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ELIMINATING WASTE AND FRAUD IN MEDICARE AND MEDICAID

HEARING

BEFORE THE

FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT INFORMATION, FEDERAL SERVICES, AND INTERNATIONAL SECURITY SUBCOMMITTEE

OF THE

COMMITTEE ON
HOMELAND SECURITY AND
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

OF THE

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WEDNESDAY, APRIL 22, 2009

U.S. SENATE,
SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT,
GOVERNMENT INFORMATION, FEDERAL SERVICES,
AND INTERNATIONAL SECURITY,
OF THE COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 3:02 p.m., in room SD–342, Dirksen Senate Office Building, Hon. Thomas R. Carper, Chairman of the Subcommittee, presiding.

Present: Senators Carper, McCaskill, McCain, and Coburn.

OPENING STATEMENT OF SENATOR CARPER

Senator CARPER. The Subcommittee will come to order. Senator Coburn and I welcome each of you today. We will be joined, I think, by several other of our colleagues, including Senator McCain, somewhere along the line. We are just concluding a vote. And I checked on the floor before I came over here and they told me we are likely to have some more later this afternoon. One or two might be Coburn amendments. You never know.

Senator COBURN. You can count on it.

Senator CARPER. OK. I am going to give a brief opening statement and call on Dr. Coburn to do that if he would like and others, if they show up before we start, or I will ask for our witnesses to begin.

Over the last couple of months, President Obama and those who are privileged to serve here in the Congress have been tasked with responding to any number of challenges that are not likely to be solved overnight. Near the top of that list has been the budget crisis that we find ourselves in.

On the day that President Bush took office, the Federal Government enjoyed, as I recall—that was literally the day I stepped down as governor and came over here—but we enjoyed billion-dollar budget surpluses literally as far as the eye could see, and we were on our way to pay down the national debt. At the time, I think it was about $6 trillion.

It didn't work out that way, and since then, we have seen the budget surpluses disappear, as we know, replaced by some of the biggest budget deficits in our history, and the one we are facing this year is even bigger than those.

In January, when President Bush left office, our Nation and our new President were left to face the cost of two wars, dealing with tax cuts that were previously adopted, an increase of more than 50 percent in government spending to try to revitalize our economy and jolt it back to life, and some $10.6 trillion in national debt, which is roughly twice the national debt we had in January 2001.

Getting our budget deficit under control is not going to be an easy task. It will require tough choices and discipline. It will also require that we make certain to the greatest extent possible that every dollar that we collect from taxpayers is spent wisely and effectively. All too often, however, agencies are failing to meet their responsibilities in this regard.

According to the most recent data from agency financial statements, the Federal Government made more than $72 billion in avoidable improper payments in 2008, up from about $42 billion in the previous year. Some of those improper payments were overpayments. In fact, most of them were. Some were underpayments. But improper payments occur when the Federal funds go to the wrong recipient, when a recipient receives an incorrect amount of funds, when funds are used in an improper manner, or when documentation is not available to explain why a payment was made in the first place.

So, in essence, agencies potentially took tens of billions of dollars in taxpayers' money and may have ended up just wasting it. Those dollars could have been spent to promote energy independence or to invest in education or health care. They could have even been given back to middle-class families, andr small businesses through tax cuts. Instead, we can't be certain that we got anything useful at all out of some of those outlays or improper payments.

The major focus of this hearing today is fraud and abuse in two areas— Medicare and Medicaid. Strikingly, improper payments in these two programs alone made up almost half of the Federal Government's $72 billion total of improper payments.

Right now, Medicare and Medicaid account for about 5 percent of GDP. When you add in Social Security, these three entitlement programs currently add up to about 9 percent of our GDP. In about 40 years, I am told, Medicare, Medicaid, and Social Security, if we don't do anything about it, may end up accounting for some 19 percent of GDP, which is roughly what we now currently spend to run the entire Federal Government.

As we look to reform our health care system this year, reining in health care costs must be one of our top priorities. And right now, the trajectory that we are on is unsustainable.

The United States spends more than $2 trillion on health care every year. Conservative estimates assert that at least 3 percent is lost to fraud each year. Three percent of $2 trillion, if I have my math right here, is about $60 billion per year. Other estimates are as high as 10 percent, which is over $220 billion per year.

We look forward to hearing from our witnesses today on what I hope will be an informative discussion on fraud and abuse in Medicare and in Medicaid. We hope to hear from all of you about what we are doing well to prevent fraud, waste, and abuse. We want to hear from you about what we can do to improve. And we want to hear from you about what Congress can do to help.

I would also note before closing that I intend in the coming days to introduce legislation with a handful of our colleagues, and I certainly hope Dr. Coburn is among those, but legislation that I believe will help Medicare, Medicaid, and programs throughout government to deal with improper payment problems.

Our bill, the Improper Payments Elimination and Recovery Act, would improve transparency so that government and the public have a better sense of the scale of the problem agencies are facing. It would also hold agencies accountable for their progress in reducing and eventually eliminating improper payments. And finally, our bill would significantly expand the use of recovery auditing within the Federal Government.

Medicare, as many of us know—we have talked about it here before—Medicare is in the process of setting up recovery auditing programs in all 50 States. They have already tested recovery auditing in three States. I am told they recovered close to $700 million in just three States. We are encouraged that they are now going to do that in the other 47 States. Who knows, maybe if we can have great success in recoveries in Medicare in 50 States, maybe we can do the same thing in Medicaid.

We look forward to working with our witnesses and with the rest of our colleagues on this Subcommittee. This is an issue that is near and dear to the heart of Dr. Coburn and myself and I am pleased to have been his partner when he sat in this seat and I sat over there. I hope we can continue to be partners on this and a bunch of other issues as we go forward.

Dr. Coburn.

OPENING STATEMENT OF SENATOR COBURN

Senator COBURN. Thank you, Senator Carper. I welcome all of you.

Hard problem. One of the reasons it is a hard problem is Medicare and Medicaid are designed, by their very design, designed to be defrauded. The idea of post-payment review and recovery audits are all sensible approaches, but one of the things that we are not doing is payment reform because if we had payment reform by the Congress, what we would see is a less defraudable system.

The other thing we are not doing is putting enough people in jail. If, in fact, you defraud the Federal Government, consequently, there ought to be a harsh penalty for that, and we have not gone to the length that there is a deterrent, even under the terrible system that we have today, there is still no deterrent. There are fines and penalties and paying back money, but you all know how bad the problems are.

The other problem with recovery audits is they are really pretty one-sided, so you could have done everything wrong and examiners see that in a different light, and yet you have limited options on that. What I am afraid is we are going to be 3 years behind on the recovery audits and we are going to be taking money from people that may or may not deserve it.

So my goal would be today to get from this hearing is to find out how bad the problem is. I think Senator Carper's numbers are way under what the real world is on fraud, in Medicare, for sure, and Medicaid, for sure. We know it is at least three times the average

of other Federal departments, which is somewhere around 3 to 5 percent. How do we approach that? Should we keep working on the details of auditing and evaluating, or should we go for something bigger like payment reform, where it is much more transparent, it is much more clear whether somebody did or did not. We can't even get contracting through the Congress on durable medical equipment (DME) payments—competitive contracting, which is one of the biggest areas of abuse.

So my hope is that we can hear your thoughts, how big you think the problem really is, and what we do about it, and start thinking out of the box a little bit. We know recovery audits are going to be work, that they are expensive. They are painful for both sides, and maybe we set up a system that doesn't require that, or requires much less.

I have a statement I would like to be added to the record, if I may.

And with that, I notice that the Ranking Member is here and I will yield.

[The prepared statement of Senator Coburn follows:]

PREPARED STATEMENT OF SENATOR COBURN

As our Nation prepares for a historic debate over the direction of health care policy, hearings on waste and fraud in Medicare and Medicaid are vitally important. They provide an opportunity to improve these enormous Federal programs and play a vital role in giving us a glimpse under the hood of government-run health care. Unfortunately, what we find is that we need a new mechanic.

If this seems like an exaggeration, look no further than the plans being offered to expand health care coverage simply by enlarging Medicare and Medicaid. Serious proposals coming out of the White House and congress aim to use these programs as a jumping off point for increasing the reach of Federal health insurance. Before this Nation takes that giant step, it should have all of the facts.

Consider the fact that Medicare costs consumed 3.2 percent of the entire U.S. GDP in 2007 to cover nearly 40 million older Americans. And yet, even this is not enough to cover the program's costs—the Medicare Trust Fund is projected to go bankrupt as soon as 2016. It is easy to imagine that adding tens of millions of additional beneficiaries to the Medicare program would only hasten the coming insolvency.

Making Medicare an even less attractive model for nationalized health care is that the program is rife with fraud, waste, and abuse. According to some estimates, the annual amount of fraudulent payments made by Medicare approaches $60 billion. That is a staggering $500 per year per family in this country. As one who treats patients in the lowest income brackets, I know first-hand how valuable that amount of money could be. By failing to eliminate waste and fraud, we are robbing these same people of opportunity.

Since 1990, the Government Accountability Office (GAO) has designated the Medicare program as high-risk because of its size, complexity, and vulnerability to mismanagement and improper payments. Last summer, the Permanent Subcommittee on Investigations conducted an investigation and found that close to $100 million had been paid for claims that used the identification numbers of physicians that had died at least 2 years before the claims were filed.

In another example, a 2008 investigation by the inspector general at the Department of Health and Human Services found that a woman operating out of her townhome submitted more than $170 million worth of fake claims to Medicare, of which more than $100 million was paid out. While the sheer size of her scheme led to her downfall, there are thousands of such cases every year on a smaller scale.

Sadly, this is not an isolated incident. Hundreds of millions of dollars have been paid by Medicare to companies who submitted claims for medical equipment they never provided, didn't exist at the addresses listed, or providing supplies and equipment to patients who didn't need them for any medical reason. These are just a few of the identified problems with Medicare.

Turning to Medicaid, the outlook is even worse. The current cost of the program is more than $333 billion annually. However, Medicaid's costs are growing by 8 per-

cent a year, a pace that will cause costs to explode to more than $670 billion by 2017. That is a doubling of the cost in only 8 years.

One of the most disturbing findings about the Medicare budget according to HHS is that the improper payment rate is above 10 percent—triple the government-wide average. In New York the problem is even worse, with improper payments reaching an estimated 40 percent of the State program budget.

As a member of this Subcommittee, and as Ranking Member on the Permanent Subcommittee on Investigations, I plan on taking an active role in rooting out waste and fraud in these programs.

Unfortunately, until we put market discipline into the health care system, waste and fraud will continue to be a reality in Medicare and Medicaid. Our health care system is in dire need of a tune up. That's why I am glad to tell you that in the very near future I will be offering a comprehensive health care reform bill which saves us billions of dollars, harnesses market forces, and puts patients first.

I appreciate the witnesses who have joined us today, and look forward to their testimony.

Senator CARPER. Welcome, Senator McCain. Thanks, Dr. Coburn.

OPENING STATEMENT OF SENATOR MCCAIN

Senator MCCAIN. Thank you very much, Mr. Chairman. I want to apologize for being a few minutes late. In this very heavy tourist season, it is hard to get on an elevator nowadays.

Senator COBURN. Especially when you are known.

Senator MCCAIN. I am glad all of our constituents are here representing their various interests.

I would just like to follow up a bit on Dr. Coburn's comments.

Our information is that in fiscal year 2008, there was $19 billion in improper payments from the Medicaid program and $17 billion from Medicare—I would just be interested if the witnesses are in agreement with that. We get that, I think, from the Office of Management and Budget. Last year, nearly 500,000 payments estimated somewhere between $76 million and $92 million were made to durable medical equipment supplies, or DMEs as the insiders say, that submitted claims using identification numbers of doctors who had been dead.

Most Americans, and I will ask that my prepared statement be made part of the record—think that we understand cost overruns. We understand why something might end up costing more to treat a patient that has unforseen complications, a staph infection, something like that. I don't think Americans are aware of the outright fraud that exists, and so waste is important, but shouldn't we place the highest priority on the fraudulent practices that have already been uncovered by you all as witnesses?

So I want to thank you, Mr. Chairman. Some of these numbers, when we get into it, some of these cases are really astonishing. So I think this hearing is important and I want to thank the witnesses for being here today and for all of their hard work. I know it is not easy.

Thank you, Mr. Chairman.

[The prepared statement of Senator McCain follows:]

PREPARED STATEMENT OF SENATOR MCCAIN

Senator Carper, thank you for holding this hearing today. With Medicare costs rising to $454 billion in fiscal year 2008 and Medicaid expenditures topping $352 billion, it is important for us to continue to exercise robust oversight of these programs.

For the past 20 years, the government Accountability Office has placed the Medicare program on its "high risk" list. the Medicaid program has been on the "high

risk" list since 2003. Things appear to be getting worse, not better. Just a few months ago, the Office of Management and Budget reported that, in fiscal year 2008, nearly $19 billion in improper payments were made from the Medicaid program and over $17 billion from Medicare. That is astounding, especially when you consider that roughly 50 percent of the government's total reported improper payments in 2008 came from these two programs alone.

The problem is not simply one of waste, but also of fraud. Last summer, the Permanent Subcommittee on Investigations reported that over an 8-year period, nearly 500,000 payments, estimated somewhere between $76 million and $92 million, were made to durable medical equipment suppliers that submitted claims using the identification numbers of doctors who had been dead for years. This is only one small segment of the Medicare and Medicaid universe; one can only imagine how much more fraud is out there that remains undiscovered.

America is enduring a monumental economic crisis, with soaring deficits from bailouts de jour and escalating government misspending. We cannot afford to squander billions of taxpayer dollars on administrative errors and deceitful practices in the Medicare and Medicaid programs. And, if this Congress is going to embark on major health care reform, we need to fully understand the complexities and weaknesses of the Medicare and Medicaid programs.

In closing, I want to thank the witnesses for their participation. I know they work hard in eliminating waste and fraud in Medicare and Medicaid, and I look forward to hearing their testimony.

Thank you again, Mr. Chairman.

Senator CARPER. Senator McCain, thank you so much for being with us and for being a part of this.

Before I recognize and introduce our first witness, I would simply say I think one of the better initiatives that came out of the George W. Bush Administration was the idea of the Improper Payments Information Act so that we would actually call on agencies to identify their improper payments or overpayments and their underpayments, and over time in this decade, more and more agencies have begun to do that so we have some idea how big the problem is.

A couple of pieces of the puzzle are still to be filled in. I think Medicare Part D, the prescription drug program is not covered yet under improper payments. And I think a good deal of the Homeland Security Department does not report yet. Those need to be done.

So the idea of having an improper payments law that the agencies actually comply with that is all well and good. And the fact that more and more of them are complying with the law, that is good. But now that we find out how big the problem is or have some idea how big the problem is, the key is to go out and get the money, as much of it back as we can. Where people have defrauded the government, the taxpayers, there has to be a price to pay for that, not just paying back the money, but a greater price than that.

We have been working on this for a while. We are going to continue to work on it. And given the kind of budget deficits we face, we need to work even harder.

Let me introduce our first witness, Kay Daly. You look so familiar. Have we seen you before? Tell our Senators, how do we know you?

Ms. DALY. I was very fortunate to have been detailed to the Subcommittee staff when I worked at GAO, and still do work at GAO.

Senator MCCAIN. You are probably glad we made so little progress. [Laughter.]

Senator CARPER. No, she was a keeper, but she went back and got a big promotion and we are happy and proud of you. She joined GAO in 1989 and has participated in a number of key oversight ef-

forts there, including the response to Hurricane Katrina and work related to fraud and abuse in health care programs at the Department of Health and Human Services. Kay Daly is a Certified Public Accountant and a Certified Government Financial Manager with a degree in business administration from Old Dominion University. She has graduated from the Senior Executive Fellows program at Harvard University's Kennedy School of Government. Welcome. Nice to see you again, Ms. Daly.

Deborah Taylor is the Acting Chief Financial Officer and Acting Director of the Office of Financial Management at the Center for Medicare and Medicaid Services. It's actually known as CMS. Before assuming these positions, Ms. Taylor served for 5 years as Deputy Director at the Office of Financial Management. She has also served as the Deputy CFO and Director of the Accounting Management Group at CMS. Before joining CMS, she was the Assistant Director for Health and Human Services audits at GAO. She is a Certified Public Accountant, as well, and has a degree in accounting from George Mason University. Welcome. Thanks, Ms. Taylor.

Lewis Morris, Chief Counsel of the Department of Health and Human Services, Office of Inspector General, where he has worked for 25 years in a number of roles. He has also served as Special Assistant U.S. Attorney for the Middle District of Florida, the Eastern District of Pennsylvania, and the District of Columbia. He serves on the Board of Directors of the American Health Lawyers Association.

Finally, James Sheehan joins us from New York, where he works as his State's Medicaid Inspector General. Before taking on that role in April 2007, he was the Associate U.S. Attorney for Civil Programs at the Eastern District of Pennsylvania in Philadelphia. He tells me he knows Joe Biden's oldest son, actually worked with him there when Beau was in the U.S. Attorney's office. Mr. Sheehan had worked in the U.S. Attorney's Office in Philadelphia, I think since 1980. He focused on health care fraud during his career there and he has supervised more than 500 fraud cases. He has degrees from Swarthmore College and Harvard Law School.

For my youngest son, one of the schools we visited was Swarthmore. He is now a freshman down at William and Mary. But when we went to Swarthmore and visited that campus, they said to my son then, "Here at Swarthmore, we have a saying. If you can't get into Swarthmore, try Harvard." And you are one of those people who not only got into Swarthmore, but also tried Harvard. That is a pretty good combination.

Ms. Daly, you are up first. Welcome. Your whole statement will be part of the record and you can summarize as you see fit. Try to keep it within 5 minutes, if you would. Thanks.

TESTIMONY OF KAY L. DALY,[1] DIRECTOR, FINANCIAL MANAGEMENT AND ASSURANCE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Ms. DALY. Thank you very much for the opportunity to be here today to discuss the government-wide problem of improper payments in Federal programs. I want to also talk about agencies' efforts to address the key requirements of the Improper Payments Information Act of 2002, which is commonly referred to as IPIA.

For fiscal year 2008, 22 agencies reported improper payment estimates for 78 programs that totaled about $72 billion. This is an increase from the fiscal year 2007 estimate, primarily due to a $12 billion increase in the Medicaid program's estimate and to newly-reported programs with improper payment estimates totaling about $10 billion.

Although overall improper payments rose by about $23 billion, we view this as a positive step because it indicates that agencies have increased their efforts to identify and report on improper payments, and that will ultimately improve the transparency over the full magnitude of improper payments. Given the increase in funding from any of these programs under the Improper Payments Elimination and Recovery Act, I think establishing the effective accountability measures is going to be critical for many of these programs, too.

Now, many agencies did report last year that they had made progress to reduce improper payments in their programs since the initial IPIA implementation in 2004. For agencies that have reported for every year from 2004 to 2008, they reported they had reduced their error rates in 24 programs. Thirty-five programs reported reduced error rates in 2008 compared to their 2007 estimates. And while this can be viewed as a positive sign, and it is promising, there are some major challenges remaining with those programs.

For example, we found that the $72 billion improper payment estimate did not reflect the full scope of improper payments across all agencies, just as the Senator pointed out. There were 10 programs that were identified as susceptible to improper payments with outlays of over $60 billion that did not report an estimate.

We further found that IPIA noncompliance issues continue to exist at several agencies. Specifically, independent auditors for four agencies reported IPIA noncompliance issues related to areas such as their risk assessments, testing of payment transactions, and development of corrective action plans to reduce those improper payments. And we also found that agencies are facing challenges in implementing internal controls to identify improper payments, but more importantly, to safeguard against them. That is what, I think, the Act is ultimately getting at. Over half of the agency Inspector Generals had identified management or performance challenges, including internal control deficiencies that could increase the risk of improper payments.

Now, the focus of the hearing today is on Medicare and Medicaid programs. Both of those programs have been on GAO's High-Risk List because they are highly susceptible to fraud, waste, and abuse.

[1] The prepared statement of Ms. Daly appears in the Appendix on page 35.

CMS, the agency responsible for administering and overseeing them, was only able to provide improper payment estimates for the Medicare fee-for-service program, Medicare Advantage, and the Medicaid programs. Those three estimates, as Senator Carper pointed out, are roughly about 50 percent of that $72 billion in improper payments. CMS did not provide an estimate for the Medicare Prescription Drug Benefit program that had outlays of over $46 billion.

I also want to point out that Medicaid was at the top of the list of all Federal programs when it comes to the size of their improper payment estimates. That is particularly alarming because additional funds are going to this program under the Recovery Act.

So in closing, I think it is important that we recognize that measuring improper payments and taking actions to reduce them aren't simple tasks. The ultimate success of the government-wide effort to reduce them will hinge on every Federal agency's diligence and commitment to identifying, estimating, determining the causes of, and taking corrective actions to reduce improper payments.

So this concludes my statement, Mr. Chairman, and I would like to thank you and the other Members of the Subcommittee for your continuing commitment to addressing this problem. I think it will take such a sustained commitment for there to be real progress in this area and we, at GAO, stand ready to help you in any way we can.

Senator CARPER. Great. Thank you so much. Ms. Taylor, you are recognized.

TESTIMONY OF DEBORAH TAYLOR,[1] ACTING DIRECTOR AND CHIEF FINANCIAL OFFICER, OFFICE OF FINANCIAL MANAGEMENT, CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. TAYLOR. Thank you. Good afternoon, Chairman Carper, Senator McCain, and Senator Coburn. I am honored to be here today to discuss with you CMS's efforts to measure and reduce improper payments in the Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) programs, as well as discuss some of our efforts to oversee these programs and combat fraud.

On the measurement front, much has been accomplished since the last time CMS appeared before this Subcommittee. For Medicare last year, we reported an error rate of 3.6 percent, a significant decrease from the 4.4 percent reported in 2006, and a reduction of greater than 50 percent from the 10 percent rate reported in 2004. This is a cumulative savings to the Medicare and taxpayers of over $10 billion.

For the first time ever, in fiscal year 2008, CMS issued a partial error rate for the Medicare Advantage program. That error rate, unfortunately, was 10.6 percent, and although that rate is high, we had a similar experience in the first years of the Medicare program. We are hopeful that we can also significantly reduce this rate by working with the plans to improve their ability to respond to audits and submit the required documentation.

[1] The prepared statement of Ms. Taylor appears in the Appendix on page 58.

CMS also issued the first complete error rate for the Medicaid and CHIP programs in fiscal year 2007. The rates for the Medicaid program included for the first time managed care and eligibility determinations. The Medicaid rate, again, was 10.5 percent and the CHIP rate was 14.7 percent. We are working with States currently to develop State-specific corrective action plans, which we hope will address the root causes of these errors and should ultimately be able to reduce the overall error rate in these programs.

Another important tool that CMS has is in the process of expanding the Recovery Act program, and thanks to the passage of the Tax Relief in Health Care Act of 2006, which mandates the use of recovery audit contractors in all States by 2010, CMS awarded contracts to four recovery auditors for the national program. The Recovery Act during the 3-year demonstration returned over $990 million in gross overpayments to the Medicare Trust Fund.

Senator CARPER. Would you say that number again, that last sentence.

Ms. TAYLOR. Sure.

Senator CARPER. The full sentence, please.

Ms. TAYLOR. Sure. The Recovery Act during the 3-year demonstration that we had on the Recovery Act program, we were able to return $990 million in overpayments.

Senator CARPER. Good. Thank you.

Ms. TAYLOR. We are currently doing a phased-in approach of the Recovery Act program. Phase one began in February of this year in 24 States and phase two will begin in February for the remaining 26 States. We are currently working closely with national and State health care associations to ensure that providers have a complete understanding of the national expansion.

And last, CMS has focused significant efforts over the past 2 years to strengthen oversight of one of the most vulnerable programs, the durable medical equipment benefit. The majority of the fraud which occurs in that benefit is perpetrated by unscrupulous providers and suppliers who have been able to obtain Medicare enrollment numbers and take advantage of the program vulnerabilities, thereby costing the program billions each year.

Specifically, CMS is implementing more front-end safeguards to ensure that fraudulent suppliers of DME cannot participate in the Medicare program. We are using a three-pronged approach in this area. The first is accreditation standards. Second is surety bond efforts, which will begin October 1 of this year. And we are currently phasing in competitive bidding. All of these efforts are designed to keep unscrupulous suppliers from participating in and billing the Medicare program.

We continue to set standards for measuring and reducing—recovering improper payments in Medicare, Medicaid, and CHIP programs. And while we are proud of our efforts, we recognize there is still room for improvement. Increased funding to reduce fraud and abuse in these critical programs is a priority and we look forward to your continued support in this area. We are committed to thoroughly analyzing the results of all our efforts to further reduce improper payments in these programs and assure that this funding is focused towards the most productive activities. We look forward

to continuing to work cooperatively with you on this effort and I will take any questions.

Senator CARPER. Thank you, Ms. Taylor. Mr. Morris, you are recognized.

TESTIMONY OF LEWIS MORRIS,[1] CHIEF COUNSEL, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. MORRIS. On behalf of the Office of Inspector General, thank you for the opportunity to discuss the OIG's health care anti-fraud strategy and suggest measures that may help strengthen the integrity of the Federal health care programs.

The United States spends more than $2 trillion on health care every year. The National Health Care Anti-Fraud Association estimates that of that amount, at least 3 percent, or more than $60 billion each year, is lost to fraud. Improper payments for unallowable, miscoded, or undocumented services, and excessive payment rates for certain items and services also wastes scarce Medicare and Medicaid resources. For Medicare and Medicaid to serve the needs of the beneficiaries and remain solvent for future generations, the government must pursue a comprehensive strategy to combat waste, fraud, and abuse.

Based on OIG's investigations as well as our audits and evaluations of the Medicare and Medicaid programs, we believe an effective health care integrity strategy must embrace five principles. These principles are equally applicable to our oversight, CMS's program integrity efforts, and Congress's legislative agenda. Let me go through those five principles.

First, we must scrutinize those who want to participate as providers and suppliers prior to their enrollment in the Federal health care programs. A lack of effective enrollment screening gives dishonest and unethical individuals access to a system they can easily exploit. As my written testimony describes in more detail, criminals too easily enroll in Medicare and steal millions before detection. We advocate strengthening enrollment standards and making participation in the Federal health care programs a privilege, not a right.

Senator CARPER. A question. You said criminals enroll in Medicare. As providers, or as participants receiving care?

Mr. MORRIS. As providers and suppliers.

Senator CARPER. All right. Thank you.

Mr. MORRIS. I would also add that, regrettably, beneficiaries are now becoming involved in some of these fraud schemes, but largely we are concerned about screening at the enrollment stage of providers and suppliers.

The second principle we believe is important to consider is establishing payment methodologies that are reasonable and responsive to changes in the marketplace. OIG has conducted extensive reviews of payment and pricing methodologies and has determined that the payments pay too much for certain items and services. When pricing policies are not aligned with the marketplace, the programs and their beneficiaries bear additional costs. In addition to wasting health care dollars, these excessive payments are a lu-

[1] The prepared statement of Mr. Morris appears in the Appendix on page 78.

crative target for the unethical and the dishonest. These criminals also can reinvest some of their profits in kickbacks, thus using the fraud funds to perpetrate the fraud scheme.

Medicare and Medicaid reimbursement systems should be designed to ensure that payments are reasonable and responsive to the market. Although CMS has the authority to make certain adjustments to fee schedules and other payment methodologies, some changes require Congressional action.

Third, we need to assist health care providers to adopt practices that promote compliance with program requirements. Health care providers can be our partners in fighting fraud by adopting measures that promote compliance with program requirements. Although compliance programs alone will not solve the problem, they are an important component of a comprehensive strategy to combat waste, fraud, and abuse in the health care system.

The importance of health care compliance programs is well recognized. Based on a recent survey by the Health Care Compliance Association, over 90 percent of hospital systems add integrated compliance measures into their systems. New York requires providers and suppliers to implement an effective compliance program as defined by the OIG as a condition of participation in its Medicaid program. Accordingly, we recommend that providers and suppliers should be required to adopt compliance programs as a condition of participating in the Medicare and Medicaid programs.

Fourth, we believe we must vigilantly monitor the programs for evidence of fraud, waste, and abuse. The Federal health care programs contain an enormous amount of data related to the delivery of health care services. Unfortunately, they often fail to use these claim processing edits and other information and technology to identify improper claims. To state the obvious, Medicare should not pay an HIV clinic for infusion when the beneficiary has not been diagnosed with that illness, or paid twice for the same service, or process a claim that relies on the identification number of a deceased physician.

In addition to improving program data systems, it is critical that law enforcement have real-time access to all relevant data. Currently, we receive data weeks or months after claims have been filed, making it more difficult to detect and thwart new scams.

We also recommend the consolidation and expansion of various adverse action databases. Providing centralized, comprehensive databases of sanctions taken against individuals and entities would strengthen program integrity.

Fifth, we need to respond swiftly to detected fraud, impose sufficient punishment to deter others, and promptly remedy program vulnerabilities. Health care fraud attracts criminals because the penalties are lower than other organized crime-related offenses, there are low barriers to entity, schemes are easily replicated, and there is a perception of a low risk of detection. We need to alter the criminals' cost-benefit analysis by increasing the risk of swift detection and the certainty of punishment.

As part of this strategy, law enforcement must accelerate the response to fraud schemes. Although resource-intensive, the Anti-Fraud Strike Force is a powerful tool and represents a tremendous return on the investment. As my written testimony describes in

more detail, the HHS-DOJ strike force in South Florida has proven highly effective in attacking DME and infusion fraud and stopping the hemorrhaging of program dollars.

In conclusion, the OIG and its law enforcement partners have a comprehensive strategy to combat waste, fraud, and abuse in the Federal health care programs. However, sophisticated fraud schemes increasingly rely on falsified records, elaborate business structures, and the participation of doctors and patients to create the false impression that government is paying for legitimate health care services. Applying the principles described above can help protect the integrity of the programs and keep them solvent for future generations. Thank you.

Senator CARPER. Thank you for that excellent testimony.

Mr. Sheehan, we are anxious to hear about what you have done in New York. I am very encouraged. Sometimes Senator Coburn and I like to bring agencies before this Subcommittee that have done a very good job to hold them up as an example. Other times, we bring them before us because they need to do a much better job. I think in your case in New York, what has happened under your leadership could be an example for the rest of us, so we are happy to hear about it and anxious to hear what you have done.

TESTIMONY OF JAMES G. SHEEHAN,[1] MEDICAID INSPECTOR GENERAL, NEW YORK STATE OFFICE OF THE MEDICAID INSPECTOR GENERAL

Mr. SHEEHAN. Chairman Carper, thank you very much, Senator Coburn. We, the Medicaid Inspector General's Office of New York, really appreciate the opportunity to be the only State representative at the table today.

Senator COBURN. You are the biggest State.

Mr. SHEEHAN. One-sixth of the national program, and we recognize that. If you look at our anti-fraud effort in New York, we have 600 people actually working on anti-fraud efforts in New York State, which is the second biggest agency of that type in the country.

In the last fiscal year, identified recoveries of over $550 million in the New York State, and also from the Medicaid program. I tell people I owe my job to the *New York Times* because the *New York Times* and Senator Grassley paid a lot of attention to New York back in 2005 and 2006, and as a result, the agency that I am the head of was created and the governor invited me to come up and run it.

I want to talk a little bit about different things than some of my colleagues at the table today. The issues that we face in health care are—especially in health care fraud are complex and I want to talk a little bit about the kinds of cases that we are seeing come up. And we talk about improper payments and we talk about fraud, and there is obviously a continuum, but in a lot of these cases, although it is clear the payment is improper, the question is how do you allocate individual responsibility, which is what the enforcement mechanism is all about.

[1] The prepared statement of Mr. Sheehan appears in the Appendix on page 87.

