Good morning, Mr. Chairman and Members of the Committee. I am here today to discuss fraud, waste, and abuse in the Medicare and Medicaid programs.

My job is to prevent and eliminate fraud, waste, and abuse in the many programs of the Department of Health and Human Services, including Medicare and Medicaid. The Office of Inspector General uncovers innocent errors, carelessness, mismanagement, exploitation of the programs, malfeasance, and outright fraud every day. Improper behaviors include providers billing for services not rendered, falsification of diagnoses, and unnecessary tests or services, abusing and neglecting beneficiaries, and accepting kickbacks. These activities cost taxpayers billions in lost and wasted dollars and deprive vulnerable beneficiaries of the care and support they need.

The Medicare and Medicaid programs are managed by the Centers for Medicare and Medicaid Services (CMS), which is the largest component of the U.S. Department of Health and Human Services (HHS). The two programs are particularly vulnerable because of their sheer size. Combined, they constitute the largest single purchaser of health care in the world with FY 2003 projected federal outlays of over $435 billion. Medicare and Medicaid outlays represented 33 cents of every dollar of health care spent in the United States in FY 2002. Both programs have inherent risks not only because of their high outlays, but because of their complex reimbursement rules and decentralized operations. Medicare alone serves approximately 40 million beneficiaries and processes almost 1 billion claims annually.

With increasing dollars at stake, and with a growing beneficiary population, the potential for vulnerabilities in these programs is greater than ever. Fraud, waste and abuse schemes are becoming increasingly complex, national in scope, and constantly changing in response to the latest oversight efforts by the congress, CMS, our office and our law enforcement partners.

RECENT MAJOR SETTLEMENTS

There is no better way to illustrate the problems we are facing in the area of fraud and abuse than to describe some of our most recent settlements. The government alleged that HCA Inc. (formerly known as Columbia/HCA and HCA–The Healthcare Company) submitted false hospital cost reports to the government and paid kickbacks to physicians in exchange for their referral of beneficiaries. HCA routinely prepared two sets of cost reports, one that was submitted to the Medicare program, and a set of "reserve" cost reports reflecting how the filed cost reports might be adjusted downward if Medicare were to audit them. The information in the detailed "reserve" cost reports showed that a variety of costs on the filed cost reports were intentionally inflated, including interest charges and capital expenditures. The government also alleged that HCA paid physicians illegal remuneration in the form of free rent, free staff, vacations, recruiting bonuses, payments for "consulting" work that was not, in fact, performed, and phony partnership distributions. Last month, HCA agreed to pay the United States $631 million in civil penalties and damages to resolve its civil liability for these activities.

HCA also entered into a separate administrative settlement with CMS under which it will pay an additional $250 million. Previously, on December 14, 2000, subsidiaries of HCA pleaded guilty to

substantial criminal conduct, and HCA paid more than $840 million in criminal fines, civil restitution and penalties for a variety of conduct, including exaggerating the value of services, submitting separate bills for lab tests that should have been bundled, and issues related to the acquisition of home health agencies. This case involved the most comprehensive health care fraud investigation ever undertaken with total recoveries of $1.7 billion, by far the largest recovery ever reached by the government in a health care fraud investigation. More needs to be done on all levels to prevent such behavior from occurring.

Other examples come from the pharmaceutical industry. Three pharmaceutical manufacturers recently entered into large settlements relating, in part, to their prescription drug pricing practices. TAP Pharmaceutical Products Inc., AstraZeneca Pharmaceuticals LP, and the Bayer Corporation agreed to pay $875 million, $355 million, and $14 million, respectively. The government alleged that each company reported their wholesale prices at levels far higher than the actual acquisition cost paid by the majority of physicians and other customers, and marketed the "spread" between the acquisition cost and the reimbursement, thereby causing their customers to receive excess Medicare and Medicaid reimbursement.

MEDICARE VULNERABILITIES

Specific areas of the Medicare program are particularly vulnerable to fraud, waste, and abuse or quality control problems. They include the following:

Prescription Drugs

As indicated by the settlements I described, prescription drug pricing is particularly problematic for Medicare. Because prescription drugs are essential to proper treatment, it is important that Medicare beneficiaries' access to pharmaceuticals not be hindered by overpricing. While the Medicare program covers only a limited family of drugs outside the hospital setting, the cost is quite substantial. Medicare and its beneficiaries paid more than $8.2 billion for covered drugs in FY 2002.

