



The Committee on Energy and Commerce

Internal Memorandum

June 5, 2012

TO: Members, Subcommittee on Oversight and Investigations

FROM: Subcommittee on Oversight and Investigations Staff

RE: Hearing on “Medicare Contractors’ Efforts to Fight Fraud – Moving Beyond ‘Pay and Chase’”

On Friday, June 8, 2012, at 9:30 a.m. in room 2123 of the Rayburn House Office Building, the Subcommittee on Oversight and Investigations will hold a hearing entitled “Medicare Contractors’ Efforts to Fight Fraud – Moving Beyond ‘Pay and Chase’.”

To combat fraud, the U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) contracts with a number of private entities to conduct program integrity activities such as preventing, detecting, and recovering fraudulent Medicare payments. The purpose of the hearing is to examine CMS oversight of its Medicare contractors and to identify ways to improve the contractors’ effectiveness at preventing and combating fraud.

I. WITNESSES

One panel of witnesses will testify at the hearing:

Mr. Robert A. Vito
Regional Inspector General, Office of Evaluations and Inspections
Office of Inspector General
U.S. Department of Health and Human Services

Ms. Kathleen M. King
Director, Health Care
U.S. Government Accountability Office

Mr. Ted Doolittle
Deputy Director, Center for Program Integrity
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services

II. BACKGROUND

Since 1990, the Government Accountability Office (GAO) has designated Medicare as a Federal program at high risk for fraud and abuse. Although estimates of the dollar amount lost to health care fraud can vary greatly, analysts agree that tens of billions of dollars are lost every year.¹ The most common types of fraud include: billing for services that were not performed or billing for a higher level of service than was performed; billing for equipment that was not delivered; the use of another individual's Medicare card to obtain care, supplies, or equipment; and billing for home medical equipment after it was returned. While anti-fraud efforts have rightfully shifted towards prevention, Medicare is required to process and pay most claims within thirty days, making it hard to conduct thorough prepayment reviews and completely pivot away from a "pay and chase" approach. Regardless of the approach employed, Medicare contractors are often the first and last line of defense against fraud and abuse.

As the agency responsible for administering Medicare, CMS contracts with a number of private entities to conduct various anti-fraud activities. In April 2010, CMS consolidated responsibility for administering and monitoring "program integrity" efforts, including contractor oversight, under a newly created organizational entity, the Center for Program Integrity (CPI). CMS identified CPI's overarching mission to be "protecting the Trust Funds and other public resources against losses from fraud and other improper payments and to improve the integrity of the health care system."² Since 1997, CMS has contracted with Program Safeguard Contractors (PSCs) to detect and investigate potential Medicare fraud and abuse in Medicare Parts A and B. CMS is in the process of transitioning the PSC anti-fraud activities to newly established zone program integrity contractors (ZPICs), though the contract recipients are primarily the same entities with the same capabilities. Program integrity activities for all claim types (Medicare Parts A, B, C, and D) will now be conducted under a single ZPIC contract for each geographic area, or zone, of which there are seven across the country. CMS has informed this Committee that contracts have now been awarded to ZPICs for six of the seven zones. For Zone 6, the Northeast region, CMS asserted that the award is currently under protest and that "CMS is providing benefit integrity oversight and monitoring via the Program Safeguard Contractors."

Currently, the PSCs/ZPICs analyze data to identify improper billing patterns, perform provider audits, investigate fraud leads, refer cases to the HHS/Office of Inspector General (OIG) or U.S. Department of Justice (DOJ) for prosecution, and implement administrative actions to recover improper payments. PSCs/ZPICs do not collect overpayments, but refer suspected overpayments to claims processors, such as Medicare Administrative Contractors (MACs).

CMS also contracts with Medicare Drug Integrity Contractors (MEDICs) to conduct program integrity activities primarily in Medicare Part D. MEDICs perform similar functions as

¹ The Federal Bureau of Investigation (FBI) refers to estimates of 3-10% of all health care billings as potentially fraudulent, see Annual Financial Crimes Report available at http://www.fbi.gov/publications/financial/fcs_report2008/financial_crime_2008.htm#health.

² Department of Health and Human Services, Fiscal Year 2012 Centers for Medicare and Medicaid Services, Justification of Estimates for Appropriations Committees.

PSCs/ZPICs, including data analysis to identify patterns of erroneous billing, investigation, development of fraud and abuse cases, referral of cases to the HHS/OIG or DOJ for prosecution, and implementation of administrative actions.

In order to better understand the effectiveness of such efforts as well as determine whether CMS is conducting adequate oversight of these contractors, Subcommittee staff met on a bipartisan basis with officials from CMS. Documents provided by the agency revealed that from the beginning of 2009 through 2011, PSCs/ZPICs recovered only 10 percent of the overpayments they identified. These documents also showed that several performance measures used to track the contractors decreased from 2007 through 2011. The number of cases the contractors referred to law enforcement agencies, the total number of investigations initiated by the contractors, and the number of investigations the contractors developed through proactive data analysis all dropped substantially during this five-year period.

In addition, a study by HHS/OIG concluded that the overpayments PSCs identified and referred for collection did not result in significant recoveries to the Medicare program. The OIG found that the PSCs identified 4,239 overpayments totaling \$835 million during 2007, but that only 7 percent of the overpayment amount had been collected by claims processors as of June 2008.³ These figures highlight the challenges in recovering funds once fraud has occurred, and illustrate the need for contractors to engage in more proactive investigation to prevent fraud before the claims are paid.

III. ISSUES

The following issues will be examined at the hearing:

- CMS oversight of the PSCs/ZPICs, MACs and MEDICs;
- The performance of the program integrity contractors, including their effectiveness at identifying and recovering fraudulent overpayments, the number of proactive investigations they initiated, their use of provider suspension authorities, and their investigative referrals to law enforcement agencies; and,
- Ways to enhance the effectiveness of the program integrity contractors.

IV. CONTACTS

If you have any questions about this hearing, please contact Todd Harrison or John Stone at (202) 225-2927.

³ HHS/OIG Report # 03-08-00030, "Collection Status of Medicare Overpayments Identified by Program Safeguard Contractors", pg.ii.