So, for example, we have a laboratory company which bills the program for an unreliable test which causes patients to get unnecessary surgery. We have pharmacies which home deliver prescriptions to patients who died weeks or months before. We have nursing home owners that bill the Medicaid program for their Lexus or their Mercedes on the theory that occasionally they drive patients to the hospital in the car. We have managed care plans in New York State that billed Medicaid for prenatal services for males. And here in the *New York Post,* there is one of those that did happen, but in general, even in New York, it is not a major event. We also have providers who we send out a letter saying, "Pay us back." They credit a refund. Then 6 months later, they send us a bill for another—for the same claim for the same service.

And all these things reflect the issue of identifying responsibility in large organizations and making them take responsibility, and I have worked on a lot of these cases and they follow a predictable course. They are investigated for a number of years. They eventually result in either a criminal declination or an indictment which has a relatively limited effect on the provider. There is a large amount of money in civil settlements. By the time the settlement occurs, the individuals who were in charge of the company at the time the bad stuff happened have moved on to other enterprises. They are not there anymore.

The government issues a press release stating, "Providers that attempt to defraud Federal insurance programs will be held accountable to the full extent of the law." The defendant issues a press release announcing, "This settlement resolves a 5-year-old government investigation and puts it behind us." The stock goes up.

I know this happens because I worked on a number of these cases in my career. It is not a reflection of anybody that does the work to say this is how it works.

We, in New York, think there is a better way to address these issues. We need to move from a system which encourages some providers to look for excuses to a system which requires and supports having effective and appropriate billing and compliance systems in place. Too often, law enforcement agencies describe their work as combatting fraud. I think we have to look and say, how are we going to get providers to do what they know they need to do?

So like Mr. Morris, I have a five-point plan, which even though we didn't collaborate in advance is remarkably close.

The first one is requiring and supporting effective compliance programs and professional compliance officers. New York, by law, requires it, as Mr. Morris said. The Medicare program suggests model compliance programs. We want the health care providers to identify and resolve issues themselves, and the best of them already do that, so we want to spread that to the rest.

Second, we want to hold the senior executives and board members in large organizations accountable for failing to have systems that prevent improper billing. So it is not the issue of, did you order this improper billing, because most of them don't do that. The issue is, do you have a system in place that is reasonably designed to detect and prevent improper payments, all right, so that is—and the Inspector General's Office has done a great job of articulating

standards and making suggestions and getting consensus statements and we think that is a great idea.

Third, we think it is important to elevate support and use the administrative tools and payment suspension, prepayment review, audits, sanctions, individual entity exclusion when improper payments are discovered. All too often, these remedies are postponed while other things go on, but the key to us is not just the severity of the sanctions. It is making sure the response is prompt and it addresses the money that is going out the door.

Fourth, recognizing the most effective deterrence requires regulator communication to and persuasion of those whose behavior we want to influence, and most health care providers are risk averse. You don't go to medical school for 20 years of education to do something you know is going to get you in trouble. There are a few that do, but CMS has historically advised individual providers of their rankings on issues of concern. Frequent and predictable interventions, we think are more effective than occasional severe sanctions.

And fifth, develop and communicate consistent measures of effectiveness of program integrity, which capture cost avoidance and reduction as well as recoveries and minimize the cost imposed by reviews and investigations. You are much more likely to get cooperation if people know what the rule is on the front end and know that there is going to be a follow-up than if they have had it for 3 years—I guess Senator Coburn is used to that—and then say, give it back to us.

So that is our five-point program. We really appreciate the opportunity to speak to the Subcommittee today.

Senator CARPER. Thank you very much for that testimony.

We have been joined by Senator McCaskill. Before we get into questions, would you have a short statement you would like to give, and then we will get right into the questions.

Senator MCCASKILL. I will wait for questions.

Senator CARPER. All right. Fair enough. We are delighted that you are here.

In the time that I spent in my last job as governor, we were active in the National Governors Association trying to learn from one another. In fact, we actually created a clearinghouse of best practices. It sounds to me like maybe what you have created in New York is a best practice that other States might emulate. Is that going on?

Mr. SHEEHAN. What, is the best practice——

Senator CARPER. Yes. And is what you are doing in New York regarded as a best practice among States?

Mr. SHEEHAN. I would like to think that some of the things we are doing in New York are regarded as best practice. CMS has actually done a very good job with the money they have been given over the last 3 years, creating a Medicaid Integrity Institute, bringing us together in program integrity across the country, training, sharing ideas, regular conference calls, all those things that the National Governors Association has done, as well.

One of the things that has happened in the last 3 years that I think is really good is the process of communication internally so that people know what works in other States, and we have been trying to do our share of that.

Senator CARPER. When you think about what could a State like Delaware or Oklahoma learn from what you are doing? And then my next follow-up is going to be, and what can we, the Federal Government, learn from what you are doing? I used to say as governor, whatever problem or issue we are dealing with in Delaware, some other State had already dealt with it and successfully, and our challenge was to find them and figure out how we could replicate that in our State.

Mr. SHEEHAN. We are very fortunate in New York in having a really robust data system which allows us to do very effective data mining, and it is tough to build that if you don't have both a lot of claims and a lot of resources to support it.

But one of the things we have done in New York that other States are starting to pick up on, every year, we issue a comprehensive workplan, an idea we stole from the Federal Inspector General's Office, that identifies for each kind of provider, these are the issues we are going to focus on. These are the issues your compliance function ought to pay special attention to this year. Our first one was last year. Other States have started to pick up on it and use it as a basis for their plans. Our next one comes out, I think at the end of this week. And again, it is a matter of communicating to people, this is what we think is important. Please pay attention. And then you have given people fair notice.

And what is impressive to me is people do conform their behavior to the message that they receive. So that is a major one, and then there are some other cost control and reporting mechanisms that we have developed that I think other States have picked up.

And on the Federal side, Mr. Morris talked about the issue of access to data on a real-time basis and I cannot tell you how important that is in our effort. One of the things that I love about the staff that I have in New York, I will get e-mails at 10 o'clock on a Saturday night. They so much enjoy the work of data analysis and data mining, and they have access to it for purposes of their work, that they will be working on weekends and come in with great ideas and sharing them with other people. It is impressive to watch.

Remember, I talked about the billing for pregnancy care for males. That was discovered by a nurse who was one of our data miners. She went to the computer and was talking at lunch. She said, there are certain things we know don't happen, so let us test our computer system and see if it is really working the way we think it is. And so she went in and she put males, prenatal care, and what you should see is, "no information found." What she found is 300 claims. And so she went through and said, OK, 120 of these sound like female names, probably a data entry error. But even after she was finished, there were over 100 male persons who had, according to the billing system, received payment for prenatal care. That is the kind of thing, not only do you need the systems and the real-time access to data, you need people to get excited about working on it, and I think law enforcement would benefit from that kind of tool.

Senator CARPER. All right. Thank you.

Senator Coburn and I worked on changes to the Improper Payments Act. I think we are going to reintroduce some legislation in

the next couple of weeks that will seek to improve on what we have done before, better ensure that agencies are actually complying with the law, try to make sure that we go after money that has been misspent, improperly spent, and sometimes spent wastefully, and not just to go after it but recover, to actually provide an incentive for agencies to go out and recover this money, maybe even by allowing them to keep a portion of it themselves to help pay for, among other things, their investigative work and to help actually use a little bit of it for their programmatic expenses, too. So that actually incentivizes them to want to get in the game.

But let me just ask you, if you are in our shoes and you are trying to fashion legislation to further improve, to strengthen the improper payments law, any of you, I don't care who wants to go first, but just talk to us about some things that we definitely should include in the legislation.

Mr. MORRIS. If I could offer one thought, and this relates to the Recovery Audit Contractors as well as the unintended consequence of incentives. From the perspective of law enforcement, we always want to be very mindful not to have it appear that we are operating on a bounty system. We all have the belief that the parking ticket we got at the end of the month was because someone was trying to make their quota. If we are going to preserve the integrity of the law enforcement effort so the citizenry believes we go after a bad guy because they are bad, not because we have a quota, I think we always have to be mindful of those incentives.

I would tell you that—and we are working with CMS constructively on this issue—we have had concerns that the Recovery Audit Contractors have a powerful incentive to identify issues as overpayments because they recover and retain a portion of those funds more readily than when reported as a fraud. If they are identified as frauds, that matter is then referred to law enforcement and it could be some time before they would see, if any, recovery from their audit work.

Based on the pilot project, I believe it is the case that we received no referrals based on the Recovery Audit Contractor's work. I must tell you, although I have no empirical evidence, it strikes me as implausible that based on all of those millions of dollars recovered, not any of them triggered fraud.

Senator CARPER. You said none of them were attributable to fraud? Is that what——

Mr. MORRIS. None of them were referred to us to develop as fraud matters. They were all resolved, I believe, as overpayments. And Ms. Taylor, you could probably speak more specifically to that.

Ms. TAYLOR. Right. Mr. Morris is correct. I don't believe we had any cases that were referred to law enforcement for fraud types of activities. The recovery audit program really was focused initially in what I would call payment kinds of issues, where either it was the setting of the service was not appropriate or it was more or less looking at issues related to perhaps too much of one thing being prescribed for an individual. So it wasn't necessarily fraud, but it was things where it did look like an improper payment was being done, but we certainly are willing to work with the IG in the future to ensure that if our recovery auditors have any evidence that this might be fraudulent, that we do refer it over to them.

Senator COBURN. The problem is, being a provider, they know how to skirt the individual definition of fraud. But we don't come back and look at repetitive skirting of that, which is fraud. And when you have a system on recovery audits that doesn't look at that, you are not going to find it. And I will guarantee you find the same guys, same gals doing exactly the same thing—they are upcoding one or they are doing this and it is fraud. It is intended fraud. But they know, if you look at the record on that one, you really can't go after them for fraud, just overpayment. So looking at the pattern of behavior rather than the actual behavior becomes important to the fraud definition.

Senator CARPER. Let me just yield to Dr. Coburn and then we will bounce it over to Senator McCaskill. You are recognized, so please proceed.

Senator COBURN. Thank you, Mr. Chairman.

I have some questions that I have prepared that I would like to enter into the record and have you all answer them through writing.

Senator CARPER. Without objection.

Senator COBURN. I want to spend my time, if I can, especially with Mr. Sheehan, but I would like all of you to answer this. If we were to start over, and the predicate for my question is when I go and talk to the insurance companies in this country, their improper payment rate and their fraud rate is about 0.4 of 1 percent and we are sitting at 25 times that. So there has got to be something with our system, either the way we have designed it or the way we manage it that makes it completely different than everybody else that is paying medical bills.

So what would you change? If you could tomorrow tell us, start over, what would we give you that would lessen the ability for you to have to have your job? How would you describe it? I wouldn't want to take your job away from you, but it is a serious question. I am convinced, if everybody works as hard as they can and everybody has the same goal, that we are going to get down to 3 or 4 percent of a trillion—well, it is $2.4 trillion, of which 61 percent now is Federal Government. That is a ton of money. So how do we change? How do we think out of the box to get to where we are not chasing our tail?

Mr. SHEEHAN. I think one of the advantages that private companies have over the government, whether it is Federal or State, is they can pick their contract partners. They can use their ability to evaluate the prior performance and the bona fides and the background to see if this is someone they want in their organization or network. And for a variety of reasons, that is much harder for a public entity to do.

But I think the issue of who do you let in and who do you let stay in the program is really important, and that is one area where CMS is focused on, the Federal Inspector General is focused on, and we are focusing on. We let people in because they have a license or a degree or a business——

Senator COBURN. Well, they have to apply. They have to get Medicaid certified or Medicare certified.

Mr. SHEEHAN. That is right.

Senator COBURN. They have to get a number.

Mr. SHEEHAN. In New York, for example, we go out and inspect every single new DME provider. We inspect every new transportation provider. We inspect every new pharmacy in the southern part of the State, which is New York City. Expensive and time consuming. We think it has a big effect in reducing bad claims on the front end.

And the second piece of that is, who do you let stay in? Do you re-review that provider? Because it may be a pharmacy that is Mr. Morris's pharmacy today. It is somebody else's pharmacy tomorrow, but his name is still on the paper because no one has ever looked at it. So we think you need to have a robust enrollment process that does a look-back further down the road to make sure we know who these people are.

And just as you have credentialing activities within hospitals, one of the concerns that we have in New York State is we exclude lots of people from the Medicaid program. What happens to them next? And the assumption, well, they all went to Texas or Florida, right. There is some merit to that, but I suspect there are quite a few that are still working here.

Senator COBURN. They renamed themselves.

Mr. SHEEHAN. Exactly. So the idea of identifying the bad players and also focusing on the front end of who you let in is really——

Senator COBURN. Why do they rename themselves? Because it is a honey pot easy to take the honey out of. That is where I am trying to go with this. How do we change the system in terms of payment reform so it is not a honey pot?

Mr. SHEEHAN. The difficulty, I think, and I have looked at a number of systems around the world for this. The Germans for a long time had a pot of money and they said, we will base payment on the number of services you provide. So what happened is the number of services went way up and they brought the patients back 20 times for backaches and headaches.

In Quebec, they cut off the payments, that when you reach a certain peak, whether it is in November or August, they don't pay anymore. So what people do is bill the system through August and then they leave Quebec as the winter is coming and then return in January.

And managed care, we felt, would—in fact, those two—the problem is, every payment system which tries to be fair, that is to recognize the effort and input of the providers, also can be gamed as long as we have human beings playing with it. I do think that the entry and control process is a significant part of it, and the essence of third-party payment is that you are going to have situations where for Medicaid we can't really charge people because they don't have any money. And so the question is, where do they fit in that picture?

Senator COBURN. OK. Mr. Morris.

Mr. MORRIS. If I could supplement that, I absolutely agree that keeping the bad guys out and then throwing them out for good is critically important. This is why ideas like databases, adverse action databases are so important so that it is easier to obtain Medicaid, Medicare, and provider information. In addition, shouldn't a nursing home be able to know what the track record is of someone

who is about to be giving direct care to a senior citizen? That is all part of it.

But I think even more critical is being able to adjust payment systems as we discover that they are being abused. To follow on Mr. Sheehan's point, whatever payment system you set in play, there will be opportunities to exploit it. Fee-for-service, overutilized. Capitated payment, underutilized. What you need is to be able to use data and market surveys and other resources to affirmatively go out and see whether payment practices are changing to respond to the market place.

If I could give you an example, when we started paying on a capitated or a DRG basis for hospital services, we bundled lab services into that payment. Initially, they were performed within 24 hours. Well, everybody shoved those tests out beyond 24 hours. Then we made it 72 hours and the tests were done beyond 72 hours because the hospital system responded to that parameter.

Senator COBURN. Yes. They are treating the system instead of the patient.

Mr. MORRIS. Exactly. And so one of the things we need to recognize is that is going to be, regrettably, part of the nature of the system. A lot of money, a lot of opportunities, a lot of consultants, and rather than try to legislate every opportunity for mischief, give CMS greater flexibility to be more responsive, to update fee schedules, to impose competitive bidding practices, and let them get to that mischief early on. So part of this is having a payment methodology and payment systems which are much more responsive so we aren't that pot of honey that attracts the criminals.

Senator COBURN. I have one question for CMS. We know there is a disparity in both outcomes and cost. Where we have better outcomes, we actually see lower costs. Have you all tracked your fraud records with the areas where you see better outcomes and lower costs?

Ms. TAYLOR. That is not something we have——

Senator COBURN. To me, that would tell me where to work, because if there is a correlation, you don't need to be spending your time in Minnesota or Iowa, where we know we have lower costs and better outcomes. You need to be working in areas, which we know, like Florida, which have poor outcomes and higher cost. It is almost a ratio of the providers to the number of beneficiaries and you will know where to go.

But it would be interesting for you all to put that out to us, here is where we see greater outcomes at lower costs and better long-term viability of the patients, and we know that fits with a lower cost to Medicare, not a higher. Actually, we spent less money to spend that. And then correlate that with where you are seeing the highest fraud and improper payments.

Ms. TAYLOR. We certainly can do that.

Senator COBURN. That is the data mining that Mr. Sheehan is talking about because that is going to tell you where to go and that is going to tell you where the priority is. It is not necessarily the most populous States. It is where you can go by the quality and cost parameters we are seeing now, that is where not to go, the places where it is highest.

I have several other questions, but my time is up. Thank you, Mr. Chairman.

Senator CARPER. There will be another round, if you would like.

Senator MCCASKILL. Thank you, Mr. Chairman.

Senator CARPER. Senator McCaskill has great interest in issues like this.

Senator MCCASKILL. Yes, and I want to compliment Dr. Coburn for thinking like an auditor.

Senator CARPER. He has been doing it for a while.

Senator COBURN. I have a degree in accounting.

Senator MCCASKILL. There you go.

I sent a letter to CMS in January and I want to not be cynical about this. I haven't been here long enough to be cynical. But I sent the letter January 16, 2009, and I got the response by fax machine at 5 o'clock last night.[1] It feels a little more than coincidental to me. I am not, frankly, understanding the responses I got. And my questions are on Medicare D and what we have done in regards to the required financial audits.

But more importantly, what I am most upset about in the response I got, we know from work done by the IG's Office that 25 percent of these bids have errors in them. Now, these are the bids that we sign off on for Medicare D plans. And half of those, they made unreasonable assumptions or errors that resulted in them making too much money.

Now, there are ways that we can reconcile that with these various companies that are offering Medicare D plans as it relates to the government. But these seniors are being overcharged. And I want to put into the record the response I got from CMS about the seniors that are being overcharged.[1]

They are being overcharged because these plans have done it wrong, not because of some vagaries in the market, but because they have done it wrong.

And here is what the response says. The beneficiary knows the premium cost before enrolling in the plan. Furthermore, beneficiaries have access to detailed plan information. Therefore, if a beneficiary is not satisfied with a plan's premium, they may enroll in a less expensive plan for the coming year.

Are you kidding me? I mean, seriously, do you think my mother is supposed to go through her plan and figure out somehow that she has been overcharged and that all she has to do the next year is pick a cheaper plan? I want to know what you all plan on doing to get the money back to these seniors who have been overcharged on these premiums, overcharged in terms of what they are paying for these prescriptions, and what mechanism are we going to put in place so they get their money back. They are very ill-equipped to be able to recover this money and I was shocked at this answer because it basically said, tough. We are not worried about them. I would like some response, Ms. Taylor.

Ms. TAYLOR. I will apologize. I am not the expert in our Part C and D programs. I do know that when we review the bids, we do ask them to rebase the next year so their bids should either go

[1] The letter submitted by Senator McCaskill appears in the Appendix on page 95.

[1] The letter from the Centers for Medicare and Medicaid Services appears in the Appendix on page 94.

down so that their premiums would go down for the beneficiaries, but I don't know all the ins and outs. I would have to get you an answer for that on the record.

[The information provided by Ms. Taylor follows:]

The statute specifies the extent to which plans and the government share risk, and places limits on the extent to which CMS recoups discrepancies between anticipated and actual costs. Under current law, once a bid is accepted and used to set plan premiums and payment levels for Medicare beneficiaries, there is no legal authority for CMS to revise the accepted bid amount for any purpose, including adjusting beneficiary premiums. CMS has implemented the reconciliation process in accordance with the statute and has made adjustments to plan payments to reflect differences between plans' anticipated costs reported in the bids and their actual experience.

If the structure of the program were changed to allow beneficiaries to request a refund of premiums paid when a plan sponsor performs better than expected, there would be a payment system built on a shared risk bidding system. The bid has to be low enough to attract customers but high enough to cover their operating costs. Studies have shown that competitive bidding produces cost effective prices.

In addition, if changes in premiums (refunds or additional payments) would be made, new administrative systems would need to be developed so that CMS could retroactively adjust premium payments. Such an administrative system would be costly to construct and difficult to administer.

Finally, the reverse situation could also be true as well. If a plan sponsor did not perform as well as it expected, then beneficiaries might receive a bill from an underperforming plan for added premiums after reconciliation. Such a result would be contrary to CMS' goal of promoting a system that establishes beneficiary protection and program stability.

Senator MCCASKILL. Can't we require them to pay back their beneficiaries? Can't they cut them a check? We have done the numbers on this now and profits went up for the drug companies. After we put Medicare D in, they went up about $6 billion a year on the backs of the U.S. taxpayer. And they stayed that high since we put Medicare D in. I mean, can't we force them to make refunds to these seniors? Isn't that a reasonable thing to do, before they are allowed to participate again?

Ms. TAYLOR. I honestly don't know the answer to that. I don't know if we can ask them to reimburse beneficiaries.

Senator MCCASKILL. Well, I just know that the most vulnerable population we have in this country is being taken advantage of, and if we are not going to be their champion, if the Federal Government is not going to bat for them, nobody is. And I am just concerned that after months of waiting for an answer to this, the answer I get from CMS is, well they just need to pick a cheaper plan next year—it won't make any difference if it is a cheaper plan if it is still wrong. They are going to be paying more than they should.

The IG recommended that if, in fact, we discover there are errors in the bid plan, that they be required to have an independent outside actuary certify their plans for the following year. Is that something that makes sense? And I don't know, Mr. Morris or Ms. Taylor, if you are in a position to comment on that, but that seems like, at minimum, a reasonable requirement, that they would be penalized by requiring an outside actuarial analysis of their bids once it is discovered that they have that overcharged.

Ms. TAYLOR. We do some review of the bids. Our actuarial contracts do look at bids. But to the extent that we would have them required to do an outside independent review of those bids, I don't believe we are doing that at this time.

Senator MCCASKILL. Well, I would. I know it is a time of transition in government and I know that many positions are changing and so forth. I don't mean to be unreasonable, but it is just hard to understand this response in light of what it represents in a practical standpoint.

Ms. TAYLOR. I understand.

Senator MCCASKILL. It is just somebody who is not paying attention to the practicalities of the situation.

Yes, Mr. Morris.

Mr. MORRIS. Senator, to answer your question, in part, and I am also not an in-depth expert in Part D, but I can tell you two things. One, we have been very concerned about the inadequacies in some of these bids and the inability through the year-end reconciliation process to get a level playing field. Not only do we think that it is important to have good data coming in on the Part D side, but this applies across the board. There are so many places where we are relying on self-reported information, for example, wage index reports from hospitals, which affect how we then build our Part A reimbursement system. The idea that if providers have submitted flawed data repeatedly, to force them to bring in an outside actuary to validate the data, has a lot of appeal to it. We would be pleased to provide you whatever technical assistance you would like.

I would offer one other thought along these lines. There is within the current law the authority to impose, I believe, a penalty for erroneous information provided as part of a Part D bid. The problem is that if you don't also have an assessment that is tied to the volume of the error, the penalty is going to be well overtaken by the profit you make in the error. So including in the current law an assessment that allows you to collect back more than the profit realized by this knowing error would create a disincentive to putting together bad bid proposals.

Senator MCCASKILL. And they don't have the ability to do that now? Do we need a change in the law for that to happen?

Mr. MORRIS. That is my understanding, yes. There is currently a penalty, but there is not an assessment.

Senator MCCASKILL. OK. It did go on to say that—which in some ways make it worse—well, if we did that, then when they didn't make as much money as they should, they would have to pay them more. Excuse me. The companies are taking the risk, not the seniors. The companies are doing business with the government. If they get it wrong to their detriment, tough. If they get it wrong to the detriment of the seniors, they need to pay and they need to pay the seniors, and that is not occurring now and we have to get that fixed, Mr. Chairman. I think it is just outrageous. We are talking billions of dollars over the period of time that seniors are paying to these companies. False profit, but it spins the same way for these companies.

Also, I was curious about the audit situation. We had a handful of audits. There is a requirement that 165 financial audits should have been done for contract year 2007 and I think there was a handful that have begun in November of last year. Now, we have a bunch of them done. I am curious. Does that mean that money has shown up that you didn't have before—are you in good shape

now in terms of having the resources to do the audits the law dictates?

Ms. TAYLOR. We are in better shape. I wouldn't say we have all the money, but we certainly are in better shape than we were at the beginning. Certainly for the 2006 audits, we had to straddle them over two fiscal years because we did not have the resources at the time. But we currently are in the process. I believe almost all of those 2006 audits have begun except for maybe a handful. We do have 50 audits in-house that we are looking at currently and we have begun to start 2007 audits.

Senator MCCASKILL. I am curious. Your productivity since January has skyrocketed. Did you add audit personnel, during that period of time, or are these being done by contracts?

Ms. TAYLOR. Part of the reason was these are contracts. These are accounting firms that we hired to do these audits. And part of it was them getting up to speed on the C and D payments and the audits and the programs. So a lot of the up-front was getting them trained on the audit protocols that we were requiring them to do.

Senator MCCASKILL. And so I am going to be much less frustrated, you are telling me, going forward, that these audits that we have mandated in the law are being done on a timely basis?

Ms. TAYLOR. I hope so.

Senator MCCASKILL. OK. Well, I will get another set of questions to you. I particularly am going to be interested in how we get money back for seniors. I hope the next answer is we are thinking about the people the program is supposed to benefit——

Ms. TAYLOR. Yes.

Senator MCCASKILL [continuing]. Instead of the companies that are getting fabulously wealthy off the backs of these seniors.

Thank you, Mr. Chairman.

Senator CARPER. You bet. Thank you very much.

I want to go back to a question that I asked, and I don't think we ever fully answered it. The question I asked is if you were advising us on changes to make to the Improper Payments Act, what might they be? Among the changes that I mentioned, I think under current law, when post-audit recovery is done, agencies, I don't believe they are allowed to keep a portion of the recoveries to pay for their recovery activities. I don't believe they are able to use that money to strengthen their financial management. I don't think they are able to use any of that money to use for programmatic purposes. Notwithstanding the caution flag that Mr. Morris raised about the bounty situation emerging, those are some changes that we are contemplating making, and I think probably will make.

One of the things that intrigues me in public policy is how do we harness market forces in order to compel good behavior, encourage and incentivize good behavior. We have seen in the case of surplus properties, Federal properties, that we have a lot of Federal properties that aren't used. We pay money to keep them secure. We pay money for their utilities and so forth. A lot of properties we don't use, we will never use. And one of the reasons why that happens is because agencies, if they sell them, they have to pay the costs related to upgrading them, repairing them, rehabbing them, knowing they are not going to get anything back out of those properties. They don't have any money to help pay for that stuff. So they

aren't going to keep anything for programmatic purposes so they just hold onto the properties.

We are trying to figure out how to incentivize agencies to unload surplus properties and hopefully to get a decent amount of money back for the taxpayers and also something for them, too.

We are looking to be able to provide a similar kind of incentive here so that we are going to have to ride herd on every one of the agencies. They don't want to be out there looking for opportunities and not making them up, but looking for opportunities to recover these dollars that are being literally pilfered away from us, not just as a government, but as a country.

What are some of the changes we ought to make in the Improper Payments Act? Are there any cautions you would raise about any of those? Please, Ms. Daly, why don't you go first.

Ms. DALY. Well, thank you, Senator Carper. I think we have been working with your staff for some time now in trying to develop provisions for improving the IPIA, and one of the key points that we talked about, and I believe we sent you a letter on last year, is about strengthening management accountability in that Act. I think it is one of the areas that has been talked about a lot, but we are not sure how much accountability is actually going on for the people responsible for running these programs. If we have more personal accountability for improper payments, that might be something that would be very helpful.

Senator CARPER. I think one of the things we did in Sarbanes-Oxley is literally the CEO of the company, when a company verifies or certifies that they have scrubbed their books, they have done the right thing. Tthe CEO has to sign his or her name on the dotted line. Some of them don't like that very much, but that is what they have to do.

Ms. DALY. That is right. It makes it personal. You take it much more seriously, other than just as an institution.

One of the other areas we think might be important, too, and we have seen some Inspector Generals and agency auditors do this, is look and see how well each agency is complying with IPIA from an agency and program perspective. That way it provides a good snapshot on the ground level on what is going on at each one of those agencies. That is something else we think might be very important that would be useful.

Senator CARPER. OK. Mr. Sheehan.

Mr. SHEEHAN. I spoke about a five-point plan, but I have six points, which matches your——

Senator CARPER. So this is a five-point plan with six points?

Mr. SHEEHAN. Six points, that is going to do it.

Senator CARPER. A bonus.

Mr. SHEEHAN. I am going to sound the same way as Mr. Morris on the issue of bounty because both of us have been in courtrooms and both of us have been before trade groups on that issue and it is an emotional and visceral issue that goes beyond rationality because people expect their government to be fair and straightforward, and once you have the bounty piece, that is cross-examination in every case. It just raises that specter of doubt.

But I have an incentive plan for you. The incentive plan is, as it stands now in Medicaid, for all the 50 States plus the District

of Columbia and Puerto Rico, if I identify an improper payment, if I identify a fraud as the Medicaid program, I then have to give back to the Federal Government its percentage share, which makes sense from one perspective, right, because this is Federal money on the front end.

But let us talk about what that incentive creates. Let us suppose I am looking at two hospitals. One is in very bad financial shape but is incapable of submitting a straight bill. One is in very good——

Senator CARPER. I am sorry. They are in very bad shape but they are what?

Mr. SHEEHAN. They are in very bad shape, but they can't get their act together to submit bills properly, and as they get deeper and deeper, they start doing things that are more and more problematic.

Senator CARPER. When you say problematic, do you mean unlawful or——

Mr. SHEEHAN. Well, it is somewhere in that range between improper and fraudulent——

Senator CARPER. OK.

Mr. SHEEHAN [continuing]. Because desperate people do desperate things. Second is hospital, very solvent, has some billing issues that are straightforward improper payments.

What the statute does now is say, if I go to hospital B and I collect the money, I give back the Federal share. Away we go. We are done. If I go to hospital A, which has much greater risks, and I know I can't get the money back, essentially the State is then going to have to pay back the Federal Government its share going forward.

And what we would like to be is partners at risk on the recovery side. So if we go look at a hospital and say, we have got these problems, here is where we are, they need to change it, we are not being penalized as a State because we then are paying back the Federal Government their 50 percent share and eating it in our program.

I will tell you that in State government, I have heard those conversations. If we change our audit plan and look at the most vulnerable but also the most problematic, we are going to end up eating that on the State budget side. So the incentive is not for us as an agency, but the incentive is for the States to say, let us either elevate the percentage or let us make the State and the Federal Government's partners on the recovery. So if we get the money back, then we take our respective shares. But don't make us pay you back and then—because it changes the direction that the audit and enforcement program focuses on.

Senator CARPER. Fair enough. Thank you. Mr. Morris.

Mr. MORRIS. This may not be directly on point, but maybe some of this thinking will inform your question. The Inspector General's Office has a robust self-disclosure protocol. We encourage providers to find problems themselves and come tell us about them. Mr. Sheehan has a comparable program in the New York Medicaid program, the thinking being that many of the problems, from simple overpayments to abuse to out-and-out fraud, are not going to get detected by us. They are either too buried in the system, and our

resources aren't expansive enough to find them. So we have been thinking about ways to create incentives for those providers to come forward to reduce their error rate.

If they are going to have to pay doubles plus potential sanction in the form of exclusion from our program or the like, they are not going to come forward. They will take the risk of sweeping it under the carpet and hoping they don't get caught. We like to make the argument that we will catch you, but the more sophisticated of their lawyers will tell you otherwise.

As we have developed the self-disclosure protocol, we have come to realize that collecting back singles, you have got to do that. This is our money. But when it comes to those multiples, this added-on penalty, if we take a much more modest sanction, 0.2 percent, 0.5 percent, it is attractive to the provider because they put this problem to bed. It is great for our program because we get money back into the trust fund that we would not otherwise have had.

And so the suggestion I would have is as we are thinking about ways to reduce error rates, we need to marshall the commitment of not just the Federal programs who should be looking at their own systems to ensure that we are paying accurately the first time, but think about how to also align, for example, in the health care system, the providers, the suppliers, the practitioners, whose money—they are really holding the vast majority of all these erroneous payments. We need to find ways to have them actually come forward and tell us they found a problem. They are giving the money back. They are fixing the problem. But knowing they are going to be treated fairly, so they work with us as partners.

