



**Testimony before the House Energy and Commerce Committee
Subcommittee on Health**

U.S. House of Representatives

**“Health Care Reform:
Opportunities to Address Waste,
Fraud and Abuse”**

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COMBATING FRAUD, WASTE, AND ABUSE IN FEDERAL HEALTH CARE PROGRAMS

INTRODUCTION

Good morning Chairman Pallone, Ranking Member Deal, and distinguished members of the Subcommittee. I am Daniel Levinson, Inspector General of the U.S. Department of Health and Human Services (HHS). In the context of current discussions about health care reform, it is critical that the Government pursue a comprehensive strategy to combat fraud, waste, and abuse to ensure that Federal health care programs remain solvent and best serve the needs of beneficiaries. I thank you for the opportunity to discuss the Office of Inspector General's (OIG) work in this area.

OIG has devoted considerable resources toward fighting fraud, waste, and abuse involving HHS's Federal health care programs. We have performed evaluations, investigations, and audits on a wide variety of issues, including fraudulent activity by health care providers; excessive payments for medical services, equipment, and prescription drugs; and financial conflicts of interests within the institutions charged with protecting the health of the American public. Through this work, we have helped identify and recover billions of dollars in fraudulent, abusive, or wasteful payments and also raised awareness of these critical issues among policy makers, government agencies, and the health care community at large. We have recommended improvements to program safeguards and payment methodologies to prevent fraud, waste, and abuse and to ensure health care quality and beneficiary safety. We have also reached out to the health care community to promote compliance. Moving forward, OIG is committed to building on our successes and achieving even greater results in protecting the integrity of government health care programs and the health and welfare of people served by them.

In my testimony this morning, I will begin by describing OIG's unique role in combating fraud, waste, and abuse in Medicare and Medicaid. I then will provide an overview of vulnerabilities in these programs and discuss current initiatives that expand our efforts to identify, investigate, and prosecute health care fraud. Finally, I will discuss OIG's "Five Principles" strategy for combating fraud, waste, and abuse, which we believe are applicable to any health care program.

OIG'S ROLE AND PARTNERS IN COMBATING FRAUD, WASTE, AND ABUSE

OIG is an independent, nonpartisan agency committed to protecting the integrity of the more than 300 programs administered by HHS. OIG's mandate is to protect the integrity of the programs of HHS, as well as the health and welfare of the beneficiaries of those programs. Thanks to the work of our 1,500 employees and our law enforcement partners, from FY 2006 through fiscal year (FY) 2008, OIG's investigative receivables averaged \$2 billion per year and

our audit disallowances resulting from Medicare and Medicaid oversight averaged \$1 billion per year. The result was a Medicare- and Medicaid-specific return on investment of \$17 to \$1 for OIG oversight. In addition, in FY 2008, implemented OIG recommendations resulted in \$16 billion in savings and funds put to better use.

Further, as reflected in OIG's Semiannual Report to Congress released earlier this month, OIG's expected recoveries for the period of October 2008 through March 2009 include \$274.8 million in audit disallowances and \$2.2 billion in investigative receivables, which includes nearly \$552 million in non-HHS receivables resulting from OIG work (e.g., the States' share of Medicaid restitution).

It comes as no surprise that the large Federal Government expenditures on health care programs attract individuals and entities seeking to exploit the health care system for their own financial gain. The National Health Care Anti-Fraud Association estimates conservatively that at least 3 percent of health care spending is lost to fraud. In FY 2009, Medicare is expected to cover an estimated 45.5 million beneficiaries at a total cost of \$486 billion to the Federal Government and Medicaid is expected to cover an estimated 51 million beneficiaries and cost the Federal Government over \$217 billion. Though the vast majority of health care providers and suppliers are honest and well intended, even a small percentage of providers and suppliers intent on defrauding the programs can have significant detrimental effects. Although it is not possible to measure precisely the extent of fraud in Medicare and Medicaid, virtually everywhere we look OIG continues to find fraud, waste, and abuse in these programs. Therefore, OIG works closely with HHS officials, the Department of Justice (DOJ), other agencies in the Executive Branch, Congress, and States to bring about systemic changes in program operations, successful prosecutions, negotiated settlements, and recovery of funds.

