AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

IMPROPER MEDICARE PAYMENTS: $48 BILLION WASTE?

HEARING

BEFORE THE

SUBCOMMITTEE ON GOVERNMENT ORGANIZATION, EFFICIENCY AND FINANCIAL MANAGEMENT

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

JULY 28, 2011

Serial No. 112–79

Printed for the use of the Committee on Oversight and Government Reform

Available via the World Wide Web: http://www.fdsys.gov
http://www.house.gov/reform

U.S. GOVERNMENT PRINTING OFFICE

71–988 PDF WASHINGTON : 2012

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

DARRELL E. ISSA, California, *Chairman*

DAN BURTON, Indiana
JOHN L. MICA, Florida
TODD RUSSELL PLATTS, Pennsylvania
MICHAEL R. TURNER, Ohio
PATRICK T. MCHENRY, North Carolina
JIM JORDAN, Ohio
JASON CHAFFETZ, Utah
CONNIE MACK, Florida
TIM WALBERG, Michigan
JAMES LANKFORD, Oklahoma
JUSTIN AMASH, Michigan
ANN MARIE BUERKLE, New York
PAUL A. GOSAR, Arizona
RAÚL R. LABRADOR, Idaho
PATRICK MEEHAN, Pennsylvania
SCOTT DESJARLAIS, Tennessee
JOE WALSH, Illinois
TREY GOWDY, South Carolina
DENNIS A. ROSS, Florida
FRANK C. GUINTA, New Hampshire
BLAKE FARENTHOLD, Texas
MIKE KELLY, Pennsylvania

ELIJAH E. CUMMINGS, Maryland, *Ranking Minority Member*
EDOLPHUS TOWNS, New York
CAROLYN B. MALONEY, New York
ELEANOR HOLMES NORTON, District of Columbia
DENNIS J. KUCINICH, Ohio
JOHN F. TIERNEY, Massachusetts
WM. LACY CLAY, Missouri
STEPHEN F. LYNCH, Massachusetts
JIM COOPER, Tennessee
GERALD E. CONNOLLY, Virginia
MIKE QUIGLEY, Illinois
DANNY K. DAVIS, Illinois
BRUCE L. BRALEY, Iowa
PETER WELCH, Vermont
JOHN A. YARMUTH, Kentucky
CHRISTOPHER S. MURPHY, Connecticut
JACKIE SPEIER, California

LAWRENCE J. BRADY, *Staff Director*
JOHN D. CUADERES, *Deputy Staff Director*
ROBERT BORDEN, *General Counsel*
LINDA A. GOOD, *Chief Clerk*
DAVID RAPALLO, *Minority Staff Director*

SUBCOMMITTEE ON GOVERNMENT ORGANIZATION, EFFICIENCY AND FINANCIAL MANAGEMENT

TODD RUSSELL PLATTS, Pennsylvania, *Chairman*

CONNIE MACK, Florida, *Vice Chairman*
JAMES LANKFORD, Oklahoma
JUSTIN AMASH, Michigan
PAUL A. GOSAR, Arizona
FRANK C. GUINTA, New Hampshire
BLAKE FARENTHOLD, Texas

EDOLPHUS TOWNS, New York, *Ranking Minority Member*
JIM COOPER, Tennessee
GERALD E. CONNOLLY, Virginia
ELEANOR HOLMES NORTON, District of Columbia

CONTENTS

	Page
Hearing held on July 28, 2011	1
Statement of:	
Levinson, Daniel R., Inspector General, Office of the Inspector General, Health & Human Services; Michelle Snyder, Deputy Chief Operating Officer, Centers for Medicare & Medicaid Services; Kay Daly, Director of Financial Management and Assurance; and Government Accountability Office, accompanied by Kathleen King, Director, Health Care, Government Accountability Office	8
Daly, Kay	26
Levinson, Daniel R.	8
Snyder, Michelle	15
Letters, statements, etc., submitted for the record by:	
Connolly, Hon. Gerald E., a Representative in Congress from the State of Virginia, prepared statement of	73
Daly, Kay, Director of Financial Management and Assurance, prepared statement of	28
Levinson, Daniel R., Inspector General, Office of the Inspector General, Health & Human Services, prepared statement of	11
Platts, Hon. Todd Russell, a Representative in Congress from the State of Pennsylvania, prepared statement of	3
Snyder, Michelle, Deputy Chief Operating Officer, Centers for Medicare & Medicaid Services, prepared statement of	18
Towns, Hon. Edolphus, a Representative in Congress from the State of New York, prepared statement of	5

IMPROPER MEDICARE PAYMENTS: $48 BILLION WASTE?

THURSDAY, JULY 28, 2011

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON GOVERNMENT ORGANIZATION,
EFFICIENCY AND FINANCIAL MANAGEMENT,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m. in room 2154, Rayburn House Office Building, Hon. Todd Russell Platts (chairman of the subcommittee) presiding.

Present: Representatives Platts, Issa, Lankford, Towns, Norton, Cooper and Connolly.

Staff present: Ali Ahmad, deputy press secretary; Adam Bordes, senior policy analyst; Gwen D'Luzansky, assistant clerk; Mark D. Marin, senior professional staff member; Tegan Millspaw, research analyst; Sang H. Yi, professional staff member; Beverly Britton Fraser, minority counsel; Mark Stephenson, minority senior policy advisory/legislative director; and Cecelia Thomas, minority counsel/deputy clerk.

Mr. PLATTS. This hearing of the Subcommittee on Government Organization, Efficiency and Financial Management will come to order.

First, I appreciate everyone's patience and understanding with both the change in time from 9:30 a.m. to 10 a.m. and also a slightly late start as we were wrapping up our conference meeting in the Capitol.

The purpose of today's hearing is to continue this committee's examination of improper payments made by the Federal Government.

In 2010, the government estimates there was $48 billion in improper payments within the Medicare Program. This figure represents approximately 38 percent of all identified improper payments made by the Federal Government in fiscal year 2010 and is likely only a partial accounting of Medicare's total amount of improper payments.

Medicare is considered a high risk program by the Government Accountability Office. It is known to be susceptible to fraud, waste and abuse. Last year, the Medicare Fee for Service Program reported more improper payments than any other Federal program. Many of these improper payments are a direct result of insufficient internal controls and financial management.

The Centers for Medicare & Medicare Services process almost 5 million claims every day, relying on automated systems to identify improper claims. Most claims are paid without any individual re-

view of the claim or the medical records associated with it. This leads to improper payments resulting from claims without sufficient documentation, insufficient or fraudulent documentation, incorrectly coded claims or services that are not reasonable or necessary.

CMS has been making efforts to better identify and decrease the amount of improper payments within Medicare. In 2009, CMS followed the recommendations of the Office of the Inspector General to implement stricter and more thorough methodologies to calculate payment error rates.

Using this new methodology, CMS identified more improper payments in 2009 and 2010. CMS is also working to calculate improper payments made through Medicare Part D, the Prescription Drug Program. CMS had not previously calculated the improper payments for Part D and will do so for the first time for the current fiscal year 2011.

CMS also plans to increase its oversight of Part D by performing more audits including onsite audits and face to face evaluations. CMS has also announced that it will evaluate the fraud and abuse programs put in place by third party insurance companies administering Part D. CMS's efforts to increase oversight are certainly commendable, however, more must be done to strengthen the internal controls, especially in CMS's contract management.

In 2006, CMS began using recovery audit contractors to identify and recover improper payments. The recovery audit contractors have identified numerous vulnerabilities in CMS's programs. Unfortunately, CMS has only taken steps to address about 40 percent of these significant vulnerabilities.

GAO has also found pervasive deficiencies in CMS's contract management internal controls. GAO issued nine recommendations to improve internal controls in 2009 but a year later, found that CMS had only taken steps to address two of the recommendations. Improper payments cost the taxpayers billions of dollars each year. This hearing is part of a continued effort by this committee to prevent improper payments and other instances of waste, fraud and abuse in government.

I certainly welcome the opportunity to hear from our witnesses today on CMS's progress to identify and prevent improper payments in Medicare and would conclude with just the focus that given the ongoing debate with deficit reduction, the ongoing debate over the debt limit and the broad picture of spending here in Washington, how we need to do better with the American peoples' money, when we are looking at debt reduction plans that talk about reducing spending by $10 billion, $20 billion, $30 billion in the coming years and then when we look and have, what we know of, at least $125 billion each and every year improperly made by the Federal Government, almost 40 percent of which is identified within the Medicare Program, we have a lot of work to do.

We are grateful for the witnesses being here today who will help us in this partnership approach to getting this work done and going forward in a positive way.

[The prepared statement of Hon. Todd Russell Platts follows:]

Rep. Todd Platts

Opening Statement
"Improper Medicare Payments: $48 Billion in Waste?"
July 28, 2011

The purpose of today's hearing is to continue this committee's examination of improper payments made by the federal government. In 2010, the government estimates that there was $48 billion in improper Medicare payments. This figure represents over 38 percent of *all* identified improper payments made by the government in Fiscal Year 2010, and is likely only a partial accounting of Medicare's total amount of improper payments.

Medicare is considered a high risk program by the U.S. Government Accountability Office. It is known to be susceptible to fraud, waste, and abuse. Last year, the Medicare Fee-for-Service program reported more improper payments than any other federal program. Many of these improper payments are a direct result of insufficient internal controls and financial management.

The Centers for Medicare and Medicaid Services (CMS) process almost 5 million claims every day, relying on automated systems to identify improper claims. Most claims are paid without any individual review of the claim or the medical records associated with it. This leads to improper payments resulting from claims without sufficient documentation, insufficient or fraudulent documentation, incorrectly coded claims, or services that are not deemed reasonable or necessary.

CMS has been making efforts to better identify and decrease the amount of improper payments in Medicare. In 2009, CMS followed recommendations from the Office of the Inspector General to implement stricter and more thorough methodology to calculate payment error rates. Using this new methodology, CMS identified more improper payments for 2009 and 2010.

CMS is also working to calculate improper payments made through Medicare Part D, the prescription drug program. CMS has not previously calculated improper payment numbers for Part D, and will do so for the first time in Fiscal Year 2011. CMS also plans to increase its oversight of Part D by performing more audits, including on-site audits and face-to-face evaluations. CMS has also announced that it will evaluate the fraud and abuse programs put in place by the third-party insurance companies that administer Part D.

CMS's efforts to increase oversight are commendable. However, more must be done to strengthen internal controls, especially in CMS's contract management. In 2006, CMS began using recovery audit contractors to identify and recover improper payments. The recovery audit contractors have identified numerous vulnerabilities in CMS's programs. CMS has only taken steps to address about 40 percent of significant vulnerabilities.

GAO has also found "pervasive deficiencies" in CMS's contract management internal controls. GAO issued nine recommendations to improve internal controls in 2009, but a year later, it found that CMS had only taken steps to address two of the recommendations.

Improper payments cost taxpayers billions of dollars each year. This hearing is part of a continued effort by this committee to prevent improper payments and other instances of waste, fraud, and abuse in government. I welcome the opportunity today to hear from our witnesses on CMS's progress to identify and prevent improper payments in the Medicare program.

Mr. PLATTS. With that, I yield to the ranking member from New York, the former chairman of the full committee, Mr. Towns.

Mr. TOWNS. Thank you very much to Chairman Issa, the chairman of the full committee, and to you, Chairman Platts, chairman of the subcommittee.

We should be clear about one thing. Improper payments by Medicare or any other agency may be over payments or under payments. They may be fraudulent payments or valid payments lacking proper documentation. They could also be inadequate payments for valid charges.

In today's context of a looming breach of the Federal debt ceiling, it might be tempting to view Medicare's improper payments as an easily identifiable budget savings but that is not the case. Solving the problem of improper payments does not necessarily translate to government savings or a lower Federal deficit. Still, eliminating improper payments is the right thing to do and we should do it. I think we can all agree on that.

I thank Chairman Platts for holding this hearing and I thank our witnesses, Inspector General Levinson, Ms. Snyder, Ms. Daly and Ms. King, for sharing their expertise with us today.

According to GAO, governmentwide improper payments totaled approximately $125 billion in 2010. Medicare alone accounted for nearly $48 billion of that as my colleague indicated. That is almost 40 percent of the improper payments in the entire government. I find these figures deeply troubling and that is why we look forward to hearing from our witnesses today.

President Obama has taken many positive steps toward reducing improper payments since the beginning of this administration. In 2009, the President signed Executive Order 13520 which sought to increase transparency in agencies' accountability regarding improper payments. In 2010, the President also issued two memorandums that instructed OMB and agencies to make it a priority not only to find improper payments, but to recapture the money that was paid.

Additionally, the administration announced last year that the Centers for Medicaid and Medicare Services would cut the fee for service plan improper payment rate in half by 2012. I certainly would like to hear more about CMS's progress in this matter.

Mr. Levinson, of the Inspector General's Office, is one of the watchdog agencies that is responsible for identifying problems and recommending solutions for improper payments in Medicare. GAO is the other watchdog. Between these two and independent innovation by CMS, I am looking forward to hearing about how and when we can eliminate improper payments.

I am encouraged by the progress the administration has made in the last 2 years in reducing improper payments. Whatever it is that this committee needs to do to assist in terms of the reduction, I would let you know that we stand ready to do just that.

Thank you very much for being here and I look forward to your testimony.

Thank you and I yield back.

[The prepared statement of Hon. Edolphus Towns follows:]

Opening Statement

Rep. Edolphus Towns, Ranking Member
Subcommittee on Government Organization, Efficiency, and Financial Management
Hearing on "Improper Medicare Payments: $48 Billion in Waste?"

August 3, 2011

In the 112th Congress alone, House and Senate Committees have held 29 hearings which examined ways to eliminate waste, fraud, and abuse in health care. This Committee is part of this growing chorus and we are determined to find a solution to it.

But we should be clear about one thing: Improper payments, by Medicare or any other agency, may be overpayments or underpayments. They may be fraudulent payments, or valid payments lacking proper documentation. They could also be inaccurate payments for valid charges.

In today's context of a looming breach of the federal debt ceiling, it might be tempting to view Medicare's improper payments as an easily identifiable budget savings. But that is not the case. Solving the problem of improper payments does not necessarily translate to government savings, or a lower federal deficit. Still, eliminating improper payments is the right thing to do. I think we can all agree on that.

I thank Chairman Platts for holding this hearing and I thank our witnesses, Inspector General Levinson, Ms. Snyder, Ms. Daly and Ms. King, for sharing their expertise with us today.

According to GAO, government-wide improper payments totaled approximately $125 billion in 2010. Medicare alone accounted for nearly $48 billion of those payments. That is almost 40% of improper payments in the entire government. I find these figures deeply troubling and that is why I look forward to your insights on how to solve this problem.

President Obama has taken many positive steps toward reducing improper payments since the beginning of his Administration. In 2009, the President signed Executive Order 13520 which sought to increase transparency and agency accountability regarding improper payments.

In 2010, the President also issued two memoranda that instructed OMB and agencies to make it a priority not only to find improper payments but to recapture the money that was paid.

Additionally, the Administration announced last year that the Centers for Medicaid and Medicare Services will cut the Fee-for-Service Plan improper payment rate in half by 2012. I certainly would like to hear more about CMS progress in meeting that goal.

Mr. Levinson's Inspector General's office is one of the watchdog agencies that is responsible for identifying problems and recommending solutions for improper payments in Medicare. GAO is the other watchdog. Between these two, and independent innovations by CMS, I am looking forward to hearing about how and when we can eliminate improper payments.

I am encouraged at the progress that the Administration has made in the last two years in reducing improper payments. Whatever it is that this committee can do to speed the reduction of improper payments in Medicare, let us know. I am confident that we can all work together on bipartisan solutions to this problem.

Mr. PLATTS. I thank the gentleman.

Members will have 7 days to submit opening statements and extraneous materials for the record. Unless any other Member wanted to make a brief opening statement, we will move to our witnesses.

We are honored to have four distinguished public servants here with us today. Daniel Levinson is the Inspector General of the U.S. Department of Health and Human Services. He also serves on the Executive Council of the Council of the Inspectors General on Integrity and Efficiency where he co-chairs the Committee on Inspection and Evaluation.

We are also delighted to have Michelle Snyder, Deputy Chief Operating Officer for the Centers for Medicare & Medicaid Services where she is responsible for leading CMS's improvement initiatives for promoting excellence in operations.

From the Government Accountability Office, we have Kay Daly, Director of Financial Management and Assurance for the Government Accountability Office where her responsibilities include financial management systems, improper payments, contracting cost analysis and health care financial management issues.

Along with Ms. Daly, we have Kathleen King. Ms. King won't be making an opening statement but is available for questions as part of today's hearing. Ms. King is the Director of Health Care for the Government Accountability Office and is responsible for leading studies of the health care system and specializes in Medicare management and prescription drug coverage.

Pursuant to the rules of the committee, all witnesses are sworn in before every hearing. So if I could ask each of our witnesses to stand and raise your right hands.

[Witnesses sworn.]

Mr. PLATTS. Let the record reflect that the witnesses answered in the affirmative.

We will set the clock for about 5 minutes. We do have your written testimony which will be made a part of the record. If you can, stay close to the 5-minutes. If you need to go over a bit, that is fine. We look forward to them getting into questions.

General Levinson, would you begin, please?

STATEMENTS OF DANIEL R. LEVINSON, INSPECTOR GENERAL, OFFICE OF THE INSPECTOR GENERAL, HEALTH & HUMAN SERVICES; MICHELLE SNYDER, DEPUTY CHIEF OPERATING OFFICER, CENTERS FOR MEDICARE & MEDICAID SERVICES; KAY DALY, DIRECTOR OF FINANCIAL MANAGEMENT AND ASSURANCE; AND GOVERNMENT ACCOUNTABILITY OFFICE, ACCOMPANIED BY KATHLEEN KING, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE

STATEMENT OF DANIEL R. LEVINSON

Mr. LEVINSON. Good morning, Chairman Platts, Ranking Member Towns, Chairman Issa and other members of the subcommittee. Thank you for the opportunity to testify about OIG's efforts to monitor and help to reduce Medicare improper payments.

In 2010, CMS reported Medicare errors totaling nearly $48 billion. My written statement describes in more detail OIG's work

analyzing CMS's error rate estimates and our targeted reviews of Medicare improper payments. My testimony this morning summarizes OIG's recommendations in this area.

Although our recommendations are tailored to specific vulnerabilities, the actions we recommend to CMS fall into the following four categories: increased prepayment and post payment review of claims; strengthen program requirements to address vulnerabilities; increase oversight and validation of supporting documentation and educate and issue more guidance to providers.

OIG has consistently recommended that CMS enhance both prepayment and post payment review of claims. For example, OIG's analysis of claims for diabetes testing supplies identified $209 million in improper payment. Prepayment edits can help reduce improper claims for these testing supplies.

In certain areas, CMS should strengthen program requirements to address integrity vulnerabilities. For example, we have recommended that CMS establish a payment cap on chiropractic claims to prevent improper payments for maintenance therapy.

We also have recommended increased review of supporting documentation to verify that requirements are being met. For example, OIG found that Medicare spent $95 million on claims for power wheelchairs that were either medically unnecessary or lacked sufficient documentation to determine medical necessity. One of our recommendations is that CMS review records from sources in addition to the wheelchair suppliers such as the prescribing physician.

Provider education is also critical to ensuring compliance in protecting beneficiaries. We found that 82 percent of hospice claims for beneficiaries and nursing facilities did not meet at least one Medicare coverage requirement, requirements that are in place to protect beneficiaries' health and well being. Medicare paid about $1.8 billion for these claims.

We recommended that CMS provide hospices with guidance on the rules for certifying terminal illness and a checklist of items that must be included in the plans of care.

For our part in provider education, this year, OIG conducted free training seminars in six cities to educate providers on fraud risks and share compliance best practices. We also published a road map for physicians to provide guidance on complying with fraud and abuse laws. I have copies of this available this morning for each and every Member.