Senator CARPER. OK. Good. Ms. Taylor, anything you want to add to that on this question, please?

Ms. TAYLOR. I would certainly echo the compliance piece of that, and certainly from a CMS perspective, Ms. Daly mentioned having it in managers' plans that they are responsible for these error rates. It is in my plan. It is in my managers' plans. And we work very closely with our Medicare contractors to ensure that their contracts are built on what the error rates are for the providers that they serve and pay in those areas. So to the extent that the error rate is high in a certain State, that contractor knows they need to do better outreach and education of providers.

Senator CARPER. All right. Anybody else on my question?

I have a series of questions I am going to read through. Some of these, you have already spoken to, a couple of you have, directly or indirectly. But I am going to go through them anyway and ask you to see if you want to add anything.

The first one was, what are the biggest challenges facing CMS, OIG, New York State in combatting fraud, waste, and abuse in our Medicare and, in your case, Medicaid programs, respectively? Again, the biggest challenges facing CMS, OIG, New York State.

Ms. TAYLOR. I would say the biggest challenge facing us is resources. We administer huge programs, very complex programs with very little administrative resources to do the oversight that we need to do.

Second, we have systems barriers that we need——

Senator CARPER. Let me interrupt.

Ms. TAYLOR. Sure.

Senator CARPER. If we amend our law so that it allows some portion of the recoveries to be used to strengthen those kinds of systems, does that make sense?

Ms. TAYLOR. That would certainly help, yes.

Senator CARPER. OK.

Ms. TAYLOR. Second is our systems, and we have talked about real-time access to systems. For us, our systems were built as the programs were developed, so we have Part A, we have Part B systems, we have Part C, we have Part D systems. We right now are looking at ways to be able to put those systems together to be able to look across the benefits on a provider and an individual basis so that for us it is a big challenge in being able to get real-time data and data that talks to each other.

The last item I guess I would say is certainly being able to partner more with our folks in the States and law enforcement and being able to have a little more mechanisms to be able to share information across.

Senator CARPER. OK. Thanks.

Mr. Morris, what are some of the biggest challenges facing OIG with respect to fraud, waste, and abuse?

Mr. MORRIS. First, I echo Ms. Taylor's statement about data, access to reliable data. This is both data from CMS as well as I had mentioned the notice of adverse action databases so we know who it is we are dealing with and we can work with our State partners to make sure perpetrators aren't crossing State lines to prey on a different program.

And then resources. If we have great data but don't have the foot soldiers to interpret it and we don't have the agents to go out and conduct the investigations, it is all for naught.

I would also mention, although I am not a member of the Department of Justice, if we have great auditors and great investigators but we don't have great prosecutors to carry that ball across the line, it is also for naught. When we are thinking about an effective law enforcement strategy, we have to have the data, recognize the problem, engage the foot soldiers to quantify the problem, and then the prosecutors to stop the problem.

Senator CARPER. That is a good point. Thank you. Mr. Sheehan.

Mr. SHEEHAN. I will do the rule of three here with only three. The first one is the real challenge for law enforcement, I think, and for program integrity over the next 5 years is—and we are already seeing this—as we move to the world of electronic medical records, one of our old ways to figure out what actually happened between a patient and a physician was to look at the paper record with the paper entries.

I walked into a doctor's office about a week ago. He had a template that showed—it had every finding normal, right. So the template had every finding normal. Before he took my pulse, he had a number in there. Before he did blood pressure, he had a number in there. I said, "What are you doing?" He said, "Well, it is a template and as I go through and I find different findings, I enter a different one."

But think about that as an electronic medical record issue and so many electronic medical records and billing systems we are seeing now already populate fields. So the kinds of proof we did 5 or

10 years ago to find out what is going wrong and the training we gave our people is going to be less and less relevant and you have these proprietary systems that we have to figure how to make work.

We are going to see, I think, a significant amount of fraud that is based upon electronic medical records, electronic claims records, electronic systems that are proprietary and difficult for the Federal Government and the State governments to figure out, and we have discussed this internally. We don't know what the answer is, but it is a huge challenge.

The second one is information. How do we let the public know what the issues are, what kinds of conduct, when they go to see their doctor, when they get an explanation of benefits, when they hear about a problem from a friend or a colleague, what information is useful to them and what should they do with it? If you look in this country at explanations of medical benefits, whether private insurance or public, I mean, I have been doing this work for 27 years. I can't read them. One of our greatest resources in the electronic age is having people communicate to us directly about what they see, what they find, what they know, and we haven't figured out how to go beyond telephone hotlines to using the information that is out there in the social world to tell us, here is what you should know.

And the third thing is to communicate to the good guys that are compliance officers, working large organizations, or board members. What questions do you ask and what should people be telling you and what should you ask for because our best allies in this whole process, to me, are the beneficiaries and the providers who want to do the right thing. In every case, the reason we win our cases is because there are good people saying, this is the truth. This is what happened. This is the right thing to do. And we need to find a way to support them, encourage them, and bring them in.

Mr. MORRIS. If I could just echo that one point about boards of directors and upper management being held accountable. We have been working very closely with the American Health Lawyers Association and others to inform boards of directors of health care systems how critically important it is that they understand not just the bottom line financially, but the quality of the care being provided by their institutions and be able to ask management, how do you know we billed it right? How do you know that we are a system of integrity? What internal controls are in place? If a board is providing that kind of oversight of its organization—as it should, as is its fiduciary duty—we have a tremendous ally in the fight against waste, fraud, and abuse.

And so thinking about ways, like Sarbanes-Oxley, to say to boards of directors, your job is to ensure the mission of this organization and it is to deliver quality health care. That is what you are all about if you are the board of a health care system. How are you doing that? We have some products out there, I think, that we could make huge inroads into corporate responsibility by thinking more about how boards of directors should be part of this effort to ensure compliance.

Senator CARPER. All right. The next question I am going to ask is one that I think you have spoken to in several instances. I am

going to ask it again and see if it jogs your memories or your minds to add to what has already been said. We have heard from several of you on the panel about vulnerabilities in Medicaid that foster waste, fraud, and abuse. What can we do at the Congressional level, this Subcommittee, this Committee, the Senate, the House, to address some of those vulnerabilities? Does anything further come to mind?

Mr. MORRIS. It looks like I draw the straw.

Senator CARPER. Sure.

Mr. MORRIS. In the time we have left this afternoon, I can't really begin. I could tell you this. First of all, we will be delighted to provide you with a great deal of information——

Senator CARPER. Do you want to answer that on the record?

Mr. MORRIS. That would probably be the most efficient. I would just tell you that we do an enormous amount of audits and evaluations, program inspections, with a wide range of recommendations to strengthen these two programs. Some of those are recommendations we make to CMS and they can implement them. Others do require legislative change. So we would be pleased to respond on the record.

Senator CARPER. If you would, that would be great. Thank you.

Mr. SHEEHAN. Senator, if we could take the same opportunity.

Senator CARPER. You may.

My next question, as part of a 3-year demonstration project that we have been talking about, CMS used recovery audits by contractors in three States—California, Florida, and Texas—to identify and to recoup overpayments in the Medicare program. The demonstration project has been seen by many, including by me, as a real success with, as I said earlier, nearly $700 million being recouped, recovered by the Federal Government. And I understand maybe more has been recovered at the end of the day. Some of that is actually still under contention. But clearly, $700 million or so has been recovered or is being recovered.

It is my understanding that the plans is to roll this program out to all 50 States. I would just be interested to hear the thoughts from any of our panel of witnesses on recovery audit contracting and if this is something that could also work in our Medicaid program.

Mr. SHEEHAN. The Medicaid program actually has already started what are called Medicaid Integrity Contractors, which are employed by CMS, or retained by CMS, and as I understand it, in New York, they are rolling it out in October 2009, but they have already been rolled out in various parts of the country.

Senator CARPER. What are they called?

Mr. SHEEHAN. Medicaid Integrity Contractors.

Senator CARPER. And when did the rollout start?

Mr. SHEEHAN. Ms. Brandt, do you know when was the start of those? I think it was the beginning of this year.

Senator CARPER. What did she say?

Mr. SHEEHAN. I am sorry. It is the beginning of this year, the beginning of 2009. So those contractors are just beginning to be rolled out, and obviously there is the coordination issue with each State and how they are going to do their work and that is going to be hard work on both sides to make it work.

I think the key for us in looking at these contractors is—I have difficulties with the bounty issue once again, but I think there are ways to design those audits so that you identify stuff that is relatively straightforward and you give people an audit plan that is going to work and they can find things that you wouldn't find otherwise.

Senator CARPER. Let me say to our staff, just make sure we ask on the record for some advice and guidance on addressing the concerns on the bounty issue.

Mr. SHEEHAN. The second issue, though, is it seems to me it is really critical when we send out audit contractors to make sure that we communicate to the health care community at each stage what it is we are looking for, what it is we are finding, what they can do to fix the problem going forward, and that is why I have concerns about that bounty issue again. It seems to me that the interest of the auditors is making sure that bad stuff continues so they get their 10 percent. What we really should be focused on is telling people how to do it right and reminding them and saying the government is going to come around. And for those who show up three or four times in audits, to say it is not just a payment issue. You have got a control issue here that you need to address and we are going to take a different approach.

Senator CARPER. OK. Thank you.

Ms. DALY. Senator Carper, I would like to add that GAO has long been an advocate of recovery auditing. I think it is something that has been proven to work well, and certainly in the Medicare program, the demonstration projects have become more successful. And as it rolls out to the rest of the States, I think there is a lot they could probably learn from the rollout of Medicare that could be applicable to Medicaid. So while Medicaid is still in the demonstration phase, they could use those lessons learned from Medicare and move that over. So that might be something that could be very useful.

Senator CARPER. OK.

Ms. TAYLOR. And certainly, Senator Carper, just to sort of clarify the contracting, we do certainly right now have Medicaid Integrity Contractors in 24 States, including the District of Columbia.

Senator CARPER. Do you have the list of the States there?

Ms. TAYLOR. I don't have them with me, but I certainly can get that to you.

Senator CARPER. Yes, please provide that. I am especially interested to see if the first State that ratified the Constitution, might be on that list.

[The information provided by Ms. Taylor follows:]

The States (24) and DC, which makes 25 total are: Delaware, Maryland, Pennsylvania, Virginia, West Virginia, Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee, Arkansas, Louisiana, New Mexico, Oklahoma, Texas, Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming, and the District of Columbia.

Ms. TAYLOR. OK. And in all 50 States by the end of this fiscal year. So we are in the process of rolling that out, and certainly I think we would want to look and see what the contractors' success rates are there before we would make any kind of decision about recovery auditing in the States.

Senator CARPER. I was talking aside here a couple of minutes ago with members of my staff and saying that one of the ideas of a future hearing not far down the road would be one where we invite CMS to come in and talk with us about the success that we have enjoyed the last 3 years, the work in three States, maybe bring in some of the folks actually doing the recoveries and talk about it.

I serve on the Finance Committee, as well, and we have jurisdiction over Treasury as well as CMS. For the last several years, Treasury has been allowed to use private sector firms to go out and do recoveries for taxes that were owed but not paid. After several years' experience, the IRS has decided the more cost effective way to do those recoveries would be not to hire folks in the private sector but to hire more people to work in IRS. I think they have asked in the budget to provide another 1,000 people to do that work and they suggest that the return on investment could be very substantial.

So that is interesting. I have been watching with some interest what is going on at IRS on trying to recover monies and to have seen the experience of CMS, I think is basically pretty encouraging in the three States. The idea that occurs to me that it might be interesting to have a panel where we would have CMS and the recovery auditors saying, this is why we think this is working. This is maybe how we can do it better. And then to have IRS come in, maybe on the same panel, and say, why don't we try this? This is why it didn't work and this is why we are going to go in-house. That might be informative for all of us.

Anyone else on this question before I move to our next question?

Mr. Morris, I think you stated that compliance programs are prevalent in hospitals but are lacking in other health care sectors. Which health care sectors in general have not adopted internal compliance programs and practices?

Mr. MORRIS. I would like to get back to you with a more specific answer, but once I learned of that question this morning, I called up the Executive Director of the Health Care Compliance Association and asked him the question. He said, based on his membership, the lower participating industries include home health, not surprisingly, DME, and some small physician practices.

I would also tell you that our Office of Evaluation and Inspections would be pleased to do some work in this area. We could actually go out and survey a group of participating Medicare and Medicaid providers and find out what percentage of them have compliance programs and what they look like. We could get you a very precise sense of what part of the industry is embracing voluntary compliance programs and what could use some more encouragement.

Senator CARPER. All right. Thank you. Mr. Sheehan.

Mr. SHEEHAN. We just completed, in New York, a review of the two industry areas, the hospitals, and most of the hospitals in New York State actually have fairly concrete compliance programs. It is a question whether they work well. That depends on the hospital.

But the biggest weakness we saw in compliance was managed care, and the issue is not just what systems they had in place, but is the industry focusing on this issue and are they getting guidance from CMS and from the Inspector General on what that should

look like. And I think there is a real opportunity here for us and for the IG and CMS to say, here is what a compliance program looks like at a managed care entity. The questions are more complicated. The guidance that is out there is ancient. I guess for IG, it is 1999 or 1998.

Mr. MORRIS. Yes.

Mr. SHEEHAN. For CMS, it is like the early 2000s, and the business models are very different. So of all the areas that need compliance, I think it is the managed care entities that are providing care both in the State Medicaid programs to most of our patients and in Medicare Part C.

Senator CARPER. All right. Thank you.

Our vote has just started, but I want to finish with another question or two and then we will wrap it up.

Ms. Daly, I think you said at one point in your testimony that while the error rate in Medicare's fee-for-service program has declined over the years, some believe that the estimates we currently have may understate the problem in several areas. Could you elaborate on that? And Ms. Taylor, maybe you or Mr. Morris can jump in and share your thoughts on this, as well. Ms. Daly, would you go first?

Ms. DALY. Yes. I think over the years, they have refined the Medicare fee-for-service error rate. When originally started, the Inspector General's Office was doing that error rate, and then recently, the Office of Inspector General has done some more work to identify what the issues were with it.

With that, I would like to defer to Mr. Morris then to provide you more details on that analysis, but at the same time, I did want to point out again that the Medicare Prescription Drug Benefit still doesn't have an estimate for their errors.

Senator CARPER. Ms. Taylor, do you want to jump in here before we go to Mr. Morris?

Ms. TAYLOR. Absolutely. The IG did do a review of our CERT, which is the comprehensive error rate for Medicare fee-for-service. They did find that there were some concerns about the way we were looking at the DME portion of the error rate. We did enter into a re-review of our CERT claims related to DME. We found that our policies could be interpreted by different folks performing medical review, or complex medical review on medical records, differently, meaning someone might interpret it as you have to have every piece of the medical record to be able to pay the claim or others were interpreting it as if I had enough information in the medical records, I could use my clinical judgment and allow the claim.

What we found was we had inconsistencies. We agreed with the IG that we need to clarify our instructions, that clinical judgment is not appropriate where it is required to have medical records on hand. So we will be applying that and I think we already are starting to do that now for this year's error rate.

The other thing that was critical for the IG's review on improper payments when they looked at the CERT rate was they actually took some set of those high-risk DME claims and went and visited the providers and the beneficiaries. And so this year, we will begin looking at some of those high-risk areas and going out and talking to the provider and talking to the beneficiary.

Senator CARPER. All right. Thank you.

Mr. Morris, the last word on this one.

Mr. MORRIS. I think Ms. Taylor has summarized it just right. I would tell you that we believe in the OIG that it is important to actually—we think you need to look past what it is that the DME company is offering you. As Mr. Sheehan referenced, the sophisticated criminal knows how to doctor up the record to make it look good. You need to actually get out there and talk to the beneficiary. It is more labor intensive. It is more resource intensive. But I think it also gives you a much more accurate snapshot of what is going on.

Senator CARPER. All right. Well, folks, we have run out of time here. I hoped we could complete our hearing before the voting began and it looks like we are just coming in right under the wire.

I want to thank each of you for preparing for the hearing today and I want to thank you for appearing today and testifying, responding to our questions. The hearing record will stay open for a while, I am not sure exactly how long—5 days? A couple of weeks? As you receive follow-up questions—people are obviously going to submit those, including me—we would ask that you respond promptly, please.

The other thing I would say in conclusion, we are going to run out of money in the Medicare Trust Fund. We are literally running out of money. There is a problem long-term with respect to Social Security, it is one that we need to act on that, but the need for action for Medicare is more pressing. There are a lot of things that we need to do in order to restore the integrity of the Medicare Trust Fund.

But one of those is what we are talking about here today and figuring out where we are spending money inappropriately, figure out how to go after that money and to recover it in ways that don't spark some kind of bounty system here with some unintended consequences.

I am grateful for the efforts that you are all doing. I especially want to say to Mr. Sheehan and folks up in New York State, thank you very much for being a good role model for the other States and for those of us in the Federal Government. I like to sometimes say I would rather see a sermon than hear one, and I think maybe in your case we see the sermon and that is good. Today, we heard from the preacher. That is not bad, either. But thank you all for a most illuminating hearing.

The other thing I would say is this is not an easy problem. It is not an easy problem to solve, to get our heads around and our arms around and to deal with. We obviously can't do it with our Subcommittee or even the full Committee or the full Senate. This is one that we need just a real collective effort, a cooperative effort, a partnership, and I think that we have that going for us and we just have to build on it.

With that having been said, thank you all very much for joining us today and we will look forward to working with you going forward. Thank you.

The hearing is adjourned.

[Whereupon, at 4:40 p.m., the Subcommittee was adjourned.]

APPENDIX

United States Government Accountability Office

GAO

Testimony before the Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security, Committee on Homeland Security and Governmental Affairs, U.S. Senate

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IMPROPER PAYMENTS

Progress Made but Challenges Remain in Estimating and Reducing Improper Payments

Statement of Kay L. Daly, Director
Financial Management and Assurance

GAO
Accountability * Integrity * Reliability

GAO-09-628T

April 22, 2009

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Highlights

Highlights of GAO-09-628T, a testimony before the Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security, Committee on Homeland Security and Governmental Affairs, U.S. Senate

Why GAO Did This Study

GAO's work over the past several years has demonstrated that improper payments are a long-standing, widespread, and significant problem in the federal government. The Improper Payments Information Act of 2002 (IPIA) has increased visibility over improper payments by requiring executive branch agency heads, using guidance from the Office of Management and Budget, to identify programs and activities susceptible to significant improper payments, estimate amounts improperly paid, and report on the amounts of improper payments and their actions to reduce them.

This testimony addresses (1) progress made in agencies' implementation of IPIA for fiscal year 2008, and (2) several major challenges that continue to hinder full reporting of IPIA information. GAO was also asked to provide an overview of Medicare and Medicaid programs' implementation of IPIA. This testimony is based primarily on GAO products, Office of Inspector General (OIG) audit reports, and agencies' fiscal year 2008 reported improper payment information, including information reported by the Department of Health and Human Service's (HHS) Centers for Medicare and Medicaid Services (CMS). GAO also analyzed fiscal year 2008 governmentwide improper payment information to identify trends and reviewed Medicare and Medicaid programs' reported actions to identify, estimate, and reduce improper payments.

To view the full product, including the scope and methodology, click on GAO-09-628T. For more information, contact Kay L. Daly at (202) 512-9095 or dalykl@gao.gov.

IMPROPER PAYMENTS

Progress Made but Challenges Remain in Estimating and Reducing Improper Payments

What GAO Found

Agencies reported improper payment estimates of $72 billion for fiscal year 2008, which represented about 4 percent of the $1.8 trillion of reported outlays for the related programs. This represents a significant increase from the fiscal year 2007 estimate attributable to (1) a $12 billion increase in the Medicaid program's estimate and (2) 10 newly reported programs with improper payment estimates totaling about $10 billion.

- **Progress made in estimating and reducing improper payments.** The governmentwide improper payment estimates rose about $23 billion from fiscal year 2007 to 2008. This represents a positive step to improve transparency over the full magnitude of the federal government's improper payments. Further, of the 35 agency programs reporting improper payment estimated error rates for each of the 5 fiscal years since implementation of IPIA—2004 through 2008—24 programs (or about 69 percent) reported reduced error rates when comparing fiscal year 2008 error rates to fiscal year 2004 error rates. Also, the number of programs with error rate reductions totaled 35 when comparing fiscal year 2008 error rates to fiscal year 2007 rates.
- **Challenges remain in meeting the goals of IPIA governmentwide.** The total improper payment estimate does not yet reflect the full scope of improper payments across executive branch agencies; noncompliance issues with IPIA continue; and agencies continue to face challenges in the design or implementation of internal controls critical to identifying and preventing improper payments. The fiscal year 2008 total improper payment estimate of $72 billion reported for fiscal year 2008 did not include any estimate for ten programs—including the Medicare Prescription Drug Benefit program—with fiscal year 2008 outlays totaling about $61 billion that were identified as susceptible to significant improper payments. Over half of the agencies' OIGs identified management or performance challenges that could increase the risk of improper payments, including challenges related to effective internal controls.
- **Medicare and Medicaid programs' implementation of IPIA and its challenges.** Medicare and Medicaid comprise 50 percent of reported governmentwide improper payments in fiscal year 2008. HHS reported improper payment amounts of $10.4 billion in Medicare Fee-for-Service and $6.8 billion in Medicare Advantage. HHS also reported in its agency financial report that it issued its first full-year Medicaid improper payment rate estimate of 10.5 percent, or $18.6 billion for the federal share of expenditures for fiscal year 2008. This Medicaid improper payment estimate represents the largest amount that any federal agency reported for a program in fiscal year 2008. While CMS has taken steps to enhance its program integrity efforts, further work remains to put in place the internal controls necessary to effectively identify and detect improper payments. For example, GAO's work on Medicare's home health care administration and enrollment of durable medical equipment suppliers found weaknesses that exposed the program to significant improper payments. The magnitude of Medicaid improper payments indicates that CMS and the states face significant challenges in addressing the program's vulnerabilities in estimating national improper payment rates for diverse state-administered programs.

Mr. Chairman and Members of the Subcommittee:

Thank you for the opportunity to be here today to discuss the governmentwide problem of improper payments in federal programs and activities and executive branch agencies' efforts to address key requirements of the Improper Payments Information Act of 2002 (IPIA).[1] Since fiscal year 2000, we have issued a number of reports and testimonies aimed at raising the level of attention and corrective actions surrounding improper payments. Our work over the past several years has demonstrated that improper payments have been a long-standing, widespread, and significant problem in the federal government. IPIA has increased visibility over improper payments[2] by requiring executive branch agency heads to identify programs and activities susceptible to significant improper payments,[3] estimate amounts improperly paid under those programs and activities, and report on the amounts of improper payments and their actions to reduce them. As the steward of taxpayer dollars, the federal government is accountable for how its agencies and grantees spend hundreds of billions of taxpayer dollars annually and is responsible for safeguarding those funds against improper payments as well as having mechanisms in place to recoup those funds when improper payments occur.

The Office of Management and Budget (OMB) has played a key role in the oversight of the governmentwide improper payments problem by providing leadership on financial management improvement initiatives. OMB continues its commitment to address governmentwide improper payments by establishing guidance for federal agencies on improper payment reporting,[4] and by working with agencies to establish corrective

[1]Pub. L. No. 107-300, 116 Stat. 2350 (Nov. 26, 2002).

[2]IPIA defines an improper payment as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. It includes any payment to an ineligible recipient, any payment for an ineligible service, any duplicate payment, payments for services not received, and any payment that does not account for credit for applicable discounts.

[3]OMB's guidance defines significant improper payments as those in any particular program that exceed both 2.5 percent of program payments and $10 million annually.

[4]OMB, Circular No. A-123, Appendix C, *Requirements for Effective Measurement and Remediation of Improper Payments* (Aug. 10, 2006).

action plans and address their root causes. OMB also reports annually on agencies' efforts to address IPIA requirements.

Today, my testimony will focus on three key areas:

- progress federal agencies have made in estimating and reducing improper payments under IPIA for fiscal year 2008,
- several major challenges that continue to hinder full reporting of improper payment information, and
- an overview of Medicare and Medicaid programs' implementation of IPIA.

My testimony today draws primarily from prior GAO reports and testimonies conducted in accordance with generally accepted government auditing standards. We also reviewed agencies' fiscal year 2008 performance and accountability reports (PAR), agency financial reports (AFR), annual reports, and Office of Inspector General (OIG) audit reports. In addition, we reviewed the Department of Health and Human Service's (HHS) AFR and Centers for Medicare and Medicaid Services' (CMS) financial report. Further, we analyzed fiscal year 2008 governmentwide improper payment information to identify trends and reviewed Medicare and Medicaid programs' reported actions to identify, estimate, and reduce improper payments. Generally accepted government auditing standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Progress Made in Estimating and Reducing Improper Payments

Federal agencies reported improper payment estimates of $72 billion for fiscal year 2008, which represented about 4 percent of the $1.8 trillion of reported outlays for the related programs and a $23 billion increase from the fiscal year 2007 estimate of about $49 billion.[5] These efforts represent a positive step to improve transparency over the full magnitude of federal improper payments so that appropriate corrective actions can be put in place. This increase was primarily attributable to (1) a $12 billion increase in the Medicaid program's estimate for its Fee-for-Service and managed care payments and payments related to incorrect eligibility determinations; and (2) 10 newly reported programs with improper payment estimates totaling about $10 billion. Of these 10 programs, we identified 4 that had been required by OMB to report selected improper payment information beginning with fiscal year 2003 budget submissions prior to the passage of IPIA.[6] In total, these 4 programs represented $3.1 billion, or 31 percent, of the approximately $10 billion in newly reported programs. Further, we noted that agencies consistently identified new programs or activities as risk-susceptible after the first year of IPIA implementation:

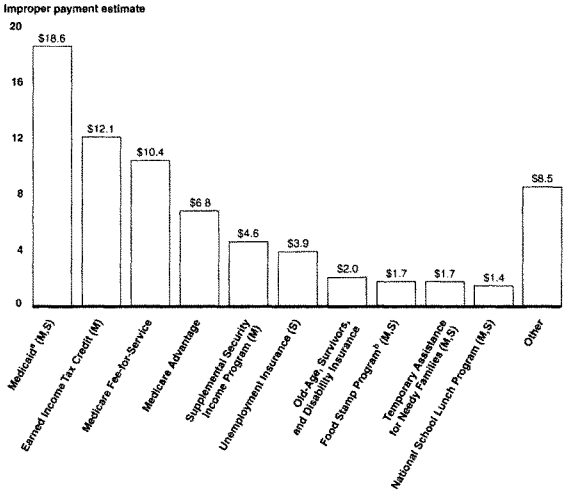
- fiscal year 2005—17 new programs or activities,
- fiscal year 2006—15 new programs or activities,
- fiscal year 2007—19 new programs or activities, and
- fiscal year 2008—10 new programs or activities.

[5]In their fiscal year 2008 PARs, AFRs, or annual reports, certain federal agencies updated their fiscal year 2007 improper payment estimates to reflect changes since issuance of their fiscal year 2007 PARs, AFRs, or annual reports. These updates decreased the governmentwide improper payment estimate for fiscal year 2007 from $55 billion to $49 billion, primarily because HHS updated Medicaid's improper payment estimate for fiscal 2007 from $12.9 billion (or 18.45 percent error rate) to about $6.6 billion (or 4.7 percent error rate), a $6.3 billion decrease (or 13.75 percent error rate decrease). HHS reported in its fiscal year 2008 AFR that the $12.9 billion estimate for fiscal year 2007 was preliminary based on two quarters (or six months) of fiscal year 2006 claim payments. In fiscal year 2008, HHS completed its review of fiscal year 2006 claim payments and derived a significantly lower error rate of 4.7 percent or $6.6 billion for fiscal year 2007.

[6]The four programs are: Child Care and Development Fund, State Children's Health Insurance Program, Temporary Assistance for Needy Families, and the Airport Improvement Program. Prior to the governmentwide IPIA reporting requirements beginning with fiscal year 2004, former section 57 of OMB Circular No. A-11 required certain agencies to submit similar information, including estimated improper payment target rates, target rates for future reductions in these payments, the types and causes of these payments, and variances from the targets and goals established. In addition, these agencies were to provide a description and assessment of the current methods for measuring the rate of improper payments and the quality of data resulting from these methods.

The $72 billion estimate of improper payments federal agencies reported in fiscal year 2008 encompasses 78 programs spread among 22 agencies (see app. I for further details) and represents about 2.4 percent of total fiscal year 2008 federal executive branch outlays of nearly $3 trillion. In addition, the majority of the $72 billion of reported improper payments in fiscal year 2008 is accounted for by ten programs, as shown in figure 1. Specifically, the ten programs account for about $63 billion or approximately 88 percent of the total estimate.

Figure 1: Fiscal Year 2008 Improper Payment Estimates by Program (dollars in billions)



Source: GAO analysis of agencies' fiscal year 2008 PARs, AFRs, or annual reports.

[a]Medicaid's reported improper payment estimate of $18.6 billion represents the federal share.

[b]The Food Stamp Program's name was recently changed to the Supplemental Nutrition Assistance Program.

Seven of the 10 programs with the largest improper payment estimates are either means-tested programs,[7] state-administered programs,[6] or both. A common control used by these programs to ensure payment accuracy includes verifying the financial eligibility of the applicant. However, our previous work has shown that the financial eligibility of an applicant can be difficult to verify in means-tested programs, increasing the risk of payment to an ineligible recipient.[9] Specifically, there are differences related to detailed aspects of the income rules such as whose income in a household is counted and the types of income included or excluded in either whole or part. For example, the Supplemental Nutrition Assistance Program (previously Food Stamp Program) considers the income of the entire household, including children aged 18 and over who are not students, in calculating income; whereas several other programs either do not include children's income or exclude portions of their income from consideration. Similar differences exist in state-administered programs as a number of states define additional and unique eligibility requirements beyond what is required at the federal level. Collectively, these multiple variations in approaches to identifying recipients' income for determining program eligibility are likely contributing factors to the high dollar value of improper payments that exist within these programs.

Federal agencies continued to report progress in reducing improper payments in their programs and activities. Of the 35 agency programs reporting improper payment estimated error rates for each of the 5 fiscal years—2004 through 2008—24 programs, or about 69 percent had reduced error rates when comparing fiscal year 2008 error rates to the initial error rates reported for fiscal year 2004. Further, we found the number of programs with error rate reductions totaled 35 when comparing fiscal years 2008 and 2007 error rates. For example, the error rate of the U.S.

[7]Means-tested programs provide cash and noncash benefits to individuals and families whose income falls below defined levels and who meet certain other eligibility criteria established for each program. Means-tested programs provide assistance in eight areas of need: (1) cash assistance; (2) medical benefits; (3) food and nutrition; (4) housing; (5) education; (6) other services, such as child care; (7) jobs and training; and (8) energy aid.

[6]State-administered programs are federal programs that are managed on a day-to-day basis at the state level to carry out program objectives.

[9]GAO, *Means-Tested Programs: Information on Program Access Can Be an Important Management Tool*, GAO-05-221 (Washington, D.C.: Mar. 11, 2005); *Means-Tested Programs: Determining Financial Eligibility Is Cumbersome and Can Be Simplified*, GAO-02-58 (Washington, D.C.: Nov. 2, 2001).

Department of Labor's (Labor) Unemployment Insurance (UI) program decreased from 10.3 percent in fiscal year 2007 to 9.96 percent in fiscal year 2008, a $649 million reduction in estimated improper payments. Labor reported that the leading cause of UI overpayments resulted from claimants who returned to work, yet continued to claim UI benefits. Early detection of these overpayments allows agencies to stop payments sooner and to recover these overpayments more expeditiously. Labor reported that matching Social Security numbers of UI claimants with the Department of Health and Human Services' National Directory of New Hires database is the most effective tool to identify UI program improper payments and had prevented about $93 million of UI overpayments during fiscal year 2008.