Collaboration and innovation are essential in the fight against fraud. On May 20, 2009, HHS Secretary Kathleen Sebelius and Attorney General Eric Holder announced a new initiative to marshal significant resources across the Government to prevent health care waste, fraud, and abuse; crack down on fraud perpetrators; and enhance existing partnerships between HHS and DOJ to reduce fraud and recover taxpayer dollars. To further this effort, the Secretary and Attorney General created the Health Care Fraud Prevention and Enforcement Action Team (HEAT) joint task force consisting of senior level leadership from both departments. Among other activities, HEAT is building on the successful OIG-DOJ Medicare Fraud Strike Force initiated in south Florida, discussed in greater detail later, by expanding Strike Forces to other metropolitan areas across the country. These Strike Forces use advanced data analysis techniques to identify criminals operating as health care providers and detect emerging or migrating fraud schemes. HEAT is also focusing on prevention strategies to combat health care fraud. For example, HEAT will expand a Centers for Medicare and Medicaid Services (CMS) demonstration project in south Florida that uses site visits to potential durable medical equipment (DME) suppliers to ensure that applicants are legitimate businesses, not criminals. HEAT also plans to enlist health care providers in the fight against fraud by increasing training about program requirements and effective compliance measures that help ensure integrity of billing practices.

Strike Force activities are one part of the Government's enforcement efforts; OIG also works with our law enforcement partners to pursue other criminal cases as well as civil and

administrative cases. In FY 2008, OIG investigations resulted in 455 criminal actions against individuals or entities that engaged in crimes against departmental programs and 337 civil and administrative actions, which included False Claims Act and unjust enrichment lawsuits filed in Federal district court, Civil Monetary Penalties Law settlements, and administrative recoveries related to provider self-disclosure matters. Also in FY 2008, OIG excluded from the Federal health care programs 3,129 individuals and entities for fraud or abuse that affected Federal health care programs and/or beneficiaries.

The collaborative antifraud efforts of HHS and DOJ are rooted in the Health Insurance Portability and Accountability Act of 1996, P. L. No. 104-191 (HIPAA), which directed the Secretary of HHS, acting through OIG and the Attorney General, to promulgate a joint Health Care Fraud and Abuse Control (HCFAC) Program. The HCFAC Program and Guidelines went into effect on January 1, 1997. HIPAA requires HHS and DOJ to report annually to Congress on HCFAC Program results and accomplishments. HCFAC activities are supported by a dedicated funding stream within the Hospital Insurance Trust Fund.

In its 11th year of operation, the HCFAC continues to demonstrate the success of a collaborative approach to identify and prosecute health care fraud, prevent future fraud and abuse, and protect Medicare and Medicaid beneficiaries. Since its inception, HCFAC activities have returned over \$11.2 billion to the Medicare Trust Fund. As I will discuss, the Government's efforts to address DME and infusion fraud in south Florida illustrate the benefits of a collaborative approach. Although I will highlight efforts focused on DME and infusion fraud in particular geographic hot spots, fraud, waste, and abuse occur among all types of health care providers and suppliers and can affect all types of services covered by Medicare and Medicaid in all geographic areas.

VULNERABILITIES IN FEDERAL HEALTH CARE PROGRAMS

Strike Force Activities Have Uncovered Numerous Program Vulnerabilities

OIG and our law enforcement partners are focusing antifraud efforts in geographic areas at high risk for Medicare fraud. In 2007, OIG and DOJ launched a Strike Force effort in south Florida consisting of staff from OIG, DOJ, the U.S. Attorney's Office for the Southern District of Florida, the Federal Bureau of Investigation (FBI), and CMS to identify, investigate, and prosecute DME suppliers and infusion clinics suspected of Medicare fraud. Building on the success in south Florida, the Strike Force was expanded to Los Angeles in March 2008 and to Houston and Detroit in May 2009 in connection with the HEAT initiative.