Our office has consistently found that Medicare pays too much for these drugs - more than most other payers. For example, Medicare payments for 24 leading drugs in 2000 were $887 million higher than actual wholesale prices available to physicians and suppliers and $1.9 billion higher than prices available through the Federal Supply Schedule used by Veterans Affairs and other federal purchasers. This excessive payment continues to grow as the amount paid by Medicare grows larger.

Excessive Medicare prescription drug payments are caused by a number of factors, including billing errors, misinterpretations or abuse of existing rules, and flaws in the reimbursement system. By law, Medicare's payment is based on the drug's average wholesale price. However, our reports have shown that published wholesale prices used to establish Medicare payment rates often bear little or no resemblance to actual wholesale prices available to physicians, suppliers, and other large government purchasers. The Medicare program does not receive average wholesale prices directly from drug manufacturers or wholesalers. Instead, Medicare relies on prices published by data reporting companies that base the reported average wholesale price, in part, on the information provided by manufacturers. Because physicians and suppliers keep the difference between the actual price they pay for a drug and Medicare's reimbursement (based on its published average

wholesale price), they have a financial incentive to buy from a drug company with the highest published amount. Thus, manufacturers may have a financial incentive to exaggerate their wholesale price in an attempt to gain market share.

Medical Equipment and Supplies

In FY 2002, Medicare allowed $9.4 billion in claims for medical equipment and supplies, of which beneficiaries paid at least $1.9 billion out of their own pockets. Medicare covers 9 varieties of medical equipment and supplies, such as durable medical equipment. These are items that can withstand repeated use and include oxygen equipment, hospital beds, wheelchairs, nebulizers, and other equipment that physicians prescribe for home use. Medical supplies include catheter, ostomy, incontinence, and wound care supplies. Medicare also covers braces and artificial limbs.

Medicare pays too much for certain items of medical equipment and supplies because Medicare reimbursement rates for these items are based on charges submitted to the program in 1987. As a result, Medicare payments bear little resemblance to prices currently available in the marketplace or to the actual cost of manufacturing and distributing the equipment. We have also uncovered flaws in payment methods and practices for specific kinds of medical equipment.

As part of a Congressional request, we compared Medicare prices for 16 medical equipment and supply items with the prices from the Department of Veterans Affairs (VA), State Medicaid agencies, federal employee health plans, and retail suppliers. These 16 items, including standard wheelchairs, IV poles, and certain hospital beds and walkers, accounted for more than $1.7 billion of the $6.8 billion Medicare paid for medical equipment and supplies in 2000. This work confirms findings from previous reviews where we found that Medicare pays higher than market prices for some items. For example, we found that the VA median prices ranged from 31 to 88 percent less than the Medicare prices. In addition, Medicare prices were more than the median retail price for 10 of the 16 items. These median prices were as much as 73 percent less than Medicare prices. If Medicare based reimbursement on such lower prices, the program could save an estimated $84 million to $958 million a year.

In another review, we found that Medicare paid substantially more for maintenance on rented equipment than repairs on purchased equipment. Under current statutory requirements, Medicare pays for maintenance even if the supplier does not need to service the equipment. We found that only 9 percent of the rental equipment actually received any maintenance and servicing. We estimated that Medicare could save approximately $100 million per year by eliminating maintenance payments and instead paying only for repairs when needed.

Medicare Contractors

The Medicare program is administered by CMS with the help of 47 contractors that handle claims processing and administration. The contractors are responsible for paying health care providers, providing a full accounting of funds, and conducting activities designed to safeguard the program. The two main types of Medicare contractors are fiscal intermediaries and carriers. Intermediaries process claims filed under Part A of the Medicare program from institutions, such as hospitals, skilled nursing facilities and home health agencies; carriers process claims under Part B of the program from other health care providers, such as physicians and medical equipment suppliers. The CMS also uses specialty contractors such as payment safeguard contractors, which focus on matters

related to fraud, waste, and abuse at the carrier and intermediary level, and the durable medical equipment regional carriers, which specialize in analysis and processing of billings for medical equipment and supplies.

