Testimony of:
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U.S. Department of Health and Human Services

Hearing:
"Ideas to Improve Medicare Oversight
To Reduce Waste, Fraud, and Abuse"

House Committee on Ways and Means
Subcommittee on Health

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Good afternoon, Chairman Brady, Ranking Member McDermott, and other distinguished Members of the Subcommittee. Thank you for the opportunity to testify about the U.S. Department of Health and Human Services (the Department) Office of Inspector General's work to improve Medicare oversight to reduce waste, fraud, and abuse. Fighting waste, fraud, and abuse in Medicare and other Department programs is a top priority. We use a range of tools in this fight, including audits, evaluations, investigations, enforcement authorities, and educational outreach.

The key takeaway from my testimony today is that more action is needed from the Centers for Medicare & Medicaid Services (CMS), its contractors, and the Department to reduce improper Medicare payments and billings and improve oversight of its Medicare contractors. Reducing improper payments and improving the oversight of contractors are two of the Department's top management and performance challenges and are critical to reducing Medicare waste, fraud, and abuse.

CMS Should Further Reduce Improper Medicare Payments

Improper Medicare payments cost taxpayers and beneficiaries about $50 billion a year. For fiscal year (FY) 2013, the Department reported improper payment information for eight programs that the Office of Management and Budget deemed susceptible to significant improper payments. Three of these programs were Medicare related: Medicare Fee-for-Service (Fee-for-Service), Medicare Advantage (Part C), and the Medicare Prescription Drug Benefits Program (Part D). In its FY 2013 Agency Financial Report,[1] the Department reported $36 billion in improper payments for Medicare Fee-for-Service, $11.8 billion for Part C, and $2.1 billion for Part D.

The Department has achieved some success in reducing improper payment rates.[2] In the FY 2013 Agency Financial Report, the Department reported reductions in rates for five of the Department's programs, including Part C. However, the Department reported increases in gross improper payment rates for Fee-for-Service (from 8.5 percent in FY 2012 to 10.1 percent in

[1] *Department of Health and Human Services FY 2013 Agency Financial Report,* available at http://www.hhs.gov/afr/2013-hhs-agency-financial-report.pdf.

[2] *U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for Fiscal Year 2013*, A-17-14-52000, April 15, 2014, available at http://oig.hhs.gov/oas/reports/other/171452000.asp.

FY 2013) and Part D (from 3.1 percent in FY 2012 to 3.7 percent in FY 2013). By having a Fee-for-Service improper payment rate that exceeded 10 percent, the Department did not comply with one of the requirements of the Improper Payments Information Act of 2002, as amended.[3]

Our recent audits and evaluations have identified opportunities to reduce improper payments throughout the Department, including three areas critical to Medicare program integrity: payments made on behalf of ineligible beneficiaries, payments for prescription drugs, and payments to hospitals.

Reducing Improper Medicare Payments on Behalf of Ineligible Beneficiaries

We have uncovered improper Medicare payments on behalf of unlawfully present, incarcerated, entitlement-terminated, and deceased beneficiaries. Obtaining more accurate and timely information that would trigger payment edits would help Medicare avoid these improper payments.

Unlawfully Present Beneficiaries. Medicare benefits are not allowable for services provided to unlawfully present beneficiaries.[4] Although CMS has procedures to identify these beneficiaries, CMS did not always prevent and detect improper payments:

- For Fee-for-Service – CMS prevented improper payments when it received unlawful presence information before the Medicare contractor processed a claim. However, when the information was not timely, CMS's controls were not adequate to detect and recoup the improper payment. We identified more than $91 million in improper payments.

- Part C – CMS did not have policies and procedures to notify the Part C plans of the unlawful-presence information in its data systems. As a result, Part C plans could neither prevent unlawfully present beneficiaries from enrolling nor could the Part C plans disenroll beneficiaries whose unlawful-presence status changed after they had enrolled. We identified more than $26 million in improper payments.[5]

[3] The IPIA has been amended by the IPERA as well as the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA; P.L. No. 112-248).

[4] Federal health care benefits are generally allowable when provided to a beneficiary who is either a U.S. citizen or a U.S. national or to an alien who is lawfully present in the United States. But when the alien beneficiary is not lawfully present in the United States (unlawfully present), Federal health care benefits are not allowable.

[5] *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.