The Strike Force model has proven highly successful. To date, the south Florida Strike Force has opened 161 cases, convicted 151 of its targets, and secured \$187 million in criminal fines and civil recoveries. In addition to prosecuting criminals and recovering funds for the Medicare Trust Fund, the south Florida Strike Force has had a powerful sentinel effect. Medicare claims data show that during the first 12 months of the Strike Force (March 1, 2007, to February 29, 2008), claim amounts submitted for DME in south Florida decreased by 63 percent to just over \$1 billion from nearly \$2.76 billion during the preceding 12 months.

In March 2008, DOJ and OIG established a second Strike Force in Los Angeles. Since operations began, the Los Angeles Strike Force has opened 48 cases and is targeting individuals and organizations that have submitted fraudulent claims to the Medicare program. The schemes include false claims for wheelchairs, orthotics, and other DME that was medically unnecessary and/or was not provided to the beneficiaries identified in claims.

The recent Strike Force investigation and prosecution of Medcore Group LLC (Medcore) and M&P Group of South Florida (M&P) illustrate key vulnerabilities in the Medicare program. Medcore and M&P operated as Miami-based HIV clinics from approximately 2004 through 2006, billed approximately \$5.3 million to the Medicare program, and received payments of more \$2.5 million. From their inception, Medcore and M&P were set up as criminal enterprises designed to defraud Medicare. The scheme was to submit claims for medically unnecessary HIV infusion and injection treatments. The three owners of Medcore and M&P included a former gas station attendant, a trained cosmetologist, and an individual currently incarcerated for Medicare fraud involving a separate DME company he operated from 2001 to 2003. None had a medical background.

At trial, one of Medcore's owners, Tony Marrero, testified that the scheme was so profitable so quickly that he became concerned about getting caught and decided to set up a second fraudulent clinic, M&P, in the name of his wife. M&P was located in the same building as Medcore, had the same employees, submitted claims under the Medicare provider number of the same physician, and submitted claims on behalf of six of the same patients. In fact, the same physician was associated with other Miami-area infusion clinics, which billed Medicare for more than \$60 million between 2004 and the end of 2005.

Mr. Marrero also testified at trial that he had an arrangement with a pharmaceutical wholesale company to buy invoices that showed the purchase of large amounts of medications, when only small amounts were actually purchased. One of the medical assistants testified that she manipulated the patients' blood samples to ensure that laboratory results would appear to support the Medicare claims.

Like many infusion fraud schemes, Medcore and M&P gained the cooperation of patients by giving them kickbacks of up to \$200 per visit. Four patients testified that they took kickbacks and never received any medication at the clinics. One patient testified that he used his payments from the clinics to support his cocaine addiction. Another patient testified that he did not have HIV, even though the clinics' documents showed that he was being infused with medication to treat HIV. By the patients' own admission, they had been receiving kickbacks from numerous Miami clinics for many years. On March 17, 2009, a Federal jury in Miami convicted two physicians and two medical assistants who worked for Medcore and M&P in connection with the fraud scheme. The Government obtained 6 pleas before trial, resulting in 10 convictions in total.

OIG's fraud-fighting efforts in south Florida also draw on the expertise of our auditors and evaluators. For example, OIG identified weaknesses in Medicare's supplier enrollment process and its supplier oversight activities. In 2006, OIG conducted unannounced site visits to 1,581 DME suppliers in south Florida and found that 31 percent, i.e., 491 suppliers, did not maintain physical facilities or were not open and staffed during business hours, contrary to

Medicare requirements. The 491 suppliers were referred to CMS so that CMS could consider revoking their billing privileges, which it subsequently did. Billing privileges were reinstated by hearing officers for 222 of the 243 suppliers who appealed. Subsequently, 74 percent of the suppliers whose billing privileges were reinstated by hearing officers (165 of 222) had their privileges revoked again or inactivated by CMS. Between April and September 2007, the U.S. Attorney's Office indicted 18 individuals connected to 15 of the 222 reinstated suppliers. As of April 2008, 10 of the 18 individuals had been convicted, sentenced to jail terms, and ordered to pay restitution. Six of the eight remaining individuals have since been sentenced to jail terms and ordered to pay restitution. Two of the eight individuals are currently fugitives. OIG's work demonstrates how important it is to strengthen the enrollment screening process and improve program safeguards.

