



U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Testimony of:
Gary Cantrell
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Office of Inspector General
U.S. Department of Health and Human Services

Hearing:
"Medicare Program Integrity: Screening Out Errors, Fraud, and
Abuse"

House Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

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Good morning, Mr. Chairman and other distinguished Members of the Subcommittee. Thank you for the opportunity to testify about the U.S. Department of Health and Human Services (the Department) Office of Inspector General’s (OIG) efforts to improve Medicare oversight and reduce waste, fraud and abuse. Fighting waste, fraud, and abuse in Medicare and other Department programs is a top priority.

We have seen strong results from coordinated Federal and state enforcement efforts across the country, including those of the Medicare Fraud Strike Force teams. Criminal prosecutions and monetary recoveries have increased while we have seen a measurable decrease in payments for certain health care services targeted by fraud schemes. Following targeted enforcement and other oversight activities, payments for CMHCs nationally decreased from \$70 million to under \$5 million per quarter.¹

Coordination between the Strike Force teams and the Centers for Medicare & Medicaid Services (CMS) has also contributed to a dramatic decline in payment for home health care in Miami and throughout Florida. After OIG uncovered billing schemes relating to home health outlier payments, CMS put into effect a limit on the percentage of outlier payments that each home health agency (HHA) can claim. Since 2010, Medicare payments for home health care nationally decreased by more than \$300 million per quarter, more than \$1 billion annually.²

We have also seen sustained declines in Medicare payments for durable medical equipment (DME) and ambulance services in targeted areas following Federal enforcement and oversight action. Total Medicare payments for ambulance services in Houston are down approximately 50 percent from \$32 million to \$16 million per quarter since 2010.³ Miami-area DME payments have decreased by approximately \$100 million annually since launch of the Medicare Fraud Strike Force in Miami in 2007.⁴

These successes are funded through the Health Care Fraud and Abuse Control Program (a joint program of the Department, OIG, and the Department of Justice to fight waste, fraud, and abuse

¹ See Appendix 1, slide titled *Outcomes: CMHC Payment Trends*.

² See Appendix 1, slide titled *Outcomes: HHA Payment Trends*. See also *Healthcare Fraud and Abuse Control Program Annual Report for Fiscal Year 2013*, p.13; available at <http://oig.hhs.gov/publications/docs/hcfac/FY2013-hcfac.pdf>.

³ See Appendix 1, slide titled *Outcomes: Ambulance Payment Trends*.

⁴ See Appendix 1, slide titled *Outcomes: DME Payment Trends*.

in Medicare and Medicaid), which returns more than \$8 for every \$1 invested.⁵ However, more remains to be done. In March 2014, OIG issued its *Compendium of Priority Recommendations*, which highlights additional opportunities for cost savings and program and quality improvements.⁶ Implementing these recommendations could result in billions of dollars saved and more efficient and effective programs. My testimony today focuses on a selection of key recommendations from the *Compendium* and other program integrity recommendations consistent with OIG's work, provides an overview of current fraud trends, and highlights challenges that impede effective oversight of Medicare and Medicaid.

Current Trends in Health Care Fraud

Fraud schemes are constantly evolving. As enforcement efforts target certain schemes, new permutations of those schemes arise. Not only are fraud schemes mutating, they are migrating – geographically and even between parts of the Medicare program. Some of OIG's highest priorities and concerns involve the emergence of criminal networks in healthcare fraud, the rise in prescription drug abuse and diversion, and the provision of illegitimate home-based care.

Criminal Networks

Over the past several years OIG has seen an increase in organized criminal elements committing health care fraud. This may be attributed to the ease of entry into some sectors of the health care industry, the lucrative nature of health care fraud, the belief that it is less violent than other types of crime, or a perception of reduced criminal penalties. Criminal networks have become a pervasive problem in DME, home health, outpatient clinics, and pharmacies. Schemes typically involve kickbacks, nominee owners, recruiters, and money laundering. In one particular Strike Force case, an organized criminal network used a fraudulent medical clinic to bill Medicare over \$77 million for services that were medically unnecessary and never provided. Co-conspirators included clinic owners; a medical director who was rarely on site at the clinic; money laundering operatives; and complicit Medicare beneficiaries, who accepted regular cash kickbacks. Over a dozen co-conspirators have been sentenced to an aggregate total of more than 45 years in prison, over \$50 million in restitution, and millions more in asset forfeiture. The clinic owner and criminal network leader was sentenced to 15 years in prison, excluded from all Federal health care programs, and ordered to forfeit over \$36 million. The medical director was sentenced to over 12 years in prison and ordered to forfeit more than \$500,000.

