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**CURBING FRAUD, WASTE, AND ABUSE MUST BE AN ESSENTIAL
COMPONENT OF ANY HEALTH CARE REFORM STRATEGY**

Introduction

On behalf of Inspector General Levinson and the Office of Inspector General (OIG), I thank you for the opportunity to discuss why combating waste, fraud, and abuse must be an essential component of any strategy to reform the health care system. OIG is an independent, non-partisan agency committed to protecting the integrity of the 300 agencies and programs administered by the Department of Health and Human Services (HHS). Approximately 80 percent of OIG's resources are dedicated to promoting the efficiency and effectiveness of the Medicare and Medicaid programs and protecting these programs and their beneficiaries from fraud and abuse. Thanks to the hard work of our 1,500 employees and our law enforcement partners, from FY 2006 through FY 2008, OIG's investigative receivables averaged \$2.04 billion and its audit disallowances resulting from Medicare and Medicaid oversight averaged \$1.22 billion per year. The result was a Medicare- and Medicaid-specific return on investment for OIG oversight of \$17:\$1. In addition, in FY 2008, implemented OIG recommendations resulted in \$16.72 billion in savings and funds put to better use.

The history of Federal health care programs shows us that the way the health care system reimburses for items and services dictates how the unethical and dishonest will exploit it. For example, when Medicare pays on a fee-for-service basis, providers have an incentive to increase the number and complexity of the services, even if those services are not medically necessary. When the program pays on a capitated basis, the incentive is reversed. Patients may not receive the necessary services for which the program has paid the health care provider. In short, the specific anti-fraud measures and program safeguards that must be integrated into a reformed health care system depend on the way that system and its payments are structured. Enacting appropriate anti-fraud measures simultaneously with any health care reform is essential to protect the integrity of the health care system.

Fraud in the U.S. Health Care System

Regardless of the structure of health care reform, detecting and preventing waste, fraud, and abuse in the health care system is critical. The United States spends more than \$2 trillion on health care every year. The National Health Care Anti-Fraud Association estimates conservatively that of that amount, at least 3 percent—or more than \$60 billion each year—is lost to fraud. Funds wasted on medically unnecessary services and other improper payments also deplete needed resources from the health care system. Although Centers for Medicare and Medicaid Services (CMS) has made progress in addressing improper payments, it continues to pay for services that were not properly documented or

medically necessary. For example, CMS reports that the improper payments rate for Medicare fee-for-service payments was 3.6 percent, or \$10.4 billion in 2008.

Sophisticated health care fraud schemes rely on falsified records, elaborate business structures, and the participation of health care providers and even patients to create the false impression that the Government is paying for legitimate health care services. Although we cannot measure the full extent of health care fraud in Medicare and Medicaid, everywhere we look we continue to find fraud in these programs.

For example, in FY 2008:

- The Federal Government won or negotiated approximately \$2.35 billion in investigative receivables, including criminal, civil, and administrative settlements or civil judgments. The Government's enforcement efforts resulted in 455 criminal actions and 337 civil actions against individuals or entities that engaged in health-care-related offenses.
- OIG opened 1,750 new health care fraud investigations and had over 2,500 health care investigations open at the end of FY 2008.
- OIG excluded 3,129 individuals and entities from participation in Medicare, Medicaid, and other Federal health care programs. Most OIG exclusions result from convictions for crimes concerning Medicare or Medicaid, for patient abuse or neglect, or as a result of license revocation.

Five Principles for Combating Health Care Fraud, Waste, and Abuse

For the U.S. health care system to adequately serve the medical needs of current patients and remain solvent for future generations, we must pursue an effective strategy to combat fraud, waste, and abuse. We believe that this strategy must embrace five principles:

1. Scrutinize individuals and entities that want to participate as providers and suppliers, prior to their enrollment in health care programs.
2. Establish payment methodologies that are reasonable and responsive to changes in the marketplace.
3. Assist health care providers and suppliers in adopting practices that promote compliance with program requirements, including quality and safety standards.
4. Vigilantly monitor the programs for evidence of fraud, waste, and abuse.
5. Respond swiftly to detected frauds, impose sufficient punishment to deter others, and promptly remedy program vulnerabilities.

I will briefly elaborate on each of these principles.

Scrutinize individuals and entities that want to participate as providers and suppliers prior to their enrollment in health care programs.