Although not all improper payments are fraudulent, all payments resulting from fraud are improper and our efforts to combat fraud are achieving historic results. OIG's investigations resulted in $3.8 billion in court-ordered fines, penalties, restitution and settlements in 2010. To prevent improper payments from compromising the Medicare Trust Fund, OIG refers credible evidence of fraud to CMS to implement payment suspensions, helping to turn off the spigot to prevent payment for fraudulent claims.

Improper payments cost taxpayers billions of dollars each year. The Executive order on reducing improper payments states that the Federal Government must make every effort to confirm that the right recipient receives the right payment for the right reason at the right time. OIG is committed to this goal and thank you for support of our mission.

I would be happy to answer your questions.

[The prepared statement of Mr. Levinson follows:]

Testimony of:
Daniel R. Levinson
Inspector General
U.S. Department of Health & Human Services

Good morning, Chairman Platts, Ranking Member Towns, and other distinguished Members of the Subcommittee. I am Daniel Levinson, Inspector General of the U.S. Department of Health & Human Services (HHS or the Department). Thank you for the opportunity to testify about the HHS Office of Inspector General's (OIG) efforts to monitor and make recommendations to reduce Medicare improper payments. OIG's mission is to protect the integrity of HHS programs, as well as the health and welfare of program beneficiaries. In fulfillment of this mission, we recommend program safeguards, follow up on those recommendations, promote provider compliance, and investigate and hold accountable those who defraud and abuse the Department's programs. My testimony will describe the scope of the problem, OIG's oversight of the Department's measurement of Medicare improper payments, and OIG's role in preventing, detecting, and reducing improper payments.

Improper Medicare Payments Cost Taxpayers Billions of Dollars Each Year
In 2010, the Centers for Medicare & Medicaid Services (CMS) reported Medicare improper payments totaling $47.9 billion. Of that total, $34.3 billion is attributable to Medicare Fee-for-Service (10.5-percent error rate) and $13.6 billion is attributable to Medicare Part C (14-percent error rate).

Some but not all improper payments are the result of fraud. Improper payments can also result from medically unnecessary claims, miscoded claims, eligibility errors, or insufficient documentation. Examples of improper payments include payments made to an ineligible recipient, duplicate payments, or payment for services not received. For example, my office recently identified $3.6 million in improper Medicare Part D payments on behalf of deceased beneficiaries.

OIG has long been at the forefront of measuring, monitoring, and recommending actions to reduce improper payments, including developing the first Medicare payment error rate in 1996, a time when there were few existing error rate models in Government. OIG identifies improper payments for specific items and services, assesses internal control and payment vulnerabilities, and makes recommendations to reduce future improper payments. To maximize the impact of these reviews, we assess program risks and employ data analysis to target our audits, evaluations, and investigations.

OIG Reviews the Measurement of Medicare Improper Payment Rates
Measuring error rates is key to monitoring program integrity and the scope of inappropriate payments. In 2003, CMS assumed responsibility for, and OIG began providing oversight of, the error rate process. CMS established the Comprehensive Error Rate Testing (CERT) program to produce a Medicare fee-for-service error rate.

OIG reviews CMS's estimates of improper payments and has analyzed the error rate by types of providers and by types of error. This analysis supports CMS's efforts to reduce the error rate by

identifying what types of errors are most frequent and which provider types are committing those errors, so that CMS can refine and target its remediation efforts accordingly. For example, OIG found that in the fiscal year (FY) 2009 CERT, inpatient hospitals, durable medical equipment suppliers, hospital outpatient departments, physicians, skilled nursing facilities, and home health agencies accounted for 94 percent of improper Medicare payments. We also found that insufficient documentation, miscoded claims, and medically unnecessary services and supplies accounted for about 98 percent of the improper payments attributable to the six types of providers. OIG is also planning audit work to follow up on "error-prone" providers, i.e., individual providers with erroneous claims in each of the past four CERT cycles, to test those providers' claims and identify improper payments.

OIG Reviews Identify Improper Payments and Recommend Corrective Actions

OIG conducts targeted reviews to determine the scope of improper payments for specific service types and recommends actions to improve program safeguards. By reviewing medical records and other documentation associated with a claim, we identify services that are undocumented, medically unnecessary, or incorrectly coded, as well as duplicate payments and payments for services that were not provided. In doing so, we uncover systemic payment vulnerabilities and make recommendations to address them.

Medically unnecessary services are particularly concerning as beneficiaries may be subjected to tests and treatments that serve no purpose and may even cause harm. Further, because beneficiaries are generally responsible for a 20-percent copayment for items and services provided under Medicare Part B, beneficiaries may pay unnecessary or inflated copayments when they receive items or services that they do not need, or more expensive versions than they need.. For beneficiaries who are eligible for Medicare and Medicaid, their Medicaid programs may bear the costs of these copayments.

For example, we reviewed claims for certain types of support surfaces used to prevent and treat bedsores and found that more than 1 in 5 claims were medically unnecessary. In a review of power wheelchairs, we determined that 9 percent of claims were not medically necessary and the records for an additional 52 percent of claims did not contain sufficient documentation to determine whether they were medically necessary. Improper payments for these claims totaled $95 million over a 6-month period. To address these and other types of errors, we recommended that CMS take a variety of actions to ensure that claims are paid appropriately, including conducting additional prepayment and post-payment medical reviews.

For some services, we have found pervasive documentation errors. For example, we found that 60 percent of Medicare claims for rehabilitation power wheelchairs did not meet all documentation requirements. These claims accounted for $112 million in improper Medicare payments over a 6-month period. We have also found significant rates of documentation error for certain types of pain management services. We recommended that CMS take actions to address these errors, including improving controls, educating providers, and clarifying guidance.

In some cases, documentation or coding errors may signal broader vulnerabilities affecting patient care. For example, we found that 82 percent of hospice claims for beneficiaries in nursing facilities did not meet all Medicare coverage requirements – requirements that are in

place to protect beneficiaries' health and wellbeing. Problems included failing to establish plans of care and providing fewer services than outlined in beneficiaries' plans of care, potentially putting the beneficiary at greater risk. To prevent these problems from recurring and to better protect hospice patients, we recommended that CMS educate hospice providers about coverage requirements, provide tools to hospice providers (e.g., guidance, templates, and checklists), and use targeted medical reviews and other oversight to improve compliance.

In addition to medical record reviews designed to flag individual improper claims, OIG also conducts data analysis to identify broader patterns indicative of improper payments and potential fraud and abuse. For example, through data analysis we have identified "outliers" that bill for services at an unusually high rate, as well as patterns in which certain geographic areas exhibit unusual billing, and also have matched claims and other data to identify billing patterns that raise concern. These types of analyses can generate leads for investigations, audits, and further medical record review. In addition, these reviews can lead to recommendations to CMS to strengthen its program oversight activities and reduce future improper payments. For example, OIG reviewed high-utilization claims for blood-glucose test strips and lancet supplies, and identified an estimated $270 million in improper Medicare payments for these supplies. We recommended that CMS contractors implement various adjustments to its payment system, such as those to identify claims with overlapping dates of service.

OIG Will Continue To Monitor and Recommend Actions To Reduce Improper Payments
OIG's work helps CMS to better identify, track, and reduce improper payments. For example, because of OIG concerns that the Medicare error rates for certain provider types may be understated, CMS made substantial changes in the CERT medical record review process in 2009. In addition, we have recommended that CMS enhance pre-payment review of claims, including the use of specific adjustments to address identified payment errors, and work with providers to educate and enforce program requirements, including documentation requirements. We also have made recommendations aimed at reducing improper payments for specific items and services, as described above.

OIG currently is conducting a series of audits of hospital compliance with Medicare requirements. Based on prior audit and enforcement work, we have identified 27 "high risk" areas of hospital billing. Using data mining, we further focus on potential problem areas and hospitals, and we then select claims for testing and conduct hospital site visits to perform comprehensive reviews of billing and medical record documentation. In addition to identifying and recovering improper Medicare payments, we are recommending improvements to internal controls to prevent future improper billings.

OIG is also conducting in-depth reviews of claims for evaluation and management services, power wheelchairs, and Part A payments to skilled nursing facilities to determine whether these payments met Medicare coverage requirements. In addition, we are conducting data analysis to identify potential improper payments in a variety of areas, including lower limb prostheses, Part D drugs, and home health care. Other planned work includes a review of prior year improper payment determinations that have subsequently been overturned on appeal and a pilot project to obtain missing documentation identified during the comprehensive error rate testing.

OIG Also Leads the Fight Against Medicare Fraud

Although not all improper payments are fraudulent, all payments resulting from fraud are improper. There is no precise measure of the magnitude of health care fraud, but we know that it is a serious problem that demands an aggressive response.

OIG has been leading the fight against health care fraud and abuse for more than 30 years. Although the majority of health care providers are honest and well-intentioned, a minority of providers who are intent on abusing the system cost taxpayers billions of dollars per year. During this FY, OIG has opened more than 1,700 health care fraud investigations. Additionally, our enforcement efforts resulted in more than 900 criminal and civil actions and $3.8 billion in court-ordered fines, penalties, restitution, and settlements in FY 2010.

We also work to help prevent fraud and promote compliance through guidance and outreach to health care providers. This year, OIG conducted free training seminars in six cities to educate providers on fraud risks and share compliance best practices. We also published a *Road Map for New Physicians* to provide guidance on complying with fraud and abuse laws.

Conclusion

Executive Order 13520 on reducing improper payments states that the Federal Government must make every effort to confirm that the right recipient receives the right payment for the right reason at the right time. OIG is committed to this goal. Thank you for your support of our mission.

Mr. PLATTS. Thank you, General Levinson.
Ms. Snyder.

STATEMENT OF MICHELLE SNYDER

Ms. SNYDER. Good morning.

Thank you, Chairman Platts, Ranking Member Towns and Chairman Issa, for being with us today and members of the subcommittee for this opportunity to discuss the Centers for Medicare & Medicaid Services' efforts to reduce improper payments to Medicare.

CMS is committed to reducing the amount of improper payments and the rate and ensuring that our programs pay the right amount for the right service to the right person in a timely manner. Like other large and complex programs, Medicare is susceptible to improper payments. In accordance with the Improper Payments Information Act, CMS calculates an improper payment rate for the Medicare Program annually. While these improper payments represent a fraction of total program spending, any level of improper payment is unacceptable and CMS is aggressively working to reduce errors.

There is confusion about what improper payments are and what they are not. Improper payments are errors that generally result from one of the following situations: the provider fails to submit any documentation or submits insufficient documentation to support the service paid; the provider incorrectly codes the service on the claim or the documentation submitted by the provider shows that the services provided were not reasonable or necessary.

Improper payments do not always represent an unnecessary loss of Medicare funds, rather they are an indication of errors made by either the provider in filing a claim or inappropriately billing for that service. Improper payments are usually not fraudulent. CMS is committed to reducing improper payments in our programs and we have developed many corrective actions to resolve and eliminate these improper payments in the future.

The traditional Medicare Fee for Service Program represents the majority of Medicare spending. This program is administered by CMS through contracts with private companies that process close to 5 million claims each day or approximately 1.2 billion claims in a fiscal year. CMS uses the comprehensive error rate testing process to estimate an improper payment rate for the Medicare Fee for Service programs.

Between fiscal years 2009 and 2010, CMS was able to reduce the improper payment rate by 1.9 percent from 12.4 percent in 2009 to 10.5 percent in 2010. The CERT Program provides valuable information to assist in the development of corrective action to reduce improper payments in the future. We believe the best way to address these documentation problems is through robust provider education and outreach efforts, performing more review of provider medical records to ensure services billed meet Medicare policies and payment rules and enhanced systems edits and automated analytic tools.

Some of our recent provider education efforts include the development of comparative billing reports, issuance of quarterly compliance reports and conducting routine forums to discuss Medicare

policies and documentation requirements. We also recently implemented nationally the National Recovery Audit Program. This program allows recovery auditors on a contingency fee basis to identify overpayments and under payments in a previously submitted and paid claim.

The Permanent Medicare Fee for Service Recovery Audit Program has corrected a total of $685 million in improper payments in a 12 month period. The program also provides valuable information about areas where increased education and outreach is needed and where prepayment medical review is most productive. These tools also assist in the development of automated edits to detect and reject claims where medical services are physically impossible and medically unlikely.

In Medicare Parts C and D they differ significantly from the Medicare Fee for Service Program and require different approaches to measure and address improper payments. CMS prospectively pays Medicare Parts C and D plans a monthly capitated payment for each enrolled beneficiary. These per person capitated payments are risk adjusted on a beneficiary's health status.

The Part C improper payment rate in fiscal 2010 was 14.1 percent, a reduction of 1.3 percent from the fiscal year 2009 rate of 15.4. Most of the Part C improper payments are the results of errors related to the fact that the supporting medical records submitted do not include the necessary diagnosis data to support the CMS risk adjusted payment.

Again, we are working very closely to implement a number of audit strategies in the Medicare Parts C and D programs. This year, we are happy to report that in November of this year, we will be reporting a composite Part D rate which will be the first time that we have reported the rate. We believe the information, as we have gone through establishment of that error, will help us to start to push that error down because of what we have learned through that measurement process.

We have a number of strategies in place I would be happy to talk about as we proceed through the hearing this morning. I would also like to assure you that we are examining techniques used by the private sector, by insurance companies and others to better inform our efforts to combat improper payments.

We are eager to learn from successful private sector efforts to reduce errors and improper payments, and have indeed begun to form partnerships across the health care sector to ensure that we have the best information we can to make a difference in the Medicare Program and to help them also learn from our experiences in what is a very large payment program.

While CMS has made significant progress in reducing waste and errors in our programs, we understand more work remains. I am confident that the systems controls and ongoing corrective actions that CMS is undertaking, plus the help of our partners and the Office of the Inspector General, and other parts of the Department, will help us in continuing this undertaking that will result in continued reduction in improper payments.

I look forward to working with the subcommittee to ensure that CMS carries out this important work and to answer an questions you may have.

Thank you.

[The prepared statement of Ms. Snyder follows:]

U.S. House Committee on Oversight & Government Reform
Subcommittee on Government Organization, Efficiency, and Financial Management

July 28, 2011

Chairman Platts, Ranking Member Towns, and Members of the Subcommittee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) efforts to reduce improper payments in Medicare. The Administration is strongly committed to ensuring that our programs pay claims in an accurate and timely manner and reducing the rate of improper payments.

Background on Improper Payments

Like other large and complex Federal programs, Medicare is susceptible to payment, billing and coding errors—called "improper payments." Estimates of improper payment rates are determined annually in an open and transparent process as required by the Improper Payments Information Act (IPIA) of 2002, and amended by the Improper Payments Elimination and Recovery Act (IPERA) of 2010. While improper payments represent a fraction of total program spending, any amount of improper payment is unacceptable and CMS is aggressively working to reduce these errors.

The IPIA uses the term "improper payment" to describe these errors, however it is important to clarify what these billing anomalies are – and are not. They can result from a variety of assorted circumstances, including: 1) services with insufficient documentation, 2) services provided that were not determined "reasonable and necessary," 3) incorrectly coded claims, or 4) services with no documentation. Further, improper payments do not mean an item or service was not needed. These payments are not necessarily fraudulent; rather, they tend to be an indication of errors made by the provider in filing a claim or inappropriately billing for a service. Most improper payments by providers are classified as such because they relate to claims where the information in the medical record did not support the services billed. Examples of common payment errors made by Medicare providers include services that were performed in a medically unnecessary setting[1], or were

[1] Medically unnecessary setting: Medicare claims fall into this category when services are provided in a more intensive (and expensive) setting than is considered reasonable and necessary by Medicare. For example, if a minor surgery is done in an inpatient hospital setting on a healthy beneficiary, instead of in an outpatient setting, the entire claim is classified as an "improper payment."

incorrectly coded.[2] Other payment errors result when providers fail to submit documentation when requested, fail to submit adequate documentation to support the claim, when Medicare pays a claim that should have been paid by a different group health plan or other liable party, or when a service is not medically necessary.

The Administration is committed to reducing waste and improper payments across the government. On November 20, 2009, President Obama issued Executive Order No. 13520, *Reducing Improper Payments,* calling on all Federal agencies to reduce improper payments by boosting transparency and accountability across Federal programs and CMS is working hard to carry out the Order. In addition, the President has issued a memorandum on intensifying and expanding payment recapture audits (March 10, 2010) and issued a memorandum to enhance payment accuracy by creating a "Do Not Pay" List (June 18, 2010). On July 22, 2010, the President signed IPERA into law to improve agencies' identification and estimation of improper payments and expand payment recovery audits to all types of programs and activities with $1 million in annual outlays if cost-effective.

Improper Payments in Medicare Fee-for-Service

The traditional, Medicare fee-for-service (FFS) program represents the majority of Medicare spending, with hospital and other institutional services representing the largest spending outlays. CMS administers the Part A and B programs through contracts with Medicare Administrative Contractors (MACs), which are private companies that process claims for Medicare beneficiaries.

In keeping with laws that require CMS to promptly pay Medicare claims, our claims processing systems were built to quickly process and pay the roughly 4.8 million claims that we receive each day, totaling an approximate estimate of 1.2 billion claims in fiscal year 2011. Due to the volume of claims processed by Medicare each day and the significant cost associated with conducting medical review of an individual claim, CMS relies heavily on automated edits to identify inappropriate claims. As such, most claims are paid by CMS without requesting or individually reviewing the medical records associated with the services listed in the claim.

[2] Incorrect coding: Claims are placed into this category when providers submit medical documentation that support a lower or higher code than the code submitted. (CMS Improper Medicare Fee-For-Service Payments Report, https://www.cms.gov/CERT/10_CERT_Reports_and_Data.asp#TopOfPage).

CMS uses the Comprehensive Error Rate Testing (CERT) process to sample and review Medicare FFS claims to estimate an improper payment rate. At the recommendation of the Department of Health and Human Services (HHS) Office of Inspector General, CMS applied a stricter and improved methodology for calculating the Medicare FFS error rate in FY 2009. As a result of this change, the FY 2009 and FY 2010 FFS error rates were higher than in FY 2008; 12.4 percent and 10.5 percent in FY 2009 and FY 2010 respectively compared to 3.6 percent in FY 2008. The Administration announced last year that CMS will cut the Medicare FFS improper payment rate in half by FY 2012, from 12.4 percent to 6.2 percent. CMS is making progress in meeting this goal, with a 1.9 percent point reduction in the error rate between FY 2009 and FY 2010.

In addition to measuring the Medicare FFS error rate, the CERT program guides CMS in developing corrective actions to reduce improper payments in the future. CMS continues to analyze the improper payment data gathered from the CERT program and uses the results to manage and provide feedback to Medicare contractors to inform and enhance their medical review efforts, focus on high-risk areas, and improve overall operations.

To help reduce medical necessity errors, which occur when documentation submitted by a provider does not sufficiently establish the beneficiary's medical need for an item or service, CMS has developed an internal control called Comparative Billing Reports, which compare a provider's billing pattern for various procedures or services to their peers on a State and national level. Also, Medicare's automated systems can detect and reject payment for medical services that are physically impossible, such as a hysterectomy billed for a male beneficiary. Additionally, CMS has developed "medically unlikely" payment systems edits, which detects services when the quantity billed exceeds acceptable clinical limits.

Recovery Audit Program in Medicare FFS

The Recovery Audit program is another financial management tool in CMS' efforts to detect and reduce improper payments. The Recovery Audit program began as a 6-State demonstration project required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.[3] Congress expanded the Recovery Audit program in the Tax Relief and Health Care Act of 2006,

[3] CMS began this demonstration in Florida, California, and New York in 2005, and later expanded to Massachusetts, South Carolina, and Arizona.

directing CMS to implement a permanent national Recovery Audit program in Medicare FFS by January 1, 2010. Recovery Auditors work to identify overpayments and underpayments in previously submitted and paid claims; per the statute, these contractors are paid on a contingency fee basis. The permanent Medicare FFS Recovery Audit program, as of July 4, 2011, corrected a total of $685 million in improper payments, including $110 million in underpayments corrected and $575 million in overpayments collected.

