THE COMMITTEE ON ENERGY AND COMMERCE

Memorandum

June 23, 2014

TO: Members, Subcommittee on Oversight and Investigations

FROM: Subcommittee on Oversight and Investigations Staff

RE: Hearing on "Medicare Program Integrity: Screening Out Errors, Fraud, and Abuse"

On Wednesday, June 25, 2014, at 10:00 a.m. in 2123 Rayburn House Office Building, the Subcommittee on Oversight and Investigations will hold a hearing entitled "Medicare Program Integrity: Screening Out Errors, Fraud, and Abuse."

The Subcommittee is following up on recent laws and reports that either authorize or recommend further actions that could be taken to protect Medicare from errors, fraud, and abuse. The U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) has also intensified efforts to address Medicare fraud, waste, and abuse. The purpose of the hearing is to review key recommendations, assess ongoing efforts, and identify additional actions that could be taken or expedited.

I. WITNESSES

One panel of witnesses will testify at the hearing:

- Shantanu Agrawal, M.D., Deputy Administrator and Director, Center for Program Integrity, Centers for Medicare and Medicaid Services;
- Gary Cantrell, Deputy Inspector General for Investigations, Office of Inspector General, Department of Health and Human Services;
    - *Accompanied by* Gloria L. Jarmon, Deputy Inspector General for Audit Services, Office of Inspector General, Department of Health and Human Services; and,
- Kathleen M. King, Director, Health Care, U.S. Government Accountability Office.

II. BACKGROUND

Since 1990, the Government Accountability Office (GAO) has designated Medicare as a Federal program at high risk for fraud and abuse.[1] As noted by GAO and others, Medicare's vulnerability to fraud and abuse arises from the program's size, complexity, decentralization, and administrative requirements. Other emerging trends, such as the expansion of electronic medical records, also increase the vulnerability.[2]

In 2013, Medicare financed health care services for approximately 51 million individuals at a cost of about $604 billion, and reported some of the largest improper payments among Federal programs.[3] The Centers for Medicare and Medicaid Services has estimated that improper payments in the Medicare program were almost $50 billion in fiscal year (FY) 2013, about $5 billion higher than in 2012.[4] In its FY 2013 Agency Financial Report, the HHS reported $36 billion in improper payments for Medicare Fee-for-Service, $11.8 billion for Medicare Advantage (Part C), and $2.1 billion for Medicare Prescription Drug Benefits Program (Part D).[5] While the Department reported reductions in improper payment rates for 5 of the programs (including Part C), there also were reported increases in gross improper payment rates for Fee-for-Service (from 8.5 percent in FY 2012 to 10.1 percent in FY 2013) and Part D (from 3.1 percent in FY 2012 to 3.7 percent in FY 2013).[6] By having a Fee-for-Service improper payment rate that exceeded 10 percent, HHS did not comply with one of the requirements of the Improper Payments Information Act of 2002, as amended.[7]

Although estimates of the dollar amount lost to health care fraud can vary greatly, the full extent of the problem is unknown.[8] However, several analysts agree that tens of billions of dollars are lost every year.[9] 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.

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[1] Testimony of Kathleen M. King, GAO, before the House Committee on Ways and Means, Subcommittee on Health, April 30, 2014. See also, GAO, High-Risk Series: An Update, GAO-13-283, (February 2013).

[2] Fred Schulte, "Growth of electronic medical records eases path to inflated bills," Center for Public Integrity, September 19, 2012. Reed Abelson, Julie Creswell, and Griff Palmer,"Medicare Bills Rise as Records Turn Electronic," New York Times, September 21, 2012. JASON, The MITRE Corporation, "A Robust Health Data Infrastructure," prepared for Agency for Healthcare Research and Quality, AHRQ Publication No. 14-0041-EF, April 2014, at 56: "Paradoxically, initial launches of local and regional EHR systems have generally been met with increases in health care costs, rather than the decreases one might expect if fraudulent activity were more transparent." JASON is an independent scientific advisory group run through the MITRE Corporation, and the name is sometimes explained as an acronym for "July August September October November."

[3] King-GAO testimony, *supra* note 1 at 1-2.

[4] *Id*.

[5] Testimony of Gloria L. Jarmon, Deputy Inspector General for Audit Services, Office of Inspector General, U.S. Department of Health and Human Services, before the House Committee on Ways and Means, Subcommittee on Health, April 30, 2014.

[6] *Id.* at 2.

[7] *Id*. at 3.

[8] King-GAO testimony, *supra* note 1 at 1.

[9] 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.

