MEDICARE CONTRACTORS' EFFORTS TO FIGHT FRAUD—MOVING BEYOND "PAY AND CHASE"

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

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C O N T E N T S

MEDICARE CONTRACTORS' EFFORTS TO FIGHT FRAUD—MOVING BEYOND "PAY AND CHASE"

FRIDAY, JUNE 8, 2012

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

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

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

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

OPENING STATEMENT OF HON. CLIFF STEARNS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

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

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

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

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

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

Since 1999, CMS has contracted with Program Safeguard Contractors, or PSCs, to prevent, identify and investigate potential fraud. They are now in the process of transitioning these responsibilities to Zone Program Integrity Contractors, or ZPICs, though the contract recipients are primarily the same entities and with the same capabilities.

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

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

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

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

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

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

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

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

Without the committee insisting that CMS and its contractors be accountable for meaningful performance metrics, we cannot achieve the significant improvements and results in reducing Medicare fraud.

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

[The prepared statement of Mr. Stearns follows:]

Opening Statement of the Honorable Cliff Stearns
Chairman, Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
"Medicare Contractors' Efforts to Fight Fraud – Moving Beyond 'Pay and Chase'"
June 8, 2012

(As Prepared for Delivery)

We convene this hearing of the Subcommittee on Oversight and Investigations to examine the efforts of the Centers for Medicare and Medicaid Services' (CMS) oversight of its Medicare contractors and to identify ways to improve the contractors' effectiveness at preventing and combating fraud. Medicare fraud is a growing plague on our health care system. And I have personally seen how fraud impacts seniors in my district and throughout Florida.

CMS, the very agency tasked with administering Medicare and conducting and overseeing anti-fraud efforts, incredibly cannot define the scope of the problem. However, we have heard the estimates: 10% of all health care billings are potentially fraudulent—a $60 to $80 billion drain on federal coffers. Regardless of the ultimate number cited, every dollar lost to fraud is a dollar that should have gone towards the care and well-being of a Medicare beneficiary.

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Since 1999, CMS has contracted with Program Safeguard Contractors, or PSCs, to prevent, identify, and investigate potential fraud. They are now in the process of transitioning these responsibilities to Zone Program Integrity Contractors, or ZPICs, though the contract recipients are primarily the same entities with the same capabilities. Unfortunately, information obtained through the Committee's investigation indicates these "benefit integrity" contractors are not getting the job done and CMS is asleep at the wheel.

Last December, I sent a letter, along with Chairman Upton and other members of the Committee, to CMS Acting Administrator Marilyn Tavenner requesting documents related to the performance of the CMS benefit integrity contractors since 2007. Three months ago, Ms. Tavenner responded to our request with systemic performance data that included some concerning trends:

- The benefit integrity contractors identify less than 1 percent of the estimated fraud out there;
- They recover only 10% of the improper payments they identify;
- They rarely employ their authority to suspend payments to suspected fraudsters;

- They initiated fewer investigations in 2011 than in 2007; and;
- Fewer of these investigations were based on proactive analysis of claims data

The figures CMS provided to the Committee are astonishing in terms of the declining contractor effectiveness they display. However, according to CMS, while the trends are correct, the numbers provided were inaccurate. Not only were they inaccurate but—knowing that they were a key element of our hearing—CMS failed to inform Committee staff about this fact until less than 48 hours ago on a phone call initiated by Committee staff on another matter. Since they did not feel confident in the accuracy of the data they had on hand, CMS was forced to reach out to the contractors and have them resubmit as much of the data that was requested as possible. More accurate numbers were provided last evening confirming the trends. Nonetheless, this error only confirms CMS' utter incompetence in conducting any meaningful oversight of these contractors – a point that is echoed loud and clear in the IG's prepared testimony.

The complacency shown by CMS towards this Committee's oversight efforts, their repeated indifference to GAO's recommendations since, and their disregard for OIG's extensive body of work in this area must end today.

While these issues are not new, they are getting worse while the fraudsters are getting better. As the OIG's office testified before this Subcommittee in June 2001: "Medicare contractors are the heart of the Medicare program…When they don't function properly, the entire program is jeopardized—those who benefit from it, those who provide care, and those who pay for it all suffer the consequences."

This hearing proves the importance of Congressional oversight. Without the Committee asking the questions, we would never know about the serious data integrity and management issues concerning CMS oversight of its contractors. Without the Committee insisting that CMS and its contractors be accountable for meaningful performance metrics, we cannot achieve the significant improvements and results in reducing Medicare fraud. I look forward to working in a bipartisan fashion to make this hearing the start of a turning point for CMS and contractor performance.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

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

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

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

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

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

The agency's new Fraud Prevention System employs predictive modeling technology in order to screen claims before payment is made. Using this system, CMS can identify patterns of fraud and deny claims, suspend payment or revoke Medicare billing privileges for suspicious actors.

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

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

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

This hearing today will primarily focus on CMS's use of contractors to monitor claims, investigate suspicious activity and refer cases to law enforcement authorities.

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

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

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

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

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

Mr. STEARNS. By unanimous consent, so ordered.

[The prepared statement of Mr. Waxman follows:]

Opening Statement of Rep. Henry A. Waxman
Ranking Member, Committee on Energy and Commerce
Hearing on "Medicare Contractors' Efforts to Fight Fraud – Moving Beyond 'Pay and Chase'"
Subcommittee on Oversight and Investigations
June 8, 2012

Mr. Chairman, Medicare fraud wastes taxpayer dollars. It affects the quality of care provided to program enrollees and it saps public confidence in Medicare. That's why I see fighting Medicare fraud as a critical need and an issue where we should be able to achieve bipartisan consensus.

The Obama Administration has an excellent record on preventing Medicare fraud, making it a priority from day one. Since 2009, the Administration has recovered almost $8 billion in fraudulent payments. In fiscal year 2011, the Administration's Health Care Fraud Enforcement Team's efforts resulted in 132 indictments against defendants who collectively billed the Medicare program more than $1 billion.

And since April 2010, the Administration has been busy implementing the new anti-fraud provisions in the landmark health care reform law. The law provides hundreds of millions of dollars in new funding to fight fraud. It imposes new penalties on fraudsters. And most important, it shifts the prevailing Medicare fraud prevention philosophy from pay and chase to inspect and prevent.

Thanks to the Affordable Care Act, Medicare fraud prevention now starts with the provider enrollment process. The health reform law added new screening requirements for Medicare providers, keeping bad actors out of Medicare before they can event attempt to commit fraud. CMS has now implemented these provisions, strengthening the enrollment process and verifying that providers are properly licensed and qualified to provide care before they are allowed into the

Medicare program. This, Mr. Chairman, is the Affordable Care Act at work.

The health reform law also gave CMS enhanced authority to suspend Medicare payments to providers while they investigate an allegation of fraud – stopping fraudulent payments before they go out the door. Last year alone, CMS payment suspensions led to over $27 million in recoveries against suspect providers.

The Affordable Care Act also provides hundreds of millions of dollars in new funding to help CMS, the Inspector General and the Department of Justice fight Medicare fraud. Those funds are being put to good use. They help fund the Medicare Strike Force operations, which last month filed charges against 107 individuals who participated in Medicare fraud schemes.

The funds help implement the new CMS Fraud Prevention System (FPS), which monitors 4.5 million claims each day and uses predictive analytics to identify and prevent fraud,

We're going to hear today from CMS, from GAO and from the HHS Inspector General. I appreciate these witnesses coming, and I thank them for their hard work to protect taxpayer dollars and prevent Medicare fraud.

The Medicare Integrity Contractors that we will hear about at this hearing conduct critical work and are key fraud-fighting partners of CMS. But the Inspector General has identified problems with the contractors and with CMS oversight of their activities. I hope to hear more from our witnesses today about the role that these contractors play and how we can improve this system to fight Medicare fraud.

Mr. Chairman, thank you for holding this hearing. I hope it results in a bipartisan approach to reducing Medicare fraud and abuse.

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

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

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

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

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

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

If we are serious about bringing down the cost of health care, we have to eliminate, not just reduce, but eliminate these inappropriate payments.

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

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

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

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

to over 30; however, backend investigations will remain a part of what the Centers for Medicare and Medicaid Services does for some time. Currently they oversee a network of private contractors that conduct various program integrity activities but as Ranking Member DeGette points out, it may be necessary to have these individuals in to the committee to understand their steps to solve this problem.

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

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

OPENING STATEMENT OF HON. JANICE D. SCHAKOWSKY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

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

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

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

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

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

Since 2009 CMS, with law enforcement partners, has recovered $7.87 billion in fraudulent Medicare payments, $2.51 billion in 2009, $2.86 billion in 2010 and $2.5 billion in 2011.

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

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

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

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

And I will yield back.

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

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

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

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

Mr. VITO. No.

Ms. KING. No.

Mr. DOOLITTLE. No.

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

Mr. VITO. No.

Ms. KING. No.

Mr. DOOLITTLE. No.

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

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

Mr. VITO. Yes.

Ms. KING. Yes.

Mr. DOOLITTLE. Yes.

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

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

STATEMENT OF ROBERT A. VITO

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

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

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

Finally, the OIG has found that very few of the overpayments identified by the benefit integrity contractors are collected and returned to the Medicare program.

CMS expects its benefit contractors to do more than just investigate complaints. They wanted their contractors to conduct proactive data analysis to identify fraud. As early as 1998, OIG raised concerns about the lack of results from proactive methods, and these concerns still remain.

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

Another way to help prevent fraud, waste, and abuse is to identify program vulnerabilities. OIG's early review of fraud units found that more than one-third had not identified any program vulnerabilities. During a 2011 review, OIG found that not all benefit contractors identified vulnerabilities. And even when vulnerabilities were identified, CMS had not taken significant ac-

tion to resolve three-quarters of them. The reported impact of the vulnerability was estimated at over $1 billion.

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

In addition, OIG work has repeatedly found that CMS performance evaluations provide very few quantitative data about the contractors' achievement in detecting fraud. OIG's most recent ZPIC review also found that data use by CMS to oversee the contractors may not be uniform or accurate. Some of the inaccurate data may be due in part to the contractors' different interpretations of fraud terms and definitions. OIG has recommended that CMS determine the cause of these variations in the contractors' activity levels; however, CMS has yet to perform these types of review.

Benefit integrity contractors are also required to refer overpayments that they identify to the Medicare claims processors for collection. In the report done in response to a request from this committee, OIG found that PSCs referred $835 million in overpayments to the claims processor for collection in 2007. However, as of June, 2008, only $55 million of the $835 million was collected.

CMS is implementing new anti-fraud tools as part of its twin pillar strategy. As the OIG did in the past, we will continue to review CMS's strategy to determine its impact on the Medicare program, and, if warranted, make recommendations for improving the strategy.

OIG also plans to continue its body of work on the Medicare benefit integrity contractors, including an update of our previous work on the MEDICs. We also have work underway on Medicare overpayments and debt collection.

Thank you again for your interest in this important topic and for the opportunity to testify before the subcommittee today.

[The prepared statement of Mr. Vito follows:]

Testimony of Robert A. Vito
Regional Inspector General for Evaluation and Inspections
Office of Inspector General
U.S. Department of Health and Human Services

"Medicare Contractors' Efforts to Fight Fraud - Moving Beyond 'Pay and Chase'"

Before the
House Energy and Commerce Committee:
Subcommittee on Oversight and Investigations

June 8, 2012
Rayburn House Office Building
Room 2123

Testimony of:
Robert A. Vito
Regional Inspector General for Evaluation and Inspections
Office of Inspector General
U.S. Department of Health and Human Services

Good morning Chairman Stearns, Ranking Member DeGette, and other distinguished Members of the Subcommittee. I am Robert Vito, Regional Inspector General for Evaluation and Inspections at the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG). Thank you for the opportunity to testify about OIG's work on the fraud detection efforts of the Medicare benefit integrity contractors.

On June 28, 2001, OIG testified before this Subcommittee on performance problems that we had found in the fraud detection units at Medicare claims processing contractors. These problems included a lack of proactive case development, limited identification of program vulnerabilities, significant variation in the level of benefit integrity results across contractors, and a lack of uniformity and understanding of key fraud terms and definitions across contractors. A decade later, many of these same vulnerabilities regarding fraud detection and preventions persist among the current benefit integrity contractors.

THE TYPES OF MEDICARE BENEFIT INTEGRITY CONTRACTORS HAVE CHANGED BUT SIMILAR PROBLEMS PERSIST

Types of Benefit Integrity Contractors

For more than a decade, OIG has been conducting reviews of the benefit integrity contractors that the Centers for Medicare & Medicaid Services (CMS) employs to reduce Medicare fraud, waste, and abuse. OIG began more than 15 years ago reviewing the anti-fraud and abuse activities conducted by the fraud units housed in the Medicare fiscal intermediaries and carriers.

In 1999, CMS began contracting with new entities called Program Safeguard Contactors (PSC) to detect and deter fraud in Medicare Parts A and B.[1] As a result of Medicare contracting reform required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, CMS is currently replacing PSCs with Zone Program Integrity Contractors (ZPIC).[2]

[1] Through the years, some PSCs were given responsibility for both Parts A and B while others only Part A or Part B.
[2] With ZPICs, CMS intended to align all benefits in the Part A and B programs (including home health, hospice, and durable medical equipment) under a single ZPIC in each of seven geographic zones.

With the inception of the Part D program, CMS contracted with Medicare Drug Integrity Contactors (MEDIC) to address potential fraud and abuse related to the Part D prescription drug benefit. In fiscal year 2007, CMS awarded contracts to three regional MEDICs. Since that time, all Part D benefit integrity activities have been assigned to a single MEDIC. This MEDIC also now has responsibility for detecting fraud in the entire Part C (i.e., Medicare Advantage) program.

Activities Performed by Benefit Integrity Contractors

CMS's benefit integrity contractors are generally tasked with:

- Proactively pursuing different sources and techniques for analyzing data to detect fraud.
- Conducting investigations to determine the facts and magnitude of alleged fraud and abuse cases.
- Referring cases of potential fraud to OIG or other law enforcement agencies.
- Assisting law enforcement by responding to requests for information.
- Identifying and reporting to CMS any systemic program vulnerabilities.
- Referring for collection any Medicare improper payments (i.e., overpayments) identified while conducting benefit integrity activities.

Problems Persist Regarding Benefit Integrity Contractors' Performance

Over the last 10 years there have been significant changes in both the number and types of contractors that CMS employs to protect Medicare from fraud, waste, and abuse. OIG reviews of these contractors have uncovered the following recurring issues that hinder the successful performance and oversight of the contractors, including:

- Limited results from proactive data analysis.
- Difficulties in obtaining the data needed to detect fraud.
- Inaccurate and inconsistent data reported by benefit integrity contractors.
- Limited use by CMS of contractor-reported fraud and abuse activity data in evaluating contractor performance and investigating variability across contractors.
- Lack of program vulnerability identification and resolution.

In addition, there is significant variance in the identification of overpayments among PSCs and only a small percentage of the overpayments referred by PSCs have been collected and returned to the Medicare program.

BENEFIT INTEGRITY CONTRACTORS HAVE HAD LIMITED FRAUD DETECTION RESULTS FROM PROACTIVE METHODS

Proactive data analysis has not represented a significant portion of benefit integrity contractors' activities. Instead, much of the benefit integrity contractors' fraud identification relies on

reactive methods, such as complaints from external sources. The lack of proactive and early identification of fraud results in the Medicare program relying on the familiar "pay and chase" model rather than a risk reduction model that includes early detection and prevention of inappropriate payments.

As early as 1996, OIG began highlighting the limited nature of benefit integrity contractors' proactive approaches. In our first evaluations of the fiscal intermediary and carrier fraud units, OIG raised concerns about the lack of results from proactive methods.[3] In the case of fiscal intermediaries, half of the fraud units did not open any cases proactively.

PSCs were supposed to use innovative, proactive data analysis more than their predecessors, the claims processing fraud units. Yet, in OIG's review of PSCs in 2007, OIG found minimal results from proactive data analysis.[4] Thirteen of the 17 PSCs had less than 19 percent of their new investigations result from proactive data analysis. Two of these had no new investigations from proactive analysis.

As CMS has transitioned from PSCs to ZPICs, OIG has found that data provided to CMS by ZPICs about their fraud and abuse activities were not always accurate or uniform across contractors.[5] However, the two ZPICs reported an average of only 7 percent of new investigations coming from proactive methods.

Similarly in Medicare Part D, OIG has found that most incidents of potential fraud identified by the MEDICs came from external sources rather than proactive methods. OIG found that only 13 percent of Part D potential fraud incidents were identified through proactive methods.[6]

DIFFICULTIES IN ACCESSING DATA HAVE HINDERED BENEFIT INTEGRITY CONTRACTORS' ACTIVITIES

The current ZPICs and MEDICs' lack of access to Medicare claims data and, in the case of the MEDICs, medical records and prescriptions, has hindered or delayed their ability to fight fraud.

ZPICs reported that the lack of data access hindered their ability to identify potential fraud and abuse, respond to law enforcement requests for information, and track overpayment collections. At the start of their contracts, ZPICs had difficulties obtaining data. One ZPIC described difficulties obtaining claims data from a previous PSC and, therefore, decided to purchase the claims data on its own from another CMS contractor. Another ZPIC stated that the data

[3] OIG, *Carrier Fraud Units* (OEI-05-94-00470), November 1996 and *Fiscal Intermediary Fraud Units* (OEI-03-97-00350), November 1998.
[4] OIG, Medicare's *Program Safeguard Contractors: Activities to Detect and Deter Fraud and Abuse* (OEI-03-06-00010), July 2007.
[5] OIG, *Zone Program Integrity Contractors' Data Issues Hinder Effective Oversight* (OEI-03-09-00520), November 2011.
[6] OIG, *Medicare Drug Integrity Contractors' Identification of Potential Part D Fraud and Abuse* (OEI-03-08-00420), October 2009

necessary to fulfill requests for information were not available to them or had to be generated from multiple sources.

ZPICs reported that improved data access would assist them in identifying potential fraud and abuse. Specifically, ZPICs indicated that having access to daily downloads of Medicare claims data would enable them to perform near-real-time analysis of provider and supplier billing activity.

Early problems with accessing and using data also hindered MEDICs' ability to identify and investigate potential fraud and abuse. MEDICs reported that they need both Part D prescription drug event (PDE) data and Medicare Part B data to effectively identify and investigate instances of potential Part D fraud and abuse. However, CMS did not provide MEDICs with access to PDE data until August 2007, nearly a year after their contracts began. In addition, two MEDICs were not given access to Part B data until Fall 2008—2 years after their contracts began. Once they received access to PDE data, MEDICs reported that important variables were missing from the datasets or entered into incorrect data fields, making effective data analysis difficult.

Further, MEDICs' lack of authority to obtain information directly from pharmacies, pharmacy benefit managers, and physicians hindered their ability to investigate potential fraud and abuse incidents. MEDICs reported that because CMS contracts with plan sponsors, MEDICs have the authority to request information only from plan sponsors. Providing MEDICs with the authority to request information directly from providers and pharmacy benefit managers that provide Part D services could improve the efficiency and effectiveness of their fraud detection efforts.

OVERSIGHT OF CONTRACTOR PERFORMANCE IS LIMITED BY INACCURATE AND INCONSISTENT DATA AND BECAUSE CMS DOES NOT EVALUATE THE CAUSES OF VARIATION ACROSS CONTRACTORS

Inaccuracies and Inconsistencies in Contractor Performance Data Limit the Data's Usefulness

Benefit integrity contractors are required to report workload statistics related to their program integrity activities, including investigations and case referrals, periodically to CMS. However, OIG found that workload data used by CMS to oversee ZPICs were not accurate or uniform. This prevented OIG from making a conclusive assessment of their activities.[7]

The inaccuracies and the lack of uniformity in ZPIC data resulted from data system issues, ZPIC reporting errors, and ZPICs' differing interpretations of fraud terms and definitions. For example, the ZPICs counted and reported new investigations differently from each other in the

[7] The lack of uniformity in ZPICs' reporting of data is similar to problems that OIG identified 15 years ago in its review of fiscal intermediary fraud units. In that review, OIG found that definitions of key fraud and abuse terms varied among CMS and its contractors, which hindered CMS's ability to interpret data and measure fraud unit performance.

workload statistics provided to CMS. Specifically, one ZPIC explained that it included all fraud complaints in its number of new investigations reported to CMS, regardless of whether those complaints were merged into one provider investigation. However, another ZPIC explained that if it received a complaint on a particular provider and started an investigation and then received another complaint on that provider, the subsequent complaint would not be counted as a new investigation in the workload statistics. This inconsistency could explain why one ZPIC reported seven times more investigations originating from external sources (e.g., complaints) than the other.

OIG has offered a number of recommendations to CMS about collecting a greater volume of benefit integrity results data, clarifying definitions of fraud terms and data definitions, and ensuring the validity and uniformity of this data. While CMS now requires benefit integrity contractors to report additional quantitative statistics, CMS still has not developed methods to ensure that all data provided by benefit integrity contractors is accurate and uniform.

CMS has not Assessed Differences in Performance Across Integrity Contractors

While one would expect that contractors would differ somewhat from one another in activity levels, OIG found significant differences in fraud detection activities across ZPICs (and in earlier work, across PSCs and fraud units). This variation could not always be explained by the size of the contractors' budget or oversight responsibility.

CMS has not systematically assessed the wide variation across contractors' activity data. In fact, CMS's contractor performance evaluations provide very few quantitative details about the contractors' achievements in detecting and deterring fraud and abuse.[8]

OIG has recommended that CMS perform more global assessments of performance across contractors; however, CMS has not performed these types of reviews. OIG continues to recommend that CMS review quantitative statistics across contractors to ensure that outlier data are investigated and to address the causes behind the variation in contractors' fraud detection levels.

BENEFIT INTEGRITY CONTRACTORS ARE REQUIRED TO REPORT MEDICARE PROGRAM VULNERABILITIES TO CMS BUT MANY REMAIN UNRESOLVED

Medicare benefit integrity contractors are required to help prevent fraud, waste, and abuse by identifying systemic vulnerabilities in the Medicare program. However, OIG has found that some contractors are not reporting any program vulnerabilities to CMS. CMS defines program vulnerabilities as fraud, waste, or abuse identified through the analysis of Medicare data. Our early review of fraud units found that more than one-third of them had not identified any

[8]OIG, *Medicare's Program Safeguard Contractors: Performance Evaluation Reports* (OEI-03-04-00050), March 2006.

program vulnerabilities. In 2009, almost half of the benefit integrity contractors reviewed did not report any program vulnerabilities to CMS. The remaining PSCs, ZPICs, and MEDICs reported a total of 62 program vulnerabilities to CMS in 2009.[9] Further, although PSCs and ZPICs are required to report the monetary impact of vulnerabilities, these contractors reported impact for only 21 of the vulnerabilities. For the 21 vulnerabilities alone, the estimated monetary impact was $1.2 billion.