- Part D – CMS also lacked policies and internal controls to identify and disenroll unlawfully present beneficiaries and to automatically reject prescription drug event (PDE) records associated with those beneficiaries. We identified more than $29 million in gross drug costs related to unlawfully present Part D beneficiaries.[6]

Incarcerated Beneficiaries. With certain exceptions, prisons (instead of Medicare) pay for the health care of incarcerated individuals who are otherwise eligible for Medicare. However, CMS does not always receive timely updates regarding incarceration information before Medicare contractors pay providers on behalf of incarcerated beneficiaries. In these instances, CMS's controls were not adequate to detect and recoup the improper payment. We identified more than $33 million in improper Fee-for-Service payments.[7]

Entitlement-Terminated Beneficiaries. We identified more than $18 million of improper Fee-for-Service payments made on behalf of beneficiaries whose entitlement to Medicare had been terminated.[8] These improper payments occurred because CMS's data systems did not always indicate that a beneficiary's entitlement had been terminated until after a claim had been processed. In addition, CMS did not have policies and procedures to review such information after payment that would have flagged improper payments that could not be detected before payment. Consequently, CMS had not notified the Medicare contractors to recoup any of the improper payments that we identified.

Deceased Beneficiaries. We have identified millions in Medicare payments made on behalf of deceased beneficiaries. Although CMS has safeguards to prevent and recover these payments, it inappropriately paid $23 million in 2011 for deceased beneficiaries. Most of these improper payments occurred despite CMS having accurate information on beneficiaries' date of death. Eleven percent of these improper payments occurred because dates of death were either missing from CMS's Enrollment Database or were incorrect.[9]

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[6] *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.

[7] *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 http://oig.hhs.gov/oas/reports/region7/71201116.asp. *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.

[8] *Medicare Improperly Paid Providers Millions of Dollars for Entitlement-Terminated Beneficiaries Who Received Services During 2010 Through 2012*, A-07-13-01127, April 7, 2014, available at http://oig.hhs.gov/oas/reports/region7/71301127.asp.

[9] *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.

Key recommendations to CMS include:

- Implement policies and procedures to detect and recoup improper payments made to unlawfully present and incarcerated beneficiaries.

- Prevent enrollment in Part D of unlawfully present beneficiaries, disenroll any currently enrolled unlawfully present beneficiaries, and automatically reject PDE records submitted by Part D plans for prescription drugs provided to this population.

- 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.

Reducing Improper Medicare Payments for Prescription Drugs

We have extensively examined CMS's monitoring and oversight of the Part D program and the effectiveness of controls to ensure appropriate payment and patient safety. Our work has found limitations in program safeguards that leave Part D vulnerable to waste, fraud, and abuse and Medicare patients vulnerable to potentially harmful prescribing.

Notably, we found that Medicare paid millions of dollars for prescriptions from unauthorized prescribers, such as massage therapists and athletic trainers.[10] We also estimated that Part D paid $25 million for Schedule II drugs billed as refills in 2009.[11] Such drugs may cause severe psychological or physical dependence if abused, and Federal law prohibits the refilling of these prescriptions.[12]

We have also uncovered extreme prescribing patterns by hundreds of general-care physicians, who prescribed, for example, extremely high numbers of prescriptions per beneficiary or ordered extremely high percentages of Schedule II or III drugs.[13] In addition, thousands of retail

[10] *Medicare Inappropriately Paid for Drugs Ordered by Individuals Without Prescribing Authority*, OEI-02-09-00608, June 21, 2013, available at http://oig.hhs.gov/oei/reports/oei-02-09-00608.asp.

[11] Drugs and other substances that are considered controlled substances under the Controlled Substances Act are divided into five schedules. Drugs are placed on a certain schedule on the basis of having a medically accepted use in treatment in the United States, their potential for abuse, and the likelihood that dependence will result from that abuse. Schedule II drugs are those with a high potential for abuse, potentially leading to severe psychological or physical dependence. http://www.justice.gov/dea/druginfo/ds.shtml.

[12] *Inappropriate Medicare Part D Payments for Schedule II Drugs Billed as Refills*, OEI-02-09-00605, September 26, 2012, available at http://oig.hhs.gov/oei/reports/oei-02-09-00605.asp.

[13] *Prescribers With Questionable Patterns In Medicare Part D*, OEI-02-09-00603, June 20, 2013, available at http://oig.hhs.gov/oei/reports/oei-02-09-00603.asp.

pharmacies demonstrated extremely high billing for at least one of the eight measures of questionable billing we developed. For example, many pharmacies billed extremely high dollar amounts or numbers of prescriptions per beneficiary or per prescriber. Such pharmacies could have been billing for drugs that were not medically necessary or that were not provided to beneficiaries.[14]

These vulnerabilities are even more concerning in light of our increasing number of investigations into drug diversion, particularly for high-cost, noncontrolled, name-brand prescription drugs such as respiratory, antipsychotic, and HIV/AIDS medications. The serious and growing problem of prescription drug abuse lends a greater urgency to efforts to address drug diversion and improve monitoring and oversight of Part D.[15]

Key recommendations include:

- Require Part D plans to verify that prescribers have the authority to prescribe drugs. Monitor Part D plans to ensure that they validate prescriber numbers for Schedule II drugs and exclude Schedule II refills when calculating payments to Part D plans.

