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PREVENTING AND RECOVERING MEDICARE PAYMENT ERRORS

HEARING

BEFORE THE

FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT INFORMATION, FEDERAL SERVICES, AND INTERNATIONAL SECURITY SUBCOMMITTEE

OF THE

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS UNITED STATES SENATE

OF THE

ONE HUNDRED ELEVENTH CONGRESS

SECOND SESSION

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PREVENTING AND RECOVERING MEDICARE PAYMENT ERRORS

THURSDAY, JULY 15, 2010

U.S. SENATE,
SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT,
GOVERNMENT INFORMATION, FEDERAL SERVICES,
AND INTERNATIONAL SECURITY,
OF THE COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:06 a.m., in room SD–342, Dirksen Senate Office Building, Hon. Thomas R. Carper, Chairman of the Subcommittee, presiding.

Present: Senators Carper and Coburn.

Also Present: Senator Klobuchar.

OPENING STATEMENT OF SENATOR CARPER

Senator CARPER. The hearing will come to order.

I am going to say something as we lead off here today that I do not think I have ever said at the beginning of a hearing, and that is, this is going to be a great hearing. [Laughter.]

I really think so. We have some terrific witnesses. The subject material is very important, and we have some good news to talk about, and we have some lessons learned and some ideas that we need to drill down on, and we can do some real good for our taxpayers.

I was on the phone earlier today with a long-time friend, a fellow who used to be Chief of Staff to former President Bill Clinton, Erskine Bowles. Erskine, along with Alan Simpson, former Senator from Wyoming, are heading up the Deficit Reduction Commission (DRC), which has begun working in recent months, and I think working effectively and with a lot of good thought, a lot of energy. So my mind is on deficit reduction today, and it is on the minds, it turns out, of a lot of people in our country. So I swapped with Erskine some ideas that the Commission is working on and some ideas that we are working on literally in this Subcommittee, talking about here today.

But our focus today is to figure out what we are doing to prevent fraud and waste with respect to Medicare, and we have some witnesses that are going to tell us about what we are doing and maybe what we could do even better.

The witnesses who are joining us today will tell an important story. Medicare, as we all know, is a critical component of health care in our Nation. I think there are some 45 million seniors that

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are participating. I am a baby boomer, and while I am too young to participate in Medicare, someday I hope to. And there are a lot of my colleagues, people born, as I was, after World War II, who have the same expectation.

As a recovering Governor, I understand the unique challenges that come along with running major programs. Unfortunately, Medicare has seen its share of problems, and while it has done a lot of good for people, we are mindful that it certainly has its share of problems.

We know that no program is perfect, and I like to say if it is not perfect, make it better. In fact, I just did a press interview with a reporter, and we were talking about my four core values: Figure out the right thing to do, just do it; treat other people the way I want to be treated; if it is not perfect, make it better; and if you know you are right, do not give up. So those are my core values, and number three applies here. If it is not perfect, make it better.

But we in Congress need to ensure that the more than $460 billion that we are spending, I think, this year in Medicare to address health care needs of our Nation's senior citizens is spent effectively and that we spend it in a cost-effective way.

Medicare, as we know, is on the Government Accountability Office's (GAO) list of government programs at high risk for waste, fraud, and abuse. There are several differing estimates of waste and fraud within the Medicare program. The Office of Management and Budget (OMB), for example, has reported $36 billion in improper payments by the Medicare program, according to data gathered from—I think that was fiscal year (FY) 2009, $36 billion in 2009. And I ought to point out that figure does not include information about payments for the Medicare prescription drug program, affectionately known as Part D, as the administration is still struggling to determine the amounts of wasteful spending in that part of Medicare. Again, that is a part of Medicare that does a lot of good. But we are certain that there is a fair amount of waste or fraud involved there, and we want to try to identify that and go out and get it.

I am told that U.S. Attorney General Holder estimates that Medicare fraud in total is probably more like $60 billion a year rather than $36 billion a year.

So what has Congress and the Executive Branch done to address these very real problems with waste and fraud? Well, again, I want to start with some good news. In 2003, Congress mandated a Recovery Audit Contractor (RAC) demonstration program to examine Medicare fee-for-service (FFS) payments. And through recovery auditing, internal auditors or outside contractors are employed to go through an agency's books, essentially line by line, to identify and recover payments that are made erroneously, such as duplicate payments or payments for medical procedures that never happened.

This innovative tool is widely used in the private sector. We used it in State government in Delaware for the Division of Revenue to go out and recover tax monies that were owed but not being collected. And now we have seen successful use by the Federal Government with Medicare.

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The Recovery Audit Contractor program for Medicare began as a demonstration program I think in March 2005. We started in three States, California, Florida, I believe New York, and a couple years later added Massachusetts and South Carolina. And the program I think has been successful by almost anybody's measure.

Looking back at 2006, we were starting with three, I think later adding South Carolina and Massachusetts, but in 2006, $54 million was recovered. In 2007, we had about, we will say, a quarter of a billion dollars recovered. In 2008, almost $400 million, in the five States was recovered. The program was essentially down in 2009 or so for a little more than a year, but that year we still collected almost $300 million while we were standing down and doing kind of lessons learned, looking back at the demonstration. But if you add up the money for those 3 or 4 years, it was about $1 billion, which is real money by our standards in Delaware, maybe even in Oklahoma.

Somewhere along the line, we said, "Well, why don't we step it up to 19 States?" And then we said, "Well, if this works in three States, if this works in five States, if this works in 19 States, maybe it would work in all of them." And there is a provision in the newly enacted health care law that the President signed earlier this year to expand the program not just for Medicare Part A and B, doctor and hospital stuff, but also Part C, which is Medicare Advantage, and Medicare Part D, which is the prescription drug program. And also, in a hearing we had here—I do not know if Dr. Coburn remembers this, but we had a guy here who I think ran the Medicaid program in New York State, and he said, "You are not collecting any money much at all on fraud in Medicaid." And he told us why. He said we ought to make some changes. And we have made those changes in the legislation that was—again, the health care law. And our expectation is not only are we going to collect a lot more money, recover a lot more money from Medicare, but also to help the States recover Medicaid waste money, and we will split that with them on roughly a 50/50 basis. So that will help both the States and we hope help the Federal situation as well.

There is an added benefit to expanding the Recovery Audit program in Medicare. The Recovery Audit Contracting pilot program has identified dozens of vulnerabilities in the Medicare payment system that can lead—can lead—to waste and fraud. According to the Centers for Medicare and Medicaid Services, (CMS) contractors hired to recoup overpayments identified ongoing vulnerabilities that could lead to future overpayments totaling more than $300 million. That is like $300 million a year, not just one time, but $300 million each year, if we do not do something about it. So not only did the contractors recover about $1 billion for us in overpayments in the 3-year pilot program; they also identified problems in the system that, if addressed, will avoid literally billions of dollars in future errors and more fraud.

Our witnesses from the Government Accountability Office will describe for us today how the Center for Medicare and Medicaid Services, the agency which oversees Medicare, could do even more to use the work of recovery audit contractors to address overpayments.

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We have a chart based on GAO's work.[1] As I recall, GAO noted about 58 vulnerabilities. They said these are things that, if you do not fix these, you are going to continue to waste more money. They identified about 58 vulnerabilities through the demonstration programs. They represent, as I said earlier, about $300 million in overpayments on an annual basis. That is obviously useful information. However, according to GAO, CMS has actually only addressed, I think, maybe 23 of the 58 vulnerabilities. That leaves about 35 to go. And while we are glad they have addressed 23, we do not want to lose sight of the other 35. They represent cumulatively about almost a quarter of a billion dollars in annual overpayments, and they are awaiting action, and we want to make sure we do not forget them.

GAO has also stated that CMS has not established steps to assess the effectiveness of any action taken to date to reduce the vulnerabilities by the auditors. So, one, the auditors identified the vulnerabilities; two, we say we are going to do something about it; three, we are going to figure out are we being effective in addressing those vulnerabilities. So it is a sort of three-step process. I look forward to hearing more about this issue from our witnesses.

The last thing I want to mention before I turn it over to Dr. Coburn is prescription identifiers—this is interesting. I was in a Walgreens pharmacy in southern Delaware, in Seaford, the little town of Seaford, where the first nylon plant was built in this country 60 years ago. But Walgreens used to be Happy Harry's. Happy Harry's was a large regional chain in our State, taken over by Walgreens. But I spent about an hour there just to see how they are doing their work, how they are filling prescriptions and some of the safeguards that they have to protect consumers and make sure people who are taking more than one prescription are not having prescriptions that are just incompatible with one another, all kinds of stuff. They use a lot of technologies. It was very impressive.

But the second issue for today's hearing will focus on the Medicare prescription drug program. An audit by the Inspector General at the Department of Health and Human Services (HHS) discovered that Medicare does not have a strong process to ensure valid identification numbers on reimbursed prescriptions under the drug program.

Now, what does that mean? When a beneficiary brings in a prescription for medication he or she has been prescribed, the pharmacy is required to enter a provider identifier showing that an actual doctor or some other authorized provider correctly OKed the prescription. It sounds like common sense to me. Probably to you, too. But, apparently, some 18 million prescription drug claims contained invalid prescriber identifiers in 2007. That represents about $1.2 billion in Medicare spending.

The Inspector General (IG), concluded and this is a quote. He said, "It appears that CMS and Part D plans do not have adequate procedures in place to ensure valid prescription identification." This is a lot of money, and we want to make sure that this is one that we address here today.

[1] The information submitted from Senator Carper appears in the Appendix on page 107.

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Our witnesses are going to report for us not only the current challenges of waste and fraud that we have outlined in the Medicare program but identify solutions, too, and we look forward to your presentations. Again, thank you for joining us.

Dr. Coburn, welcome, you are on.

OPENING STATEMENT OF SENATOR COBURN

Senator COBURN. Mr. Chairman, thank you for holding this hearing. I have a statement for the record that I would ask to be submitted for the record—and then we will go forward with the witnesses. Thank you.

Senator CARPER. Without objection, your statement will be inserted as part of the record.

Let me just introduce our three witnesses on panel one. Our first witness today will be Kathleen King, Director of Health Care at the Government Accountability Office, where she is responsible for leading various studies of the health care system, specializing in Medicare management and prescription drug coverage. Ms. King has over 25 years of experience in health policy and administration. We thank you for being here today. Thank you.

Deborah Taylor, Chief Financial Officer for the Centers for Medicare and Medicaid Services and the Director of the Office of Financial Management. Ms. Taylor is accountable and responsible for planning, directing, analyzing, and coordinating the agency's comprehensive financial management functions, including the release of the Centers for Medicare and Medicaid Services annual financial report.

And our third witness is Robert Vito—again, welcome back. Several of you have been with us before. It is good to see you all again. But Mr. Vito is a Regional Inspector General for Evaluations and Inspections at the Department of Health and Human Services. Mr. Vito works in the Inspector General's office in Philadelphia, a suburb of Wilmington, Delaware, and—— [Laughter.]

Under his leadership has been credited with identifying billions of dollars in savings for the Medicare program.

Again, welcome one and all. Your full statements will be made part of the record, and you can proceed. I will ask you to try to keep your statement to about 5 minutes. If you run a little over that, that is OK. If you run a lot over that, that is not OK.

Please proceed, Ms. King.

TESTIMONY OF KATHLEEN M. KING,[1] DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Ms. KING. Mr. Chairman and Senator Coburn, thank you so much for inviting me here today to talk about the use of recovery audit programs in Medicare.

For almost 20 years, as you pointed out, we have designated Medicare as high risk due to its size, complexity, and susceptibility to improper payments. The purpose of the RAC demonstration was to test the feasibility of using recovery auditing as a means of identifying improper payments. Congress directed CMS to test the use of RACs in a 3-year demonstration program from March 2005 to

[1] The prepared statement of Ms. King appears in the Appendix on page 48.

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2008. And in 2006, Congress enacted legislation that made the RAC program a permanent part of Medicare, and CMS launched the national program in March 2009.

In its first year, the demonstration was estimated to have recouped more than $300 million. It was the first time the agency paid contractors on a contingency basis through a share of improper payments identified. The demonstration provided a unique opportunity for CMS to identify issues at risk of improper payments. CMS could then use the information to take corrective action to address the root causes and to help reduce improper payments in the future.

The demonstration required coordination, particularly between RACs and Medicare's claims contractors. The demonstration RACs reviewed claims that had already been paid by those other contractors to identify payment errors. RACs then shared those errors and their amounts with providers and the claims contractors, which collected any overpayments due, repaid underpayments, and handled the first level of provider appeals.

Many providers expressed concerns about the operation of the demonstration. In particular, they were concerned about the use of contingency fees because they thought it created an incentive for RACs to be too aggressive in determining improper payments. They also indicated that RACs made many inappropriate determinations that resulted in thousands of provider appeals. The appeals created additional workload and coordination challenges for the claims contractors.

In 2008, CMS said it would make a number of changes to the RAC program to address these problems. In our March 2010 report, we said that CMS had learned valuable lessons from the RAC demonstration, particularly in regard to coordination between contractors and program oversight of RAC accuracy. However, we identified improvements still to be made. In particular, as of March 2010, and as your chart shows, CMS had not yet implemented corrective actions for 60 percent of the most significant RAC-identified vulnerabilities, which are those representing more than $1 million. In our report, we identified steps that CMS should take to improve the national program.

First, we said that they should establish an adequate process to address RAC-identified vulnerabilities that lead to improper payments. For the national program, CMS did develop a process to identify the vulnerabilities and take corrective actions. It is better than the process they used during the demonstration, but it still lacks essential procedures. We recommended, and CMS concurred, that they improve their process. CMS said that they would promptly evaluate findings of the RAC audits, decide on appropriate responses, and act to correct the vulnerabilities identified.

Second, we said CMS should take steps to address coordination issues among the contractors. Based on lessons learned during this demonstration, CMS has improved ways for RACs and the other contractors to communicate. CMS also improved its data warehouse that helps providers avoid duplicate reviews, and it is working to improve its storage and transfer of medical records, which was a significant issue during the demonstration.

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Third, we said that CMS should oversee the accuracy of RAC claims reviews and the quality of their service to providers. CMS did take steps to address concerns about inaccurate RAC decisions. The agency hired a validation contractor to independently review RAC decisions. They created performance metrics to monitor RAC accuracy and service. And they also changed the contingency fee payment structure so that RACs will have to refund contingency fees for any determinations overturned at any level of appeal.

CMS' experience with the RACs provides useful lessons in identifying the root causes of vulnerabilities and effectively coordinating and overseeing accuracy and customer service of contracts.

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

Senator CARPER. Thanks, Ms. King. Ms. Taylor.

TESTIMONY OF DEBORAH TAYLOR,[1] CHIEF FINANCIAL OFFICE AND DIRECTOR, OFFICE OF FINANCIAL MANAGEMENT, CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT HEALTH AND HUMAN SERVICES

Ms. TAYLOR. Thank you, Chairman Carper and Senator Coburn, for the opportunity to appear before you today to discuss the Centers for Medicare and Medicaid Services' efforts to prevent and recover Medicare improper payment errors.

As you know, the Medicare Modernization Act of 2003 required the Centers for Medicare and Medicaid Services to establish a recovery audit demonstration to pilot the potential usefulness of recovery auditing in the Medicare fee-for-service program. During the demonstration program, three demonstration States were selected: Florida, California, and New York. Within the first 18 months of the recovery audit pilots, we saw much potential and promise for results. Thus, in the summer of 2007, we expanded the demonstration to three additional States: South Carolina, Massachusetts, and Arizona. By the time the recovery audit demonstration concluded in May 2008, the six pilots in the demonstration project had collectively identified over $1 billion of improper payments and returned over a net $690 million to the Medicare Trust Fund.

At the conclusion of the demonstration program, the Government Accountability Office evaluated our results and progress. Generally, they had some positive comments about the demonstration; however, they did note, as Kathy said, 58 vulnerabilities were identified, and we had addressed or done corrective actions for 23, leaving 35 vulnerabilities with no corrective actions. At this time I am pleased to report that CMS has taken or begun corrective actions in all 35 of the remaining vulnerabilities. We appreciate GAO's recommendations, and going forward, we are committed to developing and implementing corrective actions to prevent these vulnerabilities from occurring in the future.

The ultimate goal and measure of success of the recovery audit program is to prevent these errors from occurring after they are identified. The success of the RAC demonstration provided us with valuable information about vulnerabilities where improvements in the Medicare program were needed as well as some lessons learned

[1] The prepared statement of Ms. Taylor appears in the appendix on page 58.

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for improving the recovery audit program. In general, we were able to gain valuable feedback from providers about ways to improve the recovery audit program with respect to interactions between the provider community. We took these lessons learned very seriously when designing the national recovery audit program and incorporated them into the national program.

For example, we required all recovery audit contractors to hire a physician medical director to be responsible for ensuring that the medical records were properly reviewed in accordance with our payment policies. We also established a new Issue Review Board (IRB) within the agency to review and approve all claim review areas before the recovery auditors can begin widespread medical review.

Another important step we took before the national recovery auditors could begin requesting and reviewing claims was to set up meetings with State representatives and provider associations in every single State to discuss the recovery audit program and answer their questions. These outreach meetings coupled with the incorporation of lessons learned with critical improvements to the national recovery audit program.

While the national recovery audit program is now operational, it did take time to establish these improvements and build the infrastructure that Kathleen talked about for the national program. We currently have four national recovery auditors. They are divided into four regions across the country. And as of June, the national recovery audit program has returned over $32 million to the Medicare Trust Funds.

Although the national program just began, it has also identified some significant program vulnerabilities. To date, the program has focused mostly on durable medical equipment (DME), an area where we know we have had high improper payments in the past. We are currently working on corrective actions to address these vulnerabilities.

CMS also takes seriously the use of invalid prescriber identifiers in the Part D claims, as described by the OIG's recent report and as shown on the chart. Although not an automated indicator of fraud or invalid claim, the use of invalid prescriber identifiers does hamper the oversight of the Medicare Part D benefit. Since the OIG's review of Part D claims from 2007, there has been a substantial shift away from the use of DEA numbers toward the use of a national provider identifier. CMS plans to thoroughly evaluate these more recent claims to determine whether there are similar incidents of invalid NPIs and to understand what pharmacies and prescriber practices are resulting in the use of invalid identifiers.

As the Chief Financial Officer (CFO) for CMS, it is my responsibility to ensure that we do everything possible to ensure the accuracy of all payments in the Medicare and Medicaid programs. I take this responsibility very seriously. I thank you for your continued support and interest in this program, and I look forward to answering any questions you may have.

Senator CARPER. Thanks so much. Mr. Vito, welcome back. Nice to see you. Please proceed.

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TESTIMONY OF ROBERT VITO,[1] ACTING ASSISTANT INSPECTOR GENERAL, CENTERS FOR MEDICARE AND MEDICAID AUDITS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT HEALTH AND HUMAN SERVICES

Mr. VITO. Good morning, Mr. Chairman and Members of the Subcommittee. I am Robert Vito, Acting Assistant Inspector General for the Centers for Medicare and Medicaid Audits at the U.S. Department of Health and Human Services Office of Inspector General. I would like to thank you, Mr. Chairman, for holding a hearing on this important topic.

A little more than 4 months ago, I sat before you and testified about the OIG's body of work related to program integrity efforts and payment safeguards in the Medicare Part D prescription drug program. At that time I stated the oversight of this area by the Centers for Medicare and Medicaid Services and its contractors had been limited, and as a result, the Part D program was vulnerable to fraud, waste, and abuse. Unfortunately, our current work further illustrates the potential impact of these vulnerabilities as the lack of program safeguards has actually resulted in Medicare paying for a substantial number of questionable claims for prescription drugs.

One of the most basic safeguards in paying for medical care, whether we are talking about Medicare, Medicaid, or private payers, is ensuring that an item or service was performed, provided, and prescribed by an appropriate medical professional. To that end, CMS requires that pharmacies list an identifier for the drug prescriber on most Part D claims. Without a valid identifier, we cannot even be sure that an actual practicing physician prescribed the drug, much less determine the physician's name, verify the physician was appropriately licensed, or identify questionable prescribing patterns associated with a particular physician.

In other words, even though invalid prescriber identifiers do not automatically indicate fraud, they severely inhibit our ability to detect it. In our report, "Invalid Prescriber Identifiers on Medicare Part D Drug Claims," we found that more than 18 million prescription drug claims contained invalid prescriber identifiers in 2007, representing 2 percent of the nearly 1 billion claims submitted by the plan sponsors that year. These identifiers were either not listed in the appropriate provider identifier directories or had been deactivated or retired more than a year earlier. Part D sponsors and enrollees paid pharmacies $1.2 billion in 2007 for these questionable claims.

Furthermore, CMS and the sponsors did not successfully verify that the prescriber identifiers were even in the proper format. In almost 20 percent of the cases, the invalid identifiers did not have the correct number of characters and/or contained inappropriate letters, numbers, punctuation marks, or keyboard symbols. Just to give an example, one invalid prescriber that did not meet the format specifications was a string of nine zeros. Despite this obvious issue, Medicare paid $3.7 million for almost 40,000 claims listed with this identifier in 2007.

[1] The prepared statement of Mr. Vito appears in the appendix on page 69.

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In other cases, identifiers met format requirements, but still appeared to be highly questionable on their face. Prescriber identifier AA with seven zeros after it was listed on almost 1.8 million prescription drug event (PDE) records in 2007, representing more than $100 million in paid claims for 150,000-plus beneficiaries who were enrolled in almost 250 different Part D sponsors. In other words, 10 percent of all PDE records with invalid prescribers contained this one invalid identifier.

So what can be done to fix the problem with invalid Part D prescription identifiers? To start with, we have provided invalid identifier data from our report to the Centers for Medicare and Medicaid Services. We are also conducting additional analysis and have identified specific geographical areas with an unusually large number of questionable claims. In addition, the OIG will soon issue another report that looks specifically at prescriber identifiers on claims for Schedule II drugs, like OxyContin, which are highly susceptible to fraud and abuse activity.

In terms of the systemic changes, OIG recognizes the difficult balancing act CMS faces in trying to ensure beneficiary access to needed drugs while also preventing improper payments. Therefore, rather than implementing prepayment edits, we recommended that CMS conduct periodic reviews to ensure the validity of the prescriber identifiers used on the PDE records. CMS could also require sponsors to institute procedures that would identify and flag for review any Part D claims with invalid identifiers in the prescriber identifier field. The success of these intermediate steps relies on the appropriate action being taken by CMS, the sponsors, and the program integrity contractors when problematic claims are identified.

I would also like to note that this is not the first time the OIG has identified vulnerabilities related to invalid identifiers. In July 2008, I testified that invalid identifiers were also an issue on claims for durable medical equipment, such as wheelchairs and diabetic supplies, covered under Part B. Specifically, Medicare paid millions of dollars for claims that did not accurately identify the physician that supposedly ordered the item, including many that listed a deceased doctor as the prescriber.

In conclusion, prescriber identifiers are the only data on the Part D drug claim to indicate that a legitimate practitioner has prescribed medication for Medicare beneficiaries and, as such, serves as an invaluable program safeguard. With CMS' agreement to take steps to address the findings in our report, we are hopeful that the issues with prescriber identifiers are being resolved. However, you can be assured that the OIG will continue to monitor the agency's progress in this area.

I would be happy to answer any questions that you might have at this time.

Senator CARPER. Good. Mr. Vito, thanks very much.

I have asked Dr. Coburn if he will just lead off the questioning, and he has agreed to do that.

Senator COBURN. Thank you. I appreciate the privilege. I do not know why I have it, but I appreciate it. Thank you.

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Senator CARPER. It is because of your good work on the improper payments legislation which the House passed yesterday and is going to the President and something that we can celebrate for——

Senator COBURN. We have been working on it for 6 years.

Senator CARPER. A long time. Good work.

Senator COBURN. Several reports outside of the government's reports estimated Medicare and Medicaid fraud at $80 to $100 billion. It is really interesting to me that the government estimates it at far less. So the question I have is: Given that the private insurance industry has about a 1-percent fraud rate, why do we have a pay-and-chase system? Ms. Taylor.

Ms. TAYLOR. Well, I believe part of the reason is—and we do a lot up front to ensure that providers coming into the system are legitimate as they do the enrollment. But we are a system that is any willing provider, so if a provider has a legitimate State license, we must allow that person to participate in Medicare——

Senator COBURN. I am not talking about participation. I am talking about payment of a claim. Why do we pay it and then chase it if it is erroneous? Why don't we certify it beforehand? In other words, there are statistical models out there and programs that look for abnormalities in claims. Are these models being used by HHS?

Ms. TAYLOR. We have a system that does utilize edits up front. We have medically unbelievable edits. We have unlikely edits. We do have, correct coding initiatives that look for diagnosis with an incorrect code. So we do have those up-front sort of identifiers that are in the system. We currently are looking at commercial software out there that could be added to our systems where maybe there are commercial edits that would apply to Medicare.

Senator COBURN. Have you ever gone and sat down with one of the large insurance companies and said, "Show me how you all do your proactive fraud"?

Ms. TAYLOR. We have talked to.

Senator COBURN. No. I am talking about you. Have you ever sat down and gone through one of the large insurance companies' proactive fraud detection programs?

Ms. TAYLOR. I have talked to a plan sponsor——

Senator COBURN. OK. I am going to ask the question again, and I am not trying to be combative.

Ms. TAYLOR. Right.

Senator COBURN. Have you personally sat down and gone through a proactive fraud detection program by one of the large health insurers? Gone through it so that you see how it works.

Ms. TAYLOR. No, I have not.

Senator COBURN. Would you think that would be a good idea since their fraud rate is markedly less than yours?

Ms. TAYLOR. I would agree and I do think, we should be doing more of that, and I can take that and do that. I do want to explain, though, that in Medicare we have different rules than some of the commercial. They do a lot of prior authorization of claims. We do not do that—prior authorization of services prior to services being rendered and claims paid. So we do have a different type of system where they do an up-front validation before the service and claim is ever even provided or submitted.

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Senator COBURN. Well, on large items they do.

Ms. TAYLOR. Right.

Senator COBURN. But on small items, on the vast majority of Medicare Part B, which are small items, other than the DME product, they do not. I do not have to have permission from Blue Cross/Blue Shield to see a patient in my office if they have a valid card. And that is a large portion—I know it is not the hospital-based, I am really just talking interaction.

You said that all 35 you have taken action on or have begun. Which ones—how many have you begun action on but not completed of the recommendations?

Ms. TAYLOR. I do not know that number exactly.

Senator COBURN. That is a real important number for us to know. Would you supply to the Subcommittee the ones that you have actually taken and finished the action on the others that you are taking actions and what steps you are taking? It does not have to be in detail, but so we see where you are.

Ms. TAYLOR. I can absolutely do that. I do want to stress, though, that much of the errors we are identifying are the harder ones to fix, meaning on the face of the claim the service and the payment looks absolutely valid and necessary. It is not until you get into the underlying medical records that you find that possibly progress notes are missing, a physician did not, in fact, order the service, there is no signed order from the physician. So it becomes very much human error within the medical record that is creating much of these errors, and that is very, very difficult to stop and to identify a real solid corrective action. It is really doing education and outreach with providers on what is necessary to be inside the medical record to support——

INFORMATION SUPPLIED FOR THE RECORD FROM MS. TAYLOR

From the demonstration project 58 "vulnerabilities" were identified. The GAO reported in March 2010 that CMS took action on 23 of the 58. CMS has initiated several corrective actions for the 35 vulnerabilities identified by the GAO that had not been addressed when the GAO conducted their review; since that time, three of the outstanding vulnerabilities have been addressed, 22 are on track for completion within 6 months, eight are likely to take up to a year to correct, and two are on hold pending law enforcement investigations. In response to the identified vulnerabilities, corrective actions CMS has taken to date include:

- Education to providers at various nationwide outreach events. Provider outreach occurred in all 50 States to discuss what documentation providers need to submit to support their claims;
- Education to our claims processing contractors during RAC Vulnerability Calls;
- Approval of continued review in the National RAC program for those vulnerable areas that cannot be addressed and corrected through proactive automated system edits (CMS gave RACs the approval to review on August 6, 2010);
- Publication of a Medicare Learning Network educational article on July 12, 2010 emphasizing the importance of medical record documentation and submission of documents timely;
- Publication of a Medicare Learning Network educational article published on September 23, 2010 on hospital billing codes and the importance of submitting documentation and quantifying the correct principal and secondary diagnoses and the correct procedure codes for billing purposes; and
- Publication of a Medicare Learning Network educational article published on September 23, 2010 concerning medical necessity review.

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Senator COBURN. You know the best way to educate me as a physician to do it right? Not pay me. I guarantee you the next time I will get it right.

Do you have sufficient sanction authority that you need with which to make corrective actions when people are not compliant with the record?

Ms. TAYLOR. We do not have sanction authority.

Senator COBURN. In other words, you cannot limit somebody's ability to participate in Medicare if they are not complying?

Ms. TAYLOR. All we can do is flag their claims for pre-payment review. That I believe was with the OIG, any exclusion or sanction.

Senator COBURN. Well, do you think it would be important that you could have sanction on individual providers who, in fact, do not comply with the rules under which you say they have to operate?

Ms. TAYLOR. That would maybe be helpful, yes.

Senator COBURN. I guarantee you, when I send a claim to Blue Cross/Blue Shield, if it is not backed up, I do not get paid. And then I ask why I am not getting paid, and they say, "You did not comply." So either I comply and they pay me, or I do not comply. If I do that multiple times, guess what? They sanction me. They will not let me provide benefits to their insurer.

Do any of our panelists have any thoughts on what they think we ought to do to limit the improper payments, just general thoughts, improper payments that are occurring in Medicare and Medicaid outside of the recommendations of the GAO report on what you saw on recovery audits?

Ms. KING. Senator, there is a new program that is beginning for competitive bidding for durable medical equipment that gives the agency the ability to screen providers ahead of time to make sure that they are legitimate businesses, and that gives CMS the ability not to take any willing provider but to make sure that they are legitimate and that they have the financial ability to provide services. That is something that we think is helpful.

Senator COBURN. Would the GAO think it would be helpful to give Medicare the ability to provide sanctions on providers if, in fact, they were not in compliance with the rules of Medicare? I am not talking fraud. I am just saying lack of compliance, not having the data there. In other words, do I have a responsibility as a provider if I am going to contract with Medicare to make sure the available information to justify my charge to Medicare is there?

Ms. KING. That is not an issue that we have examined, but I can say that CMS does have the ability, as has been said, to not pay providers for services that are not provided legitimately or that are provided in error, or in the case of the RACs, to take payments back. So that is one thing they can do.

When I think of sanctions, I think of that having more to do with illegal or fraudulent behavior, and that enters more into an enforcement realm. So in terms of official sanctions, you would want to think about whether it crosses over into something that is abusive or fraudulent.

Senator COBURN. So your position would be—I am out of time?

Senator CARPER. You have had 9 minutes, and we start voting at 11 o'clock.

Senator COBURN. All right. I will yield back.

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Senator CARPER. If you would.

One thing I want to just follow up on Dr. Coburn's questions is this issue of pay and chase, which is not something I have thought a lot about until actually this hearing today. But I am told Peter Tyler, who is sitting over my left shoulder, says that the new health care law gives CMS some new authority to stop pay and chase, and it requires CMS to stop payments if there is credible evidence of fraud. And as I understand, this is a significant change.

Would you just respond on the record, Ms. Taylor, as to what you are all going to do with that authority?

Ms. TAYLOR. I believe we are still drafting regulation on that authority, so I really cannot speak to it right now.

Senator CARPER. I am asking you to respond on the record what you are going to do with that new authority. All right. Thank you.

Senator Coburn, it sounds like they may have some new authority here. We will find out how they are going to use it.

INFORMATION PROVIDED FOR THE RECORD FROM MS. TAYLOR

The Affordable Care Act (ACA) provides CMS with many new authorities to combat waste, fraud, and abuse in Federal health care programs. These new authorities offer more front-end screening and enrollment protections to keep those who are intent on committing fraud out of the programs in the first place, and new tools for deterring wasteful and fiscally abusive practices, identifying and addressing fraudulent payment issues promptly, and ensuring the integrity of the Medicare and Medicaid programs. CMS is pursuing an aggressive program integrity strategy that better incorporates fraud-protection activities into our claims payment and provider processes where appropriate, with the goal of preventing fraudulent transactions from ever occurring, rather than simply tracking down fraudulent providers and chasing fake claims. CMS also now has the flexibility needed to tailor resources and activities in previously unavailable ways, which we believe will greatly support the effectiveness of our work.

On September 17, CMS put on display proposed rule CMS–6028–P that details the initial steps the Agency is taking to implement certain provisions in the Affordable Care Act, including new provider enrollment screening measures and requirements, new authority to issue a temporary moratorium on enrollment for areas at high risk of fraud in our programs, and authority to suspend Medicare and Medicaid payments for providers or suppliers subject to credible allegations of fraud. This proposed rule builds on existing authorities and on earlier rulemaking that implemented the Affordable Care Act requirement for physicians and other professionals who order or refer Medicare-covered items or services to be enrolled in the Medicare program.

Senator CARPER. OK. From Minnesota, welcome, Senator Klobuchar. Thanks for joining us.

Senator KLOBUCHAR. Well, thank you very much, Senator Carper. Thank you for inviting me to be part of this Subcommittee for the purpose of this hearing. I am not actually on this Subcommittee, but I have a great interest in this issue due to my work on Judiciary, where Senator Coburn also serves, as well as my former job as a prosecutor where we prosecuted a number of cases in this area. I am glad that you are back to report on some of the work that has been done since our last hearing a few months ago. When I say the numbers myself, I always think I get the million wrong over the billion, but $60 billion a year in fraud to taxpayers for Medicare, as we know, is just simply unacceptable. And every time I say that, I think it is million, and I am wrong. It is billion.

The recently released OIG report confirmed just that, one of the most basic oversights ensuring that a drug was prescribed by a doctor is not operating effectively. Medicare drug plans and bene-

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ficiaries paid pharmacies $1.2 billion in 2007 for more than 18 million prescriptions that contained over 500,000 invalid prescriber numbers. What is almost even most shocking is that the invalid prescriber identified, which is AA0000000, accounted for $105 million in paid claims. That is a lot of money for AA0000000. So I think that just gives us the example of the enormity of what we are dealing with here.

I guess I would start with you, Ms. King. Your report noted 58 vulnerabilities identified through the pilot program representing $303 million in overpayments. However, the CMS only addressed 23 of these vulnerabilities, leaving the 35 vulnerabilities, which I think accounted for $231 million in overpayments, still awaiting action. Was there a reason to address only some of the identified overpayments?

Ms. KING. I do not think there was a specific reason. I think there were some issues in which there were problems with categorization. There were some issues where it was hard to tell what the problem was. But there was not always a reason why they were not addressed.

Senator KLOBUCHAR. Do you think you will go back and look at them or see if they——

Ms. KING. We do not have any ongoing work looking at the RACs, but, I think CMS has testified that they are working on them.

Senator KLOBUCHAR. OK. Mr. Vito, in your testimony, you made recommendations to CMS for subjecting invalid identifiers to further review. It is alarming that just 10 invalid prescriber identifiers account for 17 percent of all the invalid prescriber identifiers. And when I saw this, I thought, Shouldn't there be some kind of flagging system in place? And if so, can you describe how your recommendations would add to what is already in place?

Mr. VITO. Well, I think the first thing is that CMS has determined that they want the beneficiaries to be able to get the prescriptions that they were given. So with that in mind, we understand the balancing act that they have to do. But we are suggesting that CMS start looking and doing work in this area to ensure that the claims that come in have valid IDs on them.

In addition to that, we are saying that CMS should remind the sponsors or make the sponsors first identify all these invalid prescriber IDs and then review them to ensure that they do not keep coming up. When you see $100 million, $100 million as a regular doctor would cause people to be very concerned. It is just the volume of the claims. And the issue really is that you do not know if the claim is a good one or a bad one until you do more work. It could be that, they just put a number in and they are using that. But you will not know that until you actually go into doing all the work, going back into it and getting the information.

So for us, it is so much more valuable to prevent it up front and to stop it right at that time and make sure that the information is correct.

Senator KLOBUCHAR. That it is correct.

And, Ms. Taylor, what do you think about his recommendations?

Ms. TAYLOR. We actually agree with all the OIG recommendations. We actually have looked at what is going on in 2009. We

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were troubled by seeing some entities with a preponderance of invalid numbers. We did have discussions with them. What we are seeing now is a trend that the pharmacies and the sponsors are using the National Provider Identifiers (NPIs). I think in the early days of the program there was confusion as to whether or not those numbers should be protected. And so, I think we have clarified that, but because they were DEA numbers, people thought they needed some privacy or protection to them. Some sponsors told us they just put in fictitious numbers rather than putting in the actual number. We told them they need to use the NPI. And we are starting to see about 75 percent of the claims now in the PDE database coming in with NPI numbers rather than, these DEA numbers.

Senator KLOBUCHAR. So do you think some of this is not really fraud, it is just them putting in any number? Is that what you are saying?

Ms. TAYLOR. We believe that may be part of the reason. They just put in a number rather than trying to look up for a valid number.

Senator KLOBUCHAR. Because they know they are going to get paid.

Ms. TAYLOR. Correct.

