

Good morning, Chairman Platts, Ranking Member Towns, and other distinguished Members of the Subcommittee. I am Daniel Levinson, Inspector General of the U.S. Department of Health & Human Services (HHS or the Department). Thank you for the opportunity to testify about the HHS Office of Inspector General's (OIG) efforts to monitor and make recommendations to reduce Medicare improper payments. OIG's mission is to protect the integrity of HHS programs, as well as the health and welfare of program beneficiaries. In fulfillment of this mission, we recommend program safeguards, follow up on those recommendations, promote provider compliance, and investigate and hold accountable those who defraud and abuse the Department's programs. My testimony will describe the scope of the problem, OIG's oversight of the Department's measurement of Medicare improper payments, and OIG's role in preventing, detecting, and reducing improper payments.

Improper Medicare Payments Cost Taxpayers Billions of Dollars Each Year

In 2010, the Centers for Medicare & Medicaid Services (CMS) reported Medicare improper payments totaling \$47.9 billion. Of that total, \$34.3 billion is attributable to Medicare Fee-for-Service (10.5-percent error rate) and \$13.6 billion is attributable to Medicare Part C (14-percent error rate).

Some but not all improper payments are the result of fraud. Improper payments can also result from medically unnecessary claims, miscoded claims, eligibility errors, or insufficient documentation. Examples of improper payments include payments made to an ineligible recipient, duplicate payments, or payment for services not received. For example, my office recently identified \$3.6 million in improper Medicare Part D payments on behalf of deceased beneficiaries.

OIG has long been at the forefront of measuring, monitoring, and recommending actions to reduce improper payments, including developing the first Medicare payment error rate in 1996, a time when there were few existing error rate models in Government. OIG identifies improper payments for specific items and services, assesses internal control and payment vulnerabilities, and makes recommendations to reduce future improper payments. To maximize the impact of these reviews, we assess program risks and employ data analysis to target our audits, evaluations, and investigations.

OIG Reviews the Measurement of Medicare Improper Payment Rates

Measuring error rates is key to monitoring program integrity and the scope of inappropriate payments. In 2003, CMS assumed responsibility for, and OIG began providing oversight of, the error rate process. CMS established the Comprehensive Error Rate Testing (CERT) program to produce a Medicare fee-for-service error rate.

OIG reviews CMS's estimates of improper payments and has analyzed the error rate by types of providers and by types of error. This analysis supports CMS's efforts to reduce the error rate by identifying what types of errors are most frequent and which provider types are committing those errors, so that CMS can refine and target its remediation efforts accordingly. For example, OIG found that in the fiscal year (FY) 2009 CERT, inpatient hospitals, durable medical equipment suppliers, hospital outpatient departments, physicians, skilled nursing facilities, and home health agencies accounted for 94 percent of improper Medicare payments. We also found that insufficient documentation, miscoded claims, and medically unnecessary services and supplies accounted for about 98 percent of the improper payments attributable to the six types of providers. OIG is also planning audit work to follow up on "error-prone" providers, i.e., individual providers with erroneous claims in each of the past four CERT cycles, to test those providers' claims and identify improper payments.

OIG Reviews Identify Improper Payments and Recommend Corrective Actions

OIG conducts targeted reviews to determine the scope of improper payments for specific service types and recommends actions to improve program safeguards. By reviewing medical records and other documentation associated with a claim, we identify services that are undocumented, medically unnecessary, or incorrectly coded, as well as duplicate payments and payments for services that were not provided. In doing so, we uncover systemic payment vulnerabilities and make recommendations to address them.

Medically unnecessary services are particularly concerning as beneficiaries may be subjected to tests and treatments that serve no purpose and may even cause harm. Further, because beneficiaries are generally responsible for a 20-percent copayment for items and services provided under Medicare Part B, beneficiaries may pay unnecessary or inflated copayments when they receive items or services that they do not need, or more expensive versions than they need. For beneficiaries who are eligible for Medicare and Medicaid, their Medicaid programs may bear the costs of these copayments.

For example, we reviewed claims for certain types of support surfaces used to prevent and treat bedsores and found that more than 1 in 5 claims were medically unnecessary. In a review of power wheelchairs, we determined that 9 percent of claims were not medically necessary and the records for an additional 52 percent of claims did not contain sufficient documentation to determine whether they were medically necessary. Improper payments for these wheelchair claims totaled \$95 million over a 6-month period. To address these and other types of errors, we recommended that CMS take a variety of actions to ensure that claims are paid appropriately, including conducting additional prepayment and post-payment medical reviews.