As a further result of OIG's work in south Florida, our analysis of Medicare billing patterns for inhalation drugs used with DME has uncovered evidence of abusive billing. Despite CMS's efforts to address inappropriate payments, problems persist. For example, in 2007, Medicare paid almost \$143 million for inhalation drugs in Miami-Dade County alone—an amount 20 times greater than the amount paid in Cook County, Illinois, the county (outside south Florida) with the next highest total payments. However, according to Medicare enrollment data, Cook County is home to almost twice as many Medicare beneficiaries as Miami-Dade County. Medicare's average per-beneficiary spending on inhalation drugs was five times higher in south Florida than in the rest of the country. Further, 75 percent of south Florida beneficiaries who received a particular inhalation drug, budesonide, had Medicare-paid claims that exceeded Medicare utilization guidelines, compared to 14 percent of beneficiaries in the rest of the country. For 62 percent of south Florida inhalation drug claims, the beneficiaries on these claims did not have a Medicare-billed office visit or other service in the past 3 years with the physician who reportedly prescribed the drug. Finally, 10 south Florida physicians were each listed as the ordering physician on more than \$3.3 million in submitted inhalation drug claims in 2007, or an average of \$12,000 per day.

Similarly, OIG found that CMS has had limited success controlling aberrant billing by infusion clinics. In the second half of 2006, claims originating in three south Florida counties accounted for 79 percent of the amount submitted to Medicare nationally for drug claims involving HIV/AIDS patients and constituted 37 percent of the total amount Medicare paid for services for beneficiaries with HIV/AIDS. However, only 10 percent of Medicare beneficiaries with HIV/AIDS lived in these three counties.

Other Program Vulnerabilities

As part of its core mission, OIG identifies vulnerabilities that put programs and beneficiaries at risk and makes recommendations to address these vulnerabilities. OIG reviews have identified payments for unallowable services, improper coding, and other types of improper payments. Improper payments range from reimbursement for services not adequately documented and inadvertent mistakes to payments that result from outright fraud and abuse. We have identified program integrity risks and vulnerabilities in every part of Medicare, as well as Medicaid. These vulnerabilities affect services ranging from inpatient hospital and skilled nursing services

to outpatient services provided by physicians and other health professionals, to payment for prescription drugs and medical equipment. Examples include:

Durable Medicare Equipment

OIG has an extensive body of work identifying Medicare fraud, waste, and abuse related to DME. Problems include DME suppliers circumventing enrollment and billing controls, high payment error rates, kickbacks, and excessive reimbursement rates for certain DME. OIG has made recommendations to CMS to strengthen program integrity and DME oversight. OIG also has recommended stronger enrollment safeguards and payment reforms to align Medicare reimbursement for DME more closely with widely available market prices.

OIG has long identified several types of DME that are particularly vulnerable to billing abuses. For example, an investigation of a large wheelchair supplier found that the company had submitted false claims to Medicare and Medicaid, including claims for power wheelchairs that beneficiaries did not want, did not need, or could not use. In 2007, the company agreed to pay \$4 million and relinquish its right to approximately \$13 million in claims initially denied for payment by CMS. Nationally, in 2004, OIG estimated that Medicare and its beneficiaries paid \$96 million for claims that did not meet Medicare's coverage criteria for any type of wheelchair or scooter and that they overspent an additional \$82 million for claims that could have been billed using a code for a less expensive mobility device.

In addition, OIG has identified reimbursement rates for certain items and services that are too high. For example, in 2006, OIG reported that Medicare had allowed, on average, \$7,215 for the rental of an oxygen concentrator that costs approximately \$600 to purchase new. Additionally, beneficiaries incurred, on average, \$1,443 in coinsurance charges. 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.

Further, in March 2009, OIG reported that Medicare reimbursed suppliers for negative pressure wound therapy pumps based on a purchase price of more than \$17,000, but that suppliers paid, on average, approximately \$3,600 for new models. Negative pressure wound therapy pumps are a type of 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.