Senator KLOBUCHAR. Of course, that also leads to a lot of fraud, I would think.

Ms. TAYLOR. Right. I mean, so we have several efforts underway now. We are looking at what is going on in 2009. We are going to validate those NPI numbers. We do want to understand if there is a systemic reason for why they cannot get to a valid number. If there is a problem with systems or look-up tables, we need to work on that. But we also want to and have started dialogue with those who seem to be not following our guidance, and we will be discussing that and telling them to cease and desist, that they need to do actual look-ups for valid numbers on the PDE claims.

Senator KLOBUCHAR. So what do you think has been the greatest—we just passed this bill. There are major fraud components in there, and I know it was just a few months ago, but, —since we had our hearing 4 months ago, or since Senator Carper did. What would you say have been the greatest improvements? And do you think you see a difference in the money that is being saved already?

Ms. TAYLOR. I think it is probably too early for me to give you an answer on that. We are still looking into it. But I do think that the plans understand we are looking and that the oversight is going to be much harder, and we will be scrutinizing the information they are giving us.

Senator KLOBUCHAR. When is the first time you will know if there has actually been savings?

Ms. TAYLOR. Maybe by the end of the year. I am not really sure.

Senator KLOBUCHAR. OK. Anyone else have any other examples of changes that you think have been significant? Nothing? So those have to be made soon. That is what we are going to do, right?

OK. Very good. Well, we will be looking forward to—we are continuing to work on legislation and pushing things. I think what

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really counts here is the numbers and those cost savings, which are going to be very important to taxpayers. So thank you.

Senator CARPER. Thanks a lot for joining us today. The welcome mat is always out for you.

Senator KLOBUCHAR. Thank you.

Senator CARPER. A first question for Ms. Taylor, if I could. I think three points are especially clear from your testimony.

First, you and CMS have recognized the importance of curbing waste. We are talking about a program where we are spending about $460 billion this year, and the amount of waste that has been identified ranges anywhere from $36 billion to, I think, $60 billion. Senator Coburn suggests it is higher than that. But we are talking about something in excess of 10 percent of the amount of money that we are spending is going in what many would describe as waste or fraudulent spending. And as pleased as I am that we are focused on that and beginning to drill down and address it more comprehensively, that is still a huge amount of money. But there is a huge upside there in reducing fraud. So we are pleased that you are focusing on this.

Second, we learned a lot from the Recovery Audit Contracting demonstration program that can apply toward the current program as well as the next expansions that are taking place right now. That is good.

Third, the Recovery Audit Contractor program has proven itself capable of not only recovering payments, but almost as important in identifying vulnerabilities that can lead to those overpayments. I think your testimony used the word "success," and overall I think the Medicare program deserves credit for increasing the level of priority for recovery auditing in order to ensure that the current program is successful. And with the signing by the President in a week or two of the improper payments bill, we are going to take what you are doing here in recovery for Medicare Parts A and B and extend to other parts of our government. So that is good.

Of course, under the recently enacted health care reform bill, the Recovery Audit Contractor program will expand, as I suggested, to Medicare Advantage, Part C, Medicare prescription drug, Part D, and to Medicaid. I think the deadline for completing this expansion is this December 31st. I believe it is very important, considering the success of the Medicare Recovery Audit Contracting demonstration and current program, that the expansion stays on track, including meeting the expansion deadline of December 31st.

Will we see the expansion by the end of this year of the Medicare Recovery Audit Contracting program to all of Medicare and to Medicaid as is required by this new law?

Ms. TAYLOR. Yes, so we are in, still planning and early stages of how we would expand it into the Medicare Advantage arena as well as the Part D program. We have some ideas specifically in the drug area where we think recovery auditing would be very valuable, such as validating the drug rebate and price concessions data. We think that would be very valuable to us. So we do have, some ideas there.

Part C, a little tougher. We know that risk adjustments are something we have had problems with. We currently are already doing some audits in that area, but we want to explore a little

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more about some opportunities for expansion of recovery audit in Part C.

For Medicaid, a little bit tougher, meaning there are 56 different programs in Medicaid. We know that it is not free to bring up a recovery audit even if it is with—pays for itself eventually. It does require contracts. It does require resources. And some State legislature may not be in positions to give States money to seed that recovery auditing.

So we are looking a little harder at Medicaid. I can say that we will do everything possible to be ready to bring it up, expand it in all three of those programs. I think Medicaid is a little bit tougher for us, just given the States' timing and the 56 very unique programs.

Senator CARPER. I understand that what we have asked you to do is not easy, and what we have asked you to do is hard, and especially with Medicaid. But I would just urge you and your colleagues to give this everything you have. There is a lot of money at stake here, and we just need your very, very best efforts. And we also need—if there are things that we need to be doing here on the legislative side, you need to tell us that, and we would do our best to try to be supportive.

A question, if I could, Ms. King, for you. The GAO testimony that you have offered describes, I think, a great opportunity provided by the Recovery Audit Contracting program. Not only has the program recouped about $1 billion over a 3-year period, but it identified vulnerabilities that can lead to future overpayments, and we talked about some of this today. However, the GAO audit in today's testimony points out that not all the recovery audit contractor overpayment vulnerabilities have been addressed by CMS. And, again, we have a chart, I think, that shows how much progress has been made right over here. Blue is good, corrective action taken on 23 out of the 58 areas. It is about 40 percent of the areas identified. Sixty percent, 35 items. And let me just say—and Ms. Taylor mentioned, she said, "We have already started working on the other 35," which is good. "We have completed some of them," which is good. But I would just ask of you, Ms. King, has there been progress in your view since the audit was completed? When was the audit completed?

Ms. KING. We finished our work in March of this year.

Senator CARPER. OK, so it was about 3 months ago. Has there been progress since the audit was completed that you are aware of? And how many of the 35 items that had not been addressed as of March have been addressed today?

Ms. KING. Senator, I am afraid I cannot answer that because we have not done any work on the issue since then.

Senator CARPER. OK. I am going to ask you to answer that for the record.

Ms. KING. OK.

Senator CARPER. Just answer that one for the record if you could.

Let me go back to you, Ms. Taylor. I understand from my staff that some of your folks from your office prepared some documents describing some of the progress in addressing the vulnerabilities identified by the recovery audit contractors, and I appreciate your providing those statements. My staff also tells me that the docu-

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ments show—I should not say "my staff." It is Subcommittee staff. Subcommittee staff tells me that documents show that CMS has a system in place, I think a database, to track the reported vulnerabilities, and I think that is one of the recommendations that GAO made. Is that correct?

Ms. TAYLOR. Yes, sir.

Senator CARPER. Thank you. Let me just ask, Ms. Taylor, if you could, could you describe further for us the process that has been in place for the current program to address all the identified vulnerabilities. Just talk to us about how you are doing that. And do you have a timeline for when you think all the vulnerabilities of the identified thus far will have been addressed?

Ms. TAYLOR. Sure. The way we track vulnerabilities is there is a data warehouse where vulnerabilities are—or denied claims are run through. What it does is it cumulates those so that we can see by provider and by provider type what are some repeated vulnerabilities, and it allows us to lump them together. We put as major vulnerabilities anything where overpayments are identified in the cumulative total of over $500,000. So that is how we are tracking and identifying the major vulnerabilities.

Right now my office is directly responsible for the day-to-day monitoring and reporting out of that data warehouse. To the extent I have to reach out to colleagues across CMS to develop corrective actions, that is what I do. But if we need to elevate things, meaning there are vulnerabilities that require policy and systems changes as well as possibly national coverage decision changes, that may involve someone at the Office of the Chief Operating Officer to get involved. But at this point, most of it is managed in my office on a day-to-day basis. I cannot give you an exact date of when I think we will resolve all the vulnerabilities. I think the fair answer there is some are easy to fix, meaning it is a systems edit that we can put into place.

For example, we had an issue with a drug where we were paying for a claim even though the dosage was too high and likely not to be reasonable. So we were able to put an edit in place to stop that drug from being paid at too high of a dosage.

Other things require policy changes which may require us to do legislative changes. It also can require us to do lots of education and outreach with our providers to understand what the documentation requirements are for the medical record.

Senator CARPER. I see. So if I understand it—in my question, do you have a timeline for when all the identified vulnerabilities of the current program will be addressed? And the answer is, "Really we do not."

Ms. TAYLOR. I do not have a timeline, mostly because many of the underlying issues require us to continue to do education and outreach. The only way to find problems is to look at medical records. It is not evident on the face of the claim. It is very difficult to find. And it is constant repeated reviewing of medical records and having education and outreach with physicians.

I will say that as an outgrowth of the recovery audit program, a lot more providers are doing compliance programs themselves where they are actually having compliance auditors and programs in-house looking through their own medical records to ensure that

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they are following our policies. So that is something where, we are seeing some positive impacts there.

Senator CARPER. My father used to say that the work expands to fill the amount of time we allocate to do a particular job. And I find it helpful for myself and for my own staff in other roles that I have held to set timelines. And I think a timeline could be helpful here as well. You all have addressed 40 percent of the vulnerabilities. That is good. We have 60 percent to go, and maybe some of those have already been addressed. And I am going to ask you to respond for the record what is a reasonable timeline, and I would like for it to be aggressive.

Ms. TAYLOR. OK.

Senator CARPER. I do not want, 5 years from now or 4 years from now or 3 years. I want it to be aggressive.

Let me just ask Ms. King, in terms of a timeline, is it important? What is a reasonable timeline for getting most of this stuff done?

Ms. KING. I do not know that we have an exact date that we think that it should be accomplished, but we do think it is important to set timely goals for achieving it.

Senator CARPER. All right.

Ms. KING. And, as Ms. Taylor pointed out, some things are more complicated than others, and some things are under appeal. So you have to take different factors into consideration, but we think it is important to press forward and to establish a timeline.

Senator CARPER. And as I said earlier, if there are some of these vulnerabilities that need some legislative action, you just need to come back and lay that out for us, and we will see what we can do and work together.

Mr. Vito, we are going to have a vote here in just a minute. I do not want to let you get away without being asked some questions. In fact, this is probably the vote starting right now. We very much appreciate your being here today and the good work that you and your folks do.

Mr. VITO. Thank you.

Senator CARPER. I think your audit has pointed out an area that Medicare needs to pay a lot more attention to, and you have described to some extent the importance of prescriber identifiers and ensuring that prescriptions are valid and also—but I am going to ask you to drill down on it a little bit more. Do you believe that the same validation process has impacts on other parts of Medicare, such as with fee-for-service?

Mr. VITO. OK. We have identified the invalid prescriber problem in both the Part B area and the durable medical equipment and in the Part D area for prescription drugs. We believe that it is very important that this information be there. I could give you an analogy. This would be similar to placing a combination lock on the gate to protect what is inside, but then allowing any combination to open the lock. This leaves whatever is behind the gate vulnerable, just like accepting invalid prescriber IDs on Part D claims leaves the program vulnerable to fraud, waste, and abuse. And when you do not have this information, there are many things you—when you look at it, there are three main controls: First, that the beneficiary is eligible for the Medicare program and is enrolled; second, that a supplier has enrolled with the program and meets

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the Medicare standards; and third is that the physician actually wrote the prescription.

So that is one of the main controls. If you cannot tell that a prescription actually—that a physician—you cannot tell who it is that actually wrote that prescription, it makes it very difficult for you to do a lot of program integrity work.

Senator CARPER. When you say "you," who is "you"?

Mr. VITO. Anyone who is doing program integrity work. It makes the Medicare Drug Integrity Contractors (MEDICs), it makes CMS, it makes the OIG. Without knowing that, you cannot—normally what is done is you do aberrancy analysis. You lay out all the claims, and then you see who the prescribers are that are hitting the higher levels. In this case, when you have an invalid number you really do not know who that prescriber is, and you have to go back and look at it. You do not know if that prescriber, is licensed. You do not know if they had actions taken against them. You do not know if they saw the patient before they actually wrote the prescription. There are many, many things that you do not know. You do not know if they can write a prescription for controlled substances.

So this is a very valuable key, and the only way you are going to find out if this information—if the claim is good, you have to do more work, and that takes a lot of effort. And that is why we are thinking that if you put this information up front, then you will be stopping the problem before you have to go on the back end to look at it and figure out what is going on.

Senator CARPER. Do we have a chart that speaks to this?

If your eyes are pretty good, you can read this, folks. But if they are not, I will help. We are looking at PDE—PDE stands for?

Mr. VITO. Prescription drug event data.

Senator CARPER. All right. Prescription drug event data. Records and payments for the top 10 prescriber identifiers in 2007. And on the left-hand column, we are looking at invalid prescriber identifiers. In the middle column, we are looking at the number of PDE records for invalid identifiers, the number of records for invalid identifiers. And then on the right-hand side, we are looking at the payments to invalid identifiers. I think you mentioned the first one in your testimony. And the invalid prescriber identifiers, AA, and then there is like about five or six zeros after that.

Then you come on down, and some of them have a lot of 1's in their identifier number, then a lot of 5's, but it adds up to a lot of money. And this is just 1 year? This is the top 10?

Mr. VITO. 2007.

Senator CARPER. I suspect that this is not all fraudulent or improper payments, but my guess is some of it might be, and we really do not know.

Mr. VITO. The only way you are going to know is when you do the work to find out what is really behind that, and that is the key, that if you are able to put edits up front, like you are trying to stop it at the very early stage, then you do not have to do all the work on the back end, because as Ms. Taylor said, some of this could be that the plans are putting in just certain numbers or dummy numbers. But you do not know if that is masking other problems that are underneath that until you actually do the work.

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Senator CARPER. This might be an obvious question, but are there some simple things that we could do to really perform checks on the identifiers?

Mr. VITO. Yes, I think there are, like in 17 percent of the cases, we knew that the actual format did not match. You know, if it was a DEA number, you had nine numbers in it. If you had an NPI, it was 10 numbers. If you do not have that exact number, right off the bat they could have stopped the problem for about $200 million because these were ones that did not meet the format requirements at all.

So, I mean, at the very easiest stage, when you see that coming in, right off the bat there is something wrong there, and you should say, OK, there is something wrong here, we need to check into it and we need to address it, make sure it does not happen again.

Senator CARPER. Do you know if CMS has data, say, for 2010 in terms of the number of PDE records that include the top 10 invalid identifiers? Do you know that?

Mr. VITO. I do not know if CMS has that information. It would be better if you would ask them. We do know that medics have been doing some analysis, the Medicare drug—they have been actually looking at this and identifying some of these numbers. And I believe according to the information we have received from them, there is a movement away from the DEA number towards the NPI number. But the question also is: When we did our work in 2007, we found that there were NPI numbers that were invalid as well. Are there going to be invalid numbers in the NPI system? Just because they are moving to a system where it is one uniform identifier, that does not mean that there might not be these problems still. So I think they still need to be vigilant in that area.

Senator CARPER. OK. We are well into our vote. I am going to just take about 2 more minutes, and then I am going to run and vote, and we will recess until I have voted, and I will come back as quickly as I can, probably within 15 minutes.

I want to stay on this issue for a bit longer and, Ms. Taylor, just ask you to talk to us about this situation. And, again, what are we doing about it? How serious are you all taking this?

Ms. TAYLOR. Sure. We obviously take this very seriously, and we are not happy that there were invalid numbers, certainly dummy numbers that on the face of the claim were not valid to begin with. I think Mr. Vito has alluded—we have asked our contractors for some of these top 10 to go back to the entity and find out why they were putting those numbers in there. We certainly are focused on the high-risk claims, meaning those where controlled substances were part of the claim. We will work closely with the IG if we find any real underlying issues. We believe that because it was in the beginning of the program, there may have just been a misunderstanding of whether or not they could put the DEA number on the face of the PDE claim. Some of the sponsors have told us they thought that was a protected number, that they would not be allowed to put it on the claim. So we certainly want to work and figure out what is going on there.

Again, we have seen a substantial shift moving away from the DEA number to the NPI. We are going to be looking at the 2009—we do not have all of 2010 yet, but we will look at 2010 also to see

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whether or not, we are just substituting invalid numbers from DEA to NPI. We want to understand that. We want to be able to give these plans and pharmacies information and guidance about how to get to a valid NPI number. We do not know if there is a systems issue. We do not know if all pharmacies and plan sponsors have the ability to get into the NPI database. We do not know if there are problems with slowness of the database, whatever. So we want to figure out what is causing some of the underlying reasons why they are just putting a number on there.

I think Mr. Vito and certainly the CMS concern is we do not want beneficiaries standing in front of the drug counter not being able to get needed and necessary drugs. So we always weigh that balance of making sure we get the valid information on the claim, but not holding up beneficiaries from getting their needed drugs. So we do not want to stop that. I think the issue here is we need the pharmacies and the sponsors to then, even if they give the information out because the system is slow or whatever, the drugs out, they still go back and validate the number, they do not leave it as a fake number on the PDE. We absolutely do not want that.

And we are absolutely going to be working directly with those who seem to not want to follow our guidance and figure out whether or not we can take some actions. We certainly will tell them cease and desist, we will be watching you. But what further actions we can take on their behalf, I mean, we will absolutely be looking at that.

Senator CARPER. All right. Again, our thanks to each of you for being here today and for your testimony and for your responses. We are going to do a lot of oversight and follow-up on this. There is real money to be saved here. We have a Medicare Trust Fund that has somewhere between—I do not know—10, 15 years of life left in it, and we need every dollar—it needs every dollar that we can save.

It appears to me that roughly one out of every seven or eight dollars that is being spent in Medicare is being spent wastefully or fraudulently. And we have a pretty good idea where some of that is coming from, and obviously work has begun to identify those and correct it and recover money where we can. But when you have a trust fund that is running out of money in the next 10, 15, or 20 years and we know that one out of every seven or eight dollars is being misspent, fraudulently spent, there is a good way to stretch the life of the trust fund without raising anybody's taxes. I appreciate the work that is being done here. Let us keep it up. As I said earlier on, one of my core values, if it is not perfect, make it better. And while we are doing better, we can still improve, and we need to. So thanks very much.

We will stand in recess for about 15 minutes, and I will hustle back as quickly as I can for the second panel. Thanks very much. [Recess.]

The Subcommittee will reconvene. Welcome. Thanks for hanging in here. We were voting. If you want to know what we were voting on, we were voting on what we call a cloture motion. That is to see whether or not we will proceed to a vote on the conference compromise that has been worked out on financial regulatory reform legislation. So we need 60 votes to proceed to the vote on the con-

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ference report, and we will find out probably by now whether we got the 60 votes. I think we did, but we will see.

I want to introduce our panel of witnesses. Our first witness, I am told, is Libby Alexander. Is Libby short for Elizabeth?

Ms. ALEXANDER. Yes.

Senator CARPER. OK. Chief Executive Officer of Connolly Healthcare, Connolly, Incorporated. Where are you all located?

Ms. ALEXANDER. Wilton, Connecticut.

Senator CARPER. OK. And I understand you provide recovery audit contracting services under Medicare. OK. Thank you.

Our next witness—this is kind of a nice—I am always after my staff, when we have names that are just names you do not hear every day, I ask them to spell it out phonetically, and they said that your name is Lisa Im, "rhymes with Kim." Is that right?

Ms. IM. That is correct.

Senator CARPER. Pretty good. Chief Executive Officer of Performant Financial Corporation. I understand you are headquartered in—is it Livermore?

Ms. IM. Yes.

Senator CARPER. Livermore, California. I used to live in Palo Alto, in Menlo Park, right across the bay, when I was a naval flight officer. It is nice to have you here. And we understand that your company, Performant, also performs recovery audit contracting for Medicare.

Ms. IM. Yes. Region A.

Senator CARPER. What is that, Region A?

Ms. IM. Region A is the Northeast.

Senator CARPER. OK. Thank you. Does that include Wilton, Connecticut?

Ms. IM. Yes.

Senator CARPER. OK. Thank you.

Our next witness is Andrea—it says "Bank-o." But your name is spelled B-E-N, like my son's name is Ben, and we call him Ben, but is your name pronounced "ban"?

Ms. BENKO. No. Benko, just like——

Senator CARPER. Benko, thank you. All right. President and Chief Executive Officer of HealthDataInsights, Incorporated. I am told that you are based in Las Vegas, Nevada.

Ms. BENKO. Correct.

Senator CARPER. OK. And that you also provide recovery audit contracting under Medicare. I just spoke with Harry Reid when I was over on the floor a few minutes ago. He said, "Be nice to the witnesses from Nevada." [Laughter.]

Our next witness is Robert Rolf, Vice president of CGI Federal. CGI is based in Montreal, Quebec, and provides recovery audit contracting services under Medicare throughout Canada. Is that right? [Laughter.]

Mr. ROLF. Senator, our U.S. headquarters is in Fairfax, Virginia.

Senator CARPER. All right. What part of the country do you all cover?

Mr. ROLF. We cover Region B, which is seven States in the Midwest, and that work is performed out of Cleveland, Ohio.

Senator CARPER. OK. And our fifth and final witness is Romil Bahl—is it "Ra-mill"?

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Mr. BAHL. It is "Row-mill."

Senator CARPER. Is the emphasis on the first or second syllable?

Mr. BAHL. If you actually do not emphasize either side of that, it works better.

Senator CARPER. It works. Romil. And your last name is B-A-H-L, but it is pronounced "ball" like in baseball. Is that right?

Mr. BAHL. Close enough again. Thank you, Mr. Chairman.

Senator CARPER. All right. President and Chief Executive Officer of PRGX Global, and I understand you are based in Atlanta, Georgia, and also do Medicare recovery audit contracting. What part of the country do you all cover?

Mr. BAHL. Sir, we have an interesting arrangement with three of my colleagues here on this panel, Regions A, B, and D. So we are actually serving about 11 States, Senator, sort of holistically on our own, and then we have roughly 24 other States that we provide other services to, for example, in the DME area and home health.

Senator CARPER. OK, good. We are happy that you are here, and you have had a chance to listen to the first panel of witnesses, and to my colleagues and I ask some questions. Now we look forward to hearing your testimony. We value the work that you and your colleagues do for our country, and we want to make sure that we get the full value out of the work that you are doing. As I said earlier, everything I do I know I can do better, and I suspect it might be the same is true for your folks as well.

So, again, Ms. Alexander, I am going to ask you to lead us off, and we will make your full statement a part of the record, and you can summarize as you see fit. Try to stick to about 5 minutes, each of you, if you would. Thank you.

TESTIMONY OF LIBBY ALEXANDER,[1] CHIEF EXECUTIVE OFFICER, CONNOLLY HEALTHCARE, CONNOLLY, INC.

Ms. ALEXANDER. Chairman Carper and distinguished Members of the Subcommittee, thank you for the opportunity to testify today on preventing and recovering government payment errors. We appreciate your interest in recovery auditing, a best practice that is increasingly recognized as an invaluable tool for returning improper payments to the government and for identifying ways to mitigate future payment errors. My name is Libby Connolly Alexander. I am the Vice Chairman of Connolly, Inc., and the CEO of Connolly Healthcare.

Connolly currently serves as a recovery audit contractor, or RAC, for the Centers for Medicare and Medicaid Services, Region C, the Southeast, and we were one of the three RACs during the demonstration program serving in New York and Massachusetts. We have also performed recovery audit work for the Department of Health and Human Services, the Department of Education, and the Defense Logistics Agency.

Since our founding in 1979, Connolly's sole focus is the identification and recovery of improper payments. I personally have lived and breathed recovery auditing for the past 25 years. Our company serves some of the world's largest——

[1] The prepared statement of Ms. Alexander appears in the appendix on page 77.

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Senator CARPER. What is it like to live and breathe something like that for 25 years?

Ms. ALEXANDER. We have something in common: Our passion for this subject.

Our company serves some of the world's largest and best-run organizations in the retail, non-retail, health care, and government arenas. We entered the health care market in 1998 and have since grown to where we now serve commercial insurers, Blue Cross/Blue Shield plans, Medicare Advantage plans, Medicaid managed care plans, and, of course, CMS. In all, we recover nearly $1 billion annually for our clients. Our growth has been dramatic, including tripling the number of employees over the course of the past 5 years to over 700 today, a reflection of the widespread adoption of recovery audit as a best practice.

Most large organizations have created dedicated teams assigned to recovery auditing and plan recovery dollars into annual budgets. The Federal Government recognized the value of recovery audits nearly 10 years ago, and since that time strides have been made, with the RAC demonstration program perhaps being the best example of how a successful national recovery audit program can be.

As we replicate and build upon the success of the national expansion of the RAC program and extend the RAC efforts to Medicare Parts C and D and Medicaid, as called for under Section 6411 of the Patient Protection and Affordable Care Act and now the Improper Payments Elimination and Recovery Act, the country should realize recoveries of billions of dollars annually.

So what made the RAC demonstration program so successful? And what can we do to build upon it? In our testimony for the written record of this Subcommittee, Connolly submitted eight recommendations to help the government successfully expand its recovery audit efforts. In the interest of time, I will discuss only five of them here today.

No. 1, establish goals. In our 30 years' experience, a successful recovery audit program is achieved when there is a strong alignment on the metrics against which the success of the program can be measured. These goals can be determined by examining agency estimated error rates and the success of previous recovery audit programs in areas such as outreach, transparency, and quality.

No. 2, executive sponsorship. Since our earliest years of conducting recovery audits, we have continually found that recovery audits are most successful when there is a champion at a high enough level to see that the program gets off the ground and continues to see success.

No. 3, provide proper funding and resources to ensure the greatest financial benefit to the government. Agencies need a comprehensive program for preventing and recovering improper payments, and resources for the audit on the agency side should be established prior to the start of the audit. This would include resources to assemble audit data and personnel to approve audit issues for recovery, to manage the collection process, and to handle provider-vendor relations. Over time these costs can be funded through a portion of the recoveries that flow back to the agencies. But to recover the most improper payments possible, funds and

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personnel should be put in place and committed up front to get the program off the ground.

No. 4, institutionalize recovery audit as a comprehensive program, not a stand-alone project. By itself, a recovery audit project can recover some money for the taxpayers which we all can feel good about. But the true value comes from being part of a comprehensive program where the agency supports the audit and uses its results to make continual improvements. Every agency's mission should include a commitment to recapture improper payments, support valid overpayments through the appeals process, and look for ways to improve the recovery audit program going forward.

No. 5, use the experts. Rely on recovery audit experts to conduct audits and provide guidance for rolling out future audits under 6411 of the Patient Protection and Affordable Care Act. Recovery audit contractors have the people, the tools, the technology, the processes, the years of experience, and independence to achieve the goals of a program. Agencies should focus their resources on the activities necessary to support the execution of a comprehensive recovery audit program in a timely fashion and on improvements to prevent improper payments from occurring in the future.

In conclusion, Mr. Chairman, recovery auditing for the government is a valuable tool in the war chest against fraud, waste, and abuse. If an effort is made to align resources and a commitment made to recover improper payments, then we will continue to see the kind of success that we saw or encountered with the RAC demonstration program.

Mr. Chairman and other Members of the Subcommittee, thank you for the opportunity to provide my insights, and I am available for any questions.

Senator CARPER. Thanks very much.

Lisa Im.

TESTIMONY OF LISA IM, CHIEF[1] EXECUTIVE OFFICER, PERFORMANT FINANCIAL CORPORATION

Ms. IM. Thank you, Chairman Carper, Members of the Subcommittee, for inviting me here to testify. As chief executive officer of Performant Financial Corporation, I am happy to say that for over 33 years we have actually worked for Federal and State agencies to help improve their fiscal and economic responsibility and accountability. Our first contract with CMS began in 2005. We were awarded the MSP demonstration project, and while we had California, which was one of the three States, we did recover 90 percent of the MSP dollars. We have had two other contracts with CMS, and we are currently a recovery audit contract for Region A.

Since February of 2009, we have invested millions of dollars into our own organization to support the recovery audit contract. And what we have learned thus far is actually fairly consistent with what we know from our work with many Federal and State agencies, including Department of Education and the Department of the Treasury.

One, seed money is critical to help an agency prepare for a smooth implementation. Budgeting is a critical issue we recognize

[1] The prepared statement of Ms. Im appears in the appendix on page 81.

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which is addressed in this contract by the self-funding allowance, but, frankly, more resources were needed up front to establish the program infrastructure and assure that CMS could dedicate organizational resources to the contract start.

Two, contingency fee structures can be and are very effective for recovery audit contracts. Sometimes this concept is misunderstood. The parties being audited describe this as a bounty when, in fact, it is a widely accepted program commonly deployed by private companies, including providers of health care. It is one of the best ways to recoup dollars at a value proposition because in contingency fee contracting, the value actually equals recovered dollars minus the fees. Therefore, recovery becomes the lever to drive value. And successful recovery contracts in our experience at both the Federal and State level are not necessarily low-priced, but they are a fixed fee, and so technical competency becomes the decision factor in a vendor selection process. And the most successful recovery contracts require that vendor partners continue to invest in the process to drive greater results over time and to provide continuous improvement efforts and feedback to the client.

Third, outreach and education of all constituents is a best practice that has been applied to this recovery audit contract. Many of these overpayment errors are inadvertently made, but still represent billions of Medicare dollars erroneously disbursed. To educate and help providers, CMS has urged us and we have committed to extend great efforts to create and maintain outreach programs to the provider community. There is a continuous feedback of learning and education with providers that we have committed to.

Fourth, collaborative efforts between the parties is a best practice, and by this I mean due to the newness of this recovery audit contract, there should be a spirit of collaboration between CMS and the vendor partners, and among vendor partners, like us, who are encouraged to provide direct feedback to CMS. This process is a discussion loop to try for greater consistency and uniformity in processes and enables continuous improvement in the contract as it matures.

Fifth, the recovery audit concept we believe can be successfully applied to many other areas of the Federal Government, including Medicare Parts C, D, and Medicaid. Clearly, there are very unique challenges to each of these areas of health care, including disparate technological platforms, budgetary constraints at the State levels and elsewhere, and differing current practices which should be understood and assessed. That said, it is our belief that Part D is a fairly intrinsic part of Part A and B claims and can be added to this RAC contract. Many government programs, including Medicare and Medicaid, employ various types of preventative programs. To be fair, CMS has a number of preventative programs in order to help guide and educate the provider groups. But as an added process, recovery audit contracts can capture dollars lost just due to errors.

As an example, Senator, Medicare processes 1.2 billion transactions per year. Provider groups have turnover in people or expertise, and there is an inherent difficulty in implementing changing reimbursement rules into systems in a timely manner. It all causes error that may never be completely addressed in a preventative

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way, irrespective of how strong the preventative program is. And that is why recovery audit contracts create value to the Federal agency. This kind of contracting is often deployed by providers in the health care community who also have very strong preventative programs, but they also will have a recovery audit kind of process on the back end to capture any lost dollars.

This RAC contract implementation we believe is just beginning, but has great potential to succeed in returning dollars to CMS. Moreover, we think the application of recovery audit contracting across other Federal agencies has very strong potential and will be successful if best practices and key lessons from contemporaries are applied.

Chairman Carper, thank you very much for the opportunity to testify today.

Senator CARPER. Thank you, Lisa Im.

And next, Andrea Benko. Welcome. Please proceed.

TESTIMONY OF ANDREA BENKO,[1] PRESIDENT AND CHIEF EXECUTIVE OFFICER, HEALTHDATAINSIGHTS, INC.

Ms. BENKO. Chairman Carper, thank you very much for inviting me to testify before this very important hearing and for your efforts to prevent and recover government payment errors. I am president and CEO of HealthDataInsights (HDI). HDI is a technology-drive health care services company that specializes in claims integrity. Our customers include both public and private payers of health care services. The company employs sophisticated proprietary software tools, database queries, and complex review strategies to retrospectively analyze 100 percent of a payer's claims data. We have an experienced, robust, physician-led clinical team and quality management team who review more than $300 billion in annual claims paid data each year. We focus our efforts on the honest end of the spectrum of waste, fraud, and abuse; that is, overpayments and underpayments due to improper billing and other sources of error.

HDI participated in the RAC demonstration program that corrected over $1 billion in improperly paid claims. During the demonstration we identified 41 percent of the total findings while working with only 31 percent of the data. HDI is the national RAC in Region D, which includes the 17 Western States and three U.S. Territories. We also serve as the payment error measurement review contractor, which establishes the error rate for the Federal Medicaid program.

I would like to thank CMS for the progress made to date on the implementation of the national RAC program and acknowledge the challenges of implementing a program that requires cooperation among a vast number of contractors while managing the potential provider impact and the quality of the audit programs.

While the national program performance to date has been encouraging, there are a number of ways to achieve greater success. Based on lessons learned, HDI has the following recommendations:

First, we strongly urge Congress to establish target recovery goals of at least 50 percent of an agency's identified payment error

[1] The prepared statement of Ms. Benko appears in the appendix on page 84.

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as estimated in the annual reports. For example, based on the 2009 Medicare fee-for-service error rate, the annual recovery goal would be $12 billion for this program, half of the projected error rate as established by the Comprehensive Error Rate Testing (CERT) program of $24 billion.

Second, claims adjustment processes to recover the improper payments identified must be expedited and expanded to materially benefit the trust fund. Currently, automated mass adjustment processes to adjudicate incorrectly paid claims are in development, and until those are implemented, we need to increase the manual throughput to accelerate returns to the trust.

Third, expansion of the quality and scope of reviews is necessary. To the extent that RACs are allowed to review inpatient claims and other new issues more quickly, we believe returns to the Medicare Trust Fund will rapidly increase. Another issue to consider is the current limitation on the ability to request medical records from providers within the RAC program.

Fourth, CMS has conducted major finding discussions with contractors to determine strategies to reduce improper payment types, and this should be implemented as this recovery program is rolled out in all agencies.

Fifth, Medicare's provider network is a key component to the delivery of quality health care, and as such, our efforts are sensitive to providers. All constituents of health care delivery systems desire claim payment integrity and accuracy. Claims should be paid according to policies and fee schedules. No more, no less. This creates a sentinel effect of ensuring that providers continue to maintain solid billing and treatment practices. Medicare policies, coverage requirements, and guidelines, which have been so carefully developed over decades, are evidence-based, proven protocols for delivering patient care that ensure quality.

Our final recommendation is to leverage the success of the Medicare RAC program by extending it to other government health care payers. While there is a mandate that a RAC-like project be implemented in Medicaid as well as Parts C and D, we believe that the benefit to the government, when data is aggregated. If data can be audited and analyzed for an entire region for Medicare fee-for-service, Medicaid, and Part D, we can identify more improper payments through better data quality, more significant statistical analysis, and the impact on the provider can be effectively managed via one coordinated program that maximizes the return to the trust fund and minimizes the impact on the provider networks. The government would also benefit by expanding the RAC to the Federal Employees Health Benefit (FEHB) Program , the VA, and TRICARE.

In summary, we believe at HDI that there is a tremendous opportunity to ensure claim payment integrity and quality and to realize literally hundreds of billions of dollars over the next 10 years in recoveries for the government.

Thank you.

Senator CARPER. Good. Thanks. And thanks for mentioning the Federal Employees Health Benefit Plan, the potential there, and the VA as well.

Mr. Rolf, welcome. Please proceed.

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TESTIMONY OF ROBERT ROLF,[1] VICE PRESIDENT FOR HEALTHCARE BPO, CGI FEDERAL, INC.

Mr. ROLF. Thank you, Chairman Carper, Ranking Member McCain, and Members of the Subcommittee. My name is Robert Rolf. I am vice president for CGI Federal, an information technology and business process services company that has been partnering with government for nearly 35 years.

In my role, I am responsible for CGI's efforts to implement the Recovery Audit Contractor program in Region B, a seven-State region in the Midwest, as well as similar audit and recovery efforts that CGI performs for its State government and commercial clients. It is my pleasure to appear today before you at this hearing to examine the use of RACs in the Medicare program.

Under CGI's contract with CMS, we are tasked with the identification of improper payments made to hospitals, physicians, clinics, and other providers of services under Medicare Parts A and B. This work involves conducting audits of paid claims using both automated and manual review processes intended to identify provider overpayments and underpayments. Although most of this work involves catching improper payments on the back end, CGI fully supports all efforts to prevent such payments from happening in the first place. We currently assist CMS in the development of an improper payment prevention plan, a mission that CGI takes very seriously.

As a result of CGI's experience with the RAC program, I would like to share a few observations about this important CMS program and some lessons learned about recovery audit efforts with the Subcommittee.

First, transparency and communication are critical to the success of the program. It is important that RACs provide transparent information to Medicare providers regarding the program, the issues under investigation, and the basis for an improper payment determination.

Second, the RAC program promotes continuous process improvement for claims processing and payment. CGI participates along with the other RACs in major finding discussions with CMS. This process informs CMS of areas representing the greatest vulnerability to the program, along with recommendations for corrective action.

Third, there is the potential for this contingency approach to expand to other areas across government. Several legislative provisions in the Affordable Care Act expand the RAC program to Medicaid as well as Medicare Parts C and D. And now, thanks to your leadership, Chairman Carper, along with Ranking Member McCain and Senators Lieberman, Collins, McCaskill, and Coburn, CGI believes that with the final passage of the Improper Payments Elimination and Recovery Act, combined with OMB fiscal year 2012 budget guidance, we will focus agency attention on this topic in an unprecedented fashion across the entire Federal Government.

When expanding into new areas for recovery audit, it is important to note that while there are many similarities, there will be some differences in approach from the existing RAC program. One

[1] The prepared statement of Mr. Rolf appears in the appendix on page 90.

