



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

**Testimony Before the United States House Committee on Ways and Means
Subcommittee on Oversight**

Combating Fraud in Medicare: A Strategy for Success

Testimony of:

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Good morning, Chairman Jenkins, Ranking Member Lewis, and distinguished Members of the Subcommittee. I am Gloria Jarmon, Deputy Inspector General for Audit Services, U.S. Department of Health and Human Services (HHS or the Department). Thank you for your longstanding commitment to ensuring that Medicare's 59 million beneficiaries are well served and the taxpayers' approximately \$700 billion annual investment is well spent. I appreciate the opportunity to discuss the Office of Inspector General's (OIG's) strategy to promote program integrity and combat fraud in Medicare.

Introduction

Congress created OIG in 1976 as an independent body to oversee HHS programs. A key component of OIG's mission is to promote integrity and efficiency in Medicare and other Federal health care programs. Our multidisciplinary team of auditors, investigators, evaluators, and attorneys strategically focuses on fraud prevention, detection, and enforcement efforts. Our work generates specific recommendations to the Centers for Medicare & Medicaid Services (CMS) for mitigating or eliminating program vulnerabilities and improving program operations.

Medicare spending represented more than 15 percent of all Federal spending in 2017.¹ As the number of beneficiaries continues to rise, and if per capita health care costs continue to increase, Medicare spending can be expected to increase. The 2018 Annual Report by Medicare's Board of Trustees estimated that the Trust Fund for Medicare Part A will be depleted by 2026. The Annual Report also projected that spending for Medicare Part B will grow by more than 8 percent over the next 5 years, outpacing the U.S. economy, which is projected to grow by 4.7 percent during that same time.

My testimony today discusses Medicare fraud and improper payments. I will also discuss ways in which OIG is engaged in prevention, detection, and enforcement activities related to Medicare. Finally, I will describe how OIG uses risk assessment to ensure efficient use of our resources and effective oversight of the Medicare Program.

Fraud and Improper Payments in Medicare

We must foster sound financial stewardship to ensure that Medicare continues to serve a growing population of senior citizens and individuals with disabilities well into the future.

¹ Henry J Kaiser Family Foundation, "The Facts on Medicare Spending and Financing," <https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/>. Accessed July 12, 2018.

Combating fraud and reducing improper payments are critical to protecting the financial integrity of Medicare. It is important to stress that while all monetary loss from fraud constitutes improper payments, not all improper payments are fraud. A comprehensive program integrity strategy that focuses on prevention, detection, and enforcement helps address multiple sources of improper payments, including fraud.

While the full extent of fraud is not known, the Improper Payments Information Act of 2002 requires Federal agencies to report to the President and Congress information on the agencies' improper payments each year. Medicare and Medicaid accounted for \$88.6 billion, or about 98 percent, of the \$90.1 billion in improper payments that HHS reported in its fiscal year (FY) 2017 Agency Financial Report. Traditional Medicare fee-for-service accounted for \$36.2 billion, or about 40 percent, of the improper payments that HHS reported. As a percentage of total Medicare fee-for-service payments, about 9.5 percent was improper. HHS attributed about 66 percent of Medicare fee-for-service improper payments to errors associated with insufficient or no documentation. For these claims, the medical records do not support that the billed services were actually provided, were provided at the level billed, or were medically necessary. Medical necessity errors accounted for about 18 percent of the errors. Medical necessity errors occur when the billed services were not reasonable and necessary as required by Medicare coverage and payment policies. Although improper payments may occur in all types of health care, home health, skilled nursing facility (SNF), and inpatient rehabilitation facility (IRF) are areas of particular concern, representing 33 percent of the overall estimated improper payment rate for Medicare fee-for-service in FY 2017.

OIG has long been at the forefront of measuring, monitoring, and recommending actions to prevent improper payments, including developing the first Medicare payment error rate in 1996 at a time when there were few error rate models in Government. In addition to OIG's reviewing and reporting on HHS's annual improper payment information, our audits, evaluations, and investigations identify improper payments for specific services and items, assess internal control and payment vulnerabilities, and make recommendations to prevent future improper payments. The Department's annual financial report, which is reviewed by our office, plays a significant role when we plan our oversight work, which I will discuss in the context of our approach to risk assessment. The high error rates associated with home health, SNF, and IRF claims have caused us to devote substantial resources to conducting work on those areas of the program. This work has resulted in fraud convictions as well as recommendations to collect improper payments and take corrective action to prevent future improper payments.

OIG drives positive change by not only identifying risks, problems, abuses, and deficiencies, but also by recommending solutions to address them. OIG identifies opportunities to promote economy and efficiency and offers recommendations to the agencies that operate HHS programs. We follow up with those agencies to get such recommendations implemented. We actively track recommendations that remain unimplemented, and each year we include the most significant recommendations in our *Compendium of Unimplemented Recommendations*.