Home Health/Personal Care Services

In general, OIG has identified fraud, waste, and abuse vulnerabilities in home health and personal care services similar to those described above for DME.

In a report released this month, OIG estimated that New York State improperly claimed over \$275 million in Federal Medicaid reimbursement during our January 1, 2004, through December 31, 2006, audit period for personal care services from providers in New York City that did not meet coverage requirements. These improper payments occurred because the State did not adequately monitor New York City's personal care services program for compliance with certain Federal and State requirements. In addition, we identified quality and safety concerns. Cases are being pursued involving allegations that beneficiaries were physically abused by personal care aides, and their property was stolen. In addition, we have investigated complaints from beneficiaries that aides have abandoned them.

Prescription Drugs

OIG has an extensive body of work identifying fraud, waste, and abuse related to prescription drug coverage under Medicaid, Medicare Part B, and Medicare Part D. Fraud concerns include pharmaceutical companies misreporting pricing information that is used as the basis of reimbursement and/or Medicaid rebates; illegal marketing tactics, including kickbacks and off-label/off-compendium promotion; pharmacies switching drugs to maximize reimbursement; and drug diversion. OIG also is concerned that Medicaid reimbursement for prescription drugs, particularly generic drugs, does not accurately reflect drug costs. For Medicare Part D, OIG has identified vulnerabilities related to sponsors' bids and the resulting payments and premiums to plan sponsors, as well as deficiencies in Part D integrity safeguards.

Medicaid-specific Services

Medicare and Medicaid share many of the same vulnerabilities, including DME, home health, and prescription drugs. Medicaid-specific vulnerabilities include improper payments for school-based health services, case management services, and disproportionate share hospital payments. For example, in 2006, OIG found that a State Medicaid agency claimed Federal Medicaid funding totaling \$86 million for unallowable targeted case management services. In a series of reviews in several States, OIG consistently found that schools had not adequately supported their Medicaid claims for school-based health services and identified almost a billion dollars in improper Medicaid payments.

Other Outpatient Services

OIG also continues to identify vulnerabilities related to certain types of services provided by physicians and other health professionals, including services related to advanced imaging, pain management, mental health services, clinical labs, and transportation services. For example, OIG found that from 1995 to 2005, advanced imaging paid under the Medicare Physician Fee Schedule grew more than fourfold, from 1.4 million to 6.2 million services. Allowed charges and utilization rate per beneficiary grew by a similar magnitude, to \$3.5 billion and 163 services per 1,000 beneficiaries. Services provided by independent diagnostic testing facilities (IDTF) accounted for nearly 30 percent of this growth. OIG work has found problems with IDTFs, including noncompliance with Medicare requirements and billing for services that were not reasonable and necessary.

Inpatient Services

Expenditures for inpatient services, including those provided by inpatient hospitals and skilled nursing facilities, account for one-third of all Medicare expenditures. Problems identified by OIG include hospitals taking advantage of enhanced payments by improperly manipulating billing; hospitals reporting inaccurate wage data, which affects future Medicare payments; inpatient facilities that may be gaming prospective payment reimbursement systems by discharging or transferring patients to other facilities for financial rather than clinical reasons; and kickback schemes.

OIG Recommendations

In addition to pursuing those who violate the law, we also alert program administrators and other departmental officials to problems and offer solutions. These recommendations for corrective action are found in OIG's audit and evaluation reports, management implication reports resulting from OIG's investigative work, and other communications. In 2008, implemented OIG recommendations resulted in an estimated \$16 billion in program savings and funds put to better use. In addition, OIG recommendations have resulted in substantial improvements in efficiency, effectiveness, and quality, as well as fraud prevention, whose impacts are more difficult to quantify.

To preserve its independence and objectivity, OIG is not authorized to implement or operate the HHS programs it oversees, nor can OIG compel the Department to implement our recommendations. However, we take several steps to follow up with program officials on the status of OIG recommendations and to encourage actions to address the vulnerabilities that we have identified. For example, the Principal Deputy Inspector General and I meet regularly with the CMS Administrator and other senior CMS officials to discuss unimplemented recommendations and other program integrity concerns. OIG is implementing a new recommendations management system that will further enhance our ability to track and follow up on OIG recommendations.