As of January 2011, CMS had not resolved or taken significant action on three-fourths of the 62 vulnerabilities reported in 2009. CMS took significant action to resolve 14 of the vulnerabilities, but only 2 of these had been fully resolved. OIG found that CMS lacked procedures to adequately track vulnerabilities and ensure that corrective actions are taken to resolve reported vulnerabilities.

OVERPAYMENTS THAT BENEFIT INTEGRITY CONTRACTORS IDENTIFIED FOR COLLECTION DID NOT RESULT IN SIGNIFICANT MEDICARE RECOVERIES

Benefit integrity contractors that are responsible for Medicare Parts A and B, i.e., the PSCs and ZPICs, are required to refer overpayments that they identify to the Medicare claims processors for collection. In response to a request from this Subcommittee, OIG issued a series of reports in 2010 concerning the identification and collection of Medicare overpayments referred by the PSCs for collection.[10] OIG found that only a very small percentage of overpayments that PSCs referred for collection was actually collected and returned to the Medicare program.

PSCs referred $835 million in overpayments to claim processors for collection in 2007. Similar to the variation found among benefit integrity contractors' fraud detection efforts, we found PSCs differed substantially in the amount of overpayments they referred for collection. Only two PSCs were responsible for 62 percent of the $835 million referred for collection by all PSCs.

Of the $835 million referred, only 7 percent, or $55 million, was collected by June 2008. The collection status for another 8 percent, or $64 million, could not be determined. For one out of every four overpayments referred by the PSCs, the claims processors reported that they did not receive the referrals or did not have any collection information.

ADDITIONAL CORRECTIVE ACTIONS ARE NEEDED TO ADDRESS PROBLEMS

OIG has recommended a number of corrective actions to address issues identified during our benefit integrity program reviews. CMS has implemented a number of these actions, but OIG

[9] OIG, *Addressing Vulnerabilities Reported by Medicare Benefit Integrity Contractors* (OEI-03-10-00500), December 2011.

[10] OIG, *Medicare Overpayments Identified by Program Safeguard Contractors* (OEI-03-08-00031) and *Collection Status of Medicare Overpayments Identified by Program Safeguard Contractors* (OEI-03-08-0003) and *Collection Rate for Overpayments Made to Medicare Suppliers in South Florida* (OEI-03-09 00570), May 2010.

continues to recommend the following additional actions to improve benefit integrity contractors' performance.

Oversee Proactive Identification of Fraud. If CMS expects ZPICs and MEDICs to continue to use proactive methods, CMS must ensure that this is being done effectively at each contactor.

Provide Timely Data Access. CMS must ensure that all contractors receive timely access to data especially during times of contractor transition. With regard to MEDICs' ability to directly access medical records and prescriptions, CMS should seek the authority to request medical records and information directly from the providers and pharmacy benefit managers that provide services for Part C Medicare Advantage and Part D prescription drug plans.

Improve Accuracy of Contractor-Reported Fraud Activity Data. CMS must develop methods to ensure that all data provided by benefit integrity contractors is accurate and uniform. CMS also needs to clearly define fraud and abuse terms that all contractor should use when reporting data.

Assess Variability in Performance Across Contractors. CMS should include more quantitative results in benefit integrity contractors' performance evaluations. Using both quantitative and qualitative data to describe achievements would provide a more comprehensive picture of contractor performance and provide CMS with valuable data for making contract renewal decisions. It would also allow CMS to conduct a more global assessment of performance across contractors. If uniform, quantitative results were included across contractors, CMS could investigate the causes of the significant variability of activity across contractors and the especially low volume of activity among certain contractors.

Ensure Program Vulnerability Identification and Resolution. To gain sufficient oversight of program vulnerabilities and reduce the risks to Medicare, CMS must have effective policies and procedures to (1) track vulnerabilities identified by all benefit integrity contractors, (2) ensure that all contractors are identifying and reporting vulnerabilities, and (3) ensure the prompt resolution of vulnerabilities.

Improve Overpayment Identification and Collection. CMS should develop effective procedures to ensure that PSCs, ZPICs, and claims processors are able to identify and track the collection status of all current and future overpayment referrals by benefit integrity contractors. CMS is responsible for ensuring that PSCs and ZPICs perform their overpayment identification effectively. To accomplish this, CMS must have complete and accurate information about overpayment referrals and the collection status of these referrals.

OIG WILL CONTINUE REVIEWING MEDICARE BENEFIT INTEGRITY ISSUES

With over $500 billion in Medicare benefit payments at risk each year, it is essential that all Medicare fraud-fighting partners do their utmost to ensure that fraud risks are minimized and program vulnerabilities are identified early and resolved quickly.

CMS is just beginning to employ its new twin pillars strategy for program integrity. The first pillar is the Fraud Prevention System (FPS). The FPS will utilize new contractors to perform predictive analytics that identify suspicious or inappropriate claims prior to payment. The second pillar is the Automated Provider Screening (APS) system, which identifies ineligible providers or suppliers prior to their enrollment or reenrollment.

As OIG did with prior strategies, we will review CMS's new strategy to determine its impact on reducing fraud and abuse in the Medicare program. OIG will begin reviews of the new enrollment procedures and the prepayment identification of inappropriate Medicare claims. OIG is also updating our previous work on MEDICs and will review how the current MEDIC has undertaken its new Part C fraud detection responsibilities. OIG is continuing to conduct evaluations regarding overpayments and Medicare debt collection. We are also conducting reviews to examine the activities of the Medicare Administrative Contractors and Recovery Audit Contractors.

Thank you for your support of OIG's mission and the opportunity to testify about benefit integrity contractors' fraud detection activities.

Mr. STEARNS. Thank you, Mr. Vito.
Ms. King, we welcome your opening statement.

STATEMENT OF KATHLEEN M. KING

Ms. KING. Mr. Chairman, Ranking Member DeGette, and members of the subcommittee, I am pleased to be here today to discuss our work regarding fraud in the Medicare program as well as recent laws and agency actions that may help reduce fraud.

Multimillion-dollar fraud convictions demonstrate that fraud is a significant problem for Medicare. However, the full extent of the problem is not known. There are no reliable estimates of fraud for the Medicare program or for the health care industry as a whole. By its very nature, fraud can be difficult to detect as those involved are engaged in intentional deception.

My testimony today focuses on the steps CMS has taken to reduce fraud and on additional steps we have recommended to them as well as work that we have underway.

Congress provided CMS with new tools to reduce fraud in the Patient Protection and Affordable Care Act and the Small Business Jobs Act. I want to focus on three key strategies. First, strengthening provider enrollment standards and procedures; second, improving pre- and post-payment claims review; and, third, developing a robust process for addressing identified vulnerabilities, which are weaknesses that can lead to payment resource.

With respect to provider enrollment, CMS has taken important steps to ensure that only legitimate providers and suppliers are enrolled to bill Medicare. Specifically, in accordance with PPACA, CMS designated three levels of risk. Those at the highest risk levels are subject to the most rigorous screening. In addition, CMS recently contracted with two contractors to automate enrollment processes and to conduct site visits for new providers in the moderate- and high-risk categories to ensure that they are legitimate providers.

We urge CMS to fully implement other key PPACA provisions, such as requiring surety bonds for providers designated as high risk, conducting fingerprint-based criminal background checks, and requiring key disclosures from providers and suppliers before enrollment, such as whether they have ever been suspended from a Federal health program.

Our work has also shown that prepayment reviews are essential to help ensure that Medicare pays correctly the first time. CMS's contractors use automated prepayment controls called edits, which are instructions programmed into IT systems to check to see if providers are eligible for payment and if claims comply with Medicare's coverage and payment policies. We have previously found weaknesses in some of these prepayment edits and are currently evaluating prepayment edits regarding coverage and payment policies.

We are also currently reviewing CMS's newest effort, the Fraud Prevention System, which uses predictive analytic technologies to analyze fee-for-service claims on a prepayment basis. These technologies are used to review claims for potential fraud by identifying unusual or suspicious patterns or abnormalities in Medicare provider networks, claims billing patterns and beneficiary utilization.

We have also found that CMS could take additional steps in improving its post-payment review of claims which are critical to identifying payment errors. In particular, the agency could make better use of two information technology tools designed to provide them with more data and analytical tools for finding fraud: the Integrated Data Repository and the One Program Integrity tool.

We have also found that CMS needs a more robust process for identifying vulnerabilities that can lead to fraud. In our work on the Medicare Recovery Audit Contract Program, we recommended CMS improve its process for implementing corrective actions regarding vulnerabilities.

We have also recently been asked to evaluate the ZPICs, the Zone Program Integrity Contractors, and we expect to start that work soon.

In conclusion, CMS has several tools at its disposal and has taken important steps toward preventing fraud; however, more work is ahead. Those intent on committing fraud will continue to find ways to do so, so continuing vigilance is critical. We will continue to assess efforts to fight fraud and provide recommendations to CMS as we see appropriate.

We urge CMS to continue its efforts as well.

Mr. Chairman, that concludes my prepared remarks. I would be happy to answer questions.

[The prepared statement of Ms. King follows:]

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Testimony

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MEDICARE

Progress Made to Deter Fraud, but More Could Be Done

Statement of Kathleen M. King
Director, Health Care

GAO-12-801T

GAO
Accountability * Integrity * Reliability

Highlights

Highlights of GAO-12-801T, a testimony before the Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, House of Representatives

June 8, 2012

MEDICARE

Progress Made to Deter Fraud, but More Could Be Done

Why GAO Did This Study

GAO has designated Medicare as a high-risk program. Since 1990, every two years GAO has provided Congress with an update on this program, which highlights government operations that are at high risk for waste, fraud, abuse mismanagement or in need of broad reform. Medicare has been included in this program in part because its complexity makes it particularly vulnerable to fraud. Fraud involves an intentional act or representation to deceive with the knowledge that the action or representation could result in gain. The deceptive nature of fraud makes its extent in the Medicare program difficult to measure in a reliable way, but it is clear that fraud contributes to Medicare's fiscal problems. Reducing fraud could help rein in the escalating costs of the program.

This statement focuses on the progress made and important steps to be taken by CMS and its program integrity contractors to reduce fraud in Medicare. These contractors perform functions such as screening and enrolling providers, detecting and investigating potential fraud, and identifying improper payments and vulnerabilities that could lead to payment errors. This statement is based on relevant GAO products and recommendations issued from 2004 through 2012 using a variety of methodologies, such as analyses of Medicare claims, review of relevant policies and procedures, and interviews with officials.

View GAO-12-801T. For more information, contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov.

What GAO Found

The Centers for Medicare & Medicaid Services (CMS)—the agency that administers Medicare—has made progress in implementing several key strategies GAO identified in prior work as helpful in protecting Medicare from fraud; however, important actions that could help CMS and its program integrity contractors combat fraud remain incomplete.

Provider Enrollment: GAO's previous work found persistent weaknesses in Medicare's enrollment standards and procedures that increased the risk of enrolling entities intent on defrauding the program. CMS has strengthened provider enrollment—for example, in February 2011, CMS designated three levels of risk—high, moderate, and limited—with different screening procedures for categories of providers at each level. However, CMS has not completed other actions, including implementation of some relevant provisions of the Patient Protection and Affordable Care Act (PPACA). Specifically, CMS has not (1) determined which providers will be required to post surety bonds to help ensure that payments made for fraudulent billing can be recovered, (2) contracted for fingerprint-based criminal background checks, (3) issued a final regulation to require additional provider disclosures of information, and (4) established core elements for provider compliance programs.

Pre- and Post-payment Claims Review: GAO had previously found that increased efforts to review claims on a prepayment basis can prevent payments from being made for potentially fraudulent claims, while improving systems used by CMS and its contractors to review claims on a post-payment basis could better identify patterns of potentially fraudulent billing for further investigation. CMS has controls in Medicare's claims-processing systems to determine if claims should be paid, denied, or reviewed further. These controls require timely and accurate information about providers that GAO has previously recommended that CMS strengthen. GAO is currently examining CMS's new Fraud Prevention System, which uses analytic methods to examine claims before payment to develop investigative leads for Zone Program Integrity Contractors (ZPIC), the contractors responsible for detecting and investigating potential fraud. Additionally, CMS could improve its post-payment claims review to identify patterns of fraud by incorporating prior GAO recommendations to develop plans and timelines for fully implementing and expanding two information technology systems it developed.

Robust Process to Address Identified Vulnerabilities: Having mechanisms in place to resolve vulnerabilities that lead to erroneous payments is critical to effective program management and could help address fraud. Such vulnerabilities are service- or system-specific weaknesses that can lead to payment errors—for example, providers receiving multiple payments as a result of incorrect coding. GAO has previously identified weaknesses in CMS's process for addressing identified vulnerabilities and the Department of Health and Human Services' Office of Inspector General recently reported on CMS's inaction in addressing vulnerabilities identified by its contractors, including ZPICs. GAO is evaluating the current status of the process for assessing and developing corrective actions to address vulnerabilities.

Mr. Chairman, Ranking Member, and Other Members of the Committee:

I am pleased to be here today to discuss our work regarding fraud in the Medicare program, Medicare contractors' roles in detecting and preventing fraud, and provisions in recent laws and agency actions that may help address this problem.[1] Fraud involves an intentional act or representation to deceive with the knowledge that the action or representation could result in gain. Although there have been convictions for multi-million dollar schemes that defrauded the Medicare program, the extent of the problem is unknown. There are no reliable estimates of the extent of fraud in the Medicare program or for the health care industry as a whole. By its very nature, fraud is difficult to detect, as those involved are engaged in intentional deception. For example, fraud may involve providers submitting a claim with false documentation for services not provided, while the claim on its face may appear valid. Fraud also can involve efforts to hide ownership of companies or kickbacks to obtain beneficiary information. Although the full extent of the problem is unknown, it is clear that the Medicare program is vulnerable to fraud, which contributes to Medicare's fiscal problems. Reducing fraud could help rein in the escalating costs of the program.

We have repeatedly designated Medicare as a high-risk program, as its complexity and susceptibility to payment errors from various causes, added to its size, have made it vulnerable to loss.[2] As one example, the fee-for-service (FFS) portion of the Medicare program processes over a billion claims a year from about 1.5-million providers and suppliers; working to ensure that those payments are accurate is a complex, ongoing task. Medicare has many individual vulnerabilities, which are

[1]Medicare is the federally financed health insurance program for persons age 65 or over, certain individuals with disabilities, and individuals with end-stage renal disease. Medicare Parts A and B are known as Medicare fee-for-service (FFS). Medicare Part A covers hospital and other inpatient stays. Medicare Part B is optional, and covers hospital outpatient, physician, and other services. Medicare beneficiaries have the option of obtaining coverage for Medicare services from private health plans that participate in Medicare Advantage—Medicare's managed care program—also known as Part C. All Medicare beneficiaries may purchase coverage for outpatient prescription drugs under Part D, either as a stand-alone benefit or as part of a Medicare Advantage plan.

[2]In 1990, we began to report on government operations that we identified as "high risk" for serious weaknesses in areas that involve substantial resources and provide critical services to the public. Medicare has been included among such programs since 1990. See GAO, *High-Risk Series: An Update*, GAO-11-278 (Washington, D.C.: February 2011). http://www.gao.gov/highrisk/risks/insurance/medicare_program.php.

service- or system-specific weaknesses that can lead to payment errors, including those due to fraud.[3] If the Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that administers the program, suspects that providers or suppliers are billing fraudulently, it can take action, including suspending claims payment, revoking billing privileges, or referring cases to law enforcement for investigation.[4] Further, it can impose a moratorium on new enrollment of providers or suppliers.[5] Since 1997, Congress has provided funds specifically for activities to address fraud, as well as waste and abuse,[6] in Medicare and other federal health care programs. In addition, Congress created the Medicare Integrity Program to conduct activities to reduce fraud, waste, abuse, and improper payments.[7] In 2010, Congress passed the Patient Protection and Affordable Care Act (PPACA), which provided additional funding for such efforts and set a number of new requirements specific to Medicare.[8] Furthermore, the

[3]CMS defines vulnerabilities to the Medicare program as issues that can lead to fraud, waste, or abuse, which can either be specific, such as providers receiving multiple payments as a result of incorrect coding for a service, or general and programwide, such as weaknesses in online application processes.

[4]In this testimony, the term *provider* includes entities such as hospitals or physicians, and *supplier* means an entity that supplies Medicare beneficiaries with durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) such as walkers and wheelchairs.

[5]Enrolling as a provider or supplier in Medicare allows an entity to provide services or equipment to beneficiaries and bill for those services.

[6]Waste includes inaccurate payments for services, such as unintentional duplicate payments. Abuse represents actions inconsistent with acceptable business or medical practices.

[7]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. 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. Improper Payments Elimination and Recovery Act of 2010, Pub. L. No. 111-204, § 2(e), 124 Stat. 2224, 2227 (codified at 31 U.S.C. § 3321 note).

[8]Pub. L. No. 111-148, 124 Stat 119 (2010), as amended by Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, 124 Stat. 1029, which we refer to collectively as PPACA. The provisions discussed in this statement are generally located in sections 6401 through 6411 and 10603 and 10605 of PPACA, as well as sections 1303 and 1304 of HCERA.

Small Business Jobs Act of 2010[9] established new Medicare fee-for-service claims review requirements and provided funding to implement these requirements.

My testimony today focuses on the progress made and steps that remain to be taken by CMS and its program integrity contractors to reduce fraud in Medicare. CMS contractors perform a number of key program integrity functions, such as screening and enrolling providers, detecting and investigating potential fraud, and identifying improper payments and vulnerabilities that could lead to payment errors. This testimony is informed by 8 years of our work on Medicare fraud, waste, abuse, and improper payments. I will focus on several key strategies CMS can undertake to help reduce fraud discussed in our prior work from 2004 to 2012, specifically:[10]

- strengthening provider enrollment standards and procedures,
- improving pre- and post-payment claims review, and
- developing a robust process for addressing identified vulnerabilities.

The products on which this statement is based were developed by using a variety of methodologies, including analyses of Medicare claims, review of relevant policies and procedures, interviews with agency officials and other stakeholders, and site visits.[11] The work on which these products were based 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.

[9]Pub. L. No. 111-240, § 4241, 124 Stat. 2504, 2599.

[10]These strategies were among those identified in our June 2010 testimony as critical to helping prevent fraud, waste, and abuse in Medicare. See GAO, *Medicare Fraud, Waste, and Abuse: Challenges and Strategies for Preventing Improper Payments*, GAO-10-844T (Washington, D.C.: June 15, 2010). A list of related products appears at the end of this statement.

[11]The products listed at the end of this statement contain detailed information on the methodologies used in our work.

CMS Has Made Progress in Strengthening Provider Enrollment, but Further Actions Are Needed

CMS has made progress strengthening provider enrollment to try to better ensure that only legitimate providers and suppliers are allowed to bill Medicare. However, CMS has not completed other actions that could help prevent individuals intent on fraud from enrolling, including implementation of some relevant PPACA provisions.

Past CMS Efforts to Strengthen Provider Enrollment

Our previous work found persistent weaknesses in Medicare's enrollment standards and procedures that increased the risk of enrolling entities intent on defrauding the Medicare program.[12] We, CMS, and the HHS Office of Inspector General (OIG) have previously identified two types of providers whose services and items are especially vulnerable to improper payments and fraud—home health agencies (HHA) and suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). We found weaknesses in oversight of these providers' and suppliers' enrollment. For example, in 2008, we identified weaknesses when we created two fictitious DMEPOS companies, which were subsequently enrolled by CMS's contractor and given permission to begin billing Medicare.[13] In 2009, we found that CMS's contractors were not requiring HHAs to resubmit enrollment information for re-verification every 5 years as required by CMS.[14]

To strengthen the Medicare enrollment process, in 2006 CMS began requiring all providers and suppliers—including those that order HHA services or DMEPOS for beneficiaries to be enrolled in Medicare. The agency also required all providers and suppliers to report their National Provider Identifiers (NPI) on enrollment applications, which can help

[12]See GAO, *Medicare: CMS's Program Safeguards Did Not Deter Growth in Spending for Power Wheelchairs*, GAO-05-43 (Washington, D.C.: Nov. 17, 2004); *Medicare: More Effective Screening and Stronger Enrollment Standards Needed for Medical Equipment Suppliers*, GAO-05-656 (Washington, D.C.: Sept. 22, 2005); *Medicare: Improvements Needed to Address Improper Payments for Medical Equipment and Supplies*, GAO-07-59 (Washington, D.C.: Jan. 31, 2007); and *Medicare: Improvements Needed to Address Improper Payments in Home Health*, GAO-09-185 (Washington, D.C.: Feb. 27, 2009).

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

[14]GAO-09-185.

address fraud because providers and suppliers must submit either their Social Security Number or their employer identification number and state licensing information to obtain an NPI.[15] In 2007, CMS initiated the first phase of a Medicare competitive-bidding program for DMEPOS.[16] This program requires suppliers' bids to include new financial documentation for the year prior to submitting the bids. Because CMS can now disqualify suppliers based in part on new scrutiny of their financial documents, competitive bidding can help reduce fraud. Finally, in 2010, CMS also required that all DMEPOS suppliers be accredited by a CMS-approved accrediting organization to ensure that they meet certain quality standards. Such accreditation also increased scrutiny of these businesses.

CMS Has Taken Action on Certain PPACA Provider Enrollment Provisions

PPACA authorized CMS to implement several actions to strengthen provider enrollment. As of April 2012, the agency has completed some of these actions.

Screening Provider Enrollment Applications by Risk Level: CMS and OIG issued a final rule with comment period in February 2011 to implement some of the new screening procedures required by PPACA.[17] CMS designated three levels of risk—high, moderate, and limited—with different screening procedures for categories of Medicare providers at each level. Providers in the high-risk level are subject to the most rigorous

[15]The Health Insurance Portability and Accountability Act of 1996 required that HHS adopt standards for unique health identifiers. CMS adopted the NPI as the standard unique health identifier for its health care providers and suppliers in its final rule: *HIPAA Administrative Simplification: Standard Unique Health Identifier for Health Care Providers*, 69 *Fed. Reg.* 3434 (Jan. 23, 2004). Consistent with the NPI final rule, beginning in 2006, the Medicare program required providers and suppliers to report their NPIs on their enrollment applications.