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common lesson learned from any recovery audit program, whether in health care claims or other payment areas, is the need for a robust process to recover funds identified by a RAC as improper.

Companies such as those before you today are adept at analyzing and identifying improper payments out of the millions of transactions that occur in programs each year. However, without the necessary infrastructure to recover the funds, the government will be slow to realize the benefit a RAC program can bring.

CGI prides itself on combining cutting-edge technology with years of domain experience in creating valuable solutions for our clients. We are especially proud of our ability to deliver successfully on the RAC program by featuring our health care expertise and broad experience in audit recovery programs. More than that, CGI remains passionate about the opportunity to partner with CMS and hopefully other Federal agencies in one of the most critical good-government efforts underway today.

I appreciate the chance to appear before you today, and I would be pleased to answer any questions you have.

Senator CARPER. Thanks, Mr. Rolf. Mr. Bahl.

TESTIMONY OF ROMIL BAHL,[1] PRESIDENT AND CHIEF EXECUTIVE OFFICER, PRGX GLOBAL, INC.

Mr. BAHL. Thank you, Mr. Chairman.

Mr. Chairman, Senator McCain, distinguished Members of the Subcommittee, PRGX very much appreciates the opportunity to testify before this Subcommittee, and it is my privilege to represent our team here today. We are gratified by the Subcommittee's efforts to tackle the problem of improper payments, most recently, of course, the passage of the Improper Payments Elimination and Recovery Act of 2010.

The act removes major impediments to successful recovery audits and, most importantly, incents agencies by allowing them to keep a portion of the funds recovered. This act, coupled with the expansion of recovery audits included in the recent health care legislation, more than doubles the levels of auditable Federal spending. We are excited about this expansion and look forward to competing for the opportunity to recover more taxpayer dollars.

While the rules for the expansion to Medicare Parts C and D and Medicaid across the 50 States will not be known until CMS and the States issue their solicitations and launch formal procurement processes, we are convinced that the application of proven recovery audit capabilities to these other areas of Medicare and Medicaid will yield great returns. Recovery audit potential has also been advanced by the administration's emphasis, including the President's personal endorsement, of the recovery audit process.

PRGX is the global leader in recovery audit and the pioneer of a new category of services we term "profit discovery." Our services: Audit, analytics and advice, are key elements of successful financial management in large private enterprises and in government agencies. We also have one of the longest track records in recovery auditing for the Federal Government.

[1] The prepared statement of Mr. Bahl appears in the appendix on page 93.

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Based on our 40-plus years of experience since pioneering the recovery audit industry, we believe there are four key success factors for a government agency to run an effective audit: One, an effective program champion; two, a broad scope audit; three, strong motivation, certainly with no disincentives; and, four, a capable recovery audit services partner.

In doing our work, we abide by a number of key principles: Integrity, confidentiality, security, and always value for our clients. Also, we are sensitive to the providers and other vendors we work with and, in fact, one of our key metrics is provider abrasion or vendor abrasion.

It is part of our commitment to our clients, including CMS, that we are fair in all our dealings with the hospitals, the physician groups, and all other providers as we audit on behalf of the taxpayer.

It may also be worthwhile to mention that there are three key pillars to how we approach recovery audit. As we have said for long at our company, first, we make sure that the juice is worth the squeeze. Our very heavy, front-loaded investments demand a high confidence that we can deliver results.

Second, we turn over big rocks before the pebbles. We do not spend dollars to chase dimes, nor should the American taxpayer.

And, finally, we focus a lot of effort on getting it right the first time. Our focus on accuracy is paramount and is demonstrated by PRGX having the lowest percentage of findings overturned on appeal during the Medicare RAC demonstration program.

We bring this expertise and commitment to our work with CMS and the provider community to optimize recoveries as a core part of their overall program integrity efforts. As an auditor in three of the four recovery audit regions, we have a broad and unique perspective on the processes and the errors that take place.

The same methodical, careful implementation that CMS is using with its national Medicare RAC program should also be emulated in other Federal agencies, and now it can be, given the means provided in your recent legislation.

PRGX's Medicaid recovery audit experience incorporates many of the lessons we have learned from the Medicare RAC program. Our estimates suggest that recoveries in Medicaid alone could be more than $1.35 billion annually.

Our recommendations for the national Medicaid expansion include the following: Create a set of guidelines for process automation and streamlining of appeals to get each State's Medicaid recovery audit program up and running quickly; and, further, the audit concepts that have already been approved for the national Medicare RAC program could be carried over to fast-track State Medicaid recovery audit programs, thereby reducing duplication of effort, reducing provider confusion.

Error rates for Medicare Parts C and D also suggest great potential for recoveries, and we are eager to begin helping CMS identify and recover these funds. We suggest focusing the recovery audit effort on the transactions between the Medicare Advantage and prescription drug plans and the provider. This is where the complexity lies. This is where the errors occur.

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Because Medicare Part C and Part D plans are administered by private enterprises that bear the actuarial risk, the recovered funds in any fiscal year could accrue back to the plans, thereby providing them the appropriate incentive to implement effective recovery audit programs. But CMS should then use the adjusted costs to revise future annual premiums, thereby effectively bending the health care cost curve going forward.

The lessons learned from the Medicare RAC program, the new authorities and incentives provided in legislation, and a renewed emphasis by the Executive Branch have set the stage for great strides in tackling improper payments. We are proud, sir, to be part of these efforts.

I would now be happy to answer any questions you may have. Thank you again.

Senator CARPER. Thank you all.

How many of you have testified before, before the House or Senate? Raise your hand. So this is the first time. That is good. Well, you did a very nice job. Very nice job.

You have the benefit of being the second panel, and you have had a chance to listen to the first panel. And I do not want to spend a lot of time on this, but I would like to ask each of you to maybe take 30 seconds or so, anything you want to reflect on that you heard from the first panel that you think should be underlined, emphasized, maybe should question, but just go back to what you heard in that first panel and let me hear from you. Ms. Alexander, I do not want to pick on you, but if there is anything you would like to just reflect on and react to the first panel's comments.

Ms. ALEXANDER. Some final remarks, actually, that Deb Taylor was making with regard to the correction of some of the identified improper payments. I do support what she was saying, that some of them are much more easily addressed than others. Some of these errors can be fixed with, adjustments to computer edits and things like that, very easy and very efficient to address. But, other the root cause of some of these errors is much more complicated. And, we have been in the recovery audit business for a very long time, and most of our business is repeat business. I would assume it is the same for my colleagues here at this table.

I think that the notion that you can completely fix and make errors go away is something that needs to be considered.

Senator CARPER. All right. Thank you.

Ms. Im, a reflection on anything that you heard that you want to just emphasize.

Ms. IM. Sure. Again, I think I just want to speak to the error correction and the prevention piece of it, sir. A good recovery audit program will continually find areas for opportunity for improvement, and I think that is what makes us good partners, is if we continue to find room for improvement. So, again, to the extent that 100 percent prevention is in a perfect world, we as partners to CMS can help continue to improve that process over time.

Senator CARPER. OK, thank. Ms. Benko.

Ms. BENKO. I have to add to that, because we have been doing health care auditing for 25 years, and we do not find the same things today that we found 5 years ago. When something gets fixed

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something else pops up because there are new treatments, there are new ways of billing, there are all kinds of new things.

The other issue is that, a lot of emphasis this morning was put on correcting vulnerabilities, and in the new program, the more dollars that we can recover, the more opportunity to identify vulnerabilities. The program is slowly ramping up. So as it ramps up, there will be more opportunity, and I think if we can accelerate the ramp-up, that would be to all of our benefit.

Senator CARPER. Good. Thank you. Mr. Rolf.

Mr. ROLF. I was intrigued by the discussion concerning the Part D error rates, and the issue that I see is you can attack both these—what we are doing now in the Part A and B program, separate from the errors that were discussed earlier today on the Part D side. But the real synergies that you are going to achieve is when you can compare across both of those programs, analyze the data across both of those programs, and identify a third set of errors that are independent from each other.

So while it was significant, the discussion that was had this morning, I think there is an untapped opportunity there to be able to discover additional improper payments by integrating the reviews between the Parts A and B and the D.

Senator CARPER. All right. Thanks. Mr. Bahl.

Mr. BAHL. Mr. Chairman, if I could first, sort of two reactions to this morning. As a taxpayer, as a good corporate citizen, I know my PRGX team would join me in saying that I was gratified. The obvious interest and passion to fix overpayments, whether they are, erroneously done or whether there is actual fraudulent misconduct conducted, was absolutely terrific.

Without saying anything different from what the other panelists have said, I do think focusing on fixing the gaps as you go along is crucial, sir. I will tell you that after 40 years of recovery auditing in this industry, we believe entirely so—and this is true right across the private sector for all our clients—that they do not only want us to fix recoveries. They want us to give them simplified, improved operating environments, to be strategic partners with them, to close those gaps that are causing those errors all the time. It is increasingly not a differentiator. It is increasingly table stakes for a recovery auditor to audit a client, to be able to fix those errors as we go. And so we look forward to being involved in that.

Senator CARPER. OK. I pressed our witness from CMS on a timeline. I said, "Give me a timeline for"—we do not have the chart up, but for the vulnerabilities that have been addressed—I think 40 percent of them have been, about 60 percent have not been. And as you suggest, Ms. Alexander, some of them are easy, some of them are not. And maybe a couple of them require legislation.

But I said before, if we do not have a timeline, if we do not have a date that we are trying to get something done or something close to that, then these kinds of things just stretch out forever.

Also, I questioned our witnesses about how realistic is it to expect to expand cost recovery in Parts C and D by the end of this year, how realistic is it to expect for us to have it done in 50 States. And let me just come back to that second part, the expansion of C and D by the end of this year, December 31st, and the expansion of this capability in all 50 States. How realistic is that? And I am

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concerned—I was encouraged by what I heard on Parts C and D, not so encouraged on what I heard about the States. As an old Governor, a former Governor, a recovering Governor, I can appreciate a little bit why that might be.

Anybody have any thoughts on the expansion, how realistic are we in our expectations? Please, Mr. Rolf.

Mr. ROLF. Chairman Carper, regarding the expansion and the time frames, I agree with you that work tends to expand the time allotted, and it is a statement within my company that what gets measured gets done. And so I would agree with you the time frames need to be set, and they need to be aggressive time frames to move forward.

Regarding the specific areas of expansion to C and D and into Medicaid, many of us up here today have experience in those areas now working with Medicare Advantage plans, working in the Medicaid arena, have the experience to be able to quickly move into those types of programs. I think it would be difficult given the current state of Federal procurement time frames, I think that the chance for the agency to be able to meet those time frames is to leverage existing contract vehicles they have in place today.

Senator CARPER. All right. Thank you. Mr. Bahl.

Mr. BAHL. Thank you, Mr. Chairman. You know, if I could be so bold as to quote what you quoted, I think, just a few months ago, you quoted Willie Sutton, did you not, sir? There is money there, right? There is over $600 billion just of auditable spend, and we must get after it.

I think one of the potential issues that is in front of the CMS is while Medicaid expansion should be relatively easy because it is very sort of RAC-style, right, fee-for-service, and the question is only will there be 50 independent procurements with the States or not. I mean, that I think can roll out quickly.

There is some complexity with respect to Parts C and D, sir. Those are obviously run by private enterprises that bear the actuarial risk, and so, our suggestions specifically in that—just like what you did in S. 1508, you provided for some incentives for the government agencies. That sort of incentive, therefore, has to be provided to the plans, the plan administrators themselves.

And so while we must audit where the money is in the transactions set between those plans and the providers, we believe that we give back, right, the recoveries in any given year back to those private players so that they are incented. But then the CMS is incented, as I said before, to bend the cost curve, to use that adjusted amount each year to apply their SGI and other cost increases.

Senator CARPER. All right. Thank you.

Ms. Benko, Ms. Im, Ms. Alexander, any other comment on this point?

Ms. BENKO. We are be ready to take on additional work with the Medicaid and the Part D plans absolutely quickly. We know where the errors are. We could incorporate that into the work we are already doing with the Medicare Part A and B, and it could happen this year. It is more CMS has to set out a goal of what they want to accomplish and make it happen.

Senator CARPER. OK. Thank you. Ms. Im.

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Ms. IM. Chairman Carper, I would agree with what Andrea has said, and, moreover, the type of infrastructure and alignment that CMS has to do in order to engage a vendor because of all of the multiple partners requires that they leverage what work has already been done. So our experience has been that these are no small tasks for any agency to face, and for CMS to expand current contracts feels a lot more effective and efficient than to actually go out and have to do another whole stream of procurements and technological matching. So it certainly sounds a bit self-serving, but we are prepared also to take on additional work based on this being a recovery audit contract, very prepared to help CMS make continuous improvements in Part D, and C as well.

Senator CARPER. Good. Thanks. Ms. Alexander, a comment?

Ms. ALEXANDER. I agree that a coordinated approach would be the most efficient under the time frame that has been established. I also think that they should move forward and segment the eligibility and the other payer liability type recovery work separately from the type of recovery audit contracting overpayment work that we are doing currently.

Senator CARPER. OK. Thank you.

I am going to ask each of you to take a shot at this question. I am supposed to be someplace else right about now, and so I am going to be mercifully brief with you. But this is a good panel. I hate to let you go too soon. But I have a question, again, for each of you.

Some of you included in your testimony specific recommendations, I think at least the first three witnesses, maybe others, but specific recommendations—I do not know if we asked for them. Did we ask for our witnesses to give us specific recommendations for improving the program? But you did, and we appreciate that.

Do you all believe that CMS should establish a goal for the collection of improper payments? I think I know the answer to that question, but do you agree that they ought to set a goal for collection of improper payments? Sort of describe that goal for us, if you would. Like if you were in their shoes and you were setting a goal, what might that goal be? How might you set it? What would you keep in mind in setting the goal? And I think that sort of thing is maybe done more often in the private sector than the public sector. But we need to set some goals here, and I think we need to set some timelines. But just respond to that, if you all would. I do not care in what order you respond.

Ms. BENKO. I will start.

Senator CARPER. Please.

Ms. BENKO. If I was running CMS, I would look at the CERT-identified error rate because that is the error rate that can be recovered. It is on the honest end of fraud, waste, and abuse.

Senator CARPER. You say the "honest end."

Ms. BENKO. It is mistakes. It is not a criminal intent where you are never going to get the money back because the person has taken the money and left the country. The money is still here. The providers are still participating in Medicare. So I would look at that CERT error rate, which is, I believe, in 2009 $24 billion of errors. And then I would look at how am I going to be impacting the

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providers and the beneficiaries and the quality of care, and I would balance it.

So I would set at least half of that as a goal, that I should be—and ultimately I would want to recover all of it, but I would say at least half of that should be able to be recovered. I mean, you saw $1 billion recovered from three States. It is definitely doable on a national program.

Senator CARPER. OK. Thanks.

Anyone else? Please, Mr. Rolf.

Mr. ROLF. Chairman Carper, I would agree with Andrea. I would also say that, as she pointed out, since $1 billion was recovered in States representing approximately 25 percent of the program, a minimum threshold should be, in rolling it out to the rest of the country, should be to achieve what was achieved during that program. So a floor should be at least $4 billion.

Senator CARPER. OK. Thank you. Mr. Bahl.

Mr. BAHL. Mr. Chairman, there is not a whole lot to add to that. The only thing I would say, because you specifically asked what else should one keep in mind, and I do think that what we are asking the agency to do—in this particular case, it is the CMS—in terms of managing those provider abrasion levels and so forth that I was so key on earlier, have to be kept in mind. And so I think, somewhat of a slow and steady approach to ramps is OK, but then absolutely, I could not agree more with Rob. Our number is closer to five on that chart than it is four.

Senator CARPER. All right. Thanks. Ladies, anything you want to add before we——

Ms. ALEXANDER. The only thing I would add is there are two pieces to goals, right? There is the quantitative goals, the financial goals, which are very, very important in creating alignment and the resources and the objectives of reaching those financial goals. But equally as important are the qualitative goals around things that are important to making the program a success beyond just the numbers. So, goals have to really reflect both qualitative and quantitative pieces.

But the projects that, have strong alignment between a client and a contractor are where those goals are clearly understood so that everybody is marching along toward the same goal line.

Senator CARPER. OK. Thanks. Ms. Im, anything else you want to add?

Ms. IM. Mr. Chairman, the only thing I would add is in a collaborative effort, which we believe this should be, those numbers will not be absolute over time, but will continue to change with feedback and learning from the RAC contract.

Senator CARPER. OK. All right.

If 2 weeks goes by and you do not hear any questions, you are free and clear, at least from my colleagues and me. My guess is that you will probably hear some questions from us, and I appreciate your willingness to respond to some of my questions today.

I said earlier I am a boomer. I was born in 1947. A lot of people were born that year and the years that followed that as well. There are a lot of us, and it is amazing how—I try to work out just about every day of my life, and one of the places I work out is the YMCA. We have great YMCAs in Delaware. I usually work out at one of

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them before I get on the train and come on down here. But you would be surprised how many people say to me, "Do you think Social Security will still be there when I am ready for it? Do you still think we will have a Medicare program when I am eligible for it?" And I say, "You bet we will. And we are determined to make sure that you do."

I was on the phone this morning with Erskine Bowles, as I said earlier, just talking through some of the entitlement programs and what we might do and sharing with him a little bit of the work that you are doing and the promise that I think it holds for our broader Federal Government. But I come back to—Dr. Coburn said that he thought maybe 1 percent of the claims paid by a private health insurance company there is fraud involved. It sounds pretty low, especially if you are looking at Medicare and these fraud numbers look to be anywhere from about 8 percent to maybe 15 percent. I cannot believe that they are that good and that we are that bad.

But whether it is 8 percent or 10 percent or 12 percent, we can do a lot better than that, and we really need to. So when those people who are at the YMCA or on the train or down in southern Delaware at the beaches, when they say, "Well, is Medicare going to be there for me?" I will say, "You bet it is." And one of the ways we are going to make that happen is what you are doing.

I think it is really—and Peter Tyler, who has helped me with putting this hearing together, one of the points that he keeps coming back to is a really good one—is it is not just important that you figure out how to go out and recover some of this money. It is important that you figure out how to provide less—what do you call it? "Provider abrasion," I think that is the term that you used—and we actually have learned from the first several years of the program how we can interact better with hospitals and doctors and nurses and other providers. But a big part of this is actually having identified the other vulnerabilities and for CMS to take that seriously and aggressively and go out and address those rather than must keep making those same mistakes. Three hundred million dollars year after year after year, that adds up pretty quick.

I am a recovering State treasurer, too. When I was elected State treasurer, I was 29, and in the State of Delaware, nobody wanted to run as a Democrat, so I got to run because nobody wanted to. And at the time we had the worst credit rating in the country. We were tied for dead last with Puerto Rico. They were embarrassed to be in our company. Delaware was very good at the time at overestimating revenues and underestimating spending, and that is how we got the worst credit rating in the country. We had all the money in the State-owned bank that was about to go under, and we had $40,000 of FDIC insurance on it. We had no cash management system, and nobody would lend us any money. And I got to be State treasurer. And from an early age, I have been interested in trying to figure out how to spend our taxpayers' money wisely.

And with respect to Medicare, we actually do spend taxpayers' money from the employers and the employees who pay into the fund, for the most part. There are some general fund monies as well. But a lot of the spending that we do in our government today is not taxpayer money. It is money that we just borrow from the

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Chinese or from the Japanese, from the Brits, and from anybody else, the folks that have all that oil who turn around and lend us money.

We have to be smarter than that, and with your help we are going to be. In fact, I think we already are.

Thank you very much, and with that, this hearing is adjourned.

[Whereupon, at 12:31 p.m., the Subcommittee was adjourned.]

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APPENDIX

FOR IMMEDIATE RELEASE

TOM CARPER

UNITED STATES SENATOR · DELAWARE

FOR RELEASE: July 15, 2010
CONTACT: Emily Spain (202) 224-2441

SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT INFORMATION, FEDERAL SERVICES, AND INTERNATIONAL SECURITY

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

HEARING: "Preventing and Recovering Medicare Payment Errors"

Opening Statement of Senator Thomas R. Carper, Chairman

"Today we will hear from several witnesses about preventing and recovering waste and fraud in Medicare. The witnesses who've joined us today will tell an important story. Medicare is a critical component of health care in our nation, with over 45 million seniors participating.

"As a recovering Governor, I understand the unique challenges that come along with running a major program. Unfortunately, Medicare has seen its share of problems. Of course, no program is perfect. But Congress must ensure sure that the more than $460 billion we spend through Medicare to address the health care needs of our nation's seniors is spent effectively and efficiently.

"Medicare is on the Government Accountability Office's list of government programs at 'high risk' for waste, fraud and abuse. There are several differing estimates of waste and fraud within the Medicare program. The Office of Management and Budget, for example, has reported $36 billion in improper payments by the Medicare program according to data gathered from fiscal year 2009.

"However, this figure does not include information about payments for the Medicare Prescription Drug Program as the administration is still struggling to determine the amounts of wasteful spending for that part of Medicare. Meanwhile, U.S. Attorney General Holder estimates that Medicare fraud likely totals about $60 billion dollars each year.

"So what has Congress and the executive branch done to address these very real problems with waste and fraud? Let me start with some good news.

"In 2003, Congress mandated a recovery auditing contractor demonstration program to examine Medicare fee for service payments. Through recovery auditing, internal auditors or outside contractors are employed to go through an agency's books essentially line by line to identify and recover payments made erroneously, such as duplicate payments or payments for medical procedures that never happened. This innovative tool is widely used in the

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private sector. And now we have seen successful use by the federal government with Medicare.

"The Recovery Audit Contractor program for Medicare began as a demonstration program in March 2005 with three states, California, Florida and New York, and was later expanded to include Massachusetts and South Carolina. And the program has been successful.

"During the first year of the demonstration program, $54 million was returned to the Medicare trust fund. In year two, $247 million was recovered. I believe the total amount of money recovered and put back into the Medicare program reached almost a billion dollars.

"The program was so successful that Congress has now mandated its expansion to all 50 states. This expansion is already well underway.

"There is also a provision in the recently-enacted health care law, the *Patient Protection and Affordable Care Act,* to expand the program to include Medicare Advantage, the Medicare Prescription Drug Program and Medicaid.

"The sooner the full program is up and running, the sooner we can recover millions of dollars – probably billions of dollars - in additional overpayments and put them to more effective use.

"There is an added benefit to an expansion of recovery auditing. The Recovery Audit Contracting pilot program has identified dozens of vulnerabilities in the Medicare payment system that can lead to waste and fraud.

"According to the Centers for Medicare and Medicaid Services, the contractors hired to recoup overpayments identified ongoing vulnerabilities that could lead to future overpayments totaling more than $300 million. So not only did the contractors recover almost a billion dollars in overpayments in the three year pilot program, they also identified problems in the system that, if addressed, will avoid billions of dollars in future errors and fraud.

"Our witnesses from the Government Accountability Office will describe today how the Centers for Medicare and Medicaid Services, the agency which oversees Medicare, could do more to use the work of the recovery audit contractors to address overpayments. GAO noted 58 vulnerabilities identified through the demonstration program, representing $303 million in overpayments. That is good, and useful.

"However, according to the GAO, the Centers for Medicare and Medicaid Services only actually addressed 23. That leaves 35 vulnerabilities - representing $231 million in annual overpayments - awaiting action. The GAO also stated that CMS has not established "steps to assess the effectiveness of any action taken" to date to reduce the vulnerabilities by their auditors. I look forward to hearing more about this issue from our witnesses.

"The second issue for today's hearing will focus on the Medicare Prescription Drug Program. An audit by the inspector general at the Department of Health and Human Services

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discovered that that Medicare does not have a strong process to ensure valid identification numbers on reimbursed prescriptions under the drug program. What does that mean?

"When a beneficiary brings in a prescription for medication he or she has been prescribed, the pharmacy is required to enter a provider identifier showing that an actual doctor or some other authorized provider correctly okayed the prescriptions. Apparently, 18 million prescription drug claims contained invalid prescriber identifiers in 2007, representing more some $1.2 billion in Medicare spending.

"The Inspector General concluded 'it appears that CMS ... and Part D plans do not have adequate procedures in place' to ensure valid prescription identification.

"Our witness will report today on not only the current challenges of waste and fraud that I have outlined in the Medicare program, but identified solutions. I look forward to their testimony."

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STATEMENT OF SENATOR JOHN MCCAIN, RANKING MEMBER

SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT,
GOVERNMENT INFORMATION, FEDERAL SERVICES AND
INTERNATIONAL SECURITY

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

"Preventing and Recovering Medicare Payment Errors"

July 15, 2010

Chairman Carper, thank you for holding this hearing today. With the federal government's record deficit and the Medicare program's deteriorating financial condition, we must continue to exercise vigorous oversight over government payments.

The Office of Management and Budget reported that over 98 billion of taxpayer dollars were identified as being paid out improperly during FY 2009, including $36 billion related to the Medicare program. Of this $36 billion, Medicare Fee-For Service accounts for $24 billion, while Medicare Advantage accounts for the other $12 billion. Some of these improper payments are attributed to outright fraud, while others resulted from simple clerical errors.

The Center for Medicare and Medicaid Service (CMS) has yet to produce an improper payment estimate for the Medicare Prescription Drug Program -- otherwise known as Medicare Part D. We learned in our March hearing on Medicare Part D's program integrity that significant lapses in the process to detect and prevent fraud, waste and abuse exists. When CMS produces an improper payments estimate for Medicare Part D, it is certain to push the federal government's overall erroneous payments to record highs.

In fact, the U.S. Department of Health and Human Service's Inspector General recently identified $1.2 billion in Medicare Part D claims that contained invalid prescriber identifiers in 2007. Surprisingly, obvious invalid prescriber identifier

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numbers were not flagged by CMS. And worse yet, claims using such invalid prescriber identifier numbers were paid. According to the Inspector General, neither CMS nor Part D sponsors verify prescriber identifiers in corresponding registries. Without verification of a valid prescriber identifier number, the risk of fraudulent claims becomes exponential.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 required CMS to implement a 3-year recovery audit contractor, or RAC, demonstration project in six states to test whether the RACs could effectively identify improper payments to be recouped. RACs are generally hired on a contingency fee basis to review previously paid claims and identify improper payments for recovery. The lessons learned from the demonstration project were to be used to strengthen the integrity of the payment process before the RAC program was expanded nationwide in 2009. Unfortunately, CMS has failed to take effective action.

In March 2010, the Government Accountability Office (GAO) reported that CMS had not addressed many of the RAC-identified vulnerabilities or systemic problems that led to improper payments during the demonstration project. Of the 58 most significant vulnerabilities, corrective action had been taken on only 23 of them. Additionally, GAO cites CMS's failure in the national rollout to establish an adequate process to evaluate RAC findings, determine appropriate responses to RAC findings, and implement corrective actions.

Last month the Senate passed, by unanimous consent, the Improper Payments Elimination and Recovery Act in 2010 that requires federal agencies to identify improper payments and conduct recovery audits for programs that expend one million dollars or more. I was pleased to co-sponsor this legislation with Chairman Carper to help combat fraud, waste, and abuse and recover payments that never should have been made. With American families and businesses struggling in the present economy and government spending increasing, we cannot afford to squander taxpayer dollars.

Thank you again, Mr. Chairman. I look forward to hearing from our witnesses on how we can help curb the federal government's erroneous payments in the Medicare program.

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Opening Statement of Senator Tom Coburn
"Preventing and Recovering Government Payment Errors."
July 15, 2010

Good morning. Thank you to Senator Carper for holding this hearing, and thank you to our witnesses for joining us.

Today we are here to examine the troubling improper payment problem that continues to plague the federal government and specifically, the Medicare program. In 2009, the federal government had an Improper payment rate of $98 billion and according to HHS, the 2009 improper payment rate for Medicare fee-for-service (FFS) was $24.1 billion. Both of these figures are unacceptable and do little to build confidence in the American people that their government is able to manage their tax dollars properly.

By looking at the billions of dollars spent improperly each year, it is clear that merely requiring agencies to submit reports to congress on their estimation of improper payments and how they might attempt to fix them has failed to eliminate or even curb improper payments. Agencies, and in this case CMS, must identify and fix the problems that are at the core of the improper payment problem so we don't spend hundreds of millions of dollars a year recovering payments that that should not have been sent in the first place.

To aid in recovering the improper payments within Medicare, Congress established a pilot program that used Recovery Audit Contractors or RACs to identify improper payments within Medicare Parts A and B. Because the pilot program was able to identify over $1 billion in improper payments, Congress expanded the program nationwide and later included Medicare Parts C and D, as well as Medicaid.

Although, identify improper payments in any federal program step in the right direction, I still have real concerns with this CMS integrity program.

First and foremost, I am concerned that CMS will not address the vulnerabilities that the RACs have identified that led to the improper payments within Medicare. As the GAO points out in their testimony "CMS has not yet implemented corrective action for 60 percent of the most significant RAC-identified vulnerabilities that led to improper payments."[1]

If CMS is having problems correcting the vulnerabilities from the pilot program, how are they going to be able to fix the vulnerabilities that the RACs identify now that the program is nationwide and includes Medicaid? It seems to me that CMS is focusing mainly on recovering post-payment errors instead of correcting the root cause of these improper payments.

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[1] Government Accountability Office, "Medicare Recovery Audit Contracting: Weaknesses Remain in Addressing Vulnerabilities to Improper Payments, although Improvements Made to Contractor Oversight", March 2010.

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I am also concerned that CMS is not prepared to fully implement the RAC program now that it includes Medicare Parts C and D, as well as Medicaid. Does CMS have the necessary guidelines in place for Medicaid so that the States will can get the recovery audit programs up and running? Will CMS be able to meet their deadline of December 31, 2010 to expand the recovery audit program to Parts C and D and Medicaid? Once improper payments are identified by the RACs, is CMS able to recovery these taxpayer dollars?

These and many other questions need to be answered before we can ensure the American taxpayer that we are being good stewards of their tax dollars.

I would again like to thank the witnesses for being here and look forward to their testimony.

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United States Government Accountability Office

GAO

Testimony

Before the Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security, Homeland Security and Governmental Affairs Committee, U.S. Senate

For Release on Delivery
Expected at 10:00 a.m. EDT
Thursday, July 15, 2010

MEDICARE RECOVERY AUDIT CONTRACTING

Lessons Learned to Address Improper Payments and Improve Contractor Coordination and Oversight

Statement of Kathleen M. King, Director
Health Care

Statement of Kay L. Daly, Director
Financial Management and Assurance



GAO-10-864T

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Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss preventing and addressing government payment errors in the Medicare program.[1] Medicare, which provides health insurance for those aged 65 and older and certain disabled persons, is susceptible to improper payments due to its size and complexity.[2] Because the Medicare program has paid billions of dollars in error each year,[3] the Centers for Medicare & Medicaid Services (CMS)—the agency that administers Medicare—conducts a number of activities to reduce improper payments. CMS administers the Medicare program with the help of Medicare claims administration contractors,[4] which are not only responsible for processing and paying approximately 4.5 million claims per day, but for also conducting pre-payment reviews of claims to prevent improper payments before claims are paid, as well as post-

[1]Medicare consists of four parts. Medicare Fee for Service (FFS) includes two parts—Medicare Parts A and B whereby providers are paid for each service, unit or bundle of services provided. Medicare Part A covers inpatient hospital services, skilled nursing facility services, some home health, and hospice services. Medicare Part B covers hospital outpatient, physician services, some home health services and preventive services, among other things. Medicare beneficiaries have the option of obtaining coverage for Medicare Part A and B services from private health plans that participate in Medicare Advantage—Medicare's managed care program, also known as Medicare Part C. All Medicare beneficiaries may purchase coverage for outpatient prescription drugs under Medicare Part D.

[2]Improper payments may be due to errors, such as the inadvertent submission of duplicate claims for the same service, or misconduct, such as fraud and abuse. Fraud is an intentional act or representation to deceive with knowledge that the action or representation could result in an inappropriate gain. Abuse typically involves actions that are inconsistent with acceptable business or medical practices and result in unnecessary costs.

[3]For example, in 2009 the Department of Health and Human Services (HHS) estimated that approximately $24.1 billion or 7.8 percent of Medicare FFS payments for claims from April 2008 through March 2009 were improper. (November 2009 "Improper Medicare FFS Payments Report" in HHS's *Fiscal Year 2009 Agency Financial Report*.) Since 1990, Medicare has been included in our reporting of "high risk" areas, those government operations involving substantial resources and that provide critical services to the public that we find to contain serious weaknesses. See GAO, *High-Risk Series: An Update*, GAO-09-271 (Washington, D.C.: January 2009) and www.gao.gov/highrisk/risks/insurance/medicare_program.php.

[4]CMS has historically used contractors, known as fiscal intermediaries and carriers, to process Medicare claims. CMS is in the process of transitioning to new contracting entities called Medicare Administrative Contractors. Because the transition is ongoing, we use the term Medicare claims administration contractors to refer to the contractors that historically have processed Medicare claims as well as the new Medicare Administrative Contractors.

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payment reviews of claims potentially paid in error. To supplement these and other program integrity efforts, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 directed CMS to conduct a 3-year demonstration project on the use of a new type of contractors—recovery audit contractors[5] (RAC)—in identifying underpayments and overpayments, and recouping overpayments in the Medicare program.[6] The RAC demonstration program began in 2005. Subsequently, the Tax Relief and Health Care Act of 2006 required CMS to implement a national recovery audit contractor program by January 1, 2010.[7]

Since the conclusion of the demonstration project, CMS and we have reported on improvements needed for the RAC national program. For example, in a June 2008 report evaluating the demonstration project, CMS reported its intent to make a number of changes to the RAC national program to better address RAC-identified vulnerabilities,[8] respond to provider concerns, and streamline operations.[9] In March 2010, we reported on weaknesses in the agency's actions to address improper payments and CMS concurred with our recommendations.[10] The findings in both reports are important in light of the administration's recent commitment to reducing payment errors in federal programs.[11] In addition, the Patient Protection and Affordable Care Act mandates the use of RACs to identify overpayments and underpayments and to recoup overpayments made in

[5]Recovery auditing has been used in various industries, including health care, to identify and collect overpayments for about 40 years.

[6]Pub. L. No. 108-173, § 306, 117 Stat. 2066, 2256-57.

[7]Pub. L. No. 109-432, div B., title III, § 302, 120 Stat. 2922, 2991-92 (codified at 42 U.S.C. § 1395 ddd(h)).

[8]A vulnerability is an issue likely to lead to an improper payment such as billing the incorrect number of units for a particular drug or service or inpatient hospital claims not meeting CMS's criteria for inpatient admission.

[9]See Department of Health and Human Services, Centers for Medicare and Medicaid Services, *The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration* (Baltimore, Md.: June 2008).

[10]See 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.: March 31, 2010).

[11]Finding and Recapturing Improper Payments, 75 Fed. Reg. 12,119 (March 15, 2010); *See also* Exec. Order No. 13,520, 74 Fed. Reg. 62,201 (Nov. 25, 2009); & OMB Circular No. A-123, Appx. C, Requirements for Effective Measurement and Remediation of Improper Payments (Revised March 22, 2010).

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Medicare Parts C and D and the Medicaid program.[12] Not only can CMS's experience with RAC contractors benefit its other programs, but lessons learned from the RAC program may also assist other agencies' payment recapture audits, increase the funds recovered, and help prevent such improper payments from being made in the future.

Our testimony today is based on our March 2010 report[13] and will focus on the lessons that can be learned from the RAC demonstration about (1) developing an adequate process and taking corrective action to address RAC-identified vulnerabilities leading to improper payments, (2) resolving coordination issues between the RACs and the Medicare claims administration contractors, and (3) establishing methods to oversee RAC claim review accuracy and provider service during the national program.

For our March 2010 report, we reviewed CMS documents and interviewed officials from CMS, as well as contractors and provider groups affected by the demonstration project. We conducted our work for this performance audit from March 2009 through March 2010. Our work was performed 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.

Background

The RAC demonstration project was designed to supplement existing claims review processes and required the RACs to review claims previously paid by existing Medicare claims administration contractors. RACs were charged with identifying payment errors, such as whether a provider billed the correct number of units for a particular drug or service. Once a RAC identified a payment error, it informed the provider of the error and its amount. The Medicare claims administration contractor then

[12]Pub. L. No. 111-148, § 6411, 124 Stat. 119, codified at 42 U.S.C. §§ 1396a(a)(42)(B) and 1395ddd(h).

[13]See GAO-10-143.

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adjusted the claim to the proper amount[14] and collected the overpayment from, or reimbursed the underpayment to, the provider. CMS paid RACs contingency fees on overpayments collected and underpayments refunded.[15] CMS and its Medicare claims administration contractors were responsible for taking corrective actions[16] for vulnerabilities identified by the RACs, including identifying the causes of each type of vulnerability and addressing them, in order to reduce future improper payments.

In a 2006 status report, CMS noted that the demonstration RACs identified $303.5 million in improper payments. However, this amount did not include the final results of any provider appeals filed afterwards or pending at that time.[17] CMS concluded that "preliminary results indicate that the use of recovery auditors is a viable and useful tool for ensuring accurate payments" and that RACs would be a "value-added adjunct" to the agency's programs. Throughout the RAC demonstration, CMS stated its intention to use information on the vulnerabilities found by the RACs to help prevent future improper payments. In addition, the agency wanted to address concerns expressed by providers prior to the implementation of a national program, such as holding the RACs accountable for the accuracy of their decisions.

