Congress Addresses Medicare, Medicaid Fraud

System 'easily exploitable,' says perpetrator of fraud scheme.

ARTICLES BY FRANCES CORREA

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 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."

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 of the CMS's Center for Program Integrity and director of CPI.

The new rule holds high-risk providers and suppliers to a higher degree of scrutiny, based on their level of previous interaction with CMS and law enforcement agencies.

Certain characteristics, including exclusions by the Office of Inspector General of the Department of Health and Human Services, could bump a provider to the high-risk level, Mr. Budetti noted.

The subcommittee also heard from Lewis Morris, chief counsel to the HHS OIG. Mr. Morris discussed the Medicare Fraud Strike Force, 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.

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The strike force is currently working toward securing legislation that would close the loophole in the current system that prevents charging executives with 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," Mr. Morris said at the hearing.

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 physicians.

"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 … 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."

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

Members of the subcommittee 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, the 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. ■

Survey: Medicare and SGR Concerns Create Anxiety

FROM TEXAS MEDICINE

A majority of Texas physicians see the current health care payment system as not economically viable, according to a survey that was conducted by the Texas Medical Association.

Sixty-nine percent of physicians who responded to the survey reported slow payment, nonpayment, or underpayment of Medicare and Medicaid claims. An additional 61% reported a significant decrease in their incomes over the past 2 years.

Dr. Steven Petak, a Houston-based endocrinologist, said that his practice nearly went bankrupt last year because of increased Medicare costs. Those low reimbursements, he said, are the reason his practice started phasing out Medicare patients over the past 2 years. Today, less than 10% of Dr. Petak's patients are covered by Medicare.

According to the Texas Medical Association, less than 42% of surveyed physicians currently accept Medicare patients; half of physician respondents said they are considering opting out of Medicare entirely.

As the immediate past president of the American Association of Clinical Endocrinologists, Dr. Petak was in Washington in early March representing the organization. He and his colleagues met with 80 members of the House and Senate to discuss a possible fix for the Sustainable Growth Rate formula.

"Economically, it's suicidal," Dr. Petak said. In his meetings, he recommended alternative measures of estimating funding such as the Medicare Economic Index, which is a tool used by the Centers for Medicare and Medicaid Services to annually calculate changes in practice cost.

In response to ongoing concerns, President Obama's 2012 budget proposal includes a 10-year, $370 billion plan to fix the SGR using funds from fraud reduction and adjustments to payments for pharmaceuticals and Medicaid.

In addition to Medicare and SGR woes, more than half (59%) of respondents to the TMA survey said that they are concerned about what the Affordable Care Act means for them and their patients. More than two-thirds (67%) said that they were concerned that the quality of health care would diminish and costs would increase under the law.

Further, 74% of respondents said they are disappointed with the proposed health reforms, 74% said that they're anxious, and 62% said that they're angry and confused.

The physician survey was conducted through monthly e-mails. Among those who responded, 95% were physicians; the rest were medical students, residents, and interns. Of the 29,764 TMA members who received the survey, 3,587 responded. ■

House Effort Seeks to Stop Payment Advisory Board

Efforts to derail the Independent Payment Advisory Board gained a bit of traction as two House Democrats joined their colleagues across the aisle in cosponsoring the Medicare Decisions Accountability Act.

Introduced by Rep. Phil Roe (R-Tenn.) in January, H.R. 452 would repeal the portions of the Affordable Care Act that would create the Independent Payment Advisory Board (IPAB).

The 15-person board, to be appointed by the President, would be charged with recommending ways to reduce Medicare spending based on the Consumer Price Index and other economic indicators. The board would submit recommendations to Congress on how to limit Medicare expenditures each January, beginning in 2015. If Congress fails to act on those recommendations by August, the recommendations would go immediately into effect.

The IPAB's "sole purpose is to control Medicare costs – giving this board the authority to approve and deny funding for care," Rep. Roe, who is an ob.gyn., said in a statement. "The IPAB will lack full Congressional oversight, compromising its accountability to the American people."

The existence of the IPAB "permanently removes Congress from the decision-making process, and threatens the long-time, open, and important dialog between hospitals and their elected officials about the needs of local hospitals and how to provide the highest quality care to their patients and communities," according to Rick Pollack, executive vice president of American Hospital Association.

The efforts of the IPAB also would be redundant to the Sustainable Growth Rate formula, which is used each year to adjust Medicare spending for physician services, according to its opponents.

"It makes no sense to subject physicians to two separate expenditure targets while at the same time exempting large segments of Medicare providers who are subject to no target at all," Dr. Michael Maves, executive vice president of the American Medical Association, wrote in a letter to lawmakers. "We have already seen first-hand the ill effects of the flawed SGR physician target and the steep cuts that Congress has had to scramble each year to avoid, along with the exorbitant price tag required for a long-term SGR solution."

H.R. 452 is supported by, the American Medical Association, the American Hospital Association, the American Association for Neurological Surgeons, the Alliance for Specialty Medicine, and other medical groups. It has been referred to several House committees for action and at press time had no Senate counterpart. ■