[16]Competitive bidding is a process in which suppliers of medical equipment and supplies compete for the right to provide their products on the basis of established criteria, such as quality and price.

[17]*Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers*, 76 *Fed. Reg.* 5862 (Feb. 2, 2011). In discussing the final rule, CMS noted that Medicare had already employed a number of the screening practices described in PPACA to determine if a provider is in compliance with federal and state requirements to enroll or to maintain enrollment in the Medicare program.

screening.[18] To determine which providers to place in these risk levels, CMS considered issues such as past occurrences of improper payments and fraud among different categories of providers. Based in part on our work and that of the OIG, CMS designated newly enrolling HHAs and DMEPOS suppliers as high risk and designated other providers at lower levels. (See table 1.) Providers at all risk levels are screened to verify that they meet specific requirements established by Medicare such as having current licenses or accreditation and valid Social Security numbers.[19] High- and moderate-risk providers are additionally subject to unannounced site visits. Further, depending on the risks presented, PPACA authorizes CMS to require fingerprint-based criminal history checks, and the posting of surety bonds for certain providers.[20] CMS may also provide enhanced oversight for specific periods for new providers and for initial claims of DMEPOS suppliers.

[18]PPACA specified that the enhanced-screening procedures would apply to new providers and suppliers beginning 1 year after the date of enactment and to currently enrolled providers and suppliers 2 years after that date.

[19]Screening may include verification of the following: Social Security number; NPI; National Practitioner Databank licensure; whether the provider has been excluded from federal health care programs by the OIG; taxpayer identification number; and death of an individual practitioner, owner, authorized official, delegated official, or supervising physician.

[20]A surety bond is a three-party agreement in which a company, known as a surety, agrees to compensate the bondholder if the bond purchaser fails to keep a specified promise.

Table 1: Categories of Medicare Providers and Suppliers Designated by Risk Level for Enrollment Screening

Risk level	Categories of Medicare providers and suppliers
Limited	Physician or nonphysician practitioners and medical groups or clinics, with the exception of physical therapists and physical therapy groups. Ambulatory surgical centers, competitive acquisition programs/Part B vendors, end-stage renal disease facilities, federally qualified health centers, histocompatibility laboratories,[a] Indian Health Service facilities, mammography screening centers, mass immunization roster billers,[b] organ procurement organizations, pharmacies newly enrolling or revalidating, radiation therapy centers, religious nonmedical health care institutions, rural health clinics, skilled nursing facilities, and hospitals, including critical access hospitals.
Moderate	Ambulance suppliers, community mental health centers, comprehensive outpatient rehabilitation facilities, hospice organizations, independent diagnostic testing facilities, independent clinical laboratories, portable X-ray suppliers, currently enrolled (revalidating) home health agencies, and physical therapy, including physical therapy groups.
High	Prospective (newly enrolling) home health agencies and prospective (newly enrolling) suppliers of durable medical equipment, prosthetics, orthotics, and supplies.

Source: GAO analysis of CMS Final Rule with Comment Period, *Medicare, Medicaid, and Children's Health Insurance Programs: Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers*, 76 Fed. Reg. 5862 (Feb. 2, 2011).

[a]Histocompatibility laboratories provide evaluations of certain genetic data and pertinent patient immunologic risk factors to allow clinician and patient to make decisions about whether transplantation is in the patient's best interest.

[b]Mass immunization roster billers are providers and suppliers that enroll in the Medicare program to offer influenza (flu) vaccinations to a large number of individuals, and these entities must be properly licensed in the states in which they plan to operate influenza clinics.

CMS indicated that the agency will continue to review the criteria for its screening levels on an ongoing basis and would publish changes if the agency decided to update the assignment of screening levels for categories of Medicare providers. This may become necessary because fraud is not confined to HHAs and DMEPOS suppliers. We are currently examining the types of providers involved in fraud cases investigated by the OIG and the Department of Justice (DOJ), which may help illuminate risk to the Medicare program from different types of providers. Further, in their 2011 annual report on the Health Care Fraud and Abuse Control Program, DOJ and HHS reported convictions or other legal actions, such as exclusions or civil monetary penalties, against several types of Medicare providers other than DMEPOS suppliers and HHAs, including pharmacists, orthopedic surgeons, infusion and other types of medical clinics, and physical therapy services.[21] CMS also has established triggers for adjustments to an individual provider's risk level. For example, CMS regulations state that an individual provider or supplier at the

[21]*The Department of Health and Human Services and the Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2011* (Washington, D.C.: February 2012).

limited- or moderate-risk level that has had its billing privileges revoked by a Medicare contractor within the last 10 years and is attempting to re-enroll, would move to the high-risk level for screening.

New National Enrollment Screening and Site Visit Contractors: In a further effort to strengthen its enrollment processes, CMS contracted with two new entities at the end of 2011 to assume centralized responsibility for automated screening of provider and supplier enrollment and for conducting site visits of providers.

- **Automated-screening contractor.** In December 2011, the new contractor began to establish systems to conduct automated screening of providers and suppliers to ensure they meet Medicare eligibility criteria (such as valid licensure, accreditation, a valid NPI, and no presence on the OIG list of providers and suppliers excluded from participating in federal health care programs).[22] Prior to the implementation of this new automated screening, such screening was done manually for the 30,000 enrollees each month by CMS's Medicare Administrative Contractors (MAC), which enroll Medicare providers, and the National Supplier Clearinghouse (NSC), which enrolls DMEPOS suppliers. According to CMS, the old screening process was neither efficient nor timely. CMS officials said that in 2012, the automated-screening contractor began automated screening of the licensure status of all currently enrolled Medicare providers and suppliers. The agency said it expects the automated-screening contractor to begin screening newly enrolling providers and suppliers later this year. CMS expects that the new, national contractor will enable better monitoring of providers and suppliers on a continuous basis to help ensure they continue to meet Medicare enrollment requirements. The new screening contractor will also help the MACs and the NSC maintain enrollment information in CMS's Provider Enrollment Chain and Ownership System (PECOS)—a database that contains details on enrolled providers and suppliers. In addition, CMS officials said the automated-screening contractor is developing an individual risk score for each provider or supplier, similar to a credit risk score. Although these individual scores are not currently used to determine an individual provider's placement in a

[22]Licensure is a mandatory process by which a state government grants permission to an individual practitioner or health care organization to engage in an occupation or profession.

risk level, CMS indicated that this risk score may be used eventually as additional risk criteria in the screening process.

- **Site visits for all providers designated as moderate and high risk.** Beginning in February 2012, a single national site-visit contractor began conducting site visits of moderate- and high-risk providers to determine if sites are legitimate and the providers meet certain Medicare standards.[23] The contractor collects the same information from each site visit, including photographic evidence that will be available electronically through a Web portal accessible to CMS and its other contractors. The national site-visit contractor is expected to validate the legitimacy of these sites. CMS officials told us that the contractor will provide consistency in site visits across the country, in contrast to CMS relying on different MACs to conduct any required site visits.

CMS Has Not Completely Implemented Some PPACA Enrollment Provisions

Implementation of other enrollment screening actions authorized by PPACA that could help CMS reduce the enrollment of providers and suppliers intent on defrauding the Medicare program remains incomplete, including:

- ***Surety bond***—PPACA authorizes CMS to require a surety bond for certain types of at-risk providers, which can be helpful in recouping erroneous payments. CMS officials expect to issue a proposed rule to require surety bonds as conditions of enrollment for certain other types of providers. Extending the use of surety bonds to these new entities would augment a previous statutory requirement for DMEPOS suppliers to post a surety bond at the time of enrollment.[24] CMS

[23]Starting March 25, 2011, CMS required the MACs to conduct site visits for categories of providers and suppliers designated as moderate and high risk. The national site-visit contactor assumed these responsibilities in 2012. The NSC will continue to conduct site visits related to provider enrollment of DMEPOS suppliers. In addition, CMS at times exercises its authority to conduct a site visit or requests its contractors to conduct a site visit for any Medicare provider or supplier.

[24]42 U.S.C. § 1395m(a)(16)(B). As of October 2009, DMEPOS suppliers were required to obtain and submit a surety bond in the amount of at least $50,000. A DMEPOS surety bond is a bond issued by an entity guaranteeing that a DMEPOS supplier will fulfill its obligation to Medicare. If the obligation is not met, the surety bond is paid to Medicare. *Medicare Program; Surety Bond Requirement for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)*, 74 *Fed. Reg.* 166 (Jan. 2, 2009).

issued final instructions to its MACs, effective February 2012, for recovering DMEPOS overpayments through surety bonds. CMS officials reported that as of April 19, 2012, they had issued notices to 20 surety bond companies indicating intent to collect funds, but had not collected any funds as of that date.

- ***Fingerprint-based criminal background checks***—CMS officials told us that they are working with the Federal Bureau of Investigation to arrange contracts to help conduct fingerprint-based criminal background checks of high-risk providers and suppliers. On April 13, 2012, CMS issued a request for information regarding the potential solicitation of a single contract for Medicare provider and supplier fingerprint-based background checks. The agency expects to have the contract in place before the end of 2012.

- ***Providers and suppliers disclosure***—CMS officials said the agency is reviewing options to include in regulations for increased disclosures of prior actions taken against providers and suppliers enrolling or revalidating enrollment in Medicare, such as whether the provider or supplier has been subject to a payment suspension from a federal health care program.[25] In April 2012, agency officials indicated that they were not certain when the regulation would be published. CMS officials noted that the additional disclosure requirements are complicated by provider and supplier concerns about what types of information will be collected, what CMS will do with it, and how the privacy and security of this information will be maintained.

- ***Compliance and ethics program***—CMS officials said that the agency was studying criteria found in OIG model plans as it worked to address the PPACA requirement that the agency establish the core

[25]At the time of initial enrollment or revalidation of enrollment, PPACA requires providers and suppliers to disclose any current or previous affiliation with another provider or supplier 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 State Children's Health Insurance Program; or has had its billing privileges denied or revoked. Pub. L. No. 111-148, § 6401(a)(4), 124 Stat. 119, 740 (2010).

elements of compliance programs for providers and suppliers.[26] As of April 2012, CMS did not have a projected target date for implementation.

Additional Action May Help Better Identify Potential Fraud through Pre- and Post-Payment Claims Review

Increased efforts to review claims on a prepayment basis can better prevent payments that should not be made, while improving systems used to review claims on a post-payment basis could better identify patterns of fraudulent billing for further investigation.

Additional Efforts to Improve Prepayment Claims Review May Help Reduce Fraud

Having robust controls in claims payment systems to prevent payment of problematic claims can help reduce loss. As claims go through Medicare's electronic claims payment systems, they are subjected to automated prepayment controls called "edits," instructions programmed in the systems to prevent payment of incomplete or incorrect claims. Some edits use provider enrollment information, while others use information on coverage or payment policies, to determine if claims should be paid. Most of these controls are fully automated; if a claim does not meet the criteria of the edit, it is automatically denied. Other prepayment edits are manual; they flag a claim for individual review by trained staff who determine if it should be paid. Due to the volume of claims, CMS has reported that less than 1 percent of Medicare claims are subject to manual medical record review by trained staff.

Having effective pre-payment edits that deny claims for ineligible providers and suppliers depends on having timely and accurate information about them, such as whether the providers are currently enrolled and have the appropriate license or accreditation to provide specific services. We previously recommended that CMS take action to

[26]A compliance program is an internal set of policies, processes, and procedures that a provider organization implements to help it act ethically and lawfully. In this context, a compliance program is intended to help provider and supplier organizations prevent and detect violations of Medicare laws and regulations. CMS has used the phrase "compliance and ethics program" and indicated it may base its program on the seven elements of effective compliance and ethics programs found in the U.S. Federal Sentencing Guidelines Manual.

ensure the timeliness and accuracy of PECOS—the database that maintains Medicare provider and supplier enrollment information. We noted that weaknesses in PECOS data may result in CMS making improper payments to ineligible providers and suppliers.[27] These weaknesses are related to the frequency with which CMS's contractors update enrollment information and the timeliness and accuracy of information obtained from outside entities, such as state licensing boards, the OIG, and the Social Security Administration's Death Master File, which contains information on deceased individuals that can be used to identify deceased providers in order to terminate those providers' Medicare billing privileges. These sources vary in the ease in which CMS contractors have been able to access their data and the frequency with which they are updated. CMS has indicated that its new national-screening contractor should improve the timeliness and accuracy of the provider and supplier information in PECOS by centralizing the process, increasing automation of the process, continuously checking databases, and incorporating new sources of data, such as financial, business, tax, and geospatial data. However, it is too soon to tell if these efforts will better prevent payments to ineligible providers and suppliers.

Having effective edits to implement coverage and payment policies before payment is made can also help to deter fraud. The Medicare program has defined categories of items and services eligible for coverage and excludes from coverage items or services that are determined not to be "reasonable and necessary for the diagnosis and treatment of an illness or injury or to improve functioning of a malformed body part."[28] CMS and its contractors set policies regarding when and how items and services will be covered by Medicare, as well as coding and billing requirements for payment, which also can be implemented in the payment systems through edits. We have previously found Medicare's payment systems did not have edits for items and services unlikely to be provided in the normal course of medical care.[29] CMS has since implemented edits to flag such claims—called Medically Unlikely Edits. We are currently assessing Medicare's prepayment edits based on coverage and payment policies, including the Medically Unlikely Edits.

[27]GAO-12-351.

[28]42 U.S.C. § 1395y(a)(1)(A).

[29]GAO-07-59.

Additionally, suspending payments to providers suspected of fraudulent billing can be an effective tool to prevent excess loss to the Medicare program while suspected fraud is being investigated. For example, in March 2011, the OIG testified that payment suspensions and pre-payment edits on 18 providers and suppliers stopped the potential loss of more than $1.3 million submitted in claims by these individuals. Furthermore, HHS recently reported that it imposed payment suspensions on 78 home health agencies in conjunction with arrests related to a multimillion-dollar health care fraud scheme. While CMS had the authority to impose payment suspensions prior to PPACA, the law specifically authorized CMS to suspend payments to providers pending the investigation of credible allegations of fraud.[30] CMS officials reported that the agency had imposed 212 payment suspensions since the regulations implementing the PPACA provisions took effect. Agency officials indicated that almost half of these suspensions were imposed this calendar year, representing about $6 million in Medicare claims.

We are currently evaluating a new CMS effort, the Fraud Prevention System (FPS), which uses predictive analytic technologies to analyze FFS claims on a prepayment basis to develop investigative leads for CMS's Zone Program Integrity Contractors (ZPIC), the contractors responsible for detecting and investigating potential fraud.[31] The Small Business Jobs Act of 2010 requires CMS to use predictive analytic technologies both to identify and to prevent improper payments under Medicare FFS.[32] The law requires these predictive analytic technologies to be used to review claims for potential fraud by identifying unusual or

[30]CMS is required to consult with the HHS OIG in determining whether a credible allegation of fraud exists. Based on how CMS used its previous payment suspension authority, in November 2010, the OIG found weaknesses in CMS's implementation of payment suspensions that could lead to delays in the suspension process. Such delays would allow payments to continue to providers suspected of fraud. Specifically, the OIG found that CMS's guidance to its contractors on procedures for implementing payment suspensions was incomplete and inconsistent. Although the OIG made no recommendations, it suggested that these weaknesses could be addressed through CMS rulemaking pursuant to PPACA.

[31]CMS is replacing its legacy Program Safeguard Contractors (PSC) with seven ZPICs. While the PSCs were responsible for program integrity for specific parts of Medicare, such as Part A, the ZPICs are responsible for Medicare's fee-for-service program integrity in their geographic zones. For simplicity, we refer to these program integrity contractors as ZPICs throughout the testimony.

[32]Pub. L. No. 111-240, § 4241, 124 Stat. 2504, 2599.

suspicious patterns or abnormalities in Medicare provider networks, claims billing patterns, and beneficiary utilization. According to CMS, FPS may enhance CMS's ability to identify potential fraud because it analyzes large numbers of claims from multiple data sources nationwide simultaneously before payment is made, thus allowing CMS to examine billing patterns across geographic regions for those that may indicate fraud. The results of FPS are used by the ZPICs to initiate investigations that could result in payment suspensions, implementation of automatic claim denials, identification of additional prepayment edits, or the revocation of Medicare billing privileges. CMS began using FPS to screen all FFS claims nationwide prior to payment as of June 30, 2011, and CMS has been directing the ZPICs to investigate high priority leads generated by the system. Because FPS is relatively new and we have not completed our work, it is too soon to determine whether FPS will improve CMS's ability to address fraud. Questions have also been raised about CMS's ability to adequately assess ZPICs' performance and we have been asked to examine CMS's management of the ZPICs, including criteria used by CMS to evaluate their effectiveness.

"Bust-out" fraud schemes in which providers or suppliers suddenly bill very high volumes of claims to obtain large payments from Medicare could be addressed by adding a prepayment edit. Such an edit would set thresholds to stop payment for atypically rapid increases in billing thus helping them to stem losses from these schemes. In our prior work on DMEPOS, we recommended that CMS require its contractors to develop thresholds for unexplained increases in billing and use them to develop pre-payment controls that could suspend these claims for further review before payment.[33] CMS officials told us that they are currently considering developing analytic models in FPS that could help CMS and ZPICs identify and address billing practices suggestive of bust outs.

[33]See GAO, *2012 Annual Report: Opportunities to Reduce Duplication, Overlap and Fragmentation, Achieve Savings, and Enhance Revenue*. GAO-12-342SP (Washington, D.C.: Feb. 28, 2012) and GAO-07-59.

Actions Needed to Improve Use of Systems Intended for Post-payment Claims Review

Further actions are needed to improve use of two CMS information technology systems that could help CMS and program integrity contractors identify fraud after claims have been paid.[34]

- The Integrated Data Repository (IDR) became operational in September 2006 as a central data store of Medicare and other data needed to help CMS's program integrity staff, ZPICs, and other contractors prevent and detect improper payments of claims. However, we found IDR did not include all the data that were planned to be incorporated by fiscal year 2010, because of technical obstacles and delays in funding. Further, as of December 2011 the agency had not finalized plans or developed reliable schedules for efforts to incorporate these data, which could lead to additional delays.

- One Program Integrity (One PI) is a Web portal intended to provide CMS staff, ZPICs, and other contractors with a single source of access to data contained in IDR, as well as tools for analyzing those data. While One PI is operational, we reported in December 2011 that CMS had trained few program integrity analysts and that the system was not being widely used.

GAO recommended that CMS take steps to finalize plans and reliable schedules for fully implementing and expanding the use of both IDR and One PI. Although the agency told us in April 2012 that it had initiated activities to incorporate some additional data into IDR and expand the use of One PI, such as training more ZPIC and other staff, it has not fully addressed our recommendations.

[34]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).

A Robust Process to Address Identified Vulnerabilities Could Help Reduce Fraud

Having mechanisms in place to resolve vulnerabilities that lead to improper payments is critical to effective program management and could help address fraud.[35] A number of different types of program integrity contractors are responsible for identifying and reporting vulnerabilities to CMS. However, our work and the work of OIG have shown weaknesses in CMS's processes to address vulnerabilities identified by these contractors.

CMS's Recovery Audit Contractors (RAC) are specifically charged with identifying improper payments and vulnerabilities that could lead to such payment errors. However, in our March 2010 report on the RAC demonstration program, we found that CMS had not established an adequate process during the demonstration or in planning for the national program to ensure prompt resolution of such identified vulnerabilities in Medicare; further, the majority of the most significant vulnerabilities identified during the demonstration were not addressed.[36] We therefore recommended that CMS develop and implement a corrective action process that includes policies and procedures to ensure 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.[37]

Our recommendations will not be fully addressed until CMS has put policies and procedures in place that will lead the agency to act promptly to correct identified vulnerabilities. In December 2011, the OIG similarly found that CMS lacked procedures to ensure that vulnerabilities identified

[35]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. 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).

[36]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).

[37]GAO-10-143.

by other contractors were resolved.[38] CMS had not resolved or taken significant action to resolve 38 of 44 vulnerabilities (86 percent) reported in 2009 by ZPICs. Only 1 vulnerability had been fully resolved by January 2011.[39] The OIG made several recommendations, including that CMS have written procedures and time frames to assure that vulnerabilities were resolved. CMS has indicated that it is now tracking vulnerabilities identified from several types of contractors through a single vulnerability tracking process. We are currently examining aspects of CMS's vulnerability tracking process and will be reporting on it soon.

Concluding Observations

Although CMS has taken some important steps to identify and prevent fraud, including implementing provisions in PPACA and the Small Business Jobs Act, more remains to be done to prevent making erroneous Medicare payments due to fraud. In particular, we have found CMS could do more to strengthen provider enrollment screening to avoid enrolling those intent on committing fraud, improve pre- and post-payment claims review to identify and respond to patterns of suspicious billing activity more effectively, and identify and address vulnerabilities to reduce the ease with which fraudulent entities can obtain improper payments. It is critical that CMS implement and make full use of new authorities granted by recent legislation, as well as incorporate recommendations made by us, as well as the OIG in these areas. Moving from responding once fraud has already occurred to preventing it from occurring in the first place is key to ensuring that federal funds are used efficiently and for their intended purposes.

As all of these new authorities and requirements become part of Medicare's operations, additional evaluation and oversight will be necessary to determine whether they are implemented as required and have the desired effect. We have several studies underway that assess efforts to fight fraud in Medicare and that should continue to help CMS refine and improve its fraud detection and prevention efforts. Notably, we are assessing the effectiveness of different types of pre-payment edits in

[38]HHS-OIG, *Addressing Vulnerabilities Reported by Medicare Benefit Integrity Contractors*, OEI-03-10-00500 (December 2011).

[39]OIG also found that CMS had not resolved or taken significant action to resolve 10 of 18 vulnerabilities (56 percent) reported in 2009 by Medicare Prescription Drug Integrity Contractors (MEDICs)—program integrity contractors for Medicare Parts C and D. Only 1 of those 18 vulnerabilities had been fully resolved by January 2011.

Medicare and of CMS's oversight of its contractors in implementing those edits to help ensure that Medicare pays claims correctly the first time. We are also examining the use of predictive analytics by CMS and the ZPICs to improve fraud prevention and detection. ZPICs play an important role in detecting and investigating fraud and identifying vulnerabilities, and FPS will likely play an increasing role in how ZPICs conduct their work. Additionally, we have work under way to identify the types of providers and suppliers currently under investigation and those that have been found to have engaged in fraudulent activities. These studies may enable us to point out additional actions for CMS that could help the agency more systematically reduce fraud in the Medicare program.

