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Medicare [1]

Medicare fraud outrunning enforcement efforts [2]

Official: agency failed to investigate 1,200 complaints due to staff shortages, and more cuts coming

Citing massive budget and staff cuts, federal officials are set to scale back or drop a host of investigations into Medicare and Medicaid fraud and abuse — even though cracking down on government waste and cutting health care costs have been top priorities for the Obama administration.

The Department of Health and Human Services Office of Inspector General is set to lose a total of 400 staffers that are deployed nationwide as a primary defense against health care fraud and abuse. Though agency officials have yet to decide which investigations will be shelved as staff dwindles, the existing staff is already stretched so thin that the agency has failed to act on 1,200 complaints over the past year alleging wrongdoing — and expects that number to rise. The OIG began shedding staff at the beginning of the year.

The budget crunch surfaced during questioning at a June 24 hearing of the Senate Committee on Homeland Security and Governmental Affairs. The hearing was called to examine prescription drug abuse in Medicare.

Gary Cantrell, Deputy Inspector General for the OIG Office of Investigations, said at the hearing that his unit "is shrinking" even as the federal Medicare and Medicaid programs grow in size and complexity. "We're set to lose roughly 400 bodies out of a total of 1,800 at our peak in 2012. That's really limiting our ability to expand our oversight in some of these areas," he said.

Stuart Wright, Deputy Inspector General for the OIG Office of Evaluations and Inspections, added that 200 of those staffers will have departed by the end of this year and 200 more are out the door by the end of 2015.

Federal agencies employ inspectors general who work independently to ferret out fraud and abuse. The HHS unit has three branches that examine payment issues and investigate complaints of criminal wrongdoing lodged by whistleblowers and the public. Cantrell said that the HHS unit won't be able to act on many complaints it logs in.

"We're operating with a reduced budget in the face of the growing program. And just last year alone, our office closed down 1,200 complaints due to lack of resources. Those are complaints that came through the door that we didn't have the resources to investigate further to determine whether it was a viable criminal case or not."

Cantrell added: "And that number doesn't appear to be going down."

Predictions of disastrous service cuts have been common in Washington in the wake of the sequester [3]— automatic spending reductions caused by Congress and the White House failing to reach a budget deal. For the most part, though, these predictions have elicited little more than a shrug from the general public.

The shortfall at the HHS office has deeper roots, however. Cantrell said sequestration hasn't helped, but he blamed a mix of budgetary issues which he called "expiring funding streams."

Nobody at the agency would agree to discuss the situation. However, in a statement released late Friday the agency said the OIG has "significantly reduced" [funds] due to the expiring of a $30 million per year appropriation from the Deficit Reduction Act of 2005 and the end of stimulus funding and other budget cuts.

The inspector general's "greatest resource" is its staff of auditors, evaluators, investigators, and attorneys, the statement said, noting: "These funding reductions have fundamentally impacted the agency's ability to conduct its mission. Reduction in staff and resources will result in decreases across all of OIG's oversight activities."

Though their findings can embarrass or infuriate agency brass, inspectors general more than pay for themselves by exposing waste and recommending fines or prosecution of wrongdoers, officials said.

Wright said that fraud investigations "returned $8 for every dollar invested in us." Medicare, which serves the elderly, is paid for by federal tax dollars. Medicaid, for low-income people, is jointly funded by the federal and state governments. Medicaid is set to expand by as many as 20 million people starting next year under the Affordable Care Act.

In a statement, Sen. Tom Carper, D-Del., who chairs the homeland security committee, called the cuts "a penny-wise, pound foolish approach that will end up costing our country in the long run."

Carper said the inspector generals' work "helps us save money, reveals and prosecutes wrongdoing, and promotes the integrity of government." The IG's are being cut back "just when we need their skills to keep our federal programs as efficient and effective as possible," Carper said.

The inspector general reported expected recoveries of about $5.2 billion from audits and investigations in fiscal year 2011. The office also identified about $19.8 billion in waste and launched more than 1,000 criminal and civil investigations of individuals or health care businesses accused of cheating Medicare or Medicaid.

Estimates of annual losses to fraud and waste in the health care industry run into the tens of billions of dollars annually. Federal agencies reported an estimated $115.3 billion in improper payments in fiscal year 2011, and more than half that figure was attributed to Medicare and Medicaid, according to the Government Accountability Office.

The cuts at HHS OIG are triggering a review of dozens of projects and audits which are spelled out in the agency's 2013 "work plan." But officials could not say at this point which ones would be scrapped or ratcheted back.