More importantly, the Recovery Auditors help CMS identify areas where policy changes, systems changes, and provider education and outreach can help prevent future improper payments. CMS employs a robust system to identify patterns in the vulnerabilities identified by Recovery Auditors and to undertake appropriate corrective actions. During the demonstration, Recovery Auditors identified a number of improper payments in claims related to inpatient rehabilitation facilities (IRF). CMS recognized that the Agency's policy was outdated and published a regulation (CMS 1538-F) to update the policy and conducted extensive provider education to ensure that providers bill IRF claims correctly. In the national program, Recovery Auditors have identified several areas where edits can be helpful in preventing improper payments. CMS has implemented edits to stop the payment of claims provided after a beneficiary's date of death, to stop the payment of durable medical equipment while the beneficiary is receiving care in an inpatient setting, and to stop the payment for individual services that should have been bundled into another payment. In addition, the claim processing contractors have been able to implement local system edits to stop improper payments relating to durable medical equipment bundling (wheelchair and accessories and knee prosthetics) and drugs paid exceeding recommended dosages.

Some vulnerabilities cannot be fixed with automated edits and may require ongoing medical review and other more resource intensive activities. As such, the President's FY 2012 Budget Request includes a legislative proposal that would allow CMS to retain a dedicated portion of the funds recovered by Recovery Auditors. This would allow CMS to implement additional corrective actions and internal controls to prevent future improper payments, such as targeted prepayment review and provider education. Funding these financial management activities to prevent future improper payments is estimated to generate net savings of $230 million over 10 years.

Improper Payments in Medicare Parts C and D

The Medicare Advantage (MA) managed care benefit (Part C) and the prescription drug benefit (Part D) differ significantly from Medicare FFS and, as a result, require different approaches and internal controls to measure and address improper payments. Unlike Medicare FFS, CMS prospectively pays Medicare Part C and Part D plans a monthly capitated payment. Each per-person payment is based on a bid amount, approved by CMS, that reflects the plan's estimate of average costs to provide benefit coverage to enrollees. CMS risk-adjusts these payments to take into account the cost associated with treating individual beneficiaries based on health status. In addition, Part D payments are also reconciled against expected costs, and risk-sharing rules set in law are applied to further mitigate plan risk.

The Part C error rate reported for FY 2010 (based on payment year 2008) is 14.1 percent, a reduction from the FY 2009 rate of 15.4 percent. Most of the Part C payment error rate is driven by errors in risk adjustment data (clinical diagnosis data) submitted by MA plans to CMS for payment purposes. Specifically, the risk adjustment error reflects the extent to which diagnoses that plans report to CMS are not supported by medical record documentation.

To reduce the level of Part C improper payments due to risk adjustment error, the President's FY 2012 budget includes a proposal to require CMS to conduct contract-level Risk Adjustment Data Validation (RADV) audits, and to extrapolate the sample results for each MA contract to all enrollees in that contract for a given year. That is, the payment error for a contract's sampled beneficiaries, which is based on diagnoses not supported by medical record documentation during the RADV process, would be extrapolated from the sample to all contract enrollees. Enactment of this proposal would result in increased collections of improper payments made to MA plans, and is estimated to save $6.16 billion over 10 years.

CMS has made strides in developing a Medicare Part D composite error estimate based on a series of payment error sources, and plans to report a Part D composite error rate beginning in FY 2011. For FY 2010 reporting, a total of four component error estimates were reported. The four components were: 1) a Part D payment system error of 0.1 percent, 2) a low-income subsidy payment error of 0.1 percent, 3) payment error related to Medicaid status for dual eligible Part D enrollees of 1.8 percent, and 4) payment error related to prescription drug event data validation of 12.7 percent. A significant portion of the prescription drug event data error rate was due to missing

prescription documentation from pharmacies. To reduce this error rate, CMS has provided Part D sponsors with additional guidance and addressed the timing of documentation submissions to assist them in improving collection of prescription documentation from pharmacies.

Recovery Audit Program in Medicare Parts C and D

The Affordable Care Act expanded the Recovery Audit program to Medicare Parts C and D and the Medicaid program, and CMS is drawing from the lessons learned from the Medicare FFS Recovery Audit program as we implement this new statutory authority. In January 2011, CMS awarded a contract to identify incorrect payments and recoup overpayments in Medicare Part D. Additionally, we sought public comment through a solicitation issued on December 27, 2010 in the Federal Register on innovative strategies for review of additional Medicare Parts C and D data, including the effectiveness of sponsors' anti-fraud plans. We are currently reviewing the comments we received.

New Efforts to Enhance Automated Provider Screening

Building on the results of a successful automated provider-screening pilot, in July 2011, we posted a solicitation for an automated provider enrollment screening solution. The successful pilot leveraged an external private sector database to test the added value of augmenting our internal data on provider enrollment with publicly available information on a rolling basis. CMS currently verifies and validates various data elements on provider enrollment applications using a multitude of websites available to the general public, however, this process of verification is somewhat cumbersome, and resource intensive. Additionally, maintaining provider data is currently dependent on providers self-reporting changes in information that is relevant to Medicare enrollment. When changes fail to be reported or are reported in an untimely manner, providers who are not or are no longer eligible for enrollment continue to bill the program. In the pilot program, which we intend to expand more widely, we found that linking an automated screening tool to our Medicare enrollment database significantly reduced the application processing time by providing "one-stop shopping" for enrollment relevant information. Continuous, automated monitoring and management of the enrollment database identified outdated provider records more quickly, and permitted the proactive confirmation of key information changes. We are excited about this new solicitation, which will provide us with another opportunity to save taxpayer money, particularly in

the area of monitoring license expiration, by timely identifying ineligible providers and taking appropriate actions to ensure they are not improperly billing.

We anticipate that this new screening technology will automatically verify information provided on an enrollment application for all Medicare provider and supplier types in all 50 States, the District of Columbia, and the five Territories. The screening will compile CMS data and appropriate external data sources, such as the National Plan and Provider Enumeration Systems for the National Provider Identifier (NPI), the General Services Administration (GSA) Excluded Parties List, and the Office of the Inspector General (OIG) exclusion database. The screening will also actively monitor compliance with requirements such as license status or changes in physical location. We anticipate awarding the contract in late September 2011, with implementation of the screening solution by the end of the year. All existing and new enrollments will be screened and validated by March 2013.

Lessons Learned from the Private Sector

As we seek to continuously improve our internal controls and data systems to reduce improper payments, CMS is also examining the techniques used by insurance companies and other private sector entities. Though our Federal programs differ from private insurance in some significant ways, CMS is eager to learn from successful private sector efforts to reduce errors and improper payments. We are now using predictive modeling technology, which is similar to technology used be private industries, to assign risk scores to Medicare claims. Predictive modeling is an innovative technology that can detect potential fraud and improper payment by simultaneously analyzing multiple data sources, such as provider billing patterns and the distance between service location and a beneficiary's address, for a very large number of claims. Our new system is able to identify suspect claims prior to payment. Through this new technology, we now have an integrated view of Medicare FFS claims nationwide. This comprehensive view alerts us about potential problems as claims are submitted, instead of relying primarily on post-payment data. In addition to harnessing improved data analysis and predictive modeling to fight fraud, CMS is using these approaches to identify areas to target with additional medical review. As part of this effort, CMS will evaluate the accuracy of commercial products, whether the products are feasible to implement, and if they could reduce improper payments.

CMS is also examining other internal controls and processes, such as ways to link claims data and provider data within and across our various healthcare programs. The ability to identify trends sooner and link data is an important tool in preventing future improper payments. Additionally, CMS is exploring ways to leverage existing compliance programs within the provider community to inform and educate providers about payment vulnerabilities. Getting providers actively involved in the identification and prevention process will keep improper payments from occurring in the first place.

Conclusion

CMS' number one goal is to ensure our Medicare beneficiaries receive the right services, at the right time, in appropriate levels of care and at the right price. While CMS has made progress in reducing improper payments, we acknowledge that more work remains. Reducing waste and errors in our programs will allow us to target taxpayer funds to provide health care services for our beneficiaries. I am confident that the systems controls and ongoing corrective actions that CMS is undertaking across our programs will result in continued reductions in improper payments. I look forward to working with the Subcommittee to ensure that CMS has the necessary administrative resources and tools to continue our efforts to carry out this important work.

Mr. PLATTS. Thank you, Ms. Snyder.
Ms. Daly.

STATEMENT OF KAY DALY

Ms. DALY. Chairman Platts, Ranking Member Towns and other members of the subcommittee, I want to thank you for the opportunity to be here today to discuss improper payments in the Medicare Program, as well as CMS's efforts to remediate them.

In 2010, Medicare covered about 47 million elderly and disabled beneficiaries and had estimated outlays of about $516 billion. It makes it one of the largest Federal programs. Medicare consists, as you know, of four parts: Medicare Parts A and B, commonly known as fee for service; Part C is the Medicare Advantage Program; and Part D is the Medicare Outpatient Prescription Drug Program.

An improper payment is defined as any payment that should not have been made or that was made in an incorrect amount and includes both overpayments and under payments. For fiscal year 2010, HHS reported an estimate of almost $48 billion in improper payments in Medicare. The $48 billion in estimated improper payments was attributable just to Medicare Fee for Service and Medicare Advantage.

From a governmentwide perspective, the Medicare Program does represent about 38 percent of the $125 billion in estimated improper payments that had been reported by the 20 Federal agencies that covered 70 programs. HHS's estimated amount of improper payments for Medicare is incomplete because it has yet to report a comprehensive improper payment estimate for the Medicare prescription drug benefits. That program had reported outlays of about $59 billion in fiscal year 2010. As Ms. Snyder just indicated, HHS expects to report a comprehensive estimate for the prescription drug benefit in fiscal year 2011.

It is important to recognize that the $48 billion in improper payments reported by HHS in fiscal year 2010 is not an estimate of fraud in Medicare. Reported improper payment estimates includes many types of over payments, under payments and payments that were not adequately documented.

In addition, because the improper payment estimation process is not designed to detect or measure the amount of fraud in Medicare, there may be fraud that exists in the program that is not encompassed in the reported improper payment estimates.

In 2010, CMS created the Center for Program Integrity to serve as a focal point for all national Medicare program integrity issues. The CPI as it is known is responsible for addressing program integrity issues and vulnerabilities that lead to improper payments. They collaborate with other CMS components to develop and implement a comprehensive, strategic plan, objectives and measures to carry out the program integrity mission and goals.

CMS has also begun a number of initiatives related to five strategies that have been identified in our previous reporting. These strategies are key to reducing Medicare improper payments. However, CMS still faces significant challenges in designing and implementing internal controls to effectively prevent or detect and recoup improper payments.

Effective implementation of prior recommendations we made from provisions in recently enacted laws and recent guidance related to these five fee strategies could help remediate fraud, waste, abuse and improper payments in the Medicare programs. The five key strategies are strengthening provider enrollment standards and procedures; improving prepayment review of claims; focusing post payment claims review on the most vulnerable areas; improving oversight of contractors; and developing a robust process for addressing identified vulnerabilities.

For example, having mechanisms in place to resolve vulnerabilities that lead to improper payments is key to effective program management, but our work has shown that CMS has not yet established an adequate process during its recovery audit demonstration project or in planning for the subsequent recovery audit of national programs to ensure that the vulnerabilities that had been identified were promptly resolved.

In conclusion, with the amount of estimated improper payments and the unknown amount of potential fraud, waste and abuse in the Medicare program, it is critical for CMS to act quickly and decisively to reduce them. As it implements recently enacted laws and other issues for Medicare, CMS has an opportunity to use new tools to help further address fraud, waste, abuse and improper payments in this program.

Chairman Platts, Ranking Member Towns and the other members of the committee, this completes my prepared statement and I would be glad to answer any questions you might have.

[The prepared statement of Ms. Daly follows:]

United States Government Accountability Office

GAO

Testimony before the Subcommittee on Government Organization, Efficiency and Financial Management, Committee on Oversight and Government Reform, House of Representatives

For Release on Delivery
Expected at 9:30 a.m. EDT
Thursday, July 28, 2011

IMPROPER PAYMENTS

Reported Medicare Estimates and Key Remediation Strategies

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

Kathleen M. King
Director, Health Care

U.S. Government Accountability Office
GAO 90 YEARS 1921-2011
ACCOUNTABILITY * INTEGRITY * RELIABILITY

GAO-11-842T

July 28, 2011

GAO
Accountability * Integrity * Reliability

Highlights

Highlights of GAO-11-842T, a testimony before the Subcommittee on Government Organization, Efficiency and Financial Management, Committee on Oversight and Government Reform, House of Representatives

IMPROPER PAYMENTS

Reported Medicare Estimates and Key Remediation Strategies

Why GAO Did This Study

GAO has designated Medicare as a high-risk program because of its size, complexity, and susceptibility to improper payments. In 2010, Medicare covered 47 million elderly and disabled beneficiaries and had estimated outlays of $516 billion. The Centers for Medicare & Medicaid Services (CMS) is the agency in the Department of Health and Human Services (HHS) responsible for administering the Medicare program and leading efforts to reduce Medicare improper payments.

This testimony focuses on estimated improper payments in the Medicare program for fiscal year 2010 and the status of CMS's efforts to implement key strategies to help reduce improper payments. This testimony is primarily based on previous GAO reporting related to governmentwide improper payments, Medicare high-risk challenges and program integrity efforts, and CMS's information technology systems intended to identify improper payments. GAO supplemented that prior work with additional information on the nature and extent of Medicare improper payments reported by HHS in its fiscal year 2010 agency financial report. GAO also received updated information from CMS in February 2011 and, in select cases, as of July 2011, on its actions related to relevant laws, regulations, guidance, and open recommendations pertaining to key remediation strategies.

View GAO-11-842T or key components. For more information, contact Kay L. Daly at (202) 512-9312 or dalykl@gao.gov or Kathleen M. King at (202) 512-7114 or kingk@gao.gov.

What GAO Found

For fiscal year 2010, HHS reported an estimate of almost $48 billion in Medicare improper payments, representing about 38 percent of the total $125.4 billion estimate for the federal government. However, this Medicare improper payment estimate is incomplete because HHS has yet to develop a comprehensive estimate for the Medicare prescription drug benefit. The improper payment estimate includes both overpayments and underpayments. Causes cited include inadequate documentation, medically unnecessary services, coding errors, and payment calculation errors. It is important to recognize that the $48 billion is not an estimate of fraud in Medicare. Because the improper payment estimation process is not designed to detect or measure the amount of fraud that may exist, there may be fraud that is not reflected in HHS's reported estimate.

CMS faces challenges in designing and implementing internal controls to effectively prevent or detect and recoup improper payments. In 2010, CMS established the Center for Program Integrity to serve as its focal point for all national Medicare program integrity issues. Based on past work, GAO identified five key strategies to help reduce fraud, waste, and abuse and improper payments in Medicare, which CMS has reported initiating actions to address. GAO has made recommendations to strengthen CMS's implementation of these strategies, some of which the agency has not implemented.

Strengthen provider enrollment standards and procedures. Strong standards and procedures can help reduce the risk of enrolling providers intent on defrauding the program. CMS has taken action to implement provisions of the Patient Protection and Affordable Care Act by screening providers by levels of risk and providing more stringent review of high-risk providers, but has yet to implement certain GAO recommendations in this area.

Improve prepayment reviews. Prepayment reviews of claims help ensure that Medicare pays correctly the first time. According to CMS, as of July 1, 2011, CMS has begun applying predictive modeling analysis to claims and plans to expand Medicare prepayment controls. CMS has not implemented GAO's recommendation to improve prepayment reviews.

Focus postpayment reviews on vulnerable areas. Postpayment reviews are critical to identifying payment errors and recouping overpayments. In March 2009, CMS began instituting a national recovery audit contractor (RAC) program to help the agency supplement its postpayment reviews. CMS has also developed information technology to help it better identify claims paid in error, but GAO recently reported that the systems are not being used to the extent originally planned and made several recommendations to address the issues.

Improve oversight of contractors. CMS has taken action to improve oversight of prescription drug plan sponsors' fraud and abuse programs, which addresses GAO's recommendation, but is still developing specific performance statistics.

Develop a robust process to address identified vulnerabilities. Having mechanisms in place to resolve vulnerabilities that lead to improper payments is critical. While CMS has begun actions in this area, it has not developed a robust corrective action process for vulnerabilities identified by Medicare RACs as GAO recommended.

Chairman Platts, Ranking Member Towns, and Members of the Subcommittee:

Thank you for the opportunity to be here today to discuss improper payments in the Medicare program, as well as the Centers for Medicare & Medicaid Services' (CMS) efforts to remediate them. In 2010, Medicare covered 47 million elderly and disabled beneficiaries and had estimated outlays of $516 billion, making it one of the largest federal programs. Medicare consists of four parts: A, B, C, and D. Medicare Parts A and B are known as Medicare fee-for-service. Part A covers hospital and other inpatient stays. Medicare Part B covers hospital outpatient, physician, and other services. Part C is Medicare Advantage, under which beneficiaries receive benefits through private health plans. Part D is the Medicare outpatient prescription drug benefit. CMS is the agency in the Department of Health and Human Services (HHS) responsible for administering the Medicare program and leading efforts to reduce Medicare improper payments.

GAO has designated Medicare as a high-risk program because of its size, complexity, and susceptibility to improper payments.[1] As defined by the Improper Payments Elimination and Recovery Act of 2010 (IPERA), an improper payment is 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.[2] For fiscal year 2010, federal agencies reported an estimated $125.4 billion in improper payments, of which Medicare accounts for nearly $48 billion—the highest estimated amount of improper payments in a single program. The Medicare improper payment estimates do not reflect all of the program's risk because HHS did not report a total improper payment estimated amount for its Medicare prescription drug benefit program (Part D). Despite progress made by CMS, reducing improper payments in the program is a continuing challenge for CMS due to the size and scope of Medicare.

[1]GAO, *High-Risk Series: An Update*, GAO-11-278 (Washington, D.C.: February 2011).

[2]Pub. L. No. 111-204, 124 Stat. 2224 (July 22, 2010). This definition includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except where authorized by law), and any payment that does not account for credit for applicable discounts. Office of Management and Budget (OMB) guidance also instructs agencies to report payments for which insufficient or no documentation was found as improper payments.

Fiscal year 2010 marked the 7th year of implementation of the Improper Payments Information Act of 2002 (IPIA).[3] IPIA requires executive branch agencies to annually review all programs and activities to identify those that are susceptible to significant improper payments, estimate the annual amount of improper payments for such programs and activities, and report these estimates along with actions taken to reduce improper payments for programs with estimates that exceed $10 million. IPERA, enacted July 22, 2010, amended IPIA by expanding the previous requirements for identifying, estimating, and reporting on programs and activities susceptible to significant improper payments and expanding requirements for recovering overpayments across a broad range of federal programs.[4] IPERA provisions generally became effective in fiscal year 2011. The Office of Management and Budget (OMB) has since issued updated guidance for federal agencies on reporting, reducing, and recovering improper payments.[5] In addition, the Patient Protection and Affordable Care Act (PPACA),[6] as amended by the Health Care and Education Reconciliation Act of 2010,[7] contains provisions designed to help reduce improper payments in the Medicare program. See appendix I for additional information about recent congressional and executive branch actions related to Medicare improper payments.

Today, my testimony will focus on two areas:

- HHS reported estimated improper payments in the Medicare program for fiscal year 2010, and
- the status of CMS's efforts to implement key strategies to help remediate improper payments in the Medicare program.

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

[4]For fiscal year 2010, OMB defined the term "significant improper payments" under IPIA as exceeding both 2.5 percent of program payments and $10 million. IPERA sets forth specific criteria to define the term "significant" for future fiscal years.

[5]OMB, Circular No. A-123, app. C, *Requirements for Effective Measurement and Remediation of Improper Payments* (Apr. 14, 2011); OMB Memorandum M-10-13, Issuance of Part III to OMB Circular A-123, app. C (Mar. 22, 2010); and OMB, Circular No. A-136 Revised, *Financial Reporting Requirements* (Sept. 29, 2010).

[6]Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010).

[7]Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010).