Fraud also may involve payments made to beneficiaries who obtain their Medicare number for fraudulent billing purposes. According to the HHS Office of Inspector General (OIG), between 2009 and 2011, CMS mistakenly paid $190 million in health care payments, including: $23 million to dead people;[10] $92 million to "unlawfully present" persons;[11] $34 million to service providers for beneficiaries who were in jail, even though prisons typically provide for the medical care of inmates;[12] and $40 million on prescription drug subsidies for undeserving beneficiaries.[13]

CMS recently has intensified its efforts to combat fraud, waste, and abuse in the Medicare program. Pursuant to the Patient Protection and Affordable Care Act (PPACA), CMS implemented categorical risk-based screening of providers and suppliers who want to participate in the Medicare program starting in March 2011.[14] The enhanced screening requires certain categories of providers and suppliers that historically have a higher risk of fraud to undergo greater scrutiny prior to their enrollment or revalidation in Medicare.[15] The existing 1.5 million Medicare suppliers and providers have been subjected to new screening requirements since March 2011. CMS also is collaborating with States "to ensure that those caught defrauding Medicare will not be able to defraud Medicaid, and those identified as fraudsters in one State will not be able to replicate their scams in another State's Medicaid program."[16]

Under the PPACA, the Secretary has authority to impose a temporary moratorium on the enrollment of Medicare, Medicaid, or Children's Health Insurance Program (CHIP) providers and suppliers, if the Secretary determines the moratorium is necessary to prevent or combat fraud, waste, or abuse under these programs. During the last year, CMS has used this authority

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[10] Medicare Payments Made on Behalf of Deceased Beneficiaries in 2011, OEI-04-12-00130, October 30, 2013, available at http://oig.hhs.gov/oei/reports/oei-04-12-00130.asp.

[11] Medicare Improperly Paid Providers Millions of Dollars for Unlawfully Present Beneficiaries Who Received Services During 2009 Through 2011, A-07-12-01116, January 23, 2013, available at https://oig.hhs.gov/oas/reports/region7/71201116.asp. OIG identified more than $26 million in improper payments under Part C to unlawfully present beneficiaries. See Medicare Improperly Paid Medicare Advantage Organizations Millions of Dollars for Unlawfully Present Beneficiaries for 2010 Through 2012, A-07-13-01125, April 23, 2013, available at http://oig.hhs.gov/oas/reports/region7/71301125.asp. OIG identified more than $29 million in gross drug costs related to unlawfully present Part D beneficiaries. Medicare Improperly Paid Millions of Dollars for Prescription Drugs Provided to Unlawfully Present Beneficiaries During 2009 Through 2011, A-07-12-06038, October 30, 2013, available at http://oig.hhs.gov/oas/reports/region7/71206038.asp.

[12] Medicare Improperly Paid Providers Millions of Dollars for Incarcerated Beneficiaries Who Received Services During 2009 Through 2011, A-07-12-01113, January 23, 2013, available at http://oig.hhs.gov/oas/reports/region7/71201113.asp.

[13] For example, OIG found Medicare paid almost $12 million for prescription drug costs for incarcerated beneficiaries. Medicare Improperly Paid Providers Millions of Dollars For Prescription Drugs Provided To Incarcerated Beneficiaries During 2006 Through 2010, A-07-12-06035, January 2014, available at http://oig.hhs.gov/oas/reports/region7/71206035.asp. OIG also identified more than $29 million in gross drug costs related to unlawfully present Part D beneficiaries. Medicare Improperly Paid Millions of Dollars for Prescription Drugs Provided to Unlawfully Present Beneficiaries During 2009 Through 2011, A-07-12-06038, October 30, 2013, available at http://oig.hhs.gov/oas/reports/region7/71206038.asp.

[14] Statement of Shantanu Agrawal, M.D., Deputy Administrator and Director, Center for Program Integrity, Centers for Medicare & Medicaid Services before the House Ways and Means Subcommittee on Health, April 30, 2014.

[15] *Id.*

[16] *Id.*

to impose temporary moratoria on the enrollment of new home health agencies and ambulance companies in several "fraud hot spot" metropolitan areas of the country.[17]

Pursuant to the Small Business Jobs Act of 2010, CMS has been using the Fraud Prevention System (FPS) to apply advanced analytics on all Medicare fee-for-service claims on a streaming, national basis. CMS reports that the models in the FPS have led to administrative actions, such as the use of revocation authority to remove bad actors from the Medicare program. In calendar year (CY) 2012, CMS revoked 11,279 providers from Medicare, a significant spike from the 2,783 revocations in CY 2011. In CY 2013, CMS revoked 3,807 providers.[18] As reported in the FPS FY 2012 Report to Congress,[19] in its first year of implementation, the FPS stopped, prevented, or identified an estimated $115.4 million in improper payments. CMS has touted the Fraud Prevention System as a way of ending "pay and chase." However, the CMS report to Congress on the second year of implementation of FPS was due October 1, 2013, and still has not been issued.

