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RPTS BINGHAM

DCMN BURRELL

MEDICARE CONTRACTORS' EFFORTS TO

FIGHT FRAUD - MOVING BEYOND

"PAY AND CHASE"

FRIDAY, JUNE 8, 2012

House of Representatives,

Subcommittee on Oversight

and Investigations,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 9:35 a.m., in Room 2123, Rayburn House Office Building, Hon. Cliff Stearns [chairman of the subcommittee] presiding.

Present: Representatives Stearns, Terry, Burgess, Blackburn, Griffith, DeGette, Schakowsky, Castor, and Dingell.

Also Present: Representative McKinley.

Staff Present: Todd Harrison, Chief Counsel, Oversight

Investigations; Dave Mehring, Detailee/Oversight (OIG/HHS); Alan Slobodin, Deputy Chief Counsel, Oversight; John Stone, Counsel, Oversight; Alvin Banks, Democratic Investigator; Phil Barnett, Democratic Staff Director; Brian Cohen, Democratic Investigations Staff Director and Senior Policy Adviser; Kiren Gopal, Democratic Counsel; and Elizabeth Letter, Democratic Assistant Press Secretary.

Mr. Stearns. Good morning, everybody, and we start the Subcommittee on Oversight and Investigations with this hearing.

We convene this hearing of the Subcommittee on Oversight and Investigations to examine the efforts of the Centers for Medicare and Medicaid Services, CMS, oversight of its Medicare contractors and to identify ways to improve the contractors' effectiveness at preventing and combating fraud.

Medicare fraud is a growing plague on our health care system. I have personally seen how fraud impacts seniors in my congressional district and throughout the State of Florida. CMS, the very agency tasked with administering Medicare and conducting and overseeing anti-fraud efforts, incredibly simply cannot define the scope of the problem. However, we have heard the estimates that 10 percent of all health care billings are potentially fraudulent, a 60 to 80 billion drain on the Federal dollars. Regardless of the ultimate numbers cited, every dollar lost to fraud is a dollar that should have gone towards the care and well-being of a Medicare beneficiary.

I applaud the recent efforts of Federal, State and local officials across six States in busting over 100 fraudsters, more than half of whom were operating in south Florida, in scams that total over $450 million.

I look forward to hearing from our witnesses today about how we can keep these criminals out of Medicare in the first place.

Since 1999, CMS has contracted with Program Safeguard Contractors, or PSCs, to prevent, identify and investigate potential

fraud. They are now in the process of transitioning these responsibilities to Zone Program Integrity Contractors, or ZPICs, though the contract recipients are primarily the same entities and with the same capabilities.

Unfortunately, information obtained from the committee's investigation indicates that these "benefit integrity contractors" are simply not getting the job done and CMS is asleep at the wheel.

Last December I sent a letter along with Chairman Upton and other members of the committee to CMS accounting administrator, Marilyn Tavenner, requesting documents related to the performance of the CMS benefit integrity contractor since 2007; 3 months ago she responded to our request with systematic performance data that includes some concerning trends. One, the benefit integrity contractors identify less than 1 percent of the estimated fraud out there. They recover only 10 percent of the improper payments they identify. They rarely employ their authority to suspend payments to suspected fraudsters. They initiated fewer investigations in 2011 than in 2007. And finally, fewer of these investigations were based on proactive analysis of claim data.

The figures CMS provided to the committee are astonishing in terms of the declining contractor effectiveness they display. However, according to CMS, while the trends are correct, the numbers provided were inaccurate. Not only were they inaccurate but knowing that they were a key element of our hearing, CMS failed to inform committee staff about this fact until less than 48 hours ago on a phone call initiated

by committee staff on another matter.

Since they did not feel confident in the accuracy of the data they had on-hand, CMS was forced to reach out to the contractors and have them resubmit as much of the data that was requested as possible.

More accurate numbers were provided last evening confirming the trends. Nevertheless, this error only confirms CMS's utter incompetence in conducting any meaningful oversight of these contractors, the point that is echoed loud and clear in the IG's prepared testimony.

The complacency shown by CMS towards this committee's oversight efforts, their repeated indifference to GAO's recommendations since and their total disregard for OIG's extensive body of work in this area must end today. While these issues are not new, they are getting worse while the fraudsters are getting better and better.

As the OIG's office testified before this subcommittee in June, 2001, Medicare contractors are the heart of the Medicare program. When they don't function properly, the entire program is jeopardized. Those who benefit from it, those who provide care and those who pay for it all suffer the consequences.

This hearing proves the importance of congressional oversight. Without the committee asking the questions we would never know about the serious data integrity and management issues concerning CMS oversight of their contractors.