Of all the problems we have observed, perhaps the most troubling has to do with the contractors' own integrity such as misusing Government funds, actively trying to conceal these actions, and altering documents and falsifying statements that specific work was performed. This was illustrated by the 2002 settlement with General American Life Insurance Company, Inc., in which the company agreed to pay the government $76 million. The settlement resolved allegations that the former Medicare carrier engaged in improper claims handling and quality assurance reporting practices to maintain a high performance ranking. However, this is only one example. To date, the federal government has settled 19 cases involving contractor fraud, with settlements ranging from approximately $48,000 to $76 million.

In some cases, contractors prepared documents that inaccurately indicated superior performance, which Medicare then rewarded with bonuses and additional contracts. Some contractors adjusted their claims processing so that system edits designed to prevent inappropriate payments were turned off, resulting in misspent Medicare Trust Fund dollars. Contractor cost reports were found to contain improprieties, such as double-billing and claiming private insurance business costs as if they were costs incurred under Medicare contracts.

Other Examples

The results of recent investigations reveal the great variety of fraudulent behavior that we must deal with. Here are a few examples.

Cancer Treatments. A physician in Indiana developed a scheme to defraud Medicare and several other insurance providers by providing unapproved treatments to terminally ill cancer patients. The doctor injected these patients with live cells from pigs and cows under the guise of "live cell therapy." He also provided "shake and bake therapy" by injecting the patients with a sand-like substance that caused the patients temperature to rise to a point where they convulsed under the theory that the cancer was being baked out of the patients' systems. All of these therapies were billed as if chemotherapy was being provided.

Nerve Conduction Tests. A South Carolina doctor schemed to defraud the Medicare program by forcing his patients to undergo unnecessary nerve conduction tests. These tests were conducted regardless of the patients' diagnoses or symptoms. The doctor would withhold the patients' medications until they agreed to undergo the tests.

Lab Tests. In Massachusetts, a laboratory submitted claims for unnecessary tests and blood draws on terminally ill dialysis patients. The blood drawn from these patients was then used to run series of unnecessary tests to receive Medicare reimbursements.

Equipment and Supplies. In Florida, over 30 people conducted a large-scale scheme to defraud the Medicare program by billing for durable medical equipment supplies that were not provided to beneficiaries and/or not medically necessary. This scheme involved billing Medicare for motorized wheelchairs and other high-cost equipment by more than 40 companies. Kickbacks were paid to doctors in return for their signing of required Certificates of Medical Necessity. Co-pays that should

have been paid by the beneficiaries for the equipment were waived in order to establish "good-will" with the beneficiaries and to keep them from possibly complaining. Much of the proceeds from this scheme were sent to overseas bank accounts.

MEDICAID VULNERABILITIES

The Social Security Act authorizes grants to states to provide medical assistance to needy persons. The Medicaid program is administered by the various states in accordance with approved state plans. While states have considerable flexibility in designing their state plans and operating their Medicaid programs, they must comply with broad federal requirements. Medicaid programs are jointly financed by the federal and state governments according to a defined formula. The federal percentage ranges from 50 percent to 83 percent, depending on each state's relative per capita income.

Prescription Drug Pricing and Drug Rebates

Like Medicare, the Medicaid program faces significant vulnerabilities in the prescription drug area, a weakness that is compounded by the fact the Medicaid currently reimburses for many more drugs than does Medicare. These vulnerabilities arise in two areas: reimbursements for prescription drugs and the collection of rebates under the Medicaid drug rebate program.

The Medicaid program faces many of the same problems as Medicare in paying for prescription drugs. States generally use the average wholesale price minus a percentage discount as a basis for reimbursing pharmacies for both brand name and generic drug prescriptions. The average discount for both brand and generic drugs combined was about 10.3 percent nationally in 1999. We believe larger discounts are warranted because of the wide disparity between what a Medicaid agency pays pharmacies for the drug as compared to the actual pharmacy acquisition cost. As discussed in the Medicare section, reimbursement based on the average wholesale price creates certain adverse incentives and is subject to abuse.

Following are the results of our brand name and generic prescription drug reviews. These reviews were limited to ingredient acquisition costs and did not address other areas such as the cost of dispensing the drugs. Generally, states pay retail pharmacies for the ingredient cost of the drug (average wholesale price minus a certain percentage) plus a dispensing fee. We have recommended that CMS require the states to bring pharmacy drug reimbursement more in line with the actual acquisition costs of both brand and generic drugs. CMS concurred that an accurate acquisition cost should be used to determine drug reimbursement and will encourage states to review their estimates of acquisition costs in light of our findings.