My statement today is based primarily on previous GAO reporting related to governmentwide improper payments, Medicare high-risk challenges and program integrity efforts, and CMS's information technology systems intended to help identify improper payments. We supplemented that prior work with additional information on the nature and extent of Medicare improper payments reported by HHS in its fiscal year 2010 agency financial report (AFR). We also received updated information from CMS in February 2011 and, in select cases, as of July 2011, on its actions related to relevant laws, regulations, guidance, and open recommendations pertaining to the key remediation strategies discussed later in this statement. A list of related GAO products is included at the end of this statement. Our prior work was conducted in accordance with generally accepted government auditing standards. Those 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.

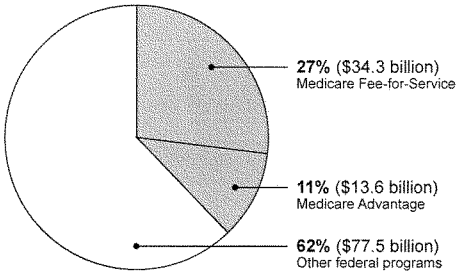
Improper Payments in the Medicare Program

HHS annually reports on improper payments in its AFR. For fiscal year 2010, HHS reported improper payment estimates for several programs, including Medicare. Collectively, HHS reported an estimate of almost $48 billion in improper payments in Medicare.[8] The $48 billion in estimated improper payments reported for fiscal year 2010 is attributable to Medicare fee-for-service and Medicare Advantage.[9] As shown in figure 1, the Medicare program represents about 38 percent of the $125.4 billion improper payment estimated amount reported by 20 federal agencies covering 70 programs. Further, Medicare's estimated improper payment amount is the highest among all federal programs that reported an estimated amount.

[8]Estimated improper payment amounts are based in part on prior years' claim data, as allowed by OMB's guidance.

[9]For fiscal year 2010, HHS reported an estimate of improper payments of $34.3 billion for Medicare fee-for-service and $13.6 billion for Medicare Advantage.

Figure 1: Fiscal Year 2010 Estimated Improper Payment Reported Amounts for Federal Programs



Source: GAO summary of agency data.

HHS's estimated amount of improper payments for Medicare is incomplete because it has yet to report a comprehensive improper payment estimate for the Medicare prescription drug benefit program, which had reported outlays of about $59 billion in fiscal year 2010. However, HHS has taken some steps to develop a comprehensive improper payment error rate.[10] Specifically, for fiscal year 2010, HHS calculated error rates for the four components of the Medicare prescription drug benefit program, with the estimates ranging from $45 million to $5.4 billion for each component. However, HHS reported that the four estimates overlap and consequently cannot be totaled. HHS reported that it expects to report a comprehensive estimate for the prescription drug benefit program in fiscal year 2011.

It is important to recognize that the $48 billion in estimated improper payments reported by HHS in fiscal year 2010 is not an estimate of fraud in Medicare.[11] Reported improper payment estimates include many types

[10]Reported error rates reflect the estimated improper payments as a percentage of total program outlays.

[11]Fraud consists of intentional acts of deception with knowledge that the action or representation could result in an inappropriate gain.

of overpayments, underpayments, and payments that were not adequately documented. In addition, because the improper payment estimation process is not designed to detect or measure the amount of fraud in Medicare, there may be fraud that exists in the Medicare program that is not included in the reported improper payment estimate.

In addition to inadequate documentation, HHS cited a number of other causes for the estimated $48 billion in reported improper payments, including the provision of services that were found not to be medically necessary, coding errors, incorrect interpretation of data, and payment calculation errors. HHS reported that its analysis showed most Medicare fee-for-service improper payments were for medically unnecessary durable medical equipment and inpatient hospital services. For Medicare Advantage, HHS reported that the majority of the improper payment estimate resulted from insufficient documentation to support the diagnoses submitted by private health plans for payment.

CMS's methodology for estimating improper payments has evolved. Beginning in 1996, HHS's Office of Inspector General (OIG) estimated improper payments in the Medicare fee-for-service program as part of its annual financial statement audit. In fiscal year 2003, CMS assumed responsibility for estimating Medicare fee-for-service improper payments and modified the methodology to improve error detection and provide more detailed information on the errors. During fiscal year 2009, HHS revised its methodology for calculating the Medicare fee-for-service improper payment error rate based on HHS OIG audit reports and input from CMS advisory medical staff. According to HHS, the revised methodology is more stringent. Using this revised methodology for a limited number of claims reviewed in fiscal year 2009, HHS reported estimated Medicare fee-for-service improper payments of $24.1 billion in its fiscal year 2009 AFR, representing an error rate of 7.8 percent. However, HHS subsequently restated the fiscal year 2009 improper payment estimate for Medicare fee-for-service by applying the results of the revised methodology to the entire year and reported a revised estimate of $35.4 billion and an error rate of 12.4 percent.

CMS set key performance measures to reduce improper payments for Medicare fee-for-service and Medicare Advantage. For fiscal year 2010, HHS reported error rates of 10.5 percent and 14.1 percent for Medicare fee-for-service and Medicare Advantage, respectively. HHS reported that it met its improper payment error rate target for Medicare Advantage in fiscal year 2010 by achieving a 14.1 percent error rate, which was better than its goal of 14.3 percent. However, CMS was not able to demonstrate

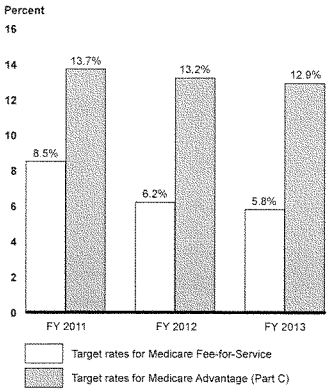
sustained progress in reducing its Medicare fee-for-service improper payment rate. As discussed previously, HHS reported that it made changes to improve the estimation methodology, which meant that previous estimates were not comparable to those HHS made in fiscal year 2010. For fiscal year 2012, CMS reported that it set improper payment reduction targets as part of the strategic plan prepared under the Government Performance and Results Act of 1993.[12] The 2012 target error rates are 6.2 percent for Medicare fee-for-service and 13.2 percent for Medicare Advantage.

Further, in response to Executive Order 13520,[13] HHS designated the Assistant Secretary for Financial Resources and Deputy Administrator for Program Integrity at CMS as the accountable officials responsible for efforts to reduce improper payments and establish improper payment reduction targets for Medicare fee-for-service and Medicare Advantage as shown in figure 2.

[12]Pub. L. No. 103-62, 107 Stat. 285 (Aug. 3, 1993).

[13]Exec. Order 13520, 74 Fed. Reg. 62201 (Nov. 20, 2009).

Figure 2: Reduction Targets for Medicare Fee-for-Service and Medicare Advantage Improper Payments



Source: GAO analysis.

Note: Data are from www.PaymentAccuracy.gov (accessed July 22, 2011). Executive Order 13520, *Reducing Improper Payments*, required that the Secretary of the Treasury in coordination with the Attorney General and OMB publish information regarding improper payments on the Internet.

In 2010, CMS created the Center for Program Integrity (CPI) to serve as its focal point for all national Medicare program integrity issues. CPI is responsible for addressing program vulnerabilities leading to improper payments, including collaborating with other CMS components to develop and implement a comprehensive strategic plan, objectives, and measures to carry out the agency's program integrity mission and goals. According to CMS documentation describing the program, CPI was designed to promote Medicare integrity through the following activities:

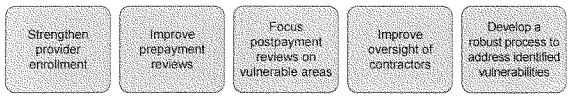
- conducting provider and contractor audits and policy reviews;
- identifying and monitoring program vulnerabilities;
- providing support and assistance to states;
- collaborating on the development and advancement of new legislative initiatives and improvements to deter, reduce, and eliminate fraud, waste, and abuse;

- overseeing all CMS interactions and collaboration with key stakeholders related to program integrity (e.g., the Department of Justice, HHS OIG, and state law enforcement agencies) for the purposes of detecting, deterring, monitoring, and combating fraud and abuse; and
- taking action against those who commit or participate in fraudulent or other unlawful activities.

Status of CMS's Efforts to Implement Key Strategies to Help Remediate Improper Payments

CMS has begun a number of initiatives related to the five strategies identified in our previous reporting that are key to reducing Medicare improper payments. However, CMS still faces significant challenges in designing and implementing internal controls to effectively prevent or detect and recoup improper payments and to prevent fraud, waste, and abuse. In March 2011, we testified that effective implementation of GAO recommendations, provisions in recently enacted laws, and recent guidance related to five key strategies could help remediate fraud, waste, abuse, and improper payments in the Medicare program.[14] Figure 3 provides an overview of those key strategies.

Figure 3: Strategies to Help Reduce Improper Payments in the Medicare Program



Source: GAO.

We testified in March 2011 that PPACA had a number of provisions that, if effectively addressed, could aid CMS in its efforts to minimize improper payments.[15] Specifically, PPACA included provisions related to strengthening provider enrollment and improving contractor oversight. CMS had issued final rules implementing some of these provisions. In addition, in June 2011, we reported on challenges CMS has faced in

[14]GAO, *Medicare and Medicaid Fraud, Waste, and Abuse: Effective Implementation of Recent Laws and Agency Actions Could Help Reduce Improper Payments*, GAO-11-409T (Washington, D.C.: Mar. 9, 2011).

[15]GAO-11-409T.

implementing information technology systems to help it identify potentially fraudulent or abusive claims that had been paid.[16]

The following sections provide an overview of CMS reported actions related to each of the five strategies we identified in our prior reporting as key to helping reduce Medicare improper payments. GAO has made recommendations to strengthen CMS's actions to address these strategies, some of which have not been implemented.

Source: GAO.

Strengthening provider enrollment standards and procedures. As discussed in our March 2011 testimony,[17] strengthening the standards and procedures for provider enrollment could help reduce the risk of enrolling providers intent on defrauding or abusing the program. CMS has previously identified two types of providers whose services and items are especially vulnerable to improper payments—home health agencies (HHA) and suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). In our 2009 report on HHAs, we found problems with the enrollment procedures—for example, CMS's contractors were not requiring HHAs to resubmit enrollment information (including information about key officials, operating capital, and practice location) for reverification every 5 years as required by CMS.[18] CMS implemented one of the recommendations from that report but did not implement a

[16]GAO, *Fraud Detection Systems: Centers for Medicare and Medicaid Services Needs to Ensure More Widespread Use*, GAO-11-475 (Washington, D.C.: June 30, 2011) and *Fraud Detection Systems: Additional Actions Needed to Support Program Integrity Efforts at Centers for Medicare and Medicaid Services*, GAO-11-822T (Washington, D.C.: July 12, 2011).

[17]GAO-11-409T.

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

recommendation to revoke billing privileges from HHAs engaged in a pattern of improper billing practices. In a 2005 report on DMEPOS suppliers, we found that CMS had not taken sufficient steps to prevent entities intent on defrauding Medicare from enrolling, and we reported that more effective screening and stronger enrollment standards were needed to ensure that new suppliers were legitimate businesses.[19] Partly in response to our recommendation to improve the provider enrollment process, CMS took steps to implement new supplier quality standards as part of an accreditation rule issued in August 2006 and proposed new supplier enrollment standards in January 2008. It proposed that suppliers would be required to meet these new accreditation standards in 2009. However, the new supplier enrollment standards were not finalized until August 2010.

Several requirements in PPACA focus on strengthening provider enrollment procedures, which could help prevent Medicare from making improper payments and address some of our previous concerns and recommendations. For example, PPACA requires the Secretary of HHS, in consultation with the HHS OIG, to establish procedures for screening providers enrolling in Medicare, including assessing the risk levels of fraud, waste, and abuse by categories of providers. At a minimum, PPACA requires all providers to be subject to licensure checks, which may include checks across state lines. Further, PPACA provides for enhanced oversight of new providers for specific periods of time and of initial claims of DMEPOS suppliers. On February 2, 2011, CMS and the HHS OIG published a final rule to implement these new screening procedures.[20] In addition, PPACA imposes specific requirements for providers to disclose any current or previous affiliation with a provider that has uncollected debt; has been or is subject to a payment suspension under a federal health care program; has been excluded from participation under Medicare, Medicaid, or the Children's Health Insurance Program or has had its billing privileges denied or revoked. The law allows CMS to deny enrollment to any such provider whose previous affiliations pose an undue risk. In February 2011, CMS officials told us

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

[20]By the end of 2011, CMS plans to further enhance provider enrollment processes by contracting for automated enrollment screening—to automate initial screening tasks now generally conducted manually—and for a national site-visit contractor to conduct unannounced site visits for certain providers.

that they were drafting a proposed rule to implement this authority. Further, providers that order home health services must have a face-to-face encounter with the beneficiary before the services can be ordered. CMS issued a final rule regarding this requirement in November 2010. To reduce spending for durable medical equipment and related supplies, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required that CMS phase in, with several rounds of bidding, a large scale competitive bidding program for certain DMEPOS.[21] CMS began to implement a Medicare competitive bidding program for durable medical equipment and supplies with prices that took effect in January 2011 from the first round of bidding. This program has the potential to help reduce fraud, waste, and abuse because it requires CMS to select DMEPOS suppliers based in part on new scrutiny of their financial documents and other application materials, among other things. PPACA required CMS to expedite implementation of the competitive bidding program for durable medical equipment, expanding the number of areas to be included in the second round of bidding from 70 to 91 by the end of 2011. CMS told us that it was working on round 2 of the competitive bidding program, which is anticipated to be operational in summer 2013.

Source: GAO.

Improving prepayment review of claims. Our prior reporting on Medicare found that prepayment reviews of claims are essential to help ensure that Medicare pays correctly the first time. Conducting these reviews is challenging due to the volume of claims. Overall, less than 1 percent of Medicare's claims are subject to a medical record review by trained contractor personnel. Therefore, having robust automated payment controls—called edits—in place to deny inappropriate claims or flag them for further review is critical. However, in our 2007 report, we

[21]Pub. L. No. 108-173, § 302(b), 117 Stat. 2066, 2224 (Dec. 8, 2003), *codified, as amended, at* 42 U.S.C. § 1395w-3.

identified weaknesses in these prepayment controls.[22] For example, we found that contractors responsible for reviewing DMEPOS claims did not have automated prepayment controls in place to identify questionable claims, such as those associated with atypically rapid increases in billing or for items unlikely to be prescribed in the normal course of medical care. Since then, CMS has added computer edits to flag claims for services unlikely to be provided in the normal course of medical care, but has not implemented our recommendation to have edits in place based on thresholds for unexplained increases in billing.

If implemented, several recent legislative requirements and administrative directives could help CMS with its prepayment review to prevent improper payments. First, the Small Business Jobs Act of 2010 requires CMS to use predictive modeling and other analytic techniques—known as predictive analytic technologies—both to identify and to prevent improper payments under the Medicare fee-for-service program.[23] These predictive analytic technologies will be used to analyze and identify Medicare provider networks, billing patterns, and beneficiary utilization patterns and detect those that represent a high risk of fraudulent activity. Through such analysis, unusual or suspicious patterns or abnormalities could be identified that could be used to prioritize additional review of suspicious transactions before payment is made. CMS published a solicitation in December 2010 for these technologies and a case management system to track findings. The legislation provides that the solicitation require contractors that are selected to begin using these technologies on July 1, 2011, in the 10 states identified by CMS as having the highest risk of fraud, waste, or abuse in Medicare fee-for-service payments. After the initial year, based on the results of the predictive analytic technologies, CMS reported that it plans to expand their use to other states beyond the 10 states identified as having the highest risk for fraud, waste, and abuse. According to CMS, as of July 1, 2011, initial predictive modeling has been used on claims prior to payment to identify their level of risk for being improper and to focus investigative efforts.

Second, a June 2010 presidential memorandum directed agencies to check certain databases—known as the "Do Not Pay List"—before

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

[23]Pub. L. No. 111-240, § 4241, 124 Stat. 2504, 2599 (Sept. 27, 2010).

making payments, to ensure that payments do not go to individuals who were deceased or excluded from receiving federal payments or to entities that had been excluded from receiving federal payments. As of July 2011, this governmentwide database was still under development. However, CMS officials stated that, in response to the presidential memorandum, the agency reviewed selected databases that it and its Medicare contractors were using to determine payment eligibility for providers and took action to ensure that the agency's method of ensuring payment eligibility was consistent with the intent of the "Do Not Pay List."

Source: GAO.

Focusing postpayment claims review on most vulnerable areas. We previously reported that postpayment reviews are critical to identifying payment errors to recoup overpayments in Medicare. CMS's claims administration contractors conduct limited postpayment reviews. Therefore, it is important that they target their postpayment review resources on providers with a demonstrated high risk of improper payments. Further, we previously reported that CMS could strengthen postpayment home health claims review by focusing postpayment claims review on the most vulnerable areas and increasing the amount of postpayment review by using recovery audit contractors (RAC) for the Medicare program. CMS has not acted to implement our recommendation about focusing postpayment home health claims review based on high rates of improper billing identified through prepayment reviews. CMS has had efforts focusing on postpayment review of claims, most recently its national RAC program, begun in March 2009, after completion of a 3-year

demonstration program in 2008.[24] The national program was designed to help the agency supplement the postpayment reviews conducted by contractors other than RACs. The RACs review fee-for-service claims after payment, but because RACs are paid a contingent fee based on the dollar value of the improper payments identified, they have focused on claims from inpatient hospital stays, which are generally more costly services. PPACA expanded Medicare's RAC program to Medicare Advantage and the prescription drug benefit program. CMS published a request for comments on the development of RACs for those programs in December 2010. CMS awarded a Medicare prescription drug benefit RAC task order for a 1-year base period that began January 2011 and included 4 option years.

In June 2011, we reported that CMS has also developed information technology to help it better identify claims paid in error, but the systems are not being used to the extent originally planned, and CMS has not measured whether they have helped in reducing payment errors.[25] To integrate claims information and improve its ability to identify fraud, waste, and abuse, CMS initiated two information technology system programs in 2006: the Integrated Data Repository (IDR)[26] and One Program Integrity (One PI) to centralize and make more accessible the data needed to conduct these analyses. The IDR was intended to provide a central source of data related to Medicare and Medicaid claims, and the One PI system is a web-based portal and suite of analytical software tools to be used to extract data from IDR and enable complex analyses of these data.

[24]The Medicare Prescription Drug, Improvement and Modernization Act of 2003 directed CMS to conduct a project to demonstrate how effective the use of RACs would be in identifying underpayments and overpayments, and in recouping overpayments in Medicare. Pub. L. No. 108-173, § 306, 117 Stat. 2066, 2256 (Dec. 8, 2003). Subsequently, in December 2006 the Tax Relief and Health Care Act of 2006 required CMS to implement a national RAC program by January 1, 2010. Pub. L. No. 109-342, div. B, title III, § 302, 120 Stat. 2924, 2991 (Dec. 20, 2006), *codified at* 42 U.S.C. § 1395ddd(h).

[25]GAO-11-475.

[26]The initiative to develop a centralized data warehouse began in 2003 as an element of the agency's Enterprise Data Modernization strategy, and CMS initially planned for the data warehouse project to be complete by September 30, 2008. In 2006, CMS expanded the scope of the project to not only modernize data-storage technology but also to integrate Medicare and Medicaid data into a centralized repository and changed the name to IDR, to reflect the expanded scope.

As we reported in June 2011, although CMS has developed and implemented IDR and One PI for use by its program integrity analysts, IDR did not include all the data the agency planned to have incorporated by the end of 2010.[27] For example, IDR includes most types of Medicare claims data, but did not include data from other CMS systems that are needed to help analysts identify improper payments. According to IDR program officials, these data were not incorporated into IDR because funding for the development of the software and acquisition of the hardware needed to meet this requirement was not approved until the summer of 2010. Since then, IDR program officials have developed project plans and identified users' requirements, and plan to incorporate these additional data by November 2011.