Federal forfeitures are a valuable tool to help defund and disrupt illegal activities and can serve as a powerful fraud deterrent. However, OIG lacks the authority to execute warrants for seizure of property for forfeiture. We must instead seek assistance from other law enforcement agencies in securing and executing relevant warrants – this has resulted in administrative inefficiencies

⁵ The \$8 to \$1 return on investment is a 3-year rolling average from fiscal year (FY) 2010-2013. For more details on this and other HCFAC accomplishments, see the *FY 2013 Health Care Fraud and Abuse Control Program Report*, available at <http://oig.hhs.gov/reports-and-publications/hcfac/index.asp>.

⁶ Office of Inspector General's *Compendium of Priority Recommendations*, March 2014, available at <http://oig.hhs.gov/reports-and-publications/compendium/index.asp>.

and costly delays. In one recent case, OIG agents identified an account into which proceeds of Medicare fraud were being deposited. By the time we enlisted another agency to obtain and issue seizure warrants, the estimated \$1.3 million in the account had been withdrawn. To ensure that the Federal government and taxpayers are made whole for losses due to health care fraud, it is important that Federal law enforcement move immediately after identifying assets that are the proceeds or fruits of criminal activity. Empowering OIG to execute forfeiture warrants would be a step in helping ensure this outcome.

Medical identity theft is a prevalent and increasing crime that is closely linked to Medicare fraud schemes, especially those involving criminal networks. Although beneficiaries can be complicit in criminal network operations, in one Strike Force case, subjects perpetrated a 100 million dollar Medicare fraud scheme that involved stealing the identities of doctors and thousands of Medicare beneficiaries for use in phony clinics around the country.

Key OIG recommendations include:

- Provide OIG with authority to execute Federal warrants for the seizure of assets for forfeiture to curb the profitability of healthcare fraud, which will exert a deterrent effect.
- Remove Social Security numbers (SSN) from Medicare cards to help protect the personally identifiable information of Medicare beneficiaries.

Prescription Drug Fraud

Medicare Part D, the prescription drug program, in calendar year 2012 cost \$66.9 billion in expenditures for 30 million enrolled beneficiaries. OIG has extensively examined CMS's monitoring and oversight of the Part D program and the effectiveness of controls to ensure appropriate payment and patient safety. Our work has found limitations in program safeguards that leave Part D vulnerable to improper payments and Medicare patients vulnerable to potentially harmful prescribing. These include extreme outlier provider prescribing patterns and questionable billings by numerous retail pharmacies nationwide.⁷ The prescription fraud schemes are complex crimes involving many co-conspirators, including health care professionals, patient recruiters, pharmacies, and complicit beneficiaries. An increasing percentage of OIG work involves prescription drug fraud.⁸ In FY2013 alone, OIG opened 312 new Part D investigations; this is an 80 percent increase over FY2009.

Overprescribing of controlled substances can lead to patient harm. Of particular concern are cases in which patient deaths occur as a result of prescription drug diversion or "doctor shopping." In one example, a physician was arrested for prescribing oxycodone-based products to bogus patients who were complicit beneficiaries that received \$150 cash per office visit for

⁷ See, e.g., *Medicare Inappropriately Paid for Drugs Ordered by Individuals Without Prescribing Authority*, OEI-02-09-00608, June 2013, available at <http://oig.hhs.gov/oei/reports/oei-02-09-00608.asp>; *Retail Pharmacies With Questionable Part D Billing*, OEI-02-09-00600, May 2012, available at <http://oig.hhs.gov/oei/reports/oei-02-09-00600.asp>; *Prescribers With Questionable Patterns In Medicare Part D*, OEI-02-09-00603, June 2013, available at <http://oig.hhs.gov/oei/reports/oei-02-09-00603.asp>.

⁸ See *Spotlight on Drug Diversion*, available at <http://oig.hhs.gov/newsroom/spotlight/2013/diversion.asp>.

their participation in the scheme. The complicit beneficiaries then used their Medicare, Medicaid or private insurance cards and cash to pay for the filled prescriptions at various pharmacies and then sold them for \$300-\$1000 to various drug-trafficking organizations, which then resold the drugs on the street. This scheme resulted in the illegal distribution of more than 700,000 pills of oxycodone, including one patient death. The physician was sentenced to 20 years in prison and forfeited \$10 million. A total of 61 defendants have been sentenced to a combined 253 years in prison.