[14]During the demonstration project, the Medicare claims administration contractors processed hundreds of thousands of RAC claim adjustments—some manually—which created significant additional workload.

[15]During the demonstration, CMS paid the RACs a total of $187.2 million in contingency fees. Initially, the RAC demonstration project did not include contingency fee payment to the RACs for identifying underpayments and refunding providers. Beginning on March 1, 2006, the RACs were paid an equivalent percentage contingency fee for the identification of underpayments.

[16]Corrective actions that could be taken by CMS or its Medicare claims administration contractors include: conducting provider outreach and education; developing guidance or new regulations; reissuing instructions for coding a claim or initiating additional service-specific local or national prepayment computer edits to deny improper claims or flag them for additional review.

[17]Providers could appeal unfavorable RAC determinations through the standard Medicare appeals process, which includes five levels of review. The Medicare claims administration contractors conduct the first level of appeal.

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Lessons Learned Highlight the Need to Develop Processes to Take Corrective Actions and to Improve Coordination and Oversight

Our March 2010 report pointed to three areas for lessons to be learned from the RAC demonstration that could be applicable as CMS expands recovery audits to Medicare Parts C and D and Medicaid and to other agencies' payment recapture efforts. Establishing an effective recovery audit program involves developing processes to take corrective action on underlying vulnerabilities that lead to improper payments; coordinating the activities of various parties that have responsibilities related to the payment process; and assuring recovery audit contractor accuracy and service through oversight. Specifically, agencies should

- *Establish an adequate process to address RAC-identified vulnerabilities leading to improper payments.* During the demonstration, we found that CMS did not develop a process to take corrective actions or implement sufficient monitoring, oversight, and control activities to ensure the "most significant" RAC-identified vulnerabilities were addressed.[18] In addition, providers informed us that CMS did not take corrective actions on RAC-identified vulnerabilities such as conducting provider education or implementing computer system edits to help prevent future improper payments. We found that CMS and the Medicare claims administration contractors did not implement corrective actions for 35 of 58 (60 percent) of the most significant vulnerabilities that led to improper payments during the demonstration as shown in figure 1. We also found that the unaddressed corrective actions represented $231 million.[19]

[18]According to CMS, the most significant vulnerabilities were those for which RACs identified more than $1 million in improper payments for medical services or $500,000 for durable medical equipment.

[19]These unaddressed vulnerabilities are a portion of 18 specific medical services CMS valued at $378 million.

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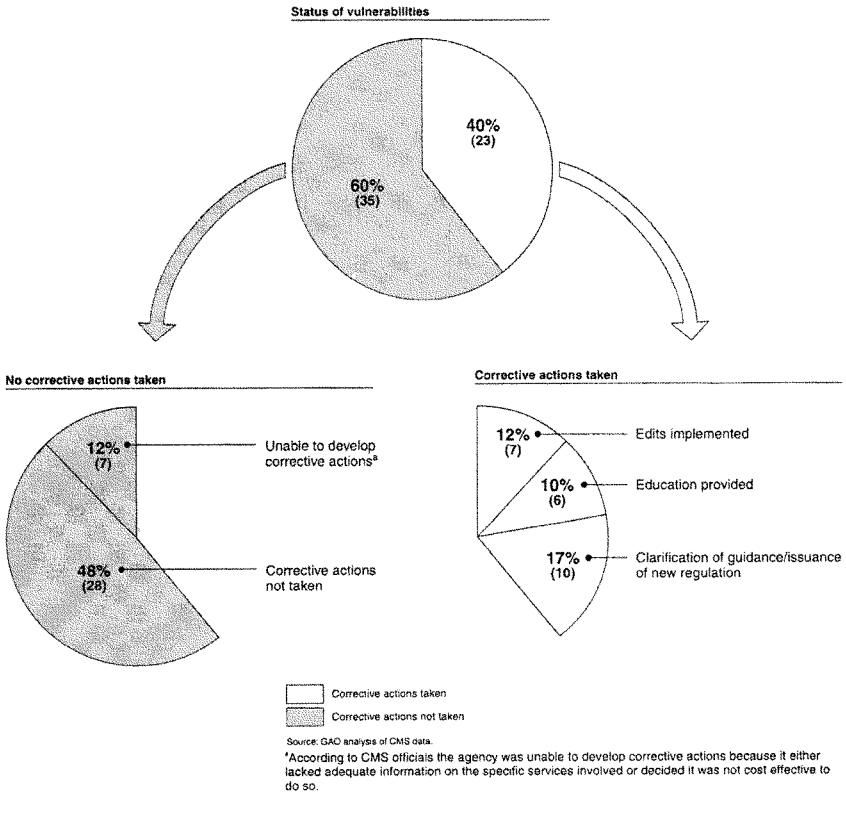
Figure 1: Status of Corrective Actions for 58 Vulnerabilities with Improper Payments of Greater Than $1 Million, as of the End of the Recovery Audit Contractor Demonstration Project—March 2008



Source: GAO analysis of CMS data.

[a]According to CMS officials the agency was unable to develop corrective actions because it either lacked adequate information on the specific services involved or decided it was not cost effective to do so.

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Note: Potential corrective actions include implementing computer edits that deny improper claims or flag claims for further review, educating providers about Medicare rules and proper billing procedures and issuing clarification of guidance or a new regulation.

Percentages in figure may not add to 100 due to rounding.

For the four RAC contractors implementing the national program, CMS developed a process to compile identified vulnerabilities and recommend actions to prevent improper payments. However, we found that this new corrective action process lacked essential procedures, such as evaluating the effectiveness of corrective actions taken, and staff with the authority to ensure that these vulnerabilities are resolved promptly and adequately to prevent further improper payments. Our report recommended that the Administrator of CMS develop and implement a process that includes policies and procedures to ensure that the agency promptly evaluates findings of RAC audits, decides on the appropriate response and a time frame for taking action based on established criteria, and acts to correct the vulnerabilities identified. As part of this process, we recommended that the Administrator of CMS designate key personnel with appropriate authority to be responsible for ensuring that corrective actions are implemented and that the actions taken are effective. In commenting on a draft of the report, CMS concurred with our recommendations and stated that the Administrator of CMS is the official responsible for assuring that vulnerabilities that cut across all agency components are addressed.

- *Take steps to address coordination issues between contractors.* The agency continued activities that worked well during the demonstration project, initiated a number of new actions, and is taking steps to address coordination challenges. According to CMS, once the RACs identify errors, Medicare claims administration contractors are responsible for re-processing the claims to repay underpayments or recoup overpayments, conducting the first level review for RAC-related appeals, and informing and training providers about lessons learned through the RAC reviews. During the demonstration project, providers noted that RAC determinations resulted in thousands of provider appeals to Medicare claims administration contractors. These appeals and re-processing of claims produced additional workload for the Medicare claims administration contractors, who are also responsible for adjudicating the first level of appeals. The appeals and adjustments workload led to coordination challenges for the Medicare claims administration contractors and RACs. As a result, CMS learned that regular communication between the RACs and the Medicare claims administration contractors regarding RAC-identified payment vulnerabilities was important due to their interdependence. In addition, CMS created a data warehouse for the demonstration that contained information on which

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claims were unavailable for RAC review to prevent the RACs from auditing claims previously reviewed by a claims administration contractor or other contractor investigating potential Medicare fraud. For the national program, CMS modified the data warehouse to include more capacity and utility. The agency also automated the manual claims adjustment process used by the Medicare claims administration contractors to recoup improper payments in order to reduce their administrative burden. Further, the volume of provider appeals made it difficult to manage all of the paper medical records that needed to be exchanged between the RACs and claims administration contractors in order to assess the RAC determinations. Provider association and hospital representatives noted the RACs sometimes requested duplicate medical records to evaluate the medical necessity or appropriateness claims as part of their reviews, thus increasing providers' administrative burden. As a result, CMS developed an electronic documentation sharing system to improve storage and transfer of medical records.

- *Oversee the accuracy of RACs' claims reviews and the quality of their service to providers.* During the demonstration project, providers stated that the contingency fee payment structure CMS employed created an incentive for RACs to be aggressive in determining that paid claims were improper. RACs were paid contingency fees during the demonstration even if their findings were later overturned on appeal. For the national program, CMS changed its payment of contingency fees so that RACs will have to refund contingency fees received on a determination overturned at any level of the appeal process. CMS also established performance metrics that the agency will use to monitor RAC accuracy and service to providers. In addition, CMS added processes to review the accuracy of RAC determinations including independent reviews by a validation contractor. Prior to pursuing a wide-scale review of any vulnerability in the national program, the RAC must submit information and a small sample of reviewed claims and related findings to CMS to check for accuracy and to ensure the RAC's compliance with the rule, policy, or regulation against which the claims will be evaluated. CMS has also established a process for ongoing oversight of RAC accuracy through a regular independent assessment of a sample of RAC-reviewed claims and determinations by the validation contractor. This will lead to an annual accuracy score for each RAC, scores which CMS intends to publish. Further, CMS established requirements to address provider concerns about service. Specifically, CMS required RACs to establish Web sites that will allow providers to track the status of a claim being reviewed and include information on each vulnerability being audited by that RAC. However, because the agency does not have a standard system to track appeals through the entire five

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levels of the appeals process, CMS does not require RACs to provide information on the status of claims' appeals on their Web sites.

In conclusion, the ultimate success of the government-wide effort to reduce improper payments hinges on each federal agency's diligence and commitment to identify, estimate, determine the causes of, take corrective actions on, and measure progress in reducing improper payments. CMS's experience provides useful lessons for the management of the Medicare and Medicaid programs, as well as other recovery auditing programs on the importance of addressing the root causes of vulnerabilities to improper payments and effectively coordinating and overseeing the accuracy of contractors. Such lessons may be useful as recovery auditing is incorporated more broadly in the federal government.

Mr. Chairman, this concludes our prepared statement. We would be happy to answer any questions you or other members of the subcommittee may have.

GAO Contacts and Staff Acknowledgments

For further information about this statement, please contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov or Kay L. Daly, (202) 512-9095 or dalykl@gao.gov.

Sheila Avruch and Carla Lewis, Assistant Directors; Jennie F. Apter; Anne Hopewell; Laurie Pachter; Nina M. Rostro; and James Walker were key contributors to this statement.

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STATEMENT OF

DEBORAH TAYLOR

CHIEF FINANCIAL OFFICER AND DIRECTOR,
OFFICE OF FINANCIAL MANAGEMENT
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

PREVENTING AND RECOVERING MEDICARE PAYMENT ERRORS

BEFORE THE

U.S. SENATE COMMITTEE ON
HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS, SUBCOMMITTEE ON
FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT INFORMATION,
FEDERAL SERVICES, AND INTERNATIONAL SECURITY

JULY 15, 2010

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U.S. Senate Committee on Homeland Security and Governmental Affairs,
Subcommittee on Federal Financial Management, Government Information,
Federal Services, and International Security
Hearing on Preventing and Recovering Medicare Payment Errors
July 15, 2010

Chairman Carper, Ranking Member McCain, and distinguished members of the Subcommittee, I thank you for the opportunity to discuss the Recovery Audit Contractor (RAC) program with you today. RACs provide the Centers for Medicare & Medicaid Services (CMS) with an important tool for identifying and correcting improper payments, a goal that we all share.

Background on CMS Programs

Before proceeding, it is helpful to consider the context in which the RAC program operates. As you know, CMS is the Federal agency responsible for oversight of Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). Through these three programs, CMS is responsible for providing health care to more than 100 million beneficiaries and expends more than $700 billion per year.[1] Medicare and Medicaid alone account for 35 cents of each health care dollar spent in the United States.[2]

While CMS administers and has general oversight over these health insurance programs, they each operate differently through a combination of direct federal administration, contracts with private insurers, and partnerships with the States. These statutory design differences require CMS to contract or work with very different entities. For instance, Medicare is a multifaceted program, with four distinct parts to provide benefits to Medicare beneficiaries. The traditional, Medicare fee-for-service (FFS) program, Parts A and B, provides hospital and medical insurance and uses a number of different payment systems to directly reimburse more than one million health care providers and suppliers such as hospitals, physicians, skilled nursing facilities, labs, ambulance companies, and durable medical equipment (DME) suppliers. Meanwhile, CMS also contracts with hundreds of different private insurance plans to provide full Medicare Part A and B benefits and additional benefits under a managed care benefit, referred to as Medicare

[1] Budget in Brief, Fiscal Year 2011, U.S. Department of Health & Human Services, page 51.
[2] National Health Expenditures data 2009.

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Advantage or Part C. In addition, CMS administers hundreds of different contracts with insurance plans that provide outpatient prescription drug coverage under the Part D benefit.

While CMS administers "the Medicaid Program" and "CHIP," it is important to remember that Medicaid and CHIP are essentially more than 50 individualized programs, in which CMS works with each State and Territory to administer a program that meets the particular health care needs and level of benefits established by that jurisdiction, within Federal guidelines.

Improper Payments and the Medicare Program

Like other large Federal programs, Medicare and Medicaid are susceptible to errors—typically called "improper payments." These improper payments represent a fraction of total program spending; however, given the staggering size of overall program expenditures, even a small percentage of improper payment is significant for both Federal and State treasuries and taxpayers. Any level of improper payment is unacceptable and CMS is aggressively working to reduce these errors.

Due to the volume of claims processed by Medicare and the significant cost associated with conducting medical review of an individual claim, claims processing contractors rely heavily on automated edits to flag problematic claims and pay most claims without requesting or individually reviewing the medical records associated with the services listed in the claim. In addition, due to requirements to promptly pay claims in Medicare, our claims processing systems were built to quickly process and pay the 4.8 million claims that we receive each day, totaling approximately 1.2 billion claims in fiscal year 2011.

Improper payments can result from a variety of assorted circumstances, such as a claim paid based on an outdated fee schedule or double payment for a duplicate claim. Improper payments are not necessarily fraudulent; rather, they are an indication of errors made by either the provider or our systems that need to be corrected. Most improper payments by providers are classified as such because they refer to claims that do not have all accompanying documentation. For example, providers may fail to submit documentation when requested, or fail to submit sufficient documentation to support the claim.

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Examples of common payment errors made by providers include services that were medically unnecessary, performed in a medically unnecessary setting, or were incorrectly coded.[3] Additionally, Medicare Secondary Payer (MSP) improper payments can occur when Medicare pays a claim that should have been paid by a different group health plan or other liable party.

The Administration is committed to reducing waste and improper payments across the government. On November 20, 2009, President Obama issued Executive Order 13520 calling on all Federal agencies to reduce waste and improper payments across Federal programs. Further, President Obama recently announced that CMS will cut the Medicare FFS improper payment rate in half by 2012. For its part, in the last year, CMS has applied a stricter and improved methodology for calculating the Medicare FFS error rate to ensure accuracy in the error rate measurement. These changes will provide CMS with more complete information that can be used to focus on corrective actions that may need to be made. CMS is also taking action to ensure that providers submit all required documentation to support a claim and that beneficiary claim histories are no longer being used to fill in missing treatment documentation at a later date.

In addition to these efforts, CMS has taken a variety of actions to prevent and reduce the number of improper payments, and recoup improper payments that have occurred. A core goal of CMS program integrity efforts is to strengthen prevention of fraudulent and improper payments, getting away from the historic "pay and chase" framework for program integrity. Bolstered by new authorities in the Affordable Care Act (ACA), we are steadily working to apply stricter scrutiny to providers and suppliers relating to program enrollment.

As our nation begins to adopt electronic health records (EHRs), the Department and CMS are working to encourage providers to use EHRs and develop standards that will make it possible for providers to electronically submit medical documentation to Medicare upon request. We anticipate that this will result in a reduced error rate for Medicare FFS because there will be fewer errors for illegible or missing signatures, and medical documentation will be easier to

[3] Incorrect coding: Claims are placed into this category when providers submit medical documentation that support a lower or higher code than the code submitted. (CMS Improper Medicare Fee-For-Service Payments Report, November 2009).

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retrieve and submit. In today's paper-intensive process, most providers and suppliers maintain and store hard-copy medical documentation. When requested by a Medicare review contractor, these records must be manually located, retrieved, photocopied and mailed to the requesting contractor, which can lead to omissions, causing missing documentation errors.

Legislative History of Medicare Recovery Audit Contractors (RACs)

In recent years, RACs have been an important tool in CMS' ongoing efforts to ensure that Medicare payments are accurate and appropriate. The RAC demonstration project was required by section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which directed CMS to establish a RAC demonstration in at least two States from among States with the highest per-capita Medicare utilization rates, and to use at least three RACs. CMS began this demonstration in Florida, California and New York in 2005, and later expanded to Massachusetts, South Carolina, and Arizona.

Congress expanded the RAC program in section 302 of the Tax Relief and Health Care Act of 2006 (TRHCA), directing CMS to implement a permanent national recovery audit contractor program by January 1, 2010. Just this year, Congress further expanded the RAC program in ACA to Medicare Parts C and D and to State Medicaid programs.

RAC Demonstration

The RAC demonstration provided valuable lessons to CMS, providers, and the RACs that have led to improvements in the national program. As part of the RAC demonstration project, Congress authorized CMS to pay each RAC a contingency fee instead of a standard contract fee award. This demonstration was the first time the Medicare program paid a contractor on a contingency fee basis; however, this type of payment methodology has been an accepted standard practice among private healthcare payers for more than 20 years. CMS found that it was possible to administratively pay the contractors a contingency fee and that contractors were willing to be paid on a contingency fee basis.

The RACs were chosen and awarded through a competitive process. CMS held a full and open competition to select the three Claim RACs and two additional Medicare Secondary Payer

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(MSP) RACs for the demonstration. CMS provided each Claim RAC with claims data from 2001 to 2007 for its assigned jurisdiction and each RAC had the flexibility to identify the claims most likely to contain improper payments. RACs reviewed all claims using their proprietary algorithms to identify improper payments that could be detected without medical review, and conducted post-pay medical record reviews of claims identified as likely to contain improper payments. Based on these results, RACs notified providers and directed Medicare claims processing contractors to make necessary adjustments to collect the overpayments or underpayments. MSP RACs were charged with obtaining and reviewing health plan information to determine whether Medicare should have been the primary payer of a claim, or whether a beneficiary had other coverage (e.g. employer-sponsored coverage or worker's compensation insurance) that should have made the primary payment.

The RAC demonstration was a success, resulting in the correction of $1.03 billion in improper Medicare payments. Ninety-six percent of these improper payment corrections – or approximately $990 million – were overpayments collected by CMS, resulting primarily from medically unnecessary care or claims that were incorrectly coded. MSP RACs accounted for only $12.7 million of the total overpayments collected, suggesting that CMS' current efforts to identify and address MSP improper payments are relatively robust. As a result, MSP RACs were not included as part of CMS' permanent national RAC program. The costs of operating the RAC demonstration program totaled $201.3 million, meaning that the program cost approximately 20 cents for each dollar collected.

Lessons Learned

CMS learned a variety of valuable administrative and programmatic lessons from the demonstration project that have informed future program efforts. First, RACs proved successful in identifying and correcting improper payments in the Medicare program. CMS also learned that the administrative cost of the RAC demonstration was significantly less than the amount of money returned to the Medicare trust funds. The structure of the RAC demonstration proved viable, with companies willing to be paid on a contingency fee basis. These contingency fee contractors did not interfere with other ongoing Medicare anti-fraud efforts, and were also willing to spend time on RAC program provider outreach activities. CMS also learned that it is

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possible to gradually expand the RAC program, which became especially important after Congress established a January 1, 2010 deadline for a nationwide implementation of the permanent program.

One of the major lessons learned was the importance of communication with providers, and that a gradual rollout provides time to develop strong communication channels with providers in advance of RAC operations. CMS also realized the importance of involving the provider community in making changes to the national program. CMS worked very closely with the provider community and associations to get feedback prior to instituting large-scale changes and continues to value their ongoing participation and feedback.

From a programmatic perspective, the RACs shed light on areas where policy changes, systems changes and education and outreach were needed by CMS. For example, the demonstration RACs identified a number of improper payments related to inpatient rehabilitation facilities (IRFs). CMS recognized that the IRF policy was outdated, and recently published a regulation to update and clarify the policy. Additionally, CMS conducted extensive provider education to ensure providers understood the updated policies and knew how to bill IRF claims correctly. The demonstration RACs also identified cases in which the billing code for a certain drug had been updated. Providers were unaware of the change and were incorrectly billing. In response, CMS implemented a national edit in the claims processing system to deny the claim. In addition, CMS conducted provider education on this vulnerability at more than 25 National conferences in FY 2007 and 2008.

National Rollout of RAC Program

While the demonstration affirmed the feasibility of the RAC model to identify and correct improper Medicare payments, it also identified a number of problems and programmatic challenges that CMS was able to address before further expanding the program. CMS acknowledged that several of the concerns raised by providers in the demonstration were valid, and addressing them prior to national rollout has resulted in positive changes that will enable the national RAC program to maximize transparency, ensure accuracy, and minimize provider burden.

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The full list of changes made in the permanent RAC program appears as an addendum to this testimony,[4] but I would like to highlight a few of these changes. Every RAC is required to hire a physician medical director, which gives providers additional assurance that the reviews of their medical decisions are accurate and handled appropriately. Providers expressed concerns that filling multiple requests for medical records for review created a burden. As a result, CMS created sliding scale limits, based on provider size, for the number of medical records that can be requested by RACs from a provider. In order to ensure accurate determinations of payments made in error, RACs must now also secure pre-approval from CMS of issues they wish to pursue for review, meaning that before a RAC can proceed with large numbers of reviews, CMS staff, and if necessary, a third party independent reviewer, must examine and approve the proposed provider type, error type, policy violated and potential improper payment amount per claim to ensure that the review is appropriate. In addition, to address the concern that RACs might have a perverse incentive to over-identify improper payments, CMS now requires RACs to refund contingency fees for any decision overturned on appeal.

With these changes in place, CMS awarded four RAC contracts in 2008. States have been brought into the national program in phases, allowing sufficient time for CMS and the RACs to conduct extensive RAC program outreach. CMS began with 19 States in October 2008, added 5 additional States in March 2009, and added the remainder of the States in August 2009. In addition to the gradual rollout of States, CMS also employed a gradual rollout of review types. RACs first began conducting automated reviews or reviews using data analysis. In these situations, data analysis indicates an improper payment has occurred and no review of the medical record is necessary. Late in 2009, the RACs began requesting additional documentation, including medical records, to conduct coding reviews and Diagnosis Related Group (DRG) validations. In coding reviews, additional documentation is necessary to support the payment of the claim. Many times these situations appear improper; however, documentation is necessary to support the finding. An example would include the billing of too much of a drug based on FDA dosage guidelines. A review of the medical record and/or additional documentation is necessary to determine the dosage given. DRG validations involve reviewing the supporting medical

[4] See Addendum 1 on page 10 of the testimony.

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documentation to ensure the correct DRG was billed and the correct principal and secondary diagnoses were used to determine the billed DRG. CMS gave the RACs authority to begin to request reviews for medical necessity. As of today, the RACs can review any claim type for any reason as long as the issue has been approved in advance by CMS.

To date, a significant portion of the review in the national program has focused on durable medical equipment and DRG validation. RACs are identifying other issues such as claims paid while a beneficiary is being treated in an inpatient setting and situations where a claim is submitted with an incorrect principal diagnosis, which results in a higher DRG being billed. As trends become apparent, CMS is reviewing and monitoring the improper payments identified by the RACs to determine if corrective actions need to occur. For example, CMS is exploring the creation of a national edit in the system to identify these issues before the claim is paid. We are also discussing the improper payment determinations with the claim processing contractors so that they can determine if local actions should take place.

Affordable Care Act Expansion of RACs

As mentioned above, Congress expanded the role of recovery audit contracting in ACA to Medicaid and Medicare Advantage (Part C) and the prescription drug program (Part D). This change requires all States to establish individual Medicaid RAC programs under their State plan or waiver. In addition, the ACA provision requires RACs to also serve in a program integrity capacity, reviewing each MA and Part D plan's anti-fraud plan.

Both expansions will take the RAC program beyond Medicare FFS for the first time. The lessons and experience that CMS has with fee-for-service Medicare RACs will certainly inform our efforts to pursue recovery auditing in Medicaid, Medicare Advantage and the Medicare prescription drug program. Each of these programs is administered and reimbursed differently and presents its own unique challenges. Although RACs proved effective and relevant to FFS Medicare, it remains to be seen how this effort will translate into the other programs. CMS looks forward to working with Congress as we move forward with implementing the ACA provision,

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and with the overarching goal of ensuring payments are made correctly in the Medicare and Medicaid programs.

Conclusion

Our past experience shows that RACs can have a positive role in identifying and correcting improper payments and returning money to the Medicare trust funds. In addition to recoveries, RACs give CMS a window into areas where additional provider education, pre-payment or post payment edits, data mining, or medical record review are needed.

As we work to implement the new requirement in ACA and expand the role of RACs to Medicare Parts C and D and Medicaid, CMS will continue to examine the lessons learned for improvements that can be made in the RAC program in the future, as well as pursuing other efforts to reduce and eliminate improper payments.

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Addendum 1: Differences between Demonstration RACs and Permanent RACs

	Demonstration RACs	Permanent RACs
RAC medical director	Not Required	Mandatory
Coding experts	Optional	Mandatory
Credentials of reviewers provided upon request	Not Required	Mandatory
Discussion with CMD regarding claim denials if requested	Not Required	Mandatory
Minimum claim amount	$10.00 aggregate claims	$10.00 minimal claims
AC validation process	Optional	Limited
External validation process	Not Required	Mandatory
RAC must payback the contingency fee if the claim overturned at any level of appeal	Only required to pay back if claim is overturned on the first level of appeals	All levels of Appeal
Vulnerability reporting	Limited	Mandatory
Standardized base notification of overpayment letters to providers	Not Required	Mandatory
Look back period (from claim pmt date – date of medical record request)	4 years	3 years
Maximum look back date	None	10/1/2007
Allowed to review claims in current fiscal year?	No	Yes
Limits on # of medical records requested	Optional. Each RAC set own limit	Mandatory. CMS will establish uniform limits
Timeframe for paying hospital medical record photocopying vouchers	None	Within 45 days of receipt of medical record
Quality assurance/ Internal control audit	No	Mandatory
Remote call monitoring	Yes	Yes
Reason for review listed on request for records letters and overpayment letters	Not Required	Mandatory
General RAC webpage	Not Required	By Jan 2010
RAC claim status webpage	Not Required	By Jan 2010

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Testimony before the U.S. Senate Committee on Homeland Security and Governmental Affairs
Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security

"Preventing and Recovering Medicare Payment Errors"

Testimony of:
Robert Vito
Acting Assistant Inspector General
Centers for Medicare and Medicaid Audits
Office of Inspector General
Department of Health & Human Services

July 15, 2010
10:00AM
342 Dirksen Senate Office Building



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Testimony of:
Robert A. Vito
Acting Assistant Inspector General
Centers for Medicare & Medicaid Audits
Office of Inspector General
U.S. Department of Health & Human Services

Good morning, Mr. Chairman and members of the Subcommittee. I am Robert Vito, Acting Assistant Inspector General for the Centers for Medicare & Medicaid Audits at the U.S. Department of Health & Human Services' (HHS) Office of Inspector General (OIG). In March of this year, I testified before this Subcommittee regarding OIG's body of work on program integrity and payment accuracy safeguards in the Medicare Part D prescription drug program (Medicare Part D).[1] At that hearing, I stated that oversight by the Centers for Medicare & Medicaid Services (CMS) and its contractors had been limited and that as a result, the Medicare Part D program was vulnerable to fraud, waste, and abuse.

Recent OIG work illustrates that because of such vulnerabilities, Medicare has paid for substantial numbers of questionable claims for prescription drugs under Part D. OIG's June 2010 report, *Invalid Prescriber Identifiers on Medicare Part D Drug Claims*, reveals that CMS and its plan sponsors have not adequately performed one of the most basic oversight checks in Medicare Part D – ensuring that a drug was prescribed by a physician.[2] As a result, Part D sponsors and beneficiaries paid pharmacies $1.2 billion in 2007 for claims in which the prescriber identifiers listed on the claims did not correspond to practicing physicians. Because prescriber identifiers are a key indicator on Part D claims that link prescribing physicians, dispensing pharmacies, and Medicare beneficiaries, they play a critical role in program integrity efforts. Without a valid prescriber identifier, CMS and its contractors cannot determine if a physician even prescribed a drug, much less verify that the physician was appropriately licensed or had not been excluded from the Medicare program. Furthermore, invalid prescriber identifiers inhibit OIG investigations by making it more difficult to identify questionable prescribing patterns and the parties responsible for potential fraud.

In my testimony, I will provide more details about the findings of our June 2010 study related to invalid prescriber identifiers on Part D claims and offer recommendations to help prevent potentially improper payments associated with this vulnerability in the future. Unfortunately, this is not the first time that OIG has identified problems with

[1] OIG, *Oversight Challenges in the Medicare Prescription Drug Program.* Testimony of Robert A. Vito before the Senate Committee on Homeland Security and Government Affairs Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security. March 3, 2010.
[2] OIG, *Invalid Prescriber Identifiers on Medicare Part D Drug Claims*, OEI-03-09-00140, June 2010.

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invalid prescriber identifiers, and my testimony will also describe earlier OIG work on the issue involving Medicare claims for durable medical equipment (DME).

Use of Invalid Prescriber Identifiers on Part D Claims Is a Significant Program Vulnerability

One of the most basic safeguards in paying for medical care – be it Medicare, Medicaid, or private payers – is ensuring that an item or a service was performed, provided, or prescribed by an appropriate medical professional. However, a recent OIG study, *Invalid Prescriber Identifiers on Medicare Part D Drug Claims*, found that this basic safeguard is not always operating effectively.

CMS contracts with plan sponsors to administer the Medicare Part D benefit and pay Part D claims. Sponsors must submit an electronic record, called a prescription drug event (PDE) record, to CMS for any covered prescription that is filled. CMS requires that most PDE records contain an identifier for the drug's prescriber, which is to be entered by the dispensing pharmacy when the claim is submitted to the sponsor.[3] This requirement not only helps to ensure that a physician, and not an unqualified provider, prescribed the drug, but also is fundamental to successful program integrity efforts, including:

- verifying a prescribing physician's licensing or disciplinary information,
- examining unusual prescribing patterns by a physician,
- verifying that a beneficiary has had an office visit with a prescribing physician,
- comparing the geographic location of a prescribing physician to the location of a beneficiary to determine if they are in the same area,
- determining whether the specialty of a prescribing physician matches the indications of a prescribed drug, and
- requesting a beneficiary's medical records from a prescribing physician to determine whether a drug was medically necessary.

Beneficiaries and Medicare Part D paid for $1.2 billion in prescription drug claims containing invalid prescriber identifiers in 2007

In our June 2010 report, we found that more than 18 million PDE records contained invalid prescriber identifiers in 2007, representing 2 percent of the nearly 1 billion PDE records submitted to CMS that year.[4] These identifiers either were not listed in the appropriate provider identifier directories or had been deactivated or retired before

[3] CMS does not require a prescriber identifier on Part D drug claims submitted to plans in nonstandard formats, such as beneficiary-filed claims and paper claims.

[4] Given that the new national provider identifier (NPI) initiative had yet to be fully implemented in 2007, almost all of these records (95 percent) had the prescriber identifiers coded as Drug Enforcement Administration numbers. Of the remaining 5 percent, 3.6 percent were coded with NPIs, 1.3 percent were coded with State medical license numbers, and less than one-tenth of 1 percent were coded as unique physician identification numbers.

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January 1, 2006. Part D sponsors and Medicare beneficiaries paid pharmacies $1.2 billion in 2007 for claims containing these invalid prescriber identifiers.

Identifiers on 17 percent of the drug claims with invalid prescriber identifiers did not conform to format specifications

Based on our analysis of claims data from 2007, CMS and plans were not successfully verifying that prescriber identifiers on Part D claims were in the proper format. In 17 percent of cases, the invalid prescriber identifiers listed on PDE records did not have the correct number of characters and/or contained inappropriate letters, numbers, punctuation marks, or symbols. These PDE records represented $213 million in payments by sponsors and beneficiaries in 2007. One invalid prescriber identifier that did not meet format specifications was a string of nine zeros (000000000). This single invalid identifier accounted for almost 40,000 PDE records worth $3.7 million in 2007.

Ten invalid identifiers accounted for 17 percent of the drug claims with invalid prescriber identifiers

In total, approximately 0.50 million different invalid prescriber identifiers were used on paid Part D claims in 2007. However, just 10 of these invalid identifiers accounted for almost one-fifth of the questionable PDE records. In fact, one invalid prescriber identifier (AA0000000) was recorded on almost 1.8 million PDE records in 2007, representing $105 million in paid claims for 151,269 beneficiaries who were enrolled with 248 different Part D sponsors. In other words, 10 percent of all PDE records with invalid prescriber identifiers contained this one invalid identifier.

Furthermore, although most of the top 10 invalid prescriber identifiers were submitted on claims by thousands of pharmacies in 2007, one particular invalid identifier, ZZ4567890, was used on drug claims submitted by just 37 different pharmacies. In 2007, virtually all of the PDE records that listed ZZ4567890 as the prescriber identifier were associated with a single company (a large pharmacy benefit manager and mail-order pharmacy) under multiple provider numbers that reflect a number of the company's locations across the country.

It is important to note that an invalid prescriber identifier does not automatically indicate that a prescription was inappropriate or that a pharmacy claim was unnecessary. However, without valid prescriber identifiers, CMS and plan sponsor efforts to determine the validity, medical necessity, or appropriateness of Part D claims will be limited, as it can be difficult to determine the name of, or any details about, the physician who prescribed the drug in question.

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Part D Claims With Invalid Prescriber Identifiers Should Be Subjected to Further Review

OIG recognizes the difficult balancing act CMS faces in trying to ensure beneficiary access while also preventing improper payments. Therefore, we recommended that rather than implementing prepayment edits (which could at times prevent beneficiaries from getting needed medication), CMS conduct periodic reviews to ensure the validity of prescriber identifiers used on PDE records. CMS could also require sponsors to institute procedures that would identify and flag for review any Part D claims with invalid identifiers in the prescriber identifier field. The success of these intermediate steps would depend on whether CMS, the sponsors, and program integrity contractors take appropriate actions when questionable claims are identified.

CMS concurs with these recommendations, and in response to our June 2010 report, acknowledged that issues with invalid prescriber identifiers are hindering oversight efforts. However, CMS also emphasized that there have been significant improvements in the use of prescriber identifiers since the period covered by our analysis. According to CMS, a major reason for these improvements is the implementation of National Provider Identifiers (NPI) as the standard method for identifying prescribing physicians on Part D claims.[5] OIG recognizes that the movement toward NPIs is a positive step, as the use of a single identifier, rather than the multiple types of identifiers previously used, will facilitate efforts by sponsors and CMS to validate prescriber identifiers listed on claims. Nevertheless, we believe that NPIs will not completely eliminate the vulnerabilities identified in our report. In fact, although only about 35 million PDE records (3.6 percent) were coded with NPIs in 2007, we found that over 300,000 of them (almost 1 percent) contained invalid prescriber identifiers. Therefore, the recommendations listed above apply equally to Part D claims containing NPIs, and CMS must remain vigilant in the invalid identifier issue.

Ongoing OIG Work on Invalid Prescriber Identifiers Is Focusing on Specific Geographic Areas and Schedule II Drugs

Recognizing the importance of the prescriber identifier issue, OIG has provided to CMS data from our report on invalid identifiers in Part D. In addition, OIG is conducting additional analysis on invalid prescriber identifiers, and we have identified specific geographic areas with unusually large numbers of questionable claims.

OIG is further reviewing invalid prescriber identifiers related specifically to Schedule II

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[5] NPIs are unique 10-digit identification numbers intended to be a single identifier to replace multiple other identification numbers (such as Drug Enforcement Administration numbers, State medical license numbers, etc.) used by providers on claims.

Testimony of Robert A. Vito, HHS OIG, before U.S. Senate Committee on Homeland Security and Government Affairs, Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security. July 15, 2010

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drugs, like Oxycontin, which are highly susceptible to abuse and fraudulent activity.[6] Claims for this type of drug containing invalid identifiers should be considered highly suspect. Our review focuses not only on whether PDE records contain invalid prescriber identifiers, but also on what steps CMS and sponsors undertake to ensure that the valid identifiers are listed on Part D claims.