Without the committee insisting that CMS and its contractors be accountable for meaningful performance metrics, we cannot achieve the

significant improvements and results in reducing Medicare fraud.

So I look forward to working in a bipartisan fashion to make this hearing the start of a turning point for CMS and contractor performance. With that, I yield to the ranking member, Ms. DeGette.

[The statement of Mr. Stearns follows:]

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Ms. DeGette. Thank you, very much, Mr. Chairman. I am glad there is bipartisan consensus on aggressively fighting Medicare fraud because it costs the government billions of dollars, and you are exactly right, it harms our most vulnerable citizens.

I am confident that we can work together to build on the provisions to strengthen the Medicare program integrity that were included in the Affordable Care Act, and I am looking forward to hearing how the CMS is implementing this new law to help fight fraud.

I appreciate all of our witnesses coming today to offer their expertise.

The Affordable Care Act provided about $350 million in increased funding to fight fraud, money that will return billions of dollars to the taxpayers. It contains over 30 new provisions to help CMS and the law enforcement authorities fight Medicare fraud. This expanded toolbox in conjunction with the leadership of the Obama administration has helped lay the groundwork for a new era in the Federal Government's response to fraud.

In the past, CMS operated under a "pay and chase" approach which made it harder to recover losses. Now, CMS is taking new important steps to prevent fraud before it occurs, and I am looking forward to hearing about that today. What CMS does is carefully screen health care providers when they sign up for the Medicare program, keeping out these criminals that the chairman talked about who prey on vulnerable seniors.

The agency's new fraud prevention system employs predictive

modeling technology in order to screen claims before payment is made. Using this system, CMS can identify patterns of fraud and deny claims, suspend payment or revoke Medicare billing privileges for suspicious actors.

During the first 10 months of operation, this new fraud prevention system has resulted in 591 new investigations and 550 direct interviews with providers suspected of participating in fraudulent activity.

CMS investigators now watch billing patterns in real time. If a provider submits a claim that seems inconsistent, for example a bill from San Francisco for a patient who lives in Maine, then it triggers a flag in the system. Medicare contractors then investigate the suspicious leads that this new system produces. The fraud prevention system now monitors 4.5 million claims every day. It is a big step forward to prevent Medicare fraud, and I am eager to see how well it is working and what improvements can be made to make it work even better.

One of the questions I have for our witnesses today is how, with a shift from pay and chase to fraud prevention we should evaluate CMS successes. Our typical measures, like the dollar value of fraud recoveries, might not be the right measures of success if you are actually preventing the fraud, because if CMS is successful at preventing the fraud in the first place, we would expect the dollar value of the recoveries to go down, not up, but we would still have to figure out how much fraud we were preventing.

This hearing today will primarily focus on CMS's use of

contractors to monitor claims, investigate suspicious activity and refer cases to law enforcement authorities.

Congress mandates that CMS use these contractors and the alphabet soup of Medicare integrity organizations -- we were talking about this at our office -- ZPIC, MEDIC, PSCs, RACs, MACs, have become a part of the efforts to fight fraud. The HHS Inspector General has identified problems with the contractors and CMS oversight of their work going back for at least a decade. And having been on this committee for the past 16 years, I know that we have investigated some of these contractors.

These are longstanding problems, but the IG's work has raised important questions that we need to learn more about today. Are Medicare anti-fraud contractors using uniform standards to identify and investigate cases of fraud and refer them to law enforcement authorities? Is CMS doing all it can to respond to concerns raised by contractors and reduce the fraud vulnerabilities they have identified? Are contractors and CMS taking appropriate action to ensure mistakes are fixed and overpayments reclaimed for the taxpayer?

Mr. Chairman, I want to make a suggestion as we look further into this issue. At our next hearing I suggest we bring the contractors in directly and get their perspective on these issues. Thank you.

Mr. Chairman, if there is more we can do to reduce Medicare fraud, I am happy to work with you and our colleagues on both sides of the aisle to address this important issue. Nobody wants to see taxpayer money wasted and we should be doing everything possible to protect the

integrity of the Medicare program.

And Mr. Chairman if I may, Mr. Waxman is unable to be with us this morning, so I would ask unanimous consent to put his opening statement into the record.

Mr. Stearns. By unanimous consent, so ordered.

[The statement of Mr. Waxman follows:]

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Mr. Stearns. I appreciate the gentlelady's willingness to cooperate and I think her idea of bringing the contractors in is very good.

With that I recognize for 3 minutes the gentleman from Texas, Dr. Burgess.

