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Statement of Rep. Diana DeGette
Ranking Member, Subcommittee on Oversight and Investigations
Hearing on “Medicare Contractors’ Efforts to Fight Fraud –
Moving Beyond ‘Pay and Chase’”
Subcommittee on Oversight and Investigations
June 8, 2012

Mr. Chairman, today’s hearing is the third that this Subcommittee has held on Medicare fraud this Congress. I’m glad that there is a bipartisan consensus on aggressively fighting Medicare fraud, because it costs the government billions of dollars and harms our most vulnerable citizens. I’m confident that we can work together to build on the provisions to strengthen Medicare program integrity that were included in the Affordable Care Act, and I’m looking forward to hearing about how CMS is implementing this new law to help fight fraud. I appreciate our witnesses from CMS, the Inspector General, and the GAO offering us their expertise today.

The Affordable Care Act provided an estimated \$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 laid 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 important new steps to prevent fraud before it occurs. They are carefully screening health care providers when they sign up for the Medicare program, keeping out criminals who prey on vulnerable seniors.

The agency’s new Fraud Prevention System employs predictive modeling technology in order to screen claims before a 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 its first ten 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's seems inconsistent – say, a bill from San Francisco for a patient that lives in Maine -- it triggers a flag in the systems. Medicare contractors then investigate the suspicious leads that this new system produces. The Fraud Prevention System now monitors 4.5 million claims each day. It's a big step forward to prevent Medicare fraud.

One question I have for our witnesses today is how, with a shift from pay-and-chase to fraud prevention, we should evaluate CMS's success. Our typical measures – like the dollar value of fraud recoveries – may not be the right measures of success at fraud prevention. After all, if CMS is successful at preventing fraud in the first place, we would expect the dollar value of fraud recoveries to go down, not up.

Today's hearing 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 this alphabet soup of Medicare integrity organizations - Z-PICS and MEDICS and PSCs and RACs and MACs - have become a key part of 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. 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've identified? Are contractors and CMS taking appropriate action to ensure mistakes are fixed and overpayments reclaimed for the taxpayer?

Mr. Chairman, I would like to make a suggestion as we look further into this issue: at our next hearing, we should hear directly from the contractors and get their perspective on these issues.

Mr. Chairman, if there's more that we can do to reduce Medicare fraud, I would be happy to work with you and your 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 protect the integrity of the Medicare program.