report," id.

keeping it in perspective, it is actually less than the overhead-and-profit costs that are routine in private health insurance, costs that do not represent the provision of needed health services but that are taken for granted.[7] [8]

Moreover, as the prepared statements of the GAO and OIG witnesses at today's hearing have outlined, HHS has already implemented many efforts to address the more serious problems of program integrity. Some of the efforts are longstanding and some of them are just underway, but there are many activities focused on making sure that Medicaid is spending its money well and they are having an effect.

But I am especially concerned that policymakers often respond to waste, fraud, and abuse with blunt instruments aimed at the wrong targets. Any review of the actual Medicaid program dollars that were stolen or misspent will reveal that the major culprits are unscrupulous providers: pharmaceutical companies that price-gouge; equipment suppliers that don't deliver; and Medicaid-mills of doctors, dentists, and clinics that

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[7] D. Archer "Medicare is More Efficient than Private Health Insurance," (Health Affairs Blog, September 20, 2011), available at http://healthaffairs.org/blog/2011/09/20/medicare-is-more-efficient-than-private-insurance/; cf. "The average adjusted [ACA Medical Loss Ratio] was 89.5% in the large group market, 85.0 percent in the small group market, and 78.8 percent in the individual market." GAO, "Medical Loss Ratios" (GAO-12-90R, October 31, 2011) available at http://www.gao.gov/new.items/d1290r.pdf

[8] Indeed, the ACA's imposition of a Medical-Loss Ratio that limits private insurance overhead and profit to as much as 15-20% was greeted with some controversy. See, T. Jost, "Implementing Health Reform: The Minimum Loss Ratio and Summary of Benefits and Summary of Benefits and Coverage" (Health Affairs Blog, May 13, 2012), available at http://healthaffairs.org/blog/2012/05/13/implementing-health-reform-the-minimum-loss-ratio-summary-of-benefits-and-coverage/

provide unnecessary services if they provide any services at all.[9] But all too frequently the political response is to institute cuts or restrictions on beneficiaries and the providers who actually care for them. Inadequate protections of millions of dollars should not be an excuse for cutting billions of dollars from States and for taking insurance from millions of people.

There is simply nothing in the recent reviews of program integrity that justifies the policy proposals that are now on the table and before this Committee. Rather than further supporting constructive State and Federal efforts to ensure that every dollar is well spent, these proposals would slash and cap Federal funding not just for the bad actors but for the good guys who are acting on behalf of people who are eligible and in need. Reduced, capped Federal funding does nothing to improve program integrity. But it does put coverage at risk for low-income Americans and shifts the costs for the most expensive services to States, localities, providers, and charities.

This is wrong. Program integrity problems are meaningful only when they are considered in the context of the many successes of Medicaid. Oscar Wilde defined a

[9] See, e.g., "Health Care Fraud Abuse Annual Report: 2015" (HHS and DOJ, February 2016), available at https://oig.hhs.gov/publications/docs/hcfac/FY2015-hcfac.pdf; D. Heath, "Senate Report Recommends Ouster of Large Dental Chain from Medicaid" (Center on Public Integrity July 23, 2013), available at https://www.publicintegrity.org/2013/07/23/13029/senate-report-recommends-ouster-large-dental-chain-medicaid-program; K. Young and R. Garfield, "Spending and Utilization of Epi-Pen Within the Medicaid Program" (Kaiser Family Foundation (KFF), October 7, 2016), available at http://kff.org/medicaid/issue-brief/spending-and-utilization-of-epipen-within-medicaid/#footnote-199903-10;

cynic as someone "who knows the price of everything and the value of nothing."[10] In that vein, too often the discussion is just of the payments of Medicaid, when in fact you can understand the real value of the program only by looking at what it is paying for.

For example, the Medicaid Expansion of the ACA means that:

- 11 million Americans have Medicaid coverage who did not have it three years ago.[11]
- The percentage of people without insurance in America is at an all-time low of 8.9%.[12] Most people have their coverage through employer-sponsored insurance, and the Exchanges are covering millions more, but Medicaid is a major part of this improvement.
- The burden of uninsured care in hospitals in Expansion States is down 39%,[13] and costs to those States are commensurately lower.[14]
- Rural hospitals in Expansion States are at half the risk of closure of those in non-Expansion States.[15]

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[10] O. Wilde, "Lady Windermere's Fan" (1892) in *The Plays of Oscar Wilde* (1988).
[11] R. Rudowitz, S. Artiga, and K. Young, "What Coverage and Financing is at Risk Under a Repeal of the ACA Medicaid Expansion?" (KFF, December 6, 2016), available at http://kff.org/medicaid/issue-brief/what-coverage-and-financing-at-risk-under-repeal-of-aca-medicaid-expansion/
[12] CMS, "Medicaid and CHIP: Strengthening Coverage, Improving Health (January 2017), available at https://www.medicaid.gov/medicaid/program-information/downloads/accomplishments-report.pdf
[13] R. Rudowitz and R. Garfield, "New Analysis Shows States with Medicaid Expansion Experienced Declines in Uninsured Hospital Discharges," (KFF, September 2015), available at http://files.kff.org/attachment/issue-brief-new-analysis-shows-states-with-medicaid-expansion-experienced-declines-in-uninsured-hospital-discharges
[14] J. Perkins and I. McDonald, "50 Reasons Medicaid Expansion is Good for Your State" (National Health Law Program, January 2017).