Notwithstanding these efforts, concerns continue to be raised about a permissive approach that allows providers with questionable backgrounds to keep billing taxpayers. For example, Bloomberg reported that at least 7 doctors who had lost a medical license because of misconduct collected a total of $6.5 million from Medicare in 2012.[20] Another analysis found that doctors who had been charged with Medicare fraud over the last 16 months were paid $17 million of taxpayer money in 2012.[21] In a November 4, 2013 letter to CMS, Chairman Thomas R. Carper and Ranking Member Tom Coburn of the Senate Homeland Security and Governmental Affairs Committee said that their committee staff identified 16 physicians who were enrolled in the Medicare program and who have been convicted of a crime that requires CMS to exclude the individual from participation in Medicare.[22] The Senate Committee found 5 more such doctors days after the letter.[23] As of last week, Majority staff for the House Energy and Commerce Committee found that 11 of the 21 physicians on the Senate Committee list still were not excluded.

Finally, Majority Committee staff identified at least 14 individuals convicted of FDA-related crimes currently debarred by the FDA, but do not appear to be excluded from Medicare.[24]

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[17] *Id.* at 4. These areas are: Miami, Chicago, Houston, Fort Lauderdale, Detroit, Dallas, and Philadelphia (on ground ambulances).

[18] April 30, 2014 letter from Shantanu Agrawal, MD, CMS to House Energy and Commerce Committee requestors.

[19] http://www.stopmedicarefraud.gov/fraud-rtc12142012.pdf.

[20] David Armstrong and Caroline Chen, "Doctors Get Millions From Medicare After Losing Their Licenses," Bloomberg, April 28, 2014.

[21] Jonathan Easley and Elise Viebeck, "Indicted docs got Medicare millions," The Hill, April 10, 2014.

[22] Letter from Chairman Thomas R. Carper and Ranking Member Tom A. Coburn, M.D., Senate Committee on Homeland Security and Governmental Affairs, to The Honorable Marilyn Tavenner, Adminstrator, CMS, November 4, 2013.

[23] Dan Mangan, "Senators: Medicare felons on 'OK-to-pay' list despite ban," cnbc.com, December 16, 2013, available at http://www.cnbc.com/id/101276154.

[24] The OIG exclusion database does not show past exclusions and reinstatements. The database also does not list the length of time of the exclusion. There is no public record of the exclusion length because many people do not get reinstated right away and remain excluded. According to the OIG, the list would be ambiguous if it listed the term; people would assume the exclusion is lifted after the period of years.

In one case, a doctor who pled guilty to injecting more than 800 victims with unapproved Botulinum toxin was both excluded and debarred. However, the co-defendant nurse who also pled guilty, with a one-year prison sentence and a FDA debarment, is not excluded under either her FDA-debarred name or alias.[25] In addition, staff identified a doctor who pled guilty to an FDA-related mail fraud felony in 2007, was permanently debarred by FDA in 2009, but is not excluded from Medicare and received over $86,000 in Medicare payments in 2012.[26] Staff also identified 4 other doctors who entered guilty pleas in the 2006-08 period, were debarred by FDA before or during 2012, but who received over $900,000 in Medicare payments in 2012. Another doctor who entered a guilty plea in 2002, whose FDA debarment was in effect during 2012, received over $38,000 in Medicare payments in 2012. All told, staff identified from the FDA debarment list that there were 6 doctors with guilty pleas entered before 2009, and debarred by FDA, who received over $1 million in Medicare payments in 2012.[27]

According to OIG staff, the Medicare exclusion database contains about 57,000 names, adds about 3,200 – 3,500 names each year, and reinstates about 600 names each year.[28] Although the exclusion program was established more than three decades ago, OIG staff members were not aware of any recent audits or evaluations of the program.[29] The exclusion database receives information from required, direct referrals from OIG investigations and Medicare Fraud control units, and voluntary information from Federal (FBI, DEA, VA), State, and local law enforcement.[30]

The OIG announced that in FY 2013, its fraud, waste, and abuse prevention and enforcement efforts in the Health Care Fraud and Abuse Control (HCFAC) program resulted in a record-breaking recovery of $4.3 billion in taxpayer dollars from individuals trying to defraud Federal health care programs serving seniors and taxpayers.[31] Over the last 5 years, these enforcement efforts have recovered $19.2 billion, up from $9.4 billion over the prior five-year period.[32] Over the last 3 years, the average investment of the HCFAC program is $8.10 for every dollar spent, which is an increase of $2.70 over the average ROI for the life of the HCFAC program since 1997.[33] However, due to reduced funding, OIG is currently in a hiring freeze and has lost over 200 people over the past two years. As a result, OIG has fewer resources available to fight Medicare and Medicaid fraud. Due to lack of resources, OIG has closed over 2,200 investigative complaints, and by the end of FY 2014, the OIG expects to reduce Medicare and Medicaid oversight by 20 percent.[34] OIG already has lost 20 percent of its Strike Force agents. An independent report noted that this reduction in OIG fraud detection staff, corresponds to about one fourth of its employees in this area, and is in opposition to the intended goal of an