Screening measures should include requiring providers to meet accreditation standards, requiring proof of business integrity or surety bonds, periodic recertification and onsite verification that conditions of participation have been met, and full disclosure of ownership and control interests. A lack of effective screening measures gives dishonest and unethical individuals access to a system that they can easily exploit. For example, in January of 2005, an individual arrived in Miami-Dade County from Cuba and soon thereafter enrolled as a Medicare provider. From April until June of 2005, his new company billed over \$4.1 million in fraudulent claims for which the Government paid \$1.65 million. He has since disappeared. In our experience, it is too easy for organized crime to recruit “front men” as the nominal owners of fraudulent medical supply companies and replace them when the scheme is detected.

It also is important to increase the structural transparency of the companies that participate in the health care system. For example, many nursing home chains adopt elaborate corporate structures designed to obscure ownership of facilities and defuse accountability. Under this scenario, when a nursing home fails to provide adequate care to its residents, it can be impossible to identify who is actually operating the facility and should be held accountable for the neglect of the residents.

Establish payment methodologies that are reasonable and responsive to changes in the marketplace.

Health care programs should have mechanisms to ensure that payments remain reasonable and reflect market conditions. OIG has conducted extensive reviews of Medicare payment and pricing methodologies, which have determined that the program pays too much for certain items and services. When reimbursement methodologies do not effectively respond to changes in the marketplace, the system and its beneficiaries bear the cost.

OIG recently found that Medicare reimburses suppliers for negative pressure wound therapy pumps based on a purchase price of more than \$17,000, but suppliers paid an average of \$3,600 for new models of these pumps. Negative pressure wound therapy pumps are a type of durable medical equipment (DME) used to treat ulcers and other serious wounds. When Medicare first started covering wound pumps in 2001, it covered only one model, which was manufactured and supplied by one company. Medicare paid for this pump based on the purchase price as identified by that company. In 2005, Medicare expanded its coverage to include several new pump models manufactured by other companies. However, Medicare reimburses suppliers for these new pumps based on the original pump’s purchase price, which is more than four times the average price paid by suppliers.

In another study of DME reimbursement, OIG found that in 2006, Medicare allowed on average of \$7,215 for rental of an oxygen concentrator that costs about \$600 to purchase new. Additionally, beneficiaries incurred \$1,443 in coinsurance charges for these

equipment rentals. We determined that if home oxygen payments were limited to 13 months rather than the current 36 months, Medicare and its beneficiaries would save \$3.2 billion over 5 years. Because Medicare's reimbursement methodologies do not respond promptly to changes in the marketplace, Medicare and beneficiaries are paying too much.

In addition, the health care system must anticipate that providers may alter their practices in response to program integrity efforts. Proactively establishing program safeguards helps to ensure that changes to payment methods result in savings and not merely to modify an abusive practice. For example, prior Medicare policy precluded separate payment for preadmission diagnostic tests performed within 24 hours before the beneficiary's admission to a hospital. OIG found that hospitals were performing the tests shortly beyond the 24-hour period to maximize reimbursement. In response, CMS changed the policy to preclude payments for tests performed within the 72-hours prior to admission. Subsequent OIG work found that hospitals responded by changing preadmission procedures and conducting these tests as far as 2 weeks before the admission date. In considering any payment system, it is important to consider the incentives that it creates and seek to maximize the positive behavior (i.e., high-quality, cost-effective care) and implement necessary safeguards to reduce the negative incentives.

Assist health care providers and suppliers in adopting practices that promote compliance with program requirements.

Health care providers must be our partners in ensuring the integrity of health care programs and should adopt internal controls and other measures that promote compliance and prevent, detect, and respond to health care fraud, waste, and abuse. Compliance programs are an essential component of a comprehensive anti-fraud strategy, and policymakers should consider how to motivate health care providers to incorporate integrity safeguards and tools into their organizations. Recognizing the importance of compliance systems, the New York Medicaid program requires its health care providers to implement an effective compliance program as a condition of participation in Medicaid.

The Government also must play a leadership role in promoting the health care industry's commitment to integrity. As part of its collaboration with the health care industry, for example, OIG publishes voluntary compliance program guidances, fraud alerts, and advisory opinions on the fraud and abuse laws. We also offer a way for providers that uncover fraudulent billings or other misconduct within their organizations to self-disclose the problem and to work with OIG to resolve the issue, including return of the inappropriate payments.