Brand Name Drugs. In a final report issued in August 2001, we pointed out that about $1 billion in savings could have been realized for 200 brand name drugs with the greatest amount of Medicaid reimbursement in 1999. Our review of pricing information from 216 pharmacies in 8 states estimated that pharmacy actual acquisition costs nationwide averaged about 22 percent below the average wholesale price in 1999.

Generic Drugs. In a report issued in March 2002, we concluded that significant savings could be realized on generic prescription drugs reimbursed by states under the Medicaid program. Our review of pricing information from 217 pharmacies in 8 states estimated that pharmacy actual acquisition cost nationwide for generic drugs averaged 65.9 percent below average wholesale price rather than the 10.3 percent discount most states averaged. For the 200 generic drugs with the greatest amount of Medicaid reimbursement in 1999, we calculated that as much as $470 million could have been saved if reimbursement had been based on a 65.9 percent average discount. Our current recommendations center on an additional analysis that I will describe next.

Multi-Tiered Pharmacy Reimbursement System. As a follow-up to our previous work on brand and generic drug pricing, we conducted an extended review by identifying discounts off the average wholesale price for specific categories of drugs. This analysis showed that there is a wide range of discounts for purchases depending on the category of drug that is being purchased. Accordingly, we recommended that if states continue to use a reimbursement system based on average wholesale price, CMS should encourage states to bring pharmacy reimbursement more in line with the actual acquisition cost of drug products.

Drug Rebates. As a condition for having their prescription drugs reimbursed by the program, Medicaid requires pharmaceutical manufacturers to enter into written agreements with the Department and to pay rebates to the states. This is a feature absent from the Medicare program. The Medicaid drug rebate program, for which no final regulation has ever been published, requires a manufacturer to report certain pricing information, including its best price, to CMS and to pay rebates to the state Medicaid programs based on the reported prices. A manufacturer's failure to properly determine and report its best price can lead to the significant underpayment of rebates to Medicaid. Three major pharmaceutical drug manufacturers recently settled False Claims Act cases for their failure to comply with requirements of the Medicaid drug rebate program and to pay appropriate rebates to the states. Bayer Corporation, GlaxoSmithKline and Pfizer Inc. paid approximately $257 million, almost $88 million, and $49 million, respectively, to resolve these cases.

We have often said that Medicaid should have a level playing field on how it collects rebates and how it pays for drugs. Currently, rebates are based on the average manufacturer's price while reimbursement is generally based on the average wholesale price. Significant savings could be realized if drug rebates and drug reimbursements both had the same basis. If the basis for reimbursement and rebates is the same, any increase in the reimbursement basis would have a corresponding increase in rebates to Medicaid.

Upper Payment Limits

The Office of Inspector General has found problems with states billing the Federal Government for payments made to public providers when in fact the funds do not remain at the provider for use for medical services. For example, we found that some states required public providers to return Medicaid payments to the state governments through intergovernmental transfers. Once the payments were returned, the states would use the funds for other purposes, some of which were unrelated to Medicaid. Although this practice could potentially occur with any type of Medicaid payment to public facilities, we identified two instances in which such payments were prevalent: Medicaid enhanced payments available under upper payment limits and Medicaid disproportionate share hospital payments. I will discuss the upper payment limit provision first.

State Medicaid agencies have flexibility to set the rates they pay to hospitals and nursing facilities. There is a limit, however, as to how much can be paid in the aggregate within the state. In regulation, this is termed a Medicaid upper payment limit. This upper limit required that all the individual payments to the facilities cannot exceed what the Medicare program would have paid for similar services. Federal regulations in effect before March 13, 2001 established two groups of aggregate limits. One group pertained to all providers in the state (private, state-, city-, or county-operated). This second group applied to the state-operated facilities.

These payments were made as enhanced or additional payments that exceeded the regular payments for Medicaid services. For example, if Medicaid paid $5,000 for a hospital inpatient service, but Medicare would have paid $6,000 for that same service, the $1,000 difference would have been the additional amount that the state could have claimed under the regulations. The states used this calculation to their advantage by claiming federal funds up to the limit but did not always allow for the facilities to retain these funds to pay for actual delivery of medical services. The Federal funds returned to the state through intergovernmental transfers were then available to the states for any purpose, including issues not related to health care.