In addition, CMS has developed and deployed One PI, but the system has been used by a limited number of analysts—less than 7 percent of the intended user community—and did not yet provide as many tools as planned. According to agency officials, plans to train and deploy the system to a broad community of users were disrupted when resources dedicated to these activities were redirected to address a need to improve the user training program. Further, as of June 2011, plans and schedules for completing the remaining work had not been finalized, and CMS had not identified risks and obstacles to project schedules that may affect its ability to ensure broad use and full implementation of the systems. Consequently, the agency may miss an opportunity to effectively use these information technology solutions to enhance its ability to detect fraud, waste, and abuse in the Medicare program. In our June 2011 report, we made seven recommendations to help ensure that the development and implementation of IDR and One PI help CMS meet its program integrity goals and objectives.[28] CMS concurred with GAO's recommendations and agreed to act upon them.

[27]GAO-11-475.

[28]GAO-11-475.

Source: GAO.

Improving oversight of contractors. As called for in our *Standards for Internal Control in the Federal Government,*[29] monitoring the activities used by an organization to address improper payments should be performed continually and should be ingrained in the entity's operations. Over the years, we have found areas where CMS's oversight of contractor activities that provide services to Medicare beneficiaries had been insufficient to ensure that required program control activities were conducted and working well. For example, all Part D drug-plan sponsors are required to have programs to prevent, detect, and correct fraud, waste, and abuse—also referred to as fraud and abuse programs. CMS is responsible for ensuring that sponsors are in compliance with this requirement. However, in 2008 we found that CMS's oversight of these programs was limited.[30] We recommended that CMS conduct timely audits of sponsors' fraud and abuse programs. CMS agreed with this recommendation. In March 2010, we reported that CMS had completed desk audits of selected sponsors' programs and was beginning to implement an expanded oversight strategy, including on-site audits to assess the effectiveness of these programs more thoroughly.[31] In November 2010, CMS officials reported that the agency had conducted on-site audits of 33 of the 290 sponsors in 2010 covering 62 percent of the enrolled beneficiaries in 2010, which addresses our recommendation. As a result of the on-site audits, CMS had taken formal enforcement

[29]GAO, *Standards for Internal Control in the Federal Government,* GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999).

[30]GAO, *Medicare Part D: Some Plan Sponsors Have Not Completely Implemented Fraud and Abuse Programs, and CMS Oversight Has Been Limited,* GAO-08-760 (Washington, D.C.: July 21, 2008).

[31]GAO, *Medicare Part D: CMS Oversight of Part D Sponsors' Fraud and Abuse Programs Has Been Limited, but CMS Plans Oversight Expansion,* GAO-10-481T (Washington, D.C.: Mar. 3, 2010).

actions against several sponsors. In addition, CMS published a final rule in April 2010 to increase its oversight efforts and ensure that sponsors have effective programs in place.[32] PPACA included provisions for CMS to evaluate contractors receiving Medicare Integrity Program and Medicaid Integrity Program funding every 3 years. In addition, PPACA requires these contractors to provide performance statistics to HHS and its OIG upon request. In February 2011, CMS officials told us that they were taking action to implement these requirements for Medicare. At that time, officials told us that CMS was tracking performance statistics and adding to and refining these statistics and was also developing the specific performance statistics for its Part D integrity contractors and expected to finalize these statistics this year.

Source: GAO.

Developing a robust process for addressing identified vulnerabilities. Having mechanisms in place to resolve vulnerabilities that lead to improper payments is key to effective program management. But our work has shown that CMS has not developed a robust process to specifically address identified vulnerabilities that lead to improper payments in Medicare. We have reported that an agency should have policies and procedures to ensure that (1) the findings of all audits and reviews are promptly evaluated, (2) decisions are made about the appropriate response to these findings, and (3) actions are taken to correct or resolve the issues promptly.[33] We have also stressed the

[32]*Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs*, 75 Fed. Reg. 19,678 (Apr. 15, 2010).

[33]These are all aspects of internal control, which is the component of an organization's management that provides reasonable assurance that the organization achieves effective and efficient operations, reliable financial reporting, and compliance with applicable laws and regulations. Internal control standards provide a framework for identifying and addressing major performance challenges and areas at greatest risk for mismanagement. GAO, *Internal Control Standards: Internal Control Management and Evaluation Tool*, GAO-01-1008G (Washington, D.C.: August 2001).

importance of holding individuals accountable for achieving agency objectives. However, as we reported in March 2010, CMS had not established an adequate process during its recovery audit contracting demonstration or in planning for the subsequent recovery audit national program to ensure prompt resolution of identified improper payment vulnerabilities in Medicare.[34] During the demonstration, CMS did not assign responsibility to agency officials or contractors for taking corrective action. According to CMS officials, the agency took corrective action only for vulnerabilities with national implications, and let the contractors that processed and paid claims decide whether to take action for vulnerabilities that might occur only in certain geographic areas. Additionally, we reported that during the demonstration CMS did not specify in a plan what type of corrective action was required or establish a time frame for corrective action. We also found that the lack of documented responsibility assignments impeded CMS's efforts to promptly resolve the vulnerabilities identified during the demonstration.

For the national Medicare RAC program, although CMS established a corrective action team to compile, review, and categorize identified vulnerabilities and discuss corrective action recommendations, the corrective action process was still incomplete. CMS appointed the Director of the Office of Financial Management to be responsible for the day-to-day operations of the program, and the CMS Administrator to be responsible for vulnerabilities that span agency components. However, the corrective action process did not include any steps to either assess the effectiveness of the corrective actions taken or adjust them as necessary based on the results of the assessments. Further, the agency had not developed time frames for implementing corrective actions. Because of these weaknesses, we recommended that CMS develop and implement a corrective action process that includes policies and procedures to ensure that the agency promptly (1) evaluates findings of RAC audits, (2) decides on the appropriate response and a time frame for taking action based on established criteria, and (3) acts to correct the vulnerabilities identified.[35] CMS concurred with this recommendation. Agency officials said they intended to review vulnerabilities on a case-by-

[34]GAO, *Medicare Recovery Audit Contracting: Weaknesses Remain in Addressing Vulnerabilities to Improper Payments, Although Improvements Made to Contractor Oversight*, GAO-10-143 (Washington, D.C.: Mar. 31, 2010).

[35]GAO-10-143.

case basis and were considering assigning them to risk categories to help prioritize their actions. In February 2011, CMS reported that the agency was still working to address the vulnerabilities identified during the demonstration program. Specific to corrective actions, CMS officials told us that its contractors were required to consider and evaluate vulnerabilities identified by various entities, including the RACs. However, as of March 2011, CMS had not yet implemented this recommendation. We will continue to follow up with CMS on its progress in this area.

Concluding Observations

With the amount of estimated improper payments and the unknown amounts of potential fraud, waste, and abuse in the Medicare program, it is critical for CMS to act quickly and decisively to reduce them. As it implements PPACA provisions concerning Medicare, CMS has an opportunity to use new tools to help address fraud, waste, abuse, and improper payments in the program. CMS has taken a number of actions related to rule making and issuing guidance to implement recent legislative and regulatory provisions, but because many efforts are in process, it is too early to gauge their effectiveness. These requirements will be critical in helping ensure integrity in Medicare operations, as will additional evaluation and oversight to determine whether they are implemented as intended and have the desired effect on ensuring that payments are made for intended and proper purposes. Notably, we are beginning new work to assess CMS's efforts to strengthen the standards and procedures for Medicare provider enrollment to reduce the risk of enrolling providers that are intent on defrauding or abusing the program. We are also examining the effectiveness of different types of prepayment edits in Medicare systems and of CMS's oversight of its contractors in implementing those edits to help ensure that Medicare pays claims correctly the first time. The level of importance CMS places on effectively implementing our recommendations and the requirements established by recent laws and guidance will be a key factor in reducing improper payments and potential fraud, waste, and abuse in the Medicare program and ensuring that federal funds are used efficiently and for their intended purposes. In this regard, we plan to continue monitoring these issues.

Chairman Platts, Ranking Member Towns, this completes my prepared statement. I would be happy to respond to any questions you or other members of the subcommittee may have at this time.

GAO Contacts and Staff Acknowledgments

For more information regarding this testimony, please contact, Kay L. Daly, Director, Financial Management and Assurance, at (202) 512-9312 or by e-mail at DalyKL@gao.gov or Kathleen M. King, Director, Health Care, at (202) 512-7114 or by e-mail at KingK@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 Valerie Melvin, Director; Carla Lewis, Assistant Director; Sheila K. Avruch, Assistant Director; Teresa Tucker, Assistant Director; Jacquelyn Hamilton; Jim Healy; Jason S. Kirwan; Crystal Lazcano; and Chelsea Lounsbury.

Appendix I: Recent Key Legislative and Executive Branch Efforts

Over the past couple of years, Congress and the executive branch have taken a number of actions intended to heighten the attention given to the issue of improper payments and to promote corrective actions. The Centers for Medicare & Medicaid Services' (CMS) efforts to identify and remediate Medicare improper payments will be affected by these new initiatives. Table 1 summarizes the recent legislative and executive branch efforts intended to improve oversight and accountability over improper payments governmentwide, as well as key actions specific to Medicare.

Table 1: Recent Key Legislative and Executive Efforts to Improve Oversight and Accountability over Improper Payments

Date	Action
March 2009	Medicare fee-for-service national recovery audit contractor program implementation begins (as required by the Tax Relief and Health Care Act of 2006)
November 2009	Executive Order 13520, *Reducing Improper Payments*
March 2010	Presidential memorandum, *Finding and Recapturing Improper Payments* Patient Protection and Affordable Care Act (PPACA), including expanding the national recovery audit contractor program to Medicare Advantage and Medicare prescription drug benefit program Health Care and Education Reconciliation Act of 2010
June 2010	President announced an Administration goal that Medicare fee-for-service error rate would be cut in half by fiscal year 2012 Presidential memorandum, *Enhancing Payment Accuracy Through a "Do Not Pay List"*
July 2010	Improper Payments Elimination and Recovery Act of 2010 (IPERA)
September 2010	Small Business Jobs Act of 2010

Source: GAO

Note: The data are from GAO summary of key improper payment initiatives.

In November 2009, Executive Order 13520, *Reducing Improper Payments*, was intended to focus on increasing transparency and accountability for reducing improper payments and creating incentives for reducing improper payments.[36] Under the Executive Order, the Office of

[36]Exec. Order 13520, 74 Fed. Reg. 62201 (Nov. 20, 2009).

Management and Budget (OMB) designated 14 programs as high-priority programs to focus attention on the programs that significantly contribute to the federal government's improper payments. Medicare fee-for-service, Medicare Advantage, and Medicare prescription drug programs have been designated as high-priority programs as part of the Executive Order.[37] Additionally, OMB established a Web site (www.PaymentAccuracy.gov) on the 14 high-priority programs that provides information on (1) the programs' senior accountable officials responsible for efforts to reduce improper payments; (2) current, targeted, and historical estimated rates of improper payments; (3) why improper payments occur in the programs; and (4) what federal agencies are doing to reduce improper payments and recover overpayments.

To supplement program integrity efforts, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 directed CMS to conduct a 3-year demonstration project on the use of a new type of contractors—recovery audit contractors (RAC)—in identifying underpayments and overpayments, and recouping overpayments in the Medicare program.[38] The RAC demonstration program began in 2005. Subsequently, the Tax Relief and Health Care Act of 2006 required CMS to implement a national RAC program by January 1, 2010.[39] CMS began implementing it in March 2009.

[37]The 14 high-error programs designated by OMB for fiscal year 2010 include: Medicare Fee-for-Service; Medicaid; Unemployment Insurance; Medicare Advantage; Supplemental Security Income; Retirement, Survivors, and Disability Insurance; Supplemental Nutrition Assistance Program; National School Lunch Program; Rental Housing Assistance Programs; Federal-Aid Highway Program, Highway Planning and Construction; Children's Health Insurance Program; Earned Income Tax Credit; High Cost Program of the Universal Service Fund; and Medicare Prescription Drug Benefit. The Children's Health Insurance Program, High Cost Program of the Universal Service Fund, and Medicare Prescription Drug Benefit programs did not report improper payment error rates and amounts for fiscal year 2010.

[38]Pub. L. No. 108-173, § 306, 117 Stat. 2066, 2256-57.

[39]Pub. L. No. 109-432, div B., title III, § 302, 120 Stat. 2922, 2991-92, *codified* at 42 U.S.C. § 1395 ddd(h).

In March 2010, the President issued a memorandum intended to expand agency efforts to recapture improper overpayments using recapture audits.[40] Also, the Patient Protection and Affordable Care Act (PPACA),[41] as amended by the Health Care and Education Reconciliation Act of 2010,[42] contains provisions intended to improve accountability over Medicare. These provisions include:

- establishing procedures for screening providers enrolling in Medicare, including assessing the risk levels of fraud, waste, and abuse by categories of providers;
- expanding the Medicare RAC program to Medicare Advantage and Medicare prescription drug benefit program;
- adding requirements for providers to disclose any current or previous affiliation with a provider that has uncollected debt; has been or is subject to a payment suspension under a federal health care program; has been excluded from participation under Medicare, Medicaid, or the Children's Health Insurance Program or has had its billing privileges denied or revoked;
- expanding the number of areas to be included in the competitive bidding program for durable medical equipment; and
- strengthening the Health Care Fraud and Abuse Control Program, a joint effort of the HHS Inspector General and the Department of Justice, which is designed to coordinate law enforcement activities regarding health care fraud and abuse, including that in Medicare.

In June 2010, the President announced that the Administration would reduce the error rate for the Medicare fee-for-service program by half by fiscal year 2012. Also, the President directed agencies to check certain databases—known as the "Do Not Pay List"—before making payments to ensure payments did not go to individuals who were deceased or excluded from receiving federal payments or to entities that had been excluded from receiving federal payments.

In addition to amending the Improper Payments Information Act of 2002 (IPIA)[43] improper payment estimation requirements, the Improper

[40]Finding and Recapturing Improper Payments, 75 Fed. Reg. 12119 (Mar. 15, 2010).

[41]Pub. L. No. 111-148, § 6402(i), 124 Stat. 119, 760 (Mar. 23, 2010).

[42]Pub. L. No. 111-152, § 1303(a), 124 Stat. 1029, 1057 (Mar. 30, 2010).

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

Payments Elimination and Recovery Act of 2010 (IPERA)[44] established additional requirements related to (1) federal agency management accountability; (2) recovery auditing aimed at identifying and reclaiming payments made in error; (3) compliance and noncompliance determinations based on an inspector general's assessment of an agency's adherence to IPERA requirements, and reporting that determination; and (4) an opinion on internal controls over improper payments. OMB issued IPERA implementing guidance on April 14, 2011.[45]

The Small Business Jobs Act of 2010 also contains a provision regarding claims review to prevent improper payments.[46] It requires CMS to use predictive modeling and other analytic techniques—known as predictive analytic technologies—both to identify and to prevent improper payments under the Medicare fee-for-service program. The law requires these predictive analytic technologies to be used to analyze and identify Medicare provider networks, billing patterns, and beneficiary utilization patterns and detect those that represent a high risk of fraudulent activity. Through such analysis, unusual or suspicious patterns or abnormalities could be identified that could be used to prioritize additional review of suspicious transactions before payment is made.

[44]Pub. L. No. 111-204, 124 Stat. 2224 (July 22, 2010).

[45]OMB, Circular No. A-123, app. C, *Requirements for Effective Measurement and Remediation of Improper Payments* (Apr. 14, 2011).

[46]Pub. L. No. 111-240, § 4241, 124 Stat. 2504, 2599 (Sept. 27, 2010).

Mr. PLATTS. Thank you, Ms. Daly and thanks to all our witnesses for your testimony.

We will now move into questions and I will yield myself 5 minutes for that purpose.

I want to first acknowledge the effort, Ms. Snyder, of CMS and we appreciate that you and your colleagues are dutiful in trying to identify and prevent improper payments and be good stewards of the American taxpayers' money.

In your written testimony, your statement is, "While improper payments represent a fraction of total program spending, any amount of improper payment is unacceptable and CMS is aggressively working to reduce these errors." I read that to say it is only a fraction and any amount, as if this is a small amount. Well, 48 billion is, you are right, about 10 percent or so of total CMS expenditures, but that is a huge amount of money, not just any amount, it is a huge amount.

I don't want to minimize the efforts to prevent it but when I share back home that the total number for the whole government that we know of is estimated at $125 billion every year, my constituents think I misspoke. When we talk about the individual program, Medicare that is about 38 percent of that, it is staggering.

One of the issues in your testimony, and each of you referenced it here today or in your written testimony, was that when we hear improper payments, we think fraud, the worst, and we do appreciate that is not the case. A lot of this is just insufficient documentation or the wrong documentation. Is there an estimate of the $48 billion that is fraud related either in overbilling, duplicate billing or fraudulent billing? Is there an estimate of that percentage?

Ms. SNYDER. Before I answer that, my mother is a Medicare beneficiary and trust me, I hear exactly what you just said when I go home. It is a big number.

Mr. PLATTS. As is my mom and she asks me lots of questions when she gets her statement, what is all this?

Ms. SNYDER. Exactly. Sometimes it makes you not want to go home for Thanksgiving.

In relation to your question about a fraud rate, one of the toughest problems we have had at CMS is to find the methodology that actually allows us in a scientific way and in a replicable way to estimate what amount of the improper payments are really fraud. It is something we have struggled with. We have gone to the private sector, we have talked to them and said, how do you estimate fraud? We have looked at literature when people make comments that a certain amount is fraud, we have looked behind it to say how did you measure it because we want to do that.

What we found is there isn't a methodology. Our Center for Program Integrity started a new program and just awarded a contract and we are going to try to estimate levels of fraud. We will start with two areas that we believe are fraud prone. We know they are fraud prone because of the work that has often been done in terms of investigations by the Office of Inspector General and reports from the Government Accountability Office. That is durable medical equipment areas and home health. Just because of the work over the years, we know there are huge issues there.

We are hoping we will be able to actually say here is a methodology that will work that you can apply to different kinds of service categories and estimate an actual fraud rate. We hope to have that work done over the next 6 to 8 months. We have invited the private sector to be part of the board that helps develop this methodology and hope we will be successful because we think this is something that will not only work for CMS, but will work for the private sector as well. If we develop something that works, we will share it.

Mr. PLATTS. I appreciate the challenge of having that methodology to estimate. Do you have what your actual fraud numbers were for 2010 that you found were fraudulent, 2010 or 2009?

Ms. SNYDER. I can submit to the record a number of collections, we have cases that went to the Department of Justice, we have investigations through the OIG where we have actually collected dollars back. It amounts to many hundreds of millions of dollars that come from those particular cases and they are estimated, but that is a specific case number.

Mr. PLATTS. Rather than trying to estimate going forward, what is the track record that you know is fraudulent in the last 3 years, 2008, 2009, 2010? How much do we know is fraudulent because we caught the perpetrators of the fraud?

Ms. SNYDER. If you would let me submit that number for the record? It is in the hundreds of millions of dollars.

Mr. PLATTS. Per year?

Ms. SNYDER. Probably over the 3-year period. Particularly, we have shown recoveries from the task forces in which we have been involved with the Office of the Inspector General, with the Department of Justice. There are particular dollars that have come back to us from those stings and those activities. It is several million dollars over that 3 year period. I don't want to give you a wrong number but it is significant.

Mr. PLATTS. Whatever the number is, if it is hundreds of millions, we know that is a portion of what the actual fraud is. That is what we have caught and been able to identify. Again, we are talking real money here that we need to go after in addition to what I will call the administrative problems, the documentation, other types of improper payments.

I would yield to the gentleman from New York, the ranking member, for 5 minutes.

Mr. TOWNS. Thank you very much, Mr. Chairman.

Let me ask, the background check, if we strengthen that, would that cut down on the amount of waste, fraud and abuse, if we strengthen the background check initially?

Ms. SNYDER. I assume you are talking about providers who participate in the Medicare program?

Mr. TOWNS. Yes, the providers.

Ms. SNYDER. That is a suggestion that has come to us. Again, usually the Government Accountability Office has certainly cited that as a possibility, as has the Office of the Inspector General. What we have found one of the best ways to prevent fraud, waste and abuse is to keep bad actors out of the program from the very beginning.