Vigilantly monitor the programs for evidence of fraud, waste, and abuse.

The health care system compiles an enormous amount of data on patients, providers, and the delivery of health care items and services. However, the Federal health care programs often fail effectively to use claim-processing edits and other information technology to identify improper claims before they are paid. For example, our review of hospital compliance with Medicare's postacute care transfer policy identified over \$200 million in improper payments made for claims that misrepresented that the patients were discharged

to home when the patients were actually discharged to postacute care settings. Although CMS implemented OIG's recommendation and installed an edit to detect transfers improperly coded as discharges, CMS continues to make some erroneous payments.

For over a decade, OIG has reported on integrity vulnerabilities related to how Medicare identifies the physicians who order medical items and services. We found that in 1999, Medicare paid \$91 million for DME claims with invalid or inactive identifiers for the prescribing physicians. Of this amount, almost \$8 million was paid for DME claims that identified deceased physicians as the prescribers. Medicare's claims-processing systems verified that the identifiers listed on claims met certain data format requirements but did not verify that the identifiers were valid and active. In 2005, Medicare began implementing a new system of provider identifiers. OIG analyzed DME claims from 2007 to determine whether the new system addressed the vulnerabilities of the former system. We found that Medicare allowed \$34 million in payments for DME claims with invalid or inactive prescriber identifiers, including \$5 million for claims that identified deceased prescribers. Although the amount of waste has declined since 1999, the failure to detect invalid and inactive provider identifiers may continue to be a problem under the new system.

Respond swiftly to detected fraud, impose sufficient punishment to deter others, and promptly remedy program vulnerabilities.

Our investigations have shown that there is an increase in organized crime elements within the health care fraud arena. Health care fraud is attractive to organized crime because the penalties are lower than those for other organized-crime-related offenses (e.g., offenses related to illegal drugs); there are low barriers to entry (e.g., a criminal can obtain a supplier number, gather some beneficiary numbers and bill the program); schemes are easily replicated; and there is a perception of a low risk of detection. Because they target health care items and services that produce excessive reimbursement, these criminals can reinvest some of their profit in kickbacks for additional referrals, thus using the program's funds to perpetuate the fraud scheme. To combat health care fraud successfully, we need to alter the cost-benefit analysis for those considering health care fraud by increasing the risk of swift detection and the certainty of punishment.

As part of this strategy, law enforcement must accelerate the Government's response to fraud schemes. By way of example, Florida's Miami-Dade County is plagued by fraudulent DME companies, infusion clinics, and other dishonest Medicare providers and suppliers. In May 2007, the Department of Justice (DOJ) and HHS created a strike force whose primary goal was to attack the fraud problem in South Florida by decreasing the amount of time between the Government's detection of a fraud scheme and the arrest and prosecution of the offenders. To date, the strike force has opened 106 cases, convicted 141 of its targets, and secured \$189 million in criminal fines and civil recoveries. Building on the success of the South Florida strike force, in March 2008, DOJ and OIG created a second strike force in another fraud hotspot—Los Angeles.

The health care system must continually upgrade procedures for identifying and preventing payments to abusive providers. Criminals will test a system's payment edits and program integrity algorithms by "pinging" the system with small batches of test claims and will then

submit fraudulent claims that are below those thresholds. Dishonest billing companies are rewarded financially by the fraudsters for their ability to circumvent payment edits and identify billing codes for exploitation. To protect itself from fraud schemes, which evolve in response to program safeguards, the health care system must continually update its payment edits and other integrity measures.

The health care system also must respond more quickly once a vulnerability is identified. For example, once identity theft is uncovered, the program must make it more difficult for scam artists to misuse a beneficiary's or legitimate provider's Medicare number. When a consumer discovers his or her credit card has been stolen, it is a simple matter to cancel the card and stop its potential abuse. Medicare also needs to be able quickly to void compromised Medicare beneficiary or provider numbers and to sanction those who traffic in this type of information.

Conclusion

In the health care system, how you pay determines how you will be cheated. A comprehensive health care integrity strategy should be an integral element of any systemic health care reforms. OIG and its law enforcement partners will need new tools and sufficient resources if we are to succeed in our ongoing fight against health care fraud, waste, and abuse.