We systematically follow up on our recommendations with the relevant HHS management officials. We frequently plan work related to unimplemented recommendations to update the results of a prior review or to provide further evidence of a vulnerability in the program. We also follow up on implemented recommendations to verify that corrective action was successful in addressing the problem.

A Focus on Prevention, Detection, and Enforcement

OIG takes a three-pronged approach to fighting fraud, waste, and abuse. This approach focuses on prevention, detection, and enforcement. With respect to preventing fraud and other types of improper payments, CMS's Fraud Prevention System (FPS) serves as an important tool that should be improved to increase its effectiveness. Data analytics and predictive analytics can help increase the effectiveness of fraud-detection programs. Once suspected fraud is identified, OIG special agents and other professionals thoroughly investigate the facts and, when indicated, OIG and our law enforcement partners aggressively pursue enforcement to hold perpetrators accountable and recover misspent taxpayer dollars. I discuss these prevention, detection, and enforcement efforts in more detail below.

Improvement of CMS's Fraud Prevention System Is Key to Preventing Improper Payments in Medicare

In June 2011, HHS launched FPS. Following a law that required HHS to use predictive modeling and other analytics technologies to identify and prevent fraud, waste, and abuse in the Medicare fee-for-service program, the Department designated CMS to develop FPS. FPS is a key component in CMS's strategy to go beyond detecting fraudulent and other types of improper payments and recovering the lost funds to preventing those claims from being paid in the first place.

Although OIG remains optimistic about FPS's future role in preventing fraud and improper payments, we have performed several audits that have identified ways to improve FPS. For example, when performing work to certify the actual and projected savings and the return on investment related to HHS's use of FPS, we discovered that HHS might not have the capability to trace the savings from administrative actions back to the specific FPS model that generated the savings. CMS could not track those savings because, according to CMS, that capability was not built into FPS. In addition, CMS did not make use of all pertinent performance results because it did not ensure that contractors' adjusted savings reported to CMS reflected the amounts certified by OIG, and CMS did not evaluate FPS model performance on the basis of the amounts actually expected to be prevented or recovered. As a result, FPS is not as effective as it could be in preventing fraud, waste, and abuse in Medicare.

CMS concurred with our recommendations that it make better use of its performance results to refine and enhance the predictive analytics technologies of the FPS models by ensuring that (1) the redesigned FPS allows CMS to track savings from administrative actions back to individual FPS models, (2) contractors adjust savings reported to CMS to reflect only FPS-

related savings amounts, and (3) evaluations of FPS model performance consider not only the identified savings but also the amount that is likely to be recovered.

OIG will continue to monitor CMS's implementation of predictive analytics technologies and will assess HHS's reporting of actual and projected savings for improper payments avoided and recovered and the related return on investment. In addition, we will follow up on corrective actions made in response to past OIG recommendations.

OIG Uses Sophisticated Data Analytics

The schemes to steal money from Medicare take many forms. They can be as simple as billing for services not provided or as complex as identity theft, kickbacks, and money laundering. The perpetrators of fraud schemes range from highly respected physicians to individuals with no prior experience in the health care industry and organized criminal enterprises. Regardless, they are all motivated by greed and often put profit before patients' health and safety, creating potentially dangerous patient care environments.

OIG's use of advanced data analytics helps us to more effectively assess risk and pinpoint our oversight efforts. We use data analytics to analyze millions of claims and billions of data points. At the macro level, OIG analyzes data patterns to assess fraud and other types of risk across Medicare services, provider types, and geographic locations to prioritize our work and more effectively deploy our resources. At the micro level, OIG uses data analytics, including near-real-time data, to identify potential fraud suspects for more in-depth analysis and to efficiently target investigations.

We are mindful that, even as our program integrity efforts have become more technology driven, the nature of health care fraud has become more technologically sophisticated. Therefore, technology is not a silver bullet. Even the most cutting-edge fraud-prevention technologies are of little value if not effectively implemented, used, and overseen.

Enforcement Efforts Hold Wrongdoers Accountable and Maximize Recovery of Public Funds

OIG partners with the Department of Justice and HHS on Medicare Strike Force teams and other health care fraud enforcement activities through the Health Care Fraud and Abuse Control (HCFAC) program. Over its 22-year history, the HCFAC program has recovered billions of dollars and has further protected Federal health care programs by convicting criminals, excluding providers from participation in Medicare and other Federal health care programs, and recovering audit disallowances.