Invalid Prescriber Identifiers Have Also Presented Vulnerabilities for Part B Claims

Vulnerabilities with prescriber identifiers have not been confined to Medicare Part D claims. OIG has identified similar problems in claims for durable medical equipment, such as wheelchairs and diabetic supplies, covered under Medicare Part B. In July 2008, I testified before the Permanent Subcommittee on Investigations and discussed two OIG reports that found Medicare paid for millions of dollars in questionable claims that did not accurately identify the physicians that supposedly ordered the items, including many claims that listed deceased doctors as the prescribers.[7]

Medicare regulations require DME suppliers to provide on the claim form the identifier of the physician who ordered the equipment.[8] As with prescription drugs, Medicare relies on physicians to act as gatekeepers to ensure that only medically necessary equipment and supplies are ordered. In conducting our DME-related work, OIG learned that Medicare claims-processing systems verified only that the physician identifier listed on a claim met certain format requirements – automated checks were not performed to ensure that the identifier listed on a claim was valid and active. A November 2001 OIG report OIG found that as a result, Medicare and its beneficiaries paid $91 million for DME claims with invalid or inactive physician identifiers in 1999.[9] Almost $8 million of the $91 million involved identifiers for physicians who were deceased prior to the dates

[6] The Controlled Substances Act of 1970 classifies certain federally regulated drugs as controlled substances and divides them among five schedules based on their medical use and potential for abuse and addiction. Schedule II drugs have high abuse risk, but also have safe and accepted medical uses in the United States. These drugs can cause severe psychological or physical dependence. Schedule II drugs include certain narcotic, stimulant, and depressant drugs.

[7] OIG, *Medicare Payments for Claims with Identification Numbers of Dead Doctors.* Testimony of Robert A. Vito before the Senate Committee on Homeland Security and Government Affairs Permanent Subcommittee on Investigations. July 9, 2008.

[8] On May 5, 2010, CMS issued a rule that institutes new requirements for DME suppliers billing Medicare. According to this rule, to receive payment for certain types of Part B items and services, a provider or supplier must meet all of the following requirements: (1) the items and services must have been ordered or referred by a physician or, when permitted, an eligible professional; (2) the claim from the part B provider or supplier must contain the legal name and the National Provider Identifier (NPI) of the physician or the eligible professional who order or referred the item or service; and (3) the physician or the eligible professional who ordered or referred the item or service must have an approved enrollment record or a valid opt-out record in the Provider Enrollment, Chain and Ownership System.

[9] OIG, *Medical Equipment and Supply Claims with Invalid or Inactive Physician Numbers*, OEI-03-01-00110, November 2001. For this study, OIG defined an invalid identifier as one that had never been assigned by Medicare; or an inactive identifier had been assigned but all the practice settings associated with it had been deactivated.

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of service entered on the claims. OIG recommended that CMS (1) revise claims-processing edits to ensure that the physician identifiers listed on DME claims are valid and active and (2) emphasize to suppliers the importance of using accurate physician identifiers when submitting claims.

Although CMS informed us that it had taken steps to address these recommendations, a followup OIG report in February 2009 showed that invalid and inactive identifiers on DME claims were still a problem almost a decade later.[10] OIG found that Medicare paid almost $34 million in 2007 for medical equipment and supply claims with physician identifiers that had never been issued or had been deactivated by CMS. This figure included $5 million for claims with dates of service after the physicians identified on the claims had died.

Other Recent OIG Oversight Work Has Focused on the Error Rate and Recovery Audit Contractors

Comprehensive Error Rate Testing (CERT) Program

OIG issued a report just yesterday analyzing data from CMS's CERT program.[11] CMS established the CERT program to determine the error rate for Medicare fee-for-service claims. The national paid claim error rate for fiscal year (FY) 2009 was 7.8 percent ($24.1 billion), a significant increase over the FY 2008 error rate of 3.6 percent ($10.4 billion). According to CMS's FY 2009 Improper Medicare Fee-for-Service Payments Report, the increase in the error rate was attributable to substantial changes in the CERT medical record review methodologies.

OIG analyzed the CERT data and identified the types of providers that caused the majority of improper payments and the most significant types of payment errors made by these providers in FY 2009. Our results indicate that six types of providers accounted for 94 percent of the improper payments. These provider types were inpatient hospitals, durable medical equipment suppliers, hospital outpatient departments, physicians, skilled nursing facilities, and home health agencies. The most significant types of payment errors attributable to these six provider groups were: (1) insufficient documentation, (2) miscoded claims, and (3) medically unnecessary services and supplies.

Recovery Audit Contractors (RACs)

In February 2010, OIG issued a report that determined the extent to which RACs referred cases of potential fraud to CMS.[12] CMS contracts with RACs to identify improper

[10] OIG, *Medicare Payments in 2007 for Medical Equipment and Supply Claims With Invalid or Inactive Referring Physician Identifiers*, OEI-04-08-00470. February 2009.
[11] OIG, *Analysis of Errors Identified in the Fiscal Year 2009 Comprehensive Error Rate Testing Program*, A-01-10-01000, July 2010.
[12] OIG, *Recovery Audit Contractors' Fraud Referrals*, OEI-03-09-00130, February 2010.

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payments of Medicare Part A and Part B claims. From March 2005 through March 2008, CMS conducted a RAC demonstration project that was designed to (1) detect and correct past improper payments in the Medicare fee-for-service program and (2) provide information to CMS and the Medicare claims-processing contractors that could help protect the Medicare trust funds by preventing future improper payments.

According to CMS, the RACs' primary focus is the identification and correction of improper payments, not the identification of potential fraud. In fact, RACs receive payment based on the amount of improper payments identified. However, given the nature of the RAC reviews, fraudulent payments could also potentially be identified and referred to CMS or OIG. In our February 2010 report, OIG found that during the 3-year demonstration project, RACs identified over $1 billion in improper payments. However, RACs referred only two cases of potential fraud to CMS during that time period. Because RACs do not receive their contingency fees for fraud referrals, there may be a disincentive for the RACs to refer these types of cases. In addition, during the demonstration project, CMS did not provide the RACs with any formal training regarding the identification and referral of potential fraud.

To address the issues identified in the report, we recommended that CMS follow up on the two referrals, implement a database system to track fraud referrals, and require that RACs receive mandatory training on the identification and referral of fraud. CMS concurred with our recommendations.

Conclusion

Ensuring that Part D claims contain valid prescriber identifiers is fundamental to successful program oversight. Without valid and accurate prescriber identifiers, CMS and its contractors have difficulty performing oversight functions, such as verifying the prescriber's licensing information, determining whether the prescriber has been the subject of disciplinary actions for inappropriate activities, or tracking potential over-prescribing issues. OIG's recent work has shown that safeguards for identifying claims with invalid identifiers have not functioned effectively for Part D claims, and these problems in Medicare Part D parallel those we have identified with respect to Part B DME claims over the past decade. However, CMS's implementation of NPI and its agreement to take steps to address the recommendations of our most recent report indicate that the agency plans to address these vulnerabilities. To ensure this is the case, OIG will continue to monitor the use of invalid identifiers on Part D claims. I would be happy to answer any questions at this time.

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July 1, 2010

Testimony by Libby Alexander, Connolly Inc. before the Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security, Department of Homeland Security

Chairman Carper, Ranking Member McCain, and distinguished members of the Subcommittee.

Thank you for the opportunity to testify today on Preventing and Recovering Government Payment Errors. We appreciate your interest in recovery auditing, a best practice that is increasingly recognized as an invaluable tool for returning improper payments to the Government and for identifying ways to mitigate future errors.

My name is Libby Connolly Alexander and I am the Vice Chairman of Connolly, Inc. as well as CEO of Connolly Healthcare. Connolly currently serves as the Recovery Audit Contractor, or RAC, for the Centers for Medicare & Medicaid Services's Region C, the Southeast, and we were one of the three RACs during the RAC Demonstration program, serving in New York and Massachusetts. We have also performed recovery audit work for the Department of Health and Human Services, the Department of Education, and the Defense Logistics Agency.

Connolly was founded in 1979 and our sole focus since inception is the identification and recovery of improper payments. I personally have lived and breathed recovery auditing for the past 25 years. Our company serves some of the world's largest and best run organizations in the retail, non-retail, healthcare, and government arenas. We count 18 out of 20 of our country's top retailers as clients and 7 out of 8 of the top commercial healthcare payers. We entered the healthcare market in 1998 and have since grown to where we now serve commercial insurers, Blue Cross Blue Shield plans, Medicare Advantage plans, Medicaid Managed Care plans, and, of course, CMS. In all, we serve over 125 clients in virtually all industries from offices throughout the Unites States, Canada, and Europe and recover nearly $1 billion annually. Our growth has been dramatic including tripling the number of employees in the past five years to over 700 today, a reflection of the widespread adoption of recovery audit as a best practice.

In the private sector today, recovery audits are performed by virtually all companies greater than $500 million in sales. Most organizations have dedicated teams assigned to recovery auditing, and plan recovered dollars into annual budgets. Recovered dollars are "found money" and therefore go straight to the bottom line as profit. Beyond the monetary impact, recovery audits have the additional benefit of uncovering payment process inadequacies and lead to actionable recommendations to reduce or eliminate future overpayments.

In our thirty years of experience, we have seen our industry move from paper-based reviews of simple transaction processing – for example finding duplicate payments – into more and more complex contractual and policy interpretations that require skilled professionals using sophisticated technology tools to uncover errors.

The Federal government recognized the value of recovery audits nearly ten years ago with the passage of the National Defense Authorization Act for Fiscal 2002. Since that time, strides have been made with

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the RAC Demonstration program being perhaps the best example of how successful a recovery audit can be. There are still many more opportunities to expand recovery audit efforts within Federal – and State – government. The current attention being paid to recovery audit by the Obama administration as well as by members of Congress including this committee, can only lead to new and improved efforts to recover improper payments. We certainly applaud last week's passage by the Senate of *The Improper Payments Elimination and Recovery Act* and wish for its speedy approval by the House and signing by the President.

Now, I would like to spend a minute to discuss some of the things a recovery audit can accomplish – whether that is for a for-profit company, an insurer, or a government agency.

First and foremost, a recovery audit will return dollars, dollars that can be used to fix problems, fund the recovery effort, and/or be returned to shareholders or taxpayers. Second, a recovery audit can correct current errors and lead to the prevention of future errors, anything from simple processing miscalculations, to more complex contractual and policy issues. An excellent illustration of this during the RAC Demonstration program was the discovery by Connolly that providers were incorrectly billing of a certain drug. This simple error resulted in nearly $10 million in improper payments. With a revision made quickly by CMS to its guidelines, along with education of providers and system edits, the problem disappeared virtually overnight. The open sharing of information like this by the RACs with both CMS and providers will continue to provide recoveries and future savings. Third, by institutionalizing recovery audit, the message is sent to providers or vendors that billing is being scrutinized carefully. As a result, correct billing becomes a higher priority and fewer mistakes will be made.

I should point out that a recovery audit is not a panacea and will not make errors disappear. It can certainly keep the error rate from growing and can effectively reduce error rates, which should be a primary goal, but no recovery audit has ever been successful in completely eliminating improper payments in any large, complex payment environment.

I think everyone agrees that the RAC Demonstration program was successful in delivering significant dollars back to the Trust Fund and in helping to eliminate future errors. The project's recovery of nearly $1 billion during the small, six-state demonstration program shows the potential of recovery audit. CMS and Congress are to be commended for initiating, implementing, and supporting the project. Recovery audit programs cannot be successful unless the client or agency wants – or better yet – is passionate about recovering the dollars identified. As we replicate and build upon that success with the national expansion of the RAC program, and extend RAC efforts to Medicare Part C, Part D, and Medicaid as called for under Section 6411 of the Patient Protection and Affordable Care Act and now the Improper Payments and Recovery Act, the country should realize recoveries of many billions of dollars annually.

So what made the RAC Demonstration program successful and what can we do to improve upon it?

Connolly has eight recommendations that we feel will help the Federal program build upon the progress it has already made with respect to recovery auditing.

- **Establish goals.** In our thirty years of experience, a successful recovery audit program is achieved when there is strong alignment on metrics against which the success of the audit can

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be measured. These goals can be determined by examining agency-estimated error rates and the success of previous recovery audit programs such as outreach, transparency, and quality.

- **Executive sponsorship**. Since our earliest years of conducting recovery audits, we have consistently found that recovery audits are most successful when there is a champion at a high enough level to see that the program gets off the ground and continues to be successful.

- **Provide proper funding and resources to ensure the "greatest financial benefit to the Government."**[1] Agencies need a comprehensive program for preventing and recovering improper payments, and resources for the audit on the agency side should be established *prior* to the start of an audit. This would include resources to assemble audit data and personnel to approve audit issues for recovery, to manage the collection process, and to handle provider/vendor relations. Over time these costs will be funded through the portion of recoveries that flow back to the agency, but there can be a considerable time period after an agency begins a recovery program before recoveries are realized and funds available to pay for it. To recover the most improper payments possible, funds and personnel should be committed upfront to get the program off the ground.

- **Institutionalize recovery audit as a comprehensive program, not a standalone project**. This is an important success factor for a recovery audit and the successful implementation of 6411 and the Improper Payments Elimination and Recovery Act. By itself a recovery audit program can recover some money for the taxpayers, which we can all feel good about. But the true value comes from being part of a comprehensive program where the agency supports the program and uses results to make continual improvements. Every agency's mission statement should contain a commitment to recapture improper payments. This should include supporting valid overpayment claims straight through the appeal process. Agencies should embrace the responsibility of seeing that overpayments are not overturned by subjective caprice when they are in fact supported by objective and sound policy. This will significantly increase the effectiveness and results of the recovery audit program, facilitate changes to prevent improper payments in the first place, and identify additional areas of recovery opportunity. Attention should also be paid to what can improve results.

- **Use the experts**. I'm sure this will sound self-serving, but you should let the *experts* in recovery auditing conduct the audit. The external recovery audit contractor has the people, the tools, the technology, the processes, the years of experience, and the independence to achieve the goals of a program. Agencies should focus on the activities necessary to support the execution of the recovery audit program in a timely fashion, and on improvements to prevent improper payments. We also encourage the use of recovery audit firms for guidance on the details and guidelines now being established for the rollout of recovery audit mandated by Section 6411. We have 30+ years experience to draw upon and can make the task much easier.

- **Consider a program to recognize providers or vendors with high program integrity**. The nature of contingency fee recovery auditing is to focus on those vendors or providers who are doing

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things incorrectly, but I would suggest that we also recognize those who are at the other end of the spectrum. These are providers or vendors who have invested in their people and systems, abide by the rules, and as a result have high billing accuracy and do not see recovery auditing as a burden since they are doing things right in the first place. Recovery auditors have the information that points to the vendors and providers who are doing things right, and they should be recognized and their examples shared as best practices so that others can benefit.

- **Prioritize other Government healthcare programs when expanding recovery auditing.** This would include TRICARE and the Federal Employees Health Benefits Program. To our knowledge, these agencies have yet to implement RAC programs, yet would benefit significantly from them. Based on our experience with other healthcare payors in the private and the public sectors, these agencies have a similar profile to those with whom we have been successful in the past.

- **Continue to foster green practices as it relates to recovery audit**. We have made considerable progress moving from paper-based auditing to electronic auditing. Nevertheless, there is much still to be done to reduce the amount of paper documents needed to do our work. The biggest improvement opportunity is in medical records, which we receive, scan and then destroy by the box load. CMS has is currently supporting initiatives to simplify the process of transferring medical record electronically. In the meantime, we continue to encourage the use of HIPAA compliant DVD's or other electronic media.

In conclusion Mr. Chairman, recovery auditing for government is here to stay and is a valuable tool in the war against fraud, waste, and abuse. The focus of a recovery audit is on recovering misspent dollars and identifying opportunities for process improvement. If an effort is made to align resources and commitment behind that focus, and there is true collaboration between the contractor and the government, then we will continue to see the kind of success we encountered with the RAC Demonstration program.

Mr. Chairman and other members of the committee, thank you for this opportunity to provide insight into recovery auditing. I would be pleased to answer any questions.

[1] IMPROPER PAYMENTS ELIMINATION AND RECOVERY ACT OF 2010 -- S.1508, SEC.2.(h).(B).(ii)

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Testimony of Lisa Im
Chief Executive Officer for Performant Financial Corporation, Parent to DCS

Before the
Senate Homeland Security & Governmental Affairs Committee
Subcommittee on Federal financial Management, Government Information,
Federal Services and International Security

Hearing on Preventing and Recovering Government Payment Errors

July 1, 2010

Chairman Carper, Ranking Member McCain and members of the subcommittee, thank you for the opportunity to testify today. My name is Lisa Im. I am Chief Executive Officer of Performant Financial Corporation which is the parent of DCS. For over thirty-three years, we have worked for Federal and State agencies to help improve their fiscal and economic responsibility and accountability.

Federal and State government agencies comprise 97% of our business. We recover billions of dollars annually for those government clients. Many of our contracts are revenue sharing programs by virtue of payment via a contingency fee. This best practice structure embodies a true pay-go program as payment is only made for results—maximum value to an agency is driven by dollars returned to the agency. We currently work for the Department of Education, Department of Treasury Financial Management Services, federally chartered student loan guaranty agencies, and state taxing authorities.

Our first contract with CMS began in 2005 with the RAC / MSP demonstration project. We were one of two MSP contractors and performed the audit and recovery for the state of California. During that demonstration, we recovered 90% of the recovery, or $11.4 million within a 12 month timeframe. We are currently a RAC for Region A. Since February 2009, we have invested millions of dollars to create the programs necessary to support the RAC contract. These investments include information technology and data management systems exclusive to the CMS; outreach meetings, establishing a call center, and developing a web-enabled capability for providers to interface successfully with the program; increased employment and staffing for every aspect of the RAC and in support for CMS's directions.

What we have learned from the MSP contract and RAC thus far is consistent with what we know from thirty-three years of working with Federal and State government clients:

- Seed money is critical to help an agency prepare for a smooth implementation: Budgeting is a critical issue which is addressed in this RAC contract by the self-funding allowance within the contract-authority conveyed to CMS. Although the program needs are paid from recovery proceeds, more resources need to be provided to establish the program infrastructure and organization needs. Performant's experience with other Federal agencies and state clients supports the concept that a strong funding mechanism up front can in fact make the program much more successful. Using the contingency fee (also known as recovery revenue funding) model, we have partnered with Department of Education to

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recover more than a billion dollars over the past ten years. The success of that program required technology and other resource commitments by the Department of Education at the start of the contract even though the majority of recovery dollars began to flow ten months later. The contract operates smoothly every year, which drives the annual $3 billion-plus recovery to Department of Education.

- Contingency fee structures can be, and are, very effective for recovery audit contracts. It is important that the contracting agency not mistake "value" for "lowest fees". In contingency fee contracting "value" equals "recovered dollars minus fees paid". Vendors are not paid unless they deliver results—if vendors are not able to invest in the processes or our people, the agency will not get best results. Successful recovery contracts in our experience are not "low bid", rather they are "fixed fee" and technical competency becomes the decision factor. Department of Education and Treasury FMS are examples of these successful practices. Each of these agencies partners with contingency fee vendors—where technical competency and results deliver value. To carry out the Department of Education example, for 2009, the Department of Education recovered $3.1 billion, or 12.6% of available inventory.
- Outreach and education of all constituents is a best practice that has been applied to this RAC. Many of these overpayment errors are inadvertently made, but still represent billions of Medicare dollars. To educate and help providers, CMS has urged us, and we have committed to extend great efforts to create and maintain outreach programs. The level of education, outreach, and communication with the provider community is unparalleled—now it is time to rapidly audit and recover dollars on behalf of the CMS.
- Collaborative effort between the parties is a best practice. This best practice is collaboration between CMS and vendor partners, and among vendor partners. When we have worked with clients in this way, we have experienced greater consistency and uniformity in processes. Collaboration has also enhanced continuous improvement as the contract matures by adjusting processes accordingly. During our eighteen year contracting relationship with Department of Education, we created a resolution method for high balance student loans. This was in collaboration with the Department of Education, which enabled all vendor partners to apply this solution. The result was an annual improvement in recovery by approximately 30%, and it was very beneficial for those borrowers who were otherwise excluded from resolving their federally guaranteed student loan obligations.
- The recovery audit concept can be successfully applied to other areas of the Federal government, including Parts C, D, and Medicaid. There are challenges to each of these areas of healthcare including, but not limited to: technological platforms, budgetary constraints and differing current practices (which should be understood and assessed). Regardless of preventive programs, recovery-audit contracts should be implemented to capture dollars lost due to errors. The purpose of preventive programs is different from that of recovery audit—even a very effective preventive program will result in some errors. The error rate is due to the sheer volume of transactions, people/expertise turnover, and the inherent difficulty in implementing changing reimbursement rules into systems in a timely fashion—these errors may never be completely addressed in a preventative way, which is

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why the recovery audit contracts create value to the Federal agency. A methodical approach, with adequate seed funding, will ensure a strong contract that drives recovery back to those agencies.

This contract implementation is just beginning, but has great potential to succeed in returning dollars to the CMS. Moreover, the application of recovery audit contracting across other Federal agencies has strong potential, and will be successful if best practices and key lessons from contemporaries are applied. We believe this will enable Federal agencies to achieve the best results and outcome.

Chairman Carper, Subcommittee Member McCain and members of the subcommittee, this concludes my testimony. I thank you for the opportunity to speak with you today.

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Written Testimony

Statement by
Andrea Benko,
President & CEO
HealthDataInsights, Inc.

on
Preventing and Recovering Government Payment Errors

before
Committee on Homeland Security and Governmental Affairs
Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security
U.S. Senate

Chairman Carper, Ranking Member McCain and distinguished Subcommittee members, thank you for inviting me to testify at this important hearing and for your efforts to prevent and recover government payment errors.

My name is Andrea Benko, and I am the President and CEO of HealthDataInsights or HDI. Headquartered in Las Vegas, Nevada with additional facilities in both California and Florida, HealthDataInsights is a technology-driven healthcare services company that specializes in claims integrity: the identification and recoupment of improper payments to providers including hospitals, physicians, Durable Medical Equipment and other specialty providers. Our customers include the public sector, specifically the Centers for Medicare & Medicaid Services (CMS), and the private sector, including a number of the largest commercial payors in the United States.

The company employs sophisticated, proprietary software tools and database queries to retrospectively analyze 100% of a payor's claims data. We have an experienced robust, physician-led Clinical Team and Quality Management Team who review the more than $300 billion in annual paid claims. The company's technology—which is deployed retrospectively (post-adjudication, post-payment) — empowers a full review of all claims paid. We focus our efforts on the "honest" end of the spectrum of improper payments— that is, overpayments and underpayments due to improper billing and other sources of errors.

HDI is the national Medicare Recovery Audit Contractor (RAC) for Region D which consists of 17 States and 3 U.S. territories. This includes Alaska, Arizona, California, Hawaii, Iowa, Idaho, Kansas, Missouri, Montana, North Dakota, Nebraska, Nevada, Oregon, South Dakota, Utah, Washington, Wyoming, Guam, American Samoa and Northern Marianas. The permanent RAC program is the next step by CMS in their comprehensive effort to identify improper Medicare payments and fight fraud, waste and abuse in the Medicare Trust Fund.

In the Tax Relief and Health Care Act of 2006, Congress required a permanent and national RAC program to be in place by January 1, 2010. The national RAC program is the outgrowth of a successful demonstration program launched in 2005 and completed in 2008 to identify Medicare overpayments and underpayments to health care providers and suppliers in California, Florida, New York, Massachusetts, South Carolina and Arizona. During the demonstration

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program HDI collected over $416 million in improper payments that were recovered in our assigned states of Florida and South Carolina. This represented 41% of the total findings working with only 31% of the total claims data.

HealthDataInsights also serves as the Payment Error Rate Measurement (PERM) Review Contractor for the Federal Medicaid Program. As a health care Claims Payment Integrity contractor with a long track record in the private sector as well as national-level experience in both the Medicare and Medicaid programs, HDI brings a unique perspective to this discussion.

The Problem: Improper Healthcare Payments

Improper medical claim payments carry an enormous economic impact in the government sector. A window into the magnitude of the problem is provided by CMS's Comprehensive Error Rate Testing (CERT) Program or CERT report, formally known as the Medicare FFS Improper Payments Report, which provides an annual assessment of Medicare's payment error rate. According to the CERT report, 7.8% of fee-for-service Medicare claims were paid improperly in Fiscal Year 2009.[1] This equates to $24.1 billion in improper payments in the Medicare FFS program. As you know, this claim payment error dollar amount does not include billions of dollars spent on other federally funded health care programs such as Tricare and the Federal Employee Health Benefits Program or the Federal and State spending on the Medicaid Program.

The Centers for Medicare and Medicaid Services (CMS) developed the Medicaid Payment Error Rate Measurement (PERM) program which is a comprehensive, ongoing federal audit intended to measure how frequently errors occur in the Medicaid program when providers submit claims to states and when states pay those claims. The PERM Medicaid error rate in fiscal year 2008 was 8.7%. The total dollar amount of claims estimated to be paid in error was $28.7B, the federal share of which was approximately $16.4B.[2] The ten (10) year estimated dollar amount of claim payment errors amounts to approximately $700B for the combined Medicare and Medicaid programs.

With mid to high single-digit healthcare inflation for the foreseeable future, I believe that claim payment integrity and accuracy is the first place that Congress should look to maintain the fiscal integrity of the Medicare Trust fund. Recovered funds help preserve the integrity of the trust fund and ensure this vital social safety net is preserved both now and for the future.

The Medicare RAC Project

In section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Congress directed the Department of Health and Human Services (DHHS) to conduct a 3-year demonstration program using Recovery Audit Contractors (RACs) to detect and correct improper payments in the Medicare FFS program. The Recovery Audit Contractor (RAC) demonstration program was designed to determine whether the use of RACs would be a cost-effective means of adding resources to ensure correct payments are being made to providers and suppliers and, therefore, protect the Medicare Trust Fund. The demonstration operated in New York, Massachusetts, Florida, South Carolina, California and Arizona and ended on March 27, 2008.

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This innovative program approached the challenge of recovering erroneously paid claims, not by pursuing the historical Medicare cost center approach, but rather by pursuing a revenue-sharing "pay for performance" approach that could recover significant Medicare Trust funds at minimal cost to the government. The result was an entirely successful proof of concept for Claims Payment Integrity in the Medicare program. Over the 3 year period, the RAC program was able to correct over $1 billion in improperly paid claims. In addition, the government retained approximately $0.80 for every $1 collected to the Medicare Trust fund.[3]

Section 302 of the Tax Relief and Health Care Act of 2006 made the RAC Program permanent and required the Secretary to expand the program to all 50 states by no later than 2010.

HealthDataInsights along with 3 other companies were awarded RAC contracts to provide retrospective review of Medicare claims in all 50 states. Two additional firms act as subcontractors to the 4 RACs. The success of the Demonstration project is currently being replicated on a national scale. When the project is fully up to speed, we believe a significant amount of the error rate can ultimately be recouped through retrospective review.

Recommendations From Lessons Learned

First, I would like to thank CMS for the progress made to date on the implementation of the national RAC program and acknowledge the challenges of implementing a program that requires cooperation among a vast number of contractors while managing potential provider impact and the quality of audit programs. While the national RAC project's performance to date has been encouraging, there are a number of ways to achieve greater success of the RAC project as CMS builds upon the progress made over the past year and half.

Tie Each Agency's Recovery Goals to Identified Errors Rates

We strongly encourage Congress to establish each agency's recovery goal based on the identified error rate. Congress, for agencies that implement recovery programs, should establish a recovery target of at least 50% of the identified payment errors as estimated by the annual reports. For example, based on the 2009 Medicare FFS Error Rate, the 2010 Medicare claim payment integrity recovery goal would be half of the projected error of $24.1 billion, or an estimated $12 billion; or based on the 2008 PERM report, the Medicaid goal would be half of the projected error of $28.7 billion, or an additional $14.3 billion (Federal portion $8.2 billion).

Claims Adjustment Processing

Efforts to retrospectively adjust applicable Medicare claims after improper payments have been identified by the RACs must be expedited and expanded to materially benefit the Trust Fund. Medicare Administrative Contractors, or "MACs," who adjust and pay Medicare FFS claims using CMS systems, on behalf of CMS, must establish efficient back-end processes with system maintainers and data centers to adjust claims on a massive scale after errors are identified by the RACs. Currently, automated mass adjustment processes to adjudicate incorrectly paid claims are in development.

In the Demonstration project, over $1 billion in claims adjustment were handled manually by the few involved MACs at a cost of less than 1% of collections.[4] Over the short term until scalable, mass claim adjustment processes are in place and functioning, we all need to work together to ensure that all incorrectly paid claims are processed in a timely manner. Anything Medicare

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claims payment contractors can do collectively to speed throughput in the MACs' adjustment of claims upon completion of the RACs' work will ultimately accelerate returns to the Medicare Trust Funds.

Expansion of Quality and the Scope of Reviews

Medicare's provider network is a key component to the delivery of quality health care, as such, the RAC efforts need to be sensitive to providers. All constituents in the health care delivery system desire claim payment integrity and accuracy: claims should be paid according to the policies and fee schedules; no more – no less. Claims integrity ensures the ultimate proper payment of claims and, at the same time, creates a sentinel effect of ensuring that providers continue to maintain solid billing and treatment practices. Medicare policies are evidence-based, proven protocols for delivering patient care that ensures quality. Achieving claims integrity through sound healthcare claim auditing ultimately improves the quality of health care. For example, in preparation of the national RAC program, many hospitals already have invested in process improvements that enhance their own compliance with Medicare policies, rules and regulations.

CMS should expand complex reviews to encompass a broader cross-section of medical claims which will have a direct impact upon returns to the Medicare Trust Fund. To date, RACs' complex review efforts have been focused on Coding Validation for inpatient hospital stays, and soon, a Durable Medical Equipment ("DME") medical necessity complex review. In the Demonstration project, 62% of the savings from inpatient hospitals, or approximately $513M, were generated from retrospective medical necessity complex reviews of hospitals' inpatient claims. To the extent that RACs are allowed to review inpatient claims and other "new issues" more quickly, we believe returns to the Medicare Trust Fund and government will rapidly increase.

With the RAC opportunity comes the ability to facilitate, through claim payment integrity, compliance with the statues, coverage requirements and guidelines Congress, HHS, CMS and its contractors have so carefully developed over decades of the provision of Medicare healthcare. This program presents a wonderful opportunity to improve the likelihood that beneficiaries will receive the healthcare that the evidence supports in every case because Medicare intends to pay only for the best care that is provided and documented. In addition, this will benefit healthcare reform as the discussion can then shift from improper payment to the provision of connected and complete care of the best sort.

Medical Record Review Limits

Another issue to consider is the current limitation on the ability to request medical record within the RAC program. "Complex" reviews—or reviews in which the RAC requests a medical record from a provider—generated the vast majority of dollar recoveries in the RAC Demonstration project. Under current guidelines, the RACs are limited in their ability to request medical records.

RACs Promote Continuous Process Improvements and Claims Integrity

During the Demonstration and in the National program, CMS has conducted major findings discussions with CMS contractors related to claims payments and review to determine strategies to discuss methods to reduce the improper payment types from continuing to occur, such as,

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claim system edits, MedLearn articles, policy clarification and even policy revisions. This best-demonstrated practice should be implemented in all agencies as a recovery program is implemented.

Contracting Strategy

A careful review of the contracting strategy and contingent fee structure is needed for the RAC program, and, more broadly, for other improper payment detection programs in the US Government. As I mentioned previously, the Medicare RAC program is an innovative step into revenue-sharing "pay-for-performance". This approach effectively transforms the review contractor from a cost center to a pure "revenue recovery entity" for the Medicare Trust Fund and eventually for other federal healthcare payment programs. The RACs are paid only on the basis of results.

What is important to recognize and consider is the impact on contracting considerations this contingent payment structure requires for successful maximization of desired outcomes. The federal government must establish contracting considerations that maximize potential returns to the government payor rather than focusing on minimizing contingent fees paid by the government payor. The attention must turn to effectiveness of contractor skill in realizing best recognition and correction of improper payments because it is the actual identification and correction of improper payments that returns "lost" dollars to the Trust Fund.

Appeals to Administrative Law Judges

A separate opportunity for improvement is related to appeals handled by Administrative Law Judges within the Medicare regulatory system. There are 5 levels of appeal in the Medicare claims process. In one of the more advanced levels of the appeal process Administrative Law Judges hold hearings and issue decisions related to Medicare payment determinations. We believe that it is critical that there be more visibility into the process, that there be more consistency in rulings and most importantly, that ALJ rulings be consistent with and grounded in Medicare laws, rules and regulations. ALJ decisions which are inconsistent with Medicare rules result in an unnecessary depletion of the Trust fund.

Expansion of RAC to other Government Healthcare Payors

Our final recommendation is to leverage the success of the Medicare RAC program by extending it to other government healthcare payors. While the Patient Protection and Affordable Care Act mandates that a RAC-like project must be implemented in the Medicaid program as well as Medicare Part C and Part D in 2010, we believe that there is a benefit to the government when data is aggregated. If the data can be audited and analyzed for an entire region for Medicare FFS, Medicaid, and Part D, we can identify more improper payments through better data clarity, more significant statistical analysis, as well as treatment patterns and trends. In addition, the impact on the provider can be effectively managed via one, coordinated program that maximizes the return to the Trust Fund and minimizes the impact on the provider networks.

We also believe that Part C Plans should be required to perform RAC-like audits which will ultimately lower the amount of future premium increases. In addition, we believe that Part C audits should include auditing the severity-adjustment of the patients, a basis on which CMS pays the Part C plans.

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The government would benefit by expanding the RAC and claims payment integrity practices to the Federal Employees Health Benefit program, the Veterans Administration, and Tricare. Ultimately, if roughly 50% of the healthcare dollar is expended by public payors, the opportunity for additional Trust Fund savings is compelling, to say the least.

Conclusion

In summary, we at HDI believe that there is a tremendous opportunity to ensure claim payment integrity and to realize literally tens of billions of dollars in recoveries for the Medicare Trust fund. It is the foundation of healthcare cost containment. We believe that pay-for-performance Recovery Audit services are a best practice in both the public and private sector. To the extent that we can accelerate the national RAC program in the ways I have discussed today, speedy returns to the Medicare Trust Fund will be achieved. We also believe that the RAC program helps strengthen quality care and encourages providers to review and update their processes and procedures which ultimately support Medicare evidence-based policies.

The next step is to rapidly extend the benefits of the program to additional government programs. We firmly believe that Medicaid, Medicare Parts C&D, the FEHP, the VA, and Tricare can benefit from this program as has the Medicare Fee-For-Service program.

We applaud Chairman Carper's leadership along with Ranking Member McCain and the other distinguished Subcommittee members of the committee's support of S. 1508, The Improper Payments Elimination and Recovery Act. This groundbreaking bill will require agency heads to conduct recovery audits for agency programs that expend $1 million or more annually. Given the results of the RAC Demonstration project and the current RAC program, such an initiative will clearly be cost-effective and beneficial to the Government. These are all clearly best practices and critically important undertakings.

It is a great honor to be invited to speak before this austere body. Thank you for your time and attention today.

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[1] Improper Medicare FFS Payments Report, November 2009 – Executive Summary
[2] U.S. Department of Health and Human Services, Medicaid Payment Error Rate Final Report, Fiscal Year 2008
[3] The Medicare Recovery Audit (RAC) Contractor Program: An Evaluation of the 3-Year Demonstration Project
[4] The Medicare Recovery Audit (RAC) Contractor Program: An Evaluation of the 3-Year Demonstration Project

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Testimony of Robert Rolf
Vice President for Healthcare BPO
CGI Federal, Inc
Before the
Senate Homeland Security & Governmental Affairs Committee
Subcommittee on Federal Financial Management, Government Information, Federal Services and International Security.

Hearing on Preventing and Recovering Government Payment Errors

July 15, 2010

Good afternoon, Chairman Carper, Ranking Member McCain, and members of the Subcommittee:

My name is Rob Rolf. I am Vice President for CGI Federal (CGI), an information technology and business process services company that has been partnering with government for nearly 35 years. In my role, I am responsible for CGI's efforts to implement the Recovery Audit Contractor (RAC) program in Region B, which is comprised of seven states in the Midwest, as well as similar audit and recovery efforts that CGI performs for its state government and commercial clients. It is my pleasure to appear today before you at this hearing to examine the use of RACs in the Medicare program.

Under CGI's contract with CMS, CGI is tasked with the identification of improper payments made to hospitals, physicians, clinics, and other providers of services under Medicare Parts A and B. This work involves conducting audits of claims paid after October 1, 2007, utilizing both automated and manual claims review processes intended to identify provider overpayments and underpayments. Although most of this work involves catching improper payments on the back end, CGI fully supports all efforts to prevent such payments from happening in the first place. CGI currently assists CMS in the development of an improper payment prevention plan, a mission that CGI takes very seriously.

Since contract inception in February 2009, CGI, much like our fellow RACs, has worked diligently to implement the program in an open and transparent fashion. Our efforts to date involved extensive outreach to the provider community in each State served, through town hall style meetings, as well as internet and audio conferences, providing education on the program and CGI's processes. To date, CGI has conducted over 80 such meetings and taken over 10,000 calls at our help desk, which we established to field provider questions and concerns.

In February 2010, CGI began sending notices of improper payments to the Medicare Claims Processors for recovery. As a result of CGI's experience with the RAC program, I'd like to share a few observations about this important CMS program and some lessons learned about recovery audit efforts with the Subcommittee:

- *Transparency and communication are critical to the success of the program.* It is important that RACs provide transparent information to Medicare providers regarding the

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program and the issues under investigation, as well as information about the basis for an improper payment determination. In this way, providers are kept informed during each step of the audit process. CGI has also established monthly conference calls with provider associations and continues to conduct provider outreach sessions which facilitate two-way communication. These activities will continue to enhance the program as it matures.

