



Prevention and Early Detection of Health Care Fraud, Abuse, and Waste

FORUM SESSION ANNOUNCEMENT

A DISCUSSION FEATURING:

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FRIDAY, OCTOBER 30, 2009
11:45AM–12:15PM—Lunch
12:15PM–2:00PM—Discussion

LOCATION

Reserve Officers Association
One Constitution Avenue, NE
Congressional Hall of Honor
Fifth Floor
*(Across from the Dirksen
Senate Office Building)*

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OVERVIEW

Fraud, abuse, and waste seem to be ubiquitous weaknesses in our health care system. Although a relatively small proportion of health care providers, patients, and insurers engage in these practices, all Americans pay the price in terms of higher spending and often poor quality care. This session will examine the most effective tools for prevention and early detection of fraud, abuse, and waste, particularly in relation to Medicare. The session also will probe whether Medicare's arsenal of anti-fraud tools is sufficient, consider whether policymakers' expectations for program savings from anti-fraud activities are realistic, and explore impediments to the adoption of promising strategies.

SESSION

Fraud and abuse schemes are illegal activities designed to intentionally con insurers into paying for items and services that are not provided, needed, or medically necessary. Health care providers, for example, might bill for services not provided, or bill for more complex and more costly services than those actually provided. Patients might allow others to use their insurance identification card, accept money for allowing a provider to bill for an item or service not provided, or re-sell prescription drugs or other health care items. An insurer might bill an employer or the government for health care or administrative services not provided. Waste adds to spending in our health care system, but it is often hard to identify and detect. Specialists, for example, might order tests already performed by a primary care physician. Physicians might prescribe therapies at a patient's insistence that may not be effective for that particular patient. The cost of fraud, abuse, and waste is paid in higher insurance premiums, greater out-of-pocket costs, and added taxes to support unnecessary spending in public programs like Medicare and Medicaid.

President Obama recently stated that the U.S. health care system is "full of waste and abuse" and that his preferred health reform approach would eliminate "hundreds of billions of dollars in waste and fraud."¹ While the dollar amounts lost to fraud, abuse, and waste are not known for sure, the National Health Care Anti-Fraud Association "estimates *conservatively* that 3% of all health care spending—or \$68 billion—is lost to health care fraud."² Other estimates are much higher.³ Medicare may or may not be subject to more fraud

and abuse than other insurers, but its sheer size, public funding, and required public reporting about fraudulent activities puts it in the spotlight of anti-fraud efforts.

Reducing the incidence of fraud, waste, and abuse in Medicare has been identified as a potential source of program savings. The extent to which significant program savings are achievable depends on the effectiveness of the tools used to detect fraud and abuse. Staying ahead of computer savvy digital perpetrators requires an investment in automated data analysis as well as traditional audit, which can be time-consuming and expensive. Maximizing program savings also depends, in part, on the point at which an effective intervention is applied; preventing health care fraud may achieve more savings than trying to recoup payments already made (and perhaps already sheltered, or offshore).

Curbing unnecessary spending is not the only motivation for pursuing anti-fraud activities. According to the Federal Bureau of Investigation, one disturbing trend involves schemes that cause harm to the patient, including conducting unnecessary surgery or prescribing potentially harmful drugs when they are not medically indicated.⁴ Given that the Medicare population is older and sicker and has lower income than the population as a whole, beneficiary protection is a particular concern.

KEY QUESTIONS

- What factors contribute to the prevalence of fraud, waste, and abuse in health care, and in Medicare in particular? Are there characteristics unique to Medicare's payment practices or beneficiaries that make the program vulnerable?
- What is Medicare doing to prevent fraud and abuse and to minimize waste? How successful have these efforts been?
- What are most effective anti-fraud tools? What is their return on investment? What anti-fraud strategies could Medicare adopt from private insurers? How does Medicare's size and public payor status affect its ability to pursue different strategies?
- Is the current investment in Medicare's anti-fraud efforts sufficient? What are realistic expectations for Medicare program savings attributable to these efforts?

SPEAKERS

Kimberly Brandt is director of the Program Integrity Group at the Centers for Medicare & Medicaid Services (CMS). Ms. Brandt will discuss CMS's efforts to detect and deter fraud and abuse in Medicare. **Edward J. Litchko** is senior director, Corporate & Financial Investigations Department at Independence Blue Cross in Philadelphia, Pennsylvania, where he oversees traditional audits as well as data mining efforts. He will discuss the tools used by a private insurer to prevent fraud and abuse, with particular emphasis on data mining. **Cesar Arias** is a private investigator and retired Miami Health Department pharmacist whose work uncovering a large fraud scheme involving counterfeit prescription drugs is the subject of the book *Dangerous Doses*, by Katherine Eban (Harcourt, 2005). Mr. Arias will discuss common health care fraud schemes, the reasons he believes health care fraud is relatively easy to commit, and what actions Medicare and private insurers could take to better prevent and detect fraud.

ENDNOTES

1. The White House, "Remarks by the President to a Joint Session of Congress on Health Care," Office of the Press Secretary, September 9, 2009; available at www.whitehouse.gov/the_press_office/Remarks-by-the-President-to-a-Joint-Session-of-Congress-on-Health-Care.
2. National Health Care Anti-Fraud Association, "The Problem of Health Care Fraud"; available at www.nhcaa.org/eweb/DynamicPage.aspx?webcode=anti_fraud_resource_cent&wpscode=TheProblemOfHCFraud.
3. Federal Bureau of Investigation (FBI), "Financial Crimes Report to the Public: Fiscal Year 2007," October 1, 2006–September 30, 2007; available at www.fbi.gov/publications/financial/fcs_report2007/financial_crime_2007.htm#health.
4. FBI, "Financial Crimes Report to the Public."