Prescription drug fraud involving non-controlled substances is becoming more common. The billing but not dispensing of non-controlled medications presents a massive financial loss to the Medicare program. Schemes typically involve brand-name, high-cost medications, including respiratory, HIV/AIDS, and anti-psychotic medications, along with co-conspirator beneficiaries who assist in obtaining the prescriptions in exchange for a kickback. In one south Florida case, a pharmacy was found to be billing but not actually dispensing expensive non-controlled medications. The pharmacy received fake invoices from a wholesaler to cover this shortage. OIG special agents infiltrated the wholesale company and arrested the owner. During the investigation it was discovered that the wholesaler had supplied fake invoices to 17 other local pharmacies.

Key OIG recommendations include:

- Strengthen the Medicare contractor's monitoring of pharmacies and its ability to identify for further review of pharmacies with questionable billing patterns.
- Require Part D plans to verify that prescribers have the authority to prescribe.

CMS issued a proposed rule that would require all prescribers of Part D drugs to be enrolled in the Medicare fee-for-service program (or officially opt out).⁹ If implemented, this requirement could help CMS, Part D plans, and the Medicare program integrity contractor enhance their monitoring and better prevent and detect Part D improper payments and potential fraud.

Home-Based Services

Concerns with home-based services include fraud in home health, hospice, and the Personal Care Services (PCS) program.

Enforcement efforts, the capping of outlier payments, and imposing moratoria have significantly decreased illegal billing for home health services.¹⁰ Schemes nonetheless continue to evolve, vulnerabilities persist, and home health remains a top oversight priority for OIG. Home health schemes often involve patient recruiters, co-conspirator beneficiaries receiving kickbacks, and HHAs billing but providing no care and/or unnecessary services. In one case, an HHA fraud scheme included company owners, health care providers, and patient recruiters conspiring to bill Medicare for services that were never rendered and that were for patients who were not

⁹ Federal Register, Volume 79, Number 7, pages 1982-1987, published January 10, 2014, available at <http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2013-31497.pdf>.

¹⁰ See Appendix 1, slide titled *Outcomes: HHA Payment Trends*.

homebound. The egregious behavior also included kickbacks to patients that included cash and the promise of prescriptions for narcotics. One of the HHA owners was sentenced to 10 years in prison and ordered to pay more than \$10 million in restitution with his co-conspirators. One subject is still a fugitive at large.

OIG has also uncovered documentation errors and other vulnerabilities that are of concern in home health. For example, physicians (or certain practitioners working with them) who certify beneficiaries as eligible for Medicare home health services must document – as a condition of payment for home health services – that face-to-face encounters with those beneficiaries occurred. The face-to-face encounter alone does not satisfy the requirement; the certifying physician must also complete documentation that is clearly titled, signed, and dated. A recent OIG review reveals that for 32 percent of home health claims that required face-to-face encounters, the documentation did not meet Medicare requirements, resulting in \$2 billion in payments that should not have been made.¹¹

As of February 29, 2012, 2,004 HHAs still owed CMS a total of approximately \$408 million for \$590 million in overpayments that the agency identified for these HHAs between 2007 and 2011. CMS could have recovered at least \$39 million between 2007 and 2011 if it had required each HHA to obtain a \$50,000 surety bond.¹²

Key OIG recommendations include:

- Increase monitoring of Medicare claims for home health services.
- Create a standardized form to ensure better compliance with the face-to-face encounter documentation requirements.
- Implement the surety bond requirement for HHAs.¹³

Medicare's hospice benefit is designed for Part A patients who have been certified as terminally ill. It covers palliative and support services including personal care, medical equipment, therapy, and other services. Fraud in this area includes falsely certifying that patients are eligible for hospice services when they are not, and upcoding. Continuous home care (CHC) is a higher level of care meant for patients in crisis. Hospice fraud schemes involve billing CHC for patients who do not need this level of care and do not receive it, even back-dating a deceased patient's file to include CHC that was never provided. In one case, a hospice company owner billed Medicare over 16 million dollars for patients who were not hospice eligible, and for higher level care services than were provided. Doctors were paid for referrals for ineligible patients while nurses and other staff co-conspirators altered patient records to fabricate a decline in patient medical conditions. Sometimes patients receive cash kickbacks and are complicit in hospice fraud schemes, while other beneficiaries are unaware that they have been falsely

¹¹ *Limited Compliance With Medicare's Home Health Face to Face Documentation Requirements*, available at <http://oig.hhs.gov/oei/reports/oei-01-12-00390.asp>.