- Community health centers are seeing 40% more patients.[16]
- Unmet health care needs among low-income adults in Expansion States has declined by more than 10% and use of preventive services has increased.[17]
- People with serious mental illness are 30% more likely to receive services in Expansion States.[18]
- Services for opioid addiction are available to working-age adults, often for the first time.[19]
- Financial security has been increased and personal debt has been lowered in Expansion States.[20] Medicaid expansion is also associated with a decline in personal bankruptcies.[21]

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[15] D. Bachrach, P. Boozang, A. Herring, and D. Reyneri, "States Expanding Medicaid See Significant Budget Savings and Revenue Gains" (State Health Reform Assistance Network, March 2016), available at http://statenetwork.org/wp-content/uploads/2016/03/State-Network-Manatt-States-Expanding-Medicaid-See-Significant-Budget-Savings-and-Revenue-Gains-March-2016.pdf

[16] J. Paradise, "Community Health Centers: Recent Growth and the Role of the ACA" (KFF, January 18, 2017), available at http://kff.org/report-section/community-health-centers-recent-growth-and-the-role-of-the-aca-issue-brief/

[17] CMS, supra, n. 12.

[18] B. Han, et al., "Medicaid Expansion Under the Affordable Care Act: Potential Changes in Receipt of Mental Health Treatment Among Low-Income Nonelderly Adults With Serious Mental Illness," (American Journal of Public Health, October 2015), available at http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2014.302521?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed

[19] D. Bachrach, P. Boozang, A. Herring, and D. Reyneri, "Medicaid: States' Most Powerful Tool to Combat the Opioid Crisis," (State Health Network, July 2016), available at http://statenetwork.org/wp-content/uploads/2016/07/State-Network-Manatt-Medicaid-States-Most-Powerful-Tool-to-Combat-the-Opioid-Crisis-July-2016.pdf

[20] L. Hu, et al., "The Effect of the Patient Protection and Affordable Care Act's Medicaid Expansions on Financial Well-Being" (National Bureau of Economic Research, April 2016), available at http://nber.org/papers/w22170.

[21] T. Gross and M. Notowidigdo, "Health Insurance and the Consumer Bankruptcy Decision: Evidence from Expansions of Medicaid" (Journal of Public Economics, March 2011), available at http://isiarticles.com/bundles/Article/pre/pdf/48303.pdf

The Medicaid Expansion of the ACA has fundamentally repaired a longstanding mistake in the program. For almost 50 years, Americans could get help only if they were poor *and something else:* Poor and pregnant, poor and a child, poor and with a disability, poor and elderly. Just being poor and uninsured was not enough. People had to fit into some sort of category.

But this "categorical eligibility" has never made sense. Poor women need health insurance both before and after they have their babies. Poor children keep needing health insurance even when they turn 19. Poor people with chronic illnesses need health insurance before they become totally disabled. Poor older adults need health insurance when they're 64, not suddenly when they are 65. The real problems are poverty and uninsurance. Categorical eligibility has irrationally rationed a sensible response.[22]

In the 32 States that have adopted the Medicaid Expansion, we are making this part of the American insurance system sensible and fair for vulnerable people. Please do not turn back this response.

Lincoln did not give up the Civil War because the government was sold bad mules. We do not stop buying drugs because drug-makers charged a fraudulent price.[23] We

[22] See, e.g., comment by Joe Parks, director of the Missouri Medicaid program, a State that has not expanded coverage: "The best way to get treatment if you're addicted to drugs in Missouri is to get pregnant." Bachrach, supra.
[23] Department of Justice, "GlaxoSmithKline to Plead Guilty and Pay $3 Billion to Resolve Fraud Allegations and Failure to Report Safety Data: Largest Health Care Fraud

punish wrongdoers, correct the price, and get the treatment to people in need. That is what should be done here.

Don't reverse all this progress by rationalizing that program-integrity problems demand wholesale legislative change in Medicaid. There are real babies in that bathwater.

Settlement in US History" (Press Release, July 2, 2012), available at https://www.justice.gov/opa/pr/glaxosmithkline-plead-guilty-and-pay-3-billion-resolve-fraud-allegations-and-failure-report; see generally, Office of Inspector General (HHS), "OIG Compliance Program Guidance for Pharmaceutical Manufacturers" (April 2003), available at https://oig.hhs.gov/fraud/docs/complianceguidance/042803pharmacymfgnonfr.pdf