Each year we issue a Compendium of Unimplemented OIG Recommendations. The Compendium consolidates significant unimplemented monetary and nonmonetary recommendations addressed to the Department that we expect would, if adopted, result in cost savings, improved program integrity, and/or greater program efficiencies. These recommendations require legislative, regulatory, and/or administrative action. While implementation of monetary recommendations would have fiscal impacts, implementation of nonmonetary recommendations would improve program operations in other ways. In some cases, the agency agrees with our recommendations but has not yet fully implemented them; in others, the agency disagrees with our recommendations.

OIG's unimplemented recommendations provide a useful roadmap for focusing efforts to safeguard and improve the efficiency and effectiveness of the HHS programs OIG oversees. However, it is difficult to draw conclusions about overall savings from these recommendations. Estimates of potential monetary benefits listed in the Compendium are unique to each recommendation and are not comparable. These are typically point-in-time estimates and are often specific to the scope and timing of OIG's underlying work. When OIG reports

implemented recommendations and resulting savings in our Semiannual Reports to Congress, we typically rely on savings estimates produced by the Congressional Budget Office (CBO) or other HHS sources. However, with respect to unimplemented recommendations, CBO or other sources for scoring potential savings frequently are not available. Therefore, OIG may use findings from our reports or other sources, as available, to estimate potential savings. Several of our recommendations that we expect would produce savings do not include estimates of those savings. Notwithstanding the limitations in estimating potential savings, the Compendium is an important tool for identifying program vulnerabilities and improvements.

ENSURING THE INTEGRITY OF FEDERAL HEALTH CARE PROGRAMS

OIG's Five-Principle Strategy to Combat Health Care Fraud, Waste, and Abuse

For Federal health care programs to best serve beneficiaries and remain solvent for future generations, the Government must pursue a comprehensive strategy to prevent, detect and remediate fraud, waste, and abuse. Based on OIG's extensive experience in combating health care fraud, waste, and abuse, we have identified the following five principles that we believe should guide the development of any national health care integrity strategy.

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

We believe that these principles provide a useful framework for designing and implementing program benefits and integrity safeguards. Consistent with these principles, OIG offers the following recommendations to strengthen the integrity of Federal health care programs.

Enrollment

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

Medicare and Medicaid provider enrollment standards and screening should be strengthened, making participation in Federal health care programs as a provider or supplier a privilege, not a right. It is more efficient and effective to protect the programs and beneficiaries from unqualified, fraudulent, or abusive providers and suppliers up front than to try to recover

payments or redress fraud or abuse after it occurs. Greater transparency in the enrollment process will help the Government know with whom it is doing business.

For example, as the Medcore and M&P case described above demonstrates, a lack of effective screening measures gives dishonest and unethical individuals access to a system they can easily exploit. Even after Medcore had billed Medicare for \$4 million in fraudulent claims, it was easy for the clinic's owner to obtain a provider number in his wife's name for a second clinic, M&P, operating in the same building as Medcore, with the same medical director, employees, and patients. One of the owners, Mr. Marrero, testified that when he ultimately sold M&P for \$100,000 in cash, he went to a lawyer's office so the lawyer could fill out paperwork to put ownership of the clinic in the name of two nominee owners. The sale was structured as a stock sale so that the new "owners" would have 90 days to notify Medicare of the change in ownership, allowing a window of time for the fraud to continue under new "ownership." In our experience, it is too easy for unscrupulous individuals to recruit nominee owners of fraudulent companies.

Providers and suppliers applying for enrollment in Medicare or Medicaid should be screened before they are granted billing privileges. Heightened screening measures for high-risk items and services could 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. The cost of this screening could be covered by charging application fees. New providers and suppliers should also be subject to a provisional period during which they are subject to enhanced oversight, such as prepayment review and payment caps.