- *The contingency payment approach works well in practice.* Medicare Administrative Contractors (MACs) have many significant duties under the Medicare program, including claim review prior to payment. The MACs simply aren't able to catch every error or omission on the front end. The RACs have one primary mission – to catch improper payments on the back end and to correct them. The contingency payment approach allows RACs to dedicate the necessary resources to this task. Contrary to some assertions, the contingency approach does not incentivize the pursuit of questionable recoveries or disincentivize the pursuit of underpayments for three important reasons. First, RACs do not get paid unless and until a recovery is received by the government. Second, fees earned on recoveries that end up reversed on provider appeals must be returned to the government. Third, RAC contractors receive an equal fee for finding provider underpayments.

- *The RAC program promotes continuous process improvement for claims processing and payment.* CGI participates along with the other RAC companies in major finding discussions with CMS. This process informs CMS of areas representing the greatest vulnerability to the program along with recommendations for corrective action. Additionally, CGI has identified situations where providers were paid in a manner that seemed incorrect, but was not addressed by an existing CMS rule forbidding payment. CGI informed CMS of the potential need for rule changes to close loopholes and front end coding edits to avoid future under/over payments. In other cases, CGI has reviewed provider billing and reimbursement situations that seemed to warrant investigation only to conclude that the arrangements were entirely appropriate. This review process provides an important check and balance function for and promotes continuous improvement of the claims payment system.

- *Through a combined use of technology and professional medical staff, CGI is able to remove much of the subjectivity from the recovery audit process.* In conducting claims review, CGI extensively employs information technology in the form of algorithm driven programs and advanced analytics that analyze claims and payments and can objectively identify erroneous overpayments and underpayments. CGI's development of its audit processes and the underlying technology capability is heavily dependent on input from our professional staff members who have extensive medical expertise. CGI's team includes physicians, pharmacists, nurses, health information professionals, fraud investigators, claim auditors and data analysts with extensive backgrounds in medical review. CMS provides oversight of this process through a detailed review and approval of all audit categories the RACs intend to pursue. Additionally, CMS has contracted with a RAC Validation Contractor who independently reviews on a monthly basis a sample of each RACs audit findings for accuracy.

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- *There is the potential for this contingency approach to expand to other areas across government.* Several legislative provisions in the Affordable Care Act expand the RAC program to Medicaid as well as Medicare Parts C and D. Now, thanks to your leadership, Chairman Carper and Ranking Member McCain along with Senator Lieberman, Senator Collins, Senator McCaskill and Senator Coburn, CGI believes that the expected final passage of S. 1508, The Improper Payments Elimination and Recovery Act, combined with OMB FY12 budget guidance, will focus agency attention on this topic in an unprecedented fashion across the entire Federal Government. As a leader in this field, CGI feels confident that other federal agencies can leverage some of our successful efforts with state, municipal, and commercial clients. For example, in the last year alone, CGI has helped the Pennsylvania Department of Public Welfare recover $30 million in improper payments under the Commonwealth's Medicaid program. Beyond healthcare, CGI has partnered with 20 states to dramatically increase delinquent collections by 10-35% from taxpayers who fail to file returns or who file but do not pay all that they owe. These implementations, many on a similar, benefits-funded model, have resulted in over $1 billion in additional revenue collected without raising taxes. Finally, CGI has partnered with many of its banking, financial services and other commercial clients on similar efforts that increase revenues by anywhere from 5-20%.

  When expanding into new areas for recovery audit it is important to note that while there are many similarities there will be some differences in approach from the program in place with Medicare parts A and B. One of these areas is the expansion into the Medicaid program. Unlike the Medicare program that has a high degree of standardization across the country, each state Medicaid program is structured differently and has its own unique payment regulations, data sources and levels of managed care penetration. This will require a RAC to treat each state uniquely during the implementation of the program. States also have varying levels of experience with benefit funded or contingency fee contracting with some utilizing the approach for many years and others having no experience at all.

  One area that is a common lesson learned from any recovery audit program whether in healthcare claims or other payment areas is the need for a robust process to recover funds identified by a RAC as improper. Often overlooked in the process of starting a recovery audit program is the need for well defined policies, processes and often systems to facilitate the recovery of the improper payments RACs will identify. Companies such as those before you today are adept at analyzing and identifying improper payments out of the millions of transactions that occur in programs each year. However, without the necessary infrastructure to recover the funds the government will be slow to realize the benefit a RAC program can bring.

CGI prides itself on combining cutting-edge technology with years of domain expertise in creating valuable solutions for our clients. We are especially proud of our ability to deliver successfully on the RAC program by featuring its healthcare expertise and broad experience in audit recovery programs. More than that, CGI remains passionate about the opportunity to partner with CMS, and hopefully other federal agencies, in one of the most critical, "good government" efforts underway today.

I appreciate the chance to appear before you all today and would be pleased to answer any questions you may have.

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Statement of Mr. Romil Bahl

President and Chief Executive Officer

PRGX Global, Inc.

Presented to a Hearing of the Subcommittee on Federal Financial Management, Government Information and International Security

Committee on Homeland Security and Governmental Affairs

U.S. Senate

July 15, 2010

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Chairman Carper, Senator McCain and distinguished members of the Subcommittee, my name is Romil Bahl, and I am President and CEO of PRGX Global.

PRGX Global is pleased to appear before this Subcommittee again to provide our views on tackling the problem of improper federal payments. PRGX is the global leader in Recovery Audit. In fact, we are the pioneer of the Recovery Audit industry and continue to break new ground every year. In addition, we at PRGX have been working in the federal space for a long time.

I first want to congratulate and commend the Committee on the passage of the much anticipated Improper Payments Elimination and Recovery Act of 2010. This legislation represents a major step toward ensuring accountability for federal expenditures.

Our nation is struggling with ever-increasing deficits and shortages of funds to finance vital federal programs. Perhaps at no time in our history has the imperative been so great to ensure that every taxpayer dollar is spent wisely. We are gratified by this Committee's efforts over the years to aggressively pursue recovery of misspent funds.

PRGX has created a new category of services named "Profit Discovery." Our services, which comprise a series of cost-saving value propositions for our customers, build on our world-class capabilities in *Audit, Analytics, and Advice*. Our services are key elements of successful financial management in large private enterprises and government agencies across the country. With a presence in over 30 countries, we are a trusted partner to CFOs around the world. PRGX is not just

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about recovering improper payments that have already been made. Our services include business analytics and advisory services to identify and help plug the gaps and address issues across an organization's financial management processes and systems, so that future improper payments can be reduced and risk be effectively managed. That is what we do, and we do it well. We provide these services to over 70 percent of the world's largest retailers[1], and to a large number of the Fortune 500 companies in the United States –companies that have recognized the value of our expertise. In fact, over the years, we have discovered billions of dollars in improper payments. Over the last five years alone, we have averaged a billion dollars of recoveries for our clients each year.

PRGX has one of the longest track records in recovery auditing for the federal government. We have worked with numerous federal agencies, including the Departments of Interior, Health and Human Services, Justice, Agriculture, Transportation, Defense, and the General Services administration. Based on our government recovery auditing experience we have found that there are four key factors to a successful recovery audit: these are having an effective program champion, a broad scope, strong motivation, and a capable recovery audit partner.

The first factor, program championship, is critical. A champion is someone who truly owns the program and works with the audit team, department heads and agency contacts to ensure that the program is implemented and executed to maximize the identification of erroneous payments. This champion acts as the advisor to all groups, and is instrumental to the internal appeals process when valid overpayments are not pursued by the agency. Under the leadership of Ms. Deborah Taylor (Office of Financial Management), George Mills (Director-Provider Compliance Group), and Connie Leonard (Director–Division of Recovery

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Audit Operations), the Centers of Medicare and Medicaid Services (CMS), has played this role effectively for the Medicare Recovery Audit Contractor (RAC) Program. This has not always been our experience with other agencies.

The second factor is a broad scope. All erroneous payment recovery audits have different characteristics and are set up based on the goals and initiatives of the agency. We have found that there are typically two different objectives within the individual agencies. The first is to have a broad scope recovery audit that tests and identifies potential process weaknesses and erroneous payments within all contracts and payables systems. We call this a "Full Scope" recovery audit. The second is to have a recovery audit that is strictly limited to data analysis of the payables system information, without any access to the overriding contracting information, also referred to as a "Disbursement Recovery Audit". Our experience has shown that when the recovery audit allows for complete access to contractual records, the likelihood of strong recoveries and actionable process improvement recommendations increases significantly. To tie back to the current CMS situation, part of our belief in the future success of the RAC Program is premised on the breadth of the scope that the Division of Recovery Audit Operations is implementing over the coming period.

The third factor is motivation. Most agencies/contracting officers are focused on the execution of current business to ensure the government operates effectively and efficiently. Since erroneous payment audits occur on prior years' payments, we have found that many times the motivation to bring up these past issues with the supplier is not as critical as moving forward with today's business needs, especially when the recoveries do not benefit the agency or worse yet, result in budget reductions in future years. Our most successful recovery audits are driven

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by agencies motivated by both the direct economic benefits received from recoveries and by closing the very 'gaps' that caused the improper payments in the first place. This Subcommittee is to be congratulated for taking strong steps to ensure that lack of motivation is not a reason for poor audit results, but it bears keeping motivation in mind as a key 'lever' to help drive optimal recoveries in the future.

The fourth factor, selecting a capable recovery audit partner, is an easily over-looked dimension in price-sensitive procurement processes. The fact is that increasing the recovery rate by just 0.01% on annual Medicare and Medicaid spend levels would yield an additional $90 million in savings. Especially because these services are priced on a contingent basis, the taxpayer is benefitted by ensuring that the best and most sophisticated recovery audit techniques are applied to recovery opportunities.

In doing our work, we abide by a number of key principles: integrity, confidentiality, security, and value for our clients. Also, we are sensitive to the providers and other vendors with whom we work. Indeed, one of our key metrics is 'provider abrasion' or 'vendor abrasion.' It is part of our commitment to our clients, including CMS, that we are fair in all our dealings with the hospitals, physician groups and all other providers as we audit on behalf of the taxpayer.

In approaching recovery audits, we follow several process guidelines:

- *"Make sure the juice is worth the squeeze."* We invest heavily in systems and people, ahead of realizing revenue; therefore, we need to ensure that

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returns are commensurate with the upfront investments.

- *"Turn over the big rocks before the pebbles."* We do not want to spend dollars chasing dimes and neither should the American taxpayer. Paying for results on a contingency fee basis places an incentive on finding the largest errors and the largest recoveries. In the Medicare RAC demonstration program PRGX corrected $330 million in improper payments, a rate of 0.37 percent of the total Medicare spend audited by PRGX.

- *"Getting it right the first time."* We go to great lengths to make sure that our claim adjudications are accurate. The Medicare appeals process is laborious and expensive and we have every incentive to get it right each time. In the Medicare RAC demonstration program, PRGX was "best in class" with an appeal overturn rate of only 4.4%.[2]

Mr. Chairman, contingency audits represent a major investment by the private sector to successfully execute a public-private partnership. For example, PRGX alone has invested millions of dollars of our corporate assets into the national Medicare RAC program and we have not yet realized any meaningful revenue from this effort. We make these investments with the belief that the United States government, including CMS, is committed to working with us as true partners to carry this program forward and to maximize the return to the American taxpayer. Therefore, it is comforting that Congress is squarely behind the effort as well.

The Improper Payments Elimination and Recovery Act of 2010 is a big step toward ensuring that all government audits are successful and yield high returns to the agencies and the taxpayers.

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- You recognized and acted on removing a great impediment by allowing recovery audit contractors to work directly with providers to expedite identification and recovery of funds.
- Recovery audit takes some effort on part of the agencies. Therefore, it has to be worth their while. You recognized this and acted on giving the agencies incentives to move aggressively on recoveries by allowing them to keep a portion of the funds they collect. You further strengthened federal accountability by directing these proceeds to financial management improvement efforts and to agency Inspectors General. We now have the right incentives in place to jump start agency efforts to work with recovery auditors.
- You recognized and acted on giving agencies the authority to conduct pilot programs to explore innovative means of identifying and recovering these overpayments.
- You recognized and acted on ensuring that the agency had a champion responsible for ensuring compliance with improper payments controls.
- And, you recognized and acted on giving the Office of Management and Budget (OMB) the ability to direct agency funds to ensure compliance with sound principles of improper payment stewardship

Moreover, you have greatly expanded the federal recovery audit program's potential. Before the recent legislation, the universe for recovery audits was limited to direct payments to vendors (approximately $500 billion) and Medicare Parts A and B (approximately $300 billion). Now, with the Improper Payments Elimination and Recovery Act of 2010 and the Patient Protection and Accountability Act of 2010, the universe is greatly expanded. Our estimate is that these two key pieces of legislation will more than double the universe of annual

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auditable federal spending. This includes Medicare Parts C and D, which we assume will be opened up to true "RAC-style" audits via appropriate procurement processes, and Medicaid "RAC-style" programs across the 50 states, along with an expansion of the definition of what is deemed an improper payment. Under these new laws, recovery auditing will expand into previously uncharted territory, including grants, loan guarantees, and insurance subsidies. We are excited to explore the potential under the new legislation for returning more funds to the taxpayer and ensuring related government expenditures are optimally leveraged for the good of the nation.

Again, we applaud you and look forward to participating with federal agencies under this new framework.

The administration has also embraced recovery audits as a means to fight waste and abuse of federal funds. This emphasis is evidenced by the following and should help jump start efforts across the government:

- The Executive Order issued in November of 2009 underscored the President's commitment to controlling this problem.
- The March White House memorandum to agencies promoted recovery audits.
- The March 10th speech in St. Louis by the President reaffirmed his commitment to use contingency auditors to fight healthcare waste.
- OMB's push toward improvements in reporting are honing in on the true extent of the improper payments problem in government.
- And, most recently, the "Do Not Pay List" initiative launched a few weeks ago is another big step towards preventing improper payments in the first place.

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This commitment and emphasis by the President and OMB coupled with the legislation will provide the needed impetus to the government and the private sector to make the recovery audit process work successfully.

The United States of America has a great healthcare system. Thousands of dedicated healthcare workers give their best each and every day to ensure the best possible care. Recovery auditors are part of this great healthcare system. By identifying waste and improper payments, we can help CMS and other government agencies direct the savings to improved services. Given the huge amount of money spent on healthcare, even what appears to be a small error rate amounts to billions of wasted taxpayer dollars. These errors occur because of complexities that are magnified by the large number of providers and transactions. Just like in our private sector business, we are committed to working with CMS and the provider community to not only optimize current recoveries, but also reduce future improper payments. The vast majority of our clients look to us not just to recover improper payments, but also to identify the root causes of the issues that create these erroneous payments in the first place and indeed, help to fix these root cause issues and process gaps. The next competitive era in the recovery audit industry is to partner strategically with our clients to ensure we leave behind a vastly simpler procurement and financial environment.

The business strategy that we have adopted to compete in this new era of recovery audit is exactly what we believe is required also by our government – not only in healthcare, but across a broader array of government agencies.

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The Improper Payments Elimination and Recovery Act of 2010 embraces and codifies many of the elements that made the Medicare RAC demonstration program successful and ensures that the CMS national RAC program lives up to the promise of the demonstration program. These elements include allowing the proceeds from recoveries to accrue to the Medicare Trust Fund and establishing a champion in the agency for attacking improper payments.

The contracted recovery audit is one weapon in the arsenal available to agencies to combat waste. CMS has artfully integrated recovery audits into its waste and fraud prevention programs. This is also the way it should be done in other federal agencies. In private-sector corporations, recovery audits are an accepted part of doing business. These audits hum along in the background of the normal business operations of corporations and dovetail nicely with efforts to provide oversight and accountability of operational programs.

We are proud to participate in the national Medicare RAC program. As an auditor in three of the four recovery audit regions, we have a broad perspective of the processes and errors. CMS has been wise to methodically step through the roll-out to enhance provider understanding and acceptance of the process. This approach ensures that our efforts cause minimal disruption to the important work of providing quality health care in the United States.

Further, CMS has been open to process enhancements and suggestions to make the program better. Our regular operational reviews provide the capability to present, adjust and proceed in a manner that adheres to principles of maximum recoveries and minimum disruption.

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The healthcare reform legislation has expanded the successful Part A and Part B Medicare RAC program to Part C, Part D, and Medicaid. We are excited about this expansion, and we look forward to competing for this business. In fact, President Obama has publicly stated that he is committed to ensuring that contingency auditors are used as a means to ferret out waste in these programs. While the rules for the expansion to Medicare Parts C and D and Medicaid will not be fully known until CMS and the states issue their solicitations and launch the formal procurement processes, we believe that the application of proven recovery audit processes to these other areas of Medicare and Medicaid will yield great returns.

PRGX's Medicaid recovery audit experience incorporates many of the lessons we learned in the Medicare RAC demonstration program and the improvements made in the national Medicare RAC program. We have been working with state agencies for several years now to build and implement recovery audit programs and know first-hand that these programs work and deliver results that meet, and in some cases exceed, those of the Medicare RAC demonstration. In the Medicare RAC demonstration, the recovery rate was 0.3% of the total dollar value of claims reviewed. Applied to Medicaid, this would yield $1.35 billion annually in recoveries. Medicaid error rate data and our own experience suggest that Medicaid recovery rates may be even higher. Further, we have evolved and refined our audit techniques to deliver a substantially improved audit, with a Medicaid appeal overturn rate that is far lower than our "best in class" appeal overturn rate from the Medicare RAC demonstration.

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Recommendations for the national Medicaid expansion include the following:

1. The creation of a set of CMS Medicaid recovery audit guidelines to get each state's recovery audit program up and running quickly. These guidelines should include tried and tested 'exclusion and suppression' methodologies for determining the universe of claims a RAC is authorized to audit. The guidelines should use the knowledge gained from the Medicare RAC demonstration and the national RAC program to include methods of automating and reducing the workload of claim processing after an overpayment has been identified. This will likely have a major impact on the actual recoveries. The guidelines should provide concrete suggestions for appeals processes that states can use in the state roll-outs.

2. Audit types and concepts that have been approved for the national Medicare RAC program should be used to fast track the Medicaid RAC programs in the states. Providers are already familiar with these audit types and concepts. This will minimize provider confusion and substantially lower the duplication of effort and cost.

Error rates for Medicare Part C and Part D published by OMB suggest great potential for recoveries. And with ever increasing demands on funding for Medicare Advantage and Prescription Drug Plans, we are anxious to begin helping CMS identify and recover funds here as well.

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Recommendations for the expansion of Recovery Audits to Medicare Part C and Part D include the following:

Our recommendations for the expansion of the CMS RAC program to Medicare Part C and Part D plans are based on the primary principle of maximizing return to the taxpayers and bending the healthcare cost curve going forward. We understand that Part C and Part D plans are administered by private enterprises that bear the actuarial risk, and as such any CMS program to expand recovery audit here should have incentives for the private enterprise similar to those that have been created for government agencies by S.1508.

1. To "*make the juice worth the squeeze*" the program must focus on auditing the transactions between the Medicare Advantage and Prescription Drug plans and the provider. That is where the complexity lies, that is where the majority of errors occur, and therefore, that is where taxpayer returns will be optimized.

2. The recovered funds in any fiscal year should accrue to the Part C and Part D plans, providing the incentive for them to make the program successful.

3. Both the plans and the recovery auditors should be required to report the total recoveries for each fiscal year. CMS could then use the "adjusted costs" (i.e., actual payment to a participating plan in a fiscal year minus recovered dollars for that year) to calculate the premium growth per member in the subsequent years, thereby effectively bending the cost curve.

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4. CMS should provide a set of guidelines, similar to that which I described for Medicaid above, for the contingency recovery audits of all Medicare Part C and Part D plans.

5. CMS has a wealth of experience from the demonstration and national Medicare RAC programs and has worked with the largest and most capable vendors in healthcare recovery auditing. CMS should provide a list of approved recovery audit contractors that the plans can work with to roll out their recovery audit programs.

Mr. Chairman, we share your commitment to addressing the issue of improper payments in the federal government. Recent emphasis by the executive and legislative branches on this problem encourages solutions that are viable from both business and public policy perspectives. This process embraces best practices where both the private sector and dedicated public servants can combine their efforts on behalf of the American people. We are privileged to be a part of it.

I would now be happy to answer any questions you may have, and thank you again.

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[1] Deloitte "Global Powers of Retailing 2009" and PRGX analysis

[2] The Medicare Recovery Audit Contractor (RAC) Program: Update of the Evaluation of the 3-year Demonstration – June 2010 (Published by CMS)

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Recovery Audit Contractor Demonstration Vulnerabilities Progress Report

In the GAO Report on the Recovery Audit Contractor (RAC) Demonstration (GAO-10-143), released in March 2010, GAO referenced that CMS had not taken any corrective action on 35 out of 58 identified vulnerabilities.

The CMS has been working diligently to close the remaining vulnerabilities identified by the RACs in the demonstration. The remaining 35 vulnerabilities can be classified into four categories: those closed in July 2010, those on track for completion within six months (February 2011), those likely to take up to December 2011 to address, and those on hold pending law enforcement investigations. The table below contains a brief description of the outstanding vulnerabilities by the four categories.

Category	Description of Vulnerabilities	Number of Vulnerabilities
Closed July 2010	**Insufficient Documentation:** Vulnerability 1 – No documentation submitted (inpatient hospital) Vulnerability 9 – No documentation submitted (skilled nursing facility) Vulnerability 35- Insufficient documentation submitted (skilled nursing facility)	3
Targeted for Closure by February 2011	**Vulnerabilities Associated with Inpatient Hospital Stays:** Vulnerability 10 – Heart Failure and Shock Vulnerability 12 – Other Respiratory System OR procedures (Closed Biopsy of Lung) Vulnerability 13 – Chest Pain Vulnerability 14 – Miscellaneous Digestive Disorders Vulnerability 16 – Medical Back Problems Vulnerability 17 – Chronic Obstructive Pulmonary Disease	

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Category	Description of Vulnerabilities	Number of Vulnerabilities
Targeted for Closure by February 2011 (cont.)	Vulnerability 18 – Cholecystectomy except by Laparoscope (OR Procedures for Infections, Parasitic Diseases) Vulnerability 19 – Nutritional & Miscellaneous Metabolic Disorders Vulnerability 20 – Other Circulatory Systems Diagnoses Vulnerability 21 – Kidney & Urinary Tract Infections Vulnerability 22 – Other Digestive System Diagnoses Vulnerability 23 – Other Vascular Procedures Vulnerability 24 – Percutaneous Cardiac Procedures Vulnerability 25 – Renal Failure Vulnerability 26 – Syncope & Collapse Vulnerability 27 – Red Blood Cells Disorder Vulnerability 28 – Transient Ischemia Vulnerability 29 – Degenerative Nervous System Disorders Vulnerability 30 - Coagulopathy Vulnerability 32 – Respiratory System Diagnosis with Vent Support Vulnerability 33 - Atherosclerosis Vulnerability 34 – Cardiac Arrhythmia	22
Targeted for Closure by	Vulnerability 2 – Medical Necessity did not meet requirements for inpatient admission	

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Category	Description of Vulnerabilities	Number of Vulnerabilities
December 2011	Vulnerability 3 – Outpatient Charges Should Apply Vulnerability 4 – Other Services with Excessive Units (Outpatient) Vulnerability 5 – Other Drug Codes Vulnerability 6 – Pharmaceutical Injectables Vulnerability 7 – Duplicate Claims	
Targeted for Closure By December 2011 (cont.)	Vulnerability 8 – Other Services with Excessive Units (Physician) Vulnerability 11 – Ambulatory Surgical Center (ASC) List Violations	8
On Hold Pending Law Enforcement Investigations)	Vulnerability 31 – Cardiac Defibrillator Implant Vulnerability 15 – Other Cardiac Pacemaker Implantation	2
TOTAL GAO IDENTIFIED VULNERABILITIES		**35**

Closed Vulnerabilities

The CMS has taken corrective actions to close vulnerabilities 1, 9, and 35 as listed in the Improper Payment Prevention Plan (IPPP). Based on an analysis of the RAC findings, CMS determined these improper payments were the result of technical deficiencies due to the providers' failure to submit any documentation to support the claim, or the documentation provided was insufficient. When the provider fails to send any documentation or the documentation sent is insufficient or incomplete, the RAC must deny the entire claim. Generally, providers who fail to send any documentation or send insufficient documentation do so because they are unfamiliar with the program requirements or don't want to expend the resources necessary to obtain all the required documents. These cases are often appealed and then documentation is submitted by the provider during their appeal.

The CMS experienced similar documentation issues when we first began the error rate measurement programs for Medicare (CERT) and Medicaid (PERM). During the initial years of these error rate measurement programs, some providers failed to send in documentation or didn't provide sufficient documentation to support the claim. The primary reason for these documentation issues was lack of understanding by providers. CMS began education and

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outreach efforts to inform providers about the error rate programs and this outreach reduced documentation errors substantially. We believe that targeted education and outreach about the importance of documentation will likewise have similar impact in significantly reducing these documentation vulnerabilities.

To resolve these vulnerabilities CMS has provided nationwide outreach to all providers on the importance of responding to a RAC documentation request. Onsite provider outreach occurred in all 50 states and CMS and the RACs held more than 140 outreach sessions to discuss how providers can be well prepared for the RAC program. In addition, CMS released a Medicare Learning Network (MLN) Matters article specifically on the need to submit documentation. This article was released on July 12, 2010 and closed out GAO's identified vulnerabilities related to no documentation and insufficient documentation. The table below contains the dates and the corrective actions CMS completed to resolve these 3 outstanding vulnerabilities.

Action Date	Corrective Action Taken
November 2008 through August 2009	Conducted nationwide outreach to all provider types on the importance of responding to a Recovery Auditor for additional documentation request in support of a paid claim. Onsite provider outreach occurred in all 50 states and CMS and the RACs held more than 140 outreach sessions to discuss what documentation providers need to submit to support their claims.
July 12, 2010	Issued a Medicare Learning Network (MLN) Matters article to all providers specifically the need to submit documentation for claims selected for review by the Recovery Auditors.

Vulnerabilities Targeted for Closure by February 2011

The CMS has begun corrective actions and is on track to close 22 outstanding vulnerabilities related to an inpatient hospital stay. The process to bill an inpatient hospital stay is complicated and involves the provider using screening software to determine the appropriate Diagnosis Related Group (DRG) to bill. The claims associated with this set of 22 identified vulnerabilities have passed all of the standard automated system edits prior to payment and appear to be accurate based on the information submitted on the claim. In order to determine if the claim is accurate, the beneficiary's medical record must be reviewed by a clinician to determine if the services provided and billed for are supported by the medical record and any other supporting documentation. When a medical record review is completed the provider receives a review results letter indicating any findings on the claim and if problems are identified, a demand for recoupment will follow this letter. While the review results letter does not tell the provider how to bill, it does inform the provider of the issues that were incorrect in the original claim as billed, and serves as a corrective action specific to the claim. Over time, the

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information sent to the provider about specific claims reviewed and denied by the RACs should assist providers in improving their documentation and help the provider to bill similar claims correctly in the future.

While this process should help reduce repeated mistakes for these types of improper payments, the only way to definitively measure the effect of the RAC program and the specific claim corrective action is through further review of the medical records. The table below contains the dates and the corrective actions CMS plans to complete in order to meet our target and resolution of these outstanding vulnerabilities by February 2011.

Projected Action Date (including actions taken to date)	Corrective Action To Be Taken
August 6, 2010	The CMS approved 22 outstanding vulnerabilities for review by the current RACs. The 22 vulnerabilities related to services provided by inpatient hospitals where the documentation for services provided did not automatically support the medical necessity of the services in an inpatient setting or the principal or secondary diagnosis and procedures billed. The CMS approved the RACs to review these 22 issues to determine if the medical necessity of the services provided and the medical necessity of the place where the services were provided are supported by the individual medical records. The RACs will also review claims to determine whether the principal and secondary diagnosis and the procedure codes billed are supported by the documentation contained in the medical record.
September 23, 2010	The CMS released a national education article to inpatient hospitals explaining the findings from the RAC demonstration concerning medical necessity reviews and what inpatient hospitals can do to prevent those types of mistakes in the future. The article will remind hospitals of the importance of submitting complete documentation and the documentation requirements to support medical necessity of services billed, as well as the place of service.
September 23, 2010	The CMS released a national education article to inpatient hospitals explaining the findings from the RAC demonstration regarding hospital billing codes. The article will remind hospitals of the importance of submitting documentation, as well as the importance of quantifying the correct principal and secondary diagnosis and the correct procedure codes for billing purposes.
October 2010	The RACs are expected to release the first wave of medical record requests to providers for the 22 vulnerabilities approved for review on August 6, 2010. The review of medical records will be ongoing and subject to the guidelines and records review limitations established for the National RAC program.

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November 2010	The RACs are expected to begin receiving medical records from providers on these 22 issues. They will review the medical records to determine the medical necessity of the services provided and the medical necessity of the setting where the services were provided.
December 2010	The CMS intends to establish a new task in the Medicare contractors' contracts requiring them to consider and evaluate vulnerabilities identified by the OIG, RACs, CERT program and others issues CMS determines are appropriate for further evaluation. In addition, the Medicare contractors must report to CMS quarterly on the status of their evaluations and the corrective actions taken.
February 2011	The CMS intends to release provider-specific reports tailored to the findings from the RAC demonstration. These provider-specific reports will be from the Program for Evaluation Payment Patterns Electronic Reports (PEPPER) database. This program released provider specific reports detailing a provider's billing pattern compared to its peers in the same locale, size or beneficiary population.

Vulnerabilities Targeted for Closure by December 2011

The CMS has begun corrective actions for the 8 outstanding vulnerabilities in this category. However, given the generic nature of these issues, it is very likely that many, not all, of these issues are duplicative of the other more specific vulnerabilities contained in the previous category. The CMS does know that specific sections of these generic issues have already been approved for RAC review. For example, the RACs have been approved to review situations of duplicate claims, excessive units, drug codes and pharmaceutical injectables. In addition, the review of the medical necessity cases listed in the previous category involve claims where outpatient charges should have applied, or where the services required were not medically necessary for an inpatient setting or an Ambulatory Surgery Center (ASC).

In November 2010, CMS intends to release the first quarterly newsletter specifically on improper payments and provider compliance. This quarterly newsletter will provide guidance to providers on how to avoid common claim submission errors. The first newsletter includes the other services with excessive units and pharmaceutical injectable vulnerabilities as well as specific examples of situations where the medical necessity did not meet the requirements for inpatient admission. Whenever possible, examples from the RAC demonstration will be included for illustrative purposes. In addition, the MLN Matters articles that were issued relating to documentation and the detailed review results letters issued by the RACs serve as individualized provider education to assist providers in effectively modifying their own billing practices.

The CMS will share the issues with the RACs and will encourage the RACs to consider these issues and develop specific HCPCS codes and/or DRGs for potential review if they

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discover that any of the issues are not related to one of the vulnerabilities contained in the previous category. These topics were shared with the RACs on October 1, 2010.

Projected Action Date (including actions taken to date)	Corrective Action To Be Taken
October 1, 2010	The CMS released a memo to the RACs providing them with information on high level vulnerability categories that remain from the demonstration. The memo will encourage the RAC to consider these areas for future review and to submit detailed issues by service and/or diagnosis code to CMS for approval.
October 5, 2010	The CMS intends to release the first quarterly newsletter specifically on improper payments and provider compliance. This quarterly newsletter will provide guidance to providers on how to avoid common errors. The first newsletter includes the other services with excessive units and pharmaceutical injectable vulnerabilities as well as specific examples of situations where the medical necessity did not meet the requirements for inpatient admission.
December 2010	The CMS intends to release a follow-up memo to the RACs providing more detail and examples of issues that were described in the October 1, 2010 memo. The CMS will conduct a call with the RACs and will encourage them to consider these areas for future review and to submit detailed issues by service and/or diagnosis code to CMS for approval.
February 2011	The RACs are expected to begin to submit new issues for CMS approval based on the October 1, 2010 and December 2010 memos.
May 2011	The RACs will begin to request medical records for the CMS approved issues first identified to the RACs in the October 1, 2010 and December 2010 memos.
July 2011	The RACs are expected to begin to receive medical records from the CMS approved issues first identified to the RACs in the October 1, 2010 and December 2010 memos.
September 2011	The CMS intends to begin to analyze the specific findings related to the high level topics shared with the RACs in the October 1, 2010 and December 2010 memos and will begin to have the issues discussed on the vulnerability calls to determine the proper form of corrective action(s).
December 2011	The CMS intends to complete all necessary corrective action(s) identified during the vulnerability calls. In the case of necessary system edits CMS will begin the process and place a high priority on the completion of the edits.

Vulnerabilities CMS Cannot Close At This Time Due to Pending Law Enforcement Investigations

CMS is not actively pursuing efforts to close Vulnerabilities 15 and 31 from the IPPP at this time, because we have been requested to not review these issues due to pending law enforcement actions. The CMS is in close contact with law enforcement on these issues and will develop corrective actions at the appropriate time in the future.

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QUESTIONS FOR THE RECORD
From Chairman Tom Carper
"RAC Oversight and Part D Issues"
Before the U.S. Senate Subcommittee on Federal Financial Management
July 15, 2010

For Ms. Deborah Taylor of CMS

Question #1 – RAC Identified Vulnerabilities – Demonstration Program
The Government Accountability Office (GAO) testimony by Ms. King describes a great opportunity provided by the Recovery Audit Contracting program. Not only had the Recovery Audit Contracting demonstration program recouped almost a billion dollars in overpayments, but identified ongoing vulnerabilities that could lead to future overpayments. However, the recent GAO audit and today's testimony points out that not all of the Recovery Audit Contractor overpayment vulnerabilities identified through the demonstration program have been addressed by the Centers for Medicare and Medicaid Services (CMS).

Of course, the GAO analysis was conducted a few months ago. Has there been progress since the audit was completed? How many of the vulnerabilities have been addressed? Will the remaining vulnerabilities be addressed? How many and when?

A: See attached chart for complete information, which is provided as a stand-alone document.

Generally, from the demonstration project 58 "vulnerabilities" were identified. The GAO reported in March 2010 that CMS took action on 23 of the 58. CMS has initiated several corrective actions for the 35 vulnerabilities identified by the GAO that had not been addressed when the GAO conducted their review; since that time, 3 of the outstanding vulnerabilities have been addressed, 22 are on track for completion within 6 months, 8 are likely to take up to a year to correct, and 2 are on hold pending law enforcement investigations. In response to the identified vulnerabilities, corrective actions CMS has taken to date include:

- **Education to providers at various nationwide outreach events. Provider outreach occurred in all 50 states to discuss what documentation providers need to submit to support their claims;**
- **Education to our claims processing contractors during RAC Vulnerability Calls;**
- **Approval of continued review in the National RAC program for those vulnerable areas that cannot be addressed and corrected through proactive automated system edits (CMS gave RACs the approval to review on August 6, 2010);**
- **Publication of a Medicare Learning Network educational article on July 12, 2010 emphasizing the importance of medical record documentation and submission of documents timely;**
- **Publication of a Medicare Learning Network educational article published on September 23, 2010 on hospital billing codes and the importance of submitting**

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documentation and quantifying the correct principal and secondary diagnoses and the correct procedure codes for billing purposes; and

- **Publication of a Medicare Learning Network educational article published on September 23, 2010 concerning medical necessity reviews.**

Question #2 – RAC Identified Vulnerabilities – Current Program

Could you describe the process been put in place for the current Recovery Audit Contractor program to address the identified vulnerabilities? Also, do you have a timeline for when the identified vulnerabilities of the current program will be addressed?

How is CMS ensuring that not only the vulnerabilities have been addressed, but that the action taken to address the vulnerabilities has been effective? If, for example, CMS determined that the new guidance should be sent to providers, how does CMS track the outcome? This, of course, is one of the recommendations of the GAO.

A: CMS is committed to addressing key findings identified by the RACs and providing additional provider education or automated claims processing adjustments to correct key findings when practicable. While all the GAO-identified vulnerabilities are not yet fully addressed, CMS is taking actions that address the majority of GAO's findings. In some instances, there is no simple automated edit that CMS can put into Medicare's claims processing system that will identify or correct these improper payments in the future. In these instances, the only way to determine if the services were medically necessary or if the correct Diagnosis-Related Group (DRG) was billed is to conduct an individualized review of the beneficiary medical record and any other supporting documentation. This review would take the skills of a registered nurse, therapist or in some cases physician, which is cost-prohibitive to do on each submitted claim.

CMS is conducting a pilot to determine whether increased incentive fees would cause RACs to view more claims where the potential for identifying large dollar overpayments in very unlikely; especially in the DME area. CMS is also adding a requirement to Medicare Administrative Contractor (MAC) contracts to ensure these contractors look into vulnerabilities that have been identified by RACs.

