Congress Addresses Fraud in Medicare System

BY FRANCES CORREA

FROM A HEARING OF THE OVERSIGHT SUBCOMMITTEE OF THE HOUSE COMMITTEE ON WAYS AND MEANS

WASHINGTON – The new Center for Program Integrity and the Medicare Fraud Strike Force are among federal efforts aimed at combating fraud and abuse in the Medicare and Medicaid programs, top federal officers testified at a hearing of the Oversight Subcommittee of the House Ways and Means Committee.

Subcommittee Chairman Charles W. Boustany (R-La.) said that he called the hearing because "without action, the problem is only going to get worse. Every dollar lost to health care fraud is a dollar not spent on patient care."

Key among new federal efforts is the Center for Program Integrity (CPI). Created by the Affordable Care Act, CPI is now one of the Centers for Medicare and Medicaid Services.

Among CPI's first tasks is to implement risk-based screening for new Medicare and Medicaid-participating providers, according to Peter Budetti, deputy administrator and director of CPI.

The new rule holds high-risk providers and suppliers to a higher degree of scrutiny, based on their level of past interaction with CMS and law enforcement agencies. Certain characteristics, including exclusions by the Department of Health and Human Services' Office of Inspector General, could bump a provider to the high-risk level, Mr. Budetti said.

The subcommittee also heard from Lewis Morris, chief counsel to the HHS OIG. Mr. Morris discussed the Medicare Fraud Strike Force, which was also created by the ACA. The strike force is a collaboration of the CMS, the OIG, and the Department of Justice. Since its inception in 2009, the strike force has brought charges against more than 1,000 defendants, recovering nearly $2.3 billion and shortening investigation time from up to a year to a few weeks, Mr. Morris testified.

The strike force is currently working toward securing legislation to close the current system loophole that prevents charging executives for committing fraud if they leave the company.

"The amendment of our discretionary exclusion authority would give us the ability [to charge executives] and be able to say to that corporate executive: 'You're out of our program because you're not treating our [participants] the way we expect you to,'" he said.

The subcommittee also heard from Aghaegbuna "Ike" Odelugo, who pled guilty in August 2010 to fraudulently billing Medicare for close to $10 million. Mr. Odelugo worked in billing for 14 different health care companies and, from 2005 to 2008, ran the fraud scheme in conjunction with patients and doctors.

"This system has a number of weaknesses which are easily exploitable," Mr. Odelugo said, adding that all he needed was a basic knowledge of data entry and people to recruit patients and falsify patient data.

"This is a nonviolent crime and is often committed by very educated people including business people, hospitals, doctors, and administrators," Mr. Odelugo testified. "It reaches across all ethnic and racial lines. It relies on an often unsuspecting victim base of Medicare recipients and other physicians who long for attention and care."

Mr. Odelugo testified that he volunteered to cooperate with authorities and testify before the subcommittee in an effort to help his case.

Subcommittee members noted that antifraud efforts must be protected from efforts to cut federal expenditures.

"It just seems intuitive then that this is an area where further budget cuts may end up costing us more in the long run, if we're taking away that enforcement capability or investigative capability," Rep. Ron Kind (D-Wis.) said at the hearing.

According to Mr. Morris, money spent on pursuing fraudsters yields a $6.80 return on the dollar. To capitalize on that return, President Obama has proposed a 10-year $370 billion plan using funds from fraud recovery as a 2-year fix for the Sustainable Growth Rate formula. ■