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[25] OIG reported to staff that this individual had been excluded for seven months, and then was reinstated.
[26] OIG confirmed to staff that there was no record of an exclusion under the name of this doctor.
[27] OIG confirmed to staff that there was no record of an exclusion under each of the names of these individuals.
[28] OIG staff briefing for House Energy and Commerce Committee bipartisan staff, June 19, 2014.
[29] *Id.*
[30] *Id.*
[31] http://oig.hhs.gov/publications/docs/hcfac/FY2013-hcfac.pdf.
[32] Agrawal-CMS, supra note 14 at 1.
[33] *Id.*
[34] Joe Carlson, "HHS inspector general's funding cuts will hurt fraud probes," Modern Healthcare, July 26, 2013, available at http://www.modernhealthcare.com/article/20130726/NEWS/307269996.

HHS initiative to prevent health care fraud.[35] The report also found that "[t]his reduction in staff is likely to reduce actions taken by CMS in response to their existing predictive analytics software that is designed to spot patterns of fraud."[36]

While CMS has taken many actions, the GAO and the OIG have found that CMS has not fully implemented other actions authorized by the PPACA.[37] These unimplemented actions include:

- *Surety Bonds*: PPACA authorized CMS to require a surety bond for certain types of at-risk providers and suppliers. The bonds also could serve as a source for recoupment of erroneous payments. CMS reported in April 2014 that it had not scheduled for publication a proposed rule to implement the surety bond requirement.

- *Providers and Suppliers Disclosure*: CMS has not scheduled a proposed rule for publication for increased disclosures of prior actions taken against providers and suppliers enrolling or revalidating enrollment in Medicare, as authorized under the PPACA, such as whether the provider or supplier has been subject to a payment suspension from a Federal health care program.

- *Compliance Program*: CMS has not established the core elements of compliance programs for providers and suppliers.

GAO also recommended that CMS increase its use of automated prepayment edits to prevent improper payments and strengthen post-payment review to identify and recoup improper payments.[38] GAO noted in April 2014 that CMS had addressed "some" of these recommendations.[39] GAO has made multiple recommendations to CMS to remove Social Security numbers from beneficiaries' Medicare cards to help prevent identify theft, but CMS has not taken action on these recommendations.[40] HHS has agreed with the recommendations, but reported CMS could not proceed for several reasons, including funding limitations.

In reports and in testimony, the OIG has issued numerous recommendations to improve CMS's Medicare oversight. Among the key recommendations are:

- Implement policies and procedures to detect and recoup improper payments made to unlawfully present and incarcerated beneficiaries.
- Identify and recoup improper payments made on behalf of entitlement-terminated beneficiaries and establish policies and procedures to prevent additional improper payments.
- Improve existing safeguards to prevent payments to deceased beneficiaries.

[35] JASON report, supra note 2 at 56.
[36] *Id.*
[37] See GAO testimony, *supra* note 1, and HHS OIG testimony, *supra* note 5.
[38] GAO testimony, *supra* note 1.
[39] *Id.*
[40] *Id.* at16.

- Require mandatory reporting by Part C and Part D plans of potential fraud and abuse incidents, and use the data from the reporting for monitoring or oversight purposes.

The OIG testified in April 2014 that more action is needed from CMS.[41]

The April 2014 JASON Report, prepared for the Agency for Healthcare Research and Quality, found that "[e]lectronic access to health data will make it easier to identify fraudulent activity, but at present there is little effort to do so using EHRs."[42] The report recommended: "Large-scale data mining techniques and predictive analytics should be employed to uncover signatures of fraud. A data enclave should be established to support the ongoing development and validation of fraud detection tools to maintain their effectiveness as fraud strategies evolve."[43]

III. ISSUES

The following issues will be examined at the hearing:

- Is CMS implementing the outstanding GAO, OIG, and JASON Report recommendations to strengthen Medicare oversight? What is the status of implementation?

- What additional sets of data can be made available and shared to prevent Medicare fraud, waste, and abuse?

- Is CMS using all the tools at its disposal to mitigate vulnerabilities to the Medicare program?

- How is CMS using State data captured by the Federation of State Medical Boards that could be used as an early-warning system to flag bad providers?

IV. CONTACTS

If you have any questions about this hearing, please contact Alan Slobodin, Sean Hayes, or Emily Newman at (202) 225-2927.

[41] HHS-OIG testimony, *supra* note 5.
[42] JASON Report, *supra* note 2 at 57.
[43] *Id.*