Challenges Remain in Meeting IPIA

While federal agencies have shown progress, major challenges remain in meeting the goals of IPIA and ultimately provide reasonable assurance as to the integrity of payments. Specifically, while improved, the total improper payment estimate reported in fiscal year 2008 does not yet reflect the full scope of improper payments across executive branch agencies; noncompliance issues with IPIA implementation continue to exist; and agencies continue to face challenges in the design or implementation of internal controls to identify and prevent improper payments. Not all agencies have yet developed improper payment estimates for all of the programs and activities they identified as susceptible to significant improper payments. As shown in table 1, the fiscal year 2008 total improper payment estimate of $72 billion did not include any amounts for 10 risk-susceptible programs—including the Medicare Prescription Drug Benefit program—with fiscal year 2008 outlays totaling about $61 billion.

Table 1: Risk-Susceptible Programs That Did Not Report Improper Payment Estimates for Fiscal Year 2008

	Agency—program	Fiscal year 2008 outlays (dollars in millions)	Target date for reporting improper payment estimate
1	Department of Health and Human Services—Medicare Prescription Drug Benefit	46,127.0	Did not report target date
2	Department of Homeland Security—Customs and Border Protection—Custodial—Refund & Drawback and Continued Dumping & Subsidy Offset Act & Payments to Wool Manufacturers	7,118.0	Did not report target date
3	Department of Homeland Security—Federal Emergency Management Agency—Homeland Security Grant Program	2,189.0	2009
4	Department of Homeland Security—Transportation Security Administration—Aviation Security—Payroll	2,012.0	Did not report target date
5	Department of Homeland Security—United States Coast Guard—Contract Payments	1,811.0	Did not report target date
6	Department of Homeland Security—Federal Emergency Management Agency—Public Assistance Programs	1,026.0	2009
7	Department of Homeland Security—Federal Emergency Management Agency—Infrastructure Protection Program	417.0	2009
8	Department of Homeland Security—Federal Emergency Management Agency—Assistance to Firefighters Grants	356.0	2009
9	Department of Homeland Security—Immigration and Customs Enforcement—Investigations	227.0	Did not report target date
10	Department of Homeland Security—Federal Emergency Management Agency—National Flood Insurance Program[a]	53.0	2009
	Total	**$61,336.0**	

Source: GAO's analysis of agencies' fiscal year 2008 PARs or AFRs.

[a]GAO placed the National Flood Insurance Program (NFIP) on its high-risk list in March 2006 as the program likely will not generate sufficient revenues to repay the billions borrowed from the Department of Treasury to cover flood claims from the 2005 hurricanes. It is also unlikely that NFIP could cover catastrophic losses in future years should they occur. The insufficient revenues highlight structural weaknesses in how the program is funded.

For fiscal year 2008, a limited number of agency auditors reported on IPIA implementation compliance issues as part of their financial statement audit, although such reporting is not specifically required by IPIA. Specifically, auditors for 4 of the 35 agencies included in our scope reported on agencies' noncompliance with IPIA.[10] Agency auditors reported noncompliance issues related to risk assessments, testing of payment transactions, development of corrective action plans to reduce

[10]The four agencies are the Departments of Defense, Homeland Security, Health and Human Services, and Transportation.

improper payments, recovering improper payments, and inadequate documentation. Fiscal year 2008 reflected the fifth year that auditors for the Departments of Health and Human Services (HHS) and Homeland Security (DHS) reported IPIA noncompliance issues, including not estimating for all risk-susceptible programs, deficiencies related to testing of payment transactions, and the lack of corrective action plans. Agency auditors at the Department of Transportation (Transportation) and DOD reported noncompliance with IPIA for a third year. For example, Transportation auditors reported that they had not received sufficient documentation by the time of PAR issuance to determine if the department's sampling plan used to estimate improper payments was statistically valid. The auditors for DOD reported for fiscal year 2008, that the department was still in the process of developing procedures to identify improper payments and that its efforts to manage recovery audit contracts had been largely unsuccessful.

As we previously testified before this Subcommittee,[11] separate assessments conducted by agency auditors provided a valuable independent validation of agencies' efforts to implement IPIA. Independent assessments can also enhance an agency's ability to identify sound performance measures, monitor progress against those measures, and help establish performance and results expectations. Without this type of validation or other types of reviews performed by GAO and agency OIGs, it is difficult to reliably determine the full magnitude of deficiencies that may exist in agencies' IPIA implementation efforts.

Agencies continue to face challenges in the design or implementation of internal controls to identify and prevent improper payments. Over half of the OIGs for agencies required to report under IPIA identified management or performance challenges that could increase the risk of improper payments, including challenges related to internal controls. Examples of fiscal year 2008 challenges are highlighted below.

- Department of Transportation—The OIG reported that its audits and investigations continue to find oversight and control deficiencies increasing vulnerability to improper payments, including fraud and abuse, and other ethics issues involving agency officials and contractors, including schemes related to bribery and kickbacks, bid rigging, and over-billing of labor and materials.

[11]GAO-08-438T.

- Department of Education—The OIG reported that effective oversight of the agency's student federal assistance programs has been a long-standing and significant challenge. Specifically, the Education OIG cited control issues related to insufficient numbers of personnel with the necessary skills and ineffective oversight and monitoring of its programs and participants, placing billions of taxpayer dollars at risk of waste, fraud, abuse, and noncompliance.
- Department of the Treasury—The OIG cited erroneous and improper payments as the sixth top management challenge facing the Internal Revenue Service (IRS). According to the OIG, erroneous and improper and payments generally involve improperly paid refunds, tax return filing fraud, or overpayments to vendors or contractors. The Treasury OIG also reported some tax credits, such as the Earned Income Tax Credit (EITC) and the Education Credit, provide opportunities for abuse in income tax claims. The IRS receives a substantial number of excessive or incorrect EITC claims. According to the OIG, the exponential growth in fraud in processing year 2007 presented a challenge for the IRS, which did not have the resources to handle the volume. The OIG noted that if this trend continues over the next few years, the IRS might issue an even greater number of improper refunds, possibly resulting in a significantly increasing annual revenue loss to the federal government.

Implementation of IPIA in Medicare and Medicaid Programs

The Department of Health and Human Services (HHS) annually reports on improper payments in its Agency Financial Report (AFR). For fiscal year 2008, HHS reported improper payment estimates for several programs, including Medicare and the Medicaid, which together provide health insurance for one in four Americans. Collectively, HHS reported improper payment estimates for Medicare and Medicaid totaling about $36 billion for fiscal year 2008.[12] (See figure 1.) This represents about 50 percent of the total $72 billion in reported improper payments. The Centers for Medicare and Medicaid Services (CMS), a component of HHS, administers Medicare and oversees Medicaid at the federal level. CMS is responsible for IPIA implementation for these programs. CMS reported it has taken steps to address improper payment requirements for its Medicare and Medicaid programs, but more work remains to measure annual improper

[12]HHS's estimated improper payments for Medicare and Medicaid do not include an estimate for Medicare Prescription Drug Benefit (Part D). Further, the improper payment estimate for Medicaid represents only the federal share and not the portion funded by the state.

payments for all its risk-susceptible programs and to design and implement effective internal controls to prevent improper payments.

Medicare

Medicare provides health insurance to roughly 44 million elderly and disabled beneficiaries. As HHS's largest program, it represented nearly $400 billion or almost 60 percent of HHS's outlays for fiscal year 2008. The Medicare Program is comprised of Medicare Fee-for-Service (FFS) which includes Hospital Insurance (Medicare Part A) and Supplementary Medical Insurance (Medicare Part B), Medicare Advantage (Medicare Part C), and Medicare Prescription Drug Benefit (Medicare Part D).

Medicare FFS represents the largest share of Medicare payments and covers an array of items and services including hospital, skilled nursing and home health care; physician services; ambulance services; and medical equipment and supplies. CMS has a long-history of estimating improper payments for its Medicare FFS program that predate IPIA. Beginning in 1996, HHS's Office of Inspector General (OIG) estimated improper payments in the Medicare FFS program as part of its annual financial statement audit. In fiscal year 2003, CMS assumed responsibility for estimating Medicare FFS improper payments and modified the methodology to improve error detection and provide more detailed information on the errors. This coincided with the implementation of the IPIA. For fiscal year 2008, Medicare FFS improper payment estimate totaled $10.4 billion, or 3.6 percent of benefit payments for the prior year.[13] As part of its testing, CMS reported it determined whether the claim payments complied with Medicare coverage, coding, and billing rules. In its fiscal year 2008 AFR, HHS reported causes of improper payments included provision of medically unnecessary services, incorrect coding, and insufficient documentation.

Medicare Advantage is designed to provide health coverage through private health plans for Medicare beneficiaries who choose to enroll in this option. Fiscal year 2008 marks the first year that CMS reported estimated improper payments for Medicare Advantage, with an error rate of 10.6 percent or $6.8 billion in estimated improper payments. While HHS's AFR states that medical record reviews were performed, they did not specifically identify the types of attributes tested to identify the improper payments. The causes of improper payments cited were errors in

[13]The Medicare FFS improper payment estimate is based on a review of 2007 claims.

transferring data, interpretation of data, payment calculations, and incorrect diagnoses resulting in incorrect beneficiary risk scores.

Medicare Prescription Drug Benefit is an outpatient prescription drug benefit for Medicare beneficiaries who opt to enroll. As we highlighted earlier in this testimony, CMS had not yet estimated an error rate for its Medicare Prescription Drug Benefit, which had total outlays of about $46 billion for fiscal year 2008.

Medicaid

The Medicaid program is a joint federal/state program,[14] administered by the states to provide health insurance to certain low income individuals. Although it was required by OMB to report improper payment information beginning with its fiscal year 2003 budget submission, CMS began reporting estimated improper payments for this program in fiscal year 2007. For fiscal year 2008, CMS estimated improper payments for fee-for-service providers, managed care plans, and for ineligible recipients—and reported an error rate of 10.5 percent or $18.6 billion as the federal share of these improper payments.[15] Among all federal programs reporting in fiscal year 2008, Medicaid had the highest estimated dollar value of reported improper payments. (See figure 1.) To estimate improper payments for the Medicaid program, CMS developed a multi-faceted strategy that included obtaining claim payment data from the 50 states and the District of Columbia, utilizing a three-year state rotation cycle. Using this methodology, CMS selects 17 states each year to generate and report a national improper payment estimate for Medicaid. CMS reported that the most common causes of Medicaid improper payments resulting from its medical and data processing reviews included insufficient or lack of documentation (which accounted for 90 percent of the errors), pricing errors, and non-covered services. As reported in the fiscal year 2008 AFR, HHS expressed the view that the high percentage of errors related to insufficient documentation follows a trend similar to the early years of the Medicare FFS error rate measurement program. From its eligibility reviews, HHS reported that based on an informal survey of states, caseworker errors and a lack of internal controls were the causes for the errors in eligibility determinations.

[14]Medicaid is a federal and state program that is financed by the federal government and states according to a formula established in law.

[15]The total Medicaid improper payment estimate for fiscal year 2008 was $32.7 billion of which $14.1 billion was the state's share.

Management Challenges in Meeting IPIA Requirements

While CMS has made efforts to estimate improper payments, challenges remain to design and implement internal controls to effectively prevent improper payments and to address fraud, waste, and abuse. Since 1990 and 2003, respectively, we have designated Medicare and Medicaid as high risk and included them on our High-Risk list.[16] These programs were designated as high risk in part due to the high level of estimated improper payments and growing concerns about the quality of fiscal oversight, which is necessary to prevent inappropriate spending. Although the Medicare FFS payment error rate has decreased in recent years, HHS OIG raised concerns that the error rates for certain provider types may be understated based on its review of additional medical records and interviews with beneficiaries and providers. CMS has taken steps to enhance its program integrity efforts, but further work remains to put in place the controls necessary to effectively identify and detect improper payments. Our recent work in Medicare continues to identify fraudulent and abusive practices within the program.[17] For example, our review of Medicare's spending on home health care found that home health agencies' practice of upcoding (overstating the severity of a beneficiary's condition), providing kickbacks, and billing for services not rendered contributed to Medicare's home health spending and utilization. We reported that inadequate administration of the Medicare home health benefit left the program vulnerable to improper payments. Likewise, our review of enrollment of Medicare's durable medical equipment suppliers found weaknesses in Medicare's screening process that exposed the program to potentially paying millions of dollars for medical equipment and supplies that were not necessary or were not provided to beneficiaries.

Similarly, challenges exist for the Medicaid program. In fiscal year 2008, the HHS OIG reported that the shared oversight and enforcement activities between multiple federal and state entities create significant challenges to program oversight and integrity. The HHS OIG also reported that CMS's efforts to identify payment errors, their causes, and vulnerabilities in Medicaid is particularly challenging because of the diversity of state programs and the variation in their administrative and control systems.

[16]GAO, *High-Risk Series: An Update*, GAO-09-271 (Washington, D.C.: January 2009).

[17]GAO, *Medicare: Improvements Needed to Address Improper Payments in Home Health*, GAO-09-185 (Washington, D.C.: Feb. 27, 2009); *Medicare: Covert Testing Exposes Weaknesses in the Durable Medical Equipment Supplier Screening Process*, GAO-08-955 (Washington, D.C. July 3, 2008).

These findings are consistent with our prior work on federal and state coordination to estimate improper payments for state-administered programs, like Medicaid. Specifically, in April 2006, we reported that communication, coordination, and cooperation among federal agencies and the states are critical factors in estimating national improper payment rates and meeting IPIA reporting requirements for state-administered programs.[18] Further, putting in place a culture of accountability over improper payments and transparency of the issue helps to reduce fraud and address the wasteful spending that results from lapses in controls. As we previously reported,[19] measuring improper payments within the Medicaid program is critical to recouping and reducing them. The magnitude of the program's payment errors indicates that CMS and the states face significant challenges to address the program's vulnerabilities. Identifying and reducing improper payment in Medicaid are important first steps toward improving the integrity of the program.

Concluding Observations

In closing, in light of the current fiscal stress and looming deficits, the need to ensure that every federal dollar is spent as intended has never been more important. With more federal dollars flowing into risk-susceptible programs, establishing effective accountability measures is critical. In this regard, implementing strong internal controls can serve as the front-line of defense against improper payments. Nonetheless, effectively identifying improper payments and designing and implementing actions to reduce them are not simple tasks or easily accomplished. Consequently, agencies' efforts to fulfill the requirements of IPIA will require sustained top-level attention and commitment. The ultimate success of the governmentwide effort to reduce improper payments hinges on each federal agency's diligence and commitment to identify, estimate, determine the causes of, take corrective actions, and measure progress in reducing improper payments.

Mr. Chairman, this concludes my statement. I would be pleased to respond to any questions that you or other members of the Subcommittee may have.

[18]GAO, *Improper Payments: Federal and State Coordination Needed to Report National Improper Payment Estimates on Federal Programs*, GAO-06-347 (Washington, D.C.: Apr. 14, 2006).

[19]GAO-09-271.

Contact and Acknowledgments

For more information regarding this testimony, please contact, Kay L. Daly, Director, Financial Management and Assurance, at (202) 512-9095 or by e-mail at dalykl@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this testimony. Individuals making key contributions to this testimony included Carla Lewis, Assistant Director; F. Abe Dymond; Natasha Guerra; Crystal Lazcano; Christina Quattrociocchi; and Sabrina Springfield.

Appendix I: Improper Payment Estimates Reported in Agency Fiscal Year 2007 and 2008 Performance and Accountability Reports, Agency Financial Reports, or Annual Reports

	Department or agency		Program or activity	Fiscal year 2007 total estimate (dollars in millions)	Fiscal year 2007 error rate (percent)	Fiscal year 2008 total estimate (dollars in millions)	Fiscal year 2008 error rate (percent)
1	Agency for International Development	1	Cash Transfers	3.0	0.2	2.0	0.1
		2	Contracts	96.0	1.2	69.0	1.2
		3	Grants and Cooperative Agreements	0.0[a]	0.2[a]	36.0	1.2
2	Department of Agriculture	4	Child and Adult Care Food Program	12.0	1.7	11.0	1.6
		5	Conservation Reserve Program	9.0	0.5	24.0	1.3
		6	Conservation Security Program (previously Farm Security and Rural Investment)	1.0	0.5	0.0[b]	0.0[b]
		7	Direct and Counter-Cyclical Payments	37.0	0.4	47.0	0.7
		8	Federal Crop Insurance Corporation Program Fund	63.0	2.7	165.0	4.7
		9	Loan Deficiency Payments	18.0	0.5	0.8	0.6
		10	Marketing Assistance Loan Program	458.0	7.5	92.0	1.8
		11	Milk Income Loss Contract Program	8.0	2.2	0.3	0.2
		12	Miscellaneous Disaster Programs	25.0	6.8	5.0	3.1
		13	National School Lunch Program	1,402.0	16.3	1,449.0	16.6
		14	Noninsured Assistance Program	8.0	13.1	18.0	14.7
		15	Rental Assistance Program	26.0	3.1	35.0	4.0
		16	School Breakfast Program	520.0	24.9	538.0	25.0
		17	Special Supplemental Nutrition Program for Women, Infants, and Children	25.0	0.7	34.0	0.9
		18	Supplemental Nutrition Assistance Program (previously Food Stamp Program)	1,794.0	6.0	1,713.0	5.6
		19	Wildland Fire Suppression Management	13.0	1.0	0.2	0.0[c]
3	Department of Commerce[d]	20	All programs and activities	0.0	0.0	0.0	0.0
4	Department of Defense	21	Civilian Pay	74.6	0.3[e]	73.9	0.3
		22	Military Health Benefits	88.6[e]	0.9[e]	178.0	2.0
		23	Military Pay	416.4[e]	0.6[e]	434.6	0.6
		24	Military Retirement Fund	48.7	0.1	44.0	0.1

	Department or agency		Program or activity	Fiscal year 2007 total estimate (dollars in millions)	Fiscal year 2007 error rate (percent)	Fiscal year 2008 total estimate (dollars in millions)	Fiscal year 2008 error rate (percent)
		25	Travel Pay	43.6	1.0	103.0	2.0
5	Department of Education	26	Federal Student Aid—Federal Family Education Loan	384.0[a]	1.7[a]	404.0	1.7
		27	Federal Student Aid—Pell Grants	613.0[a]	4.1[a]	630.0	3.7
		28	Title I	87.6	0.7	40.0	0.3
6	Department of Energy	29	Payment programs	19.7	0.1	15.3	0.1
7	Environmental Protection Agency	30	Clean Water State Revolving Funds	1.6	0.1	8.3	0.4
		31	Drinking Water State Revolving Funds	0.0[a]	0.0[a]	0.0[a]	0.0[a]
8	Export-Import Bank of the United States[f]	32	All programs and activities	0.0	0.0	0.0	0.0
9	Farm Credit System Insurance Corporation[g]	33	All programs and activities	0.0	0.0	0.0	0.0
10	Federal Communications Commission	34	Universal Service Fund—High Cost Support Program	620.0	16.5	970.3[h]	23.3[h]
		35	Universal Service Fund—Low Income Program	75.5	9.5	75.5[h]	9.5[h]
		36	Universal Service Fund—Schools and Libraries	210.0	12.9	232.7[h]	13.8[h]
11	Federal Deposit Insurance Corporation[g]	37	All programs and activities	0.0	0.0	0.0	0.0
12	General Services Administration[c]	38	All programs and activities	0.0	0.0	0.0	0.0
13	Department of Health and Human Services	39	Child Care and Development Fund	0.0[i]	0.0[i]	573.0	11.5
		40	Foster Care	52.6[a]	3.3	99.6	6.4
		41	Head Start	89.5[a]	1.3	206.3	3.0
		42	Medicaid	6,575.0[a]	4.7[a]	18,642.0	10.5
		43	Medicare Advantage	0.0[i]	0.0[i]	6,848.0	10.6
		44	Medicare Fee-for-Service	10,800.0	3.9	10,400.0	3.6
		45	Medicare Prescription Drug Benefit	0.0[i]	0.0[i]	0.0[i]	0.0[i]
		46	State Children's Health Insurance Program	0.0[i]	0.0[i]	834.4	14.7

	Department or agency		Program or activity	Fiscal year 2007 total estimate (dollars in millions)	Fiscal year 2007 error rate (percent)	Fiscal year 2008 total estimate (dollars in millions)	Fiscal year 2008 error rate (percent)
		47	Temporary Assistance for Needy Families	0.0[i]	0.0[i]	1,663.0	9.3
14	Department of Homeland Security	48	Customs and Border Protection—Custodial—Refund & Drawback and Continued Dumping & Subsidy Offset Act & Payments to Wool Manufacturers	2.0[a]	0.0[b,a]	0.0[i]	0.0[i]
		49	Federal Emergency Management Agency—Assistance to Firefighters Grants	0.0[i]	0.0[i]	0.0[i]	0.0[i]
		50	Federal Emergency Management Agency—Homeland Security Grant Program	0.0[i]	0.0[i]	0.0[i]	0.0[i]
		51	Federal Emergency Management Agency—Individuals and Households Program	46.0[a]	7.2[a]	42.0	7.0
		52	Federal Emergency Management Agency—Infrastructure Protection Program	0.0[i]	0.0[i]	0.0[i]	0.0[i]
		53	Federal Emergency Management Agency—National Flood Insurance Program	0.0[i]	0.0[i]	0.0[i]	0.0[i]
		54	Federal Emergency Management Agency—Public Assistance Programs	0.0[i]	0.0[i]	0.0[i]	0.0[i]
		55	Federal Emergency Management Agency—Vendor payments	144.0[a]	7.6[a]	107.0	7.0
		56	Immigration and Customs Enforcement—Detention and Removal Operations	10.0[a]	0.9[a]	13.0	0.8
		57	Immigration and Customs Enforcement—Federal Protective Service	267.0[a]	36.9[a]	194.0	26.0
		58	Immigration and Customs Enforcement—Investigations	4.0[a]	1.9[a]	0.0[i]	0.0[i]
		59	Transportation Security Administration—Aviation Security—Payroll	2.0[a]	0.1[a]	0.0[i]	0.0[i]
		60	United States Coast Guard—Active Duty Military Payroll	21.0[a]	0.8[a]	21.0	0.8
		61	United States Coast Guard—Contract Payments	0.0[c]	0.0[c]	0.0[i]	0.0[i]
15	Department of Housing and Urban Development	62	Community Development Block Grant (Entitlement Grants, States/Small Cities)	0.0[c]	0.0[c]	0.0[c]	0.0[c]
		63	Low Income Public Housing	322.9	1.2	63.5	0.2
		64	Section 8—Project Based	410.8	1.5	396.5	1.4

	Department or agency		Program or activity	Fiscal year 2007 total estimate (dollars in millions)	Fiscal year 2007 error rate (percent)	Fiscal year 2008 total estimate (dollars in millions)	Fiscal year 2008 error rate (percent)
		65	Section 8—Tenant Based	785.4	2.9	532.6	1.9
16	Department of the Interior[d]	66	All programs and activities	0.0	0.0	0.0	0.0
17	Department of Justice[g]	67	All programs and activities	0.0	0.0	0.0	0.0
18	Department of Labor	68	Federal Employees' Compensation Act	2.6	0.1	0.5	0.0[c]
		69	Unemployment Insurance	3,248.0	10.3	3,897.0	10.0
		70	Workforce Investment Act	2.9	0.1	2.5	0.1
19	National Aeronautics and Space Administration	71	Program payments	0.9	0.0[c]	11.6	0.1
20	National Credit Union Administration[g]	72	All programs and activities	0.0	0.0	0.0	0.0
21	National Science Foundation	73	Research and Education Grants and Cooperative Agreements	0.0[k]	0.0[k]	0.0[k]	0.0[k]
22	Nuclear Regulatory Commission[g]	74	All programs and activities	0.0	0.0	0.0	0.0
23	Office of Personnel Management	75	Background Investigations Program	0.0[l]	0.0[l]	22.2	4.3
		76	Federal Employees Group Life Insurance	0.8	0.1[e]	0.6	0.1
		77	Federal Employees Health Benefits Program	168.7	0.5	83.7	0.2
		78	Retirement Program (Civil Service Retirement System and Federal Employees Retirement System)	253.5	0.4	245.9	0.4
24	Pension Benefit Guaranty Corporation[d]	79	All programs and activities	0.0	0.0	0.0	0.0
25	United States Postal Service[i]	80	All programs and activities	0.0	0.0	0.0	0.0
26	Railroad Retirement Board	81	Railroad Unemployment Insurance Benefits	2.1[e]	2.0[e]	2.3	2.0
		82	Retirement and Survivors Benefits	92.7[e]	1.0[e]	95.5	1.0
27	Securities and Exchange Commission	83	Disgorgements and Penalties	0.0[b]	0.0[b]	0.0[b]	0.0[b]
		84	Operational Vendor Payments	0.0[c]	0.0[c]	0.0[c]	0.0[c]

	Department or agency		Program or activity	Fiscal year 2007 total estimate (dollars in millions)	Fiscal year 2007 error rate (percent)	Fiscal year 2008 total estimate (dollars in millions)	Fiscal year 2008 error rate (percent)
28	Small Business Administration	85	504 Certified Development Companies (Debentures)	0.0[b]	0.0[b]	0.0[b]	0.0[b]
		86	504 Certified Development Companies (Guaranties)	0.0[b]	0.0[b]	0.0[b]	0.0[b]
		87	7(a) Business Loan Program (Guaranty Purchases)	2.6	0.4	6.5	0.5
		88	7(a) Business Loan Program (Guaranty Approvals)	0.0[b]	0.0[b]	0.0[b]	0.0[b]
		89	Disaster Loan Approvals	4.5	0.6	6.1	0.7
		90	Small Business Investment Companies	4.0	0.2	0.0[b]	0.0[b]
29	Smithsonian Institution[g]	91	All programs and activities	0.0	0.0	0.0	0.0
30	Social Security Administration	92	Old Age and Survivors' Insurance	2,504.0	0.5[e]	1,963.0	0.3
		93	Disability Insurance	0.0[e]	0.0[e]	0.0[e]	0.0[e]
		94	Supplemental Security Income Program	4,089.0	10.1	4,552.0	10.6
31	Department of State[d]	95	Business Class Travel and Sensitive Payments	0.0[c,e]	4.0	0.0	0.0
		96	International Information Program—U.S. Speaker and Specialist Program	0.9	4.0	0.0	0.0
32	Tennessee Valley Authority	97	Payment programs	6.6	0.1	6.2	0.1
33	Department of Transportation	98	Federal Aviation—Airport Improvement Program	0.0[b]	0.0[b]	1.0	0.0[c]
		99	Federal Highway—Federal Aid Highway Program	55.2	0.2	55.1	0.2
		100	Federal Transit—Capital Investment Grants	0.6	1.1	87.0	3.1
		101	Federal Transit—Formula Grants	4.3	0.3	47.6	5.6
34	Department of the Treasury	102	Earned Income Tax Credit	11,350.0	25.5	12,100.0	25.5
35	Department of Veterans Affairs	103	Compensation	240.8	0.8	340.2	1.0
		104	Dependency and Indemnity Compensation	0.0[e]	0.0[e]	0.0[e]	0.0[e]
		105	Education programs	101.0	3.7	63.7	2.2
		106	Insurance programs	0.0[e]	0.0[e]	0.0[e]	0.0[e]
		107	Loan Guaranty	4.7	0.5	3.9	0.4

Department or agency		Program or activity	Fiscal year 2007 total estimate (dollars in millions)	Fiscal year 2007 error rate (percent)	Fiscal year 2008 total estimate (dollars in millions)	Fiscal year 2008 error rate (percent)
	108	Non-VA Care Civilian Health and Medical Program (CHAMPVA)	12.4[e]	3.8[e]	17.1	3.2
	109	Non-VA Care Fee	92.6	5.9	24.8	1.3
	110	Pensions	303.9	8.6	375.1	10.2
	111	Vocational Rehabilitation and Employment Program	4.0	0.7	0.0[k]	0.0[k]
		Total	**49,286.8**		**72,095.9**	

Source: GAO's analysis of agencies' fiscal year 2007 and fiscal year 2008 performance and accountability reports (PAR), agency financial reports (AFR), or annual reports. Figures were rounded to the nearest tenth for reporting purposes.

[e]Agency combined with program above.

[f]Agency reported that the annual improper payment amount or error rate was zero.

[r]Agency program estimate or error rate rounded to zero for purposes of this testimony.

[d]Agency reported that it had no programs or activities susceptible to significant improper payments.

[e]Fiscal year 2007 estimate or error rate was updated to the revised estimate or error rate reported in the fiscal year 2008 PAR, AFR, or annual report.

[i]Agency did not address improper payments or IPIA in its PAR, AFR, or annual report for fiscal year 2007, fiscal year 2008, or both.

[g]Agency PAR, AFR, or annual report was not available as of the end of fieldwork.

[h]We obtained this amount from the Office of Management and Budget (OMB).

[i]Agency reported that it would estimate improper payments in the future for this program.

[j]Agency did not report an annual improper payment estimate or error rate for this program.

[k]Agency reported that it received a waiver from OMB, exempting it from the requirement to annually report improper payment information, because the program's estimate was below the reporting threshold (exceeding $10 million and 2.5 percent of program payments) for 2 consecutive years.

STATEMENT OF

DEBORAH TAYLOR
ACTING DIRECTOR AND CHIEF FINANCIAL OFFICER,
OFFICE OF FINANCIAL MANAGEMENT
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

ELIMINATING WASTE AND FRAUD IN MEDICARE AND MEDICAID

BEFORE THE

SENATE HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS COMMITTEE SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT INFORMATION, FEDERAL SERVICES, AND INTERNATIONAL SECURITY

APRIL 22, 2009

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

TESTIMONY OF
DEBORAH TAYLOR
ACTING DIRECTOR AND CHIEF FINANCIAL OFFICER
OFFICE OF FINANCIAL MANAGEMENT
IN THE
CENTERS FOR MEDICARE & MEDICAID SERVICES
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APRIL 22, 2009

Chairman Carper, Senator McCain, and distinguished Subcommittee members, thank you for inviting me here to discuss the Centers for Medicare & Medicaid Services (CMS) initiatives to reduce improper payments in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

Today, I would like to give you some background on our efforts to ensure payments to providers in Medicare, Medicaid, and CHIP are accurate, including an overview of the tools CMS has developed to address the problem of waste and fraud. I will describe how CMS succeeded in lowering the Medicare Fee-for-Service (FFS) error rate for Fiscal Year (FY) 2008 and our status in measuring improper payments in the Medicaid program and CHIP. I will also discuss briefly some of the challenges we face complying with the Improper Payments Information Act of 2002 (IPIA, P.L. 107-300). It is important to note that most of the improper payments I will be discussing are generally not due to willful

fraud. Rather, most of these errors are the result of documentation and processing mistakes.

Background on Medicare, Medicaid, and CHIP

Medicare is a Federal health insurance program that provides medical insurance to about 46 million people. About 38 million individuals are entitled to Medicare because they are age 65 or older, and about 8 million beneficiaries who are under age 65 are entitled because of disability. Those under age 65 generally begin to get Medicare when they have been entitled to Social Security disability cash benefits for 24 months. Total gross Medicare benefits for FY 2008 were $454 billion.

The majority of Medicare spending is FFS Medicare, with hospital and physician services currently representing the largest shares of this spending. The FFS component of Medicare also covers a wide range of other items and services, including home health care, ambulance services, medical equipment, and preventive services. This component of Medicare is administered by CMS through contracts with private companies that process claims for Medicare benefits.

Medicare also offers a prescription drug benefit in Part D and, as an alternative to FFS Medicare, medical coverage through privately-run plans in Part C. More than 26 million beneficiaries have Part D prescription drug coverage in 2009 through a Prescription Drug Plan (PDP) or a Medicare Advantage Prescription Drug Plan (MA-PD). Medicare

beneficiaries are filling 100 million prescriptions a month under Part D. Over 10 million people are enrolled in some type of Medicare Advantage plan.