In short, this use of intergovernmental transfers as part of the enhanced payment program was a financing mechanism designed to maximize federal Medicaid reimbursements by avoiding the federal/state matching requirements. The result is a lack of accountability for Medicaid dollars, including their being used for purposes not intended by the Medicaid statute.

In an effort to curb these practices and ensure that state Medicaid payment systems promote economy and efficiency, CMS issued a final rule, effective March 13, 2001, which modified upper payment limit regulations in accordance with the Benefits Improvement and Protection Act of 2000. The regulatory action created three aggregate upper payment limits -- one each for private, state, and non-state government-operated facilities. The new regulations will be gradually phased in and become fully effective on October 1, 2008. We commend CMS for changing the upper payment limit regulations. The CMS projected that these revisions will save $55 billion in federal Medicaid funds over the next 10 years. The CMS also changed the enhanced payments that states may pay public hospitals from 100 percent to 150 percent of the amount that would be paid under Medicare payment principles. We recommended continuing to limit payments to 100 percent, and CMS implemented the recommendation, achieving an additional savings of $24.3 billion over 10 years. At the request of CMS, our office will conduct audits to monitor compliance with the new regulations.

When fully implemented, CMS's changes will dramatically limit, though not entirely eliminate, the amount of state financial manipulation because the regulation does not require that enhanced funds be retained by the targeted facilities to provide medical services to Medicaid beneficiaries.

Disproportionate Share Hospital Payments

Medicaid makes special payments designed to assist hospitals that provide care to a large number of Medicaid beneficiaries and uninsured patients. These "disproportionate share" payments are important because public "safety net" hospitals face special circumstances and play a critical role in providing care to vulnerable populations. However, we found that hospitals that retained enhanced payments available under the upper payment limit regulations did not use the special payments for their disproportionate share of Medicaid and uninsured beneficiaries. Instead, audit results in

several states showed that public hospitals returned large portions (80 to 90 percent) of the payments to the state Medicaid agencies through intergovernmental transfers. We have expanded our audit work to additional states to further review these special payments being made to hospitals.

In addition, we have found that disproportionate share payments to individual hospitals exceeded hospital specific limits imposed by OBRA of 1993. To date, we have identified about $645 million (federal share) in payments that exceed the OBRA limit. The limits were exceeded for a variety of reasons, including the lack of a mechanism at the state level to ensure that the payments did not exceed the actual cost of providing services, duplication of costs, exceeding Medicare cost limits, and the inclusion of unallowable/non-hospital costs in uncompensated care costs.

We recommend that public hospitals retain the state and federal shares of the enhanced Medicaid payments up to the 100 percent aggregate limit payable under Medicare payment principles and receive and retain 100 percent of the state and federal shares of allowable disproportionate share payments and use the funds for delivering medical services to Medicaid beneficiaries.

REMEDIAL MEASURES

Health Care Fraud and Abuse Control Program

The problems that I have discussed with you today are extremely complex. The Office of Inspector General helps prevent and detect fraud, waste, and abuse through a comprehensive and sustained program of audits, investigations, evaluations, enforcement, and outreach. Since the passage of the Health Insurance Portability and Accountability Act of 1996, our effectiveness has been strengthened through an increased and predictable funding base for our office and CMS for fraud and abuse control efforts. Annual increases were authorized through the end of this year.

With these resources, our office conducted or participated in 568 successful health care prosecutions or settlements in FY 2002. A total of 3,448 individuals and entities were excluded, many as a result of criminal convictions. In the same period, the Department acted on our recommendations to disallow almost $300 million in improperly paid health care funds, and another $1.5 billion is expected as receivables from investigative activities. Implementation of our recommendations to correct systemic vulnerabilites resulted in more than $19 billion in savings in FY 2002.

The Office of Inspector General does not work alone. We are joined by the Department of Justice and a host of other partners, among them the state Medicaid Fraud Control Units (MFCUs) and state auditors.