Part of keeping bad actors out of the program from the very beginning is making sure we do appropriate provider certification and

screening. Part of that is taking a look at an application and looking to make sure you have a license, have you been debarred somewhere else, have you lost your license somewhere else, are you indeed a real operation, do you have a real building, so going through a number of screening criteria and doing it upfront and never giving the person a Medicare provider number is one of the best ways to proceed, absolutely.

We are in the process right now of where we are going to recertify the 1.4 million providers that participate in the Medicare Program. We hope to have that mostly done or a large part underway by 2013. There are certain kinds of providers where we have recently said in regulation that we do want to have the opportunity to do background checks, fingerprinting, to take a look at them through that scope.

In fact, recently we just hired a contractor who will start to take information about providers particularly in areas we know we have had problems and start to look at all the kinds of public information we have to bring it together to look at and say, is this somebody Medicare should be doing business with. It is an excellent technique and we are employing it.

Ms. KING. If I might add, we agree that keeping the bad actors out is one of the most effective ways to prevent fraud and also improper payments in the program and there are provisions in the Affordable Care Act that give CMS considerable authority to strengthen the enrollment process.

They have infact separated providers into different categories of risk with home health and durable medical equipment being in the highest category. They have strengthened the ability to look at providers getting into the program. That is work that we have ongoing to look at what is going on there.

Mr. TOWNS. Let me ask in the context we are talking about this morning, correction, what does it really mean when you talk about making a correction? Just go right down the line, what does it mean to you?

Mr. LEVINSON. Mr. Towns, I think the Executive order states exactly what the goal is for every dollar expended and that is to get it right. If there is missing information, if the record is not complete, there is simply no assurance that the dollars spent are appropriately spent. In that sense, it is an error.

Is it necessarily fraud? No. Those are two very different concepts. I would underscore that some of the most successful, sophisticated frauds reveal no improper payment at all because the paper record is so well done. While the improper payment amount is likely to include cases of fraud, it would be counterintuitive to think that they don't, it doesn't really capture a fraud figure.

Mr. TOWNS. Ms. Snyder.

Ms. SNYDER. Correction I think, to us, is very similar to what Mr. Levinson is saying but it really means when you look at the claim that is filed, remember we got several million of them going through the system a day, when you look behind the face of that record, what you will find is a justification for the expenditure and that you give folks every opportunity to make sure that record is correct before you declare it to be an improper payment.

To us, it means the service occurred, it was an appropriate service, it occurred in the right setting and that we paid you the right amount for it. If that is not the case, then it is an improper payment and needs to be corrected. You need to bill me correctly, you need to make sure you are providing the service in the right place. You, the provider, need to do the right thing. You are a partner with the Medicare program.

Mr. TOWNS. Ms. Daly.

Ms. DALY. I would have to echo some of the sentiments that Mr. Levinson and Ms. Snyder have just spoken. I think having the right documentation to pay the bill, making sure the patient is due for the services and so forth are all very important. All of that needs to be done correctly in each step of the process.

Making it all done right the first time saves a lot of time and effort and avoids what is commonly referred to the pay and chase mode where if it is not done correctly the first time, it is considered to be payable and we have to spend a lot of time and effort to make corrections.

Ms. KING. To add to that, when we talk about a corrective action, we are thinking about is when a vulnerability has been identified, you know people are doing things they shouldn't, you put a process in place to try to prevent that in the future either by strengthening your enrollment standards, strengthening your prepay audits or doing it on post pay.

Mr. TOWNS. Mr. Chairman, my time has expired but let me ask just one question. If you have a situation where a group comes to you and says, this is a problem, can you make that adjustment? For instance, I was looking at the power wheelchairs. I know there have been issues that have been raised over and over again which to me seems to be a legitimate kind of concern, but nobody is responding to it. Do you respond when a group comes and says this is a problem, you look at it and see it is a legitimate problem, can you then make an adjustment?

Ms. DALY. Let me take a stab at that because that is a particularly interesting one to me, the power wheelchairs.

The first place that we go is to look at what is the statutory requirement of that benefit category, how has it been defined. For power wheelchairs are part of what is called a homebound benefit which was established in the statutes which basically say you have to be able to use that power wheelchair inside your home. You have to be unable to walk more than three to four steps inside the confines of your apartment, your house, whatever it may be.

When you take a look at that and folks come to you and say this power wheelchair enhances the quality of my life because it lets me go to the mall, to church on Sunday, however it might allow you to get outside the walls of your apartment, that certainly is a valuable thing to the quality of that individual's life.

However, if you look at the statute behind it and the legal requirements, by definition, you don't meet the requirement of the law in order for that power wheelchair to be provided to you. That is a particularly tough one because, yes, if you are a doctor on one hand if you are somebody's daughter and you go in to a doctor and say, my mama could really use this, as a doctor you want to pro-

vide that. However, the ability to do something about that is limited by what is in statute in that particular example.

The second place you look is to see is there regulatory policy around this. Is there a regulatory policy or any ability if it makes sense to make some change and then take a third look at it to say, is it a matter of policy that we have interpreted, that we have put something in place, so how much room do you have to work with that particular group of providers or that particular service to change it.

It is a pretty rigorous process. We do listen to folks. They come in, talk to us and we look to see what makes the best sense for the beneficiary, but what makes the best sense to the beneficiary in terms of the laws and regulations that are in place that bound that particular benefit category.

One of the things we found with wheelchairs, when we have looked back at them we have a really high error rate. It is pretty much for the reason I described. It does not satisfy the definition of the benefit. We are looking at ways we can put some controls in place on the front end of it so that we are not paying and chasing for power wheelchairs or power mobility devices that don't meet the requirements of the benefit.

Mr. TOWNS. Thank you, Mr. Chairman, for your generosity.

Mr. PLATTS. The gentleman from Oklahoma, Mr. Lankford, for 5 minutes.

Mr. LANKFORD. Thank you, all of you, for what you do. My mom is also one of those Medicare recipients. She will never have the opportunity to meet people like you serving behind the scenes and say thank you, so I would pass that on from her and millions of other seniors. What you do is a great service to a lot of people, so we appreciate that and the dedication you put into it.

The fraud, like you I go home on Thanksgiving and that is what we are going to talk about, Medicare fraud, friends she has bumped into and things she perceives to be fraud and all those things. Let me flip to the other side of it.

I also hear from doctors and hospitals who are very frustrated with recovery audit contractors. There is a perception in their minds that they walk through the door and they are guilty and they are going to stay there until they prove they are guilty, no matter how long it takes.

They understand they are paid by the paperwork, so they are going to stay, dig through and find some nurse who was in a hurry who did not put the date on the form and they are going to get fined for it. They fight and fight and fight, sometimes for years through the process; this code was active and now suddenly, it is not and they are getting hammered sometimes thousand and millions of dollars in fines when they are the good providers. I am talking good hospitals.

How do we fix this? Because they hate the Federal Government because those recovery audit contractors are their enemies and they are going to stay until they make money off them. They are not there for their benefit. They are there for our benefit as far as recovering things, but that hospital says, I am the good guy, how come I am getting hammered? How do we fix that?

Ms. KING. We did an evaluation of the demonstration of the Recovery Audit Program and I think we did identify some missteps in terms of some of the initial actions that were taken by the RACs. It is our understanding that CMS has instituted a process, a committee inside CMS that has to prove the issues that the RACs are going to undertake.

Mr. LANKFORD. That has not trickled down actually yet, because I can tell you as recently as of the last couple weeks, I have been in communication with yet another hospital in my district that is fighting the same thing. It is a bounty hunter coming through their doors and they are determined to find something wrong, and they will. They are not happy at all because they are adding additional staff in compliance areas for things that are not fraud.

My understanding is these contactors are paid even if later they determine that it wasn't true, it really was correct. Is that correct?

Ms. KING. Actually, that was the case in the demonstration but it is not the case in the national program. If something is overturned on appeal, then the RAC does not get paid.

Mr. LANKFORD. That is a good fix for a start on that, but how do we develop this relationship because they are no longer our friends, we are setting out as an enemy to them.

Ms. SNYDER. We have heard that, so the good news is that is not new news to us but it is a continuing concern.

In the demonstration which went on for 3 years, we did learn a lot of things and we learned a lot better about how to manage the contractors. Some of the things Ms. King referenced like having a committee that says, is this legitimate, before you go after somebody, making it clear to the RAC contractors if this is overturned on appeal, you are going to pay back the money and the provider gets back the money.

We actually recently hired two of what I call someone to watch the RAC, a validation contractor if you will. They do spot checks of the RAC's work, the particular contractor's work to say, were you inappropriately aggressive, were you looking at the wrong things, did you really use standard accounting practices.

I think it, again, is a continuing education, an outreach. We have regular standing forums with our provider community, one of the topics that's always on those calls, and we get hundreds of providers who call into those forums. We talk about the issues with the RAC program and have said to folks, if you think your area RAC is being overly aggressive, if you have continuing problems with them, let us know and we will look into it.

In reference to the particular hospital that you just mentioned, if you would give me the name of the hospital, we will reach out to them and look to see if it is a matter of what I will call hard feelings because they don't like the program, whether or not those corrective actions have reached out in that particular setting, and redouble our efforts to make sure folks understand the intention is not gotcha. The intention of this really is making sure we are paying appropriately. I would be very happy to reach out to that community.

Mr. LANKFORD. I would completely agree it is a good thing for us to be aggressive in this process but they perceive it very much as gotcha and the smallest minutiae that is going with it. I have

had several hospitals I have talked to about it. The one I most recently talked to didn't want me to bring up their name on it because they feel there will be punitive action against them even harder next time. They are very careful to say, we are cautious on how we move on that because they have so much power on us now, our functioning and operation. This is not one of your large major hospitals, but it is a good charitable hospital.

That is no way to live and operate, so I want you to stay aggressive on it. This system is not working for them at all.

Mr. LEVINSON. If I can add a couple of things, we actually will be looking at the RAC process in our office later this year in the sense of looking at CMS's oversight of the RACs. I wouldn't want my comments to be part of some effort to say RACs are necessarily a bad idea.

As our work starts in this area, there are a couple of observations worth putting into the mix as we try to understand the pros and cons of RACs. One issue is that the RAC process is really a variation on the model of pay and chase because the money has already gone out the door. RACs are trying to recover money and that, in a sense, certainly is good, but it is a continuation of a model that the government is trying to get away from. We are trying to catch the problems before they leave.

The other is in the brief work we have been able to do in the first few years with the RAC process, RACs referred only two case of potential fraud to CMS in the 3-years of the demonstration between 2005 and 2008, even though they found a billion dollars in improper payments.

It is important to understand that the incentives need to be aligned in a way so that while improper payments are identified, in as least intrusive and most productive way, that it also is a process that should reveal where fraud occurs and because the RACs don't see any money coming from identifying fraud, those cases wind up being referred for investigation.

Mr. LANKFORD. We are catching paperwork mistakes and not fraud.

Mr. LEVINSON. There is actually disincentive in a sense potentially to refer cases of fraud because then they are taken out of the universe of improper payments. I think these are the kinds of very important issues that need to be teased out as we look at the RAC program.

Mr. LANKFORD. Thank you.

Mr. Chairman, thank you for allowing a couple extra moments. I yield back.

Mr. PLATTS. I thank the gentleman and I would associate myself with the gentleman's comments because your term of bounty hunter is also what I hear whether it be from an institution or individual providers where they feel they are not innocent until proven guilty, that they are guilty of wrongdoing and in essence, they are trying to prove 6 months ago when they treated a patient, they did it by the book, did provide the service they were paid for, yet are put in the position of having to prove their innocence as opposed to assuming their innocence.

I yield to the gentleman from Tennessee, Mr. Cooper.

Mr. COOPER. Thank you, Mr. Chairman.

The headline of this hearing is the $48 billion in improper payments, but already we have parsed that and have a better understanding because apparently a relatively small percentage of that is fraudulent but it is also possible to have fraudulent payments that are not covered by the $48 billion.

I would like to ask what percentage of the $48 billion are overpayments as opposed to under payments or mispayments? Essentially what we are doing when we put out a figure like $48 billion, we are talking about the quality of the red tape. Good quality of the red tape doesn't show up in that $48 billion number. If there is a flaw in the red tape, then wham, it is in the $48 billion. I am guessing, and perhaps I am wrong, that most of the $48 billion is still overpayments.

Ms. KING. The vast majority.

Mr. COOPER. That is still a real concern to taxpayers. It is interesting that in your data, when you are comparing fee for service problems with managed care problems, actually managed care problems are slightly higher at this point. You think with managed care, you get more management and better quality red tape but apparently that is not true. It will be fascinating to see what the Medicare Part D numbers are now that you are finally able to evaluate that.

To put this in context, people also need to know that fee for service problems usually indicate overpayments and over utilization of services where sometimes managed care problems indicate under utilization of services, denial of care. It is a completely different human result. One injures the taxpayer, the other injures the patient.

Again, to put it in context, we had a hearing this morning regarding the Pentagon. I think the Pentagon is still number one on the GAO's list of high risk government agencies because they have never been auditable. After decades of trying, they are still not even close to being able to be auditable. When the Simpson Commission asked how many contractors the Pentagon had, the official response was somewhere between 1 million and 10 million.

I am in no way justifying Medicare problems but that is astonishing incompetence when you can't tell within an order of magnitude who your payees are because somebody has to write the contractor a check. They don't do this work for free.

Another area of serious concern is Medicaid. It is just not nearly as centralized as Medicare because that is farmed out to the States. That gives you at least 50 different opportunities to have confusion, mismanagement and lack of accountability, fraud and improper payments.

One of the fundamental issues that has barely been touched in this hearing is the Federal Government has actually paid people very promptly under the Federal Prompt Pay Act. That is what creates this situation of pay and chase. At least in the health care area, you have some of the slowest payers on the planet.

In the private sector, private insurance companies will stretch out accounts receivable for 180 days or longer. Meanwhile, the good old Federal Government steps up and pays you in 30 days. That makes the process of pre-certification so tough. No one has ever

written us a thank you note saying thank you for paying us in 30 days. They take that for granted.

Meanwhile, even the GAO set up two fake DME companies and was able to scam the system. A lot of folks in the small business and provider communities do not want to say thank you for coming through with payment within 30 days. That creates the situation where we have to chase the improper payment.

I am in no way defending the bounty hunters or the RACs but sometimes the Federal Government is an easy touch too. That balance has to be struck in a proper way. I am glad you are improving your system so you are able to get a better handle on that.

I see that my time is about to expire, Mr. Chairman. Maybe I should just stop there. Thank you.

Mr. PLATTS. I thank the gentleman, the first of us four to actually be dutiful with the time and it is appreciated.

I would comment with the gentleman with the issue with fraud is we don't really know what percentage, we don't know that it is a small percentage. We don't really know because it is not geared to signal out fraud. I don't know we can say it is a small percentage of the improper payment number. Even if it is just 10 percent, that is still close to $5 billion but we don't really know what the percentage is. That is why I asked what has been identified as we know for certain was fraud in the past 3 years, to start to look at that issue, how to better identify it.

Also, your point about the Department of Defense is well made and we are looking at a hearing in the fall on DOD and the issue you touched on. GAO has well recognized the challenges at that department.

With that, I yield to the gentleman from Virginia, Mr. Connolly.

Mr. CONNOLLY. Thank you, Mr. Chairman.

I want to thank everyone for being here. I want to add to the testimony. My parents have been major consumers, unfortunately, of Medicare for about 25 years. When we were voting on health care reform last year, my dad said to me, you need to know that in those 25 years, I am talking major, major stuff, never once has there been an error, never once have they had to be reminded to meet an obligation, never once have they arbitrarily denied something that was important to us in sharp contrast to the private insurance system.

He said, at least speaking for us, we are very satisfied customers and by the way, it has allowed them, in their eighties now, to live autonomous, productive lives, managing their health care frankly because of Medicare. Let us remember that as a context as we now look at a feature of Medicare that is not so good.

I think we have to begin with accepting the fact that $48 billion is a staggering sum of money. It is unacceptable for two reasons. We owe it to the taxpayers to do something about it. It is their money. Second, frankly, it feeds into the narrative which I reject that we cannot afford Medicare.

What do you mean we can't afford it? If we can get $48 billion to zero times 10, you have a huge significant chunk of savings in the program that doesn't touch benefits. It is critical that we get our arms around this.

Nothing happens without being measured. Ms. Snyder, have we in fact set an ambitious goal knowing we will never get to zero but to get to zero? Is the goal to get to zero and are there milestones and metrics that allow us to do that?

Ms. SNYDER. Yes, sir. The administration has set what I think is an incredibly aggressive goal, to cut the error rate in half by 2012, so we would be right around 6 percent. Again, I think most folks will argue when you get to 6 percent, then it is going to be cut it in half again to 3 percent.

I think one of the difficulties in driving down the error rate is that you put interventions in place against a sample that was drawn and evaluated, and then within 3 months of that being in place, you start drawing a sample again of claims. It is the ability for interventions to actually take effect that is one of the greatest challenges in terms of driving down the rate. That is going to make it tough but we know we are on the hook to do it and we are going to do our best to get there.

Mr. CONNOLLY. I would simply say nothing happens without stretch goals in government. I ran a very large government across the river. I really would like to see you come back with very ambitious stretch goals, understanding that getting to zero is a noble goal, never attainable, but if you press the system to get to that goal, we will have far more dramatic and positive results.

Ms. SNYDER. In response to what you are saying, it is very important to know that probably 10 million of the claims inside the billion claims are the ones that are the biggest dollar ones. They are the hospital inpatients, so focusing there, we hear you.

Mr. CONNOLLY. I want to sneak in two more questions. One is in looking at the data, Medicare Advantage compared to Fee for Service surprisingly is 35 percent higher in improper payments. Why is that?

Ms. SNYDER. Medicare Advantage, when we looked behind the numbers on that, we found is when we pay a capitated rate, that capitated rate is based on a risk score. In other words, inside your files, if you have Medicare Advantage plan, you have to be able to have medical justification or documentation that says you are a really sick guy and I need to pay you more for it.

When we started looking behind the patient panels, we found there wasn't documentation necessarily that said you are a really sick guy, so when I figure out your capitated payment, it should be a higher rate. When we look at that, some of it was missing documentation similar to fee for service, but part of it is trying to determine what the sickness score, if you will, of a particular plan and what the rate adjustment should be against the fact that the patient panel may not be as sick as reported.

Mr. CONNOLLY. Do some of the measures we took in health care reform help you in that regard with respect to Medicare Advantage?

Ms. SNYDER. I think the risk adjustment pieces of it and knowing how to look inside of that, and those metrics coming out of the Affordable Care Act will be very useful to us. Through a series of audits, we are trying to take the measurement, go back against the audit and figure out what the reduction and capitation really should be so it is a real dollar financial number.

Mr. CONNOLLY. Mr. Chairman, given your incredible generosity, would you allow me one more question and I don't think it is a long one.

It is my impression in talking with the U.S. Attorneys Offices that Medicare fraud has increasingly moved up as a priority for them and consumes a lot of their time in terms of bringing charges against organized fraudulent activity on Medicare. Mr. Levinson, Ms. Snyder and Ms. Daly, is my anecdotal impression confirmed by data and what is your interaction with the U.S. Attorneys Office to ensure that while we don't want to be bounty hunters, on the other hand, people who are deliberately organizing and orchestrating fraud against the U.S. Government and taxpayers need to be brought to justice. What is the interaction and what is the data?

Mr. LEVINSON. Mr. Connolly, the interaction is robust, especially over the last several years as these anti-fraud strike forces have taken hold in cities around the United States. There has been a very ambitious effort to root out systemic health care fraud especially in places where it exists like south Florida, Los Angeles, parts of the Gulf States, New York and Detroit.

That is in large part why you are hearing more about it, more resources are being expended. It does require careful coordination between the Justice Department, the prosecutors, and OIG as the investigators. Let me put in a plug that this is funded on our part by the Health Care Antifraud Account that was established in HIPPA and has grown. It certainly has helped us to recover more than $6 for every dollar put into the fund back to the trust fund and the Treasury.