¹² *Surety Bonds Remain an Unused Tool to Protect Medicare from Home Health Overpayments*, available at <http://oig.hhs.gov/oei/reports/oei-03-12-00070.asp>.

¹³ In January 1998, CMS promulgated a final rule requiring each HHA to obtain a surety bond in the amount of \$50,000 or 15 percent of the annual amount paid to the HHA by Medicare, whichever is greater. However, this regulation remains unimplemented.

categorized as hospice eligible. In another case, a hospice company owner conspired with an individual who provided names and identifying information of Medicare beneficiaries in exchange for cash; the signatures of referring physicians and Medicare beneficiaries were then forged on medical documents. OIG reviews also suggest that Medicare's hospice payment methodology may lead some hospices to inappropriately seek out beneficiaries in nursing facilities.¹⁴

Key OIG recommendations include:

- Monitor hospices that depend heavily on nursing facility residents.
- Modify the payment system for hospice care in nursing facilities, seeking statutory authority if necessary.

The Medicaid Personal Care Services (PCS) program assists the elderly, those with disabilities, and those with chronic conditions with health care that they can receive while remaining in their homes. The services are provided by a personal care attendant (PCA). In 2011 alone, the PCS program spent \$12.7 billion. Fraud in this program is increasing and includes schemes where PCAs and beneficiaries act as co-conspirators and care isn't needed or isn't provided. As of the first quarter of 2013, the State Medicaid Fraud Control Units had more than 1,000 such investigations nationwide. This fraud is very difficult to detect, often coming to our attention through whistleblowers. In one case, an individual who was on Medicaid disability herself, fraudulently signed up as a PCA. To avoid losing her own Medicaid benefits, the individual first misappropriated her daughter's name, and then conspired with a neighbor to use his name to obtain status as a PCA. The individual became the PCA to a family friend who was a Medicaid beneficiary. The individual ignored the patient's serious medical issues which should have led to hospitalization and the patient died from malnutrition and sepsis because of neglect. The individual was sentenced to 4 years of incarceration and the co-conspirator neighbor was sentenced to six months in prison.

Key OIG recommendations include:

- Consider whether additional controls are needed to ensure that the PCS are allowed under the program rules and are provided.
- Take action to provide States with data suitable for identifying overpayments for PCS claims when beneficiaries are receiving institutional care being paid for by Medicare or Medicaid.

Oversight Challenges

Data challenges and resource constraints pose significant challenges for program integrity efforts.

¹⁴ *Medicare Hospices That Focus on Nursing Facility Residents*, available at <http://oig.hhs.gov/oei/reports/oei-02-10-00070.asp>.

Technology is Driving Changes in Program Integrity Efforts

Advances in data analysis and the proliferation of electronic health records (EHR) have changed the way OIG detects and investigates health care fraud. With the proliferation of EHR systems, we hope to see an increase in legibility and portability, more accurate billing, and improved quality of care. However, health care fraud itself has become more sophisticated as criminals use technology, including EHRs, to facilitate fraud. This has already been observed in the illegitimate use of cut-and-paste record cloning and over-documentation with false and irrelevant material to justify upcoding.

Additionally, with the growing use of EHR systems, evidence collection is moving increasingly away from paper files to an unprecedented amount of electronic evidence. As a result, law enforcement is developing new investigative techniques to supplement the traditional methods used in examining the authenticity and accuracy of records. We confront additional challenges relating to the collection and analysis of unprecedented amounts of electronic evidence. For example, the amount of digital data collected by OIG's Office of Investigations has grown ten-fold since 2009. While such advances have the potential to provide OIG and its law enforcement partners with more leads to investigate than ever before, the data deluge strains electronic server capacity and staff resources.