During 2008, Medicare contractors processed almost 1.2 billion claims from providers, physicians, and suppliers for items and services that Medicare covers. Specifically, CMS administers the claims processing and payment systems for Medicare through contracts with Medicare Administrative Contractors (MACs). These entities, in addition to Quality Improvement Organizations (QIOs), review claims submitted by providers to ensure payment is made only for medically necessary services covered by Medicare for eligible individuals.

Medicaid is a partnership between the Federal government and the States. While the Federal government sets broad guidelines and provides financial matching payments to the States, each State is responsible for overseeing its Medicaid program, and each State essentially designs and runs its own program within the Federal structure. The Federal government pays the States a portion of their costs through a statutorily determined matching rate called the Federal Medical Assistance Percentage, or FMAP, that normally ranges between 50 and 76 percent. The American Recovery and Reinvestment Act (ARRA, P.L. 111-5) temporarily increased FMAP rates by a minimum of 6.2 percent through December 31, 2010. In FY 2008, total Medicaid expenditures – those that include both Federal and State contributions – were estimated to be approximately $352 billion.

In addition to Medicaid, CMS also jointly administers CHIP with States. Federal matching funds are provided to help States expand health care coverage to uninsured children. Each State sets its own guidelines regarding eligibility and services within certain Federal parameters. On February 4, 2009, President Obama signed the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3). CHIPRA reauthorizes CHIP through FY 2013 and provides an additional $44 billion in new funding to finance the program, effective April 1, 2009. CHIPRA also includes outreach and enrollment funds to extend coverage to an estimated 4 million more low-income uninsured children. Total enrollment for both Medicaid and CHIP for FY 2009 is estimated to be approximately 57 million.

CMS IPIA Compliance

Given the staggering size of these programs' expenditures, even small amounts of payment error can have a significant impact on both Federal and State treasuries and taxpayers. CMS uses improper payments calculations to estimate the amount of money that has been inappropriately paid, identify and study the causes of the inappropriate payments, and focus on strengthening internal controls to stop the improper payments from continuing. However, the variation in financing and administration among Medicare, Medicaid, and CHIP requires distinct approaches to applying these financial management tools.

Medicare IPIA Compliance

In 1996, the Department of Health & Human Services (HHS) Office of Inspector General (OIG) began estimating improper payments in the Medicare FFS program as part of the Chief Financial Officer's Audit. The OIG produced FFS error rates from FY 1996 to FY 2002. Beginning in FY 2003, CMS, working with the OIG, developed and implemented a process capable of looking in more detail at where errors were occurring. Entitled the Comprehensive Error Rate Testing (CERT) program, it not only produces a national paid claims error rate, but also improper payment rates specific to claims-processing contractors, participating providers, and errors specific to either regions of the country or reasons for error. Thus, in 2002 when the IPIA was enacted, CMS needed to make only minor changes to our existing processes for FFS Medicare to come into compliance with the Office of Management and Budget's (OMB) guidance on the IPIA.

In November 2008, HHS reported a Medicare FFS paid claims error rate of 3.6 percent. This exceeded our 2008 goal of 3.8 percent, and was a decrease from the 3.9 percent reported in 2007, and lower than the 4.4 percent rate reported in 2006. The FFS error rate has declined significantly from the 10.1 percent reported in 2004 to the 3.6 percent reported in 2008.

CMS reported for the first time an error rate for improper payments in the Medicare Advantage (MA) program, and is also on track to develop a composite payment error methodology for the Part D program. The MA error rate for calendar year (CY) 2006 was 10.6 percent. The MA error rate represents the combined impact of two sources of error:

- The MA payment system error estimate captured calculation errors and other system issues in CMS' data systems that affected Part C prospective payments to plans.
- The risk adjustment error estimate captured errors in risk adjustment data (clinical diagnosis data) submitted by MA plans to CMS.

CMS uses diagnosis data to calculate a risk score for each beneficiary, which is a key element of CMS' monthly Part C premium payment to a health plan for that beneficiary. To validate risk scores, CMS conducts medical record reviews on a national sample of beneficiaries to determine the extent to which plan-reported diagnoses are supported by medical record documentation. The FY 2008 reported risk adjustment error estimate was based on corrected risk scores for the sampled beneficiaries, due to diagnoses not supported by medical record documentation. The sample estimate was extrapolated to the program level.

This is the first year CMS measured an MA composite error rate under the IPIA. Improper payments due to payment system errors are routinely resolved and payment adjustments are made.

In response to an OIG audit in which the adequacy of CERT medical review of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) claims was questioned, as well as to strengthen our confidence in the CERT review findings and assure the accuracy of the reported error rate, CMS began an effort to independently perform blind, random reviews of its CERT review contractors' payment determinations

starting with the FY 2008 measurement.[1] We expect the results of those reviews to be completed later this summer.

Medicaid and CHIP IPIA Compliance

Since CMS last appeared before the Subcommittee, the Agency has successfully implemented the Medicaid and CHIP payment error rate measurement (PERM) program to calculate and report a national error rate for Medicaid and CHIP.

FY 2007 represented the first year of "full" implementation of the PERM program, expanded from FY 2006 to include reviews of Medicaid managed care and eligibility, as well as CHIP FFS, managed care, and eligibility. This expansion made Medicaid and CHIP fully compliant with the IPIA by 2008. The FY 2007 Medicaid error rate estimate was 10.5 percent. Likewise, for CHIP, the FY 2007 error rate estimate was 14.7 percent. However, these rates would be lower if undetermined eligibility cases were not factored in. A case is cited as undetermined in the eligibility reviews when, after due diligence on the part of the PERM reviewer, a definitive determination of eligibility or ineligibility can not be made. When considering these error rates, it is important to remember that under the PERM program, each State is measured against its own policies and standards. The error rate therefore reflects: 1) how well a State complied with its own program requirements, and 2) any payments that may have been paid incorrectly but were not necessarily fraudulent.

In addition, CMS initiated the State corrective action process, whereby States analyze root error causes that contribute to improper payments and develop corrective action

[1] OIG Report A-01-07-00508

plans to address error causes which should ultimately reduce improper payments over time.

CMS has increased State outreach in an effort to further educate States on the PERM program. We have developed PERM 101 documents which provide an introduction to the PERM program and are available to assist States in educating stakeholders. For FY 2009, CMS also issued early guidance to States on the error rate measurement process and allowed States to submit test data in preparation for the regular PERM cycle.

Also, in response to States' expressed desire to provide input beyond the rulemaking process, CMS is working to improve communications with the States. For example, we have expanded the PERM Technical Advisory Group (TAG) capacity by establishing an Error Rate Reduction Subcommittee, an Eligibility TAG, and a Difference Resolution Committee. The TAGs have provided States the opportunity to offer and discuss suggestions and recommendations for reducing State cost and burden. We have also established monthly calls with all States participating in a PERM cycle where States have the opportunity to communicate any questions or concerns directly to CMS.

CHIPRA provides for a 90 percent Federal match for CHIP spending related to PERM administration and excludes such spending from the 10 percent administrative cap. It also requires the Secretary to publish a new rule addressing CHIP PERM requirements by August 4, 2009. CMS is currently developing a notice of proposed rulemaking that will include CHIPRA requirements and clarify existing guidance. The rule on PERM must illustrate clearly defined criteria for errors for both States and providers; clearly defined

processes for appealing error determinations; and clearly defined responsibilities and deadlines for States in implementing any corrective action plans.

States sampled under PERM in FY 2007 or FY 2008 under former rules have the option to elect any payment error in whole or in part for the States on the basis of that data for those fiscal years as its base PERM year or elect to have FY 2010 or FY 2011 as it base year under the new rule created by this provision. States also have the option to apply PERM data for meeting MEQC requirements and vice versa, with certain conditions.

To help ensure IPIA compliance, CMS expects to:

- Continue efforts to achieve greater program efficiency;
- Reduce improper payments in Medicaid and CHIP through State corrective actions;
- Have States initiate recovery of erroneously paid Federal funds in these programs as identified through the PERM program; and
- Report national Medicaid and CHIP program error rates for each fiscal year measured.

CMS will continue to identify areas in improper payment measurement that can be improved upon to make the PERM program more efficient, to reduce cost and burden, and to help ensure accurate program error rates. Through experience, lessons learned, and State partnership, CMS is committed to advancing the efficiency and accuracy of the PERM program as it evolves.

Health Care Fraud and Abuse Control (HCFAC) Funding

CMS' actions to safeguard Federal funds are not just limited to the error rate programs described in this testimony. Program integrity and fiscal oversight is an integral part of CMS' financial management strategy and a high priority is placed on detecting and preventing improper or fraudulent payments. To that end, CMS has made significant changes to its program integrity activities in recent years. These changes include the creation of new divisions within CMS to focus on identifying problem areas through trend analysis of claims data.

Title II of the Health Insurance Portability and Accountability Act (HIPAA) established the HCFAC program to detect, prevent, and combat health care fraud and abuse. HCFAC is comprised of three separate funding streams, with the majority of funding supporting the Medicare Integrity Program (MIP). $720 million in annual MIP funding supports medical claims review, benefit integrity, provider and health maintenance organization (HMO) audits, Medicare secondary payer oversight, and provider education and training.

HCFAC funding supports four key CMS program integrity strategies: prevention, early detection, coordination, and enforcement. Each of these strategies is designed to ensure that CMS can address improper payment issues as quickly and efficiently as possible, and allows the Agency to coordinate with our colleagues at OMB, OIG, and the U.S. Department of Justice (DOJ) to maximize our return on investment.

In recent years, the President's budget requests have sought additional funding for HCFAC activities. The Omnibus Appropriations Act of 2009 (P.L. 111-8) allocated $198 million in new discretionary funding to the Agency in FY 2009. This funding will enable CMS to expand our existing efforts against fraud and abuse in the Medicare, Medicaid, and CHIP programs. This appropriation will supplement existing HCFAC programs, such as our regional HCFAC satellite offices, and strengthen combined HHS/DOJ investigatory efforts into Medicare Advantage, the Part D drug benefit, Medicaid (through the Medicaid Integrity Program), and CHIP. The President's Budget Overview has also made increased HCFAC funding a strong priority by again requesting a discretionary allocation adjustment of $311 million in FY 2010. A five-year investment in a discretionary allocation adjustment for HCFAC is estimated to yield $2.7 billion in program savings between FY 2010 and 2014.

Medicaid Integrity Program

Section 6034 of the Deficit Reduction Act of 2005 (DRA) established the Medicaid Integrity Program in section 1936 of the Social Security Act (P.L. 109-171). The Act directs the Secretary to establish a 5-year comprehensive plan to combat fraud, waste, and abuse in the Medicaid program, beginning in FY 2006. The first Comprehensive Medicaid Integrity Plan (CMIP) covering FYs 2006 to 2010 was released in July 2006; the second, covering FYs 2007-2011, was released in October 2007; the third, covering FY 2008-2012, was released in June 2008. CMS' Medicaid Integrity Group (MIG) is responsible for implementing the Medicaid Integrity Program.

The Medicaid Integrity Program offers a unique opportunity to prevent, identify, and recover inappropriate Medicaid payments. It also supports the efforts of State Medicaid agencies through a combination of oversight and technical assistance. Although each state works to ensure the integrity of its respective Medicaid program, the Medicaid Integrity Program provides CMS with the ability to more directly ensure the accuracy of Medicaid payments and to deter providers who would exploit the program.

The DRA states that CMS must enter into contracts to perform four key activities: 1) review provider actions; 2) audit claims; 3) identify overpayments; and 4) educate providers, managed care entities, beneficiaries, and others on payment integrity and healthcare quality. To date, CMS has awarded umbrella contracts to several contractors to perform the functions outlined above. These contractors are known as the Medicaid Integrity Contractors (MICs). Currently, there are MICs performing review and audit functions in 24 States and the District of Columbia. We plan to have MICs working in all fifty States by the end of FY 2009.

In addition to implementing key program integrity functions such as reviewing Medicaid providers and identifying inappropriate payments, the DRA requires CMS to provide effective support and assistance to States to combat provider fraud and abuse. CMS provides this support in the form of State program integrity reviews, training opportunities, resource support for special projects, and ongoing technical assistance. Specifically, the MIG created the Medicaid Integrity Institute (MII), a national Medicaid program integrity training partnership with DOJ's national training center in Columbia,

SC. The MII provides State employees a comprehensive program of course work encompassing all aspects of Medicaid program integrity. In FY 2008, the MII, provided training to 417 staff from almost every State and estimate at least 750 State staff to attend in FY 2009.

CMS recognizes the valuable role of the provider community as an ally in identifying potentially fraudulent practices in their respective industries as well as serving as a source of intelligence regarding specific conduct. We have done extensive outreach to the provider community through presentations and speeches at conferences and other national forums, interviews for trade publications, and through the CMS Open Door Forums.

CMS also understands the value of education in preventing fraud, waste, and abuse because many overpayments are the result of billing mistakes rather than intentional fraud. The Education MICs will work closely with all of Medicaid's partners and stakeholders and provide education to providers on various program integrity issues.

Regional Fraud, Waste and Abuse Efforts

Experts agree that the most effective way to eliminate fraud is to stop it before it ever starts. One way this can be done is by exercising more due diligence on providers and suppliers before issuing them the Medicare numbers that enable them to bill Medicare. Over the last two years, CMS has begun focusing resources on front-end controls with the end goal of reducing or eliminating common schemes by sham providers by

thoroughly vetting all providers before allowing them to obtain a Medicare enrollment number.

Where we see unusual, high volume, or high-dollar claims, we will still examine the claims, but we may also visit the provider or supplier, interview beneficiaries, and, in the case of home health, we may visit the ordering physician. We look at the entire chain to ensure that high volume prescribers are prescribing only what is medically necessary, to ensure that suppliers or other providers are in fact providing what was prescribed, and to ensure that the beneficiary has a true medical need and is not, willingly or otherwise, a part of a criminal enterprise.

Home medical equipment—DMEPOS—is an industry that is historically at high risk for fraud. In South Florida and Los Angeles, where Medicare billing is disproportionately high, the number of DMEPOS suppliers increased nearly 20 percent between 2005 and 2007.

One important tool to help fight DMEPOS fraud is competitive bidding for DMEPOS suppliers, authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173). Under current law, CMS is required to begin this program in 2009. CMS will be issuing further guidance on its timelines and bidding requirements for the competitive bidding program. In finalizing these guidelines, CMS will continue to seek input from all affected stakeholders to ensure program

implementation consistent with the legislative requirements and ensuring that CMS' processes for collecting and evaluating bids are fair and transparent.

Until DME competitive bidding is fully operational, CMS is pursuing a "stop-gap program" to focus on Medicare fraud in seven high-risk areas across the country where CMS is increasing our oversight of the highest paid DMEPOS suppliers and the highest billed DMEPOS equipment and supplies. The "stop-gap program" increases pre-payment reviews of medical equipment suppliers and will also single out the highest-billed claims—continuous positive airway pressure (CPAP) devices, oxygen equipment, glucose monitors and test strips, and power wheelchairs—which are the most lucrative items for suppliers and thus, at the greatest risk of fraud. The plan toughens background checks on new suppliers and increases scrutiny on the highest ordering physicians and the highest utilizing beneficiaries.

The "stop-gap plan" goes beyond the current durable medical equipment Provider Enrollment Demonstrations in Los Angeles and Miami, which have already revoked more than 1,150 billing numbers and raised the tally of suppliers expelled from Medicare by 50 percent. The plan also targets the highest utilizing beneficiaries who are potentially receiving kickbacks, and focuses on the equipment and supplies most likely to be abused.

In January 2009, CMS issued a new rule to require most non-physician suppliers of durable medical equipment to obtain a $50,000 surety bond, in order to deter illegitimate

suppliers from enrolling in Medicare. Effective October 1, 2009, most DME suppliers participating in the Medicare program will be required to have both a surety bond and accreditation from a deemed accrediting organization. The combination of the surety bond and accreditation requirements is an important step to ensure that CMS is only doing business with legitimate partners and will allow CMS to expel fraudulent suppliers from the program and keep them out.

CMS recently took the opportunity to consolidate the myriad anti-fraud contractors we utilize for integrity efforts for DMEPOS suppliers under one umbrella. The new contractors, Zone Program Integrity Contractors (ZPICs), serve the same jurisdictions as the MACs. CMS continues to fight waste, fraud, and abuse by those who are determined to steal from the Medicare trust funds and the Agency relies upon the ZPICs to assist us in developing innovative ideas and methods to stop this fraudulent flow of money and protect the trust funds. The ZPICs have a broad portfolio, ranging from conducting investigations and providing support to law enforcement, to conducting data analysis against all Medicare FFS payment types. Five ZPICs will concentrate on fraud "hot spots" in FL, IL, TX, NY and CA where we know the program has the greatest vulnerabilities. By better focusing our program safeguard activities and consolidating contractors to allow them to look across multiple claims types, CMS will be able to more efficiently and accurately detect and prevent fraud before it occurs.

While the majority of CMS' focus has been on the numerous aspects of Medicare FFS fraud, the past two years have also included an increased focus on oversight of the Medicare Part D prescription drug program and the Part C managed care program. CMS currently utilizes special contractors called the Medicare Part D Integrity Contractors

(MEDICs) to oversee marketing, enrollment and eligibility issues that are potentially fraudulent. During 2007, the MEDIC contracts were expanded to include oversight of the Part C managed care program. The MEDICs have worked closely with the Medicare Advantage Organizations (MAOs) and the Part D Plan Sponsors to cull complaint information received through the MEDIC fraud hotlines, information obtained by the MAOs or Part D Sponsors, and complaints received through the complaints tracking system in CMS' regional offices. These complaints are then vetted to determine which have elements that would potentially be considered fraud. Those are then referred over to the OIG for further investigation, and the MEDICs provide support to OIG and DOJ as the investigations develop into civil or criminal matters. CMS also has internal oversight mechanisms for the Part D Sponsors and MAOs to ensure they are complying with CMS' contract requirements and all applicable regulations. Entities which are found to be non-compliant are subject to corrective action plans, sanctions, or civil money penalties.

Recovery Audit Contractors

Section 306 of the MMA gave CMS authority to pilot new tools designed to detect improper payments. This MMA provision directed the Secretary to demonstrate the use of Recovery Audit Contractors (RACs) in identifying Medicare underpayments and overpayments, which would collect Medicare overpayments and return any underpayments. The over- and underpayments were identified through a careful review of individual Medicare claims to determine if the claims were medically necessary, correctly coded, and conformed to Medicare payment policy. This initial demonstration project ran from 2005 to 2008 in California, New York, Florida, Massachusetts, South

Carolina, and Arizona. The demonstration proved to be successful, recovering $992.7 million in gross overpayments, as well as $37.8 million in underpayments that were paid out to providers.

The demonstration results showed the effectiveness of a recovery auditing program. The Tax Relief and Health Care Act of 2006 (P.L. 109-432) mandated the use of recovery audit contractors in all States by 2010. The national RAC program began work on February 6, 2009. CMS' implementation plan is to phase-in the recovery audit contractors nationally. This incremental approach will allow CMS to work closely with the national and State health care associations to ensure that health care providers have up to date information regarding the nationwide expansion process.

CMS learned many key things during the RAC demonstration phase. As important as the recovery of past improper payments is, CMS sees the RAC program more importantly as a tool in reducing and eliminating future improper payments. To that end, CMS responded to feedback from providers on the demonstration project and made some important modifications prior to implementing the national program. These changes include: mandatory medical director and coding experts included to oversee each RAC claims review; a mandatory independent validation of the RACs; a 3-year maximum look-back period going back to October 1, 2007; quality assurance reviews; and a mandatory payback of any contingency fee by the RAC if the claim is overturned on appeal. With these important improvements, CMS seeks to ensure accuracy, maximize

transparency, and minimize provider burden as the RAC program goes national. Further information on the status of the RAC program can be found at: www.cms.hhs.gov/RAC.

Conclusion

CMS is strongly committed to protecting taxpayer dollars and ensuring the sound financial management of the Medicare, Medicaid, and CHIP programs. As evidenced by the testimony today, the Agency has taken action to meet IPIA standards in Medicare and is taking a number of proactive steps to become IPIA-compliant in Medicaid and CHIP. The Agency has developed a strategy that will strengthen Federal oversight of State financial practices. We have made progress, but there remains work to do to root out waste, fraud and abuse in the Medicare, Medicaid, and CHIP programs. Congress appropriated additional funds to HCFAC for FY 2009, and the Administration has again requested a discretionary allocation adjustment in the President's FY 2010 Budget Overview. We will use any funds appropriated by Congress to build upon our work to date, to more rapidly respond to emerging program integrity vulnerabilities and to identify and recoup improper payments. CMS looks forward to continuing to work cooperatively with the Congress. CMS and the Administration fully support this Subcommittee's efforts as a steward of taxpayer dollars to improve the fiscal integrity of the Medicare, Medicaid, and CHIP programs.

I look forward to answering any questions you might have.

Statement of Lewis Morris
Chief Counsel
Office of Inspector General
Department of Health and Human Services

April 22, 2009
Before the Senate Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security

THE FRAMEWORK FOR COMBATING FRAUD, WASTE, AND ABUSE IN FEDERAL HEALTH CARE PROGRAMS

On behalf of Inspector General Levinson and the Office of Inspector General (OIG), I thank you for the opportunity to discuss the OIG's health care antifraud strategy; the different ways Federal health care programs are vulnerable to waste, fraud, and abuse; and the ways Congress can help strengthen the integrity of these critical programs.

Collaboration Is Essential to a Successful Antifraud Strategy

OIG is an independent, nonpartisan agency committed to protecting the integrity of the 300 agencies and programs administered by the Department of Health and Human Services (HHS). Approximately 80 percent of OIG's resources are dedicated to promoting the efficiency and effectiveness of the Medicare and Medicaid programs and to protecting these programs and their beneficiaries from fraud and abuse. Thanks to the hard work of our 1,500 employees and our law enforcement partners, from FY 2006 through FY 2008, OIG's investigative receivables averaged $2.04 billion and its audit disallowances resulting from Medicare and Medicaid oversight averaged $1.22 billion per year. The result was a Medicare-and Medicaid-specific return on investment for OIG oversight of $17 to $1. In addition, in FY 2008, implemented OIG recommendations resulted in $16.72 billion in savings and funds put to better use.

OIG is not alone in the fight to combat fraud and preserve the integrity of Federal health care programs. We work closely with the Department of Justice (DOJ) and our State law enforcement partners, as well as with our colleagues in the Centers for Medicare & Medicaid Services (CMS) and the Food and Drug Administration. The Government's enforcement efforts in FY 2008 resulted in 455 criminal actions against individuals or entities that engaged in crimes against departmental programs and 337 civil actions, which included False Claims Act and unjust enrichment lawsuits filed in Federal district court, Civil Monetary Penalties Law settlements, and administrative recoveries related to provider self-disclosure matters. Also in FY 2008, OIG excluded 3,129 individuals and entities for fraud or abuse that affected Federal health care programs and/or our beneficiaries. Common reasons for exclusion included convictions for crimes concerning Medicare or Medicaid, patient abuse or neglect, and license revocation.

The collaborative antifraud efforts of HHS and DOJ are rooted in the Health Insurance Portability and Accountability Act of 1996, P. L. 104-191 (HIPAA), which directed the Secretary of HHS, acting through OIG and the Attorney General, to promulgate a joint Health Care Fraud and Abuse Control (HCFAC) Program. The HCFAC Program and Guidelines went

into effect on January 1, 1997. HIPAA requires HHS and DOJ to report annually to Congress on HCFAC Program results and accomplishments. HCFAC Program activities are supported by a dedicated funding stream within the Hospital Insurance Trust Fund.

In its 11th year of operation, the HCFAC Program's continued success confirms the soundness of a collaborative approach to identify and prosecute health care fraud, to prevent future fraud and abuse, and to protect Medicare and Medicaid beneficiaries. Since its inception, HCFAC Program activities have returned over $11.2 billion to the Medicare Trust Fund. As I will discuss, the Government's efforts to address durable medical equipment (DME) and infusion fraud in South Florida and Los Angeles exemplify the benefits of a collaborative approach. Although I will highlight fraud in the area of DME and infusion, fraud and abuse occur among all types of health care providers and suppliers.

The Federal Health Care Programs Are Vulnerable to Waste, Fraud, and Abuse

The United States spends more than $2 trillion on health care every year. The National Health Care Anti-Fraud Association estimates conservatively that of that amount, at least 3 percent—or more than $60 billion each year—is lost to fraud. For Federal health care programs to serve the medical needs of beneficiaries and remain solvent for future generations, the Government must pursue an aggressive and comprehensive strategy to address waste, fraud, and abuse. That strategy must be broader than investigating and prosecuting detected instances of fraud. Thus, our strategy is also informed by OIG audits, evaluations, and inspections, which have identified payments for unallowable services and improper services not rendered, and other types of improper claims. OIG also has found that Medicare's reimbursement rates for certain items and services are too high, resulting in wasteful expenditures and opportunities for fraud.

OIG reviews have identified payments for unallowable services, improper coding, and other types of improper payments for various inpatient and outpatient services. Improper payments range from reimbursement for services provided to inadequately documented and inadvertent mistakes to outright fraud and abuse. Expenditures for inpatient services, including those provided by inpatient hospitals and skilled nursing facilities, account for one-third of all Medicare expenditures. OIG work has uncovered problems with hospitals taking advantage of enhanced payments by manipulating billing; hospitals reporting inaccurate wage data, which affects future Medicare payments; and inpatient facilities that may be gaming prospective payment reimbursement systems by discharging or transferring patients to other facilities for financial rather than clinical reasons.

OIG also continues to identify vulnerabilities related to certain types of services provided by physicians and other health professionals, including services related to advanced imaging, pain management, and mental health. For example, OIG found that from 1995 to 2005, expenditures for advanced imaging paid under the Medicare Physician Fee Schedule grew more than fourfold, from $1.4 million to $6.2 million. Services provided by independent diagnostic testing facilities (IDTFs) accounted for nearly 30 percent of this growth. OIG work has found problems with IDTFs, including noncompliance with Medicare requirements and billing for services that were not reasonable and necessary.

While we are continuing to identify vulnerabilities throughout the program, OIG and our law enforcement partners also are focusing antifraud efforts in geographic areas at high risk for Medicare fraud, including South Florida and Los Angeles. Our investigations identified significant vulnerabilities, including: (1) DME suppliers circumventing enrollment and billing controls; (2) high levels of improper Medicare payment for certain types of DME, prosthetics, orthotics, and supplies (DMEPOS); and (3) inappropriate reimbursement rates for certain DMEPOS. In 2007, the Government launched in South Florida a Medicare Fraud Strike Force (Strike Force) made up of staff from OIG, the U.S. Attorney's Office for the Southern District of Florida, the Federal Bureau of Investigation, and DOJ. The Strike Force's mission is to identify, investigate, and prosecute DMEPOS suppliers and infusion clinics suspected of Medicare fraud. To date, the Strike Force has opened 137 cases, convicted 146 of its targets, and secured $186 million in criminal fines and civil recoveries.

The recent investigation and prosecution of Medcore Group LLC (Medcore) and M&P Group of South Florida (M&P) illustrates the Medicare program's vulnerabilities. Medcore and M&P operated as Miami-based HIV clinics from approximately 2004 through 2006, billed approximately $5.3 million to the Medicare program, and actually received more than $2.5 million in payments. From their inception, Medcore and M&P were set up as criminal enterprises designed to defraud Medicare. The scheme was to submit claims for medically unnecessary HIV infusion and injection treatments. The three owners of Medcore and M&P included a former gas station attendant, a trained cosmetologist, and an individual currently incarcerated for Medicare fraud involving a separate DME company he operated from 2001 to 2003. None had more than a high-school education and none had any medical background.

At trial, one of Medcore's owners, Tony Marrero, testified that the scheme was so profitable so quickly, that he became concerned about getting caught and decided to set up a second fraudulent clinic, M&P, in the name of his wife. M&P was located in the same building as Medcore, had the same employees, submitted claims under the Medicare provider number of the same physician, and had six patients in common. In fact, the same doctor worked at other Miami-area infusion clinics, which billed Medicare for more than $60 million between 2004 and the end of 2005. Mr. Marrero testified that when his wife no longer wanted to be associated with M&P, he sold the clinic to Gustavo Smith in exchange for $100,000 delivered to him in cash in a paper bag. Mr. Smith was later convicted of health care fraud in connection with a different DME scheme and has since fled to Cuba.

Mr. Marerro also testified at trial that he had an arrangement with a pharmaceutical wholesale company to buy invoices that showed the purchase of large amounts of medications, when only minor amounts were actually purchased. One of the medical assistants testified that she manipulated the patients' blood samples to ensure that lab results would appear to support the Medicare claims.

On March 17, 2009, a federal jury in Miami convicted two physicians and two medical assistants who worked for Medcore and M&P in connection with the $5.3 million fraud scheme. The government obtained six pleas before trial resulting in 10 convictions in total.

EXPLOITATION OF THE SYSTEM'S VULNERABILITES

OIG's fraud-fighting efforts in South Florida and Los Angeles also draw on the expertise of our auditors and evaluators. For example, OIG identified weaknesses in Medicare's supplier enrollment process and its supplier oversight activities. In 2007, OIG found that 31 percent of DMEPOS suppliers in three South Florida counties did not maintain physical facilities or were not open and staffed, contrary to Medicare requirements. Similarly, in 2008, OIG inspected 905 suppliers in Los Angeles County and found that 13 percent did not have physical facilities or were not open during repeated unannounced site visits.

OIG also found that CMS has had limited success controlling aberrant billing by infusion clinics. In the second half of 2006, claims originating in three South Florida counties accounted for 79 percent of the amount submitted to Medicare nationally for drug claims involving HIV/AIDS patients and constituted 37 percent of the total amount Medicare paid for services for beneficiaries with HIV/AIDS. However, only 10 percent of Medicare beneficiaries with HIV/AIDS lived in these three counties.

In additional work, OIG identified strategies that DMEPOS suppliers had used to circumvent billing controls and defraud the program. Medicare regulations require DME suppliers to provide the Medicare provider identifier of the physician who ordered the equipment on the claim. Until May 23, 2008, Medicare used unique provider identification numbers (UPIN) and then switched to national provider identifiers (NPI). Requiring the UPIN (or NPI) on claims is intended to indicate that a physician has verified the need for the DMEPOS and to enable CMS to determine who prescribed the DMEPOS as part of any post-payment reviews. OIG studies have uncovered: (1) the use of invalid or inactive UPINs, (2) the use of UPINs that belonged to deceased physicians, (3) the improper use of surrogate UPINs, and (4) the use of legitimate UPINs that were associated with an unusually large number of claims. UPIN vulnerabilities, as well as other challenges, may affect the integrity of the new NPI system. Therefore, OIG has planned additional work to examine the accuracy and completeness of NPIs.

OIG also has found that certain types of DMEPOS are particularly vulnerable to improper payments. For example, an investigation of a large wheelchair supplier found that the company had submitted false claims to Medicare and Medicaid, including claims for power wheelchairs that beneficiaries did not want, did not need, or could not use. In 2007, the company agreed to pay $4 million and relinquish its right to approximately $13 million in claims initially denied for payment by CMS. Nationally, in 2004, OIG estimated that Medicare and its beneficiaries paid $96 million for claims that did not meet Medicare's coverage criteria for any type of wheelchair or scooter and that they spent an additional $82 million in excessive payments for claims that could have been billed using a code for a less expensive mobility device.