It has been very successful thus far and we are continuing to build on that. A very critical part of the fraud piece in health care fraud does have to do with enrollment, making it too easy for folks masquerading as health care providers to get into the program, to get a provider number. Title VI of the Affordable Care Act does strengthen that whole enrollment process so if we can get that initial piece, if we can keep the wrong people out of the program in the first instance, that makes a huge impact on the fraud problem.

Mr. CONNOLLY. Thank you very much. Thank you, Mr. Chairman, for your indulgence.

Mr. PLATTS. You are welcome.

The gentlelady from the District of Columbia, Ms. Holmes Norton.

Ms. NORTON. Thank you very much.

This hearing has been very informative and educational, particularly when you get into what is actual fraud. I would like to break down what overpayments really mean. Do they mean cheating? Do they mean miscalculating? Do they mean paperwork? When I hear overpayments, that would seem to say somebody is putting in for too much money relative to the service provided. What is your view of that, any of you?

Ms. DALY. Congresswoman Norton, I would like to clarify that overpayments can mean all of the things you mentioned. It can be for the wrong amount, it could be a duplicate payment, it could be a payment that was made to someone who was ineligible to receive it, it could be someone eligible to receive it, or they received the wrong amount. It could be any number of things under contractual,

statutory or regulatory restrictions for that payment. There is a broad swath there it can cover.

Ms. NORTON. I understand the limitations of statistics, but I must say the reporting of these numbers in this way does add to what I think Mr. Connolly was referring to. When people hear a word like overpayment, they are used to that meaning. They don't even think in terms of their own overpayment of their credit card bill. They think the government is overpaying people who should not be paid.

I would urge you to find a category, I recognize we have to break down these categories, but find a category that would make the public understand how much of this overpayment comes from malfeasance. I think that would turn the public off more than anything else.

Yes, we want the rest of it to be reported, but it does a disservice to the most popular and perhaps most important Federal program, especially since not everyone seems to be for that program, at least not here in Congress, when words like that are used. I recognize this may put an additional burden on you, but I do think it is a burden worth taking on. I would ask you to look at that. Ms. King?

Ms. KING. If I might, it is a difficult thing to do because if you are talking about malfeasance or fraud, that has a legal definition and involves a deliberate attempt at wrongdoing.

Ms. NORTON. You are doing pretty well. I saw your statistics on referral of cases to the U.S. Attorney. The public is interested in wrongdoing, Ms. King.

Ms. KING. I understand.

Ms. NORTON. Yes, they are interested in mistakes, too, because they hold the government accountable for being efficient, but the first thing of interest is somebody cheating us with this program that is so important to us. I understand how impossible it is to get a definition that meets with a statistically valid notion. That is why I only asked you to look at it.

I was just perplexed about Medicaid Part D, that only in January was the government beginning, this is the first of the really large programs, to look at overpayments for Part D, the drug program. What have we been doing with that program?

Ms. KING. It began in 2006.

Ms. NORTON. Yes. We have not been doing the same kind work on overpayments, under payments, etc. for Part D that we have been doing for the rest of Medicare?

Ms. SNYDER. Why don't I try to answer that? I am sure my colleagues from GAO can help me out on this one.

I don't think we would say we haven't looked at error inside the program. We essentially have spent the last 3½ to 4 years figuring out what you should report and how to separate the particular components of the measurement. In fact, we have looked at four different aspects of the Part D program and found error in all four of those aspects. Three of them, low income subsidy payments, actual computations within the system that pays the drug benefit itself, was well under 1.5 to 2 percent.

The area that seems to be driving inside the Part D drug benefit comes back to if you go to the point of service, where the beneficiary goes in to get their prescription filled, what is not there at

the pharmacy is supporting documentation for that order to be filled. We found in terms of the prescription drug events, that was the biggest issue, documentation at the point of service. I think that number, I hope I have this right, was around 13 percent. That was the biggest number in Part D.

Ms. NORTON. That is the same issue, often documentation, with the rest of Medicare. In January 2011, CMS awarded a contract to identify incorrect payments and recoup payments in Medicare Part D. That program wasn't paid for, unlike the health care laws which we just passed. That means the taxpayers have been really paying through the you know what for this one for errors.

Is your testimony that it has taken that long to develop a system for doing the very same thing you were doing with rest of Medicare?

Ms. SNYDER. I think my testimony on that is like any error rate program, you want to make sure you are getting it right because it is a partnership with the provider.

Ms. NORTON. You just began in January. I commend you. This is an administration that has been here for a couple of years. I am not sure if in prior hearings there were reports on progress to measure Medicare Part D in the same way that we measure other parts of Medicare. Have there been? Has the Congress been kept informed or did this just pop up, this is something we ought to look at because we have been working on it and maybe we ought to report it to the Congress?

Ms. SNYDER. I think we, as part of the Improper Payment Act, are required to report on all of our programs. Certainly in terms of being a high risk agency because of the Medicare Program generally, any major new program that comes to CMS, we would look at it and be required to report an error rate on it. It has taken us a little while to get there.

I think the good news is that will be a composite error rate reported this November with our audited financial statement.

Ms. NORTON. Can I ask one more question? Will you be able to go back or will this reporting begin as of 2011 or 2010? How far back will you be able to go on error rates?

Ms. KING. Just forward in Part D.

Ms. NORTON. That means in 5 or 6 years, people got off scot-free. I understand startup so I am not blaming you. But my goodness, you can imagine and perhaps some of that information, some of that experience will help us to develop going forward how to better track that data.

Thank you very much. We will never get back that money.

Mr. PLATTS. I thank the gentlelady.

One bright note I would highlight on Part D is when it was passed, the estimates of its cost had been about 40 percent lower than what was initially anticipated, so there is a positive message out there about how that program is being operated.

I yield myself 5 minutes for questions. I have a couple follow-ups to my colleagues.

Mr. Lankford talked about the recovery audit contractors and Ms. King, you referenced it is a contingency fee approach but if what they find is overturned on appeal, then the RACs are not allowed to keep that. That assumes there is an appeal made. I guess

my question is, how easy is an appeal done, what is the cost of doing it?

I am wondering if someone is found to have made improper payments, are they going to just give up the money, don't bother doing an appeal so the RAC still gets paid even though it may not have been a legitimate improper payment?

Ms. KING. That is sort of a tough question to answer. I think the RACs initially, and I presume so in the national program, are sort of going after big ticket items. If you are a provider and an inpatient hospital service, there is a lot of money on the line, I would think you would be more likely to appeal than not.

Mr. PLATTS. Ms. Snyder, do you have anything to add to that?

Ms. SNYDER. I would say there has been a robust appeals process. The provider community hasn't been shy about pushing back. When they have pushed back, we have looked at it and it has resulted in certain changes, certain edits in our system, to help folks bill right on the front end. The ultimate with this would be if we are doing it right moving from a pay and chase environment to pay it right to begin with, ultimately RAC contractors would be much more limited in our set of interventions on improper payment because we would be paying it right to begin with.

Mr. PLATTS. One of those aspects of paying right up front is the certification of the providers, that they are legitimate medical providers. The ranking member talked about that as well.

You mentioned that you are recertifying all providers? Can you expand on what that involves and how quick a process is it to recertify all providers?

Ms. SNYDER. We are going to do it in stages. If you are a new provider coming into Medicare, then there are more stringent requirements on the very front end. We divided it up into different groups, new folks coming in, people who are already Medicare providers, about 1.4 million providers.

We have hired a contractor to help us with that. We automated applications so people can come back and give us their updated information like billing places, actual physical locations, all the things that help us determine whether or not you are a legitimate provider. We have already started the recertification and we plan to have 100 percent of the community either completed in terms of recertified or significantly underway by January 2013. There are very specific project plans in-house in our Center for Program Integrity that is responsible for that activity.

I think we have done something like 25 newsletters and articles to the provider community. We have been doing open forums with them to say this is coming, this is what we need you to do to work with them.

Mr. PLATTS. In going through this process of recertification or just in general, if you find a provider who is not legitimate, can you expand on how you pursue them or how you work with the Department of Justice if they have been fraudulent and what type of penalties usually would be pursued?

Ms. SNYDER. If it is a new guy, we don't give him a billing number or we give him a temporary billing number which means that within 3 months, we have to make sure they are indeed a good guy.

That is like a stop loss policy. That is one of the new policies in place.

The other is as we go through looking at recertification, we are also sending out people to do face to face visits with folks, particularly in areas where we know there have been a problem. We always go back to the durable medical equipment suppliers. We not only do a face to face visit with you, and we are going to show up randomly over a period of time to make sure you are indeed a legitimate provider.

We have a new tool that we are more than willing to use, suspension of payment if need be which is different from the philosophy in the past. The philosophy for Medicare all along was we take any willing provider. That philosophy now has changed because as you stated, $38 billion is a big number.

We refer people immediately. We referred something like 40 providers in the last quarter to the Office of the Inspector General to say take a look at this. We may sometimes continue payments because law enforcement wants to build a case. There are a number of ways we are stopping payment to begin with or at least limiting the damage.

Mr. PLATTS. You mentioned face to face which I think is important and recognize that within your own entity, the ability to go out and have a face to face with the 1.4 million providers. I don't know if it has ever been looked at but perhaps it sounds like about a 2-year process to go through recertification, once every 10 years we have an entire fleet of individuals out on the street doing census where they literally are walking the neighborhoods in every town, every city, every community in this country. It is a pretty simple approach that when they are in the neighborhood, Medicare partners with the Census Bureau to say, we have these 10 providers that say they are located in this neighborhood. As you go through that neighborhood, make a visit to confirm there is an entity there operating. It uses a resource already walking that street.

We are 9 years away from the next census but at least once every 10 years there is someone showing up at a provider's location to say yes, there is a doctor's office here operating, another way we are trying to weed out the bad guys.

A lot of outreach has been talked about with providers. When my mom has services provided, she gets a statement of services. She is extremely grateful for the services provided and the payment of those services. She looks down that list and she looks at the cost and is overwhelmed by how much the service was in total cost.

Is there an effort in those statements that clearly says if something is not right on here, that there is an easily identified 800 number? Is that part of every statement?

Ms. SNYDER. Yes, sir. We have statements that run all the time on those notices of beneficiary payment that say if you have a question, call 1–800. Our Center for Program Integrity has just started, and it has gotten a lot of interest on the part of the beneficiary community, if you have a question and think there is something wrong with your bill, you think there is something funny going on, please call 1–800. We set up a component within the 1–800 number to receive those calls.

We then run them against the other kinds of data analysis and modeling we do to see is there something going on here. We have received a number of those complaints. We are logging them in. I shouldn't call them complaints but questions. We log them in so we can get back to the beneficiary to close it out or get back and say we really can't answer this now because we have to take more of a look.

Mr. PLATTS. You have tens of millions of partners out there who can help you on the front lines in identifying something that is fraudulent and bring it to your attention.

A final question before I yield to the ranking member if he has other questions or comments, the issue of medically unnecessary services. General Levinson, you talk about this in your testimony and payment for services deemed not medically necessary, so the taxpayers are paying, the Medicare beneficiary is paying 20 percent on average for that, something they don't need, and perhaps it is even unsafe because they went through a procedure they didn't need and were put at risk in getting that service.

You referenced the 6-month period and the tens of millions of dollars of improper payments related to being medically unnecessary. Can you expand on what your recommendations were to try to try to address that aspect of improper payments and where you see CMS is in responding to your recommendations?

Mr. LEVINSON. It is crucial that there be the documentation in order to demonstrate that indeed this was exactly the kind of service or product actually needed by the patient, by the beneficiary. As you point out, this is a burden that is placed on both the taxpayers and beneficiaries when you don't have that medical necessity determination.

I think the power wheelchair example is a pretty good one because there are different types of power wheelchairs. Obviously the more sophisticated are going to be more expensive. If the paperwork doesn't demonstrate and you look at the actual beneficiary, there is no reason to provide a premium kind of power wheelchair that has features that really aren't necessary, that is a cost to the government, to the beneficiary and it raises questions about gaming the entire system. That is just an example and this does constitute a significant portion of the improper payments.

Mr. PLATTS. Ms. Snyder, your perspective on that aspect of improper payments and how you are trying to prevent it up front rather than chasing after the fact?

Ms. SNYDER. I think for us one of the best ways to prevent it is if we find there was over utilization of services or unnecessary services, we translate that into an edit that goes into the front part of our payment system. We literally have over a thousand edits in the claims payment system. Part of those are to push out a claim if it appears, based on a diagnosis code and the service being requested, if it doesn't match, it kicks it out, so you don't pay it.

The wheelchairs are a good example, but I think another really good example is people with ulcers, bed sores. There is a special mattress surface and we often find it is appropriate for a certain kind of mattress to be prescribed but they go to what I will call the deluxe mattress, the person with really significant sores and who needs that kind of surface to be well rather than going to a

different kind of surface that may be appropriate to the medical condition of that person.

It is not reasonable and necessary. There is a service that is necessary but what actually gets prescribed for the person is not reasonable and necessary. If we start to see kick-ups in payment, and this is part of the front end of our data analysis, you see a kick-up in a particular benefit category, then you start to look behind that and say what is really going on here. There should be a service of some sort but is the intensity of the service actually one that should occur. If we can track that and do it from all kinds of leaks from all kinds of folks, we then put that edit in the front of the system to shut it down.

Mr. PLATTS. Thank you.

Mr. Towns, any other questions? I yield to the gentleman from New York.

Mr. TOWNS. Thank you very much.

GAO made nine recommendations. You have actually implemented two. Is there any reason why you have not implemented the other seven? Have you responded to them in some way?

Ms. SNYDER. We are actually setting up a meeting with our GAO colleagues next week because we thought we had closed seven of the nine. I think partly what has happened is we have done some internal kinds of things in terms of policy statements, some training and development that quite frankly we have not shared with the GAO.

We think we are a lot closer to having the bulk of those recommendations closed. As I said, I think next week we are sitting down with them to give them some documentation we have done. We have totally rewritten a training manual. Part of this is about contractor closeout and how one audits overhead rates, how one tracks cost allocation systems and a bunch of very technical contracting kind of work.

I think the one open recommendation we are totally in agreement about is out of about $4 billion worth of contracting activity we do, there was a question of about $88 million of incurred costs. When we went through those incurred cost contracts, we believe we are at a point where probably $86 million of that is actually allowable. We think there is about $2 million that is not. We put some of those in what we call an interim audit file where we want to do more intense looking.

We really do owe GAO an answer on that. We have given them different numbers at different times as we worked through that audit process, but I really think we are a lot closer to having the bulk of those closed. I really look forward to sitting down with GAO next week and going through that.

There is an internal policy document that we did not share with them that we should that is sitting with our Office of General Counsel and the Office of Financial Management which addresses a number of the weaknesses. My guess is it will get us most of the way there. I think there will be areas where CMS will be taking the position that we believe we are willing to incur the business risk on this rather than putting in a set of resources. GAO may or may not agree with that but we certainly need to sit down together and work through that. I think we are closer to closed than not.

Mr. TOWNS. GAO?

Ms. DALY. Congressman Towns, I appreciate the opportunity to discuss this and I agree with what Ms. Snyder said. We have not received documentation to confirm whether or not CMS had indeed taken the actions we had recommended related to the contract weaknesses we identified. We are very encouraged to be having meetings with them to review what steps have they taken to address issues such as having appropriate contract closeouts, improving their invoice review procedures, all of these things that are critical to protecting and making sure those contract actions are legitimate.

Ms. SNYDER. We really appreciated the recommendations we got from GAO. We think we can strengthen our internal controls by acting on them and are happy and glad to do that. We are glad to have the benefit of that review.

Mr. TOWNS. In talking to administrators in the health care field, they are saying that electronic records might solve a lot of the problems or would it further complicate the problem? What will it do with the problem? Do you feel that is the case?

Ms. KING. I don't think we know for sure yet. I think it is too soon to tell. Certainly they are going to provide better documentation. There should be better documentation on file, so that would be a positive step but I think before there is further implementation and we have an opportunity to look at it, I don't think we can say it would solve the problem for sure.

Mr. TOWNS. Thank you very much, Mr. Chairman.

I yield back.

Mr. PLATTS. I thank the gentleman.

Before we wrap up, just a couple of other quick things. One, to follow up on Mr. Towns' focus on the internal controls and contract management aspects, I am glad to hear we are further along than maybe we thought in that area and just in the testimony today where we have recovery audit contractors, we have validation contractors to cover the recovery audit contractors and even when improper payments are identified by the recovery audit contractors, they don't collect, and I forget the term for the contractors that actually do the collection. We have a lot of contractors. Managing those contractors is key if we are going to get a true handle on improper payments. That partnership between CMS, GAO and the IG's Office is critical.

Just to refocus on Ms. Norton's issue of Part D, I appreciate this is an ongoing effort, that we are now in the first year where we will have a good assessment of Part D improper payments and if we apply a rough average of the fee for service, Part C, 10 percent, 12 percent, 14 percent, somewhere in there, we are still talking about $5–$6 billion perhaps of improper payments in Part D on top of what has already been identified.

It is all the more important that effort move forward as it is and we are dutiful in how to address those.

In closing, I guess I would emphasize what I think just about all of us have hopefully conveyed, the importance of what you do and the gratitude of our constituents for Medicare ensuring that our seniors are getting the medical care they need and that we do right by them. We certainly want to recognize CMS's efforts in ensuring

that is the case and also the partnership between all three entities represented here, CMS, the IG Office within the Department and GAO. I hope that the three of you and your entities will see this committee in a very positive partnership manner because that is really the intent of this hearing.

I think, Ms. Snyder, you referenced not playing gotcha. I sometimes forget the references because I have been chairman with him as my ranking member on two occasions and he has been chairman with me as his ranking member and the bottom line is we have a shared focus which is just to have good government and to partner with all of our colleagues in government to achieve that. I hope that comes through as our intent with this hearing and going forward to continue to partner and how we can further partner in the months and years to come, especially if there are legislative issues.

One that was mentioned concerned statutory language with the power wheelchairs and how you have to start there. If there are issues you identify at CMS that perhaps the intent of Congress is not fulfilled accurately or appropriately in the way the statute was written versus what you think we were trying to do, you probably will learn that before us because of implementing the statute, we hope you will come back to our committee or Ways and Means and Energy and Commerce with Medicare and Medicaid and partner with Congress.

That is what we are hoping to do in every aspect and at the end of the day, as far as this subcommittee's focus, we hope to do our best to ensure that every dollar of the American people's hard earned funds sent to Washington are handled and used in a responsible, accountable fashion.

I know that is what the four of you as public servants are after and are appreciative of your efforts. We look forward to going forward in a positive way with you.

We will keep open the record for 7 days for any additional information, specifically those numbers on actual fraud dollars identified in the past 3 years. That would be great. We look forward to continuing at the committee level with Members as well as their staffs in how we can work with you.

With that, this hearing stands adjourned.

[Whereupon, at 11:48 a.m., the subcommittee was adjourned.]

[The prepared statement of Hon. Gerald E. Connolly and additional information submitted for the hearing record follow:]

Statement of Congressman Gerald E. Connolly
"Improper Medicare Payments: $48 Billion in Waste?"
July 28th, 2011

Thank you, Chairman Platts for helping keep the Centers for Medicare and Medicaid Services (CMS) focused on reducing improper payments through Medicare. You have been one of the most persistent advocates for reducing improper payments for good reason. Combining Medicare fee-for-service, Medicare Part C, and Medicare Part D, improper payments exceed $120 billion annually. CBO found that that Affordable Care Act provisions to cut down on improper payments could save $60-$80 billion annually. Whether or not we agree on other Affordable Care Act provisions, it is imperative that we stay focused on reducing improper payments to protect the solvency of Medicare and maintain high quality health care for seniors.