Due to the amount of program funding at risk, fraud will remain a continuing threat to Medicare, so continuing vigilance to reduce vulnerabilities will be necessary. Individuals who want to defraud Medicare will continue to develop new approaches to try to circumvent CMS's safeguards and investigative and enforcement efforts. Although targeting certain types of providers that the agency has identified as high risk may be useful, it may allow other types of providers committing fraud to go unnoticed. We will continue to assess efforts to fight fraud and provide recommendations to CMS, as appropriate, that we believe will assist the agency and its contractors in this important task. We urge CMS to continue its efforts as well.

Mr. Chairman, this concludes my prepared statement. I would be happy to answer any questions you or other members of the committee may have.

For further information about this statement, please contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Thomas Walke, Assistant Director; Michael Erhardt; Eden Savino; and Jennifer Whitworth were key contributors to this statement.

Related GAO Products

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Mr. STEARNS. Thank you, Ms. King.
Mr. Doolittle, welcome for your opening statement.

STATEMENT OF TED DOOLITTLE

Mr. DOOLITTLE. Thank you, sir. My name is Ted Doolittle. I am the Deputy Director of the Center for Program Integrity within CMS.

Chairman Stearns, Ranking Member DeGette, before I give my statement, I wanted to personally apologize for the compilation mistakes in the information that CMS first provided in response to Chairman Upton's recent oversight request. One of our greatest priorities is to always provide accurate information to Congress, and as a former Federal prosecutor I recognize the importance of having accurate data on which to base important public decisions. So I am very chagrined by that occurrence. I am sorry we didn't live up to that standard in response to your recent data request. I want you to know that we do take this problem very seriously. I have already asked my staff to investigate what happened and to determine how we can prevent problems like this in the future.

Chairman Stearns, I would like to, I hope that today I can show to you that we are indeed not complacent about oversight. We welcome it. And I also at least hope to convince you that I am awake. I am not just awake, I am excited about trying to discharge the responsibilities that Congress has given to us in this tough fight against health care fraud.

So I want you to know that we welcome your oversight, we welcome the oversight also of the GAO and the OIG. And frankly, I hope that this exchange that we are going to have today is the first step in a renewed partnership and perhaps a series of oversight events.

I wanted to make sure the data we gave you was clean so that you can perhaps be able to look at it in the future and be able to compare with a good baseline. So we are changing a lot of our operations and the way we compile data is one of the changes that we are making and I hope to improve.

So I came here today to speak about CMS's program integrity efforts and how they are moving away from pay and chase and toward fraud prevention through two new automatic systems: one called the Automated Provider Screening system, which I will be referring to as APS, and one called the Fraud Prevention System, which I will call FPS.

The Automated Provider Screening system is a first line of defense in protecting us against fraudsters and ineligible providers who would do harm to the program if they got in. It enables us, for the first time, to very rapidly conduct routine and automated screen checks against thousands of private and public databases to more efficiently identify and remove ineligible providers and suppliers.

The Fraud Prevention System, for its part, is a historic development and it is a way to apply advance analytics against Medicare fee-for-service claims on a streaming and national basis. We hope in the future to expand that to include Part C, D, and Medicaid. That is a very long-term goal, of course.

These new systems are key to our twin pillars strategy, which is a key to making real improvements to Medicare's program integrity efforts as we try to focus on prevention and detection and move away from pay and chase.

As OIG's data has shown, our Medicare administrative contractors who screen and enroll providers and process 4–1/2 million claims each day are not able to always collect the overpayments that our anti-fraud contractors, the ZPICs, identify. The reason for that is simple. The mission of the ZPICs is to find fraudsters. When we find fraudsters, when they learn that we are on to them they can abscond with the money. That makes it very difficult to get the money back.

The point of the ZPICs is while we don't want to back away from the overpayments and we do recover up to 10 percent of that—and that is real money—if you are looking for cash back into the program, you have to look to other of our contractors such as the RACs. It is just difficult to get money out of a fraudster in any arena, be it public or private.

So because of the challenges with the outdated "pay and chase" approach, we are moving towards focus on prevention, as I mentioned, to keep bad actors out of our program, to kick them out when we find them, and to use our array of administrative tools to stop payment when we suspect fraud. Overpayments are only part of the Medicare program integrity story, and we are moving toward a more comprehensive and sophisticated view of how we should view these improvements and the difficulties in our performance and in our contractors' performance.

I assure you, members of the panel, that we are currently developing metrics to measure not just the Fraud Prevention System but our entire operation, and with respect to the Fraud Prevention System you should be on the lookout for our report on the first year and that is due to Congress on September 30th, and you will find there I hope a really thought provoking first attempt, first cut at trying to move to a true metrics around prevention and detection.

The Fraud Prevention System is providing, today, CMS with a national view. It gives us the opportunity to divide the work up amongst the ZPICs. They formerly didn't know what the other might be working on; the right hand didn't necessarily know and now we do because of this new system. It will be much more easy for us to see whether a ZPIC has referred an investigation to law enforcement or has requested a payment suspension.

We are currently working around a lot of metrics, as I mentioned, but we are working specifically to develop weekly reports based on the information in the FPS that we can share with the ZPICs and our law enforcement partners so that we can summarize all the investigative activity around the country.

CMS is now at a major and very exciting, in my view, transitional period for program integrity. It is not without its bumps along the way, and in terms of bumps I certainly apologize for the data errors in the oversight request and, again, I am working to make sure that doesn't happen again. I want to stress that the changes that are being put into place now are going to modernize and simplify our current data systems so that problems like this

can be avoided and so our program integrity strategy overall will improve.

Thank you so much for your attention and, again, I do hope that we can continue this dialogue.

[The prepared statement of Mr. Doolittle follows:]

STATEMENT OF

TED DOOLITTLE

DEPUTY DIRECTOR FOR POLICY

CENTER FOR PROGRAM INTEGRITY

CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

MEDICARE CONTRACTORS' EFFORTS TO FIGHT FRAUD:

MOVING BEYOND "PAY AND CHASE"

BEFORE THE

U.S. HOUSE COMMITTEE ON ENERGY & COMMERCE,

SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS

JUNE 8, 2012

U.S. House Committee on Energy & Commerce
Subcommittee on Oversight & Investigations
Medicare Contractors' Efforts to Fight Fraud: Moving Beyond "Pay and Chase"

June 8, 2012

Chairman Stearns, Ranking Member DeGette, and Members of the Subcommittee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) program integrity efforts and its management of its contractors for the Medicare program. The Administration has made important strides in reducing fraud, waste, and improper payments across the government. Over the last two years, CMS has implemented powerful new anti-fraud tools provided by Congress, as well as designed and implemented large-scale, innovative improvements to our Medicare program integrity strategy to shift beyond a "pay and chase" approach to preventing fraud. CMS' antifraud contractors are integral to our efforts to fight fraud and reduce improper payments.

CMS Fee-for-Service Antifraud Contractors

CMS' mission is to ensure health care security for all Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries. A major component in achieving this mission is the successful administration of Original Medicare, commonly known as fee-for-service (FFS) Medicare. The Medicare FFS program represents the majority of Medicare spending, with hospital and other institutional services representing the largest spending outlays.

CMS uses a variety of different contractors to administer and oversee the Medicare fee-for-service program. Each of these contractors has different roles and responsibilities. Some contractors specifically assist CMS in combating fraud and identifying improper payments, while others assist CMS' fraud fighting efforts as part of their broader responsibilities as fee-for-service contractors who process claims and recover overpayments. The antifraud contractors do not perform any inherently governmental functions. Their actions are performed consistent with detailed standards and guidance provided by the agency to perform an administrative function in support of the agency's mission.

The CMS' Office of Acquisition and Grants Management (OAGM) procures these contracts and the contracts are subject to Federal contracting laws and regulations. Once any procurement is finalized, contractor management is handled by the CMS component with primary responsibility based on the contractor's core functions. CMS' program integrity strategy is moving away from pay and chase toward a more effective strategy that identifies fraud before payments are made, keeps bad providers and suppliers out of Medicare in the first place, quickly removes wrongdoers from the program once they are detected, and recovers improper payments as early and swiftly as possible. This approach builds upon CMS' use of Medicare Administrative Contractors, Zone Program Integrity Contractors, and Recovery Audit Contractors. A description of each of these contractors is below:

Medicare Administrative Contractors (MACs)

MACs are the central point of contact for providers within the national fee-for-service program. CMS' Center for Medicare directly oversees MACs. MACs are the entities responsible for provider and supplier screening and enrollment, and they process approximately 19,000 provider and supplier enrollment applications per month to determine whether these entities meet the requirements to receive billing privileges. MACs also audit the hospital cost reports upon which CMS bases Medicare reimbursements to hospitals. CMS directs the MACs to revoke provider and supplier billing privileges when CMS, the ZPICs, or MAC data shows it as appropriate. In CY 2011, as CMS took steps to reduce vulnerabilities in the Medicare program, CMS revoked the billing privileges of 4,850 providers and suppliers, and deactivated 56,733 billing numbers.

The MACs process, approve, and deny enrollment applications according to the enrollment standards established by CMS. MACs process 4.5 million claims each day, totaling approximately 1.2 billion claims in fiscal year (FY) 2011, and handle the first level of a provider's claim appeal. They implement all Medicare payment system changes, and conduct regular training and outreach to providers to educate them on proper claims coding and new Medicare payment policies. While MACs focus on claims processing and enrollment activities generally, they also play important roles in CMS' anti-fraud efforts. For instance, MACs put automated edits in place to identify and address claim coding errors, mutually exclusive claims, or medically unlikely claims. MACs regularly analyze claims data received to identify providers

and suppliers with patterns of errors or unusually high volumes of particular claims types, and to develop additional prepayment edits. MACs coordinate the timing and implementation of these edits with other contractors. When MACs do identity potential fraud, they send the leads to the antifraud contractors to investigate further.

Zone Program Integrity Contractors (ZPICs)

CMS has nearly completed the process of transitioning from Program Safeguard Contractors (PSCs) to Zone Program Integrity Contractors (ZPICs). CMS created seven program integrity zones to align with the MAC jurisdictions. The ZPICs focus exclusively on a wide range of program integrity issues and projects. Six of the seven ZPICs have been awarded. The ZPICs and remaining PSC perform program integrity functions in these zones. The Center for Program Integrity within CMS directly manages the ZPICs. The ZPICs' main responsibilities are to:

- Develop investigative leads generated by the new Fraud Prevention System (FPS) and a variety of other sources;
- Perform data analysis to identify cases of suspected fraud, waste, and abuse;
- Make recommendations to CMS for appropriate administrative actions to protect Medicare Trust Fund dollars;
- Make referrals to law enforcement for potential prosecution;
- Provide support for ongoing investigations;
- Provide feedback and support to CMS to improve the FPS; and
- Identify improper payments to be recovered.

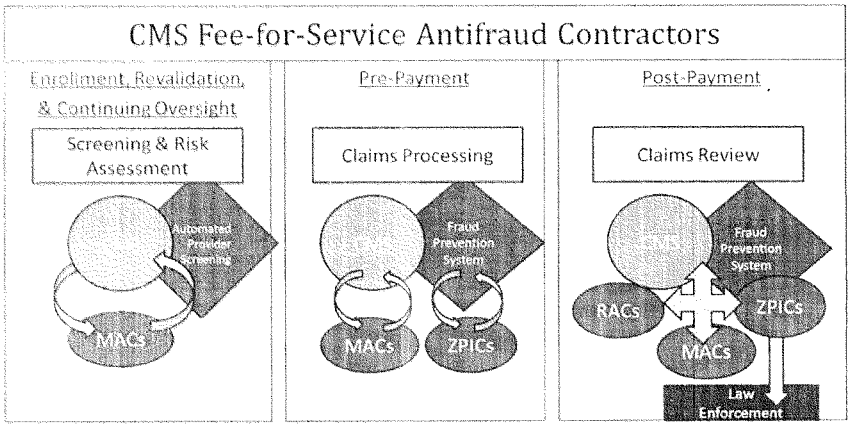
Unlike the MACs, the ZPICs' activities are dedicated exclusively to the prevention, detection, and recovery of potential fraud, waste, or abuse. The ZPICs coordinate with the MACs to implement administrative actions, including claim edits, payment suspensions, and revocations. ZPICs also refer overpayments to the MACs for collection. During 2011, CMS saved $208 million by denying claims through pre-payment edits that ZPICs recommended to automatically stop improper claims before they are paid. ZPIC-recommended payment suspensions led to over $27 million in recoveries against providers with overpayment demands.

Recovery Audit Contractors (RACs)

RACs' primary responsibilities are to identify a wide range of improper payments – including, but not limited to fraud – and to make recommendations to CMS about how to reduce improper payments in the Medicare program. In the fee-for-service Medicare program, RACs have identified several vulnerabilities where CMS has implemented corrective actions to prevent future improper payments. For example, CMS' contractors have implemented edits to stop the payment of claims provided after a beneficiary's date of death, stop the payment of durable medical equipment claims while the beneficiary is receiving care in an inpatient setting, and stop the payment for individual services that should have been bundled into another payment. If RACs identify or uncover potential fraud, they are required to report it directly to CMS, and to refrain from reviewing claims that are subject to an ongoing fraud investigation. In FY 2011, Medicare fee-for-service RACs collected nearly $797 million in overpayments, and already in the first half of FY 2012, Medicare fee-for-service RACs collected nearly $1 billion in overpayments.

Figure 1 below shows how CMS and its contractors communicate with each other during three key points within the Medicare fee-for-service process.

Figure 1



Moving Beyond Pay and Chase: The Twin Pillar Strategy

CMS has recently implemented a twin pillar approach for advancing our fraud prevention strategy in Medicare. The first pillar is the new Fraud Prevention System (FPS) that applies predictive analytic technology on claims prior to payment to identify aberrant and suspicious billing patterns. The second pillar is the Automated Provider Screening (APS) system that is identifying ineligible providers and suppliers prior to enrollment or revalidation. Together, these two innovative, comprehensive new systems (the FPS and APS) are growing in their capacity to protect patients and taxpayers from those intent on defrauding our programs. These pillars represent an integrated approach to program integrity – preventing fraud before payments are made, keeping bad providers and suppliers out of Medicare in the first place, and quickly removing wrongdoers from the program once they are detected. The twin pillar approach builds on CMS' use of the MACs, ZPICs, and RACs, and over time will leverage these contractor resources to more efficiently and effectively combat fraud, waste, and abuse and reduce improper payments.

The First Pillar: The Fraud Prevention System

CMS is committed to the goal of detecting potential fraud before suspect claims are paid. The FPS is the predictive analytic technology required under the Small Business Jobs Act. Since June 30, 2011, the FPS has been running predictive algorithms and other sophisticated analytics nationwide against all Medicare fee-for-service and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) claims prior to payment and identifying automated claims edits that the MACs have then implemented. CMS is well ahead of the statutory implementation schedule, which called for phasing in the technology in the 10 highest fraud States in the Medicare fee-for-service program by July 1, 2011. Nationwide implementation of the technology maximizes the benefits of the FPS and permits CMS to efficiently integrate the technology into the Medicare fee-for-service program and train our anti-fraud contractors.

For the first time in the history of the program, CMS is using a system to apply advanced analytics against Medicare fee-for-service claims on a streaming, national basis. This system has enabled CMS to identify schemes operating across Medicare Parts A and B claims and across the country. The FPS aggregates Parts A and B claims in near-real time, and this comprehensive

view of claims is revolutionizing our program integrity work. For example, ZPIC investigators formerly had to check multiple systems to determine whether a beneficiary ever visited the doctor who billed Medicare for services and supplies. The FPS has consolidated the dispersed pieces of potentially-related claims data – beneficiary visits with a doctor or orders for DMEPOS billed under Part B, and hospital and other provider services billed under Part A – enabling CMS and the ZPICs to automatically see the full picture. Equally important, the FPS organizes the data to quickly show when two providers or suppliers on opposite ends of the country are billing Medicare on behalf of the same beneficiary, rooting out potential compromised beneficiary numbers and other fraudulent activity.

Importantly, the FPS is a resource management tool; the system automatically sets priorities for our program integrity contractors' workload to target investigative resources to suspect claims and providers, and swiftly impose administrative action when warranted. The system generates alerts in order of priority, allowing program integrity analysts to further investigate the most egregious, suspect, or aberrant activity. CMS and our antifraud contractors use the FPS to stop, prevent, and identify improper payments using a variety of administrative tools and actions, including claim denials, payment suspensions, revocation of Medicare billing privileges, and referrals to law enforcement. The FPS is also strengthening CMS' ability to manage the ZPICs, for instance by permitting CMS to better observe and understand differences in how various ZPICs are managing similar issues.

In the first ten months of implementation of the FPS, the new preventive system resulted in:

- Leads for 591 new investigations
- Supporting information for 419 pre-existing investigations
- Leads for 550 direct interviews with providers and suppliers suspected of participating in fraudulent activity
- Leads for over 1,541 interviews with beneficiaries to confirm whether they received services for which the Medicare program had been billed.

The FPS may be compared to similar, more well-known predictive modeling technologies, such as the algorithms employed in the credit card industry to generate interviews of cardholders

when suspect items are charged. Indeed the FPS metrics related to provider, supplier, and beneficiary interviews are particularly encouraging and exciting because they show that CMS has turned Congress' vision of bringing this proactive strategy to bear on a large scale in the Medicare arena into reality.

The Second Pillar: Enhanced Provider Enrollment and Automated Provider Screening

CMS must go beyond pay and chase to stop criminals whose intent is to enroll in Medicare, quickly submit a high dollar value of claims, and then close up shop once they have been paid. To prevent this from occurring, CMS has been working to strengthen upfront protections to keep bad actors out, as provider enrollment is the gateway to the Medicare program. This approach is more effective than one based solely on recovering overpayments because it is extremely difficult to recover overpayments from fraudulent providers and suppliers, whose goal is not to provide quality care to our beneficiaries, but rather to defraud taxpayers and CMS. Strengthened provider enrollment standards also protect beneficiaries from fraudulent providers who may provide inappropriate or low-quality care.

In September 2011, CMS began an ambitious project to revalidate the enrollment of all existing 1.5 million Medicare suppliers and providers by 2015 under the new Affordable Care Act screening requirements. The new requirements directed the Secretary to establish different levels of screening for categories of providers and suppliers based on risk. The three risk levels that have been established – limited, moderate, and high – correspond to increasing levels of scrutiny. Providers and suppliers in the moderate and high screening levels are subject to announced or unannounced site visits prior to either initial enrollment or revalidation. CMS has estimated that approximately 50,000 additional site visits will be conducted between March 2011 and March 2015 to ensure providers and suppliers are operational and meet certain enrollment requirements. Providers and suppliers in the high level of screening will be subject to new fingerprint-based criminal history checks after CMS awards a contract with an FBI-approved company in early 2013.

To complement the new screening requirements, CMS launched the Automated Provider Screening (APS) system on December 31, 2011. The MACs have historically relied on paper

applications and crosschecking information manually against various databases to verify enrollment requirements such as licensure status. The APS conducts routine and automated screening checks of providers and suppliers against thousands of private and public databases to more efficiently identify and remove ineligible providers and suppliers from Medicare. CMS anticipates that the new process will decrease the application processing time for providers and suppliers, while enabling CMS to continuously monitor changes that may affect the accuracy of its enrollment data even after providers and suppliers are enrolled or revalidated, and to assess applicants' risk to the program using standard analyses of provider and supplier data.

Since March 25, 2011, CMS has enrolled or revalidated enrollment information for approximately 275,439 Medicare providers and suppliers under the enhanced screening requirements of the Affordable Care Act. The first phase of revalidation led to 13,066 deactivations of provider and supplier practice locations for non-response to the revalidation request, as of March 1, 2012. The second phase of revalidation has resulted in the deactivation of 6,278 provider and supplier enrollment records for non-response and 4,319 revocations after it was determined the providers and suppliers were not properly licensed in the State in which they were enrolled, as of May 1, 2012.[1]

Provider enrollment safeguards, recently improved by the new APS, are CMS's first line of defense against paying fraudulent or improper claims. These improvements are vitally important because they enable legitimate providers and suppliers to enroll easily and quickly in the Medicare program, while clamping down on bad actors to keep them out of the program.

Post-Payment Review and Recovery of Improper Payments

CMS has an additional opportunity to administratively recover improper payments after payment is made, through analysis and investigation conducted by Medicare contractors.

After payment is made, CMS and its contractors continue to analyze FPS results and historical claims data to identify suspected overpayments and potential fraud. ZPICs may make fraud

[1] We note that the first and second phase revalidation results are preliminary results as deactivated providers could reactivate over time with updated practice information or after showing evidence of proper licensing.

referrals to law enforcement for further investigation, or identify and send potential fraudulent or improper payments to MACs to collect, or in some situations, do both.

In cases of fraud, CMS vigorously pursues post-payment remedies, including overpayment recoveries, in close collaboration with our law enforcement colleagues. In conjunction with CMS' antifraud efforts, our law enforcement partners have recovered $4.1 billion in FY 2011, including $2.5 billion to the Medicare Trust Fund. Our recovery efforts have been strengthened by collaboration between Department of Health and Human Services (HHS) and the Department of Justice (DOJ) on the joint Health Care Fraud Prevention & Enforcement Team (HEAT) which combines the agencies' analytic, investigative, and prosecutorial resources in fraud hot spots to form Strike Forces. Since 2008, the number of defendants charged with criminal health care fraud has increased by more than 75 percent, from 797 in 2008 to 1,430 in 2011.

For potential overpayment referrals to a MAC, the MAC makes a final determination as to the dollar amount to demand for recovery and sends the demand letter to the provider. MACs validate ZPIC-recommended potential overpayments against a variety of sources, including contractual and regulatory requirements, as well as their review of the claims information. The MAC reviews the claims history to determine if there have been other adjustments or recovery actions, which could affect the demanded amount, and if the amounts identified were for claims paid within the past four years, the period that is open for collection of overpayment unless there is "fraud or similar fault." If there have been other adjustments or recovery actions on a claim, then the overpayment amount could be affected because portions of the ZPIC-identified overpayment may have already been recovered by the other Medicare contractors. While providers and suppliers may repay the overpaid amounts directly to a MAC, it is more typical for MACs to collect overpayments by adjusting future claims payments, making it operationally simple and effective to recoup payment from providers and suppliers that are still actively billing. If a provider or supplier appeals the determination, collection must be stayed until completion of the administrative appeals process. The provider or supplier has 120 days to appeal the overpayment determination. If providers or suppliers are delinquent on the repayment of determined overpayments after 6 months, the debt is referred to the Department of Treasury for collection.

