



U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES  
OFFICE OF INSPECTOR GENERAL

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 Contractors (PSC) to detect and deter fraud in Medicare Parts A and B.<sup>1</sup> 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).<sup>2</sup>

---

<sup>1</sup> Through the years, some PSCs were given responsibility for both Parts A and B while others only Part A or Part B.

<sup>2</sup> 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 Contractors (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.<sup>3</sup> 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.<sup>4</sup> 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.<sup>5</sup> 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.<sup>6</sup>

#### **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

<sup>3</sup> OIG, *Carrier Fraud Units* (OEI-05-94-00470), November 1996 and *Fiscal Intermediary Fraud Units* (OEI-03-97-00350), November 1998.

<sup>4</sup> OIG, *Medicare’s Program Safeguard Contractors: Activities to Detect and Deter Fraud and Abuse* (OEI-03-06-00010), July 2007.

<sup>5</sup> OIG, *Zone Program Integrity Contractors’ Data Issues Hinder Effective Oversight* (OEI-03-09-00520), November 2011.

<sup>6</sup> 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.<sup>7</sup>

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

---

<sup>7</sup> 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.<sup>8</sup>

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

---

<sup>8</sup>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.<sup>9</sup> 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.<sup>10</sup> 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

---

<sup>9</sup> OIG, *Addressing Vulnerabilities Reported by Medicare Benefit Integrity Contractors* (OEI-03-10-00500), December 2011.

<sup>10</sup> 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.