CMS is continuing the weekly vulnerability calls with the claims processing contractors and the RACs, which began during the RAC demonstration and proved to be very successful. The calls provide valuable insight into potential corrective actions that can be taken to address emerging vulnerabilities. The potential corrective actions include:

- **Installation of local edits by claims processing contractors;**
- **Installation of national edits by CMS to flag certain types of claims for further review;**
- **Clarification or changes in policy; and**
- **Provider outreach and education.**

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After a corrective edit has been placed into the claims processing system either locally or nationally, CMS can track the success of the edit at reducing improper payments with future data analysis. For vulnerabilities that cannot be automatically addressed with claims processing edits, policy clarifications or provider education is conducted. However, in those instances, further review is the only way to determine the success of the initiative. This is usually the case when the vulnerability identified is that the services were not medically necessary or the incorrect DRG was billed. The additional review requires the skill set of a registered nurse, therapist or in some cases physician and is currently conducted by the RACs.

Question #3 – Challenges in Administering the RAC Claims of Overpayments
I understand that the Recovery Audit Contractors rely on Medicare claims payment contractors to process the identified overpayments.

Is there a backlog of overpayment that is unprocessed by the claims processing contractors? How many are in the backlog for each RAC?

A. During the RAC demonstration backlogs occurred at the claim processing contractors because the claims were adjusted manually and the amount of claims requiring adjustment exceeded the staffing capability. CMS took steps in April 2010 and July 2010 to implement a process in all three standard systems (Fiscal Intermediaries Shared System for Part A claims, Multi-Carrier System for Part B claims and ViPS Medicare System for DME claims) to allow for a large number of claims to be adjusted at one time. Additionally, if a RAC believes it has a large backlog of improper payments, CMS works with the RAC and the claims processing contractor to develop a timeline to allow the adjustments to occur. Although we do not have a precise number, the current backlog volume is minimal.

Question #4 – Establishing a Goal for RAC Identified Overpayments
I have heard that in the private sector it is common for companies to give recovery audit contractors specific dollar amounts or other targets for their audits. Would this be helpful for the Medicare program? Has CMS established a goal for the amount of improper payments to be recovered for 2010? For 2011?

A: Recovery audit contracting activities focus on identifying and correcting overpayments to support the agency's mission to make accurate payments to providers. Recovery audit contractors focus on this goal, and not necessarily achieving a target dollar value of collections. While private sector recovery audit programs are driven by profit, the CMS RAC program is driven instead by the agency's mission to provide cost efficient and effective health care to beneficiaries.

Question #5 – Prescriber Identifiers – Top Ten Identifiers

The HHS Office of Inspector General described some major short-comings in validating prescriber identifiers used for reimbursement under the Medicare prescription drug program.

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I understand that the HHS OIG audit on prescriber identifiers showed that just ten invalid identification numbers represented 17% of the invalid prescriber identifiers in 2007.

Does CMS have data for 2009 and 2010 in terms of the number of Medicare Part D reimbursements that include the same ten invalid identifiers?

A: Yes. CMS' MEDIC analysis indicates that there was a 66% decrease in the submission of the top ten invalid identifiers on prescription drug events from contract year 2007 to contract year 2009. Additional analysis for contract year 2010 indicates an 86.9% decrease in the submission of the same invalid prescriber identifiers. The OIG report states that there were 3,151,867 submissions of the top ten invalid identifiers on prescription drug events from contract year 2007. However, by contract year 2009, this count had decreased to 1,074,398, and estimates to date for the contract year 2010 show a total of 414,445.

Question #6 – Prescriber Identifiers - Timeline
Could you describe what CMS is doing to address the findings of the inspector general audit? Has CMS taken these steps? Could you give us timelines as part of your answer?

A: The HHS Office of Inspector General (OIG) report entitled "Invalid Prescriber Identifiers on Medicare Part D Drug Claims" (OEI-03-09-00140, June 2010) found that $1.2 billion in Medicare Part D claims contained invalid prescriber identifiers in 2007. The claims accounted for 2 percent of all prescription drug event (PDE) records submitted to CMS in 2007. Invalid prescriber DEA numbers accounted for 98 percent of the invalid prescriber identifiers on these records.

CMS has thoroughly reviewed this report and appreciates the OIG's recommendations. CMS understands that prescriber identifiers collected on PDE records can provide valuable information for program oversight and, therefore, recognizes the importance of collecting valid prescriber identifiers. However, CMS believes the OIG's findings should be assessed in light of prevailing pharmacy practice in the treatment of DEA numbers for non-controlled substances as well as more recent shift toward the use of NPIs as prescriber identifiers.

As CMS has evaluated the OIG's report, the Agency has come to the following conclusions:

- **The OIG report's findings do not identify and did not determine whether any payments were made for invalid claims.**

Invalid prescriber DEA numbers on pharmacy claims transactions have been a long-standing issue that predates Medicare Part D, but generally is not indicative of invalid prescriptions. Instead, it often reflects that the pharmacy did not have access to a prescriber's DEA number when filling valid prescriptions for non-controlled substances because prescribers are only required to provide their DEA number when prescribing controlled substances.

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CMS recognizes the importance of having strong program integrity initiatives that will deter criminal activity and attempts to defraud the Medicare and Medicaid programs. The Agency shares your commitment to ensuring taxpayer dollars are being spent on legitimate items and services. However, CMS must make sure to do this in a way that is fair and transparent to plans and providers, who are our partners in caring for beneficiaries, and ensures that beneficiary access to necessary medicines is not impeded.

Further, the prescriber identifier is not generally indicative of invalid prescriptions. While CMS agrees that valid prescriber identifiers can improve oversight efforts to monitor the prescribing practices of specific providers, a missing or invalid prescriber identifier is not an automatic indication of invalid prescriptions or fraudulent pharmacy claims. In OIG's response to CMS' comments on the report, OIG agreed with CMS that "invalid prescriber identifiers do no automatically indicate invalid prescriptions or pharmacy claims."

- **These 2007 findings should be considered in light of the significant changes in prescriber identifiers that have occurred since 2007.**

Specifically, the OIG's findings were driven by invalid DEA numbers that represented 98 percent of invalid prescriber identifiers in 2007. In 2010, however, the national provider identifier (NPI) is now the standard prescriber identifier on the majority of pharmacy claims. Unlike invalid DEA numbers, the OIG report did not identify default NPIs as a significant source of invalid prescriber identifiers. Rather, invalid NPIs accounted for less than 2 percent of all claims with invalid prescriber identifiers found in the OIG report. As the percentage of prescriber NPIs on pharmacy claims continues to increase, the significance of invalid prescriber DEA numbers is also expected to decrease drastically. After the implementation of the NPI, CMS completed an initial review of 2009 PDE data and learned that the NPI was reported on a majority of PDE records.

- **CMS is initiating a detailed evaluation process to resolve this issue.**

CMS plans to implement a process to periodically review and evaluate trends associated with the validity of prescriber identifiers on PDE records and issue guidance to Part D plans to implement policies and procedures to identify and review invalid prescriber identifiers on Part D claims.

CMS will begin a prescriber identifier project in September 2010. The project is motivated by the e-prescribing incentive program included in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) as well as by the OIG's findings. For CMS to use PDE data for the purpose of determining whether a professional is eligible for the e-prescribing incentive program, PDEs must include accurate individual prescriber identifiers. The purpose of this project is to assist CMS in developing a strategy to improve the percentage of prescriber NPIs on PDEs thereby improving the accuracy of the prescriber information on PDEs, eliminating invalid identifiers, and enabling CMS to better monitor and evaluate the diffusion of e-prescribing in Part D. CMS will use the results of this survey to inform its development of new regulations and future guidance to improve oversight and management of the Part D program.

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In the meantime, CMS has discussed this problem with stakeholder groups, to help remind plans about the requirements, and to help us understand what factors may be leading to non-compliance. In particular, CMS made a presentation to the National Community Pharmacists Association in March 2010 and a presentation to the National Council of Prescription Drug Programs workgroup in May 2010.

CMS intends to follow through on the OIG's recommendation to issue new guidance to its Part D sponsors to institute procedures to identify and flag for review Part D claims that contain invalid prescriber identifiers. In August 2010, CMS issued a memorandum to Part D plans alerting them to the OIG's findings and CMS' concern about missing or invalid prescriber identifiers and our intent to award a contract to monitor use of prescriber identifier's on Part D claims data. Before issuing further guidance, however, CMS wants to fully understand through the monitoring project the challenges that its partners face in addressing this issue, in order to provide informed and meaningful guidance to Part D plans and providers.

- **Preserving beneficiary access to legitimate, medically necessary prescription drugs is CMS' top priority.**

CMS will continue to caution Part D sponsors not to implement point-of-sale edits to reject all Part D claims with invalid prescriber identifiers in order to appropriately balance the need to collect valid prescriber identifiers on all Part D claims while ensuring beneficiary access to legitimate, medically necessary drug therapies. Preserving beneficiary access to necessary prescription medications is at the heart of CMS' mission for the Part D program, and the problem identified by the OIG, while serious, should be addressed by CMS in a manner that does not jeopardize the Agency's mission to provide needed medical services and supports for our beneficiaries.

Timeline for CMS Actions to Address Invalid Prescriber Identifiers:

CMS Action	Purpose	Implementation Period
Meeting with the National Community Pharmacists Association	To review and discuss this problem with stakeholder groups, to help remind Part D plan sponsors about the requirements, and to help CMS learn more about what factors may be leading to non-compliance.	March 2010
Meeting with the National Council of Prescription	To review and discuss this problem with stakeholder groups, to help remind Part D plan sponsors about the requirements, and to help CMS learn more about what factors may be leading to non-compliance.	May 2010

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Drug Programs		
Notice to Part D Plan Sponsors	To notify Part D plan sponsors of the OIG's findings, our concerns about missing or invalid identifiers, and CMS' intent to award the prescriber identifier (NPI) monitoring contract and provide guidance clarifying that valid prescriber identifiers must be used on Part D claims.	August 2010
Prescriber Identifier Contract	To assist CMS in developing a strategy to improve the percentage of valid prescriber NPIs on PDEs, thereby improving the accuracy of the prescriber information on PDEs, eliminating invalid identifiers, and enabling CMS to better monitor and evaluate the diffusion of e-prescribing in Part D. The contractor engaged for the project will: • Analyze PDE data to identify trends as well as high and low performing outliers in the submission of valid NPIs, including Part D sponsors, claims processors and pharmacies; • Conduct outreach to the outliers to determine the problems/issues they have encountered and identify potential solutions and best practices; and • Suggest recommendations for the CMS strategy for improving the percentage of valid prescriber NPIs on PDEs and inform future CMS guidance to plans on the use of valid prescriber identifiers.	Project begins in September 2010, with the initial contract award for 1 year. *Note: CMS has the option to extend these monitoring efforts if it deems an extension is necessary for conducting periodic reviews of PDE records.*

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Questions for the Record
Submitted to Deborah Taylor
From Senator Claire McCaskill
"RAC Oversight and Part D Issues"
July 15, 2010

Questions:

1. Part of this program is about recovering payments that shouldn't have been made, due to either innocent mistakes or deliberate deceptions, but the Recovery Audit Contractors (RACs) are involved after the fact. We should be learning, however, from the most common causes of improper payments and fixing them on the front end. RACs can only suggest structural fixes and it is up to Medicare Administrative Contractors (MACs) or the Centers for Medicare and Medicaid Services (CMS) to make system changes. The Government Accountability Office (GAO) issued a report that said that most of the structural fixes suggested by RACs during the demonstration project weren't implemented because there isn't a general framework in place to systemically address weaknesses discovered by RACs. According to the GAO report it can take seven months to implement changes in the Medicare reimbursement system. It doesn't seem that we have a system in place to continually fix the identified vulnerabilities that are going to keep coming in month after month. Do you feel that there is a system in place to do this? Please explain.

   A: CMS is committed to addressing key findings and vulnerabilities identified by the RACs and when practicable, providing additional provider education or claims processing updates to correct key findings. We do have a system in place that allows us to identify new vulnerabilities as they arise and track our efforts to minimize their occurrence or correct them. CMS staff participates in routine calls with RAC contractors to learn of new issues that have been identified and notifies MAC claims processing contractors of possible vulnerabilities and solutions when appropriate. In addition to these calls and the corrective actions that result from them, CMS is adding a requirement to our MAC contracts to ensure these contractors look into vulnerabilities that have been identified by RACs. CMS is also in the process of developing a new electronic system that will better track program vulnerabilities.

2. You mentioned in the hearing that it is your responsibility to identify vulnerabilities, but it wasn't clear that you also had complete authority to implement fixes. Is there sufficient focus and support within CMS to make fixing vulnerabilities a priority? Please explain.

A: See attached chart for complete information, which is provided as a stand-alone document.

CMS recognizes the importance of preventing improper payments. From the demonstration project 58 "vulnerabilities" were identified. The GAO reported in March 2010 that CMS took action on 23 of the 58. CMS has initiated several corrective actions for the 35 vulnerabilities identified by the GAO that had not been addressed when the GAO conducted their review; since that time, 3 of the outstanding vulnerabilities have been addressed, 22 are on track for completion within 6 months, 8 are likely to take up to a year

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to correct, and 2 are on hold pending law enforcement investigations. In response to the identified vulnerabilities, corrective actions CMS has taken to date include:

- **Education to providers at various nationwide outreach events. Provider outreach occurred in all 50 states to discuss what documentation providers need to submit to support their claims;**
- **Education to our claims processing contractors during RAC Vulnerability Calls;**
- **Approval of continued review in the National RAC program for those vulnerable areas that cannot be addressed and corrected through proactive automated system edits (CMS gave RACs the approval to review on August 6, 2010);**
- **Publication of a Medicare Learning Network educational article on July 12, 2010 emphasizing the importance of medical record documentation and submission of documents timely;**
- **Publication of a Medicare Learning Network educational article published on September 23, 2010 on hospital billing codes and the importance of submitting documentation and quantifying the correct principal and secondary diagnoses and the correct procedure codes for billing purposes; and**
- **Publication of a Medicare Learning Network educational article published on September 23, 2010 concerning medical necessity reviews.**

3. Not all of the vulnerabilities need a fix from CMS, but rather can be addressed at the MAC level. How often do they initiate their own fixes? What incentive do MACs have to implement changes identified by RACs or CMS? If they don't have the right incentives how could we give them the right incentives?

A: CMS is pursuing a change to our MAC Contracts to add a requirement that these contractors look into vulnerabilities that have been identified by RACs. Currently, CMS staff is exploring possible metrics/incentives under the MAC award fee plans that would provide incentives to ensure that MACs address known vulnerabilities, raise vulnerabilities to CMS, and address vulnerabilities locally when appropriate.

Additionally, CMS, in its FY 2011 Budget Request, has proposed significant alterations to the responsibilities and structure of the MACs in order to streamline their operations, improve their efficiency, and incentivize strong program integrity work. CMS is proposing to consolidate Medicare provider enrollment activities into a smaller number of specialized MACs to lower administrative costs, increase efficiencies, and improve oversight as provider enrollment moves online. This consolidation will be a continuation of the successful MAC consolidation process that CMS has been implementing for the past few years. Consolidations will occur during already scheduled MAC contract re-competitions to reduce costs. We expect that this consolidation will significantly reduce administrative costs, provide more consistent application of CMS policy, and improve program oversight.

4. What is the estimated error rate for Part A and B payments and what is the goal that you are aiming to reduce improper payments to? How does this compare to the error rate of private insurers and what is realistically the lowest rate we can hope to practically achieve?

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A: In the last year, CMS has applied a stricter and improved methodology for calculating the Medicare Fee-For-Service (FFS) error rate (which is the error rate for Medicare Part A and Part B) to ensure accuracy in the error rate measurement. In FY 2009, the error rate for Medicare FFS increased from 3.6 percent in FY 2008 to 7.8 percent (or $24.1 billion) using the blended criteria for calculating the error rate. The error rate using the strictest review criteria was 12.4 percent (or $35.4 billion) for FY 2009. President Obama recently announced that CMS will cut the Medicare FFS improper payment rate in half by 2012 and CMS is committed to reducing the error rate from 12.4 percent to 6.2 percent by 2012.

Historically, private insurers have not publicly announced their error rates. However, the Medicare program, by design, is fundamentally different from private insurance, and as a result, and cannot be compared to the private sector with regards to claims payment errors.

5. Right now RACs are limited to requesting 1% of the detailed claims records and the rationale for this is that providers need reassurance that they're not going to spend all of their time filling data requests from RACS instead of taking care of their patients. Given that RACs can audit 100% of the high-level claims data, is it possible to find recoverable overpayments without the detailed record audits? Please explain what effect the 1% detailed record retrieval limitation has on the ability to meaningfully recover overpayments.

A: It is possible for the RACs to find recoverable overpayments without looking at the detailed medical records. In fact, RACs initially conducted reviews based on data analysis and were able to identify and recover mistaken payments.

The 1% record retrieval limit only pertains to cases where the medical record must be reviewed prior to a determination of an improper payment being made; the limit does not apply to improper payments identified from data analysis alone.

CMS has imposed a medical record limit on the RACs to ensure Medicare providers are not unduly burdened and can focus their attention on providing quality care to Medicare beneficiaries. The current medical record limits for inpatient and outpatient hospitals is 1% of their Medicare claims volume or a maximum of 200 claims at a time. CMS reviews this limit on an annual basis based on feedback from the provider community and the RACs.

6. CMS approves each audit area before RACs can run queries. I understand right now there have been no complex reviews allowed yet in 2010. How do you decide what areas to allow audits on and do you have a "master plan" for which areas should be focused on and when?

A: **CMS used a staggered approach for review when implementing the RAC program. CMS instructed the RACs to begin with automated reviews that can identify an improper payment through data analysis. CMS began with these issues because they are clear and easy for the provider community to understand. Subsequently, the RACs were approved to request medical records from providers to determine if the proper codes and/or procedures were billed. Lastly, CMS began approving medical necessity reviews for RAC**

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audits. CMS believes that this staggered approach to implementation allowed the program to develop a good baseline relationship with the provider community and will help the program achieve long term success. For example, CMS approved the first issue requiring complex review in September 2009. In November 2009 CMS approved widespread complex reviews for DRG Validations. In August 2009 CMS approved several complex reviews for medical necessity.

CMS established a New Issue Review Board as part of the lessons learned during the demonstration project. The New Issue Review Board consists of CMS staff experts from our policy, coverage, appeals, and financial management areas. The board reviews medical necessity issues developed by the RACs. The New Issue Review Board ensures: 1) the RAC's review methodology is consistent with CMS policy; 2) clear and accurate language is used when communicating to providers; and 3) CMS is aware of all RAC requested reviews and rationale for the approved issues. When necessary, the board also reviews sample medical records to support the improper payment determinations. The New Issue Review Board is a critical element to ensure that the RACs are properly reviewing claims consistent with CMS policy.

7. Do you have data on where the most overpayments are in Medicare (e.g. durable medical equipment (DME), or inpatient hospitals stays)? If so, where are they and what are the figures? Is the relative error rate in certain areas driving your decisions on which audits are allowed?

A: During the first two quarters of the national RAC program, over 90% of the claims that resulted in a demanded overpayment involved Durable Medical Equipment (DME). Physician claims constituted about 5% of demanded claims. We expect RACs to continue to audit claims in areas that are most likely to result in the recovery of overpayments, which may vary from one region to the next.

CMS does not currently dictate what the RACs review because RACs are paid on a contingency basis. CMS does however approve issues prior to RAC review. Issues are typically identified for potential review by a RAC based on prior experience/knowledge, vulnerabilities identified in OIG/GAO reports, and the Comprehensive Error Rate Testing (CERT) report.

CMS is working to modify the RAC contracts to provide additional incentives to the RACs for reviewing potential vulnerabilities referred to the RACs by CMS. This includes potential vulnerabilities arising out of OIG reports and CMS' internal data analysis.

8. The Affordable Care Act is going to steer Medicare away from fee-for-service and toward bundled reimbursements. What is this going to do to both the numbers of claims as well as the potential for waste, fraud and abuse? Will improper payments increase or decrease with this bundling? Will it be easier or harder for RACs to do their job?

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A: CMS believes that bundled payments should act to reduce the potential for waste, fraud, and abuse in the Medicare program by providing a global payment to a single entity, rather than individual payments for each component of a service to one or more billing entities. Because an established, reasonable payment amount for a bundle of services will reduce the number of claims that a provider (or multiple providers) files, Medicare will be better able to focus its oversight efforts. CMS will continue to monitor improper payments through existing mechanisms.

9. The Affordable Care Act also calls for RACs to be expanded to state Medicaid programs as well as Medicare Parts C and D by the end of the year. Is that too ambitious of a timeline? What do you foresee doing differently in those programs than in the current program? How do you structure a contingency payment in a capitated program like Medicare Advantage? Is there going to be unhealthy overlap between the role of MEDICs and RACs in Part D?

A: CMS appreciates Congress' continued interest in using RACs to recover overpayments. However, the RAC model used in Medicare Part A and Part B does not translate easily to Medicare Parts C and D because of the differences in how CMS pays private plans in the Part C, or Medicare Advantage (MA), and Part D prescription drug programs. For example, CMS makes monthly capitated payments to these private plans who in turn, pay providers, pharmacies, and other entities to deliver the MA and/or prescription drug benefit to their enrollees. The Affordable Care Act also imposed specific requirements on Part C and D RACs to perform certain activities that current FFS RACs do not perform. Because of these differences, we believe the expansion of RACs to Parts C and D represents a new and significant undertaking that requires careful consideration and planning. We want to prevent any unintended consequences that may arise from this expanded use of RACs and ensure we are coordinating the work of RACs operating in all parts of Medicare and Medicaid. Coordinating this expansion of RACs in a timely and deliberate manner will also ensure that we are not duplicating ongoing work being conducted by existing MA and Part D contractors (e.g., the MEDICs) responsible for identifying and assisting CMS in the recoupment of overpayments.

Further, the RAC model for Medicare FFS doesn't translate seamlessly to Medicaid because of the States' primary role in paying claims. To comply with the new provisions in the Affordable Care Act, on October 1, 2010, CMS notified States and Territories through a State Medicaid Directors (SMD) letter that they will need to submit a State plan amendment (SPA) to attest that a State will either establish a Medicaid RAC program by December 31, 2010, or indicate that it is seeking an exemption from this provision. State programs to contract with Medicaid RACs are not required to be fully operational by December 31, 2010; however, CMS expects States to fully implement their RAC programs by April 1, 2011. The SMD letter also provides States and Territories with guidance on the specifics of a Medicaid RAC program, including appeals, collection of contingency fees, and exceptions to the RAC program. CMS looks forward to continuing to work with States and Territories to successfully implement the requirements of the Affordable Care Act in a timely fashion through further regulations, education, and guidance.

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10. In the next ten years the Medicare population is expected to increase by 15 million (32%) and the growth over 20 years will be 32 million (68%). Right now we're experimenting with ways to fix problems of waste and fraud with our existing beneficiaries and claims in an efficient way; meanwhile we've got a potentially new problem of sheer capacity. How does the current realignment of claims processing affect our ability to deal with the major increases in beneficiaries in the coming years?

A: CMS has fully anticipated the expected growth in the Medicare beneficiary population, thanks in no small part to the work of the CMS Office of the Actuary and the annual report produced by the Medicare Trustees. CMS has made improving its data management and claims processing functions a key component of its strategic plan. CMS has been implementing a Contracting Reform initiative that will significantly improve the operating efficiency of its fee-for-service claims processing and data management operations. Under this initiative, CMS has consolidated over one dozen individual data centers into three Enterprise Data Centers. This has produced greater performance, security, reliability, flexibility and operational control as well as cost savings. These qualities are critical in meeting the future challenges inherent in beneficiary and workload growth. In addition, CMS is planning to accomplish further improvements through a multi-year initiative known as the Health Care Data Improvement Initiative (HCDII). Through CMS' investment in HCDII, CMS will build upon its Integrated Data Strategy, introduce modern reporting and data analysis tools, create more opportunities for public reporting and dissemination of CMS data, and improve overall program integrity and program administration capabilities.

11. According to the June 2010 Office of Inspector General (OIG) report, 18 million Medicare Part D prescription drug claims worth $1.2B in 2007 contained invalid prescriber identifiers, the only data on Part D drug claims to indicate that legitimate practitioners have prescribed medications for Medicare enrollees. These invalid prescriber identifiers are not an automatic indication of illegitimate claims, but are suspicious. Does CMS have any plans to individually investigate these claims? What other information is on the Prescription Drug Event (PDE) record form could identify the prescribers? Would it be easier to fight fraud if some other duplicate information like the prescriber's name were also required on the form?

A: The prescriber identifier is not generally indicative of invalid prescriptions. While CMS agrees that valid prescriber identifiers can improve oversight efforts to monitor the prescribing practices of specific providers, a missing or invalid prescriber identifier is not an automatic indication of invalid prescriptions or fraudulent pharmacy claims. In OIG's response to CMS' comments on the report, OIG agreed with CMS that "invalid prescriber identifiers do no automatically indicate invalid prescriptions or pharmacy claims."

All of the identified invalid prescriber identifiers are under current MEDIC and/or law enforcement investigation. Prescriber identifier field analysis is included as part of routine threshold and outlier analysis in every MEDIC investigation of potential fraud.
There are currently no additional fields on the PDE to identify a prescriber.

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CMS recognizes the importance of having strong program integrity initiatives that will deter criminal activity and attempts to defraud the Medicare and Medicaid programs. The Agency shares your commitment to ensuring taxpayer dollars are being spent on legitimate items and services. However, CMS must make sure to do this in a way that is fair and transparent to plans and providers, who are our partners in caring for beneficiaries, and ensures that beneficiary access to necessary medicines is not impeded.

CMS began a prescriber identifier project in September 2010. The purpose of this project is to assist CMS in developing a strategy to improve the percentage of prescriber NPIs on PDEs, thereby improving the accuracy of the prescriber information on PDEs, eliminating invalid identifiers, and enabling CMS to better monitor and evaluate the diffusion of e-prescribing in Part D. CMS will use the results of this survey to inform its development of new regulations and future guidance to improve oversight and management of the Part D program, including consideration of whether the collection of additional data on the prescriber would be a useful strategy.

12. Two Medicare Drug Integrity Contractors (MEDICs) identified problems with invalid prescriber identifiers on PDE claims to CMS in 2007 and 2008 reports. The MEDICs stated that they had concerns about their inability to investigate fraud without a prescriber identifier. What actions did CMS take in 2007 and 2008 when these were originally reported? Has CMS gone back to investigate these other specific cases identified by the MEDICs? What were the results?

A: Initial and current MEDIC analysis indicates that the majority of submitted invalid prescriber identifiers is associated with the submission of DEA numbers. MEDIC analysis supports CMS' ongoing effort to require sponsors to submit the NPI as the prescriber identifier in accordance with the Health Insurance Portability and Accountability Act.

As indicated above, all of the top ten identifiers are being investigated by the MEDIC and/or law enforcement. Because the majority of invalid prescriber identifiers submitted are not valid DEA or NPI codes, they cannot be traced to a specific prescriber's activity.

13. According to the June 2010 OIG report, CMS recommends in the Medicare Prescription Drug Benefit Manual that the contracted plan sponsors prepare and review reports of the drug prescribing patterns by physician to identify potential prescriber fraud. However, according to CMS, when CMS electronically processes claims records they do not have any automated controls in place to even check the validity of the data entered into the prescriber identifier field. Why aren't Part D claims required to have valid prescriber ID numbers and why doesn't CMS electronically verify the prescriber ID numbers on claims? Is it a technical issue?

A: While CMS agrees that valid prescriber identifiers can improve oversight efforts to monitor the prescribing practices of specific providers, a missing or invalid prescriber identifier is not an automatic indication of invalid prescriptions or fraudulent pharmacy claims. In OIG's response to CMS' comments on the report, OIG agreed with CMS that "invalid prescriber identifiers do no automatically indicate invalid prescriptions or

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pharmacy claims." To date, CMS has not determined that undertaking the systems development work to augment PDE processing to automatically validate prescriber identifiers would be the appropriate approach, in part because reliable electronic databases for all acceptable prescriber identifiers (NPI, DEA, UPIN and State License numbers) have not been available.

CMS recognizes the importance of having strong program integrity initiatives that will deter criminal activity and attempts to defraud the Medicare and Medicaid programs. The Agency shares your commitment to ensuring taxpayer dollars are being spent on legitimate items and services. However, CMS must make sure to do this in a way that is fair and transparent to plans and providers, who are our partners in caring for beneficiaries, and ensures that beneficiary access to necessary medicines is not impeded.

14. I understand that CMS will continue to instruct plan sponsors not to simply implement point-of-sale edits to reject Part D claims with "invalid" prescriber identifiers because of the significant potential to interrupt medically necessary drug therapies. Is CMS considering financial penalties against Part D plans for non-compliance measures? If CMS is not considering financial penalties please explain what incentive or enforcement mechanism it is considering.

A: Preserving beneficiary access to necessary prescription medications is at the heart of CMS' mission for the Part D program, and the problem identified by the OIG, while serious, should be addressed by CMS in a manner that does not jeopardize the Agency's mission to provide needed medical services and supports for our beneficiaries. Thus, CMS must carefully consider any penalties or enforcement actions that may lead to denial of immediate access to medications due to a pharmacy's failure to provide administrative data to which neither the pharmacy nor the sponsor may have reliable access.

To better understand the reasons why prescriber identifiers are missing or invalid on claims, CMS initiated a prescriber identifier project in September 2010. The purpose of this project is to assist CMS in developing a strategy to improve the percentage of accurate prescriber information on claims, eliminate invalid identifiers, and enable CMS to better monitor and evaluate the diffusion of e-prescribing in Part D. CMS intends to use the results of this survey to inform its development of new regulations and future guidance to improve oversight and management of the Part D program, including consideration of additional requirements in this area and future compliance actions.

15. Responding to the June 2010 OIG report, CMS stated it would issue guidance instructing Part D plan sponsors to implement policies and procedures to identify and review invalid prescriber identifiers on claims. However, CMS recently told the subcommittee that they plan to hire a contractor to perform a study on the invalid prescriber identifier issue and will wait until the study is complete before issuing any guidance. How long will this study take, what will this study entail, what is the deliverable of the contractor, and how much do you expect this to cost? More importantly is CMS asking a contractor to decide CMS policy?

A: CMS began a prescriber identifier project in September 2010, with an initial contract award for one year. The project is motivated by the e-prescribing incentive program

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included in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) as well as by the OIG's findings. For CMS to use PDE data for the purpose of determining whether a professional is eligible for the e-prescribing incentive program, PDEs must include accurate individual prescriber identifiers. The purpose of this project is to assist CMS in developing a strategy to improve the percentage of accurate prescriber NPIs on PDEs, eliminate invalid identifiers, and enable CMS to better monitor and evaluate the diffusion of e-prescribing in Part D. CMS intends to use the results of this survey to inform its own internal development of new regulations and future guidance to improve oversight and management of the Part D program.

In the meantime, CMS has discussed this problem with stakeholder groups to help remind plans about the existing requirements and to help the Agency better understand what factors may be leading to non-compliance. To that end, CMS made a presentation to the National Community Pharmacists Association in March 2010 and a presentation to the National Council of Prescription Drug Programs workgroup in May 2010.

16. While this study is being performed, do you plan to have the MEDICs investigate the past invalid identifiers for potential fraud while waiting for the study results and issuing guidance to plan sponsors?

A: As previously stated, all of the top ten invalid prescriber identifiers have been or are currently under investigation by the MEDICs and/or law enforcement. In addition, the MEDICs will continue to investigate the case specific and national scope impact associated with the submission of invalid prescriber identifiers. As this analysis is completed, CMS will determine if additional guidance is warranted.

17. CMS stated in the OIG report that significant improvements have been made since 2007 with the top ten invalid prescriber identifiers dropping from 3.2 million claims in 2007 to 450,000 in the last six months of 2009. This still represents a large number of inaccurate claims. Have the number of improper IDs gone down by luck or did CMS do something that led to the reduction? Has any analysis been performed on the invalid NPI prescriber identifiers used in 2009?

A: The OIG's findings were specifically driven by invalid DEA numbers that represented 98 percent of invalid prescriber identifiers in 2007. In 2010, however, CMS' national provider identifier (NPI) is now the standard prescriber identifier on the majority of our pharmacy claims. Therefore, we believe that the availability of NPIs reduced the need for pharmacies to utilize invalid DEA numbers. Importantly, the analysis of 2007 data by the OIG did not identify NPIs as a significant source of invalid prescriber identifiers; rather, invalid NPIs accounted for less than 2 percent of all claims with invalid prescriber identifiers found in the OIG report. As the percentage of prescriber NPIs on pharmacy claims continues to increase, the significance of invalid prescriber DEA numbers is also expected to decrease drastically. After the implementation of the NPI, CMS recently completed an initial review of 2009 PDE data and discovered that the NPI was reported on a majority of CMS' PDE records.

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CMS plans to implement a process to periodically review and evaluate trends associated with the validity of prescriber identifiers on PDE records and issue guidance to Part D plans to implement policies and procedures to identify and review invalid prescriber identifiers on Part D claims.

CMS also intends to follow through on the OIG's recommendation to issue new guidance to its Part D sponsors to institute procedures to identify and flag for review Part D claims that contain invalid prescriber identifiers. In August 2010, CMS issued a memorandum to Part D plans alerting them to the OIG's findings and CMS' concern about missing or invalid prescriber identifiers and our intent to award a contract to monitor use of prescriber identifiers on Part D claims data. Before issuing further guidance, however, CMS wants to fully understand through the monitoring project the challenges that its partners face in addressing this issue, in order to provide informed and meaningful guidance to Part D plans and providers.

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Post-Hearing Questions for the Record
Submitted to Robert Vito
From Senator Claire McCaskill

"Preventing and Recovering Government Payment Errors"
July 15, 2010

Questions:

1. According to the June 2010 Office of Inspector General (OIG) report, 18 million Medicare Part D prescription drug claims worth $1.2B in 2007 contained invalid prescriber identifiers, the only data on Part D drug claims to indicate that legitimate practitioners have prescribed medications for Medicare enrollees. These invalid prescriber identifiers are not an automatic indication of illegitimate claims, but are suspicious.

(a) Does the OIG have any plans to individually investigate these claims?

The OIG provided files containing Part D drug claims with invalid prescriber identifiers to CMS. We are also working to determine if any potential fraud cases may be developed as OIG investigators conduct their own reviews of these Part D claims.

In addition, OIG is currently conducting other work on invalid prescriber identifiers on Part D claims for Schedule II drugs only. These drugs are highly susceptible to abuse and a well-documented area of fraudulent activity. We hope to a release a report detailing the findings of this review by the end of the year.

(b) What other information is on the Prescription Drug Event (PDE) record form that could identify the prescriber?

The prescriber identifier is the only data field on the PDE record that identifies the physician who prescribed the drug. If the prescriber identifier is invalid, CMS and Part D plans cannot determine who prescribed the drug. To track down the identity of a prescribing doctor, a number of labor-intensive steps would have to be taken starting with contacting the pharmacy that submitted the claim or contacting the beneficiary for whom the prescription was filled.

(c) Would it be easier to fight fraud if some other duplicate information like the prescriber's name were also required on the form?

We believe that it is most important that the information in the prescriber identifier field be accurate and valid. The addition of prescriber name information to the PDE record would not help to prevent payments for potentially inappropriate Part D claims with invalid prescriber identifiers. Prescriber name information may be helpful in identifying prescribers when paid drug claims are found to be questionable and lack valid, unique prescriber identifiers. However, the prescriber name information would only be helpful in this post-payment review context if it were accurate and valid.

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2. CMS stated in response to the June 2010 OIG report that significant improvements have been made since 2007 with the top ten invalid prescriber identifiers dropping from 3.2 million claims in 2007 (98% of them being Drug Enforcement Agency (DEA) numbers) to 450,000 in the last six months of 2009. However, the drop from the original top ten invalid prescriber identifiers is mostly attributed to the increased use of National Provider Identifier (NPI) numbers and the diminishing use of DEA numbers.

(a) Is this correct?

OIG has not undertaken a review to verify the results of the analysis CMS described in its response to our June 2010 report. However, it is important to note that even though relatively few PDE records contained NPIs in the prescriber identifier field in 2007, OIG did find invalid prescriber NPIs in addition to invalid prescriber DEA numbers on Part D claims. Over 300,000 PDE records contained invalid prescriber identifiers that were coded as NPIs. These PDE records represented $23 million in plan and enrollee payments. For most of these records, the identifiers did not conform to NPI format specifications. For example, NPIs are 10-digit numbers, but many invalid identifiers coded as NPIs contained more or fewer than 10 digits. Again, legitimate NPIs contain only numbers, but we observed invalid NPIs that contained letters, punctuation marks, and keyboard symbols. By itself, the increased use of NPIs in the prescriber identifier field will not address the issues OIG identified. It is still necessary for CMS and plans to ensure that NPIs used to identify prescribers are valid and accurate.

(b) Has any analysis been performed on the invalid prescriber numbers for NPIs in 2009?

OIG has not reviewed calendar year 2009 PDE records to identify invalid prescriber identifiers. In planning future work, OIG may consider conducting follow-up on the results presented in our June 2010 report.

3. The Affordable Care Act calls for Recovery Audit Contractors (RACs) to be expanded to Medicare Part D by the end of the year.

(a) Is that too ambitious of a timeline?

Since CMS is charged with implementing the expansion of the RAC program, we think that CMS would be in the best position to answer this question.

(b) What do you suggest doing differently in those programs than in the current program?