Medicaid Fraud Control Units

The responsibility for detecting, investigating and prosecuting fraud and abuse in the Medicaid program is shared between the federal and state governments. Each state is required to have a program integrity unit dedicated to detecting and investigating suspected cases of Medicaid fraud. Most states fulfill this requirement by establishing a Medicaid Fraud Control Unit. Each of the Medicaid state agencies also has a Medicaid Management Information System. A subpart of this data system is the Surveillance and Utilization Review Subsystems Units. These units are charged with ferreting out fraud by conducting preliminary reviews of providers and beneficiaries with

aberrant claims or billing patterns that possibly indicate criminal fraud. When potential fraud cases are detected, the cases are referred to the MFCUs.

Since the inception of the Medicaid fraud control program, the MFCUs have recovered hundreds of millions of program dollars. The Office of Inspector General, MFCUs, and other law enforcement agencies work together to coordinate anti-fraud efforts. These partnerships have greatly enhanced our ability to carry out our mission. In FY 2002, we conducted joint investigations with the MFCUs on 218 criminal cases and 37 civil cases. During this time there were 70 criminal convictions and 17 civil settlements or judgments on cases worked jointly with the MFCUs.

State Medicaid Audit Partnership

Another important cooperative effort includes state Medicaid audit partnerships. The partnership plan was created as a way to provide broader coverage of the Medicaid program by collaborating with state auditors, state Medicaid agencies, and state internal audit groups. The level of involvement of each partner is flexible and can vary depending upon specific situations and available resources. The OIG role might entail sharing our methodology and experience in examining similar Medicaid issues. In other cases, we may join together with state teams to audit suspected problems.

For example, an audit conducted with the Delaware state auditor indicated that a state agency had overpaid Medicaid managed care organizations and other health care providers $364,000 for services rendered on behalf of deceased recipients. The overpayments resulted because of major weaknesses in internal controls. The state agreed to recover the overpayments and has begun to strengthen internal controls. Other issues examined in this partnership program with state auditors include `Medicaid outpatient prescription drugs, unbundling of clinical laboratory services, outpatient non-physician services already included as an inpatient charge, excessive costs related to hospital transfers, excessive payments for durable medical equipment, acquisition costs for Medicaid drugs, and program issues related to managed care.

To date, these joint efforts have been developed in 25 states. Completed reports have identified $263 million in federal and state savings and included recommendations for improvement in internal controls and computer systems operations.

Industry Outreach and Education

The Office of Inspector General is interested not only in detecting and dealing with fraud, waste, and abuse, but also in preventing it. One way we do this through outreach. We have engaged in numerous outreach efforts designed to work with the health care industry to assist providers in preventing fraud, waste, and abuse, and to increase their compliance with federal health care program requirements. Information about these outreach efforts and results of our audits, investigations, evaluations, and enforcement initiatives are routinely made available through the Internet on our website at www.oig.hhs.gov. Our office continues to work with the health care industry to gain an understanding of the issues confronted by the industry as providers implement and maintain compliance programs. Prevention initiatives, such as those listed below, inform and assist the health care industry and program beneficiaries.

Compliance Program Guidance. Compliance program guidances promote industry awareness of models for corporate integrity and compliance programs. Thus far, we have issued 11 compliance program guidances for various sectors of the health care industry such as hospitals, laboratories, home health agencies, and ambulance services. Each guidance provides concrete suggestions for designing and implementing internal controls and procedures to address identified risk areas for the applicable health care sector. These guidances are not mandatory. They provide recommendations on the voluntary establishment of systems, structures and policies that enhance compliance with federal health care program requirements.

Advisory Opinions. Through the advisory opinion process, parties can obtain binding legal guidance as to whether their existing or proposed health care business transactions violate the federal anti-kickback statute, the civil monetary penalties laws, or our office's exclusion authorities. The advisory opinion process enhances OIG's understanding of new and emerging health care business arrangements and informs our development of new safe harbor regulations, fraud alerts, and special advisory bulletins. We have issued 20 advisory opinions in FY 2002 and 14 to date in FY 2003. More than 100 advisory opinions have been issued since 1997.