Additional Safeguards Are Needed to Protect Electronic Health Records

New digital environments also necessitate new safeguards for patient data. Yet through a survey of hospitals that received EHR incentive payments, OIG learned that not all recommended fraud safeguards have been implemented in hospital EHR technology.¹⁵ For example, nearly half of hospitals indicated they could delete audit logs, and a third of hospitals indicated that they could disable their audit logs. Audit functions, such as audit logs, track access and changes within a record chronologically by capturing data elements, such as date, time, and user stamps, for each update to an EHR. An audit log can be used to analyze historical patterns that can identify data inconsistencies. To provide the most benefit in fraud protection, audit logs should always be operational while the EHR is being used and be stored as long as clinical records. Users should not be able to alter or delete the contents of the audit log. Deleting or disabling audit logs makes it harder to prevent and detect fraud. Further, most hospitals did not analyze audit logs with the intent to try to identify duplicate and fraudulent claims and inflated billing. In a separate review, we discovered that CMS and its contractors had not adjusted their program integrity strategies for electronic records versus paper records.¹⁶

Key OIG recommendations include:

- Mandate the use of the audit log feature in all EHRs.

¹⁵ *Not All Recommended Fraud Safeguards Have Been Implemented in Hospital EHR Technology*, available at <http://oig.hhs.gov/oei/reports/oei-01-11-00570.asp>.

¹⁶ *CMS and Its Contractors Have Adopted Few Program Integrity Practices To Address Vulnerabilities in EHRs*, available at <http://oig.hhs.gov/oei/reports/oei-01-11-00571.asp>.

- Work with contractors to identify best practices and develop guidance and tools for detecting fraud associated with EHRs, with specific guidance to address EHR documentation and electronic signatures in EHRs.

Oversight of Medicare and Medicaid is Hampered By Lack of Accurate, Timely, Complete Data

Data challenges manifest not only with respect to EHRs, but in other parts of Medicare and Medicaid. OIG is combining field intelligence with data mining, predictive analytics, and modeling to more efficiently target oversight, support ongoing investigations, and pursue shifts in health care fraud patterns. However, oversight of Medicare Part C (Medicare Advantage, or MA) and Medicare Part D is hampered by a lack of accurate, timely, and complete data that would facilitate oversight efforts. For example, MA and Part D plans' efforts to identify and address potential fraud and abuse are crucial to protecting the integrity of the Parts C and D programs. Since 2008, OIG has repeatedly recommended that CMS require mandatory reporting of fraud and abuse data by MA and Part D plans. CMS has disagreed and therefore does not require mandatory reporting of fraud and abuse by these plans. Under the current voluntary reporting system, less than half of Part D plans reported fraud and abuse data to CMS. Twenty-eight percent of plans that identified fraud reported initiating no inquiries or corrective actions with regard to any of the incidents.¹⁷

Further, barriers exist to obtaining Medicare Part C claims data. CMS contracts with private organizations under Part C to provide private health plan managed care options. There is limited data availability and there are difficulties with access to information. There is no centralized Part C data repository, which hinders the ability to identify and investigate Part C fraud. Also the Medicare Drug Integrity Contractor is unable to share specific information with other program integrity contractors.

National-level oversight of Medicaid is similarly impeded by the lack of timely, accurate, and complete Medicaid data. OIG has uncovered significant shortcomings in the data available to conduct efficient, national Medicaid program integrity oversight through data analysis and data mining. While CMS has taken steps to improve Medicaid data through the Transformed Medicaid Statistical Information System, or T-MSIS, our review of early T-MSIS implementation outcomes raised questions about the completeness and accuracy of T-MSIS data upon national implementation.¹⁸

Key OIG recommendations include:

- Amend regulations to require MA and Part D plans to report to CMS, or its designee, their identification of and response to incidents of potential fraud and abuse.

¹⁷ Testimony of Robert Vito, Regional Inspector General for Evaluation and Inspections, before House Committee on Energy and Commerce, March 4, 2014, available at http://oig.hhs.gov/testimony/docs/2014/vito_testimony_03042014.pdf.

¹⁸ *Early Outcomes Show Limited Progress for the Transformed Medicaid Statistical Information System*, available at <http://oig.hhs.gov/oei/reports/oei-05-12-00610.asp>.

- Establish a deadline for when complete, accurate, and timely T-MSIS data will be available.