Prior OIG work also has found that Medicare pays too much for certain pieces of DMEPOS and related supplies, such as power wheelchairs, hospital beds, diabetic supplies, and home oxygen equipment. For example, in a 2006 report, OIG found that Medicare had allowed, on average, $7,215 for the rental of an oxygen concentrator that costs about $600 to purchase new. Additionally, beneficiaries incurred, on average, $1,443 in coinsurance charges. We determined that if home oxygen payments were limited to 13 months rather than the current 36 months,

Medicare and its beneficiaries would save $3.2 billion over 5 years. In other work related to Medicare pricing, OIG currently is conducting work to examine the appropriateness of prices that Medicare pays for wheelchairs by comparing Medicare prices to suppliers' purchase prices.

OIG recently found that Medicare reimburses suppliers for negative pressure wound therapy pumps based on a purchase price of more than $17,000 but that suppliers paid an average of $3,600 for new models of these pumps. Negative pressure wound therapy pumps are a type of DME used to treat ulcers and other serious wounds. When Medicare first started covering wound pumps in 2001, it covered only one model, which was manufactured and supplied by one company. Medicare paid for this pump based on the purchase price as identified by that company. In 2005, Medicare expanded its coverage to include several new pump models manufactured by other companies. However, Medicare reimburses suppliers for these new pumps based on the original pump's purchase price, which is more than four times the average price paid by suppliers.

An Effective Antifraud Strategy Should Embrace Five Principles

Based on the Government's investigation and prosecution of health care fraud and oversight of Federal health care programs, we believe an effective strategy to combat health care waste, fraud, and abuse must embrace five principles:

1. Scrutinize individuals and entities that want to participate as providers and suppliers prior to their enrollment in health care programs.

2. Establish payment methodologies that are reasonable and responsive to changes in the marketplace.

3. Assist health care providers and suppliers in adopting practices that promote compliance with program requirements, including quality and safety standards.

4. Vigilantly monitor the programs for evidence of fraud, waste, and abuse.

5. Respond swiftly to detected frauds, impose sufficient punishment to deter others, and promptly remedy program vulnerabilities.

These principles are equally applicable to OIG's enforcement strategy, CMS's program integrity efforts, and Congress's legislative agenda. When OIG provides CMS with the results of its audits, inspections, and investigations, these principles are often reflected in OIG's programmatic recommendations and suggested corrective actions. We offer the following ideas if Congress is considering strengthening the integrity of Federal health care programs.

Scrutinize individuals and entities that want to participate as providers and suppliers prior to their enrollment in health care programs.

As the Medcore and M&P case demonstrates, a lack of effective screening measures gives dishonest and unethical individuals access to a system that they can easily exploit. Even after

Medcore had billed Medicare for $4 million in fraudulent claims, it was easy for the clinic's owner to obtain a provider number in his wife's name for a second clinic, M&P, operating in the very same building as Medcore, with the same medical director, employees, and patients. When one of the owners, Mr. Marrero, ultimately sold M&P for $100,000 in cash, he testified that he went to a lawyer's office so the lawyer could fill out paperwork to put ownership of the clinic in the name of two nominee owners—rather than Gustavo Smith's name. Although it involved cash exchanged in a paper bag in a parking lot, the sale was structured as a stock sale so the new "owners" would have 90 days to notify Medicare of the change in ownership, allowing a window of time for the fraud to continue under new "ownership." In our experience, it too easy for organized crime to recruit nominee owners of fraudulent companies.

We advocate strengthening enrollment standards and making participation in Federal health care programs as a provider or supplier a privilege, not a right. All providers and suppliers applying for enrollment in Medicare or Medicaid should be screened before they are granted billing privileges. Heightened screening measures for high-risk items and services could include requiring providers to meet accreditation standards, requiring proof of business integrity or surety bonds, periodic recertification and onsite verification that conditions of participation have been met, and full disclosure of ownership and control interests. New providers and suppliers should be subject to a provisional period during which they are subject to enhanced oversight, such as prepayment review and payment caps. The cost of this screening could be covered by charging application fees.

Establish payment methodologies that are reasonable and responsive to changes in the marketplace.

OIG has conducted extensive reviews of Medicare payment and pricing methodologies and has determined that the program pays too much for certain items and services. When reimbursement methodologies do not respond effectively to changes in the marketplace, the program and its beneficiaries bear the cost. As the experience of South Florida illustrates, excessive payments are a lucrative target for criminals. These criminals also can reinvest some of their profit in kickbacks for additional referrals, thus using the program's funds to perpetuate the fraud scheme.

We support efforts to pay appropriately for the items and services covered by Federal health care programs. Although CMS has the authority to make certain adjustments to fee schedules and other payment methodologies, for some changes, congressional action is needed. Medicare and Medicaid reimbursement systems should be aligned to ensure that payments are reasonable and responsive to market changes.

Assist health care providers and suppliers in adopting practices that promote compliance with program requirements.

Health care providers and suppliers must be our partners in ensuring the integrity of Federal health care programs and should adopt internal controls and other measures that promote compliance and prevent, detect, and respond to health care fraud, waste, and abuse. Requiring health care providers and suppliers to incorporate integrity safeguards and tools into their organizations is an essential component of a comprehensive antifraud strategy. In many sectors

of the health care industry, such as hospitals, compliance programs are widespread and often very sophisticated; other sectors have been slower to adopt internal compliance practices. Compliance programs benefit industry stakeholders by improving their business practices, by fostering early detection and correction of emerging problems, and by reducing the risk that they will become the subject of a fraud prosecution.

States also have begun to recognize the value of compliance systems. For example, New York now requires providers and suppliers to implement an effective compliance program, as defined by OIG, as a condition of participation in its Medicaid program. Medicare Part D also requires that prescription drug plan sponsors have compliance plans that address eight required elements. Although compliance programs do not guarantee reduced fraud and abuse, they are an important component of a comprehensive government-industry partnership to promote program integrity.

We recommend that providers and suppliers should be required to adopt compliance programs as a condition of participating in the Medicare and Medicaid programs. As part of its effort to promote compliance with program requirements, OIG has extensive experience in the development of compliance program guidance and could assist in this important integrity initiative.

Vigilantly monitor the programs for evidence of fraud, waste, and abuse.

The health care system compiles an enormous amount of data on patients, providers, and the delivery of health care items and services. However, Federal health care programs often fail effectively to use claims-processing edits and other information technology to identify improper claims before they are paid. To state the obvious, Medicare should not pay a clinic for HIV infusion when the beneficiary has not been diagnosed with the illness, pay twice for the same service, or routinely process a claim that relies on the UPIN of a deceased physician. Like many infusion fraud schemes, Medcore and M&P gained the cooperation of patients by giving them kickbacks of up to $200 per visit. Four patients testified that they took kickbacks and never received any medication at the clinics. One patient testified that he used his payments from the clinics to support his cocaine addiction. Another patient testified that he did not have HIV, even though the clinics' documents showed he was being infused with medication to treat HIV. By the patients own admission, they had been receiving kickbacks from numerous Miami clinics for many years. The Medicare data showed they had received millions of dollars in infusion treatment, DME, and other services they did not require. Had the government been vigilantly monitoring the claims submitted on behalf of these beneficiaries, the scheme might have been detected more quickly.

CMS has taken significant steps to enhance payment accuracy and internal controls. For example, CMS proposed a centralized data repository, known as One Program Integrity System Integrator (One PI), which would warehouse data on Medicare Parts A, B, and D and on Medicaid. However, the target implementation date for One PI has been delayed, and CMS has not provided a new expected timeframe for completion and operability.

In addition to structural improvement to the data systems, real-time access to all relevant Medicare and Medicaid data by law enforcement is critical to the success of the antifraud effort.

Currently, law enforcement receives data weeks or months after claims have been filed, making it more difficult to detect and thwart new scams. We advocate that law enforcement have real-time access to Medicare and Medicaid program data. In addition, we recommend that Congress authorize OIG to streamline the process for matching Medicare data to other relevant databases, such as Medicaid data obtained from States and data from the Social Security Administration. We also recommend the consolidation and expansion of the various provider databases, including the Health Care Integrity and Protection Data Bank, the National Practitioner Data Bank, and OIG's List of Excluded Individuals/Entities. Providing a centralized comprehensive database of adverse actions and other sanctions imposed on individuals and entities would be an effective means of preventing providers and suppliers with problem backgrounds from moving from State to State unnoticed by licensing, government, and health plan officials.

Respond swiftly to detected fraud, impose sufficient punishment to deter others, and promptly remedy program vulnerabilities.

Our investigations have shown an increase in organized crime in health care. Health care fraud is attractive to organized crime because the penalties are lower than those for other organized-crime-related offenses (e.g., offenses related to illegal drugs); there are low barriers to entry (e.g., a criminal can easily obtain a supplier number, gather some beneficiary numbers, and bill the program); schemes are easily replicated; and there is a perception of a low risk of detection. We need to alter the cost-benefit analysis by increasing the risk of swift detection and the certainty of punishment.

As part of this strategy, law enforcement must accelerate the Government's response to fraud schemes. The Government's strike force model has proved highly successful. In addition to prosecuting criminals and recovering funds for the Medicare Trust Fund, the South Florida Strike Force has had a powerful sentinel effect. Medicare claims data show that during the first 12 months of the Strike Force (March 1, 2007, to February 29, 2008), claim amounts submitted for DME decreased by 63 percent to just over $1 billion from nearly $2.76 billion during the preceding 12 months (a drop exceeding $1.7 billion).

Although resource intensive, the strike force is a powerful antifraud tool and represents a tremendous return on the investment. Building on the success of the South Florida Strike Force, in March 2008, DOJ and OIG created a second Strike Force in Los Angeles. Since operations began, the Strike Force has opened 46 cases and indicted individuals and organizations that collectively have made almost $13 million on fraudulent claims to the Medicare program. The schemes include false claims for wheelchairs, orthotics, and other DME that was medically unnecessary and/or was not provided to the beneficiaries identified in claims.

OIG uses a range of administrative sanctions, including civil money penalties (CMPs) and program exclusions, as an adjunct to criminal and civil enforcement. We have identified a number of enhancements to these administrative authorities that, if mandated by Congress, would increase our ability to address emerging schemes, such as authorizing CMPs for the submission of erroneous data used as the set Medicare payment and a CMP for the ordering or prescribing of items or services by an excluded person.

Conclusion

OIG and its law enforcement partners have implemented a comprehensive strategy to combat waste, fraud, and abuse in Federal health care programs. However, sophisticated health care fraud schemes increasingly rely on falsified records, elaborate business structures, and the participation of health care providers, suppliers, and even patients to create the false impression that the Government is paying for legitimate health care services. Applying the principles described above as the framework will identify new ways to protect the integrity of the programs, meet needs of beneficiaries, and keep Federal health care programs solvent for future generations.

Statement of

JAMES G. SHEEHAN
MEDICAID INSPECTOR GENERAL
NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL

before

COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS
SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT,
GOVERNMENT INFORMATION, FEDERAL SERVICES,
AND INTERNATIONAL SECURITY

on

Eliminating Waste and Fraud in Medicare and Medicaid

April 22, 2009

Office of the Medicaid Inspector General

Committee Chair Senator Carper, Ranking Member Senator McCain, and all committee members present, I appreciate the opportunity to appear today to talk about the New York Office of the Medicaid Inspector General, known as OMIG, and our approach to the issue of Medicare and Medicaid fraud, abuse, and waste.

OMIG is New York's Medicaid program integrity agency. We have 600 employees working on audits, investigations, data mining and analysis, and program exclusion, in the Nation's largest Medicaid program (over $46 billion per year). We work in partnership with the New York Department of Health which administers New York's Medicaid program, and the New York Medicaid Fraud Control Unit. I have been the Inspector General for two years, after spending 27 years in the Department of Justice, working primarily on health care fraud. During that time, I handled or supervised over 500 Medicare, Medicaid, and OPM fraud matters.

Today I want to talk about the approach New York is taking to Medicaid program integrity. Measured by fraud and abuse recoveries reported to CMS, New York was the most successful state in the nation in Medicaid program integrity over the past year, identifying recoveries of over $550 million. This success results from the commitment of state elected officials and state agencies, and the support of federal agencies. It is also the result of congressional, media, and legislative attention in 2005 and 2006 to the significant failures of New York Medicaid oversight.

Although we have been successful in identifying significant recoveries, New York's long-term program integrity goal is to prevent and to detect improper payments. In working toward that goal, we have reviewed the approaches of other program and oversight agencies, the work of Congress in oversight, the scholarly literature, the reports and results of government contractors and think tanks, and the analysis of trade, professional, and advocacy groups as well as New York's (and my) own experience.

Based on our review, opportunities exist for significant improvements which will reduce program costs, reduce collateral costs to providers, and improve outcomes.

The public health care system suffers significant losses from improper payments to large organizations where individual responsibility can be difficult to assign:

- The laboratory company which bills the program for an unreliable test whose results cause patients to get unnecessary surgery;
- The pharmaceutical company which fails to disclose that its product causes weight gain and diabetes in significant numbers of patients;
- The pharmacies which provide "home-delivered" prescriptions to patients who died weeks or months before;
- The nursing homes that bill the Medicaid program for the cost of the administrator's Lexus or Mercedes on the theory that they are occasionally used for patient transport;
- The managed care plans and hospitals that bill Medicaid for prenatal services for males;

- The mental health services facility that bills Medicaid for "patient management" to take a patient shopping at the Dollar store;
- The transportation company that bills Medicaid for patients who are dead, or hospitalized, or in a nursing home, or incarcerated at the time the outpatient services were allegedly rendered:
- The providers who credit a refund when an agency review identifies an overpayment, and then rebill the State for the same services six months later.

At best, investigations of improper payments, when they involve large organizations and the potential for intentional conduct, have followed a predictable course. They are investigated for many years, eventually resulting in a criminal declination or an indictment which will have a very limited effect on the provider (a defunct subsidiary or a non-program misdemeanor), payment of large amounts of money in a civil settlement, and a corporate integrity agreement to address future conduct. By the time the settlement occurs, the individuals who were in charge at the time have moved on, and the business models have changed. The government issues a press release stating "Providers that attempt to defraud federal insurance programs will be held accountable to the full extent of the law." The defendant issues a press release announcing "This settlement resolves a five-year old government investigation, and puts it behind us." The stock goes up. I know this because I have worked on many of these cases.

We think there is a better way to address these issues. We need to move from a system which encourages some providers to look for excuses to a system which requires and supports having an effective and appropriate billing and compliance systems in place. Too often, law enforcement and oversight agencies describe the task of enforcement as "combating" rather than preventing fraud and waste. This focus means that agencies describe their goals "to conduct" investigation and "facilitating enforcement" (from the program goals section 2007 Health Care Fraud Abuse Control Program). We need to move to a system which makes program integrity a major goal of oversight, investigative, and prosecutive efforts.

- First, require and support effective corporate compliance programs and professional compliance officers. New York requires by law that larger providers have an effective compliance program, with eight elements. The Medicare program suggests model compliance programs. We want health care providers to identify and resolve issues themselves; the best already do.

- Second, hold senior executives and board members accountable for failing to have systems to prevent improper billing. Corporate and non-profit law requires boards to have systems in place "reasonably likely to detect and prevent" violations of law. The Office of Inspector General (HHS) has done a great job of articulating its expectations for board members of hospitals and nursing homes. We need to assure that the focus of program integrity efforts is on systems control failures by management and the board as well as wrongful intent.

- Third, elevate, support and use the administrative tools of payment suspension, pre-payment review, audit, sanction, and individual and entity exclusion when improper payments are discovered. All too often, these remedies are deferred pending the outcome of the extended criminal investigation-this means that we keep providers in the program who are most likely to be collecting improper payments and continue to pay those providers. In New York, we have significantly expanded the use of pre payment reviews, payment suspensions and individual and entity exclusions.

- Fourth, recognize that the most effective deterrence requires regulator communication to and persuasion of those whose behavior we are trying to influence. Most health care providers are risk-averse; "expected severity of sanctions does not predict compliance" (Braithwaite: 2005). CMS historically has advised individual providers of their ranking in use of specific codes of concern. Frequent and predictable interventions for providers are more effective than occasional severe sanctions.

- Fifth, develop and communicate consistent measures of effectiveness of program integrity which capture cost reduction and avoidance as well as recoveries, and minimize costs imposed by reviews and investigations. Measuring program integrity by recoveries alone, or by prosecutions alone, or by the cost of auditors divided by their recoveries does not give a clear picture of what is expected or of what is being accomplished.

- Sixth, recognize incentives which cut against effective program integrity. CMS currently requires states to repay the federal share of identified Medicaid recoveries as soon as they are identified (Section 1903 (d)(2)(A) of the Social Security Act, 42 U.S.C. 1396b (d)(2)(A). This discourages states from investing in program integrity efforts against program providers who are in financial difficulty and will be unable to repay identified overpayments. Let the state and federal governments face the same risk of non-payment from providers who have obtained improper payments, or provide an enhanced percentage to states for identified overpayments.

On behalf of OMIG and New York, I want to thank you for the opportunity to present this testimony today.

For additional information, please check our website www.omig.state.ny.us, or I can be reached at 518-473-3782, jgs05@omig.state.ny.us.

APR-21-2009 17:35 CMS OFFICE OF LEGIS 2022055157 P.01

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Office of Legislation
200 Independence Avenue SW
Washington DC 20201
Ph. 202-690-5960
Fax 202-690-8168

Date: 4/21/09 #pages: 4 (including cover)

TO: Claire McCaskill	FAX# 202-228-6326	PHONE#

FROM: Charlene Frizzera, Acting Administrator, CMS; Staff contact: Greg Jones, OL	FAX#	PHONE# 202-690-8326

MESSAGE: Attached you will find CMS' response to Sen. McCaskill's 1/16/09 letter to CMS regarding Audits of the Part D program.

Please contact me w/any questions
202-690-8326
GREG Jones

04/21/2009 5:34PM

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

APR 21 2009

The Honorable Claire McCaskill
United States Senate
Washington, DC 20510

Dear Senator McCaskill:

Thank you for your letter regarding audits of the Medicare Prescription Drug program (Part D program). As explained in further detail in the enclosed document, the Centers for Medicare & Medicaid Services (CMS) has contracted for all scheduled 2006 audits and will complete contract award for all 2007 audits in May 2009. We expect that all 2006 and 2007 audits will be completed by early 2010.

It is important to note that bid reviews occur during the contract year, payment reconciliation begins 7 months after a contract year closes, and financial audits occur after reconciliation is complete. We believe that each element of the process has a particular purpose and together these elements safeguard Medicare expenditures and protect beneficiaries. The enclosed document responds to the questions you raised in your letter.

I appreciate your interest in the Medicare program. CMS will continue to monitor the program and make adjustments as necessary.

Sincerely,

Charlene Frizzera

Charlene Frizzera
Acting Administrator

Enclosure

Responses to Questions Regarding Part D Audits

Question 1
How many financial audits for 2006 have been started as of January 2009? How many completed?

CMS Response
As of April 20, 2009, CMS contractors had begun 148 and completed 50 of the required 165 audits for contract year 2006.

Question 2
If not all 165 required financial audits have even been initiated, why not?

CMS Response
Due to financial constraints, CMS awarded contracts to perform 2006 audit work in separate fiscal years. Contracts to perform 81 audits were awarded in September 2007. Contracts for the remaining audits were awarded in September 2008. In addition, in September 2008, CMS awarded contracts to perform 87 of the required 188 audits for 2007. The CMS plans to award contracts for the remaining 2007 audits in May 2009. The CMS expects to have all of the 2006 and 2007 financial audits completed by early 2010.

In addition, audits cannot be conducted until the Part D payment reconciliation is completed which is seven months after the benefit year has closed. The final payment reconciliation is a crucial element in the financial audits and without data submitted during the final reconciliation, audits cannot be initiated. So the earliest 2006 Part D audits could be started was approximately September 2007 which is when CMS contracted to begin the audits.

Question 3
What is the status of CMS' efforts to ensure overpayments identified in financial audits are recovered, including a description of structures or sanctions that are in place?

CMS Response
The CMS is working to determine the appropriate follow-up actions to the audit reports. In the event that the financial audits reveal a need for recoveries, CMS will follow the usual process for recouping overpayments from contractors; e.g., sending a demand letter and offsetting future payments.

Question 4
Please explain what regulatory or statutory changes are needed, if any, to hold plans accountable for submitting accurate bids.

CMS Response

The CMS requires bids to be prepared in accordance with Actuarial Standards of Practice (ASOP), to be certified by a qualified actuary, and to have undergone a detailed actuarial review before they are approved. Plans must demonstrate that they followed the ASOP, and the instructions and guidance, for completing the bids throughout the review process. The bid review process is predominately a statistical analysis focused on outliers. Errors or unacceptable methods identified during the review process must be corrected before the bid can be approved. In addition to the actuarial attestations and bid reviews, plans are held accountable to those projections since they serve as the basis of the payment reconciliation process.

After bids are approved, CMS randomly selects Part D organizations for a bid audit. The bid audits look at the details of how the bid was developed. If a bid audit identifies any area that did not meet standards, a finding is noted which must be addressed in subsequent bid submissions. In addition, if CMS should identify any significant misrepresentations or fraud as a result of the bid audit, CMS has procedures in place and will address any plan noncompliance and will forward information regarding the finding to the appropriate law enforcement agencies.

Question 5
Please provide a description of how recipients can request reimbursement for excess premiums they have paid.

CMS Response
Because the plan sponsor is required to deliver the benefit in compliance with CMS requirements and at the beneficiary cost level submitted in the final bid. This means the beneficiary knows the premium cost before enrolling in the plan. Furthermore, beneficiaries have access to detailed plan information; therefore, if a beneficiary is not satisfied with a plan's premium, the beneficiary may enroll in a less expensive plan for the coming year.

Finally, if a structure could be established that would allow beneficiaries to request a refund of "excess premiums paid" when a plan sponsor performs better than expected, then the reverse would likely have to be true as well. When a plan sponsor did not perform as well as it expected, then beneficiaries might receive a bill from an under-performing plan for added premiums after reconciliation. Such a result would be contrary to CMS' goal of promoting a system that establishes beneficiary protection and program stability.

Prepared Statement of Jack Holt
CEO/COO, S3 Matching Technologies
April 22, 2009

For the Senate Committee on Homeland Security and Governmental Affairs
Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security
Hearing on Eliminating Waste and Fraud in Medicare and Medicaid

Chairman Carper, Ranking Member McCain, and Distinguished Committee Members:

On behalf of S3 Matching Technologies, we appreciate the opportunity to share our views on the critical topic of Medicare and Medicaid waste, fraud and abuse. We applaud your leadership in highlighting this important problem, which threatens to sap the Medicare and Medicaid programs of limited resources and thereby jeopardize health care services for beneficiaries in greatest need.

I. Introduction

S3 Matching Technologies is an Austin, Texas based company focused on providing data quality management software for the IT, telecom, financial services, and health care industries. S3 invented TeraMatch®, the first ever hybrid algorithmic and rules-based matching engine. The company provides mission critical data services to numerous Fortune 50 enterprises and has partnered successfully with a large State Medicaid Agency to use its advanced information technology to prevent fraud and abuse in the Medicaid program.

Conservative estimates by the National Health Care Anti-Fraud Association indicate that more than $68 billion is lost each year to fraud, seriously threatening the Medicare and Medicaid programs. While some controls exist to reduce this risk, they are applied inconsistently, are easily bypassed, and focus on recovering improper payments rather than preventing them – essentially relying on a "pay-and-chase" model focused on audits and recovery efforts.

Clearly, a more cost-effective approach would be to prevent fraudulent or improper payments in the first place, and advanced information technology can accomplish that objective. Specifically, available tools can prevent excluded providers from enrolling or reenrolling in Medicaid and Medicare and give honest providers the ability to conduct meaningful self-audits in real time.

II. Advanced Information Technologies Can Prevent Fraud and Improper Payments

A. Ensuring Accurate Verification Prior to Provider Enrollment

Many factors currently inhibit meaningful fraud prevention efforts. One significant problem is the inability to track providers who have already been excluded for fraudulent, wasteful, or abusive practices. Currently, provider names are not added to the Department of Health and Human

Services Office of Inspector General (OIG) list of excluded providers and the General Services Administration (GSA) debarment list in a timely manner. Further, fraud schemes often cross state lines, and excluded providers frequently simply move from one state to another and continue their fraudulent practices.

While States are required to perform a check of the federal exclusion list before enrolling providers in Medicaid, there are no minimum standards. This enables excluded health care providers to make simple changes to distinguishing information and thereby re-enter the Medicaid provider network. States' failure to consistently share information on excluded providers allows providers to simply cross state lines and continue to defraud the Medicaid program.

This situation also impacts Medicare by reducing the visibility of providers demonstrating patterns of fraud at the state level. The combination of insufficient controls and the lack of interstate information-sharing thus contribute to the "pay-and-chase" approach to fraud, create unnecessary costs and administrative burdens, and divert scarce resources from the delivery of health care services.

Innovative information technology solutions, such as advanced matching technology, can enable the states and the Federal government to detect and prevent fraud. Accurate, real-time technologies can actually stop improper payments before they occur and identify signs of fraud earlier than current auditing techniques.

Advanced technology systems can recognize subtle distinctions in data to identify providers with multiple identification numbers, to recognize duplicate entries, or to distinguish inadvertent errors from intentional fraud. These real-time, interactive capabilities can match an individual to all of the excluded provider lists at once, through a single point of service.

These technologies interface with centralized reporting centers to consolidate exclusion data and digitally fingerprint each transaction to identify internal fraud and ensure program compliance. Automation improves the quality and completeness of accreditation lists to speed the enrollment process for valid providers, thereby expanding available provider coverage for beneficiaries. These advanced technology systems can also prevent fraud by improving the recognition of improper claims prior to payment through enhanced analysis and sophisticated matching of claims patterns.

The number of providers on the federal exclusion list and the quality of self-reported data make it impractical to perform this validation without the use of advanced information technology that can recognize both exact and similar matches across any number of databases. Such technology has been used in the private sector and on a limited basis in the Medicaid program to identify both new and currently enrolled providers who should be excluded.

In fact, we estimate that advanced data verification systems could save the Medicaid and Medicare programs more than $500 million dollars each year (based on internal analysis by S3 Matching Technologies) by preventing thousands of ineligible providers from fraudulently billing the programs.

B. Facilitating Provider Self-Audits

Advanced information technologies can also prevent improper payments by giving providers the tools they need to conduct self-audits to detect "bad actors" in their systems and to identify inadvertent overpayments. A more effective self-auditing system could greatly increase program compliance, while lessening the burden of third-party audits and reducing the potential for liability.

Self-disclosing overpayments, in most circumstances, would produce a better outcome for providers than independent discovery by third-party auditors. Allowing providers the opportunity to reliably self-audit will encourage them to work in partnership with state and federal agencies to help capture overpayments without the threat of costly lawsuits.

Today, however, many providers may be hesitant to utilize available tools without clear guidance from federal and state regulators. By facilitating providers' selection and use of available information technologies, the federal government could vastly improve the integrity of the Medicaid and Medicare programs and help dollars flow back to state and federal coffers.

III. Policy Recommendations for Congress:

To achieve these important objectives, we respectfully submit the following policy recommendations for the Committee's consideration:

- Congress should strengthen the provider enrollment process by integrating Medicare and Medicaid exclusion lists in a standardized, real-time manner utilizing advanced information technologies.
- Congress should also establish more stringent screening procedures to prevent excluded Medicaid or Medicare providers from enrolling or reenrolling, including a review of other relevant records such as delinquent taxes, licensing verification, death registries, business registrations and sex offender registries.
- States play a key role in fraud prevention, and they should be required to remove providers from the Medicaid and Medicare network if they become excluded providers; and timely report excluded providers to the federal List of Excluded Individuals/Entities (LEIE).
- Congress should also provide financial incentives and technical assistance to assist states in adopting best-practice information technology solutions to detect fraudulent providers and to identify improper claims before they are paid.
- To ensure that states take these crucial fraud prevention steps, Congress should establish meaningful penalties for state noncompliance with federal requirements.
- Congress should also direct the Secretary of Health and Human Services to establish a process for certifying advanced information technologies for provider self-auditing purposes under Medicare and Medicaid.

IV. Conclusion

On behalf of S3 Matching Technologies, thank you for considering our views. We are grateful for the Committee's efforts to eradicate waste, fraud, and abuse in the Medicare and Medicaid programs, and we believe that advanced information technologies hold enormous potential to help

solve those vexing problems. We look forward to working with Members on these important issues and would be glad to provide any additional information or assistance you may require.

Respectfully submitted,

Jack Holt, CEO / COO
S3 Matching Technologies

United States Government Accountability Office
Washington, DC 20548

July 20, 2009

The Honorable Thomas R. Carper
Chairman
The Honorable John McCain
Ranking Member
Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable Tom Coburn, M.D.
United States Senate

Subject: *Improper Payments: Responses to Posthearing Questions Related to Eliminating Waste and Fraud in Medicare and Medicaid*

On April 22, 2009, we testified[1] before your subcommittee at a hearing entitled, "Eliminating Waste and Fraud in Medicare and Medicaid." At that hearing, we discussed federal agencies' progress in estimating and reducing improper payments, as well as existing challenges for federal agencies to fully meet the requirements of the Improper Payments Information Act of 2002 (IPIA).[2] Further, our testimony provided an overview of implementation of IPIA with respect to the Medicare and Medicaid programs by the Centers for Medicare and Medicaid Services (CMS), a component of the Department of Health and Human Services (HHS).

This letter responds to a May 29, 2009, request for responses to questions for the record related to our April 22, 2009, testimony. Our responses are based on work associated with previously issued GAO reports (see Related GAO Products at the end of this correspondence), data included in HHS's fiscal year 2008 annual financial report (AFR), and data reported for fiscal year 2008 by CMS. We conducted our work from May 2009 to July 2009 in accordance with all sections of GAO's Quality Assurance Framework that are relevant to our objectives. The framework requires that we plan and perform the engagement to obtain sufficient and appropriate evidence to meet our stated objectives and to discuss any limitations in our work. We

[1]GAO, *Improper Payments: Progress Made but Challenges Remain in Estimating and Reducing Improper Payments*, GAO-09-628T (Washington, D.C.: Apr. 22, 2009).

[2]Pub. L. No. 107-300, 116 Stat. 2350 (Nov. 26, 2002).

believe that the information and data obtained, and the analysis conducted, provide a reasonable basis for any findings and conclusions in this product. Your questions, along with our responses, follow.

1. *What do you see as the biggest challenge for CMS to provide an estimate for improper payments under Medicare Part D?*

With total outlays of about $46 billion in fiscal year 2008, Medicare Part D is the last significant part of Medicare for which the department has yet to develop an estimate of improper payments. CMS testified in April 2009 that it is on track to develop that methodology, but a completion date was not provided. We have not yet evaluated CMS's current efforts to develop a methodology for estimating improper payments associated with Medicare Part D (Prescription Drug Benefit).

In developing its estimate, it will be important for CMS to determine where the vulnerabilities and risks exist in the Medicare Part D structure and operations that could impact CMS's ability to effectively detect, measure, and ultimately reduce improper payments. In HHS's fiscal year 2008 AFR, the department reported that it had calculated payment error rates for two components of Medicare Part D but also that its measurement was not fully implemented. Also, it will be important to consider HHS's Office of Inspector General (OIG)-identified concerns about CMS's implementation of internal controls to ensure payment accuracy as well as inadequate analysis of claims data.

2. *Has GAO identified any problems with the current process for reviewing and paying Medicare claims that would make the program more vulnerable to fraudulent claims?*

We have identified several weaknesses with the current process for reviewing Medicare claims. Limitations in the number of medical reviews conducted leave the home health benefit—within the Medicare program—vulnerable to improper payments, including payments resulting from fraud and abuse. We reported in February 2009 that in fiscal year 2007, only 0.5 percent of the more than 8.7 million home health agency (HHA) claims processed were subjected to prepayment review by Medicare's contractors.[3] The contractors focused primarily on claims submitted by HHAs whose billing patterns differed from their peers on measures such as cost per episode. Of those claims that were reviewed, over 40 percent were denied in whole or in part. Furthermore, the contractors rarely performed postpayment medical reviews to recover funds previously paid in error, even when the HHA was identified as billing improperly through prepayment review. Thus, although the limited claims-review process that was performed was valuable in reducing potential improper payments, the extent of errors found would suggest that both prepayment

[3]GAO, *Medicare: Improvements Needed to Address Improper Payments in Home Health*, GAO-09-185 (Washington, D.C.: Feb. 27, 2009).

and postpayment medical reviews should be increased to more effectively avoid or recoup overpayments.