For some services, we have found pervasive documentation errors. For example, we found that 60 percent of Medicare claims for rehabilitation power wheelchairs did not meet all documentation requirements. These claims accounted for \$112 million in improper Medicare payments over a 6-month period. We have also found significant rates of documentation error for certain types of pain management services. We recommended that CMS take actions to address these errors, including improving controls, educating providers, and clarifying guidance.

In some cases, documentation or coding errors may signal broader vulnerabilities affecting patient care. For example, we found that 82 percent of hospice claims for beneficiaries in nursing facilities did not meet all Medicare coverage requirements – requirements that are in place to protect beneficiaries’ health and wellbeing. Problems included failing to establish plans of care and providing fewer services than outlined in beneficiaries’ plans of care, potentially putting the beneficiary at greater risk. To prevent these problems from recurring and to better protect hospice patients, we recommended that CMS educate hospice providers about coverage requirements, provide tools to hospice providers (e.g., guidance, templates, and checklists), and use targeted medical reviews and other oversight to improve compliance.

In addition to medical record reviews designed to flag individual improper claims, OIG also conducts data analysis to identify broader patterns indicative of improper payments and potential fraud and abuse. For example, through data analysis we have identified “outliers” that bill for services at an unusually high rate, as well as patterns in which certain geographic areas exhibit unusual billing, and also have matched claims and other data to identify billing patterns that raise concern. These types of analyses can generate leads for investigations, audits, and further medical record review. In addition, these reviews can lead to recommendations to CMS to strengthen its program oversight activities and reduce future improper payments. For example, OIG reviewed high-utilization claims for blood-glucose test strips and lancet supplies, and identified an estimated \$209 million in improper Medicare payments for these supplies. We recommended that CMS contractors implement various adjustments to its payment system, such as those to identify claims with overlapping dates of service.

OIG Will Continue To Monitor and Recommend Actions To Reduce Improper Payments

OIG’s work helps CMS to better identify, track, and reduce improper payments. For example, because of OIG concerns that the Medicare error rates for certain provider types may be understated, CMS made substantial changes in the CERT medical record review process in 2009. In addition, we have recommended that CMS enhance pre-payment review of claims, including the use of specific adjustments to address identified payment errors, and work with providers to educate and enforce program requirements, including documentation requirements. We also have made recommendations aimed at reducing improper payments for specific items and services, as described above.

OIG currently is conducting a series of audits of hospital compliance with Medicare requirements. Based on prior audit and enforcement work, we have identified 27 “high risk” hospital billing practices. Using data mining, we further focus on potential problem areas in selected hospitals, and then we select claims for testing. We conduct hospital site visits to perform comprehensive reviews of billing and medical record documentation. In addition to identifying and recovering improper Medicare payments, we are recommending improvements to internal controls to prevent future improper billings.

OIG is also conducting in-depth reviews of claims for evaluation and management services, power wheelchairs, and Part A payments to skilled nursing facilities to determine whether these payments met Medicare coverage requirements. In addition, we are conducting data analysis to identify potential improper payments in a variety of areas, including lower limb prostheses, Part D drugs, and home health care. Other planned work includes a review of prior year improper

payment determinations that have subsequently been overturned on appeal and a pilot project to obtain missing documentation identified during the comprehensive error rate testing.

OIG Also Leads the Fight Against Medicare Fraud

Although not all improper payments are fraudulent, all payments resulting from fraud are improper. There is no precise measure of the magnitude of health care fraud, but we know that it is a serious problem that demands an aggressive response.

OIG has been leading the fight against health care fraud and abuse for more than 30 years. Although the majority of health care providers are honest and well-intentioned, a minority of providers who are intent on abusing the system cost taxpayers billions of dollars per year. During this FY, OIG has opened more than 1,700 health care fraud investigations. Additionally, our enforcement efforts resulted in more than 900 criminal and civil actions and \$3.8 billion in court-ordered fines, penalties, restitution, and settlements in FY 2010.

We also work to help prevent fraud and promote compliance through guidance and outreach to health care providers. This year, OIG conducted free training seminars in six cities to educate providers on fraud risks and share compliance best practices. We also published a *Road Map for New Physicians* to provide guidance on complying with fraud and abuse laws.

Conclusion

Executive Order 13520 on reducing improper payments states that the Federal Government must make every effort to confirm that the right recipient receives the right payment for the right reason at the right time. OIG is committed to this goal. Thank you for your support of our mission.