Improper payments remain far too high: 10.5% of total payments for Medicare fee-for-service and 14.1% for Medicare Part C. While agencies deserve credit for reducing total fee-for-service improper payments from 12.2% to 10.5% in the last year, the total amount of improper payments still grew. Not surprisingly, the relatively new Medicare Part D program put it at "particular" risk, according to GAO. To reduce overpayments it is imperative that we strengthen both the federal workforce and contractors who work with CMS to reduce improper payments.

To achieve this goal, we will need to hold both CMS and contractors to the highest performance standards. CMS needs to do a better job following up on vulnerabilities identified by Recovery Audit Contractors, as GAO found that CMS had only followed up on 40% of those identified. Contractors should be scored for efficiency and accuracy of payment recovery, as their business model incentivizes aggressive payment recovery. Transparency is necessary to ensure that recovery audit contractors follow proper procedures in recovering overpayments, as we must maintain public credibility if those contractors are to succeed in their mission. Fortunately, the business model structure is fairly well designed so that contractors do not get paid for recovering money incorrectly following an appeal. One question we may wish to consider is whether Recovery Audit Contractors could help reduce overpayments in TRICARE or FEHBP.

As with most issues of federal oversight, our success is contingent on a high quality workforce. Running CMS is a very challenging job, and we need to recruit and retain the best talent for the job. CMS will not be able to crack down on improper payments if potential recruits face the prospect of interminable wage freezes, drastic increases in pension contributions, and reductions in retirement pay. Moreover, proposals to gut FEHBP have the potential to discourage highly skilled employees from entering the workforce, lest they lose good health care coverage as a result of political stunts. It may be tempting to use federal employees to mop up savings and score political points, but those who do so will prevent us from reaching our shared goals of reducing improper payments and maintaining Medicare performance.

Chairman Platts, you have been a thoughtful and conscientious leader of this Subcommittee, and I look forward to our continued collaboration to maintain oversight of improper payments.

Questions for Daniel Levinson
Inspector General
U.S. Department of Health & Human Services

Rep. Todd Russell Platts
Committee on Oversight and Government Reform
Subcommittee on Government Organization, Efficiency and Financial Management

Hearing on "Improper Medicare Payments: $48 Billion in Waste?"

---

1. ***Do you believe that the Recovery Audit Contracting (RAC) program has been effective? What recommendations would you make for improving the RAC program? Please provide your reasoning in your answer.***

OIG has not yet conducted a thorough review of the RAC program, although a review is planned in the future (please see response to question 2 for details).

In February 2010, we conducted an initial assessment of the RAC demonstration project, focusing on the extent to which RACs referred cases of potential fraud to CMS. In that review, we found that during the 3-year demonstration program, RACs referred two cases of potential fraud and abuse to CMS. However, CMS reported that they received no referrals from RACs during this timeframe. We also found that CMS did not provide any formal training to RACs regarding the identification and referral of potential fraud. We recommended that CMS (1) conduct followup to determine the outcomes of the two referrals made during the demonstration project, (2) implement a database system to track fraud referrals, and (3) require RACs to receive mandatory training on the identification and referral of fraud. CMS concurred with all three recommendations. To our knowledge CMS has not yet implemented a fraud-referral tracking system but has taken some steps in that direction. CMS has implemented our remaining recommendations.

2. ***OIG plans to review CMS's oversight of the RAC program this year. Please provide information on the status of this review, and how OIG plans to evaluate the RAC program.***

OIG plans to review the performance of the RAC program as well as CMS's oversight of the RAC program. This review has not yet begun; as such, the scope of work is subject to change. However, our initial plans include determining the amount of funds recouped for Medicare, the number of RAC cases appealed and overturned at any level of appeal, and whether RACs are meeting contractual obligations. We also intend to determine how many performance reviews CMS has done and what actions CMS took when problems were identified.

3. Has CMS been effective in identifying and preventing fraud? What improvements can be made to prevent fraud? In your answer, please provide your reasoning.

There are many opportunities for improvement. OIG's work has identified persistent vulnerabilities in CMS's oversight of the program integrity contractors who play a crucial role in safeguarding the Medicare and Medicaid programs. For well over a decade, OIG has found that contractors performed inconsistently – but CMS could not explain why. We found that CMS's evaluations of contractors did not include sufficient information, and were not timely enough to be used in assessing contractors' performance prior to contract renewals. We also found that CMS sometimes failed to give contractors the data access needed to accomplish their objectives. Furthermore, even when CMS explicitly recognized the importance of conducting proactive data analysis to uncover fraud and abuse, that new focus was not successfully implemented at the contractor level; we found that program integrity contractors produced minimal results in this key area. We are hopeful that CMS's new predictive modeling contracts will result in the increased use of technology and analytics to help eliminate Medicare payments to fraudulent providers. Although these new information technologies hold promise, even the best fraud prevention techniques will be of no value if not effectively implemented and appropriately overseen.

An equally important factor in safeguarding Medicare is ensuring that only legitimate providers are allowed into the program. Unfortunately, provider enrollment has historically been a serious vulnerability. Past OIG work has demonstrated that all too often, sham providers and suppliers are able to obtain Medicare billing numbers and bill for millions of dollars in fraudulent claims. In the wake of new Affordable Care Act requirements, CMS has made changes to provider enrollment screening and oversight that show promise. However, given the severity of this problem in the past, and the critical role of provider enrollment safeguards in protecting Federal health care programs, this area should continue to be a focus for improvement.

Within the Medicaid program, the lack of timely, accurate data poses a serious barrier to program integrity efforts. Currently, two primary data sources are available: the Medicaid Statistical Information System (MSIS) and the Medicaid Management Information Systems (MMIS). Neither database allows for the type of robust data analysis that oversight entities should ideally conduct. For example, MMIS does not include all variables necessary to make key determinations – for example, information about who is enrolled and receiving Medicaid services through a waiver is necessary to determine who is entitled to certain services.

Additionally, MMIS includes service-specific claims only for services provided on a fee-for-service basis. However, well over half of beneficiaries receive all or some services through managed care. MSIS is intended to include both fee-for-service and managed care data, but OIG has found that in practice, not all managed care data is reported. CMS's Integrated Data Repository, operational since September 2006, was intended to include both Medicare and Medicaid data; however, GAO recently reported that Medicaid data have not been integrated into the system, and CMS has not finalized plans or developed reliable schedules for efforts to do so. Without complete, timely, accurate data, the types of innovative data analytics being implemented for Medicare oversight are not options for Medicaid oversight.

4. ***CMS is in the process of recertifying all hospitals and providers. Is OIG evaluating this process? What recommendations does OIG have for the recertification process?***

OIG does not have any work ongoing regarding the recertification process. http://www.cms.gov/MLNMattersArticles/downloads/SE1126.pdf. However, given the vulnerabilities that OIG has identified relating to the provider enrollment process (see 9/15/10 Testimony of Inspector General Levinson for fuller discussion of OIG's work on vulnerabilities relating to provider enrollment, available at http://oig.hhs.gov/testimony/docs/2010/testimony_levinson_09152010.pdf), this will be one of many potential areas for future OIG review.

5. ***Please provide any information on CMS's current process of establishing a payment error rate for Medicare Part D.***

OIG has not assessed CMS's current process of establishing a payment error rate for Medicare Part D and thus defers to CMS as the programmatic agency for response.

Questions for Michelle Snyder
Deputy Chief Operating Officer
Centers for Medicare & Medicaid Services

Rep. Todd Russell Platts
Committee on Oversight and Government Reform
Subcommittee on Government Organization, Efficiency and Financial Management

Hearing on "Improper Medicare Payments: $48 Billion in Waste?"

The Honorable Todd Russell Platts

1. In FY 2010, CMS identified $47.9 billion in improper payments. How many of the improper payments identified were overpayments? Please provide both the percentage of payments that are overpayments and the dollar amount.

Answer:

Medicare Error Rate for FY 2010 (Dollars in Billions)

Medicare Program	Total Dollars Paid	Overpayments		Underpayments		Gross Payment Amount Overpayments + Underpayments	
		Payment	Rate	Payment	Rate	Improper Payments	Rate
FFS	$326.4	$33.2	10.2%	$1.1	0.3%	$34.3	10.5%
Part C Composite Payment Error Estimate (based on CY 2008 payments)	$96.4	Overpayments		Underpayments		Gross Payment Amount (Overpayments + Underpayments)	
		Payment	Rate	Payment	Rate	Improper Payments	Rate
		$11.5*	12.0%	$2.0*	2.1%	$13.6	14.1%

*Part C Composite Payment Error Estimate figures do not sum due to rounding

2. How many cases of fraud has CMS identified in the last three years? How much money has CMS lost through fraud? Please provide information for FY 2008, 2009, and 2010.

Answer: When CMS does identify and detect potential cases of fraud, it takes necessary administrative action when warranted and makes referrals to law enforcement to investigate and prosecute. Below is a chart showing the number of potential fraud cases our Zone Program Integrity Contractors and Program Safeguard contractors have referred to the OIG.

Calendar Year	Cases Referred to the OIG
2008	632
2009	617
2010	827

We do not have an exact dollar amount about how much money is lost to fraud in our programs as there is yet no agreed upon method to estimate fraud in the Medicare program. As stated during my testimony, CMS is collaborating with the Assistant Secretary for Planning and Evaluation (ASPE) to develop a pilot measurement of the amount of probable fraud for certain services in the Medicare program. We expect significant progress will be made to develop fraud rates for Home Health and Durable Medical Equipment over the next year.

Below is a chart showing how much money has been transferred to the Medicare Trust Fund based on investigations, settlements and prosecutions in fraud cases. More information about CMS, DOJ, and OIG's combined efforts to fight Medicare fraud is available in the Health Care Fraud and Abuse Control (HCFAC) Program Annual Report for FY 2010 at http://oig.hhs.gov/publications/docs/hcfac/hcfacreport2010.pdf.

Fiscal Year	Transfers to the Medicare Trust Fund based on efforts from health care fraud judgments and settlements
2008	$1.94 billion
2009	$2.51 billion
2010	$2.86 billion

3. What action is CMS undertaking currently, or has recently undertaken, to counteract fraud?

Answer: The Administration is committed to reducing fraud, waste, and improper payments. The Affordable Care Act is the most comprehensive legislative step forward to fight health care fraud in over a decade. In addition, on June 13, 2011, President Obama launched the Campaign to Cut Waste, a campaign to find and eliminate misspent tax dollars in every agency and department across the Federal government.

Complementing that effort, on July 1, 2011, CMS implemented a new predictive modeling technology developed with private industry experts to fight Medicare fraud. Similar to the technology used by credit card companies, predictive modeling will help identify fraudulent Medicare claims on a nationwide basis so we can begin to take action to stop fraudulent

payments. This initiative builds on the new anti-fraud tools and resources provided by the Affordable Care Act.

All Medicare fee-for-service claims across the country are now being screened with this new predictive modeling technology prior to payment. The ones with the highest risk scores will be prioritized to receive immediate attention and additional review by our analysts through our new rapid response strategy. The rapid response strategy will permit us to examine the conduct that produced the high-risk score, and then to consider a wide variety of appropriate actions, including claim denial, payment suspension or revocation of billing privileges, as well as referral to law enforcement. We decided to implement the technology nationwide to maximize the benefit from predictive models as soon as possible. Nationwide implementation also helps CMS integrate the technology into the Medicare fee-for-service program efficiently across our Medicare Administrative Contractors and anti-fraud contractors. We will also evaluate the expansion of predictive modeling to Medicaid and CHIP over the next few years.

On September 7, 2011, the Attorney General and HHS Secretary announced a nationwide takedown by Medicare Fraud Strike Force operations in eight cities that resulted in charges against 91 defendants, including doctors, nurses, and other medical professionals, for their alleged participation in Medicare fraud schemes involving approximately $295 million in false billing. CMS continues to provide data, analytical and programmatic support to the Strike Force teams as part of the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative, a joint HHS-DOJ cabinet-level commitment to prevent and prosecute health care fraud. Since their inception in March 2007, Strike Force operations in nine locations have charged more than 1,140 defendants who collectively have falsely billed the Medicare program for more than $2.9 billion.

4. In your testimony, you discussed an effort to recertify providers. Please describe this process and its current status. In your description, please provide an overview of the process, its estimated completion date, and what actions CMS plans to take with providers who are identified as having submitted fraudulent or improper claims.

Answer: On July 27, 2011, CMS posted a solicitation for an automated provider enrollment screening solution. CMS' program integrity mission is to ensure that CMS makes accurate payments to legitimate providers and suppliers for appropriate, reasonable, and necessary services and supplies for eligible Medicare beneficiaries. In order to achieve that goal, CMS posted the solicitation to find a contractor who will be able to perform automated screening on new and existing enrollments of providers/suppliers and conduct automated risk assessments for potential fraud, waste, and abuse on a pre- and post-enrollment basis. These abilities will result in alerts and reporting of ineligible providers and suspected fraud, waste, and abuse to designated CMS business partners. The winning contractor of the solicitation must develop comprehensive verification and screening methods, covering all Medicare provider/supplier categories and types, to include physicians and non-physician practitioners, and encompassing providers in all 50 states and 6 territories. The contractor will use both CMS data and appropriate external data sources to enhance risk screening. The contractor's solution must have the capability to:

- Verify enrollment and re-enrollment data for all provider/suppliers and output results of data checks,
- Output risk-based vulnerability assessment and deliver risk screening alerts whenever providers or suppliers fail to meet the requirements established by CMS, or where other data checks create a risk of potential fraud,
- Provide a screening results interface to pass results of enrollment data and risk screening back to CMS and CMS business partners, and
- Support new/updated sources of data to improve the accuracy of data checks/risk identification.

CMS anticipates that this contract will be awarded this fall. By December 2011, the contractor will have implemented a comprehensive verification/screening and risk assessment solution, for all Medicare provider/supplier categories and types, to include physicians and non-physician practitioners, and encompassing providers in all states and territories. The provider screening solution must determine a risk score, identify and prioritize providers that are high risk of being potentially fraudulent based on screening criteria, and return mismatches between enrollment and external data sources, as well as supplementary data from external sources that is relevant to the risk assessment and appropriate feedback reports to designated CMS business partners. A complete revalidation of all enrolled providers and suppliers in the Medicare fee-for-service (FFS) program is required by March 23, 2013. A more detailed description of the solicitation and the Provider Screening Statement of Work can be found on the Federal Business Opportunities website (www.fbo.gov). Search for the solicitation number: RFP-CMS-2011-8A-0029.

5. CMS noted that it has altered the RAC payment structure to remove RACs' incentive to aggressively target providers. What other actions is CMS taking to improve the accuracy and integrity of RACs?

CMS learned a variety of valuable administrative and programmatic lessons from the Recovery Auditor demonstration project that have informed current program efforts. CMS acknowledged that several of the concerns raised by providers in the demonstration were valid, and addressing them prior to national rollout has resulted in positive changes that will enable the national Recovery Audit program to maximize transparency, ensure accuracy, and minimize provider burden.

Every Recovery Auditor is now required to hire a physician medical director, which gives providers additional assurance that the reviews of their medical decisions are accurate and handled appropriately. Providers expressed concerns that filling multiple requests for medical records for review created a burden. As a result, CMS created sliding scale limits, based on provider size, for the number of medical records that can be requested by Recovery Auditors from a provider. In order to ensure accurate determinations of payments made in error, Recovery Auditors must now also secure pre-approval from CMS of issues they wish to pursue for review, meaning that before a Recovery Auditors can proceed with large numbers of reviews, CMS staff, and if necessary, a third party independent reviewer, must examine and approve the

proposed provider type, error type, policy violated and potential improper payment amount per claim to ensure that the review is appropriate. In addition, to address the concern that Recovery Auditors might have a perverse incentive to over-identify improper payments, CMS now requires them to refund contingency fees for any decision overturned on appeal.

6. The CERT process is designed to detect improper payments, but is less useful in identifying fraud. How does CMS identify fraudulent behavior, and what steps is CMS taking to improve its detection of fraud?

Answer: The CERT program does not and cannot label a claim fraudulent. CERT is used to identify claims that did not comply with Medicare coverage, coding, documentation or billing rules. However, as previously mentioned, CMS is developing and will pilot a methodology to measure probable fraud.

CMS is responsible for identifying and detecting instances of potential fraud in the Medicare program and referring such cases to our law enforcement partners, absent an estimate of the fraud rate. Zone Program Integrity Contractors (ZPICs) are tasked by CMS with identifying potential fraud, developing cases thoroughly and in a timely manner, and referring those cases to the OIG. Since the beginning of the calendar year, the ZPICs have made over 461 referrals to the OIG.

CMS anticipates that the newly implemented predictive analytic technology will increase detection as well as enhance our contractors' efficiency in responding to fraud leads. Additionally, CMS plans on continuing to refine the provider enrollment process, reducing the burden on legitimate providers while targeting resources towards high-risk areas. To assist us with screening providers according to their levels of risk, as recently established in the new enrollment rule which became effective this spring, CMS is seeking to award a National Site Visit contractor this fall who will provide quick-turn-around support to verify a provider's location and eligibility for enrollment. CMS also plans to award another contract this fall for an automated screening solution that will implement key enrollment eligibility checks on a rolling basis – meaning we will find key information such as expired licenses very quickly.

7. Please provide the Committee with an update on the current status of establishing a payment error rate for Part D. In your update, please include CMS's methodology in establishing a payment error rate.

Answer: CMS is committed to reducing error rates in the Medicare, Medicaid, and CHIP programs. As you know, Medicare Part D is a relatively new and complex program, and it has taken several years to develop an improper payment measurement for the program. However, CMS expects to report a Part D program baseline error estimate in the fall of 2011. In FY 2009 and FY 2010, CMS reported payment error estimates for several components of Part D payments. CMS has made significant strides in developing a methodology for combining all component error measures – including those components previously measured and reported in FY 2009 and FY 2010 – into a Part D composite payment error estimate.

The payment error rates are calculated by dividing the gross payment error amount by total Part D payments for the calendar year. The component estimates are described below:

(1) MPE Rate. The Medicare Advantage Prescription Drug (MARx) Payment System Error estimate captures errors in prospective Part D payments caused by errors in the transfer of data, interpretation of data, and payment calculations in the MARx payment system. The FY 2009 MPE estimate was 0.59 percent or $250 million in gross payment error, and the FY 2010 MPE estimate was 0.1 percent or $44.5 million.

(2) PELS Rate. The Payment Error related to Low-Income Subsidy estimate captures errors due to incorrect information on beneficiaries' low-income status, which affects the level of low income cost sharing subsidy a beneficiary receives. The FY 2009 PELS estimate was 0.25 percent or $106.5 million in gross payment error, and the FY 2010 PELS estimate was 0.12 percent or $53.5 million.

(3) PEMS Rate. The Payment Error related to Medicaid Status estimate captures payment errors due to incorrect assignment of Medicaid status. This may result in three types of erroneous LIS-related payments (low income cost sharing, the low income premium subsidy and direct subsidy amounts). If beneficiaries were incorrectly assigned Medicaid eligibility, the LIS-related payments would be overstated. Thus, the PEMS estimate only reflects overpayments to plans. The FY 2009 PEMS estimate was 1.06 percent or $449 million in gross payment error, and the FY 2010 PEMS estimate was 1.76 percent or $785 million. This increase occurred because this estimate is driven by the Medicaid program's improper payment estimate of error in eligibility determination, which increased from 3.2 percent to 8.9 percent from FY 2007 to FY 2008.

Note: The PELS and PEMS error amounts cannot be summed because this would double-count some errors. Both measures capture incorrect Low Income Subsidy payments, and the beneficiaries included in the PEMS measure are also represented in the PELS measure. The difference is that the PEMS measure uses a separate data source from the Medicaid program to estimate the extent to which Medicaid eligibility was incorrectly assigned to Medicare beneficiaries.

(4) PEPV Rate. The Payment Error Related to Prescription Drug Event (PDE) Data Validation measures error in payments due to invalid and/or inaccurate PDE records, which result in adjustments to beneficiaries' benefit phases and in turn impact low income cost sharing and reinsurance payments. The accuracy of sampled PDE records is evaluated using supporting documentation, including the prescription hard copy.

The FY 2010 PEPV estimate was 12.74 percent or $5.37 billion in gross payment error.