While post-payment reviews may suffice to recover overpayments from legitimate, established providers and suppliers, there are significant challenges to recovering overpayments from those that are attempting to defraud the Medicare program. ZPICs target their analysis and investigative resources exclusively towards identifying possible illegitimate providers and fraud. However, MACs sometimes have difficulty recovering the ZPIC-identified overpayments since such illegitimate providers tend to close their businesses, liquidate their assets, or leave the country as soon as Medicare payments stop or when they receive an overpayment demand letter from the MACs. In these situations, the MACs' typical way of collecting overpayments by adjusting future claims may not be as effective, since there will be no future claims. Because of the nature of fraud and the fact that bad actors often are not operating legitimate, ongoing healthcare businesses, CMS' fraud prevention strategy is the key to protecting the Trust Funds from would-be bad actors. New tools available to CMS, like our twin pillar strategy, prevent payment to fraudsters in the first place and provide new ways to keep them from re-enrolling in some other guise, while working in conjunction with the aggressive pursuit of overpayment recoveries and support of our law enforcement partners in criminal investigations and prosecutions.

RACs conduct post-payment reviews and make recommendations to CMS by identifying opportunities for reducing improper payments. Overpayments identified by the Medicare FFS RACs are also sent to the MACs for collection. In the past, RAC reviews in Medicare have focused on incorrect coding, erroneous billing practices, and billing for the wrong setting of care. Unlike other Medicare program integrity contractors, RACs' reviews are more likely to identify overpayments from providers who are still enrolled and billing in Medicare.

The Medicare FFS RAC program has had increasing success since its national implementation in October 2009, which has resulted in the recovery of over $1.86 billion in overpayments. Already in the first half of FY 2012, the RACs have collected more overpayments than during all of FY 2011.

CMS MA and Part D Contractors

The Medicare Advantage (MA) managed care benefit (Part C) and the prescription drug benefit (Part D) differ significantly from Medicare fee-for-service and, as a result, require different approaches and internal controls to measure and address improper payments. Unlike Medicare fee-for-service, 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 adjusts these payments to take into account the cost associated with treating individual beneficiaries based on health status. This process is called "risk adjustment." CMS is using the Risk Adjustment Data Validation (RADV) program to reduce the payment error rate in the MA program and save taxpayer money. In addition, Part D payments are also reconciled against expected costs, and risk-sharing rules authorized in law are applied to further mitigate plan risk. All MA and Part C plans are required to have a compliance program in place, which includes a program to prevent, detect, and refer fraud, waste, and abuse. As part of these compliance program efforts, MA and Part D plans are also required to apply these policies and procedures to their downstream entities, such as their Pharmacy Benefit Manager, network pharmacies, and contracted providers.

CMS contracts with two private organizations, called Medicare Drug Integrity Contractors (MEDICs) for all MA and Part D program integrity work. The national benefit integrity MEDIC has the following responsibilities:

- Managing all incoming complaints about Part C and Part D fraud, waste, and abuse;
- Using new and innovative techniques to monitor and analyze information to help identify potential fraud;
- Working with law enforcement, MA and prescription drug plans, consumer groups, and other key partners to protect consumers and enforce Medicare's rules; and Identifying program vulnerabilities.

The outreach and education MEDIC has the following responsibilities:

- Facilitating a quarterly workgroup with key partners; and
- Providing basic tips for consumers on how to protect themselves from potential scams.

The national benefit integrity MEDIC also conducts proactive analyses that result in case referrals to law enforcement. For example, the national benefit integrity MEDIC conducts a proactive analysis called Miles Too Great. Miles Too Great identifies instances when it is unlikely that a beneficiary could fill a prescription in two or more locations that are too far apart. This relatively simple calculation may identify drug-seeking beneficiaries, over-prescribers, or services not rendered. Another method is to look at pharmacy change of ownership and determine if there is a sudden change in billing behavior after the change of ownership. From April 2010 to May 2012, the national benefit integrity MEDIC referred cases associated with $169 million in Part D payments to law enforcement because of proactive data analysis.

In FY 2011, the national benefit integrity MEDIC received approximately 342 actionable complaints (within the MEDIC's scope) per month, processed 34 requests for information from law enforcement per month, and referred an average of 36 cases per month. The national benefit integrity MEDIC was responsible for assisting the HHS Office of Inspector General and DOJ (through data analysis and investigative case development) in achieving 4 guilty pleas, 7 arrests, and 8 indictments. One case produced a 34-count indictment and included a group of 25 individuals and 26 pharmacies owned by one individual in the Detroit area involving approximately $38 million in Medicare funds.

The outreach and education MEDIC hosts quarterly Part C and Part D fraud workgroup meetings where attendees share information and data on identified or suspected fraudulent schemes. CMS, pharmacy benefit managers, sponsoring organizations, MA plans, as well as local, State, and Federal law enforcement officials attended the workgroups. The Part D workgroup recently provided a useful forum for discussion of inventory shortages involving Part D claims (for example, drugs billed, but not dispensed).

Looking Forward

Medicare provides essential health benefits to millions of Americans who depend on the program to receive the health care they need. Protecting these benefits relies on coordination and communication between CMS and the contractors described today, as well as Medicare providers, beneficiaries, and law enforcement. CMS has demonstrated success in the collection

of overpayments using the RACs, and I believe the new innovative, preventive antifraud tools will likewise provide increasingly greater program integrity protections to Medicare for a long time to come. CMS continues to implement a wide range of improvements aimed at preventing payments to bad actors that may not continue in business once their fraudulent activities are uncovered. Today, I am happy to say, CMS and our contractors have more tools than ever to implement strategic changes in pursuing and detecting fraud, waste, and abuse. I look forward to continuing to work with you as we make improvements in protecting the integrity of Federal health care programs and safeguarding taxpayer resources.

Mr. STEARNS. All right, I will start my questions. Mr. Doolittle, thank you for your apology. It was a little startling to the staff to get information from you folks and then, when we called recently, to find out the information we asked for was totally incorrect. Is that correct?

Mr. DOOLITTLE. Yes, sir.

Mr. STEARNS. OK. And this is a, I would think this is a little embarrassing to you considering you have the necessary people to provide the information, don't you?

Mr. DOOLITTLE. Yes, we do, sir.

Mr. STEARNS. And do you have the necessary equipment, computers and things that you can accurately provide the committee the information in the future?

Mr. DOOLITTLE. Yes, sir.

Mr. STEARNS. When do you think we can actually get the latest and greatest information that is accurate that you feel comfortable sending us?

Mr. DOOLITTLE. We are working, of course, as hard as possible. I can't tell you exactly the date, it's going to be as soon as possible where we update all the detailed sheets behind the summary.

Mr. STEARNS. Well, since fraud is a major issue for the American people and this committee and to find that you don't have a handle on this and that the information you provided, by your own admission, is incorrect, don't you think that creates a disturbing sense of confidence in the committee and the American people to think that you in your position cannot even provide information on a consistent basis and yet you are the Deputy Director, Center for Program Integrity, as I understand it, Center for Medicare and Medicaid Services?

So don't you think that that leaves us with a sense of incredulity and a lack of credibility and integrity on your department?

Mr. DOOLITTLE. I can't tell you what sense you are left with, sir, but I can tell you that in this instance there was a human error. The underlying data was accurate, but two fields that were added together shouldn't have been added together.

Mr. STEARNS. This is across the board on the data you gave us. It's not just two fields. And it's also this is not the first time, wouldn't you agree on that?

Mr. DOOLITTLE. Not the first time for what, sir?

Mr. STEARNS. Getting information to us that was incorrect.

Mr. DOOLITTLE. This is the—I am aware of this, we're working to——

Mr. STEARNS. You submitted data to us in March of this year that were initially inaccurate, isn't that true?

Mr. DOOLITTLE. Well, they were actually based on accurate data, and they were correct in that sense. The integrity of the data is sound. It was a human error——

Mr. STEARNS. Back in March.

Mr. DOOLITTLE. Yes. We have never compiled——

Mr. STEARNS. I am just trying to confirm that back in March you gave us information that was incorrect.

Mr. DOOLITTLE. Right.

Mr. STEARNS. That's all we need to know.

Mr. DOOLITTLE. OK.

Mr. STEARNS. And so you are saying information we recently got is incorrect and you are saying that you will get this new information to us, you are not clear when. Yes or no, do you have the correct numbers in front of you?

Mr. DOOLITTLE. I have what was given to your staff last night.

Mr. STEARNS. So you haven't got anything corrected in front of you yet. OK. Yes or no, since 2007 has the total number of investigations initiated, have they steadily declined?

Mr. DOOLITTLE. I wouldn't say that they have steadily declined. I think it has been up and down.

Mr. STEARNS. So you are saying they have not declined?

Mr. DOOLITTLE. I would say that if you look across that there has been——

Mr. STEARNS. Our figures show that they declined.

Mr. DOOLITTLE. Excuse me?

Mr. STEARNS. Our figures show that they declined. Is that true? Can any one of the panelists confirm that the total number of investigations initiated has steadily declined? Ms. King?

Ms. KING. Are you speaking about investigations done by the ZPICs?

Mr. STEARNS. Yes.

Ms. KING. No, I don't know the answer to that. But I can tell you that we are doing work that tracks the number of investigations and convictions, both civil and criminal, in 2005 and 2010.

Mr. STEARNS. Mr. Doolittle, I have something that you have in front of you in which you show that the ZPICs workload, 2007, the total number of investigations were 8,300, in 2008 it went down to 7,700; 2009, 6,800; 2010, 5,800; and 2011 about 5,800. So it looks to me from the data that you've provided in the data you have in front of you it declined. Is the data that you provided here incorrect too?

Mr. DOOLITTLE. No. You were right, sir, and if you would like a further explanation——

Mr. STEARNS. No, that's all right because you had indicated they had not declined but I want to make it clear to you that you are incorrect again.

CMS purports to be shifting its emphasis to prevention based upon pro active data analysis. Yes or no, is the total number of investigations initiated as a result of proactive data analysis lower than each of the previous 4 years? Yes or no?

Mr. DOOLITTLE. For the 2011? No—excuse me—let me——

Mr. STEARNS. Because when I am looking at the figure that you also have——

Mr. DOOLITTLE. For ZPICs, yes. For ZPICs, yes.

Mr. STEARNS. So the answer is yes, they have declined. We have established that.

Mr. Vito, does it surprise you that CMS was unable to provide basic contractor performance data to this committee?

Mr. VITO. I think it's very difficult——

Mr. STEARNS. Just yes or no. Can you pull the mic a little closer? We're not asking how to get to the Moon here. We're just asking a yes or no question here.

Mr. VITO. Could you repeat the question?

Mr. STEARNS. Mmh hmm. Does it surprise you that CMS is unable to provide basic contractor performance data to this committee? They are responsible, they are the integrity office, they've admitted that they have not provided information that's accurate. Does that surprise you? Yes or no? Or is this typical what you expect from CMS?

Mr. VITO. No. I think it's—we have been——

Mr. STEARNS. We think it is deplorable. What do you feel?

Mr. VITO. Well, we think that there's been problems with the data, and we have presented that information to you as part of——

Mr. STEARNS. But isn't the fact is that your office has had the same issues with CMS providing accurate or uniform data that's hindered your ability in conduct critical oversight? Isn't that true?

Mr. VITO. We have identified problems for over 12 years.

Mr. STEARNS. Sometimes you just have to say yes or no. Just yes or no. Isn't that true?

Mr. VITO. Yes.

Mr. STEARNS. Yes. Has CMS adequately addressed these data concerns that OIG raised in its November 2011 report titled "Zone Program Integrity Contractors?"

Mr. VITO. I think it would be better to ask them if they've resolved them. I am not sure that they——

Mr. STEARNS. You don't know.

Mr. VITO. Well, we believe that some of them might and some of them might not be, so it would be better for you to ask them. I think they would have a better answer.

Mr. STEARNS. All right, my time has expired. The gentlelady from Colorado.

Ms. DEGETTE. Thank you, Mr. Chairman. Well, we're obviously all concerned that we get accurate data.

And I just want to ask you, Mr. Doolittle, the error in the data was a human error in your agency, is that correct?

Mr. DOOLITTLE. Yes, absolutely, the underlying data were correct.

Ms. DEGETTE. You discovered that on your own as an agency, is that correct?

Mr. DOOLITTLE. Yes, on Wednesday.

Ms. DEGETTE. You discovered it on Wednesday when preparing for this hearing?

Mr. DOOLITTLE. Yes, ma'am.

Ms. DEGETTE. And when you discovered it you informed the staff and yesterday you provided the correct information to the committee at 5 o'clock?

Mr. DOOLITTLE. Yes, ma'am.

Ms. DEGETTE. Are you aware of any other situations since you've been there when incorrect data has been provided to this committee or to any other congressional committee?

Mr. DOOLITTLE. I am not aware of it.

Ms. DEGETTE. And was this incorrect information provided willfully to try to avoid a thorough investigation to your knowledge?

Mr. DOOLITTLE. Quite to the contrary. It was a human error.

Ms. DEGETTE. It was just an accident?

Mr. DOOLITTLE. It was a human error, yes.

Ms. DEGETTE. OK. And what steps are you taking to make sure these—let's see. My staff says this accident happened when a former employee—so they're not there any more, right?

Mr. DOOLITTLE. Yes.

Ms. DEGETTE. Accidentally added up one wrong cell of the spreadsheet while summarizing data. So they added it up wrong, right?

Mr. DOOLITTLE. Right. They added in field B6 instead of field B7.

Ms. DEGETTE. People need to show up at this committee with accurate information. I understand that you are going to get us even more accurate information, right?

Mr. DOOLITTLE. Yes, ma'am.

Ms. DEGETTE. And when is that going to happen?

Mr. DOOLITTLE. As soon as possible. A lot of this information does go back to 2007. So it goes to previous contractors.

Ms. DEGETTE. OK. Well, get it to us as quickly as you can, and let's try not to have this happen again. But what I really want to talk about is the fight against Medicare fraud. So let's talk a little bit about that.

Briefly, Mr. Doolittle, can you tell me what the administration is doing that's different to try to fight Medicare and Medicaid fraud?

Mr. DOOLITTLE. Yes, ma'am. We're moving away from pay and chase, we're starting, we have almost a year into our first major data analytics program. And we also have instituted Automated Provider Screening that allows us to catch the bad guys on the front end before they get into the program and monitor them if they turn bad while they're in the program.

Ms. DEGETTE. So the administration is shifting to try to preventing fraud rather than to catch the evil-doers right?

Mr. DOOLITTLE. That's right.

Ms. DEGETTE. And there is this HEAT program, the health care fraud prevention and enforcement team. As I understand it, this initiative aims to coordinate strategies to fight fraud among the Department of Justice, U.S. Attorney's Office, CMS and the HHS Office of Inspector General, is that right?

Mr. DOOLITTLE. Yes. I would add FBI.

Ms. DEGETTE. And FBI. And there's anti-fraud strike forces in seven regions of the country, right?

Mr. DOOLITTLE. Yes.

Ms. DEGETTE. So what's the purpose of the strike forces, and have they achieved any results yet?

Mr. DOOLITTLE. The purpose of the strike force is to try to be able to accelerate and compress the time that it takes for criminal investigations and to get more throughput through the criminal justice system for health care fraud.

Ms. DEGETTE. OK. Mr. Vito, are you familiar with this HEAT program?

Mr. VITO. Yes, ma'am.

Ms. DEGETTE. And what's your opinion of it?

Mr. VITO. Well, I think they're doing great things. It's in nine locations. They have charged more than 1,300 defendants, and with over $4 billion—that had billed over $4 billion. It's a way that the OIG uses data to identify the hotspots and then put the resources in the hotspot to make things happen.

Ms. DEGETTE. And the prosecutions are way up too from 797 in fiscal year 2008 to almost double, 1,430 in 2011, is that right?

Mr. VITO. [Nodding.]

Ms. DEGETTE. So that seems to be a pretty good avenue that we could go to try to catch, to catch criminals, right?

Mr. VITO. Yes.

Ms. DEGETTE. Now, Ms. King, can you just briefly talk to me about some of the Affordable Care Act provisions that are targeted to reduce fraud and have they begun to be implemented?

Ms. KING. Some of the most important provisions I think in the Affordable Care Act have to do with enrollment processes because it's important to try and keep out people that you think might be wanting to cheat you from entering the program. So there are new screening processes at the front end to take a closer look at providers and they are stratified by risk and there's increased scrutiny on providers deemed to be at high risk. And at the moment, those providers are home health providers and durable medical equipment providers.

Ms. DEGETTE. And have those provisions gone into effect?

Ms. KING. They have gone into effect.

Ms. DEGETTE. When did they go into effect?

Ms. KING. Earlier this year, I believe.

Ms. DEGETTE. Earlier in 2012?

Ms. KING. Yes.

Ms. DEGETTE. Have you seen any results from them?

Ms. KING. We have not. I think it's too soon to really gauge the full effect of this.

Ms. DEGETTE. When do you think you'll see results?

Ms. KING. I would say in about a year we ought to be able to tell whether they're having any effect.

Ms. DEGETTE. I have just one more question for Mr. Vito. So, this is an issue I raised in my opening statement, is if—and Mr. Doolittle says they're trying to prevent fraud rather than catch the bad guys after they defraud Medicare. So the question is what kind of metrics can we use to see if our efforts at prevention are actually working, if we're spending our money wisely? Because what you are going to do is have the number of people who are caught go down if you are preventing fraud.

Mr. VITO. I think there are a number of ways. I think you are bringing a very good point. For example, in the program vulnerabilities, what you are able to do is you have identified a program vulnerability and then you put an edit in place, that edit will give you the dollars that they're saving. So that actually will work in one way of making you know exactly how well it's going.

In addition to that, there's other metrics like in south Florida they took a lot of action down there, the strike force in the DME area, we were told that the dollars that are now being billed in DME have dropped substantially. So there are all these good things that you can see, and they are difficult to make that comparison.

The other thing is you'll never be able to determine the sentinel effect, and I think that's what you are asking about, is what, when we go out and we make people realize that we're doing the job and that there's a chance that they're going to get caught and if they get caught they're going to have to pay. Those are the things that

it's hard to keep an eye, you know, to really determine that level of detail. Those are the, I think that's your point that you are bringing forth.

Ms. DEGETTE. Yes. Thank you. Thank you, Mr. Chairman.

Mr. STEARNS. I thank the gentlelady.

I recognize Dr. Burgess for 5 minutes.

Mr. BURGESS. Mr. Vito, let's just pick up on that sentinel effect for just a moment because that is an extremely important point and part of the effectiveness of the sentinel effect is that people truly believe that you have a way to watch and are, in fact, watching, there is someone actually at the terminal watching. Because I can recall in the late 1990s there was, in the Clinton administration there was a great hue and cry, Janet Reno was really goes to clamp down on Medicare fraud and they went all around the country talking about this. But as a provider, I got the sense that it was all for show, that these were photo ops and there wasn't anything really different happening. And I don't know whether that was an accurate opinion that I had but certainly it wasn't unique to me. Other people talked about it as well.

There was a program, and it was a crop insurance program. Charlie Stenholm, a Democrat from Texas, had worked with a Dr. Bert Little at I think it was Tarleton State University, a small college in west Texas, because Charlie was concerned about the amount of crop insurance fraud that he saw. And they worked out a computer algorithm, essentially predictive modeling, and they talked about it in the community about how this was going to be applied. And one of the first things they noticed was the requests for crop insurance claims fell. And it was the sentinel effect that they were observing.

So if you guys know that and you know there's been other experiences in the crop insurance program right next door to your agency, why has it been so difficult for this thought to permeate in to the bureaucracy? I appreciate the stuff that's happening in the Affordable Care Act, I appreciate the enrollment process improvement. I've got to tell you I've got my doubts there. But why not do this years ago if you knew that it worked?

Mr. VITO. A very good question. I would like to point out to you that the work of the OIG has recognized it's better to prevent fraud than actually pay and chase. And if you look at the work that we have talked about today, largely it focuses on preventing.

In addition to that, once it occurs, you have to have swift, you know, law enforcement action, and you have to make the prosecutions. And our Office of Investigation is one of the best groups that investigate health care fraud. And the people that prosecute it, I think we are doing our best now to move where people are starting to believe that they are at risk when they take advantage of this program.

We have to do a better job up front. We have to make sure the people we're doing business with are the people that we want to do business with, and that's very important that that happens. And then once things are starting, overpayments occur, we have to stay on top of that. We can't allow the overpayments to be billions of dollars which we can't collect.

Mr. BURGESS. Let me just point out to you what I think is a problem, and I hear this all the time. People who make a legitimate coding error, and it is just a error, that is the little low hanging fruit in your system. You can go after those folks and clobber them. But that ain't your problem. Your problem is down in McAllen, Texas. I was there 2 years ago after Atul Gawande's article was published and the doctors down there were feeling significantly put upon and would you come down and hear our story, hear our side of the story. And someone just offered to me, and I don't remember exactly the number, but they said we have grown from 40 home health agencies to 150 in about a year and a half's time. Well, that ought to be a red flag. There's something going on there. Were there all these people that needed home health services that were just being ignored previously? Or has somebody found a business model that works for them, and this business model may be actually outside the parameters of the law or what is lawfully allowed? And you know rather than going after an individual who may have made a coding error and calling them to task, why don't we go after the big stuff?

Mr. VITO. Again, that is when you, if you are doing proactive data analysis, you are going to be able to see that there's all of a sudden this many more home health agencies, there's this many more people getting these services and there's this many more people billing for it. So then if you were doing that then you could investigate that very——

Mr. BURGESS. Why didn't we?

Mr. VITO. I don't know that answer, but I can tell you that we have focused, the OIG has focused on the importance of doing proactive data analysis to make sure that all this type of action is identified.

Mr. BURGESS. I appreciate what you are doing and I don't mean to be critical, but it just seems to me sometimes we leave, we ignore the biggest problem and go after what's easy to correct.

Mr. Doolittle, I just have to ask you, you'd have to be stone deaf in this town to not recognize the Supreme Court is considering a mighty big case. In a week or 2 or 3 we're all going to get the result of that case and as a result of their opinions, the Affordable Care Act possibly could be struck from the books.

Now, are your efforts at eliminating or reducing fraud and inappropriate payments, are they going to end when the Affordable Care Act ends?

Mr. DOOLITTLE. No, they're not going to end. We have several other bills that we operate under such as the Hicks Act bill.

Mr. BURGESS. Correct, and it's not like you weren't doing anything before the Affordable Care Act was enacted to crack down on fraud. After all, Janet Reno came to Dallas, Texas in 1998 or 1999 and outlined all the things that she was doing to eliminate Medicare fraud. So you've been doing stuff all along. It may not have been effective but you've been doing stuff.