Payment

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

We support efforts to pay appropriately for the items and services covered by Federal health care programs. Medicare and Medicaid payments should be sufficient to ensure access to care without wasteful overspending. Payment methodologies should also be responsive to changes in the marketplace, medical practice, and technology. Although CMS has the authority to make certain adjustments to fee schedules and other payment methodologies, for some changes, congressional action is needed.

OIG has conducted extensive reviews of Medicare and Medicaid payment methodologies and has determined that the programs pay too much for certain items and services. As OIG's reviews of home oxygen equipment and wound therapy pump payments demonstrate, when reimbursement methodologies do not respond effectively to changes in the marketplace, the program and its beneficiaries bear the cost. As the experience of south Florida illustrates, excessive payments also are a lucrative target for criminals. These criminals can reinvest some of their profit in kickbacks for additional referrals, thus using the program's funds to perpetuate the fraud scheme.

All payment methodologies create incentives and fraud risks that should be identified and addressed. For example, fee-for-service payments create financial incentives to maximize the number and complexity of services provided, even when such services are not medically necessary. Conversely, under a fixed, prospective payment system, financial incentives encourage fewer services and patients may not receive all of the care that they need and for which the program is paying. In considering any payment structure, it is imperative to identify the incentives that it creates and associated risks and to implement necessary safeguards to remediate the negative incentives and reduce fraud risks.

Compliance

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

Health care providers and suppliers must be our partners in ensuring the integrity of Federal health care programs and should adopt internal controls and other measures that promote compliance and help prevent, detect, and respond to health care fraud, waste, and abuse. To this end, OIG has published on its Website extensive resources to assist industry stakeholders in understanding the fraud and abuse laws and designing and implementing effective compliance programs. These resources include sector-specific Compliance Program Guidance that describes the elements of an effective compliance program and identifies risk areas, advisory opinions, and fraud alerts and bulletins.

In many sectors of the health care industry, such as hospitals, compliance programs are widespread and often very sophisticated; other sectors have been slower to adopt internal compliance practices. Compliance programs not only benefit the Federal health care programs; they also benefit industry stakeholders by improving their business practices, by fostering early detection and correction of emerging problems, and by reducing the risk that they will become the subject of a whistleblower complaint or fraud prosecution.

States also have begun to recognize the value of compliance systems. For example, New York now requires providers and suppliers to implement an effective compliance program as a condition of participation in its Medicaid program. Medicare Part D also requires that prescription drug plan sponsors have compliance plans that address certain required elements.

Although compliance programs do not guarantee reduced fraud and abuse, they are an important component of a comprehensive government-industry partnership to promote program integrity. We advocate that providers and suppliers be required to adopt compliance programs as a condition of participating in the Medicare and Medicaid programs. Further, the obligation of providers and suppliers to repay overpayments they discover through compliance efforts or otherwise should be made explicit in the statute. There should be no question that providers and suppliers must return taxpayer dollars they should not have received in the first place.

Oversight

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

As fraud schemes become more sophisticated and migratory, access to real time data and the use of advanced data analysis to monitor claims and provider characteristics are critically important. OIG is using innovative technology to detect and deter fraud, and we continue to develop and implement cutting edge initiatives to enhance our technology infrastructure and support a data-driven antifraud approach. More must be done to ensure that agencies governmentwide are able to use 21st century information technology effectively in the fight against health care fraud.

This data-driven approach should underpin the development of fraud enforcement and prevention activities. The health care system compiles an enormous amount of data on patients, providers, and the delivery of health care items and services. However, Federal health care programs often fail to use claims-processing edits and other information technology effectively to identify improper claims before they are paid and to uncover fraud schemes. For example, Medicare should not pay a clinic for HIV infusion when the beneficiary has not been diagnosed with the illness, pay twice for the same service, or process claims that rely on the provider identifiers of deceased physicians. Better collection, monitoring, and coordination of data would allow Medicare and Medicaid to detect these problems earlier and avoid making improper payments. Moreover, effective use of data would enhance the Government's ability to detect and respond to fraud schemes more quickly.