Dr. Burgess. Thank you, Mr. Chairman, for the recognition and maybe acknowledging the ranking member's comments on a metric that we could employ in the future is how many years the CMS or Medicare payment system is not on the high risk list at GAO. It seems like it spent the last 25 years there. That might be a good metric where we could concentrate and all understand that perhaps we are finally doing a good job with this because apparently we are not and we all know that not enough has been done to address fraud. Our Nation's health care systems needlessly waste billions of dollars every year.

It seems like this embarrassing hemorrhage for the program really should have been a priority to fix before these programs were expanded under the Affordable Care Act. Analysts estimate that up to 10 percent of the total health care expenditures are lost yearly to fraud. That is a pretty big number, probably over $1 billion a week.

Now Members of the United States Congress rightly were outraged when a private industry, JPMorgan Chase lost $2 billion of investor money. We lose $2 billion of taxpayer money twice a month and yet there are no headlines on that. Perhaps if we had the appropriate focus, we would do our job.

If we are serious about bringing down the cost of health care,

we have to eliminate, not just reduce, but eliminate these inappropriate payments.

Medicare spending currently represents 15 percent of Federal spending and almost a fifth of national health care spending. Yet we pay providers in practically an automatic fashion without review or scrutiny, actually inviting the type of behavior that we are getting.

I support prompt pay. As a physician that is critically important to our providers across the country. But the size, the scope, the complexity of the Medicare program makes this highly susceptible to fraud, highly susceptible to mismanagement and highly susceptible to improper payments.

The U.S. Government Accountability Office and others have said these characteristics are unsustainable, and the GAO has placed Medicare on its high risk list since 1990. That was after the program had been in effect for 25 years. We are rapidly approaching the 50-year anniversary, and once again I would suggest that it would be a great 50-year anniversary goal to remove Medicare off of the high risk list that the GAO maintains.

Our office has been briefed on the Center for Medicare & Medicaid Services's efforts to move away from a "pay and chase" mindset into one that is builds on predictive modeling. That is a great step and I welcome it. I have long suspected these programs are already proving to be an innovative way to build upon each other in nine original algorithms in just a few months have grown to over 30; however, backend investigations will remain a part of what the Centers for Medicare and

Medicaid Services does for some time. Currently they oversee a network of private contractors that conduct various program integrity activities but as Ranking Member DeGette points out, it may be necessary to have these individuals in to the committee to understand their steps to solve this problem.

Mr. Chairman, I thank you for calling the hearing, and I will yield back the balance of my time.

[The statement of Dr. Burgess follows:]

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Mr. Stearns. I recognize the gentlelady for however many minutes that she consumes. You can have the 5 minutes. Ms. Schakowsky.

Ms. Schakowsky. I don't know that I will take that. Thank you very much, Mr. Chairman. I just want to make sure that everybody understands that everyone on both sides of the aisle in this committee as well as the Obama administration makes fraud prevention absolutely a priority. So I hope there is no misunderstanding about that, that we are all working together to do that.

In May of 2009, Health and Human Services and the DOJ announced the creation of the health care fraud prevention and enforcement team, HEAT, designed to coordinate Cabinet level agency activities to reduce fraud.

In January 2010, HHS and DOJ held the first national summit on health care fraud to bring together public and private sector experts to identify and discuss ways to investigate and eliminate health care fraud.

In fiscal year 2011, HEAT's efforts resulted in 132 indictments against defendants who collectively billed the Medicare program more than $1 billion as well as 17 jury trials and the imprisonment of 175 defendants.

And in April 2010 CMS established the Center for Program Integrity, consolidating the agency's Medicare and Medicaid anti-fraud activities in an effort to improve coordination between the two programs with other agencies at the State and local level.

Since 2009 CMS, with law enforcement partners, has recovered

$7.87 billion in fraudulent Medicare payments, $2.51 billion in 2009, $2.86 billion in 2010 and $2.5 billion in 2011.

And since the passage of the Affordable Care Act, which I affectionately call "ObamaCare," the Obama administration has implemented key anti-fraud provisions in the law. The ACA contains over 30 provisions to help CMS, HHS, OIG and DOJ to reduce Medicare and Medicaid fraud. The most important provisions involve a shift from the traditional "pay and chase" approach to a strategy based on prevention, keeping fraudulent suppliers out of the program before they can commit fraud.

The nonpartisan Congressional Budget Office estimates that these provisions will save taxpayers over $7 billion over the next decade.

Clearly, we want to do as much as we can, and if there is more to be saved, which we all think there is, we should do it.

So today what I want to do is talk to the witnesses and find out just what those tools are, how they are being implemented and how we can all work together to make sure that these all work to the benefit of the consumer and the taxpayer. We want to look at that OIG report on vulnerabilities reported by the Medicare benefit integrity contractors. Certainly we want to make sure that they are doing their job and all of us will pursue this together to make the Medicare program even more efficient and to root out every dollar of fraud.