Improvements Are Needed to States' Reporting to OIG of Adverse Actions Against Providers

One of the key administrative tools OIG utilizes is the authority to exclude individuals and entities from participating in the Federal health care programs. Like debarment in government procurement, the effect of an exclusion is that the excluded individual or entity cannot submit claims for services provided to Federal health care program beneficiaries. OIG receives important information from State licensing boards' notices of adverse actions, which enable us to identify numerous individuals who are subject to exclusion. However, we do not receive reports of all adverse actions from all States. State licensing boards are not statutorily required to refer adverse actions against providers to OIG. We currently receive this information on a voluntary basis from the State boards, general public notices of board actions in various States, or working relationships developed by OIG exclusions analysts with staff from various other agencies and organizations. Furthermore, the manner and timing of the notices is entirely dependent on each State licensing board. More reliable and standardized reporting from States would improve OIG's ability to exclude problematic providers.

Key OIG recommendations include:

- Explore requirements to increase and standardize State licensure boards' reporting of adverse actions to OIG.

Conclusion

OIG is responsible for oversight of about 25 cents of every Federal dollar. Our oversight priorities extend not only to safeguarding Federal dollars but also to quality of care consequences for the programs and patients. As noted throughout my testimony, health care fraud is not just about dollars lost – health care fraud can also put patients' health at risk. Unfortunately OIG's mission is challenged by declining resources for Medicare and Medicaid oversight at a time when these programs and our responsibilities are growing. Since 2012, we have closed over 2,200 investigative complaints because of lack of resources. We expect to reduce our Medicare and Medicaid oversight by about 20 percent by the end of this FY. Yet the Department estimated that Medicare and Medicaid outlays would grow by about 20 percent from 2012 to 2014. Full funding of our 2015 budget request would enable us to provide more robust oversight and advance solutions to protect the Medicare and Medicaid programs, beneficiaries, and taxpayers.

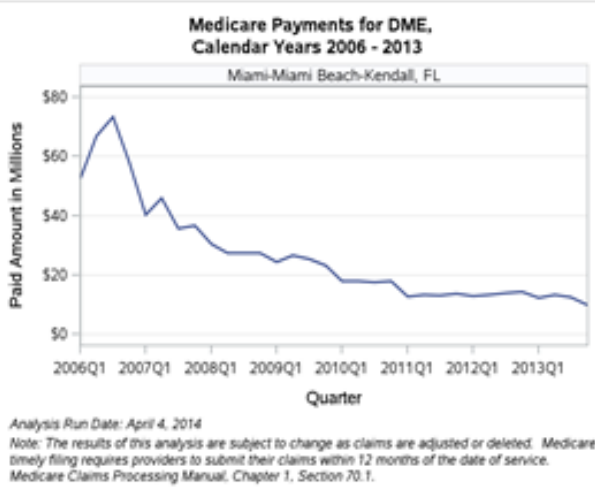
Thank you for your interest and support and for the opportunity to discuss some of our work. I am happy to answer any questions you may have.

APPENDIX I



Outcomes: DME Payment Trends

Sustained declines in Medicare payments have followed Federal enforcement and oversight action.

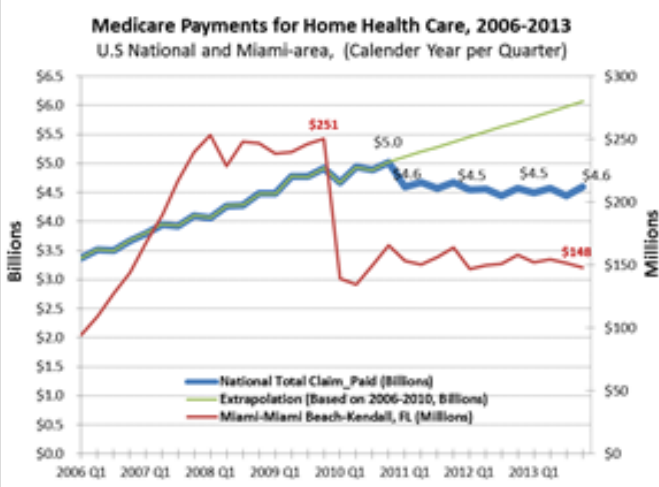


- Medicare payments for DME in Miami peaked at more than \$60 million per quarter in 2006
- In 2007, numerous federal oversight and administrative initiatives were launched by CMS, OIG and others, including the Medicare Fraud Strike Force in May 2007
- Miami-area DME payments decreased from over \$40 million per quarter in 2007 -before the Strike Force's first takedown- to \$15 million per quarter in 2011 (e.g., approximately \$100 million in annual savings thereafter)



Outcomes: HHA Payment Trends

Sustained declines in Medicare payments have followed Federal enforcement and oversight action.