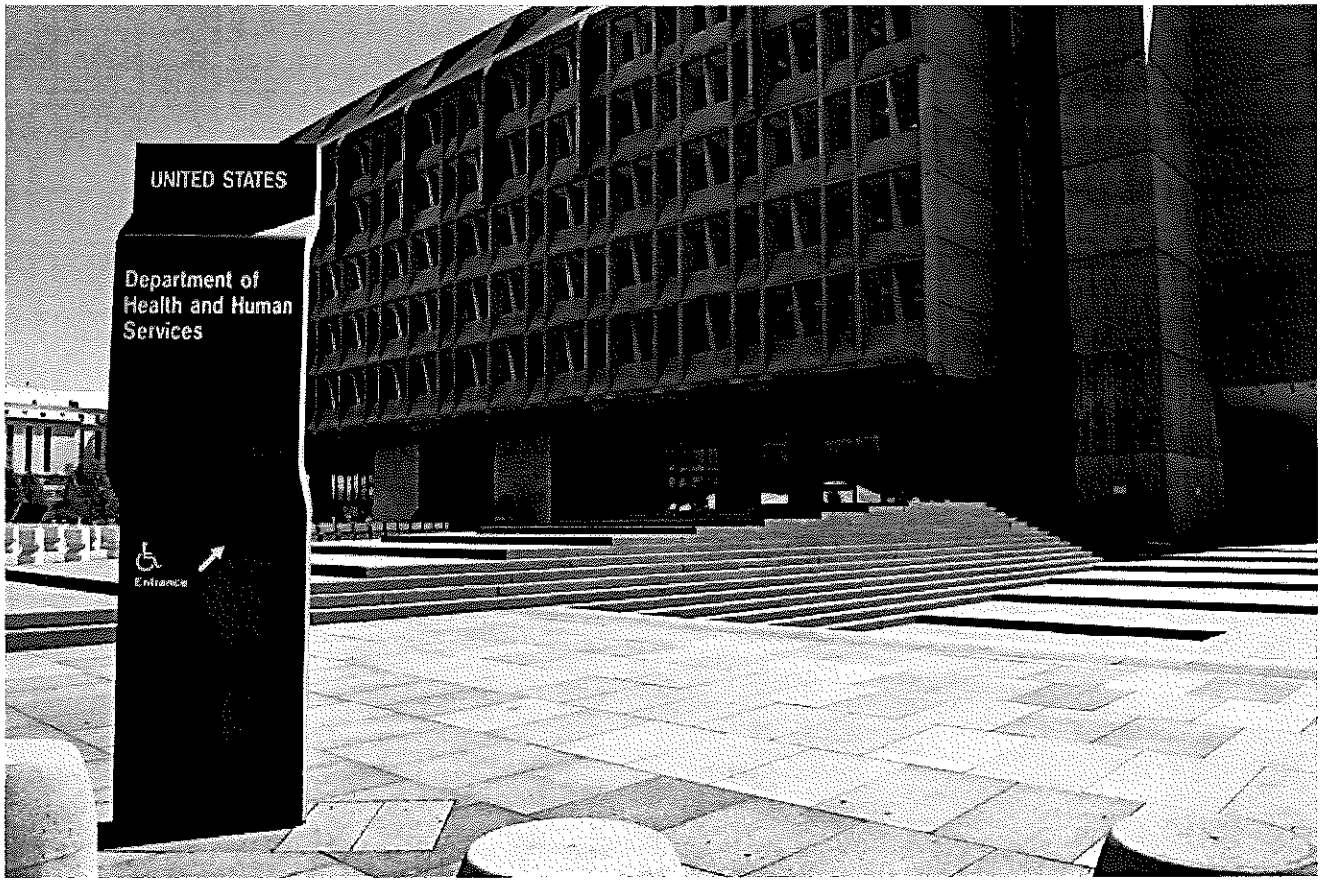
The OIG's annual work plan serves as a kind of barometer of where government officials suspect fraud or billing abuse may be occurring and a warning to the industry to clean up its act. That's often necessary because Medicare and Medicaid billing policies lack clarity on precisely what constitutes improper conduct.

One major project that's likely to be scaled back is an ambitious plan to "identify fraud and abuse vulnerabilities" in electronic health records. The federal government is spending about $36 billion in economic stimulus funds to help doctors and hospitals purchase the digital technology in the hopes that it will ultimately reduce waste from duplicative tests and make health care more efficient and less costly.

Criticism from Republicans in Congress has mounted in the wake of the Center for Public Integrity's "Cracking the Codes" [4] series published last September. The investigative project documented that thousands of medical professionals have steadily billed Medicare for more complex and costly health care over the past decade — adding $11 billion or more to their fees — and strongly suggested that the rapid growth in the use of electronic health records [5] and billing software has contributed to the higher charges.

The Obama administration has often touted its record for cracking down on health care fraud, pointing to recoveries of more than $10 billion since 2008, and pointed to criminal cases that busted major fraud rings.

For instance, one operation in October 2012 in seven cities led to charges against 91 individuals — including doctors, nurses, and other licensed medical professionals — for alleged fraud schemes that involved some $432 million in false billing.



[2]

Jasmine Norwood/The Center for Public Integrity

Kicker:
Medicare fraud burying feds
Agency couldn't investigate 1,200 complaints, and more cuts coming.

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