And I will yield back.

[The statement of Ms. Schakowsky follows:]

******** COMMITTEE INSERT ********

Mr. Stearns. And the gentlelady yields back. And does anyone else seek an opening statement? We have a couple of minutes left. If not, we will move to our witnesses.

We have three witnesses. Mr. Robert A. Vito is Regional Inspector General, Office of Evaluations and Inspections, Office of Inspector General, the United States Department of Health and Human Services. We welcome you.

Ms. Kathleen M. King, Director, Health Care, U.S. Government Accountability Office, and Mr. Ted Doolittle, Deputy Director, Center for Program Integrity, Center for Medicare and Medicaid Services, U.S. Department of Health and Human Services. Welcome.

As you know, the testimony you are about to give is subject to title 18, section 1001 United States Code. When holding an investigative hearing, this committee has the practice of taking testimony under oath. Do you have any objection to taking testimony under oath?

Mr. Vito. No.

Ms. King. No.

Mr. Doolittle. No.

Mr. Stearns. The chair then advises you that under the rules of the House and the rules of the committee you are entitled to be advised by counsel. Do you desire to be advised by counsel at this time?

Mr. Vito. No.

Ms. King. No.

Mr. Doolittle. No.

Mr. Stearns. In that case, will you please rise and raise your right hand? I will swear you in.

Do you swear that the testimony that you are about to give is the whole truth and nothing but the truth, so help you God?

Mr. Vito. Yes.

Ms. King. Yes.

Mr. Doolittle. Yes.

Mr. Stearns. Welcome again and Mr. Vito, we welcome your 5-minute summary of your written statement. Just make sure your speaker is on.

STATEMENTS OF ROBERT A. VITO, REGIONAL INSPECTOR GENERAL, OFFICE OF EVALUATIONS AND INSPECTIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; KATHLEEN M. KING, DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE; AND TED DOOLITTLE, DEPUTY DIRECTOR, CENTER FOR PROGRAM INTEGRITY, CENTER FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF ROBERT A. VITO

Mr. Vito. Good morning, Mr. Chairman and members of the subcommittee. I am Robert Vito, Regional Inspector General for the Office of Evaluation and Inspections at the U.S. Department of Health and Human Services Office of Inspector General. Thank you for your continued interest in this important topic.

For more than a decade, the OIG has been conducting work on Medicare benefit integrity contractors. OIG has reviewed the fraud units at the Medicare claims processors, then the Program Safeguard Contractors, or PSCs, and now the Zone Program Integrity Contractors and the Medicare Drug Integrity Contractors, known as ZPICs and MEDICs.

Time after time, regardless of the type of contractor under review, the OIG work has uncovered similar problems. These problems include limited results from proactive data analysis, difficulties in obtaining data needed to prevent and detect fraud, a lack of program vulnerability identification and resolution, inaccurate and inconsistent data reported by contractors, and limited use by the CMS of quantitative data in evaluating contractor performance and investigating their ability across contractors.

Finally, the OIG has found that very few of the overpayments identified by the benefit integrity contractors are collected and returned to the Medicare program. CMS expects its benefit contractors to do more than just investigate complaints. They wanted their

contractors to conduct proactive data analysis to identify fraud. As early as 1998, OIG raised concerns about the lack of results from proactive methods, and these concerns still remain.

The lack of proactive and early identification of fraud results in the Medicare program relying on familiar "pay and chase" models rather than the risk reduction model that includes early detection prevention of inappropriate payments. We all recognize that without data there can be no proactive data analysis. However, OIG repeatedly found that contractors have difficulty accessing data especially in the early years of their contracts. The Congress can help correct this problem by authorizing the MEDICs to obtain information like prescriptions directly from pharmacies and physicians.

Another way to help prevent fraud, waste and abuse is to identify program vulnerabilities. OIG's early review of fraud units found that more than one-third had not identified any program vulnerabilities. During a 2011 review, OIG found that not all benefit contractors identified vulnerabilities, and even when vulnerabilities were identified, CMS had not taken significant action to resolve three-quarters of them. The reported impact of the vulnerability was estimated at over $1 billion.

OIG also found that CMS has not taken full advantage of the contractor report data to evaluate performance or investigate variability among contractors. The OIG has found extreme variation in the number of fraud cases being investigated and referred by the benefit integrity contractors. These variations could not be

explained by the size of the contractor's budget or the oversight responsibility.

In addition, OIG work has repeatedly found that CMS performance evaluations provide very few quantitative data about the contractor's achievement in detecting fraud. OIG