Corporate Integrity Agreements. Many health care providers that enter into agreements with the United States in settlement of potential liability for violations of the False Claims Act or Civil Monetary Penalties Law also agree to adhere to a "corporate integrity agreement." Under the agreement, the provider commits to establishing a program or taking other specified steps to ensure its future compliance with federal health care program requirements. The duration of most agreements is 5 years, during which time providers must undertake audits of their billings to the federal health care programs, typically conducted by an independent review organization, such as an accounting firm, and submit periodic reports to our office. Integrity agreements require a substantial commitment by the provider to ensure that the organization is operating in accordance with federal health care program requirements and the parameters established by the agreement itself. Breach and default provisions in the CIAs help to ensure compliance with their requirements. As of the current date, we are monitoring more than 350 corporate integrity agreements.

Assessment of Progress in Addressing the Challenge

To help ensure the financial integrity of the Medicare program, and the continued availability of Medicare benefits, it continues to be essential that documented and accurate bills are submitted for correct payment for properly rendered health care services. We reported that improper payments under Medicare's fee-for-service system totaled an estimated $13.3 billion during 2002, or 6.3 percent of the $212.7 billion in fee-for-service payments processed by CMS. That estimate is about half of the $23.2 billion that was estimated for 1996, when OIG developed the first national error rate. The error rate does not include improper payments made as a result of falsified documents, kickbacks, or other types of undetectable fraud. It does reflect progress in reducing waste due to improper billings. Our 7-year analysis indicates that over 80 percent of the claims that did not meet reimbursement requirements were attributable to unsupported and medically unnecessary costs – two areas that will receive ongoing monitoring. As in past years, we estimated that over 92 percent of the 2002 fee-for-service payments met Medicare reimbursement requirements. CMS has demonstrated continued vigilance in monitoring the error rate and developing appropriate corrective action plans. In addition, due to CMS's work with the provider community to clarify reimbursement rules and to impress upon health care providers the importance of fully documenting services, the

overwhelming majority of health care providers follow Medicare reimbursement rules and bill correctly.

In FY 2003, CMS will fully implement its Comprehensive Error Rate Testing Program and the Hospital Payment Monitoring Program to produce a Medicare fee-for-service error rate. This methodology will establish, for the first time, baselines to measure each contractor's progress toward correctly processing and paying claims. The results will reflect the contractor's performance and will identify specific provider billing anomalies in the region. Contractors will then develop targeted corrective action plans to reduce payment errors through provider education, claim reviews, and other activities, and CMS will evaluate their rate of improvement.

CONCLUSION

As I stated at the beginning of my testimony, I believe a concentrated effort by a large number of people has resulted in tangible progress in combating fraud, waste, and abuse in recent years. However, the problems that remain are serious, complicated, and have profound consequences. I am particularly concerned about the deliberate fraud that we know continues. We must never let down our guard, and we must continue to dedicate the resources and make the concerted effort to reduce these problems.

We are doing our best to stay on top of this situation, and are continuously involving all of our partners in the enterprise. Since the Congress itself is one of our partners, I would like to take this opportunity to recommend for your consideration a dual strategy for dealing with fraud, waste, and abuse on the legislative front.

The first strategy is to prevent these abuses from happening. This can be done through legislation to address aspects of programs where their underlying statutes make them vulnerable or where changes in the statutes would be more conducive to effective administrative action. One good example is the authority for Medicare payments for prescription drugs, frequently mentioned in my testimony. This problem needs prompt action to prevent wasteful spending of hundreds of millions of taxpayer dollars every year, with the losses mounting with each passing month. Additional proposals are found in our Red Book of savings that we publish annually based on our audits and evaluations.

Of course, it is important to make sure that legislation for new programs does not create new vulnerabilities. Protection from fraud, waste, and abuse needs to be crafted into the legislation itself. We stand ready to assist the Congress in this regard. Indeed, one of our responsibilities under the Inspector General Act is to provide advice on proposed legislation.

The second strategy is to ensure that adequate, reliable, and predictable resources are available to our office and our law enforcement and administrative partners. Most of the achievements by our office were made possible by the enhanced resources provided through the Health Care Fraud and Abuse Control Program. As stated previously, funding under this program at enhanced levels is essential to our continued success in addressing the problems I have identified in my testimony today. It will also further assist our office in its continued outreach activities with the health care industry to increase the industry's awareness and further improve its record of voluntary compliance.

I appreciate the opportunity you have given me today to focus attention on the continuing problems and vulnerabilities that confront us and to share with you some of our efforts and recent initiatives. I welcome your questions.