Needed improvements in program oversight include real-time access to data for law enforcement; uniform, comprehensive data elements; more timely collection and validation of data; robust reporting of data by States and others; interoperability of systems; consistent data extraction methods; and the ability to draw and analyze claims and provider data across Medicare Parts A, B, C, D, and Medicaid. CMS is building an Integrated Data Repository (IDR) that will, when completed, contain a wealth of data across several programs. Although the system is still under development, the prospect of such a comprehensive data warehouse holds considerable promise for detecting and preventing fraud and abuse.

In addition, we advocate the consolidation and expansion of the various provider databases, including the Health Care Integrity and Protection Data Bank (HIPDB), the National Practitioner Data Bank (NPDB), and OIG's List of Excluded Individuals/Entities (LEIE). Providing a centralized, comprehensive, and public database of adverse actions and other sanctions -- including a national registry of patient abuse and neglect -- would be an effective means of preventing providers and suppliers with problem backgrounds from moving from State to State unnoticed by licensing, government, and health plan officials.

Response

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

To ensure the integrity of Federal health programs, law enforcement is working to accelerate the Government's response to fraud schemes by reducing the time needed to detect, investigate, and prosecute fraud. The Government's Strike Force model has proven highly successful in this regard, and although resource intensive, is a powerful antifraud tool and represents a tremendous return on investment. In addition to prosecuting criminals and recovering funds for the Medicare Trust Fund, the Strike Forces have had a strong sentinel effect, as evidenced by the 63 percent decrease in DME claims submitted in south Florida over the first 12 months of Strike Force operations there.

Even the best antifraud efforts are ineffective if fraud is not promptly detected and, once detected, promptly punished and deterred. For example, our investigations have found evidence of an increase in organized crime in health care. 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 easily obtain a supplier number, gather some beneficiary numbers, and bill the program); schemes are easily replicated; and detection efforts often are hampered by lack of access to real-time data. We need to alter the cost-benefit analysis by increasing the risk of swift detection and the certainty of punishment.

In addition, it is currently difficult to stop the flow of Medicare dollars to criminals who are under investigation for known health care fraud schemes. An explicit payment suspension authority would enable Medicare to keep taxpayer dollars out of the pockets of criminals in cases where the Government has credible evidence of fraud. These criminals often take the money and disappear before the Government can complete an investigation and prosecute them. An explicit payment suspension authority is a critical, money-saving tool in these situations.

OIG currently uses a range of administrative sanctions, including civil monetary penalties (CMP) and program exclusions, as an adjunct to criminal and civil enforcement. However, OIG has identified a number of enhancements to these administrative authorities that would increase our ability to address emerging schemes, such as authorizing CMPs for false provider enrollment applications and for the ordering or prescribing of items or services by an excluded entity. Amending the law to align our CMP authorities with the recent False Claims Act amendments would also be helpful.

In addition, in the course of our investigations, audits, and evaluations, OIG often identifies program vulnerabilities that have been or could be exploited and recommends corrective actions. Program administrators and policy makers have important roles in responding quickly to address these vulnerabilities and reduce the risk of future fraud, waste, and abuse.

CONCLUSION

In conclusion, in the context of health care reform, it is an especially important time to consider how to best safeguard health care programs from fraud, waste, and abuse to protect beneficiaries and taxpayer dollars. OIG's mission is to protect the integrity of HHS programs, including the Medicare and Medicaid programs, and the well-being of program beneficiaries. In fulfilling our mission, OIG has identified for recovery billions of dollars lost to fraud, waste, and abuse; helped remove thousands of fraudulent providers from Federal health care programs; pinpointed numerous items and services for which the Government is substantially overpaying; and recommended actions to better protect programs and beneficiaries. These experiences and results have applicability to the current discussions of health care reform. It is critical that the Government pursue a comprehensive strategy to combat fraud, waste, and abuse. We believe that our "Five Principles" strategy provides the framework to identify new ways to protect the integrity of the programs, meet the needs of beneficiaries, and keep Federal health care programs solvent for future generations. We look forward to working with the Committee on these issues, including providing you with information and technical assistance. This concludes my testimony, and I would be pleased to answer any questions.