There are also weaknesses with respect to selecting claims to review in Medicare Fee-for-Service. In January 2007, we reported on shortfalls in the automated prepayment controls that are used to deny durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) claims that should not be paid or to identify claims that should be reviewed.[4] For example, CMS's contractors responsible for the medical review of these claims did not have edits with predesigned thresholds in place to identify claims for review that were part of an atypical increase in billing.[5] Further, there are weaknesses in monitoring home health agencies' claims. We found that CMS did not routinely send verification of services billed by the HHAs to the authorizing physicians, to determine whether the type and frequency of home health visits were consistent with what physicians had authorized.[6]

In addition to the weaknesses with the current Medicare claims review process, we found that failure to effectively screen health providers before granting them billing privileges also increases the program's vulnerability to fraudulent claims. In September 2005, we reported on weaknesses in standards, procedures, and oversight of the screening process for DMEPOS suppliers,[7] which could leave the program vulnerable to fraudulent claims activities. Despite some improvements, in July 2008, we reported on deficiencies in CMS's enrollment and inspection process for DMEPOS suppliers that would allow them to fraudulently bill Medicare for unnecessary supplies or supplies from nonexistent suppliers.[8] As part of our investigation, we created fictitious DMEPOS companies to which CMS granted billing privileges despite having no clients and no inventory. Those billing privileges could have allowed the fictitious companies to bill Medicare for potentially millions of dollars for nonexistent supplies. We also reported that criminals who create similar fictitious DMEPOS companies typically steal or illegally buy Medicare beneficiary numbers and physician identification numbers and use them to repeatedly submit bogus claims. HHS acknowledged that CMS's oversight of DMEPOS suppliers contains gaps in oversight that still require improvements. In addition, we identified issues with screening potential and current home health agencies that may enable problem providers to enter and remain in the Medicare program. For example, we reported

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[4]GAO, *Medicare: Improvements Needed to Address Improper Payments for Medical Equipment and Supplies*, GAO-07-59 (Washington, D.C.: Jan. 31, 2007).

[5]Due to the absence of the threshold edits, we found that from the first quarter of 2003 through the first quarter of 2005, 225 suppliers increased their billing to Medicare by $500,000 and 50 percent from at least one 3-month period to the next.

[6]GAO-09-185.

[7]GAO, *Medicare: More Effective Screening and Stronger Enrollment Standards Needed for Medical Equipment Suppliers*, GAO-05-656 (Washington, D.C.: Sept. 22, 2005).

[8]GAO, *Medicare: Covert Testing Exposes Weaknesses in the Durable Medical Equipment Supplier Screening Process*, GAO-08-955 (Washington, D.C.: July 3, 2008).

that CMS does not require its home health contractors responsible for screening applications to verify the criminal history of persons named on the application.

Health care fraud is a serious financial drain on our health care system. HHS reported in its fiscal year 2008 AFR that an estimated $17.2 billion of Medicare Fee-for-Service and Medicare Advantage claims were improperly paid for reasons such as medically unnecessary services and insufficient documentation. It is unclear how much of this estimate resulted from fraudulent claims. Our work to uncover vulnerabilities to fraud in the Medicare program focused on specific areas as discussed above; consequently, opportunities for fraud may also exist in other areas of the Medicare program.

3. *Is there any reason CMS cannot include penalties in its Medicare Administrative Contractor contracts for paying improper or fraudulent claims that you are aware of?*

Consistent with the Social Security Act[9] and applicable federal procurement regulations, CMS may include provisions in Medicare Administrative Contractor (MAC) contracts to: (1) prescribe the costs incurred by MACs in processing and paying Medicare claims that CMS may reimburse; (2) provide incentives or disincentives related to payment accuracy; and (3) hold MACs and their employees liable for improper or fraudulent claims payments under limited circumstances.[10] Otherwise, neither the Social Security Act nor applicable federal procurement regulations expressly provides for CMS to reduce amounts owed to MACs under their contracts or to assess charges against MACs for improper or fraudulent claims payments.

The MAC contracts contain requirements for MACs to take certain actions and implement certain plans to manage Medicare trust fund finances and achieve

[9]Act of Aug. 14, 1935, ch. 531, 49 Stat. 620, as amended, 42 U.S.C. secs. 301 et seq.

[10]As required by section 911 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), CMS is replacing its Medicare Part A and Part B claims payment contractors (fiscal intermediaries and carriers) with MACs. This process must be completed by October 1, 2011. On behalf of CMS, MACs provide Medicare Part A and Part B claims processing and benefit payment services for providers and suppliers, among other functions. CMS awards cost-plus-award-fee type contracts to MACs, meaning that MACs are reimbursed for their allowable, allocable, and reasonable costs plus an award fee, up to amounts prescribed in the contracts, calculated using criteria in an award fee plan, in addition to a base fee amount. These contracts generally are subject to the Federal Acquisition Regulation (FAR), which includes rules, standards, and requirements for the awarding, administration, and termination of government contracts.

payment accuracy.[11] Under the MAC contracts, CMS reimburses MACs for the allowable, allocable, and reasonable costs of these efforts. While not considered a penalty, CMS may disallow any costs claimed by a MAC related to claims and payment processing, including finance and payment management, that fail to meet these standards.[12]

The Secretary of HHS is authorized to develop MAC-specific performance requirements and provide incentives to MACs to provide quality service and promote efficiency.[13] This is consistent with provisions in the Federal Acquisition Regulation, subpart 16.4, that authorize the use of positive and negative incentives in incentive-type, cost-reimbursement contracts. These provisions appear to authorize performance standards in the MAC contracts related to making proper payments that would be considered in determining the amount of the fee earned by the contractor under a cost-plus-award-fee type contract or other incentive-type contract, as mutually agreed to by both the government and the contractor.

CMS has developed mechanisms—within the framework established by the statute—to encourage MACs to perform effectively and efficiently such as establishing an award fee program.[14] Currently, we have ongoing work to examine how CMS has assessed the performance of the MACs. During our preliminary work, we noted that CMS has developed specific performance metrics as part of the award fee program to provide an incentive for MACs to achieve desired results. One of those metrics includes measuring a MAC's payment accuracy and ability to reduce improper claims payments. Because the MAC contracts have been awarded relatively recently, it is too soon to evaluate the effectiveness of providing an award fee for meeting a payment-accuracy metric.

With respect to improper or fraudulent benefit payments made by a MAC, section 1874A(d)(3) of the Social Security Act provides that a MAC shall not be held liable to the United States for payments made by its certifying or disbursing officers unless the MAC acts with reckless disregard of its contractual obligations or with intent to defraud the United States. It also provides that this exemption from liability does not

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[11]Under section 1874A of the Social Security Act, as amended by section 911 of MMA (42 U.S.C. § 1395kk-1), and the terms of their contracts with CMS, MACs receive and review Medicare Part A and Part B claims and approve those that comply with applicable laws, regulations, and CMS policies. To cover claims paid, the MACs draw on funds from a benefits account held by the commercial bank. CMS issues a letter of credit to authorize the funds into the benefits account. Payments may be made only by disbursing officers designated in writing by the MAC, based on the authorization of a separate certifying officer designated in writing by the MAC. (MACs are required by their contracts to account for benefit payments separately from their administrative costs.)

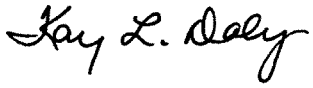
[12]Agencies may assess penalties for indirect costs submitted for payment that contain indirect costs expressly unallowable or determined unallowable pursuant to FAR §§ 42.709 through 42.709-6.

[13]42 U.S.C. § 1395kk-1(b).

[14]CMS also employs other tools to detect improper payments and fraud in the Medicare payment system, such as engaging Program Safeguard Contractors under the Medicare Integrity Program and Recovery Audit Contractors.

extend to violations of the False Claims Act.[16] The False Claims Act authorizes a court to impose a civil penalty on a person for certain acts, including knowingly presenting or causing to be presented to an officer or employee of the United States a false or fraudulent claim for payment or approval.

We are providing copies of this correspondence to interested parties. This correspondence is also available on GAO's home page at http://www.gao.gov. Should you have any questions on matters discussed in this correspondence or need additional information, please contact me at (202) 512-9095 or by e-mail at dalykl@gao.gov.



Kay L. Daly
Director
Financial Management and Assurance

[16]31 U.S.C. §§ 3729-3731. Individual certifying and disbursing officers are afforded the same exemption from liability.

Senate Homeland Security and Government Affairs
Subcommittee on Federal Financial Management

Hearing "Eliminating Waste and Fraud in Medicare and Medicaid"

Questions for the Record
April 22, 2009

Senator Tom Coburn, M.D.

Questions for Ms. Deb Taylor, CMS

Budget Cuts:

- **Are Medicare and Medicaid expected to trim their budgets in response to the President's call for all cabinet agencies to go through spending line-by-line and make cuts?**
- **What programs at CMS do you believe are the best candidates for cuts right now?**
- **When will these cuts be made and when can we expect to see them?**

Answer:
Like other participants in the health delivery system, Medicare and Medicaid need improvements to emphasize efficiency, quality and accountability. A number of proposals to do so are included in the President's Budget Overview (released February 26, 2009), with the savings from these proposals set aside in a health care reform reserve fund. One of our top priorities is to modernize Medicare and Medicaid to make them leaders in value-based purchasing and quality.

Some of the President's Budget proposals to reduce spending in Medicare include aligning incentives toward quality, promoting efficiency and accountability, and encouraging shared responsibility. Specifically, the Administration proposes aligning hospital incentives toward quality of care provided, reducing hospital readmission rates, and enabling physicians to form voluntary groups to coordinate care for Medicare beneficiaries. Some of the ways the President plans to promote efficiency and accountability in Medicare include establishing a competitive bidding system in Medicare Advantage, bundling Medicare payments for inpatient hospital services and post-acute services, and ensuring that Medicare makes appropriate payments for use of radiology services. In addition, investments in Medicare program integrity activities will reduce fraud in the program.

To improve efficiency and accountability in the Medicaid program, the President's Budget proposes increasing rebates on prescription drugs to reduce overall costs for the Federal and State governments, increasing access to family planning services for low-income women, and improving Medicaid program integrity.

Post-Payment Review Process:
My understanding is that CMS typically pays for claims and then reviews those payments only afterward in a "post-payment" review process. What is the percentage of claims reviewed during the post-payment review process?

Answer:
Much of our effort to ensure accurate payments and reduce improper payments is focused on front end approaches such as prepayment review and provider education. More than 99 percent of the medical review (MR) we conduct is completed pre-payment. The most frequent MR activity is contractor front end edits. In FY 2008, Medicare processed over a billion claims of which approximately 2.5 percent were subjected to some level of medical review.

In addition to their work on prepayment review, Medicare Administrative Contractors (MACs) conduct complex post-pay probe reviews and post-pay complex review. Post-pay medical review allows the contractor to make a determination to deny a claim (in full or in part) and assess an overpayment. In FY 2008, over 55,000 post-pay complex reviews were conducted. The percentage of post-payment review is subject to change with the implementation of the Recovery Audit Contractors (RACs) review of claims exclusively on a post payment basis. During the 3-year demonstration project, the RACs conducted post-pay complex review on close to 500,000 claims and returned $693.6 million to the Medicare Trust Funds, as of March 2008. In addition to RAC reviews, each year approximately 130,000 claims are subjected to post-pay complex review as part of our Comprehensive Error Rate Testing program. Program Safeguard Contractors also conduct post-pay reviews as part of fraud case development.

What percentage of the post-payment reviewed claims has been identified as improper or fraudulent?

Answer:
CMS does not report the post-payment reviewed claims in terms of improper or fraudulent percentage amounts. Rather, CMS monitors savings garnered from post payment review.

CMS reports hundreds of millions of dollars are deemed "currently not collectable" each year. Where do these figures come from?

Answer:
The "currently not collectable" (CNC) amounts are account receivable amounts reported by the Medicare contractors (those that process claims on behalf of CMS) based on CMS' established policy. CMS reports this financial information to Treasury in accordance with OMB guidance (OMB Circular A-129, Managing Federal Credit Programs) and Agency policy. This guidance allows an agency to move certain uncollectable delinquent debt into memorandum entries, which removes the receivable from the financial statements. CNC debts accumulate over time. It is CMS' policy that all accounts receivable being reported by the Medicare contractors that are 180 days delinquent with no collection activity must be recommended for CNC reclassification. CNC is classified into 5 aging categories: 181 days to 1 year, 1 to 2 years, 2 to 6 years, 6 to 10

years, and over 10 years. CNC debts are mainly for accounts receivables that pertain to terminated providers. These providers are no longer billing Medicare so we have no opportunity to initiate offsets on subsequently submitted claims. These debts will continue to be referred for collection and litigation, but they are not recognized as accounts receivable for financial statement reporting purposes because of the unlikelihood of collecting. Although these debts are deemed uncollectible, CMS continues to track them. The CMS policy is to use the collection tools of the Debt Collection Improvement Act of 1996, thus allowing delinquent debt to be worked until the end of its statutory collection life cycle.

What is CMS doing to improve the collection and return of these funds to Medicare?

Answer:
Overpayments are Medicare payments a provider or supplier has received in excess of amounts due and payable under the statute and in regulations. Once CMS establishes that an overpayment exists, providers are informed of the amount owed and their appeal rights. CMS uses a variety of tools to collect debts owed to the Medicare program. For instance, CMS can directly offset claims, establish extended repayment schedules, refer debts to the Treasury, offset or other cross-servicing efforts, and litigation (if appropriate).

Medicare contractors collect the majority of our debt by offsetting claims against the debt. Medicare contractors apply present and future Medicare payments to a provider's debt. CMS also offsets Medicare debt by withholding and applying the Federal share of funds due to the provider from a non-Medicare source, such as Medicaid. Debts that are over 180 days delinquent are subject to the Debt Collection Improvement Act of 1996 (DCIA). Under the DCIA, CMS refers all eligible debts over 180 days delinquent to Treasury for collection. Treasury uses a variety of collection tools including: sending additional demand letters; including debts in the Treasury Offset Program (TOP); referring debts to Treasury-contracted private collection agencies; negotiating repayment agreements; and, referring some debts to the Department of Justice for litigation. Please note that while debts classified as "currently not collectible" are not reported on the financial statements, the collection process for these debts permits and requires the continued use of applicable collection tools, including the DCIA process. This allows delinquent debt to be worked until the end of its statutory collection life cycle.

What can Congress do to ensure these payments are not made in the first place, or that these funds can be collected?

Answer:
For FY 2009, Congress appropriated additional funds to the Health Care Fraud & Abuse Control (HCFAC) account, and the Administration has again requested a discretionary allocation adjustment in the President's FY 2010 Budget. We will use funds appropriated by Congress to build upon our work to date, to more rapidly respond to emerging program integrity vulnerabilities, and to increase the effectiveness of our program integrity and medical review efforts. With additional resources, CMS will consider possible refinements to our medical

review program such as increasing the number of automated prepayment edits and increasing the number of complex prepayment reviews conducted by the MACs.

What does CMS intend to do to either strengthen the post-payment review program or develop a pre-payment review program to stop these payments from being made in the first place?

Answer:
CMS is strongly committed to protecting taxpayer dollars and ensuring the sound financial management of the Medicare, Medicaid, and CHIP programs. As evidenced by the testimony today, the Agency has taken action to meet the Improper Payments and Information Act (IPIA) standards in Medicare and is taking a number of proactive steps to become IPIA-compliant in Medicaid and CHIP. The Agency has strengthened Federal oversight and understanding of State financial practices through comprehensive State program integrity reviews, identifying problems that warranted correction or improvement in overall State operations and also highlighting commendable practices. Nineteen such reviews were completed in FY 2008. We have made progress, but there remains work to do to root out waste, fraud and abuse in the Medicare, Medicaid, and CHIP programs. In addition, CMS is currently in the process of implementing the Recovery Audit Contractor (RAC) program nationwide. These contractors will focus on the post-payment activity and will provide us with important information to inform our medical review program. CMS is also in the process of transitioning our 10 Program Safeguard Contractors (PSCs) to 7 Zone Program Integrity Contractors (ZPICs) to be more aligned with the Medicare Administrative Contractors (MACs) through competition. The ZPICs will focus on high-risk fraud areas. These contactors will also have access to consolidated Medicare program data through the Integrated Data Repository, which allows for enhanced data analysis and allows us to look at providers across the Medicare benefit programs.

For FY 2009, Congress appropriated additional funds to HCFAC and the Administration has again requested a discretionary allocation adjustment in the President's FY 2010 Budget. We will use funds appropriated by Congress to build upon our work to date, to more rapidly respond to emerging program integrity vulnerabilities and to identify and recoup improper payments.

CMS and the Administration fully support this Subcommittee's efforts, as a steward of taxpayer dollars, to improve the fiscal integrity of the Medicare, Medicaid, and CHIP programs.

CMS testified that the Recovery Audit Contractors recovered $900 million during the 3-year test of the program. What was the total the RACs identified as overpayment during that same time frame?

Answer:
During the Recovery Audit Contractor (RAC) demonstration, the RACs identified and demanded just over $1 billion ($1.03B) in Medicare improper payments. The RACs collected $992.7 million in overpayments and $37.8 million in underpayments. Even after subtracting the dollars

in refunded underpayments, overpayments overturned on appeal, and RAC demonstration operating costs, the RACs returned $693.6 million to the Medicare Trust Funds.

Was any part of the "currently not collectable" amounts mentioned in the Inspector General's Early Alert Memorandum for 2005 and 2006 part of the amount identified by the RACS?

Answer:
The currently not collectable amounts mentioned in the OIG Early Alert Memorandum for 2005 and 2006 (OEI-06-07-00080) were not identified by the RACs. The claims mentioned in the Early Alert Memorandum were from a sample of 10 DMEPOS suppliers in Texas and the RACs did not review claims submitted by Texas providers during the demonstration project. During the demonstration project, the RACs operated only in Florida, New York, and California.

What are the CNC figures for 2007 and 2008?

Answer:
CMS reports, quarterly to Treasury, the Medicare CNC amounts on the Treasury Report on Receivables (TROR). For FY 2007 and FY 2008, the CNC amounts were $7,968,910,186 and $8,960,373,135 respectively. These amounts are considered cumulative since the current fiscal year amount would include outstanding amounts from the prior fiscal year after accounting for any current fiscal year collections or adjustments.

Are there any provisions in the new Medicare Administrative Contractors (MAC) contracts that allow for penalties to be assessed when payments are made for fraudulent or questionable claims?

Answer:
By law, the MACs cannot be held liable for their Medicare claims payment activities unless they conduct their payment operations in a reckless or fraudulent manner, or otherwise violate sections 3729 through 3731 of Title 31 of the United States Code (see section 1874A(d)(3) of the Social Security Act). Congress included this substantial liability protection in the MAC statute in appropriate recognition of the scale, and exceedingly complex and dynamic nature, of the Medicare claims payment environment, and the difficulty associated with identifying fraudulent providers within this complex and dynamic environment.

Collectively, the Medicare claims processing contractors (MACs as well as legacy fiscal intermediaries and carriers) administer approximately 1.2 billion Medicare claims and disburse well in excess of $300 billion in program payments annually. These contractors execute their responsibilities at an administrative cost of less than $2 billion (i.e., less than 1% of payments). More than one million providers, practitioners, and suppliers bill the Medicare program, ranging from sophisticated institutions (e.g., hospital systems) to small businesses (e.g., some durable medical equipment suppliers). The MACs must understand and administer numerous billing

rules and payment systems and, due to statutory and regulatory changes, these systems are frequently changing – CMS issues nearly 400 changes to its Medicare program manuals each year. To properly administer Medicare claims, the contractors and their systems must also be capable of handling thousands of diagnosis, procedure, and other kinds of codes.

In the new MAC acquisition environment, CMS does have greater tools to incentivize strong MAC performance than it had in the former statutory environment. Whereas the fiscal intermediary and carrier contracts were framed on a straight cost-reimbursement basis, CMS is able to negotiate appropriate incentives into the MAC contracts in keeping with general Federal acquisition statutes. In particular, CMS measures improper Medicare FFS payments through a protocol known as the Comprehensive Error Rate Testing (CERT) program. CMS is actively working to incorporate this metric into the MAC FFS award fee plans.

What performance matrix is used by CMS to evaluate the performance of the Medicare Administrative Contractors?

Answer:
Oversight of Medicare Administrative Contractor (MAC) performance is conducted by means of performance assessment and performance monitoring. Performance assessment is supported by reviews of both contractor Quality Control Plans (QCP) and performance standards evaluated through the Quality Assurance Surveillance Plan (QASP) process. In addition, performance criteria exceeding standards published in each MAC Statement of Work (SOW) are evaluated in accordance with MAC Award Fee Plans. Performance monitoring is conducted through day-to-day oversight of the contractor by contract administration staff, including each MAC Project Officer (PO).

The SOW for each MAC establishes the requirement for a QCP, which is a contract deliverable. The QCP formally documents the framework for how a MAC will implement a quality management system and meet the established performance standards defined in the SOW. There are seven principal elements of a QCP including: documenting procedures and processes; documenting change management program to ensure that correct procedures and processes are followed; implementation of an inspection and audit system; providing for a method to identify nonconformance or deficiency in the quality of services performed; providing for a formal system to implement corrective action; implementing a system to maintain all quality records including inspections, audits and the corrective actions; and, providing for Government inspections and audits while work is in process or complete. The contractor is required to submit their QCP 45 days after contract award and yearly thereafter. CMS conducts on-site QCP reviews to assure that the provisionally approved QCP for each MAC is operating as defined and, if not, work through the Project Officer to have the contractor make the necessary changes to bring operations into compliance. Once validated by the on-site review, the QCP deliverable is formally accepted. As such, the QCP is a work product of the MAC.

The QASP is a sub-set of the performance standards in each MAC SOW. Using monthly performance monitoring as a guide, each lead business component (Appeals, Audit and Reimbursement, Provider Enrollment, etc.) select those performance standards which will be

evaluated once each contract year. Evaluations of performance standards selected for QASP reviews may be conducted either on-site or as desk audits. Results are reported to each Project Officer who works with other contract administration staff to implement Action Plans, as appropriate, for corrective action. As such, the QASP reviews support CMS' oversight of performance standards to ensure contractors are meeting the requirements as stated in the SOW. QASP reviews are conducted annually as part of the MAC oversight process. Both the QCP and QASP activities support MAC Performance Assessment.

The award fee evaluation is an annual evaluation that takes into account MAC performance against the standards identified in the Award Fee Plan. The standards in an Award Fee Plan establish stretch goals exceeding those in the MAC SOW. In addition to evaluating criteria established in the award fee, the Fee Determining Official (FDO) takes into account the MAC's overall performance on the contract when making an award fee determination and may, at his or her discretion, reduce the amount of the award fee under the contract, or determine not to make payment of any award fee, after such consideration.

The Project Officers, supported by contract administration staff as well as the business components, conduct on-going oversight and monitoring of MAC operational performance. The Project Officers are often on-site. In doing so, they take into account a variety of performance related information from both internal and external review activities. In addition to internal reviews (QCP and QASP), Project Officers evaluate the results from external audits such as SAS-70 and the Chief Financial Officer's Audit. Moreover, they monitor monthly performance information supplied by each MAC. This information is considered in its totality when developing the MAC's overall performance rating which is entered into the National Institutes of Health Contractor Performance System.

Senator John McCain

Questions for Ms. Deb Taylor, CMS

Please describe the pre-payment review process currently in place to mitigate improper payments for both Medicare and Medicaid.

Answer:
MEDICARE: Medicare Administrative Contractors (MACs) conduct several types of prepayment medical review. Each contractor establishes a medical review strategy based on analysis of their jurisdiction so that their efforts may be most effective in mitigating improper payments. Contractors decide how much of each type of review they will conduct based on their budget allocation. Automated review decisions are made at the system level, using available electronic information, without the intervention of contractor personnel. Routine reviews are conducted and requires the intervention of specifically trained nonclinical medical review staff. Prepay probe reviews are done to verify that the program vulnerabilities identified through data analysis actually exists and will require additional education and possible review. Prepay

complex review involves a licensed medical professional using clinical judgment to evaluate medical records

CMS also utilizes its benefit integrity (BI) contractors to conduct targeted prepayment review on high vulnerability providers in particular geographic areas. These reviews are intended to look at claims, and all supporting documentation, before they are paid in order to ensure they meet the Medicare requirements for payment. If they do not, it gives CMS additional information that, in conjunction with data analysis and other facts, can be used so that CMS can take administrative actions against the provider. This is a very resource intensive process as full medical records must be requested, obtained and reviewed prior to payment. Therefore, CMS is only able to utilize this approach for a limited number of providers.

The most effective way of preventing improper payments is through the enrollment process. The majority of the improper or fraudulent payments are made by providers who really should not have been admitted into the Medicare program. However, CMS currently has limited authority to keep these providers out. As a result, CMS has begun an aggressive onsite visit and pre-screening process to ensure the legitimacy of those individuals who seek to obtain a Medicare billing number. CMS is also utilizing its BI contractors to do more post enrollment visits to ensure that providers are maintaining compliance with Medicare enrollment requirements and then revoking their billing numbers when they are found to be noncompliant.

Finally, the presence of the CMS field offices in high vulnerability areas is an additional tool CMS utilizes to monitor areas where there are potentially fraudulent or improper payments. CMS field staff goes out to conduct interviews with providers and beneficiaries to verify that billed services were ordered and/or provided. This additional verification helps to identify areas for additional in-depth medical review if it appears that claims are being paid and the interviews indicate the services were not provided.

MEDICAID:
In the Medicaid program, the States have primary responsibility to conduct pre- and post-payment reviews to mitigate improper payments made to providers. In addition to the payment review activities performed by the States, the Deficit Reduction Act of 2005 created the Medicaid Integrity Program in section 1936 of the Social Security Act. The Act requires CMS to hire contractors to perform four key payment review activities: review of provider actions to determine whether fraud, waste, or abuse occurred or may have occurred; audit provider claims; identify overpayments; and, educate State or local employees involved in Medicaid administration, providers, managed care entities, beneficiaries and others with respect to payment integrity and quality of care.

Based on the results of provider audits and other Medicaid data analysis activities, CMS will provide feedback to States with regard to potential policy changes and/or system edits that the State(s) should implement to prevent improper payments from occurring in the future. System edits are one method that the States can use to conduct an automated pre-payment review of claims. Additionally, CMS is currently developing a prototype for a provider enrollment system that will allow States to screen providers seeking to enroll in Medicaid and identify suspect providers whose claims should be reviewed more closely prior to being paid.

CMS is planning to work with one of its Education Medicaid Integrity Contractors on other front-end initiatives with the goal of producing cost-savings to the Medicaid program while improving the quality of care for beneficiaries. Specifically, CMS will work with its contractor to electronically analyze claims of prescribing providers for specific drugs or services in order to identify those providers whose prescribing practices lie outside established best practice norms. CMS will then inform these providers of their comparative results, and provide them with relevant research and educational materials, with the goal of modifying prescribing behavior which will ultimately lead to reduced costs and improved quality of care.

In addition to the Medicaid Integrity Program work, each Federal fiscal year, CMS establishes a Regional Office Medicaid/Children's Health Insurance Program financial management (FM) work plan. This yearly work plan is developed in close collaboration between the Central and Regional Offices and is rooted in our authority under Federal regulations (42 CFR 430.32 and 430.35) to review State compliance with Federal regulatory and statutory requirements as well as provisions of a State's Medicaid plan. Some reviews also focus on compliance with stated CMS policy decisions.

The FM work planning process has been established to address continued risks and criticisms identified in the Medicaid program by the General Accountability Office and the Office of the Inspector General (OIG). Focused financial reviews are selected based upon an assessment of relative risk for misuse of Federal funds within each individual State. The Regional Offices give careful consideration in proposing areas that pose the greatest impact on Federal financial participation (FFP). Further, the work planning process documents individual risk assessment factors to aid in this evaluation. Such risk assessment factors include claims submitted at an enhanced Federal matching rate, follow up on prior OIG audits, and use of consultants for FFP maximization.

According to the OMB, there are still a number of major programs and activities that are unable to report improper payment estimates in accordance with the Improper Payments Information Act (IPIA) – including Medicare Part D, which had $46 billion in outlays in FY 2008. a) Why is CMS unable to provide an estimate for the improper payment under Medicare Part D? b) What is CMS doing to ensure that there are proper internal controls for payments under Medicare Part D? c) What are you doing to ensure that CMS is able to provide improper payment estimates in the near future?

Answer:
FY 2008 was the first year that HHS reported two component error estimates for Part D, the Medicare Prescription Drug program. CMS is on track to develop a composite payment error methodology for the Part D program that combines all component estimates.

In 2008, HHS reported two CY 2007 Part D component error estimates: a payment system error and payment error due to incorrect Low-Income Subsidy (LIS) status.

- The Part D payment system error estimate captures calculation errors and other system issues in CMS' data systems that affect Part D prospective payments to plans.

- The Part D payment error amount, due to incorrect LIS status, is the sum of payment error estimates for three types of payments affected by LIS status: (1) the Low-Income Cost Sharing Subsidy; (2) the Low-Income Premium Subsidy; and, (3) the Direct Subsidy error estimate, due to the low-income multiplier applied to the beneficiary risk score.

- The Part D payment system error estimate was about $250 million, or 0.59 percent of total CY 2007 prospective Part D payments of about $42 billion. The Part D error due to incorrect LIS status was about $107 million, or 0.25 percent of total Part D payments.

Improper payments due to errors in prospective payments in the Part D payment system are found and resolved on an ongoing, routine basis. As a consequence, payment adjustments are routinely made. In addition, some payment errors are resolved during the annual Part D reconciliation process, including a portion of the error associated with low-income payments.

A July 2008 Permanent Subcommittee on Investigations report estimated that between 2000 and 2007, nearly 500,000 payments totaling somewhere between $76 million and $92 million were made to durable medical equipment suppliers that had submitted claims using the identification numbers of 17,000 deceased doctors. The subcommittee also made several recommendations to help curb Medicare fraud and abuse. They include: 1) strengthen the claims review process; 2) develop procedures to link diagnosis codes to medical procedures; 3) develop procedures to link claims for medical equipment with a corresponding claim for medical treatment; and, 4) strengthen contractor oversight. a) Which, if any, of the recommendations made by PSI has CMS implemented and to what extent? b) How have they been effective in mitigating more fraudulent claims?

Answer:
Since this issue was brought to our attention last year, we have been working diligently with the Social Security Administration (SSA) to coordinate our data systems in a way that enables us to prevent inappropriate payments for medical services or supplies ordered, referred, or provided under the billing numbers of deceased physicians. That effort has included implementing many of the Subcommittee's recommendations to CMS.

Specifically, CMS has new Memorandums of Understanding (MOU) in place with SSA, and in April began receiving monthly feeds of the SSA "master death file." We also now have in place a systematic matching process that runs the SSA data against CMS' provider enrollment system. Providers, owners, and authorized/delegated billing officials identified as deceased have their billing numbers (national provider identifier) revoked. This information is communicated to contractors to prevent further payment from being made. Combined, these efforts will enable CMS to significantly strengthen its claims review process and ensure greater contractor oversight. The situation is a bit more complicated when the physician number is being used in the ordering or referring context, since there can be legitimate reasons for a deceased provider's identifier to be used. For example, the provider may have been alive when an item or service

was ordered, but deceased by the time the beneficiary fills the order. Notwithstanding this complexity, we are working to eliminate the inappropriate use of deceased provider numbers in this context as well.