Mr. DOOLITTLE. That's right, and we will implement any new tools——

Mr. BURGESS. Are you making any contingency plans for what might happen from an adverse ruling from the Court?

Mr. DOOLITTLE. Many of our activities, for instance, the FPS, the Fraud Prevention System, that is funded under the Small Business Jobs Act and authorized under the Small Business Jobs Act, that won't be affected. Many of our activities won't be affected.

Mr. BURGESS. Are you making any plans for a contingency if the Supreme Court were to remove the Affordable Care Act?

Mr. DOOLITTLE. We're confident that the ACA is going to be upheld by the Supreme Court and we're going to move forward——

Mr. BURGESS. You are taking the Fifth on this, too. I can't get anybody from your agency. Are you looking at what's going to happen to you after sequestration kicks in in January? Sequestration after all is a law that was signed by the President. You are going to be cut 7 to 8 percent across the board in discretionary funding at HHS. Are you preparing for that?

Mr. DOOLITTLE. I have—I am not sure if the agency has been preparing for that. I haven't been party to those conversations.

Mr. BURGESS. Thank you, Mr. Chairman.

Ms. DEGETTE. Mr. Chairman, I'd just like just the record to reflect I know that Mr. Burgess was using the phrase "taking the Fifth" in a colloquial way, but however the witnesses today are under oath, and I just want the record to reflect that none of the witnesses has actually exercised their Fifth Amendment right against self-incrimination.

Mr. STEARNS. I thank the gentlelady.

The gentlelady from Illinois is recognized for 5 minutes.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman.

Mr. Chairman, I would like to note that, though you certainly we're all disappointed that there was an error in the data, the data—the error was reported by Mr. Doolittle and his office. It's not like there was any effort to cover up that there was a mistake, either now or I understand in March that's true as well, that there is concern, maybe more so than we are, that a mistake is made. We all look forward to the corrections.

I just for one want to say, Mr. Doolittle, that I appreciate that you did inform the committee and obviously want you to do a quick a job to get us the information. But this isn't something that was another example of some sort of deliberate fraud on the part of CMS.

Did you want to comment on that?

Mr. DOOLITTLE. Certainly it was not, madam.

Again, let me apologize and let me just state for the record we did give you corrected summary information last night. We are working to get you the backup for that.

Ms. SCHAKOWSKY. Thank you.

Ms. King, let me just apologize to you, in my opening remarks I didn't mention the importance of GAO and the information that you provide.

And I also appreciate the comments that you've made about the improvements that have been made in our fraud prevention through Obamacare, the Affordable Care Act. And it is interesting to me that, on the Republican side, concerns seem to be raised on, oh, what's going to happen if Obamacare disappears, since almost every week that we're in session there are efforts to get rid of Obamacare.

Clearly, we would want fraud mechanisms and prevention to go forward. This isn't the first time that Dr. Burgess has raised this.

He also seemed concerned of what's going to happen to doctor fees if Obamacare goes away. These are things that perhaps before asking for its repeal that my Republican colleagues might have thought about in addition to the millions of people who have already benefited from the provisions in that legislation.

I also just wanted to point out that we don't have to look any further than recent headlines to see the priority that the Obama administration has placed on fighting fraud and the enhanced tools provided to CMS by Obamacare to fight fraud.

Just yesterday, the Justice Department announced that Orthofix, Inc., a medical device company, agreed to pay $34.2 million to resolve civil claims that the company defrauded the Medicare program when selling bone growth simulator devices.

Last month was the biggest crackdown on Medicare fraud in history. The Medicare Fraud Strike Force uncovered $452 million worth of false billings to Medicare by more than 100 people in seven cities, including Chicago, which is my hometown, across the country.

So let me ask you, Mr. Doolittle. Why do we rely on these private entities to engage in this and exactly what we're going to do to make sure they are performing?

And before you do, let me just say that it has also been sort of religion on the other side of the aisle that always the private sector does better than the public sector. Now they want to move Medicare itself into the private sector through a voucher program and the Medicare Advantage program, where I know we've found many examples of fraud, even though the companies haven't always found the fraud.

So let me just ask you about these private contractors and how we are going to keep them in line.

Mr. DOOLITTLE. So, first, why we rely on the contractors? This was the system that was set up by Congress, and we're vigorously implementing it.

In terms of oversight of our contractors, we have a vigorous system of oversight for the Zone Program Integrity Contractors. We have training rotations every other week where they come into our headquarters. Each one of the contractors has at least one full-time employee that's assigned to oversight. We do site visits. We do random pulls of files. We also at the end of the year go through an award fee process, go carefully through their performance, and they can qualify for some—there's mostly a cost—fixed-cost contract, but there are some awards that they can qualify for.

So those are some of our oversight tools.

Ms. SCHAKOWSKY. Thank you very much.

Mr. STEARNS. The gentlelady yields back.

The gentleman from Nebraska is recognized for 5 minutes.

Mr. TERRY. Thank you, Mr. Chairman.

And, Mr. Doolittle, I don't think anyone on our side of the aisle has accused you of purposefully deceiving us, so I'm a little—I want to make sure you didn't feel that way. We're being accused of that, but I just want to make sure that we knew it was a mistake. There was no malfeasance, but it does just show that there's a level of

inability to really keep track of the numbers there, and that's what we are trying to fix here.

Also, one other point goes to my question to you, Mr. Doolittle, is perhaps if we had a Medicare fraud reform bill it would have been very bipartisan, and truly I think the way that every business model is working is to the money ball predictive prevention model. If baseball can develop it, CMS can develop it, predictive preventive fraud analysis.

And the beauty of what makes it best business practice now with as predictive as we can make it is that when those anomalies occur, like Mr. Burgess brought up where there is a spike in increase of home health care, those things tend to stand out like a sore thumb. You then can go back and say, OK, something in our predictive analysis is showing an anomaly that we need to investigate here. So in baseball and money ball if that pitcher that you thought was going to have so many strikeouts per year and isn't performing, that sounds out in your predictive analysis.

So I like that you're going in that direction.

So let me ask you, you mention that you'll have kind of the rough draft by December 31st or you hope that—is that an accurate statement or regurgitation of your testimony, December 31st?

Mr. DOOLITTLE. So what I was speaking of on September 30th, under the provisions of the Small Business Jobs Act of 2011, we're required to provide Congress with a report on the first year of our modeling system.

Mr. TERRY. So the predictive modeling is already in place now.

Mr. DOOLITTLE. Right. It started on June 30th of last year.

Mr. TERRY. OK.

Mr. DOOLITTLE. We were assigned to start it in 10 States by July of last year. Instead, we started it in 50 States, 1 day early.

Mr. TERRY. So by December 31st we'll have the first year rough analysis of it's working or not working.

Mr. DOOLITTLE. Right. And we hope to have some——

Mr. TERRY. Who is in charge of developing that model? Is that you or some other—I would think there's probably multiple mathematicians doing this.

Mr. DOOLITTLE. That facility is contained within my unit, the Center for Program Integrity, and contractors that we're using as well. We are working closely with OIG through the whole process as well.

Mr. TERRY. What are some of the—I guess if it is predictive, what are you looking at—what area of statistics are you looking at from your contractors to be able to determine if there's anomalies that are occurring?

Mr. DOOLITTLE. So there's a variety of different types of predictive modeling, and I would be happy to go into this at great depth. But the most sophisticated types of predictive modeling which we're starting to do is rare even in private industry, but in government we are starting to do it, is where you take attributes of known bad guys, you develop what characteristics they might have in common, and then you apply it to the raw data set and see who fits that model.

Mr. TERRY. All right. Well, I appreciate that.

Ms. King, I want to ask a question. Maybe, Mr. Vito, if you can help us here. But Mr. Doolittle made a statement that I think is fairly correct and may answer why many of us feel like the private sector can do things more nimbly, not necessarily better, but they've adopted more of the predictive analysis, fraud prevention in the private sector. So do we have any comparison of the ability of government CMS to detect and prevent fraud as compared to the private-sector insurance companies?

Ms. KING. We're also looking at the Fraud Prevention System and the predictive analytics, and we'll have a report out later this fall. And as part of that, we are looking at how does what CMS does compare to what's going on in the private sector.

Mr. TERRY. Thank you.

Mr. Vito, do you want add quickly on to——

Mr. VITO. I think in general we don't have the oversight of private. But we do see some of our cases identify problems that are occurring in the private sector, and we share with them.

In addition to that, we have other work where we are going out to all the managed care companies and asking if they had identified incidents of fraud, waste, and abuse; and they had.

In addition to that, we have some new work that will be coming out on the MEDICs, and the MEDICs have responsibility for Part C, which is the Medicare Advantage, and we will be able to give you details on that.

Mr. STEARNS. Thank the gentleman.

The gentlelady from Florida, Ms. Castor, is recognized for 5 minutes.

Ms. CASTOR. Well, thank you, Mr. Chairman, and good morning.

Mr. Chairman, I would like to thank you for calling this hearing on the Obama administration's efforts to fight fraud in Medicare. I think it is very important, and I would like to thank our expert panel for being here today.

From where I sit, I believe the Obama administration has a very strong record on rooting out fraud and waste in Medicare. I represent the Tampa Bay area in Florida, and we are one of the seven communities across the country—I guess Florida has been a hot spot and south Florida but also in the Tampa Bay area. So we have one of those strike forces that brings together the United States Attorneys Office, HHS, the Florida Department of Law Enforcement, other law enforcement agencies, the Department of Justice.

And my colleague, Ranking Member DeGette, asked you all have you achieved results yet. Well, from what I have seen, you all have been very aggressive. We had a major bust last month, arrested a pharmacist that has been a real fraudster. You've also arrested a lot of folks all across the State. That followed on last year another huge roundup of people who are bilking Medicare and really putting the trust fund at risk. So my hat's off to the aggressive stance the Obama administration has taken to root out fraud and waste in Medicare.

And I'm very gratified that you all are putting the tools provided in the Affordable Care Act to good use. We gave you some additional tools under the Affordable Care Act to be more aggressive, and it feels like you're just getting started, but I think we're seeing significant progress already.

I think there is one problem area that I think deserves attention and should be improved when it comes to the ZPIC and these audits. I'm hearing from a lot of folks all across the State they kind of feel like this is the Wild West. Because these auditors come in, and there is no real due process, there are no real checks and balances. And I don't think it's fair for an auditor to come in, to upset their business, to take documents and not have some time frame for or even a dialogue. It's kind of a one-way dialogue, and I think these businesses deserve to have some due process.

Tell me, Mr. Doolittle, who trains the ZPIC staff on Medicare policy? What is their experience auditing claims? Who insures that that training is adequate? And what rules govern the ZPIC audit procedures?

Mr. DOOLITTLE. So we within CMS train the ZPICs on a regular ongoing basis. As I mentioned before, every other week one of the ZPICs is at our headquarters for training. We are constantly going out to them to train them on various aspects.

I believe that the problem that you're referring to—and I agree it is a problem—is probably stemming from what we call prepayment edits, prepayment medical review. That is a tough system. Obviously, fraud is a tough problem. It is a tough system. I will say that I have started to review our processes on that. We have to stay tough, but we have to be fair as well. So we're trying to take a fresh look at that.

Ms. CASTOR. Are there rules that govern time frames that the auditors—so that it is not completely open ended, what are the due process rights for some of these visits?

Mr. DOOLITTLE. So the way the due process works is they are able to, after the claim is examined and determined whether it is denied or paid, they can appeal a denial. Now they still stay on prepay, and that's the frustrating part for the providers.

Ms. CASTOR. That is very frustrating.

Mr. DOOLITTLE. Right.

Ms. CASTOR. Because it is so open ended.

Mr. DOOLITTLE. Yes.

Ms. CASTOR. And I just—and then they are also hiring subcontractors. Do the same rules apply to the subcontractors? Are these subcontractors approved by CMS? We've had cases where they've had to give files to the subcontractors, and it is months and months and months and months before they hear anything from an auditor or CMS.

Mr. DOOLITTLE. If the ZPICs were to use subcontractors, they would have to be approved by our office, yes.

Ms. CASTOR. OK. I'm going to submit some other questions for the record from CMS on the ZPICs. Because when people are calling it the Wild West and you're subjecting—I know you're going to catch some fraudsters, but you're subjecting good businesses to a process that doesn't appear to have any end and appears to be unreasonable, I think there is a lot of room for improvement here.

Mr. DOOLITTLE. I agree with that.

Can I just say that as we try to be more aggressive we feel that one of the down payments we have to put on the table is we have to be fair to the vast majority of good and honest providers, and we're trying to work from several angles, including, for instance,

we recently implemented a new process—totally new process by which a provider whose number has been scammed—the provider number has been scammed—and they found out that, when they received a bill from the IRS for the $2 million of income they never received, it is an innocent provider, before they had been left to their own devices to try to find a way out of that jam. If we are convinced that it is an innocent provider, we now have a systematized process where we are able to go out to help that provider and even help them work through their issues with the Department of Treasury.

Ms. CASTOR. Good. I will look forward to the answers to these additional questions.

I yield back.

Mr. STEARNS. I thank the gentlelady.

The gentlelady from Tennessee is recognized.

Mrs. BLACKBURN. Thank you, Mr. Chairman.

The bell has rung, and we're going to have votes, and I know that Mr. Griffith has some questions.

I do have a couple of things I want to ask you. Because being from Tennessee and having had TennCare, which I know all three of you are familiar with the TennCare program, which is our Medicaid delivery, we have been on the fraud issue for a long time. I did the first field hearing on fraud dealing with TennCare and Medicaid delivery systems in 2004 and then another one in 2005 in our district in Tennessee. So I have got a couple of things I want to quickly go into, and then Mr. Griffith will be able to get his questions in.

Let's look first—and, Mr. Doolittle, I guess this probably would best come to you. Let me just direct it to you, and then if either of you want to add something that would be great.

DME claims. The DMEPOS claim, the average, is estimated at $75 per month, with the low being only a couple of dollars per month to a high range of several hundred dollars per month or a one-time sale. Yet we are hearing that the ZPIC and the other audit process is very paper-intensive. The auditors may send one letter per patient claim audited, and it is all in separate envelopes, takes a lot of work. So you've got thousands of separate mailings, et cetera. Private insurers are sending one spreadsheet, and they are working from that or they are getting one email.

So we've heard that some of the auditors are asking for the same paperwork for the same patients month after month, even though the patient is chronically ill. So I would like to know what you have in place to look at that high administrative burden and the cost of auditing that this is for our providers? And what is the return on investment on what is a very expensive and labor-intensive process for these providers? And what can you learn from them and incorporate into these Medicare audits?

Mr. DOOLITTLE. So I certainly appreciate the comment about the labor-intensiveness. We are always looking for ways to streamline, aggregate. Of course, it is frustrating and aggravating to get 500 letters. We need to get one letter describing the same—similar situations for 500.

In terms of DME, we've taken a variety of special approaches. As you know, it is an area that is of extremely high risk, and we have to be as careful as possible.

There were several provisions in the ACA that have dramatically reduced the DME costs, including the face-to-face requirement, a requirement that a doctor meet face to face before a DME prescription, as well as a surety bond requirement. So we feel that we have opened a dialogue as well with the providers. We feel that we are on track to try to rationalize the system while still clamping down very hard in what is a very fraud-prevalent area.

Mrs. BLACKBURN. Well, it is important to us because one of the things that we have found through our experience with TennCare was that if you've got someone that is more prone to fraud you're going to have unnecessary care that is in there, and then it's going to be more difficult on the other end that you're able to process these claims.

If you simplify your system, if you make it easier for people to read through, if you're getting one email in one spreadsheet instead of separate mailings, cleaning the system up, we will have a better outcome and a better quality of care. It is all related. We want to work with you on this and would love to see a timeline for moving some of these forward.

I am going to yield back my time.

Mr. STEARNS. The gentleman from West Virginia is recognized.

Ms. DEGETTE. No, Mr. Dingell is recognized.

Mr. STEARNS. There is still time.

Mr. GRIFFITH. If I could take Mrs. Blackburn's 23 seconds.

Mr. STEARNS. Yes, go ahead.

Mr. GRIFFITH. I will just make a quick statement.

It appears that we are failing in tracking down the fraud we should be tracking down. I know everybody's trying. It is not a Democrat problem. It is not a Republican problem. It is the government is failing the people. And this is extremely important to all of us on both sides of the aisle.

And I will tell you quickly that last night at a town hall meeting a lady was wondering why her home health was being cut back because she has MS and her mother has diabetes. These are real-life problems for folks out there.

So all I can say to you is get us better numbers and track down the bad guys. Because as a team working for the American people we have got to stop this fraud.

Thank you.

Mr. STEARNS. I thank the gentleman, and the gentleman from Michigan is recognized for 5 minutes.

Mr. DINGELL. Thank you, Mr. Chairman.

These will be yes-or-no questions to the witnesses.

As we all know, Medicare fraud is a serious issue, costing us billions of dollars, an unacceptable situation. Because of the deplorable nature of Medicare fraud and abuse, this committee and I worked hard to make sure that the Affordable Care Act gave the Centers for Medicare & Medicaid Services new tools to fight the swindlers who perpetrate these frauds.

Mr. Doolittle, I want to thank you for being here today, and I want you to know we appreciate your hard work in fighting Medicare fraud.

Now, yes or no, we all agree that CMS must move away from the pay-and-chase models to more proactively of mechanisms to catch wrongdoers. Since the Affordable Care Act has passed, CMS has begun screening providers and suppliers on three risk levels: limited, moderate and high. Will screening based on risk levels help CMS to better target their resources to high-risk suppliers and providers? Yes or no.

Mr. DOOLITTLE. Yes, sir.

Mr. DINGELL. Now does CMS have the ability to adjust the level of risk for screening as needed? For example, if you have a low-risk provider and supplier whose billing privileges have been revoked, would they be subject to high-level screening? Yes or no.

Mr. DOOLITTLE. Yes, sir.

Mr. DINGLE. CMS has begun conducting announced and unannounced site visits of moderate and high-risk providers prior to initial enrollment or revalidation since the Affordable Care Act. How many site visits does CMS intend to conduct?

Mr. DOOLITTLE. Over 50,000 additional site visits over what we were doing before.

Mr. DINGELL. Is that number sufficient?

Mr. DOOLITTLE. It's a start. We'll see how we are at this time next year.

Mr. DINGELL. Do you believe the site visits will better help CMS to identify if providers and suppliers are legitimate and meet Medicare standards? Yes or no.

Mr. DOOLITTLE. Yes, sir.

Mr. DINGELL. As a part of your screening process, do you now have the ability to terminate from Medicare providers that have already been terminated from any Medicaid programs? Yes or no.

Mr. DOOLITTLE. Yes, sir.

Mr. DINGELL. The Affordable Care Act provided nearly $500 million in increased funding to help fund efforts like those to fight fraud. Does CMS have the resources it needs, financial and personal, to fight fraud in Medicare and Medicaid? Yes or no.

Mr. DOOLITTLE. Yes, sir.

Mr. DINGELL. At the beginning of May, the Medicare Fraud Strike Force took down 107 individuals for $452 million in false Medicare billing. In Detroit alone, 22 defendants were arrested for $58 million in Medicare fraud. This involved the highest amount of false Medicare billings in a single takedown in your strike force history. As a member who has participated in one of these ride-alongs of the strike force I know they are working hard to recover taxpayers' dollars. Do you know the Affordable Care Act requires CMS to share data with the States, the Department of Justice, and the Inspector General, amongst others, to help fraud and abuse? Will this authority help the strike force continue their good work?

Mr. DOOLITTLE. Yes, sir.

Mr. DINGELL. Would you submit to us any additional authorities that you might need in that particular for the record, please?

Mr. DOOLITTLE. Uh——

Mr. DINGELL. Is it fair to say that the Affordable Care Act significantly increases the ability to suspend payments until an investigation is complete so that Medicare does not make overpayments or payments for false services? Yes or no.

Mr. DOOLITTLE. Yes, it is fair.

Mr. DINGELL. Is this sufficient? Is this authority sufficient?

Mr. DOOLITTLE. Yes.

Mr. DINGELL. Now would you agree that because of the Affordable Care Act CMS now has the most tools it has ever had to detect and prevent waste, fraud, and abuse? Yes or no.

Mr. DOOLITTLE. Yes.

Mr. DINGELL. Would you submit to us, if you please, sir, whether additional authority is needed and how your authorities are working and whether new authorities are needed and what they might be for the record?

Mr. DOOLITTLE. Yes, sir.

[The information follows:]

ENERGY & COMMERCE COMITTEE
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
HEARING ON
"Medicare's Contractors' Efforts to Fight Fraud—Moving Beyond Pay & Chase"

June 8, 2012

This is the answer for the record to be inserted into the transcript for this hearing:

Lead-In:
MR.DINGELL: Do you know the Affordable Care Act requires CMS to share data with the States, the Department of Justice, and the Inspector General, amongst others, to help fraud and abuse? Will this authority help the strike force continue their good work?

MR.DOOLITTLE: Yes, sir.

MR.DINGELL: Is it fair to say that the Affordable Care Act significantly increases the ability to suspend payments until an investigation is complete so that Medicare does not make overpayments or payments for false services? Yes or no.

MR. DOOLITTLE: Yes, it is fair.

MR. DINGELL:Is this sufficient? Is this authority sufficient?

MR. DOOLITTLE: Yes, it is fair.

MR. DINGELL: Now, would you agree that because of the Affordable Care Act CMS now has the most tools it has ever had to detect and prevent waste, fraud, and abuse? Yes or no.

MR. DOOLITTLE: Yes.

MR. DINGELL: Would you submit to us, if you please, sir, whether additional authority is needed and how your authorities are working and whether new authorities are needed and what they might be for the record?

INSERT: Page 65

MR. DOOLITTLE: Yes, sir. Over the last two years, CMS has implemented powerful new anti-fraud tools provided by Congress in the Affordable Care Act, as well as designed and implemented large-scale, innovative improvements to our Medicare and Medicaid program integrity strategy to shift beyond a "pay and chase" approach by focusing new attention on preventing fraud. Simultaneously, CMS is using the same innovative tools to further enhance our collaboration with our law enforcement partners in detecting and preventing fraud.

