



Testimony before the United States House of Representatives

Committee on Appropriations

Subcommittee on Labor, Health and Human Services,
Education, and Related Agencies

“Improper Payments”

Testimony of:

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March 17, 2011

10:00AM

2358-C Rayburn House Office Building



Good morning, Chairman Rehberg, Ranking Member DeLauro, 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 improper payments. My testimony will describe the scope of the problem and our recommendations to prevent improper payments, with a focus on improper payments that exist in the Department's two largest programs – Medicare and Medicaid. I will also discuss OIG's efforts to oversee the Department's measurement of improper payments and to prevent, detect, and recoup wasteful payments.

Improper Payments Cost Taxpayers Billions of Dollars Each Year

In 2010, the Office of Management and Budget (OMB) designated 14 programs as “high-error” based on improper payment information included in agencies' annual performance and financial reports. HHS administers five of these high-error programs – Medicare Fee-for-Service, Medicaid, Medicare Advantage, Children's Health Insurance Program, and Medicare Prescription Drug Benefit. For fiscal year 2010, HHS reported improper payments totaling \$56.8 billion in Medicare Fee-for-Service and Medicaid alone.

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, a time when there were few existing error rate models in Government. OIG identifies improper payments for specific products and services, assesses internal control and payment vulnerabilities, and makes recommendations to prevent 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 and Medicaid 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 detailing 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 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' populations of claims and identify improper payments.

In addition to the CERT program, CMS developed the Payment Error Rate Measurement (PERM) program to measure improper payments in Medicaid and the Children's Health Insurance Program (CHIP). OIG's review of the PERM program has included testing and analysis of the PERM sampling and estimation methodology, the medical records request

process, medical review, and the error estimation calculation. Measuring payment errors and their causes in the Medicaid and CHIP programs is particularly challenging because of the diversity of State programs and the variation in their administrative and control systems. OIG is performing audit work to determine whether problems similar to those discovered in the CERT program exist in the PERM program.

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 payment vulnerabilities and make recommendations to address them.

For some services, we have found pervasive documentation errors. For example, we found that during the first half of 2007, 60 percent of Medicare claims for standard and complex rehabilitation power wheelchairs did not meet one or more documentation requirements. These claims accounted for \$112 million in improper Medicare payments. We have also found significant rates of documentation error for certain types of pain management services. We recommended that CMS take several actions to address these errors, including improving controls, educating providers, and clarifying guidance.

Medically unnecessary services are particularly concerning, as beneficiaries may be subjected to tests and treatments that serve no purpose and may even cause harm. In some cases, as with durable medical equipment, beneficiaries may also be charged significant copayments for items or services that they did not need. 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. 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 postpayment medical reviews.

In some cases, documentation or coding errors may signal broader vulnerabilities affecting patient care that need to be addressed to prevent improper payments and help ensure quality of care. For example, we found that 82 percent of hospice claims for beneficiaries in nursing facilities did not meet at least one Medicare coverage requirement – requirements that are in place to protect beneficiaries’ health and wellbeing. Problems we identified 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.

Similarly, a recent review of Medicaid personal care services found that for 18 percent of claims, personal care service attendant qualifications were not properly documented, resulting in \$724 million in improper payments. Without documentation of attendant qualifications, it is difficult to determine whether vulnerable beneficiaries are receiving care from appropriately screened and trained individuals. We recommended that CMS work with States to ensure that they verify attendants’ qualifications.

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 this type of analysis we have identified “outliers” who 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 prevent future improper payments. For example, OIG recently reviewed high-utilization claims for blood-glucose test strips and lancet supplies, and identified an estimated \$270 million in improper Medicare payments for these supplies. We recommended that CMS contractors implement various payment edits, such as edits 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 prevent improper payments. For example, based on 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 by using specific edits 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 preventing and reducing improper payments for specific items and services, as described above.

OIG currently is conducting in-depth reviews of claims and associated documentation for evaluation and management services, power wheelchairs, and Part A payments to skilled nursing facilities to determine whether these payments met Medicare coverage requirements. We also are conducting data analysis to identify potential improper payments in a variety of areas, including lower limb prostheses, Part D drugs, portable X-ray, and home health care. Additional planned work includes a review of prior year improper payments that have subsequently been overturned on appeal, a pilot project to obtain missing documentation identified during the

comprehensive error rate testing, and a review of FY 2008 PERM testing, which includes an independent medical review of claims to determine if the conclusions reached by the CMS contractor are in accordance with PERM guidance.

Conclusion

Executive Order 13520 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. I would be happy to answer any questions.