- Instruct the Medicare contractor to expand its analysis of prescribers and provide Part D plans with additional guidance on monitoring prescribing patterns.

- Strengthen the Medicare contractor's monitoring of pharmacies and its ability to identify for further review pharmacies with questionable billing patterns.

Reducing Improper Medicare Payments to Hospitals

Since 2010, OIG has issued approximately 100 reports to hospitals across the Nation recommending that the hospitals collectively return about $60 million in overpayments to the Federal Government and take corrective action to address the vulnerabilities we identified. These hospital reviews uncovered systemic hospital billing and payment issues related to canceled elective surgeries, early hospital discharges to hospice care, and improper payments for mechanical ventilation, to name a few. In separate audits of these three areas, we found:

- Medicare could save about $600 million over a 2-year period by applying a hospital transfer payment policy for early discharges to hospice care. Many of the hospital discharges to hospice care that we reviewed were early discharges that would have received per diem payments, rather than full payments, if there had been a hospital transfer payment policy.[16]

[14] *Retail Pharmacies With Questionable Part D Billing*, OEI-02-09-00600, May 9, 2012, available at http://oig.hhs.gov/oei/reports/oei-02-09-00600.asp.

[15] See *Spotlight on Drug Diversion*, available at http://oig.hhs.gov/newsroom/spotlight/2013/diversion.asp.

[16] *Medicare Could Save Millions by Implementing a Hospital Transfer Payment Policy for Early Discharges to Hospice Care*, A-01-12-00507, May 28, 2013, available at http://oig.hhs.gov/oas/reports/region1/11200507.asp.

- Medicare could save about $38 million over a 2-year period by ensuring that inpatient admissions related to short-stay hospital claims involving canceled elective surgeries satisfy the Medicare requirement that the admissions be reasonable and necessary. [17]

- Hospital claims sometimes included incorrect procedure codes when beneficiaries had received fewer than 96 hours of mechanical ventilation. These claims resulted in more than $7 million in Medicare overpayments.[18]

Key recommendations to CMS include:

- CMS should change its regulations or pursue a legislative change, if necessary, to establish a hospital transfer payment policy for early discharges to hospice care.

- Strengthen guidance to better explain Medicare rules for billing for elective surgeries that were canceled and instruct Medicare Administrative Contractors (MACs) to emphasize to hospitals the need for stronger utilization review controls for claims that include admissions for elective surgeries that did not occur.

- Direct Medicare contractors to review any claims with a procedure code indicating that a beneficiary had received at least 96 hours of mechanical ventilation when the beneficiary's length of stay was 4 days or fewer.

CMS Should Strengthen Oversight of Medicare Contractors

CMS relies on contractors to administer the various parts of the Medicare program. These contractors play a vital role in many facets of the Medicare program, including claims payment, overpayment identification, and overpayment recoupment. CMS contracts with MACs to process claims; Part C plans to provide managed care services; Part D plans to provide prescription drug coverage; and benefit integrity contractors to protect Medicare from waste, fraud, and abuse. In addition, CMS contracts with Recovery Auditors to identify and collect overpayments.

Regardless of the type of Medicare contractor, there are common issues that limit CMS's oversight. Chiefly, CMS has not leveraged contractor-reported data to improve oversight or addressed contractor performance issues in a timely manner.

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[17] *Medicare Could Save Millions by Strengthening Billing Requirements for Canceled Elective Surgeries*, A-01-12-00509, August 5, 2013, available at http://oig.hhs.gov/oas/reports/region1/11200509.asp.

[18] *Medicare Inappropriately Paid Hospitals for Beneficiaries Who Had Not Received 96 or More Hours of Mechanical Ventilation*, A-09-12-02066, September 17, 2013, available at http://oig.hhs.gov/oas/reports/region9/91202066.asp.

CMS Should Better Leverage Contractor Data To Improve Oversight of Part C and Part D Plans

We have performed a number of reviews of both the data that Part C and Part D plans report to CMS, the Medicare Drug Integrity Contractor (MEDIC) and the data that the MEDIC reports to CMS. Among other things, we have found deficiencies with what data the plans report and CMS's use of the data that it receives. These are described below.