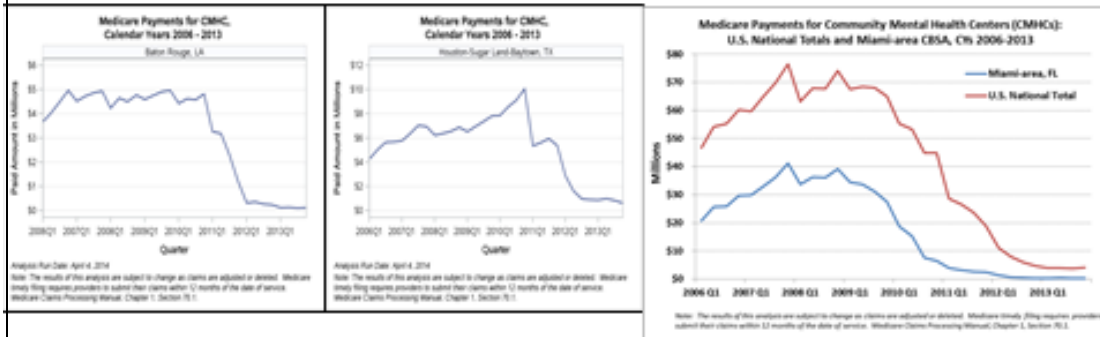
- Medicare payments for Home Health care increased from 2006 until 2010
- In 2009, federal enforcement actions (initiated by the HEAT Strike Force case *U.S. v. Zambrana* in Miami), followed by the OEI HHA Outlier Payments report, influenced CMS to change Medicare's HHA outlier coverage policy
- Since 2010, Medicare payments for home health care nationally decreased by more than \$300 million per quarter (e.g., more than \$1 billion annually)
 - In Miami, payments for HHAs decreased by \$100 million per quarter since peak in 2009
 - In Dallas and McAllen, TX, payments for HHAs are down by \$30 million per quarter
 - In Detroit, payments for HHAs decreased by \$15 million per quarter since peak in 2009





Outcomes: CMHC Payment Trends

Sustained declines in Medicare payments have followed Federal enforcement and oversight action.



- In Baton Rouge: Medicare payments fell nearly \$3 million per quarter
- In Houston: Medicare payments fell nearly \$10 million per quarter
- In Miami: Medicare payments declined about \$40 million per quarter
- Nationally, payments for CMHCs decreased from \$70 million to under \$5 million per quarter (>\$250 million annually)

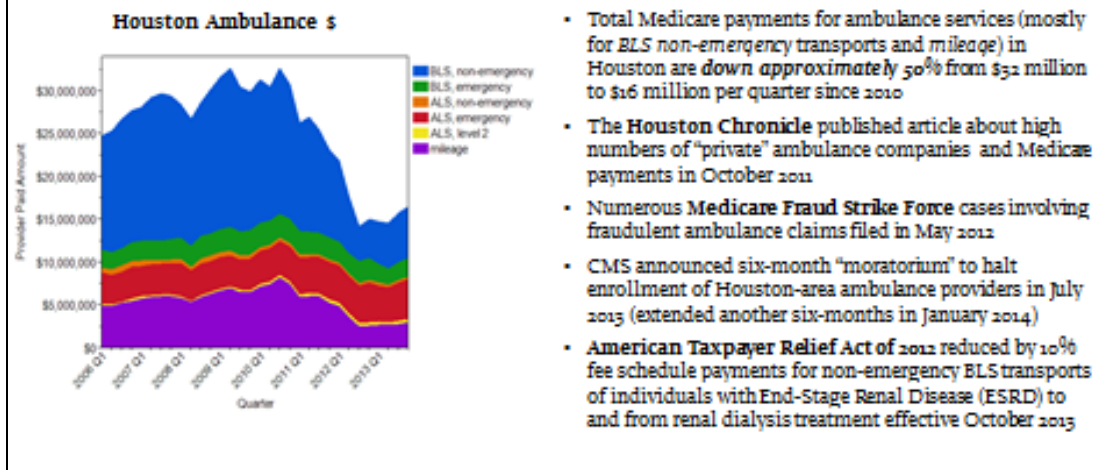


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Outcomes: Ambulance Payment Trends

Sustained declines in Medicare payments have followed Federal enforcement and oversight action.



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