CMS is exploring ways to incorporate the Subcommittee's recommendations to develop procedures to link diagnosis codes to medical procedures and link claims for medical equipment with the corresponding claim for medical treatment. The current claims system does not allow for these types of linkages. However, CMS is exploring other areas to accomplish this such as having CMS' benefit integrity contractors perform an analysis to look at linking these types of information and how much benefit that would add to CMS' oversight efforts. Specifically, the contractors are analyzing whether edits could be implemented in the claims system to control for just these types of linkages.

Medicare Administrative Contractors are compensated on a cost plus award fee basis. a) Does CMS have published guidance on the use of this contract type? b) What are the factors used to evaluate contractor performance?

Answer:
a) In brief, CMS has decided to utilize the cost-plus-award-fee contract type as the best available contract instrument within the federal acquisition framework, in view of the Agency's present Medicare Fee-For-Service (FFS) program and acquisition challenges.

In selecting and in administering this contract type, CMS fully considered the guidance provided in the Federal Acquisition Regulation (FAR, 48 CFR Chapter 1), specifically, the criteria for selecting and implementing various contract types that are set out in Part 16 of the FAR (note, in particular, FAR Subpart 16.1, FAR Subpart 16.3, and FAR Subpart 16.4). CMS also considered applicable provisions of the HHS Acquisition Regulation (HHSAR, 48 CFR Chapter 3).

The critical factors considered by CMS include the scope, complexity, and dynamic nature of the Medicare FFS program operating environment. The scale of the Medicare FFS program is immense (1.2 billion claims, over 1 million providers, more than $300 billion in payments). The Medicare FFS operation is also very complex (numerous provider types and payment systems, thousands of health care codes). Finally, the Medicare FFS program's operating requirements are very dynamic. Due to statutory changes and other developments, CMS issues nearly 400 changes to its official Medicare FFS manuals and several hundred additional technical direction letters to the Medicare claims contractors each year.

Moreover, in moving to the MAC environment, the MACs are adjusting to contracts that are larger in scope than the traditional Medicare fiscal intermediary and carrier contracts were. Further, the workload volumes under the MAC contracts are subject to considerable uncertainty and fluctuation. Finally, most of the MACs – former fiscal intermediaries and carriers – have needed to implement new contract accounting systems in order to achieve compliance with the Federal Cost Accounting Standards (CAS, see Part 30 of the FAR, and 48 CFR Chapter 99), as the former Medicare contracts were not required to be fully CAS compliant. Realistically, CMS and these entities need to achieve more familiarity with their new cost structures before we could

structure a fixed price contract. All of these programmatic and acquisition factors make this a difficult environment in which to implement fixed price contracting.

In view of all these issues, CMS determined that the cost-plus-award-fee contract type would serve the Medicare FFS program best at this time. The cost-plus-award-fee contract type fits well with CMS's "best value" approach to the MAC procurements. A primary objective of the cost-plus-incentive-fee contract type is to incentivize the contractor to reduce costs, whereas the cost-plus –award-fee contract instrument enables the government to consider both hard and "soft" performance metrics.

CMS did not give serious consideration to either the straight cost-reimbursement contract type, or the cost-plus-fixed-fee contract type, as those contract types give minimal incentive to the contractor to achieve exceptional performance. CMS will continue to re-visit the contract type of the MAC contracts as we continue to gain experience with the new contracts and program cost baseline.

b) To answer the second part of your question, oversight of Medicare Administrative Contractor (MAC) performance is conducted by means of performance assessment and performance monitoring. Performance assessment is supported by reviews of both contractor Quality Control Plans (QCP) and performance standards evaluated through the Quality Assurance Surveillance Plan (QASP) process. In addition, performance criteria exceeding standards published in each MAC Statement of Work (SOW) are evaluated in accordance with MAC Award Fee Plans. Performance monitoring is conducted through day-to-day oversight of the contractor by contract administration staff, including each MAC Project Officer (PO).

The SOW for each MAC establishes the requirement for a QCP, which is a contract deliverable. The QCP formally documents the framework for how a MAC will implement a quality management system and meet the established performance standards defined in the SOW. There are seven principal elements of a QCP including: documenting procedures and processes; documenting change management program to ensure that correct procedures and processes are followed; implementation of an inspection and audit system; providing for a method to identify nonconformance or deficiency in the quality of services performed; providing for a formal system to implement corrective action; implementing a system to maintain all quality records including inspections, audits and the corrective actions; and, providing for Government inspections and audits while work is in process or complete. The contractor is required to submit their QCP 45 days after contract award and yearly thereafter. CMS conducts on-site QCP reviews to assure that the provisionally approved QCP for each MAC is operating as defined and, if not, work through the Project Officer to have the contractor make the necessary changes to bring operations into compliance. Once validated by the on-site review, the QCP deliverable is formally accepted. As such, the QCP is a work product of the MAC.

The QASP is a sub-set of the performance standards in each MAC SOW. Using monthly performance monitoring as a guide, each lead business component (Appeals, Audit and Reimbursement, Provider Enrollment, etc.) select those performance standards which will be evaluated once each contract year. Evaluations of performance standards selected for QASP reviews may be conducted either on-site or as desk audits. Results are reported to each Project

Officer who works with other contract administration staff to implement Action Plans, as appropriate, for corrective action. As such, the QASP reviews support CMS' oversight of performance standards to ensure contractors are meeting the requirements as stated in the SOW. QASP reviews are conducted annually as part of the MAC oversight process. Both the QCP and QASP activities support MAC Performance Assessment.

The award fee evaluation is an annual evaluation that takes into account MAC performance against the standards identified in the Award Fee Plan. The standards in an Award Fee Plan establish stretch goals exceeding those in the MAC SOW. In addition to evaluating criteria established in the award fee, the Fee Determining Official (FDO) takes into account the MAC's overall performance on the contract when making an award fee determination and may, at his or her discretion, reduce the amount of the award fee under the contract, or determine not to make payment of any award fee, after such consideration.

The Project Officers, supported by contract administration staff as well as the business components, conduct on-going oversight and monitoring of MAC operational performance. The Project Officers are often on-site. In doing so, they take into account a variety of performance related information from both internal and external review activities. In addition to internal reviews (QCP and QASP), Project Officers evaluate the results from external audits such as SAS-70 and the Chief Financial Officer's Audit. Moreover, they monitor monthly performance information supplied by each MAC. This information is considered in its totality when developing the MAC's overall performance rating which is entered into the National Institutes of Health Contractor Performance System.

Senator Carper Subcommittee on Federal Financial Management, Government Information, Federal Services and International Security hearing on "Eliminating Waste and Fraud in Medicare and Medicaid"

April 22, 2009

Follow-Up Questions-For-The Record for Lewis Morris, HHS-OIG Chief Counsel

Senator Tom Coburn, M.D. Questions

Question: What are the five biggest investigations conducted by the HHS OIG office in the past several years, specifically in the area of Medicare and Medicaid?

OIG's Office of Investigations' (OI) conducts and coordinates criminal, civil, and administrative investigations of fraud and abuse related to HHS programs and operations. The majority of OI's investigative efforts are dedicated to pursuing fraud committed against the Medicare and Medicaid programs. Over the past 3 years, the five largest criminal restitution or civil settlements involving Medicare and Medicaid were as follows:

1. In 2009, Eli Lilly and Company (Lilly), a drug manufacturer, agreed to plead guilty and pay approximately $1.4 billion to the Federal Government and participating States under a global settlement for promoting its drug Zyprexa for uses not approved by the Food and Drug Administration (FDA) and not covered by Medicaid or other Federal programs. Under the civil settlement, Lilly agreed to pay the Federal Government $438,171,544 and the States up to $361,828,456 to resolve False Claims Act allegations for the period from September 1999 to the

end of 2005. Lilly agreed to pay a criminal fine of $525 million and forfeit assets of $100 million. In its plea agreement, Lilly admitted that it promoted Zyprexia for unproved uses in elderly populations, such as for treating dementia, including Alzheimer's dementia.

2. Tenet Healthcare Corporation, operator of the Nation's second largest hospital chain, agreed to pay the Government $900 million plus interest in 2006, and enter into a 5-year Corporate Integrity Agreement to resolve its liability under the False Claims Act and related authorities. Tenet agreed to pay over $788 million of the settlement amount to resolve claims related to outlier payments that Tenet received based on inflated charges for inpatient and outpatient care.

3. In 2005, Serono, S.A., along with its U.S. subsidiaries, Serono, Inc., Serono Holdings, Inc., and Serono Laboratories, Inc. (collectively "Serono"), agreed to enter a global criminal, civil, and administrative settlement that included the payment of $704 million plus interest and a 5-year Corporate Integrity Agreement. The global settlement resolved allegations that Serono engaged in the illegal promotion of its AIDS-related drug Serostim and offered and paid illegal remuneration to physicians and pharmacies to induce them to prescribe and/or purchase Serostim. The company also used an unapproved medical device as a marketing tool to diagnose AIDS-wasting syndrome, the condition that Serostim was approved to treat.

4. Merck and Company, Inc. (Merck), agreed to pay more than $650 million to resolve allegations that it failed to pay proper rebates to Medicaid and other Government health care programs and paid illegal remuneration to health care providers to induce them to prescribe the company's products. The allegations were brought in two separate lawsuits filed by whistleblowers under the *qui tam* provisions of the False Claims Act. According to the allegations, Merck offered hospitals deep discounts on its products Pepcid, Vioxx, Zocor, and Mevacor, then overcharged Government programs by failing properly to include these discounts in the "best prices" reported to the Centers for Medicare & Medicaid Services (CMS) under the Medicaid drug rebate program.

5. As part of a global criminal, civil, and administrative settlement agreement, the Purdue Frederick Company, Inc., and Purdue Pharma L.P. (collectively, the Purdue Companies) and three top executives agreed to pay almost $635 million in 2007 to resolve a variety of Federal, State, and private liabilities. Specifically, the agreement resolved allegations that the Purdue Companies waged a fraudulent and deceptive marketing campaign aimed at convincing doctors nationwide that OxyContin, because of its time-release formula, was less prone to abuse and that it was less likely to cause addiction or to produce other narcotic side effects than competing immediate release opioids. The Purdue Frederick Company, Inc. is subject to 25-year exclusion; Purdue Pharma L.P. agreed to enter a 5-year Corporate Integrity Agreement with OIG. In January of this year, an

administrative law judge affirmed OIG's imposition of 15-year exclusions on each of the three executives.

Large monetary recoveries do not tell the whole story. Some of OIG's most significant cases focus on egregious deficiencies in the quality of care furnished to Medicare and Medicaid beneficiaries. The following three investigations illustrate the substantial impact of OIG's work in protecting quality of care.

1. The owners and operators of Grant Park Care Center (GPCC), a 296-bed skilled nursing facility in the District of Columbia, agreed to pay the United States and the District of Columbia $2 million to settle allegations of fraudulent billings arising from the submission of claims to the Medicare and Medicaid for services that failed to meet the needs of the residents at GPCC in one or more of the following areas: resident nutrition and hydration; needs assessments and evaluations; care planning and nursing interventions; medication management; fall prevention and management; and pressure ulcer care, including the prevention and treatment of wounds. In addition, the United States alleged that the facility had insufficient staffing and knew that resident care would be compromised as a result. GPCC is owned and managed by affiliated companies that collectively constitute one of the largest nursing home owners in the United States. As part of the settlement, GPCC agreed to enter into a 5-year Corporate Integrity Agreement with OIG that mandates a detailed compliance program and an independent monitor to assess the facility's quality assurance and quality improvement systems.

2. A former dermatologist in Florida was sentenced to 22 years in prison and was ordered to pay $3.7 million in restitution, forfeit an additional $3.7 million, and pay a $25,000 fine for performing 3,086 medically unnecessary surgeries on 865 Medicare beneficiaries. The dermatologist falsely diagnosed patients with skin cancer so he could bill Medicare for expensive surgeries.

3. A Kansas couple was convicted on charges of involuntary servitude, forced labor, conspiracy, health care fraud, and mail fraud. Operating a group home for mentally ill patients, the social worker and his wife forced and coerced patients to perform manual labor in the nude and participate in sexually abusive "therapy" sessions. The husband and wife were sentenced to respective prison terms of 30 years and 7 years.

Question: Which programs, if any, are the most frequently cited for occurrences of waste, fraud and abuse?

Over the past year, the Office of Investigations has opened cases involving the following CMS programs, in descending order based on the number of cases opened:

1. Medicare Part B
2. Medicaid/Medical Assistance
3. Medicare Part A
4. Medicare Part D
5. Medicare Part C.[1]

We find fraud and abuse in every part of the Medicare program. Types of services particularly prone to fraud and abuse include durable medical equipment (DME), home health, infusion therapy, Medicaid outpatient prescription drugs, and personal care services. In general, fraud and abuse are particular problems for services with low barriers to entry (e.g., minimal investment needed in infrastructure or no licensure or specialized professional training required) and high mobility (e.g., no "bricks and mortar" to relocate), such as DME and home health agencies. In addition, OIG finds abuse and waste in many parts of Medicare because Medicare pays too much compared to market prices. Examples of excessive payment include DME, clinical laboratory services, imaging services, and outpatient prescription drugs.

Question: What has the IG done to ensure CMS is either implementing recommendations made in reports to CMS or providing valid reasons why they cannot implement these recommendations?

Under the Inspector General Act of 1978 (the "IG Act"), as amended, the Inspector General (1) conducts and supervises audits and investigations relating to HHS programs; (2) provides leadership and coordination and recommends policies for activities designed to promote economy, efficiency, and effectiveness in the administration of HHS programs and to prevent and detect fraud and abuse in such programs; and (3) provides a means for keeping the Secretary and Congress fully and currently informed about problems and deficiencies relating to the administration of HHS programs and operations and the necessity for and progress of corrective actions. (IG Act, section 2.) To preserve its independence and objectivity, OIG is not authorized to implement or operate the HHS programs it oversees. For the same reasons, the Inspector General may not compel CMS to respond to recommendations or take corrective action.

Although OIG may not step into the shoes of program officials and implement corrective actions directly, OIG does take steps to prompt CMS to implement OIG recommendations. First, under the IG Act, we are directed to report, in our "Semiannual Reports to the Congress," information with respect to any significant recommendations made by OIG that CMS (or other HHS program agency) declines to implement, or has not yet fully implemented. For decades, OIG also publishes an annual "Compendium of

[1] Cases can involve more than one CMS program. For example, a case involving a physician who is over-prescribing controlled drugs might impact Part B (for billings for related office visits and medical tests), Part D (for the drugs prescribed to traditional Medicare beneficiaries), Medicare Part C (if the provider is also a member of a Medicare Advantage network), and Medicaid.

Unimplemented OIG Recommendations," which identifies measures that, if adopted, would result in cost savings or improved program integrity or effectiveness. Further, we annually assess and report on the "Top Management and Performance Challenges" facing the Department of HHS; this assessment is included in the Department's "Agency Financial Report" to Congress. In 2008, these top management challenges included, among others, Medicare Integrity, Oversight of Medicare Part D, and Integrity of the Medicaid and the Children's Health Insurance Program.

The Inspector General and the Principal Deputy Inspector General meet regularly with the CMS Administrator and other senior CMS officials to discuss unimplemented recommendations and other program integrity concerns. Senior OIG executives are required to meet with their program counterparts in all HHS operating divisions, including CMS, to follow up on unimplemented recommendations. OIG is implementing a new recommendations management system that will further enhance our ability to track recommendations made in OIG reports. We also provide additional feedback to CMS in the form of "Management Implication Reports," which result from our investigations.

Question: What efforts does the Inspector General plan to implement to improve oversight of CMS and the Medicare program?

OIG works closely with HHS and its Operating and Staff Divisions, the Department of Justice and other agencies in the executive branch, Congress, and the States to bring about systemic changes, successful prosecutions, negotiated settlements, and recovery of funds. We will also continue to use our audits and evaluations to identify program vulnerabilities. Our annual work planning for audits and evaluations is guided by our mission and statutory obligations, our funding, and our annual assessments of the top management and performance challenges facing HHS. The annual review of top challenges is beginning now for the upcoming year. To select topics for audits and evaluations, OIG assesses the relative risks in the programs for which OIG has oversight authority to identify the areas most in need of attention and to set priorities for the sequence and proportion of resources to be allocated. We will continue to use this process to identify those aspects of CMS's operations and the Medicare program on which we will focus our oversight resources.

Further, we are exploring new ways to ensure that we are, in an appropriate and timely manner, sanctioning abusive practices uncovered by investigations, audits, and evaluations. OIG has significant administrative authorities that are used to address fraud and abuse. For example, kickbacks present a significant threat to the integrity of the Federal health care programs. OIG uses its administrative authorities (including civil monetary penalties (CMPs) and exclusion) to attack this problem. As another example of how we use our administrative authorities, OIG reports identified drug manufacturers that failed to file timely information on drug pricing as required by law. The law provides for a CMP for such failures, and accordingly we recently sent demand letters to the errant manufacturers proposing sanctions.

OIG has long been a sponsor of and regular participant in the Senior Fraud Working Group, an interagency task force that includes CMS, the Federal Bureau of Investigation (FBI), and DOJ and that focuses on fraud and abuse enforcement and prevention. OIG is a member, along with CMS, DOJ, and others, of the new Health Care Fraud Prevention & Enforcement Action Team (HEAT) created by the Secretary of HHS and the Attorney General. These working groups promote interagency collaboration and give law enforcement a platform to address concerns about the integrity of the programs. We have formed a new Data Forensic Analysis Team to upgrade and further our internal use of advanced data analysis techniques to detect and track fraudulent schemes and identify program vulnerabilities. We will be working with our HEAT partners to improve data sharing and analysis across agencies and health care programs.

Question: What audit or investigative efforts has the IG undertaken to review the performance of the various Medicare contractors?

OIG completed two reviews on Program Safeguard Contractors (PSCs) since 2005. The first review, "Medicare's Program Safeguard Contractors: Performance Evaluation Reports (March 2006)," examined the information provided in performance evaluation reports issued by CMS about PSCs' results related to detecting and deterring fraud and abuse. We also assessed whether performance evaluation reports were issued on time.

OIG found that performance evaluation reports issued by CMS contained minimal information about PSC achievements related to detecting and deterring fraud and abuse. OIG also found that 28 percent of the evaluation reports were not issued on time. OIG recommended that CMS address PSC results in its performance evaluation reports and include quantitative, as well as qualitative information, about required fraud and abuse detection and deterrence activities and ensure that all reports are issued on time. CMS concurred in part with our recommendations.

The second review, "Medicare's Program Safeguard Contractors: Activities To Detect and Deter Fraud and Abuse (July 2007)," assessed selected activities that PSCs performed in 2005 to detect and deter fraud and abuse in Medicare Parts A and B. OIG found that PSCs differed substantially in the number of new investigations and case referrals to law enforcement. For example, PSCs produced between 5 and 479 new Part A investigations, with a median of 60, and between 18 and 3,707 new Part B investigations, with a median of 196. Neither the size of the PSCs' budgets nor their oversight responsibility was strongly correlated with the number of new investigations or new case referrals to law enforcement. OIG also found that PSCs had minimal results from proactive data analysis and that there was no consistency across PSCs regarding the level of detail about their proactive data analysis. OIG recommended that CMS review PSCs with especially low volumes of activity in investigations and case referrals for Medicare Parts A and B and that CMS require PSCs to provide more detailed explanations of their investigations, case referrals to law enforcement, and proactive data

analysis activities. CMS concurred in part with OIG's first recommendation and concurred with OIG's second recommendation.

OIG is currently conducting a review to determine the extent to which Medicare Drug Integrity Contractors (MEDICs) identified and investigated potential fraud and abuse. The report is expected to be issued in the fall of 2009. OIG also plans future reviews that will examine the performance of Zone Program Integrity Contractors and CMS's oversight of the MEDICs.

In addition, OIG investigates credible allegations of unlawful conduct by Medicare contractors. The matters investigated range from allegations of willful failure to employ proper audit controls to allegations of contractor fraud. For example, OIG has investigated allegations of Medicare contractors' willful failure to implement and/or enforce overutilization safeguards in processing Medicare Part B claims and contractors' willful failure to implement Medicare secondary payer rules. OIG's audit and investigative efforts in one contractor case resulted in a civil recovery of $4,547,954. OIG's investigation of allegations related to a contractor's willful failure to adjust hospitals' cost-to-charge ratios (resulting in excessive Diagnostic Related Group outlier payments to hospitals) resulted in a civil recovery of $2,100,000. OIG's efforts related to Medicare contractors have also focused on allegations of fraudulent documentation and reporting of information, including the creation of false reports regarding the contractors' review of providers.

Question: Previous IG reports regarding DME suppliers found that several suppliers who received billing identification numbers from the National Supplier Clearinghouse contractors did not actually exist at the location identified in the application. Other than reporting this issue to CMS and ensuring the billing numbers were revoked, what review or investigation has the IG conducted into how these suppliers received the numbers in the first place?

OIG is currently conducting a study that examines Medicare enrollment screening mechanisms used to identify suppliers of durable medical equipment prosthetics, orthotics, and supplies (DMEPOS) and home health agency enrollees that pose fraud risks to Medicare. This work resulted from a November 2008 memorandum issued by OIG's Office of Evaluation and Inspections (OEI) to CMS describing associations between selected DMEPOS suppliers with debt owed to the Medicare program and related businesses that received Medicare payments. OEI anticipates completing this study in the summer of 2010.

In addition, OI has been investigating fraudulent providers. In its work in South Florida, OI observed many examples of Medicare DME suppliers' offices that appeared to be vacant after the provider numbers had been issued. In some cases, agents found that

there were no physical locations for the supply companies. The typical scheme found by agents involves the following steps that enabled the fraudulent supplier to obtain billing numbers without detection by CMS:

1. A nominee owner is recruited by the scheme's organizer.

2. The nominee owner, at the direction of the organizer, opens a bank account, files the articles of incorporation, completes the application for a Medicare provider number, and meets with the Medicare surveyor for the onsite inspection.

3. The nominee owner has little to do with the day-to-day operation of the supplier other than depositing or withdrawing funds from the bank and signing checks for the organizer.

4. The organizer, often through the use of compromised physician provider numbers and beneficiary identification numbers, submits fraudulent claims for services to Medicare, Medicaid, and other insurance programs.

5. The organizers can continue to submit false claims, allowing the nominee owner to serve as the first "target" for an investigation.

6. If the nominee owner is targeted by law enforcement, the organizer often moves on to the next nominee owner and continues the fraud scheme.

Question: How many IG attorneys are currently identified as Special Assistant United States Attorneys for the purpose of prosecuting Medicare Fraud?

OIG currently has two employees working as Special Assistant United States Attorneys (SAUSAs) prosecuting Medicare and Medicaid fraud. During the past 3 years, eight OIG employees have worked at various times as SAUSAs. These attorneys have provided support to OI by tackling the backlog of criminal cases and bring back to the Office of Counsel to the Inspector General valuable trial experience, which strengthens our ability to pursue administrative cases, including CMPs for violations of the anti-kickback statute. Because of the success of this effort, we will hire five new attorneys in the near future who will work as SAUSAs.

Senator John McCain Questions

Question: Since CMS is unable to provide improper payment figures for Medicare Part D, has the HHS OIG looked into the program for payment of invalid claims? If so, what kind of investigations have you conducted and what are your findings?

OIG has a robust portfolio of audit, evaluation, and investigative work related to Medicare Part D, including work related to potentially invalid claims and other payment accuracy issues. This includes work involving Prescription Drug Event (PDE) data, the data that CMS collects from Part D plan sponsors that represent Part D claims for individual prescriptions, and reviews related to the accuracy of the subsidy payments that Medicare makes to Part D plans through monthly capitated payments.

PDE-Related Payment Work

Earlier this month, OIG issued a report assessing the extent to which Medicare Part D paid for drugs for beneficiaries in Part A skilled nursing facility (SNF) stays. Part D coverage excludes drugs for beneficiaries in Part A SNF stays if the drugs were for use in the facility or were used to facilitate the beneficiaries' discharge; such drugs are covered by the Part A payment to the SNF. We found that Medicare Part D paid for 1.2 million drugs, amounting to $75 million, for beneficiaries in Part A SNF stays in 2006; the majority of these payments were most likely inappropriate. We recommended several actions that CMS should take to ensure that Part D does not make inappropriate payments for beneficiaries in Part A SNF stays. CMS generally concurred with OIG's recommendations.

In addition, OIG has numerous ongoing reviews and investigations involving PDE data. For example, we are auditing the pharmacy documentation and support for PDE data submitted to CMS by drug plan sponsors. We are also identifying PDE data for claims for "less than effective" drugs (a designation related to FDA disapproval of the drug), which are not covered by Medicare Part D. In addition, we are identifying PDE records for drugs that are not covered by Part D because they were prescribed by providers that have been excluded from participation in Medicare. We are also analyzing PDE data to identify records that lack valid prescriber identifiers. A particular focus is prescriptions for Schedule II controlled substances. Open cases involving Part D include, among others, investigation of allegations related to drug diversion; billing for services not rendered; illegal, forged, or altered prescriptions; and kickbacks.

Subsidy-Payment-Related Work

Medicare makes monthly capitated payments to Part D plan sponsors. These payments are based on estimates that sponsors provide in their bids prior to the beginning of the

plan year. After the close of the plan year, CMS reconciles these payments with sponsors' actual costs to determine whether sponsors owe money to Medicare or Medicare owes money to sponsors.

For plan year 2006, OIG assessed the reconciliation payments that sponsors would owe to or receive from Medicare and estimated that Part D sponsors owed approximately $4.4 billion to Medicare. The majority of funds owed were unexpected profits that were due to Medicare in accordance with risk-sharing requirements. Sponsors that owed Medicare money during the reconciliation overestimated the cost of providing the benefit in their bids. As a result, the monthly payments that these sponsors received from Medicare and the beneficiaries were significantly greater than the sponsors' costs. Although Medicare recoups a portion of its higher payments through reconciliation, beneficiaries do not directly recoup any of the money that they paid in higher premiums. OIG is currently conducting a review of reconciliation amounts owed for plan year 2007.

Additionally, OIG has identified vulnerabilities in CMS's oversight of bids and plan sponsors' support for their bids. CMS uses bid audits, which focus on the actuarial assumptions underlying bids, as part of its oversight of sponsors' bids. OIG found that one-quarter of bid audits completed for plan years 2006 and 2007 identified at least one material finding, which CMS defines as a significant issue that, if corrected, would change the bid. Both Medicare payments and beneficiary premiums are affected when bid amounts are not calculated appropriately. However, CMS has not adjusted plan sponsors' bid amounts based on these material findings because of timing issues and because some material findings are not quantifiable. As a result, Part D payments and premiums for that plan year are based on bids with flawed actuarial assumptions. CMS uses bid audits to influence the submission, review, and audit of bids for future plan years. In addition, Federal regulations do not currently contain provisions to adjust or refund incorrect beneficiary premium amounts.

OIG is also reviewing price concessions estimated in drug plan bids prior to the plan year and actual price concessions reported to CMS after the close of the plan year. Price concessions include discounts, direct or indirect subsidies, rebates, and other forms of direct or indirect remuneration (DIR). Part D plan sponsors are required to report all expected price concessions and rebates in full in their bids. Including expected price concessions in drug plan bids generally results in lower Medicare subsidy payments and beneficiary premiums. After the close of the plan year, Part D plan sponsors are required to report to CMS rebates and other DIR received on the plans' behalf to determine net drug costs for reconciliation. OIG is reviewing the nature and extent of price concessions received by selected Part D sponsors and assessing how these sponsors reported price concessions to CMS in their bids and in their DIR reports. Ongoing audit work has preliminarily identified some expected rebates that were not included in bids, as required, as well as some rebates that were received but not reported to CMS for reconciliation, as required.

Question: How much of the $46 billion spend on Medicare Part D in FY

2008 do you think was improperly paid? In other words, do you believe that Medicare Part D has a high risk factor for improper and fraudulent payments?

CMS has not performed improper payment estimates for Medicare Part D. However, we believe that Medicare Part D is at substantial risk of fraud and improper payments.

The structure and operation of the Part D benefit contain features that present significant management challenges. Part D coverage is provided by private entities that contract with CMS to provide Part D drug benefits. Within the Federal Government, CMS bears primary responsibility for implementing and administering Part D. However, administration and oversight of Medicare Part D depend upon extensive coordination and information sharing between Federal and State Government agencies, Part D drug plan sponsors, contractors, health care providers, and third-party payers.

In addition to identifying the payment concerns and vulnerabilities described in the response to above Question, OIG has identified concerns about limited oversight and implementation of program safeguards to prevent and detect fraud, waste, and abuse in Part D. These vulnerabilities increase the risk of improper and fraudulent payments. CMS and drug plan sponsors share responsibility for protecting the Part D program from fraud, waste, and abuse. CMS is responsible for oversight and implementation of safeguards to protect the integrity of the Part D benefit. CMS has contracted some of its Part D program integrity functions to Medicare Drug Integrity Contractors (MEDIC). OIG has reviewed the roles of all three of these key entities--CMS, Part D sponsors, and MEDICs--in protecting the integrity of Part D.

OIG's review of the early implementation of CMS's Part D integrity strategy found that as of October 2006, CMS had relied primarily on complaints to identify potential fraud and abuse. Other safeguards needed further development and application. CMS has made progress since then; however, some of the concerns identified in 2006 have not been fully addressed. For example, as of April 2008, only 4 percent of the required financial audits of plan year 2006 had begun, and CMS had contracted for less than half the required number of audits.

In another early review, OIG found that Part D sponsors' compliance plans contained only broad outlines of fraud and abuse plans and did not include details or describe specific processes. Only 7 of 79 sponsors' compliance plans met all CMS requirements. In follow-up work, OIG found that CMS's oversight of plan sponsors' implementation of compliance plans was limited and that CMS had not conducted the compliance plan reviews that it committed to performing. OIG currently is reviewing Part D sponsors' internal controls to guard against fraud, waste, and abuse, including reviewing components of the sponsors' compliance plans.

OIG also found evidence suggesting that additional focus on fraud and abuse detection and response by plan sponsors is needed. Specifically, we found that in the first 6 months of 2007, 24 of 86 plan sponsors did not identify any potential fraud and abuse incidents. Seven plan sponsors accounted for 90 percent of the incidents identified, and most incidents were associated with pharmacies. Further, OIG found that not all plan sponsors that identified potential fraud and abuse incidents conducted inquiries, initiated corrective actions, or made referrals for further investigation. OIG is currently evaluating the extent to which MEDICs have identified and investigated potential fraud and abuse incidents and examining any barriers to MEDICs' identification of such incidents.

Question: Generally, what do you see as the most significant factors in Improper payments for Medicare and Medicaid and how can these factors be mitigated?

A variety of factors contribute to improper payments, ranging from human error to outright fraud. To protect Medicare and Medicaid funds, the Government must pursue a comprehensive strategy to combat fraud, waste, and abuse. We have identified the following five principles of an effective health care integrity strategy that will mitigate health care waste, fraud, and abuse.

1. Scrutinize individuals and entities that want to participate as providers and suppliers prior to their enrollment in health care programs.

2. Establish payment methodologies that are reasonable and responsive to changes in the marketplace.

3. Assist health care providers and suppliers in adopting practices that promote compliance with program requirements, including quality and safety standards.

4. Vigilantly monitor the programs for evidence of fraud, waste, and abuse.

5. Respond swiftly to detected frauds, impose sufficient punishment to deter others, and promptly remedy program vulnerabilities.

These principles provide a useful framework for designing and implementing program benefits and integrity safeguards. These principles also are reflected in OIG's programmatic recommendations and suggested corrective actions, which OIG provides to CMS with the results of its audits, evaluations, and investigations.

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