Require Reporting of Fraud and Abuse Data

CMS does not require Part C or Part D plans to report fraud and abuse data to CMS or the MEDIC.[19] CMS merely encourages plans to voluntarily report this data. We found that less than half of Part D plans reported fraud data, and reporting varied significantly from plan to plan.[20] Due to CMS's lack of follow up, we do not know whether Part C and Part D plans are reporting incorrect data, have ineffective programs to detect fraud and abuse, or lack a common understanding of what constitutes a potential fraud and abuse incident. Further, without detailed information on fraud and abuse incidents, CMS is missing the opportunity to discover and alert plans and law enforcement to emerging fraud and abuse schemes.

Make Better Use of Existing Data and Share as Appropriate With Stakeholders

CMS has made limited use of data to oversee Part C plans despite investments in contractor reviews of the data.[21] For example, CMS has not determined whether outlier data[22] reflect inaccurate reporting or atypical plan performance. CMS also has not used its contractor data reports and analysis to inform the selection of plans for audits or to issue compliance notices for performance concerns.

CMS is also not fully leveraging Part D data. CMS does not require Part D plans to report fraud and abuse data, but even when plans do report this data to CMS, CMS has not used it for monitoring or oversight purposes.

[19] *MEDIC Benefit Integrity Activities in Medicare Parts C and D*, OEI-03-11-00310, January 9, 2013, available at http://oig.hhs.gov/oei/reports/oei-03-11-00310.asp.

[20] *Less Than Half of Part D Sponsors Voluntarily Reported Data on Potential Fraud and Abuse*, OEI-03-13-00030, March 3, 2014, available at http://oig.hhs.gov/oei/reports/oei-03-13-00030.asp.

[21] *CMS Regularly Reviews Part C Reporting Requirements Data, But Its Followup and Use of the Data Are Limited*, OEI-03-11-00720, March 3, 2014, available at http://oig.hhs.gov/oei/reports/oei-03-11-00720.asp.

[22] An outlier data value is one that falls outside a specified range of reported values, or falls above or below a predetermined benchmark value.

Address Contractor Performance Issues in a Timely Manner

CMS conducts quality assurance reviews to ensure that MACs are providing the quality of services required in their contracts. We have found that while CMS's performance reviews of MACs were extensive, they were not always completed in a timely manner.[23] Even when CMS identified quality standards that were not met, CMS did not always ensure that MACs resolved the problem.

Further, two MACs consistently underperformed across various CMS reviews, but these MACs had their contract option years renewed. CMS told us that they considered not extending the option years, but the timeframe for renewal made the decision impractical based on the resources and risk involved in conducting an unforeseen procurement.

Key recommendations to CMS include:

- CMS should require mandatory reporting by Part C and Part D plans of potential fraud and abuse incidents.

- CMS should determine whether outlier data values submitted by Part C and Part D plans reflect inaccurate reporting or atypical performance.

- CMS should seek a legislative change to increase the time between MAC contract competitions to give CMS more flexibility in awarding new contracts when MACs are not meeting CMS requirements.

Conclusion

Effectively combating waste, fraud, and abuse requires a concerted effort by a number of key players, including CMS, CMS contractors, providers, beneficiaries, law enforcement, and Congress. While CMS has had some success in reducing Medicare waste, fraud, and abuse, our recent work demonstrates that further reductions are possible. A comprehensive list of OIG's priority recommendations can be found in our *Compendium of Priority Recommendations* on our Web site.[24]

While my testimony focuses on our work to help CMS improve program operations, I would like to make a request that would help OIG better meet our growing oversight responsibilities. We are responsible for oversight of about 25 cents of every Federal dollar, but our mission is challenged by declining resources, and our oversight responsibilities are increasing. By the end of this fiscal year, we expect to reduce Medicare and Medicaid oversight by about 20%. To

[23] *Medicare Administrative Contractors' Performance*, OEI-03-11-00740, January 8, 2014, available at http://oig.hhs.gov/oei/reports/oei-03-11-00740.asp.

[24] Available at http://oig.hhs.gov/reports-and-publications/compendium/index.asp.

ensure that we can continue to provide needed oversight as these programs expand, we ask for the Committee's support of our 2015 budget request.

We are committed to continuing our strong oversight of Medicare to reduce waste, fraud and abuse as comprehensively and effectively as possible with the tools and resources we have available. At stake are billions of dollars, the solvency of the program, and the health and well-being of beneficiaries.

Thank you for your interest and support and for the opportunity to discuss some of our work related to Medicare oversight. I am happy to answer any questions you may have.