For FY 2013, the President submitted a package of legislative proposals to build on the Affordable Care Act's unprecedented fraud-fighting authorities. These 16 legislative proposals enhance pre-payment scrutiny, increase penalties for improper actions, strengthen CMS's ability to implement corrective actions, and promote integrity in Federal-State financing while saving Medicare, Medicaid, and CHIP

$3.6 billion over 10 years. In addition, the President's FY 2013 budget request includes $1.9 billion for the Health Care Fraud and Abuse Control Program (HCFAC) through both mandatory and discretionary funding streams. We urge Congress to fully fund the HCFAC program, which plays a critical role in the fraud-fighting efforts of CMS and our law enforcement partners.

Mr. DINGELL. Please.

Mr. Chairman, I thank you,

Mr. STEARNS. I thank the gentlemen. And he makes a very good point. You have all the tools you need as you pointed out.

By unanimous consent, the documents Ms. DeGette has requested is part of the record.

Ms. DEGETTE. Mr. Chairman, I didn't yet request them.

Statements from the American Medical Association and the American Federation of State, County and Municipal Employees.

Mr. STEARNS. By unanimous consent, so ordered.

[The information follows:]

Statement of the

American Medical Association

before the

House Energy & Commerce Committee
Oversight and Investigations Subcommittee

RE: Medicare Contractors' Efforts to Fight Fraud:
Moving Beyond 'Pay and Chase'

June 8, 2012

The American Medical Association (AMA) is pleased to provide the Oversight and Investigations Subcommittee of the House Energy & Commerce Committee with information regarding Medicare fraud prevention and the role of Medicare contractors.

Physicians are firmly committed to eradicating fraud and abuse from the federal health care programs. Monies that inappropriately flow from the federal health care programs divert vital resources that should be devoted to patient care. The AMA has long believed that the most efficient way to combat fraud is to employ targeted, streamlined methods of fraud identification and enforcement, rather than overly burdensome requirements for all physicians, the majority of whom strive to comply with the rules and regulations governing participation in the Medicare program.

Physicians are also concerned about efforts to recoup improper payments, which often occur in the absence of fraud. Many physicians are unaware when they are incorrectly documenting or billing. Others are confused about frequent changes to Medicare payment policy and are overwhelmed by divergent billing requirements and guidance. The AMA believes that burdensome audits and payment reviews are not the most efficient way to reduce the health care programs improper payment rate. Rather, education regarding payment and documentation policies, with an eye toward statistical outlier billing patterns, is the most efficient way to effectively reduce the improper payment rate.

Combating Fraud

Predictive modeling and data analytics, if employed properly, can result in more efficient health care fraud identification. Seamless fraud detection methods that move from "pay and chase" to identify aberrant billing patterns and activity can be the way forward from onerous post-payment activities, which can be expensive for the federal government and physicians. However, because claims coding and documentation implicates complicated clinical issues, such efforts must be coupled with physician input and ongoing review.

Coordination among law enforcement agencies is also an effective tool to prevent fraud. The AMA has recently engaged in regional health care fraud summits convened by the Department of Health and Human Services (HHS) Office of Inspector General, the Department of Justice (DOJ), CMS, and local law enforcement to collaborate on new methods for fighting fraud. Integral to

this inter-agency effort is the use of Health Care Fraud Prevention and Fraud Enforcement (HEAT) Teams, which have contributed to record recoveries in the past several years. These efforts are consistent with AMA objectives to employ focused fraud investigations that are less likely to waste taxpayer or physician resources.

Physician identity theft also poses a threat to the federal health care programs. Earlier this week a member of a crime ring that stole physicians' identities to perpetrate a $18.9 million Medicare fraud scheme was found guilty. (*United States v. Shagoyan*, C.D. Cal., No. CR 08-01084, *verdict* 6/1/12). Physician identities are vulnerable because physician identifiers are publically available, and something as simple as a prescription pad may be enough to engage in fraudulent activity. Physician victims of identity theft can face devastating financial liabilities, among other problems. In recognition of this issue, CMS recently launched a new program to aid physician victims of identity theft in resolving erroneous financial liabilities, an effort that the AMA supports.

Reducing Improper Payments

Greater physician education and outreach is the first step in reducing the improper payment rate. Overall, improper payments are not the result of fraud or willful abuse. Instead, misunderstanding regarding payment policy or documentation requirements is often at the root of improper payments, as these guidelines are ever-changing. While the AMA often serves as an educator of the physician community, the partnership of federal regulators is required. To effectively reduce the improper payment rate, increased physician education and outreach from CMS concerning correct coding and billing requirements is a necessity.

Part of this education is the employment of physician Contractor Medical Directors (CMDs) to facilitate clinical-based discussions and serve as a bridge between physicians and federal programs on coverage and coding matters. Physician CMDs are a valuable resource for physicians to obtain education about Medicare's payment and coverage policies, and a venue for physician-to-physician discussion of Medicare policies that impact patient care. However, the interaction between physicians and CMDs has been inhibited by the overall reduction of CMDs. Since the transition from carriers and fiscal intermediaries to the MACs, and the subsequent reduction of the number of MACs nationwide, the number of CMDs at the MAC-level has also decreased, leading to confusion in the medical community. Unless a state medical society decides that a regional, multi-state CMD is appropriate, there should be a minimum of one physician CMD per state who is devoted to Medicare Part B issues.

The sheer number of audit contractors is also a serious concern for physicians. Currently, CMS contracts with Zone Program Integrity Contractors (ZPICs), Comprehensive Error Rate Testing (CERT) contractors, Medicare Recovery Auditors (Medicare RACs), Medicaid Recovery Audit Contractors (Medicaid RACs), Program Safeguard Contractors (PSCs), Payment Error Measurement Rate (PERM) Contractors, Medicaid Integrity Contractors (MICs), Medicare Administrative Contractors (MACs), Medicare Advantage (MA) audits, and others.[1] While some of these programs do have unique functions, there is considerable overlap and duplication among them. These auditors largely employ divergent operational guidelines and standards; demand letters, appeals processes, documentation limits, and look back periods are inconsistent.

[1] CMS, *Contractor Entities At A Glance: Who May Contact You About Specific Centers for Medicare & Medicaid Services (CMS) Activities*, at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ContractorEntityGuide_ICN906983.pdf.

Physicians spend a great deal of time determining which contractor is auditing them, under what authority, and what the guidelines are for response. This confusion and misspent time unduly burdens physicians and contravenes the swift recoupment of improper payments to the federal government. In recognition of this inefficiency, CMS has committed to undertake an "Audit of Audits" to review the myriad federal audit contractors and identify areas of duplication. The AMA strongly supports this effort, and believes that the ultimate goal of this effort should be a reduction in conflicting and overlapping audits and audit policies.

Lastly, the AMA continues to have serious concerns with the Medicare & Medicaid RAC programs. The programs' contingency fee structure inappropriately incentivizes the RACs to conduct "fishing expeditions" that are exceedingly burdensome for physician practices. The RACs are also often inaccurate: CMS' FY2010 Recovery Auditor Report to Congress reported that 46.2 percent of the claims appealed were decided in the provider's favor. This number is far too high; these errors result in needless expense for Medicare appeals tribunals and physicians. To promote efficiency and the best use of federal funds to identify improper payments, greater oversight of RAC contractors and safeguards for physicians are needed.

Conclusion

Thank you for the opportunity to provide a statement for today's hearing. We look forward to a continued dialogue with the Oversight and Investigations Subcommittee on these important issues.

Statement for the Record
by the

American Federation of State, County and Municipal Employees (AFSCME)

for the Hearing
on

Medicare Contractors' Efforts to Fight Fraud – Moving Beyond "Pay and Chase"

Before the

Subcommittee on Oversight and Investigations
Committee on Energy and Commerce

U.S. House of Representatives

June 8, 2012

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Statement for the Record
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For the Hearing on
Medicare Contractors' Efforts to Fight Fraud – Moving Beyond "Pay and Chase"

Before the
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
U.S. House of Representatives
June 8, 2012

This statement is submitted on behalf of the 1.6 million workers and retiree members of the American Federation of State, County and Municipal Employees (AFSCME) for the hearing held June 8, 2012 on Medicare fraud.

AFSCME is proud of labor's historic role in the creation of Medicare. It is an indispensable federal social insurance program. Medicare provides what commercial health insurance companies did not, would not, and could not: affordable, adequate health coverage for America's elderly population regardless of income or health status. Before the enactment of Medicare, only half the population age 65 and older had health insurance and those who did have coverage paid close to triple what younger people paid for premiums and other out-of-pocket costs.

As a social insurance plan, Medicare's purpose is to spread risk in order to make coverage affordable for everyone. Medicare unites the resources of the entire nation to shield one generation after another of older Americans and individuals with disabilities from financial ruin in the event of illness, injury or expensive chronic conditions. All American workers contribute to fund the program and reap its benefits once they are eligible. No one is shut out because of health status or income. Medicare by design pays for all necessary medical care for beneficiaries. Medicare will pay claims without discriminating against an individual because of where they live, their history, their diagnoses or preferences.

Medicare waste, fraud and abuse takes critical resources out of our health care system, injuring all Americans. Waste, fraud and abuse in Medicare comes in many shapes and sizes. It can be the tiny clinic that bills Medicare for non-existent services. Or it can be one of the nation's largest for-profit hospital chains such as HCA Inc. (formerly known as Columbia/HCA and HCA- The Healthcare Company), whose CEO at the time of the fraud was now Florida Governor Rick Scott, that bilked Medicare and Medicaid through fraudulent billing, pled guilty to multiple felonies and ultimately paid $1.7 billion in criminal and civil penalties.

The Affordable Care Act Combats Medicare Fraud, Waste and Abuse

Fortunately, the Affordable Care Act (ACA) protects taxpayer and Medicare dollars against fraud, waste and abuse by beefing up enforcement tools, ramping up detection and pursuing those who steal, waste or abuse Medicare dollars. Below are some highlights of the many provisions in the health care reform law that help to make Medicare more secure and safe from waste, fraud and abuse.

Investing Resources to Fight Fraud.

The ACA provides $350 million in new funds to hire new officials and agents who can help prevent, identify, investigate and fight fraud.

Getting Tougher on Criminals Who Steal From Medicare.

If you commit Medicare fraud, you will see more time in prison. The law requires the U.S. Sentencing Commission to increase the federal sentencing guidelines for health care fraud offenses by 20-50% for crimes that involve more than $1,000,000 in losses. The ACA makes obstructing a fraud investigation a crime. Thanks to the ACA, it will be easier for the federal government to recapture monies acquired through fraudulent practices. It also makes investigating potential fraud or wrongdoing at nursing homes easier for the Department of Justice (DOJ).

The law gives the Office of the Inspector General (OIG) at the Department of Health and Human Services (HHS) the authority to impose stronger civil and monetary penalties on those found to have committed fraud.

HHS also has new authority to prevent providers from participating in Medicare or Medicaid, where appropriate. For example, the Secretary may reject providers and suppliers who provide false information on an application to enroll or participate in a federal health care program. Individuals who order or prescribe an item or service while being excluded from a federal health care program, make false statements on applications or contracts to participate in a federal health care program, or providers who identify a Medicare overpayment and do not return it are also subject to strict new fines and penalties under the new law. The law also helps states to terminate a provider under Medicaid if that provider is terminated under Medicare or another state's Medicaid program.

Fraud Prevention– Foiling Criminals Before They Get a Chance to Steal From Taxpayers.

Preventing fraud protects Medicare and beneficiaries. The ACA has new authority for stepped-up oversight of providers and suppliers participating or enrolling in Medicare, such as mandatory licensure checks. Based on the level of risk of fraud, waste and abuse, providers could be subject to fingerprinting, site visits and criminal background checks before they begin billing

Medicare or Medicaid. The law also allows the Secretary to withhold payment to any Medicare or Medicaid providers if a credible allegation of fraud has been made and an investigation is pending.

The ACA enhances data matching and integration to make it easier for our law enforcement agencies to identify criminals and prevent fraud among federal agencies that pay for health care. The DOJ and OIG both have clearer rights to access Medicare and Medicaid claims and payment databases.

The law beefs up surety bond requirements as a condition of doing business with Medicare. To crack down on fraud in orders and referrals from providers and suppliers who order items or services for Medicare beneficiaries, these providers and suppliers will be required to enroll in Medicare and maintain better documentation.

Recovering Medicare Overpayments, Stopping Insurance Abuse and Improving Medicare's Solvency.

The law expands Recovery Audit Contractors (RACs) in order to recover overpayments made by Medicaid, Medicare Advantage and Part D (the Medicare drug benefit). Providers, suppliers, Medicare Advantage plans, and Part D plans must self-report and return Medicare and Medicaid overpayments within 60 days of identification.

In addition to preventing fraud, the ACA will reduce waste by promoting cost-efficient delivery of quality care under Medicare in two important ways. The law taps into Medicare's purchasing power to prompt providers to do more to control their costs. These payment reforms will reduce waste but, importantly, do not affect Medicare's traditional benefits or shift costs onto beneficiaries. In fact, the law spells out loud and clear that the guaranteed benefits in Medicare Part A and Part B will not be reduced or eliminated as a result of payment reforms to the Medicare program. Secondly, the law cuts taxpayer handouts to insurance companies under the Medicare Advantage program.

By cutting waste and taxpayer handouts to insurance companies, the ACA helps reduce seniors' costs for preventative care and prescription drugs.

Conclusion

Medicare is an amazing success story – providing health and financial security to millions of Americans, even during the worst economic crisis since the Great Depression. The new health care law does much to combat waste, fraud and abuse in Medicare, but the greater threat to Medicare is not fraud – it is the House-passed budget. This Republican-championed budget will lead to the end of traditional Medicare, replacing its guaranteed benefits with a privatized system where seniors will pay more and get less. It will leave seniors at the mercy of insurance companies. It will make it harder for seniors to choose their own doctors and it will

raise seniors' costs for preventative care and prescription drugs. The House-passed budget would expose Medicare to more waste, fraud and abuse and leave beneficiaries to be preyed upon by unscrupulous criminals and insurance companies because it would abolish the new enforcement tools in the recent health care reform law that help enforcement agencies fight and detect waste, fraud and abuse in Medicare.

Mr. STEARNS. I want to thank the witnesses for coming today for the testimony and members for their devotion to this hearing today.

The committee rules provide that members have 10 days to submit additional questions for the record to the witnesses.

With that, the committee is adjourned.

[Whereupon, at 11:05 a.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

House Energy & Commerce Subcommittee on Oversight & Investigations Hearing on
"Medicare Contractors' Efforts to Fight Fraud – Moving Beyond "Pay and Chase"
June 8, 2012

Background Statement

Thank you Mr. Chairman for holding this important hearing today to address the growing problem of inadequate oversight in the Medicare program. I am disturbed that CMS engages Medicare Administrative Contractors, commonly known as MACs, to carry out Medicare payments and reviews, using taxpayer dollars, without the proper oversight.

Some months ago it was brought to my attention that a local hospital in my district had been receiving an inordinate number of claim denials, without explanation, for common procedural codes that had been previously reimbursed without issue or concern raised. Despite every effort on the part of this hospital to comply with the unclear and redundant claims review process set forth by the resident MAC for Oklahoma, Trailblazer Enterprises, the hospital continues to face claim denial rates in the range of 30 percent under the guise of improper payments and fraud investigations.

The denials stemming from the review process, and subsequent appeals by the hospital, have resulted in a net loss of over $565,000 to the hospital, impacting significantly the hospital's overall operations, and the problem is only getting worse. Over the last three months alone, over $1 million in revenue to the hospital for legitimate procedures have been delayed due to this high volume of payment reviews initiated by Trailblazer Enterprises, where reviews have been taking nearly 90 days rather than the usual 14-21 days.

Repeated efforts have been made on the part of our hospital and my staff to address this problem with CMS and Trailblazer Enterprises, in the hope of gaining clarity and guidance on the required documentation needed to approve these claims; we're still waiting. The rationale for Trailblazer's individual denials have been wholly inconsistent, and appears as if arbitrary decisions have been made to reduce the number of paid claims for specific procedures.

I commend CMS' for vocalizing their commitment to Medicare program integrity, and reducing and recovering fraudulent payments, but actions speak louder than words, and my praise stops there. Because of CMS' sub-par oversight, the hospital in my district has been placed in jeopardy of not being able to offer the high-quality care to its' patients and the Tulsa community. I have serious concerns over CMS' ability to implement effective and targeted program integrity operations to reduce waste, fraud and abuse in the Medicare program; it appears that your efforts have become misguided and lack the oversight necessary to protect those providers and facilities that enhance the Medicare provider community. I look forward to hearing your response on how you plan to address MAC oversight to improve the efficacy of these operations and protect taxpayer dollars.

Mr. Doolittle's
Additional Written Questions for the Record
"Medicare Contractors' Efforts to Fight Fraud—Moving Beyond Pay and Chase"
Committee on Energy & Commerce
Subcommittee on Oversight and Investigations
June 8, 2012

The Honorable John Sullivan

1. **In its Spring 2012 report to Congress, the Health and Human Services Office of the Inspector General recommended that CMS educate hospitals on how to submit and document a complete appeal to reduce the likelihood of an unwarranted denial. What steps is CMS taking to help hospitals avoid denials in the first place?**

Answer: The Centers for Medicare & Medicaid Services (CMS) education and outreach strategy ensures that Medicare fee-for-service (FFS) providers and suppliers are properly informed about the program, ongoing changes and new requirements under the program in a consistent and timely manner. CMS facilitates easy access to information through web tools, contact centers, training calls, education products, electronic messaging, and partnerships with national, state and local associations to ensure proper billing.

A key education component is the extensive inventory of Medicare Learning Network (MLN) national educational products which are available for FFS providers and their staff, which can be viewed at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html?redirect=/MLNProducts/. These products assure a coordinated and consistent approach to educating Medicare FFS providers and their billing and practice administration staff on Medicare-related topics such as enrollment, preventive services, claims processing, provider compliance, and payment policies. CMS uses MLN products in our provider outreach efforts to further ensure consistency as content and messaging originates from one central source.

In addition, CMS issues, on a quarterly basis, a newsletter called the Medicare Quarterly Compliance newsletter. This newsletter, which is distributed as a Medicare Learning Network document, describes those issues recently identified by the Comprehensive Error Rate Testing program, the FFS Recovery Auditors, the Office of Inspector General where there have been improper payments identified. The newsletters provide information on the errors, the Medicare policy and what providers can do to assure compliance with Medicare rules. The newsletter can be viewed at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedQtrlyComp_Newsletter_ICN904943.pdf

Ongoing maintenance and timely dissemination of educational information is designed to facilitate the FFS provider community understanding of Medicare policy/operations and requirements, and ongoing changes to program requirements, thereby promoting proper billing of the Medicare program.

2. **What is CMS doing to ensure that Recovery Audit Contractors (RACs) are completing their audits within the allotted time frame, providing notification of hospitals' appeal rights and deadlines, and not asking hospitals for charts that go unaudited?**

Answer: CMS continues to work closely with the provider communities to minimize provider burden, address issues and refine the Medicare FFS Recovery Audit program. CMS oversees the Recovery Auditors to ensure they are complying with the Recovery Audit Program process and timeframe for completing a review. For example a Recovery Auditor is required to issue a written notification of the review decision within 60 calendar days of receiving the medical records from the provider. If a Recovery Auditor is not timely with their reviews CMS can limit the number of claims that they will be allowed to review until they can consistently achieve timeliness. Failure of a Recovery Auditor to consistently complete reviews timely and accurately can and will be used as a measure of past performance for future contracts.

In addition, CMS ensures that throughout the Recovery Auditor process the providers are given information related to medical record requests and appropriate next steps. Providers receive review results letters on the status of their medical record requests. When the Recovery Auditor makes an overpayment determination the provider is sent a demand letter that includes the amount of the overpayment, due dates, and applicable appeals rights for the provider.

3. **Why are the Pre-Payment DRG's Audits being reported as Fraud and subsequent statistics being publicized that indicates unnecessary procedures are being performed? This is truly a documentation issue, not an issue of fraud.**

Answer: Every year as part of the agency's financial report, CMS is required by the Improper Payments Information Act of 2002 (IPIA), amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA) to produce an estimate of the improper payments in the Medicare program. The estimate is calculated by the Comprehensive Error Rate Testing (CERT) program and reported in the CMS and HHS annual financial reports. This estimate of improper payments is not an estimate of the rate of fraud. The CERT program uses random samples to select claims, reviewers are unable to see provider billing patterns that indicate potential fraud when making payment determinations. The CERT program does not, and cannot, label a claim fraudulent.

CMS agrees that many of the improper payments are related to non-fraudulent insufficient documentation errors that may be reversed when supporting documentation is received After the official improper payment rate is calculated and reported, providers and suppliers retain the right to submit additional documentation supporting claims found in error (within certain guidelines). In 2011, the reported improper payment rate was adjusted to prospectively account for this late activity, along with the results of appeals that occurred after the official reporting cutoff date. While it has been shown through experience that many of these errors can be reversed when supporting documentation is received, this does not negate the requirement that appropriate documentation be available when the claim determination is being made. The high incidence of insufficient documentation errors has prompted CMS to implement corrective actions to reverse such errors. For example, in FY 2011, 91% of DMEPOS improper payments were due to insufficient documentation errors. As a result of these findings, CMS began notifying ordering physicians when an DMEPOS item is selected for CERT review, reminding

them of their responsibilities to maintain documentation of medical necessity for the DMEPOS items ordered.

Additionally, CMS announced on November 15, 2011, three demonstration projects that aim to strengthen Medicare by reducing improper payments. One of those demonstrations, the Recovery Audit Prepayment Review Demonstration, will allow Medicare Fee-for-Service Recovery Auditors (RACs) to review claims before they are paid to ensure that the provider complied with all Medicare payment rules. The RACs will conduct prepayment reviews on certain types of claims that historically result in high rates of improper payments – including some categories of short inpatient hospital stay DRGs. These reviews will focus on seven states with high populations of fraud- and error-prone providers (FL, CA, MI, TX, NY, LA, IL) and four states with high claims volumes of short inpatient hospital stays (PA, OH, NC, MO) for a total of 11 states. This demonstration will not replace the ongoing MAC prepayment review program and will serve as a separate process that aims to help lower the error rate. Providers will not be subject to review for the same topic or issue by two different contractors. If the RACs or MACs identify potential fraud related to these types of DRG claims, then the contractors will refer the claims to law enforcement for further investigation.

An additional demonstration aims to reduce fraud for power mobility devices (PMD) claims, which will help ensure the sustainability of the Medicare Trust Funds and protect beneficiaries who depend upon the Medicare program. Under this demonstration, CMS will implement a Prior Authorization process for PMDs, such as scooters and power wheelchairs, for people with Fee-For-Service Medicare who reside in seven states with high incidences of fraud and improper payments(CA, IL, MI, NY, NC, FL and TX).[1] The purpose of this demonstration is to test the effectiveness of using prior authorization to develop improved methods for the prevention of improper payments and fraud. Moreover, the program will assist in preserving a Medicare beneficiary's ability to receive quality products from accredited suppliers.