Just last month, OIG, along with our State and Federal law enforcement partners, participated in an unprecedented nation-wide health care fraud takedown aimed at combating health care fraud and the opioid epidemic. Enforcement activities took place across the Nation, representing the largest multiagency enforcement operation in history, both in terms of the number of defendants charged and total loss amount. More than 600 defendants in 58 Federal

districts were charged for their alleged participation in schemes involving approximately \$2 billion in losses to vital health care programs, including Medicare. Of those subjects charged, 165 are medical professionals—including 32 doctors who were charged for their roles in prescribing and distributing opioids and other dangerous narcotics. More than 1,000 law enforcement personnel took part in this operation, including more than 350 OIG special agents.

We will continue to use enforcement activities to hold fraud perpetrators accountable and recover stolen or misspent funds. In addition, we will continue to share information about prescription-drug fraud schemes, trends, and other matters related to health care fraud with our partners in the Healthcare Fraud Prevention Partnership and the National Healthcare Anti-Fraud Association.

A Risk-Based Approach to Oversight

Integrating risk management practices improves decision making in governance, strategy, objective setting, and day-to-day operations. It helps to enhance performance and provides a path to creating, preserving, and realizing value. OIG uses risk assessments to develop and prioritize our oversight work to maximize our positive impact for HHS beneficiaries and taxpayers. With particular respect to OIG's audit work, our risk assessment process considers specific risk factors related to the potential liability and level of exposure of Medicare and other HHS programs to fraud, waste, and abuse. The risk factors related to fraud are based on the Government Accountability Office's *A Framework for Managing Fraud Risks in Federal Programs*² and the Committee of Sponsoring Organizations of the Treadway Commission's (COSO's) *Fraud Risk Management Guide*. We consider other areas based on COSO's updated *Enterprise Risk Management—Integrated Framework*, including:

- governance and culture;
- strategy and objective setting;
- performance;
- review and revision of practices to enhance entity performance; and
- information, communication, and reporting.

To assess the severity of identified risks, we generally evaluate the likelihood of a risk occurring and the potential impact or result of the risk. For example, rapid growth in program authority or spending may signal a greater likelihood of fraud, waste, or abuse. The number of beneficiaries affected by the rapid growth may be an indicator of impact. Risks may be categorized in a variety of ways. For example, the tool we developed to manage reported recommendations uses strategic, financial, informational, operational, and compliance risks to assist us in evaluating the potential impact. An audit ranked as high risk may be the target for a followup audit to ensure management has taken corrective action. An analysis of the high-risk

² U.S. Government Accountability Office, *A Framework for Managing Fraud Risks in Federal Programs*, July 2015. Accessed July 12, 2018. <https://www.gao.gov/assets/680/671664.pdf>.

recommendations for an HHS agency or program may lead us to new audit areas.

Our office uses a variety of other information to help identify and prioritize audits, including an environmental scan that considers the expectations of external stakeholders (including statutory mandates), OIG's strategic goals, and an analysis of Department operations and previous audits (including analyses to identify recurring audit findings and control deficiencies).

We use the information we obtain throughout the year from risk assessments and stakeholders to prioritize our work and develop our *Work Plan*. While we have traditionally published a static annual *Work Plan*, this document now reflects our dynamic ongoing process, and we update the plan throughout the year to keep the public informed of our currently planned work. It is critical that we appropriately plan an agenda of audits, investigations, and evaluations given the limited resources we have to oversee more than 100 programs and over \$1 trillion in Federal spending. To focus the Department's attention on the most pressing issues, each year OIG identifies the top management and performance challenges facing the Department. These challenges can affect one or many HHS programs and cover a range of critical HHS responsibilities that include delivering quality services and benefits, exercising sound fiscal management, safeguarding public health and safety, and enhancing cybersecurity. Ensuring program integrity in Medicare remains a top management challenge for HHS.

Conclusion

As discussed earlier, the schemes used to steal money from Medicare range from straightforward false billings by physicians to complex schemes perpetrated by organized criminal enterprises. OIG will continue to develop and use cutting-edge tools and technology to provide Medicare oversight that prevents and detects fraud, waste, and abuse, and we will take appropriate action when they occur. Specifically, we will continue to perform audits and evaluations aimed at recommending improvements to the Medicare Program and reducing improper payments. With an eye on prevention, we will monitor CMS's efforts to implement our previous recommendations and to improve the FPS. By leveraging advanced data analytic techniques and using risk assessments in our work planning, we will detect potential vulnerabilities and fraud early and better target our resources to those areas and individuals most in need of oversight. Finally, we will continue to focus on the principle of enforcement, holding accountable those who commit fraud and building on successes such as the takedown that occurred in late June.

Thank you for your ongoing leadership and for affording me the opportunity to testify on this important topic.