4. **For some months now, a reputable hospital in my district has experienced an unacceptable number of claim denials for a small group of common procedures, despite exhaustive efforts to gain clarity and guidance from the local MAC in Oklahoma, Trailblazer Enterprises. When a local MAC is unwilling to work with the providers struggling to comply with an audit program, does CMS have the authority to help mediate when a situation, such as my hospitals, is untenable?**

Answer: Any time there is a concern about Medicare claims administration contractor performance, CMS is immediately available to work through the issues and concerns, either through its regional offices, which work directly with health care providers on a regular basis, or through agency offices in Baltimore or Washington. Over the past six months, CMS has been working with TrailBlazer and numerous health care providers in Oklahoma to clarify coverage policies and medical documentation requirements that have recently generated a higher volume of payment denials and adjustments upon claims and medical records review. CMS performs close oversight of Medicare Administrative Contractors to ensure that they are complying with performance requirements, and requires action plans in all instances where performance does not meet contract requirements.

[1] https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/PADemo.html

The Honorable Marsha Blackburn

1. **Critical to fraud investigations is the ability to uniquely identify and track the activities of a healthcare practitioner over time. To what extent has the continued prevalence of multiple practitioner identifiers (e.g., National Provider Identifier, state Medicaid identifiers, DEA number, Taxpayer Identification Number) adversely impacted the investigative process?**

Answer: Each of the multiple identifiers listed serves a unique purpose in the Federal, State medical licensure and regulatory field, the commercial insurance market, and in Medicare and Medicaid. While there is an interrelationship between these identifiers, each serves to uniquely ensure that services are provided to qualified individuals by qualified health care practitioners. For example, the National Provider Identifier (NPI) is a national standard under the Health Insurance Portability and Accountability Act (HIPAA) administrative simplification provisions and is a unique identification number for covered health care providers and health care providers that practice within covered organizations. All providers and suppliers who provide services and bill Medicare for services provided to Medicare beneficiaries must have an NPI.

The presence of multiple identifiers alone does not adversely impact the investigative process. Further, the implementation of the Automated Provider Screening (APS) system, the Fraud Prevention System (FPS), and other enrollment related verification processes work --in concert-- across numerous authentication databases to ensure the integrity of all new and existing providers and suppliers. These databases include those that validate the accuracy and relationships between applicant NPIs, DEAs, SSNs/EINs and other identifying information. The FPS and APS systems have improved CMS's ability to prevent program entry for those whose credentials are problematic upon application, and to continuously monitor the provider network and remove others from Medicare whose credentials do not meet the ongoing enrollment criteria.

2. **Would CMS be better off utilizing one unique identifier to keep tabs on a practitioner rather than numerous government identifiers that are not typically up to date?**

Answer: There is no compelling evidence that indicates utilizing one unique billing identifier would improve efficiency in claims processing or strengthen program integrity efforts. Currently, Medicare suppliers and providers are identified by a unique combination of the National Provider Identifier (NPI) and a Provider Access Transaction Number (PTAN).

The NPI is a national standard under the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification provisions and is a unique identification number for covered health care providers. A PTAN is a Medicare-only number issued to providers by Medicare contractors upon enrollment to Medicare. All providers and suppliers who provide services and bill Medicare for services provided to Medicare beneficiaries must have an NPI. When a Medicare contractor approves an enrollment and issues an approval letter, the letter will contain the PTAN assigned to the provider.

The NPI and the PTAN are related to each other for Medicare purposes. A provider must have one NPI and will have one, or more, PTAN(s) related to it in the Medicare system, representing the provider/supplier's enrollment. If the provider has relationships with one or more medical groups or practices or with multiple Medicare contractors, separate PTANs are generally assigned. Together, the NPI and PTAN identify the provider, or supplier in the Medicare program. CMS maintains both the NPI and PTAN in the Provider Enrollment, Chain and Ownership System (PECOS), the master provider and supplier enrollment system.

CMS recognizes the importance of keeping enrollment information accurate and is currently in the process of revalidating the enrollment information for providers and suppliers. Section 6401 (d) of the Affordable Care Act established a requirement for all enrolled providers and suppliers to revalidate their enrollment information under new enrollment screening criteria.

This revalidation effort applies to those providers and suppliers that were enrolled prior to March 25, 2011. CMS has structured the revalidation processes to reduce the burden on the providers by implementing innovative technologies and streamlining the enrollment and revalidation processes. The revalidation effort along with the Automated Provider Screening process will enable CMS to verify and continuously monitor the enrollment data tied to the NPI-PTAN.

3. **It's just common sense that consumers/patients are better off when we eliminate waste fraud and abuse in the healthcare system. Patients receive higher quality care and better health care services--not to mention value--when they aren't paying physicians who commit fraud. Do you agree?**

Answer: Yes, when Federal taxpayer dollars are spent on fraudulent or wasteful activities, the integrity of the Medicare and Medicaid programs is severely damaged. Fraud and abuse directly deter from CMS' goals to provide better care for our beneficiaries while also lowering health care costs. CMS is committed to detecting and preventing healthcare fraud in the Medicare and Medicaid programs. Over the last two years, CMS has implemented powerful new anti-fraud tools provided by Congress, as well as designed and implemented large-scale, innovative improvements to our Medicare and Medicaid program integrity strategy to shift beyond a "pay and chase" approach by focusing new attention on preventing fraud. Simultaneously, CMS is using the same innovative tools to further enhance our collaboration with our law enforcement partners in detecting and preventing fraud.

4. **I'm not going to go through the list of examples of medical providers and others committing fraud, engaging in illegal activities, overcharging for services, or providing unneeded or unnecessary care. These sad stories and the harm they cause patients can be found in the GAO reports, the IG reports, and, unfortunately, found regularly in our daily news. The cost of fraud and abuse in terms of human lives and health is an unforgivable tragedy. And the cost in taxpayer dollars and the quality of our health care system is embarrassing. Do you believe that health care providers who commit fraud, overcharge for services, or harm patients by providing unnecessary care negatively impact the quality of healthcare? Do you see the two working hand-in-hand?**

Answer: Health care fraud undermines the integrity of Federal health care programs. I agree that taxpayer dollars lost to fraud, waste, and abuse harm multiple parties, particularly some of our most vulnerable seniors by putting them at risk for unnecessary care. Fraudsters use our limited Federal resources for personal gain, directly working against CMS' goal to lower health care costs while providing better, more coordinated care to our beneficiaries. Eliminating the problem of fraud requires a long-term, sustainable approach that brings together beneficiaries, health care providers, the private sector, and Federal, State, and local governments and law enforcement agencies, in a collaborative partnership to develop and implement long-term solutions. The authorities in the Affordable Care Act offer additional front-end protections to keep those who intend to commit fraud out of Federal health care programs, as well as new tools for deterring wasteful and fiscally abusive practices, and promptly identifying and addressing fraudulent payment issues, which will ensure the integrity of Medicare, Medicaid and CHIP.

5. **In 2010, I wrote a letter to Sec. Sebelius making these same arguments, and making the direct connection between fraud prevention and activities that deter fraud, abuse, and waste as critical to improving the quality of care that patients receive in our federal programs. I also suggested that these very same investments the private sector makes--in predictive modeling and other screening technologies--and that CMS hopes to employ themselves, have a spillover effect on our public programs. Healthcare companies don't stop their fraud and abuse prevention activities just because a patient is in Medicare or Medicaid. These investments and efforts work across the system and hand-in-hand with the efforts of CMS. So I find it hard to understand why CMS would not include fraud prevention costs as a quality measure. I believe this is a missed opportunity for public-private partnerships that could generate significant taxpayer savings--taxpayer savings that are far greater than those delivered under the traditional pay-and-chase methods.**

Answer: CMS is working to develop updated methodologies to better measure the fraud and waste prevented by these new Fraud Prevention System (FPS) and Affordable Care Act tools, and their sentinel effects. Under the old pay and chase approach, it was much easier to track how much money is recovered after the fact. Our new front-end approach will require CMS to develop new approaches to measuring prevention. CMS is currently identifying the range of performance metrics that will fully capture the success of the FPS and will report these metrics in the first implementation year report due to Congress this fall.

However, measuring fraud prevention, similar to measuring how much fraud exists, is a difficult task because of the hidden nature of insurance fraud. Despite these difficulties, CMS continues to attempt to create a more accurate picture of the state of Medicare and Medicaid fraud and our prevention efforts.

6. **HHS has indicated significant efforts are underway to root out fraud, waste and abuse within the Medicare system. Including the Recovery Audits (RACs) and backend analytics. In a recently, CNBC expose, a task force headed by Health and Human Services Office of Inspector General and including US Secret Service, US Marshals and the Federal Bureau of Investigations were profiled tracking down and apprehending**

criminals stealing millions from the Medicare program. (http://www.cnbc.com/id/46824701) The agent in charge of the task force, Special Agent in Charge Tom O'Donnell tells CNBC there are lots of unscrupulous people getting National Provider Numbers and billing Medicare.

A. What are the checks that go into acquiring a National Provider Number for any provider or supplier that wants to bill Medicare? What sort of check is done to verify providers are legitimate, credentialed or certified and eligible to be in the Medicare program before a National Provider Number is issued?

Answer: All health care providers, as defined at 45 CFR 160.103, are eligible to obtain an NPI. This applies to all health care providers and not just those providers that are enrolled or enrolling with Medicare. National Plan and Provider Enumeration System (NPPES) collects and stores information sufficient to uniquely identify a health care provider, communicate with that health care provider if necessary, and assign an NPI. Identifying and uniquely enumerating health care providers for purposes of the NPI is separate from the process that CMS uses to enroll providers into Medicare. The assignment of the NPI does not eliminate the screening and credentialing process that Medicare uses to enroll providers for enrollment.

NPPES verifies the name/SSN/DOB combination through SSA's State Online Query (SOLQ) system if the SSN is submitted for an Entity Type 1 - Individual provider's application (while the SSN is preferable, the Claim Account Number (CAN) and Beneficiary Identification Code (BIC) may be submitted instead). If the SSN or CAN is not submitted, the Entity Type 1 provider is required to submit two proofs of identity with the completed and signed paper application (CMS-10114). For all applicants, NPPES also checks the data for consistency, checks the addresses utilizing address standardization software, and checks for duplicate submissions. When applying for the NPI, the applicant must certify (via signature on paper or by checking the certification statement checkbox online) that he/she/it meets the definition of a health care provider, as defined at 45 CFR 160.103.

Obtaining an NPI does not:

- Ensure a provider is licensed or credentialed;
- Guarantee payment by a health plan;
- Enroll a provider in a health plan;
- Turn a provider into a covered provider;
- Require a provider to conduct HIPAA transactions; or
- Change or replace the current Medicare enrollment or certification process.

All providers and suppliers who provide services and bill Medicare for services provided to Medicare beneficiaries must have an NPI and furnish them on their enrollment application. An enrollment application submitted without an NPI will be rejected. The NPI alone does not grant a provider or supplier Medicare billing privileges. Upon application to a Medicare contractor, the provider or supplier's enrollment information will be verified to ensure the provider or supplier is eligible to enroll in the Medicare program using the Automated Provider Screening (APS) process and other data sources utilized by CMS. Verification includes:

- Medicare exclusions for all entities and persons listed on the CMS-855 using the Medicare Exclusion Database and the GSA Excluded Parties List System,
- Licenses, certifications, accreditation and education requirements via the State Licensing Board websites or documentation submitted by the provider or supplier,
- Adverse legal history of the provider and all entities and persons listed on the CMS-855,
- All practice locations and phone numbers listed on the CMS-855 via telephone listings or site visits,
- Legal business names and employer identification numbers of all entities listed on the CMS-855 via IRS submitted documentation,
- Verify Name, DOB, and SSN or CAN/BIC via SSA's State Online Query (SOLQ) system,
- Date of Death via SSA's SOLQ system.

If the provider or supplier's enrollment application is approved, a Provider Transaction Access Number (PTAN) is issued. A PTAN is a Medicare-only number issued to providers by Medicare contractors upon enrollment to Medicare.

B. **Once providers and suppliers have their numbers, how do they authenticate they are the rightful individual to bill Medicare under that number? Is there any authentication function before a transaction is processed? Are they using a token or smart card to verify they are legitimate? Our concern is a lack of front end authentication and verification of providers and suppliers in order to keep criminals out of the system. So if the provider number was stolen could a criminal bill Medicare as the legitimate provider?**

Answer: CMS has embarked on an ambitious project to revalidate the enrollments of all existing 1.5 million Medicare suppliers and providers by 2015 under the new Affordable Care Act screening requirements. Since March 25, 2011, CMS has enrolled or revalidated enrollment information for approximately 217,340 providers and suppliers under the enhanced screening requirements of the Affordable Care Act. These efforts will ensure that only qualified and legitimate providers and suppliers can provide health care items and services to Medicare beneficiaries.

CMS also recently launched the Automated Provider Screening (APS) system. The APS technology is a major component of our approach to implementing the enhanced screening requirements enacted in the Affordable Care Act, and has strengthened the enrollment process and improved the controls that assist in the identification of providers and suppliers that do not meet enrollment requirements. When CMS identifies ineligible providers and suppliers, we initiate the denial of an enrollment application or revocation of billing privileges for those already enrolled. This new screening strategy is tailored to both categorical and individual provider risk, rather than a one-size-fits-all approach.

Categories of providers and suppliers in the moderate level of risk are now required to undergo a site visit prior to enrolling or upon revalidation of their Medicare billing privileges. This new requirement expanded site visits to many providers and suppliers that were previously not subject to such site visits as a requirement for enrolling in the Medicare program. In addition to announced and unannounced site visits, providers and suppliers who are designated in the high-risk level will be subject to fingerprint-based criminal background checks. CMS has estimated that approximately 50,000 additional site visits will be conducted between March 2011 and March 2015 as a result of the new Affordable Care Act screening requirements to ensure providers and suppliers are operational and meet certain enrollment requirements. CMS has completed the procurement of a national site visit contractor to increase efficiency and standardization of the site visits and the contractor has recently started performing these site visits.

7. **HHS has spent a lot of time talking about backend analytics and using predictive modeling technology to verify claims. In the financial services industry, they use both front end authentication through a card *and* backend analytics to keep fraud out of the system. These two approaches are complimentary. In fact, the US is the last G-20 nation to finally transition to chip based "Chip & PIN" credit and debit cards – VISA and MasterCard both announced they will start this transition and will begin deploying chip-based cards in the US next year. Why isn't CMS using a similar front end, chip-based card for front end authentication of both provider and beneficiaries within Medicare in conjunction with the back end analytics?**

Answer: The United States has not yet deployed the technology necessary to support the chip based cards referenced. The requisite credit/debit card terminals necessary to read and transmit the information are not yet widely deployed in the private sector. We continue to monitor technological developments in this industry and will evaluate options for Medicare as they become available.

8. **The Department of Justice estimates fraud within Medicare to be $60 billion per year. CNBC estimated Medicare and Medicaid fraud to be $80 billion per year. Many other countries use smart cards within their healthcare systems as a way to reduce administrative costs and lower fraud rates. According to the French Healthcare system, using smart cards has reduced the cost of processing a claim by 155% (originally costing €1.74 Euro to process one claim – after deploying smart cards the same claim cost only € .27 Euro cents to process). Equally interesting is that Taiwan, through their healthcare smart card program, was able to reduce fraud dramatically and bring their administrative costs down to only 2% of overall program cost. Is CMS looking at piloting or testing smart cards in Medicare and if not, why?**

Answer: CMS has begun investigating the potential application of smart card technology to the Medicare program, including the possible benefits in preventing fraud, and the costs of implementation. Additionally, the Affordable Care Act provided CMS with significant authorities to enhance its oversight of Medicare, helping shift the focus to fraud prevention by moving CMS beyond the pay-and-chase approach that had been the central focus of antifraud

efforts. These new activities are complemented by the passage of the Small Business Jobs Act of 2010 (P.L. 111-240), which required CMS to implement predictive analytics technology, and provided the resources to do so. CMS is now deploying predictive analytics technology in its Fraud Prevention System (FPS) to review all Medicare fee-for-service claims prior to payment. For the first time, CMS has a near real-time view of fee-for-service claims across claim types and the geographic zones of its claims processing contractors. This allows CMS to more easily identify fraudulent providers by detecting patterns and aberrancies.

The Honorable Cathy Castor

I believe we have made great strides in combating waste, fraud, and abuse, but we need to ensure there is due process in place so that businesses playing by the rules are not negatively impacted by these ZPIC audits. I would like for Mr. Doolittle and CMS to answer the following questions for the record:

1. **Who trains the ZPIC staff on Medicare policy and what is their experience auditing claims? Who ensures that the training is adequate?**

Answer: CMS does not train, or use an outside entity to train the zone program integrity contractors (ZPICs) on Medicare policy. The ZPIC procurements were designed to obtain the services of organizations with experience and expertise in Medicare fraud detection and prevention. The evaluation of the proposals received was predicated in large part on the extent to which the offerors had proven and demonstrable competency in Medicare and Medicare fraud detection and prevention—including review of claims. We provide guidance to ZPICs through a variety of mechanisms consistent with standard contract management practices. ZPICs are instructed on Medicare policy through statute, regulations and CMS guidance, e.g., the Program Integrity Manual (PIM) and the Statement of Work (SOW). The contractor Statement of Work specifies the statutory, regulatory and programmatic guidance that governs the contractor's work. The performance of each contractor is evaluated in the context of the statement of work.

2. **What rules govern ZPIC audit procedures?**

Answer: The authority for the ZPIC review activities includes Title 18 of the Social Security Act including sections 1812, 1816, 1832, 1833(e), 1842, 1842(a)(2)(B), 1861, 1862(a), 1862(a)(1), 1861, and 1874, and regulatory authority including 42 CFR 421.100 and 42 CFR 421.200. The PIM also, serves as guidance for performing ZPIC review for benefit integrity purposes. The ZPICs use a variety of sources when making a review determination:

- Code of Federal Regulations
- CMS Internet Only Manuals
- Local Coverage Determinations (LCDs)
- National Coverage Determinations (NCDs)
- Internal review guidelines

3. **Who is auditing the private contractor auditors? When files are requested, are there any controls on private contractors sub-contracting out the work? Are these subcontractors approved by CMS?**

Answer: All ZPIC contractors are managed according to agency policy and regulations that govern government contract management. As mentioned earlier, ZPICs are instructed on Medicare policy through statute, regulations and CMS guidance, e.g., the Program Integrity Manual (PIM) and Statement of Work (SOW). The contractor Statement of Work specifies the statutory, regulatory and programmatic guidance that governs the contractor's work. The performance of each contractor is evaluated in the context of the statement of work. If a ZPIC chooses to utilize a subcontractor or subcontractors to fulfill any of its contractual responsibilities, including any review of records submitted by an individual or entity under any type of review, that is permissible. However, all work performed by both the prime contractor and any subcontractor is evaluated by the CMS Contracting Officer Representative (COR), as a part of the ongoing contract monitoring and oversight. Subcontractors must follow all Medicare requirements and are approved by CMS.

4. **What is the standard for placing someone on 100% prepayment review?**

Answer: CMS does not impose prepayment review lightly; indeed, we regard it as one of our most substantial administrative actions available. A number of factors are taken into account before placing a provider or supplier on 100% prepayment review.[2] The decision is made on a case-by-case basis, e.g. money at risk, losses to the Trust Fund, and number of claims subsequently denied as a result of the prepay review.

5. **Why can't the ZPIC be required to give written notice to the provider that they have formally been put on prepayment review, including the basis for the review, and an opportunity for due process at *that* point, either to challenge or confront the ZPIC decision?**

Answer: ZPICs are not required to provide written notice to the providers or suppliers because such notice may interfere with an active fraud or abuse investigation or case. Additional Documentation Requests (ADRs) are automatically generated by the MAC when a provider is on prepayment review and the ADRs serve to provide written notice. Until a ZPIC makes a decision about any particular claim submitted by a provider or supplier, no final administrative action has been taken and therefore there is no ability to appeal. Once a decision has been made on a particular claim, the provider or supplier has appeal rights on the ZPIC decision.

6. **What protections are there for the provider to challenge prepayment review?**

Answer: The provider is afforded full claims appeal rights.[3] A provider may appeal any claims processing decision that results in a claim denial.

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[2] http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c03.pdf
[3] http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedicareAppealsProcess.pdf

7. What is the process of getting off 100% prepayment review?

Answer: Providers and suppliers are put on prepayment review because their claims do not meet Medicare requirements—either payment policy or basic claims preparation and submission requirements. All providers and suppliers are educated about proper claims submission requirements when they first enroll in Medicare and are given additional training and instruction if needed subsequently. CMS makes substantial information on compliance requirements available on www.cms.gov.[4] Providers and suppliers who are subject to prepayment review are in violation of one or more Medicare requirements and are likely submitting claims that are not supported by the records and documentation supplied by the provider or supplier. Providers that are seeking to be removed from prepayment review must ensure the claims that are subject to the prepayment review process are supported by documentation, medical records, or other information that substantiates the billed services. Providers and suppliers that submit claims and the appropriate supporting documentation that meet Medicare requirements will be taken off of prepayment review.

8. Is CMS looking to implement deadlines for the contractors to respond to the records provided by the business being audited?

Answer: Because each instance of prepayment review may differ from all others, it is difficult to develop a single standard for processing times. Some cases of prepayment review may be complex and require a longer assessment, and others may be much easier to resolve. However, each case is unique and response times vary on a case by case basis. As mentioned above, each ZPIC contract is managed via a Contracting Officer Representative (COR). The COR is responsible for assuring that the processes included in the contractor's Statement of Work are followed—including any instances when processing times are called into question. Due to the constraints specified above we are exploring approaches to develop and include in ZPIC contracts some form of timeliness measures.

9. Providers have informed me that it is difficult to talk with someone from the ZPIC. Is CMS working on communication standards for the auditors?

Answer: CMS expects all contractors to achieve good customer service. The ZPICs have established phone lines for providers and suppliers to contact them. As set forth in the ZPIC Umbrella Statement of Work (USOW), the ZPICs shall be available on an ad hoc basis to respond to questions regarding ZPIC denials and shall respond to denial inquiries within two business days. Periodically, CMS receives comments directly from providers and suppliers and from their elected officials that ZPICs have not responded promptly as required in their contract. We review these concerns thoroughly and address them promptly when we receive them.

[4] http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html