In the course of reviewing claims for improper payments, RACs may come across instances where the improper payments may involve fraudulent activity. RACs are responsible for referring these instances of potential fraud to CMS. In its February 2010 report, OIG found that between March 2005 and March 2008, RACs referred two cases of potential fraud to CMS. However, CMS reported that it received no potential fraud referrals from RACs during this period. OIG also found that, during the demonstration project, RACs received no formal training from CMS regarding the identification and referral of potential fraud. OIG recommended that

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CMS require RACs to receive mandatory training on the identification and referral of potential fraud. CMS concurred with this recommendation and had provided some training sessions to the permanent RACs. OIG believes that this mandatory training should be a key feature of the expanded RAC program. While RACs are responsible for referring potential fraud incidents to CMS, they do not receive contingency fees for these cases when they are determined to be fraud. OIG suggests that CMS eliminate this financial disincentive for RACs to refer cases of potential fraud. Finally, OIG believes that RACs must be required to refer potential fraud incidents to OIG and law enforcement in addition to CMS.

(c) How do you structure a contingency payment in a capitated program like Medicare Advantage?

We think that CMS would have to address this issue with its Part C and Part D contractors.

(d) Is there going to be unhealthy overlap between the role of Medicare Drug Integrity Contractors (MEDICs) and RACs in Part D?

There may be chances for overlap of activities between RACs and MEDICs, but it is important to note that the role of MEDICs is much broader than post payment identification of claims with underpayments or overpayments. In addition, CMS requires RACs to coordinate with other program integrity contractors and law enforcement entities through the RAC Data Warehouse to avoid working on the same claims. Increased coordination should help to minimize or prevent duplication of effort between the RACs and MEDICs in their Parts C and D work. However, OIG may consider this issue when planning future work.

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Response from Libby Alexander to:

QUESTIONS FOR THE RECORD
From Chairman Tom Carper
Preventing and Recovering Medicare Payment Errors
Hearing of July 15th Before the U.S. Senate Subcommittee on Federal Financial Management

Question #1- RAC Expansion
The Patient Protection and Affordable Care Act greatly expands recovery audit contracting, including Medicare Parts C and D and Medicaid.
Would you please provide the Subcommittee with your views on how this expansion can be best implemented to achieve the best results for CMS?

We talked about several recommendations in our testimony that would apply to any recovery audit program, but we would emphasize again that establishing specific goals against which the success of the effort can be measured is very important. We would also recommend that the government establish a contracting process for the rollout where contingency rates are driven to maximize recoveries rather than minimize or cap contractor fees. There is a direct correlation between recoveries and the contingency fee paid. Simply stated, more complex errors require additional work effort to fully research and document the issue at hand. Doing so requires a higher compensation level for the RAC to perform the work economically. If the rate is too low, then the recoveries will be low as well since the contractor cannot afford to dig deeply enough to perform a comprehensive review to uncover improper payments.

We would also add that an effort should be made not to bundle services in a request for proposal such that an expert in one area would be precluded from bidding because it is not experienced in all areas of the RFP. For instance, the expertise needed to perform third party liability work is very different than that needed for clinical review; these two audits should not be bundled into one RFP. Capitated makes it different, but still auditable.

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Responses From Libby Alexander to:
Post-Hearing Questions for the Record
Submitted to Libby Alexander
From Senator Claire McCaskill

"Preventing and Recovering Government Payment Errors"
July 15, 2010

1.) *With regards to Medicare Administrative Contractor (MAC) and Recovery Audit Contractor (RAC) Relationships, could you rate how close your relationship is with the MACs in your regions, and what could be done to improve them? Do MACs have the right incentives to help you recover payments?*

Connolly has established good relationships and communication channels with the eight MACs we work with in region C, including holding bi-monthly meetings to discuss processes and work status. Significant progress has occurred with regard to processing our improper payments, especially in recent months. Since the program launch, Connolly has also facilitated calls between the MACs to share best practices relating to RAC claims processing, as most requirements related to the program are new to the MACs.

Connolly is not aware of specific incentives that exist between CMS and the MACs related to the RAC program. The importance of alignment between the MACs and the RACs and the need for the MACs to support RAC findings including the appeal process cannot be emphasized enough. Delays in processing our work not only prevent dollars from returning to the trust fund and offsetting program costs, but also create significant financial burden on the RACs who are compensated only at the point the government has received a financial benefit. The RACs will not be successful without the timely support of the MACs.

2.) *Do you also have commercial clients? If you do, how does working for CMS differ from working for private insurance companies and what can we learn from private industry? What is a typical payment error rate in the private sector and what is your rate of error detection? Does the private sector do a better job fixing systemic vulnerabilities?*

Yes. We serve 7 out of 8 of the top commercial healthcare payers. Founded as a recovery audit firm in 1979, Connolly entered the healthcare market in 1998 and has since grown to where we now serve commercial insurers, Blue Cross Blue Shield plans, Medicare Advantage plans, Medicaid Managed Care plans, and, of course, CMS. In all, we serve over 125 clients in virtually all industries. When comparing our experience in the private sector versus CMS, the private sector is highly motivated to recover the most improper payments possible, but values the importance of strong provider relations equally.

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We estimate an overall error rate of 3-6% in the private sector, which would include errors identified by both internal and external efforts. We estimate that roughly 80% of identified errors leading to overpayments are recovered.

The private sector does an excellent job of fixing systemic vulnerabilities, but CMS is also doing an equally good job. During the RAC national rollout, CMS modified its approach to sharing and addressing vulnerabilities such as weekly calls with the RACS and MACs to discuss how improper payments can be addressed. That said, the payment systems in both the private sector and at CMS are highly complex and constantly changing, which naturally leads to the emergence of new types of errors as quickly as existing vulnerabilities are addressed.

3.) *There is currently a relatively high rate of erroneous payments in Medicare. Ideally, the RAC program will identify common problems and once providers have to return payments for the same mistakes, the lessons learned would be realized and the problem would diminish over time. RACs are also charged with communicating systemic flaws to CMS and MACs so that regulatory or administrative fixes can be enacted to lessen waste. If this system performs as promised then each year the percentage of erroneous payments should go down and the RACs are going to have to work harder to make the same return on investment. First of all, do you believe that this slow but steady reduction in error rate will happen? If not, how can we make this happen? Secondly, does this affect the long-term sustainability of this program as constructed? Do MACs and CMS have a good system in place for fixing systemic errors?*

Yes, the Medicare error rate should certainly diminish over time and more closely approximate that of the private sector. Nevertheless, errors will never be completely eliminated due to the complex nature of large scale, high volume payment environments. This is why the RAC effort should be institutionalized as a long-term *program* rather than a short-term *project*. In fact every large federal agency should commit to recapturing improper payments including supporting valid overpayment claims straight through any appeal process. The very fact that the RAC program is in place will help ensure that the error rate will not grow over time, as providers are now much more aware of the scrutiny being placed on proper billing practices.

We believe the system in place for addressing systemic errors is an effective one and that CMS is highly focused on the issue of tackling identified vulnerabilities.

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4.) It has been argued that you may actually have reason to not stop systemic improper payments since it would eliminate a source of steady income. Do you feel that is true? Please explain.

No, we do not believe this is true. CMS has done an excellent job through the contractual obligations required of the RACs to ensure vulnerabilities are widely exposed and actionable recommendations to fix errors shared between CMS, providers, and even other RACs. During Connolly's 30+ years of experience in the private sector, we have also found that the longevity of our client relationships – many of which exceed ten years – is the direct result of our ability to uncover and share the root cause of overpayments with our clients. If we did not do so, there is always another firm standing in line to take our place.

5.) Related to question number 2 above, if the error rate in the private sector is lower, does your error discovery process work differently in the private sector?

No, in fact whether the private sector or public, healthcare, retail, manufacturing or virtually any industry, our error discovery process is remarkably similar. That said, the private sector, including Medicare Advantage and Medicaid managed care plans, have run recovery audit programs much longer than the government. This fact, coupled with the profit motive inherent in the private sector, naturally drives error rates lower.

6.) As an experienced RAC could you provide a few suggestions on how to best construct the recovery programs that we'll be rolling out soon for state Medicaid programs and Medicare Parts C and D? How should it be constructed differently than for Parts A and B? Does the capitated nature of these programs create challenges? Is there going to be unhealthy overlap between the role of MEDICs and RACs in Part D?

The OIG, DOJ, ZPICs, MEDICs and RACs all have clearly defined roles with little direct overlap. Where overlap exists, CMS has implemented a clearing house to coordinate the activities of the various entities. The RACs focus is clearly on the recovery of overpayments, while the other entities focus mainly on fraud. We talked about several recommendations in our testimony that would apply to any recovery audit program, but we would emphasize again that clearly established goals against which the success of the effort can be measured is very important. We would also recommend that the government establish a contracting process for the rollout where contingency rates are driven to maximize recoveries rather than minimize or cap contractor fees. There is a direct correlation between recoveries and the contingency fee paid. Simply stated, more complex errors require additional work effort to fully research and document the issue at hand.

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Doing so requires a higher compensation level for the RAC to perform the work economically. If the rate is too low, then the recoveries will be low as well since the contractor cannot afford to dig deeply enough to perform a comprehensive review to uncover improper payments. We would also add that an effort should be made not to bundle services in a request for proposal such that an expert in one area would be precluded from bidding because it is not experienced in all areas of the RFP. For instance, the expertise needed to perform third party liability work is very different than that needed for clinical review; these two audits should not be bundled into one RFP. Capitated makes it different, but still auditable.

7.) *The Affordable Care Act is going to steer Medicare away from fee-for-service and toward bundled reimbursements. What is this going to do to both the numbers of claims as well as the potential for waste, fraud and abuse? Will your job get easier or harder with this bundling?*

We will follow this closely as changes are implemented and adapt as necessary. Complexity always leads to improper payments, as does change. An example would be the upcoming move to ICD-10 coding requirements, which are more detailed than the current ICD-9 system and intended to reduce coding ambiguity. We expect there to be a period of time during the transition, however, when *more* errors will occur until such time as the new system is firmly in place.

8.) *In the next ten years the Medicare population is expected to increase by 15 million (32%) and the growth over 20 years will be 32 million (68%). Right now we're experimenting with ways to fix problems of waste and fraud with our existing beneficiaries and claims in an efficient way; meanwhile we've got a potentially new problem of sheer capacity. How do you see the growth of Medicare affecting the current claims process and likelihood of improper payments?*

If you break down the expected population growth to an annual basis of 3-4%, this will certainly present challenges but none that we see as insurmountable. A permanent RAC program should help to minimize errors even as the Medicare population increases dramatically. With the RAC program in place as well as other CMS fraud, waste, and abuse initiatives to reduce improper payments, the *error rate* should not increase along with an increase in covered lives, even if the raw numbers do.

9.) *CMS approves each audit area before RACs can run queries. As I understand it right now there have been no complex reviews allowed yet in 2010. How do you prioritize which areas to audits and do you have a master plan?*

The RACs have the go ahead to perform complex reviews, and the process for approving medical necessity complex reviews is currently being established. As during the RAC Demonstration Program, we always prioritize our reviews based

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on opportunity and focus our work on those areas within our approved scope that will produce the greatest financial benefit for the government. The RAC demonstration program showed that medical necessity claims were the biggest source of recoveries for the Trust Fund, at 40% of overpayments collected.[1] Once auditing is underway in this area we expect that total recovered dollars will increase substantially. The vulnerabilities we are addressing now represent 3.8% out of the total 7.8% error rate identified by CERT, leaving the 4% that represents medical necessity yet to be audited.[2] The sooner we begin these reviews, the faster dollars can be identified and returned to the Trust Fund.

Connolly currently has excess capacity now and prioritization is not an issue. Our master plan is based on our experience with the Demonstration Program along with our experience in the commercial sector.

[1]2008 Medicare Recovery Audit Contractor Program – An Evaluation of the 3-Year Demonstration, Figure 6.

[2]2009 Improper Medicare FFS Payments Report, Table 1D

10.) Do you have data on where (i.e. Durable Medical Equipment (DME) or inpatient hospitals) the most overpayments are in Medicare? If so, where are they and what are the figures? Is the relative error rate in certain areas driving your decisions on which audits you seek approval for?

We have two main sources of data: Comprehensive Error Rate Testing (CERT) Reports (see November 2009 Improper Payments FFS Payments Report) and the RAC Demonstration Program results (see June 2008 The Medicare Recovery Audit Contractor Program Report). We find that overpayments typically mirror the CERT findings in terms of the *number* of claims with errors, but the *dollar* recoveries are often higher in areas that might have lower CERT error rates. For example, DME MAC claims, which have a CERT error rate of 51.9%, have a high number of errors, but not high dollar recoveries given the substantially lower expenditures in this area (only 4% of total Trust Fund). Error rates do not drive our decisions on areas to audit; we attempt to review *all* potential improper payment areas, but starting with those areas that have the highest potential to return dollars to the Trust Fund.

11.) What is the estimated error rate for Part A and B payments and what is the goal that you are aiming to reduce improper payments to? How does this compare to the error rate of private insurers and what is realistically the lowest rate we can hope to practically achieve?

The November 2009 Improper Payments FFS Payments Report stated an error rate of 6.1% for Part A Inpatient, 3.9% for Part A Non In-patient, and 9.9% for Part B Carrier claims. The overall error rate was reported at 7.8% or $24.1 billion

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for FY 2009. Our goals are a function of the scope available to audit but we believe a fully-implemented recovery audit program should reach an annual recovery rate of between 1-4% , or roughly between $3 and $12 billion, or half of the total projected error rate dollars.

12.) Right now RACs are limited to requesting 1% of the detailed claims records and the rationale for this is that providers need reassurance that they're not going to spend all of their time filling data requests from RACS instead of taking care of their patients. Given that RACs can audit 100% of the high-level claims data, can you find errors without the detailed record audits? If so, then what effect does the 1% detailed record retrieval limitation have?

The RACs perform two types of reviews, "automated" and "complex." Automated reviews look only at the claims data to determine if there are errors, and do not require a medical record to document error findings. "Complex" reviews require medical records to determine if an error was made. CMS determines the documentation requirements based on the complexity of the issues we submit for audit approval.

In some cases we are required to request medical records even though the improper payment is "beyond a reasonable doubt" but not "beyond all doubt." In the commercial sector, most improper payments that meet the "beyond reasonable doubt" standard are permitted to be applied without medical record documentation. This is a win-win since the provider is not burdened with providing medical records where they agree with the audit determination.

The detailed documentation limit in place now is not impacting our reviews at this time because we are not yet performing a full-scope audit. As CMS continually improves its process for approving new issue submissions, this will allow for more concepts available to audit. We hope that approval to audit medical necessity issues will increase in the near future and the RACs will be performing true full-scope audits without limits, thereby returning the most money possible to the Trust Fund. At that time the 1% limit might become a restrictive factor and a reassessment become necessary.

To CMS's credit, the RAC program is designed in such a way as to minimize impact on providers, and in effect has created a "built-in restraint system." Since the RACs are required to pay providers for each medical chart requested, and since the contingency model means the RAC gets paid for its work if and only when a chart review results in an improper payment validation, the RACs must be highly accurate with the charts they request if they are to earn their fee.

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Post-Hearing Questions for the Record
Submitted to Lisa Im
From Senator Claire McCaskill

"Preventing and Recovering Government Payment Errors"
July 15, 2010

Questions:

1. With regards to Medicare Administrative Contractors (MAC) and Recovery Audit Contractors (RAC) Relationships, could you rate how close your relationship is with the MACs in your regions and what could be done to improve them? Do MACs have the right incentives to help you recover payments?
    a. Overall the relationships we have with our MACs are very good. We have Joint Operating Agreements with each of them and have bi-weekly clinical and operational meetings. They meetings are productive and there is a healthy exchange of worthwhile information. Yes, MACs have the right incentives to the extent that they are appropriately compensated for the additional work that RACs bring to bare on the traditional role of the MACs.

2. Do you also have commercial clients? If you do, how does working for CMS differ from working for private insurance companies and what can we learn from private industry? What is a typical payment error rate in the private sector and what is your rate of error detection? Does the private sector do a better job fixing systemic vulnerabilities?
    a. We currently do not have commercial clients.

3. There is currently a relatively high rate of erroneous payments in Medicare. Ideally, the RAC program will identify common problems and once providers have to return payments for the same mistakes, the lessons learned would be realized and the problem would diminish over time. RACs are also charged with communicating systemic flaws to CMS and MACs so that regulatory or administrative fixes can be enacted to lessen waste. If this system performs as promised then each year the percentage of erroneous payments should go down and the RACs are going to have to work harder to make the same return on investment. First of all, do you believe that this slow but steady reduction in error rate will happen? If not, how can we make this happen? Secondly, does this affect the long-term sustainability of this program as constructed? Do MACs and CMS have a good system in place for fixing systemic errors?
    a. We agree that the error rate should have a slow but steady reduction and believe it will effect the long term program as follows: 1) The work will be more difficult and cost to do the job well will increase—this contract can not continue to be a low-fee bid. CMS will compromise quality of work for low price. 2) The contracts should be extended to current well performing RAC's as they would have relevant experience and infrastructures already well established with CMS, MACs and the myriad of other contractors who are involved in Medicare reimbursement processes.

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4. It has been argued that you may actually have reason to not stop systemic improper payments since it would eliminate a source of steady income. Do you feel this is true? Please explain.
    a. RAC's do not control the remedy of systemic improper payments—we only identify those and report them as inappropriate. If RAC's are doing a good job, the errors that can be fixed up-stream will become clear to CMS—who works with front end organizations separately from RACs. CMS has a variety of programs that continue to fix common errors as indicated by the large percentage of correctly paid claims. The CERT has dipped as low as 3% and due to change in calculation methodology is now hovering in the 7% range. For the volume of beneficiaries, claims, and number of providers who participate in Medicare, an error rate in the 3% to 7% is very good. That means 97% to 93% of 12 billion payments are done properly. Even in the most automated for-profit environment, there are RAC's to capture the fall out. This gets to question 3—the work will become more difficult, but worthwhile for CMS to pay for as it will still represent continued efforts toward fixing more errors and reclaiming erroneously distributed dollars.

5. Related to question number 2 above, if the error rate in the private sector is lower, does your error discovery process work differently in the private sector?
    a. Not applicable

6. As an experienced RAC could you provide a few suggestions on how to best construct the recovery programs that we'll be rolling out soon for the state Medicare programs and Medicare Parts C and D? How should it be constructed differently than for Parts A and B? Does the capitated nature of these programs create challenges? Is there going to be unhealthy overlap between the role of MEDICs and RACs in Part D?
    a. Part D is a natural part of Parts A and B because prescription medication is a routine part of those providers' care for beneficiaries. It can and should be done under the current RAC contract to minimize start up time and maximize efficiency.

    b. The Medicare programs on the states' side are hampered by state budgetary constraints. State governments do not have the funds to put into a program requiring additional administrative expense burdens (system feeds, technology platforms, resources to manage records). The most effective way for RAC to be done on Medicaid is to utilize the CMS technology capability from the Federal side—so the RAC program for Medicaid is controlled by CMS (information, claims auditing, etc) and reconciled to the states—this will be a challenge without additional funding. Moreover, the pace at which it will expand is likely to be long-term—so contract terms, fees, and vendor partners should be thought of for the long-term.

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7. The Affordable Care Act is going to steer Medicare away from fee-for-service and toward bundled reimbursements. What is this going to do to both the numbers of claims as well as the potential for waste, fraud and abuse? Will your job get easier or harder with this bundling?
    a. The number of overall claims should drop slightly as one claim will be used for particular bundled procedures where previously there were two (one facility and one professional). It's unknown at this point what the impact on potential fraud and abuse will be. For bundled services it will require our auditing staff to educate themselves on new billing rules and methods and how that impacts the accurate coding of claims.

8. In the next ten years the Medicare population is expected to increase by 15 million (32%) and the growth over 20 years will be 32 million (68%). Right now we're experimenting with ways to fix problems of waste and fraud with our existing beneficiaries and claims in an efficient way; meanwhile we've got a potentially new problem of sheer capacity. How do you see the growth of Medicare affecting the current claims process and likelihood of improper payments?
    a. While these numbers are daunting in a snapshot, it equals about a 3% to 7% growth per year depending on year. The current claims process will grow gradually over time with the increase in beneficiaries. Improper payments are likely to remain at a consistent percentage (e.g. with today), but of a higher dollar amount of total spend.

9. CMS approves each audit area before RACs can run queries. As I understand it right now there have been no complex reviews allowed yet in 2010. How do you prioritize which areas to audit and do you have a master plan?
    a. Complex reviews are allowed (now) and are being performed by all RACs, both coding reviews and reviews for medically necessary care. We prioritize areas to audit after reviewing most if not all of the following:
        i. Procedure known for having high improper payment amounts as provided to the RACs through such areas as OIG reports, PEPPER reports, CMS guidance, MAC input and personnel experience
        ii. Return to Medicare
        iii. Return to the company based on contingency fees and expenses in pursuing particular cases
        iv. Strength of support for improper payments in clearly defined coverage determinations

10. Do you have data on where (i.e. Durable Medical Equipment (DME) or inpatient hospitals) the most overpayments are in Medicare? If so, where are they and what are the figures? Is the relative error rate in certain areas driving your decision on which audits you seek approval for?
    a. The most overpayments appear to be in the physician space due to the sheer number of providers. For instance we've identified over 200,000 errors in physician claims but the amount of overpayments are small due

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($10,000,000). The largest percentage of errors are in the DME space but again the amounts associated with each claim are relatively small. The highest overpayment and underpayment amounts are associated with inpatient hospital stays but also represent the lowest overall number of cases. We estimate the overpayment amounts in the hundred's of millions of dollars each year just in the acute care setting. Yes, the relative error rate and other factors as previously mentioned in #9 above drive our decisions on which issues to seek approval for.

11. What is the estimated error rate for Part A and B payments and what is the goal that you are aiming to reduce improper payments to? How does this compare to the error rate of private insurers and what is realistically the lowest rate we can hope to practically achieve?
    a. We estimate between 3% - 7% error rate for Part A and B payments. Our goal is to reduce this by one half. We do not have private insurance contracts at this time to compare this with.

12. Right now RACs are limited to requesting 1% of the detailed claims records and the rationale for this is that providers need reassurance that they're not going to spend all of their time filling data requests from RACs instead of taking care of their patients. Given that RACs can audit 100% of the high-level claims data; can you find errors without the detailed record audits? If so, then what effect does the 1% detailed record retrieval limitation have?
    a. High-level claims data, in most cases, is not sufficient to accurately identify errors. Detailed record audits are necessary. The 1% record retrieval limitation ensures that CMS will be unable to identify the majority of improper payments.

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Post-Hearing Questions for the Record
Submitted to Andrea Benko
From Senator Claire McCaskill

"Preventing and Recovering Government Payment Errors"
July 15, 2010

Questions:

1. With regards to Medicare Administrative Contractor (MAC) and Recovery Audit Contractor (RAC) Relationships, could you rate how close your relationship is with the MACs in your regions, and what could be done to improve them? Do MACs have the right incentives to help you recover payments?

   HDI has a very close working relationship with all of the MACs and legacy Claims Processing Contractors ("CPC") that work with the providers physically located in RAC Region D. The MACs should receive award incentive fees to work with the RACs, to support RAC initiatives and to accommodate RAC workloads. There should be additional incentives implemented to help ensure the effective and timely implementation of the RAC program. The RACs, which are paid on a contingency fee basis (i.e., only if they produce results), are incentivized to work as expeditiously and efficiently as possible. The MACs are not adequately incentivized to implement, in a timely manner, important RAC initiatives and additional workloads that may appear to be non-core MAC contractual responsibilities.

2. Do you also have commercial clients? If you do, how does working for CMS differ from working for private insurance companies and what can we learn from private industry? What is a typical payment error rate in the private sector and what is your rate of error detection? Does the private sector do a better job fixing systemic vulnerabilities?

   Yes, HDI and its predecessor companies have performed retrospective claim reviews in the private sector since 1985. It is difficult to assess a "typical" payment error rate with respect to commercial clients because efficiency and accuracy in claims payment varies a great deal among health plans. The payment error rates among commercial payers are approximately three (3%) percent of paid claims, which is obviously lower than the estimated 7.8% Medicare CERT (Comprehensive Error Rate Testing) error rate. The fact that the private sector has utilized the broad spectrum of retrospective claims review tools for decades may be one reason for the difference in error rates. But many vulnerabilities will always require review of medical records, and as such, are not amenable to remediation simply by implementing claim edits. Furthermore, ongoing changes in Medicare payment codes, policies, procedures, and technology will likely always result in some additional level of claim payment errors. **Retrospective claim payment review will always be a needed tool in any payer's tool kit; still, fully utilized, retrospective review will significantly lower the Medicare claim payment error rate.**

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Almost one and one-half years after CMS launched the permanent RAC program, CMS has not fully implemented complex medical necessity claim reviews (requiring reviews of medical records to confirm payment errors). In October 2008, CMS issued a press release announcing the initiation of aggressive new steps in the fight against waste, fraud and abuse in the Medicare system, which included the national RAC program. This announcement was on the heels of a very successful RAC demonstration project in a small handful of states, which identified over $1 Billion in claim payment errors to the Medicare trust fund in a 3 year period, the vast majority of which was generated by use of complex reviews. Complex reviews often involve much higher-dollar claims and, therefore, associated payment errors result in costly vulnerabilities to the Medicare claim system. Clearly this is an area that warrants further attention.

While there are certainly similarities in working with CMS and commercial clients, there are also a number of significant differences.

Commercial clients understand that the depth of HDI's recoupment effort is directly impacted by the level of its contingency fee; in other words, higher contingency fees enable auditors to delve "deeper" into the claims pool and explore lower-probability cases and thereby strengthen the integrity of all paid claims. Commercial clients generally identify integrity of the payment system as well as the concept of "total return" as the primary objectives of the recoupment effort rather than minimization of the auditors' fees.

Commercial clients generally do a great job of identifying clear overall recoupment metrics or goals, while also ensuring quality and integrity in the process. A clearly stated overpayment recoupment/underpayment target, in concert with quality objectives, must be incorporated into the RAC program to ensure that vulnerabilities are identified and to ensure integrity of the claim payment process and the Medicare Trust Fund. It is imperative to recognize that Medicare program vulnerabilities can ultimately be corrected only after the RACs are able to review all claim data to be able to identify vulnerabilities which are continuously changing. Effective identification of vulnerabilities is tied to the RACs' ability to review claim data, particularly complex claim reviews. The slow ramp-up of the permanent RAC program is inhibiting the ability of the government to identify the full scope of vulnerabilities in a timely fashion, thereby foregoing the opportunity to address vulnerabilities, reduce the error rate and identify billions of dollars in claim payment errors. **President Obama recently stated that CMS will cut the Medicare Fee-For-Service improper payment error rate in half by 2012. This important goal can be achieved if the RACs are granted access to the claim data, are allowed to conduct the full spectrum of audits which will result in the identification of vulnerabilities which will enable CMS to reduce the improper payment error rate.**

As far as fixing systemic vulnerabilities is concerned, certain types of vulnerabilities can be fixed with system edits; however, it is important to note that most vulnerabilities cannot be so easily addressed. Many vulnerabilities are identified only through a complex audit involving a review of medical records. In addition, correction of associated claim payment errors, in many instances, will require ongoing vigilance in the retrospective review of claim payments.

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This is true in both the commercial and government sectors. "Systemic vulnerabilities" are not solely culpable for payment errors—please see our answer to #3, below.

3. There is currently a relatively high rate of erroneous payments in Medicare. Ideally, the RAC program will identify common problems and once providers have to return payments for the same mistakes, the lessons learned would be realized and the problem would diminish over time. RACs are also charged with communicating systemic flaws to CMS and MACs so that regulatory or administrative fixes can be enacted to lessen waste. If this system performs as promised then each year the percentage of erroneous payments should go down and the RACs are going to have to work harder to make the same return on investment. First of all, do you believe that this slow but steady reduction in error rate will happen? If not, how can we make this happen? Secondly, does this affect the long-term sustainability of this program as constructed? Do MACs and CMS have a good system in place for fixing systemic errors?

We believe the claim payment error rate can, and should, diminish over time. In our previous response, we touched upon the challenges in implementing claim edits or "system fixes." Some vulnerabilities are conducive to system fixes while other, particularly involving complex audits, may not be amenable to a system or edit related fix. The existence of the RAC program will continue to be the critical tool in the government's overall waste, fraud and abuse program in healthcare, and will continue to bear fruit over the long term, for three primary reasons.

First, despite our collective best efforts in both the public and private sectors, healthcare expenditures continue to increase at a greater rate than CPI inflation, year over year, with no sign of abatement. Thus a decrease in error rates over time could very well be offset by the counterweight of larger overall health expenditures (as mentioned in question #8, below).

Second, in both the public and private sector, the rules surrounding reimbursement are constantly changing. In an extremely complex payment system, with multiple human inputs involved, payment errors will continue to occur. ("You squeeze here, it pops up there" is the tendency in a complex system).

Third, the underlying nature of the errors that drive a large portion of claim payment errors will continue to necessitate the RAC efforts. Simply put, a very significant portion of the errors cannot be detected without a complex detailed retrospective review of clinical records associated with the claim.

According to CMS's Comprehensive Error Rate Testing (CERT) program, of the estimated $9.6 billion paid improperly to inpatient hospitals in 2009, 70%, or $6.7 billion, was due to medically unnecessary services (38%) and insufficient documentation (32%). These types of claim payment errors and program

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vulnerabilities can only be identified through complex reviews. Identification and verification of these errors requires a thorough, retrospective review of provider-submitted records and documentation that is not required for initial "automated" payment.

CMS is working with the MACs to take corrective action with regard to system vulnerabilities and it is clear that there is continued focus on improving the process.

4. It has been argued that you may actually have reason to not stop systemic improper payments since it would eliminate a source of steady income. Do you feel that is true? Please explain.

Any argument that it is in the RACs' interest not to stop systemic improper payments or to perpetuate leaks in the system are not supported by the facts and the compensation structure of the program. **As contingent fee contractors, the RACs are fully incentivized to identify claim payment errors and system vulnerabilities. If the RACs do not identify claim payment errors they do not get compensated. The RACs, therefore, have every incentive to identify claim payment errors and as many vulnerabilities as possible.** The claim payment errors and vulnerabilities, whether defined as system or not, are identified by the RACs and made known to both CMS and the MACs and are loaded into CMS' RAC data warehouse.

The RACs have no ability or incentive to adversely impact the correction of claim payment vulnerabilities. In fact, many providers have begun to use or expanded the use of so called revenue cycle management firms to maximize revenues. Given the growth of the Medicare and Medicaid programs, ongoing changes in policy, procedure, coding and technology and the growth of the revenue cycle management industry, the government, with the RACs full support, will be challenged to maintain a reduced claim payment error rate for the foreseeable future.

5. Related to question number 2 above, if the error rate in the private sector is lower, does your error discovery process work differently in the private sector?

No, our error discovery process for the relevant HDI products—automated data mining, DRG validation, and Utilization Review (complex reviews) is substantially the same, except that due to higher contingent fees paid by commercial clients, HDI is often able in the private sector to delve deeper into lower-dollar cases.

6. As an experienced RAC could you provide a few suggestions on how to best construct the recovery programs that we'll be rolling out soon for state Medicaid programs and Medicare Parts C and D? How should it be constructed differently than for Parts A and B? Does the

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capitated nature of these programs create challenges? Is there going to be unhealthy overlap between the role of MEDICs and RACs in Part D?

a) First and foremost, each and every program should establish recoupment goals and metrics. Without such goals and metrics, the program's value and effectiveness cannot be evaluated objectively. As we have seen with the current RAC program, without recoupment goals and metrics, the program has a very slow ramp-up period and the identification of vulnerabilities is compromised, delaying the ability of the government to reduce the claim payment error rate. Even if the government were to establish a goal of recouping just ten (10%) percent of the erroneously paid claims, the Medicare Trust Fund would recoup approximately $3 billion dollars per year in the Medicare Fee-for-Service program. As previously indicated, CMS recently testified that the current national RAC program has recovered, approximately one and one-half years since its launch, less than $35 million in overpayments.

b) Competition for the Part C, Part D, and Medicaid contracts should, therefore, be driven by which qualified contractors can identify the greatest number of claim payment errors and vulnerabilities and recoup the greatest dollars for Medicare and Medicaid programs, while maintaining the highest levels of quality and integrity and properly managing provider impact. In the Medicare RAC bidding, competition was driven by qualified contractors with the lowest contingency fees.

c) There are obviously significant synergies of employing Medicare RACs to carry out Medicaid, Part C and Part D programs as well. Medicare RACs already have years of experience in identifying claim payment errors and recouping overpayments from the same providers that will be subject to Medicaid RAC activities in the Medicaid and Part C programs.

d) CMS should mandate that Part C and Part D plans implement, by January 1, 2011, a RAC-like program. Although these plans are capitated, identification of claim payment errors and correcting associated vulnerabilities will eventually reduce the government's contributions to these programs and will mitigate future cost increases.

e) Consider increasing the limits on complex reviews, and the significant impact this carries on the identification of claim payment error and system vulnerabilities.

f) Implement a mechanism to further discourage frivolous appeals and gaming of the appeals system. While the vast majority of providers are honest and ethical in responding to audits, with the spread of "revenue cycle management" firms whose goal is to maximize provider revenue, one must be concerned about ensuring the integrity of the entire claim payment system and appeal process.

g) Incentivize CMS' MACs or claim payment processors to prioritize RACs activities and workloads. .

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h) There should be more visibility into the appeals process, to ensure, most importantly, that ALJ rulings be consistent with, and grounded in, Medicare laws, rules and regulations.

7. The Affordable Care Act is going to steer Medicare away from fee-for-service and toward bundled reimbursements. What is this going to do to both the numbers of claims as well as the potential for waste, fraud and abuse? Will your job get easier or harder with this bundling?

   We cannot definitively state what the ultimate impact of such a change may have on the program. Issues with bundling and unbundling errors will obviously exist and possibly increase over time. The current DRG based system to pay for in-patient services in, in a way, a "bundled" claim reimbursement.

8. In the next ten years the Medicare population is expected to increase by 15 million (32%) and the growth over 20 years will be 32 million (68%). Right now we're experimenting with ways to fix problems of waste and fraud with our existing beneficiaries and claims in an efficient way; meanwhile we've got a potentially new problem of sheer capacity. How do you see the growth of Medicare affecting the current claims process and likelihood of improper payments?

   The growth of the Medicare and Medicaid programs will strain the current system and without a fully implemented RAC program one can only conclude that improper payment will continue to increase. Up to the present time, we have faced major delays in the MACs reprocessing of claim payment errors identified by the RACs. We encourage CMS to implement incentives for the MACs to work with the RACs as efficiently as possible; the RAC-related workloads and issues will only increase and become more challenging over time with the expected potential growth of the Medicare population. However, the ability to timely and efficiently process RAC related claims should be greatly improved with the implementation of the CMS mass adjustment tools. Obviously, the growth in the programs and increased demand will warrant continued investment in the latest claims payment and auditing technologies and continued development of CMS's claims processing system.

   HDI's systems and processes are fully scalable and we are highly confident that we can handle substantially greater workloads. HDI currently reviews over **$300 billion of claims on an annual basis**.

9. CMS approves each audit area before RACs can run queries. As I understand it right now there have been no complex reviews allowed yet in 2010. How do you prioritize which areas to audits and do you have a master plan?

   CMS has recently approved the RACs to conduct a limited number of complex medical necessity audits. HDI has made significant investments in time, personnel, and equipment to conduct the necessary reviews on a much greater scale.

   Since HDI is paid only on performance (i.e., paid on contingency) by both its commercial

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and government claims integrity clients, proper prioritization of the audit opportunities is of critical importance. Stated differently, we incur the cost of the review whether or not it identifies claim payment errors, vulnerabilities or generates savings for CMS or our commercial clients.

Therefore, out of necessity we have developed over many years highly sophisticated proprietary statistical analyses that help us identify the areas that carry the highest probability of payment errors. We couple the highest probability cases with the highest dollar opportunities, while ensuring quality results, in order to maximize the dollars returned to the Medicare Trust Fund. We have distilled this analysis into a tiered system that guides our audit and claim payment error identification efforts.

10. Do you have data on where (i.e. Durable Medical Equipment (DME) or inpatient hospitals) the most overpayments are in Medicare? If so, where are they and what are the figures? Is the relative error rate in certain areas driving your decisions on which audits you seek approval for?

The relative payment error rate is certainly one of the factors that guide our efforts, coupled with our many years of experience in the commercial sector and our highly sophisticated proprietary processes. Two of the best resources for analysis of Medicare overpayments are:

CMS's November, 2009 CERT Report
https://www.cms.gov/CERT/Downloads/CERT_Report.pdf

HHS OIG's July 2010 analysis of the CMS CERT Report
http://oig.hhs.gov/oas/reports/region1/11001000.pdf

11. What is the estimated error rate for Part A and B payments and what is the goal that you are aiming to reduce improper payments to? How does this compare to the error rate of private insurers and what is realistically the lowest rate we can hope to practically achieve?

According to the November 2009 CERT report published annually by CMS (direct link above), the estimated error rate for Medicare Part B payments was 9.9%; the error rate for Part A inpatient payments was 6.1%; and the error rate for Part A non-inpatient payments was 3.9% (please see page 10 of the November, 2009 CERT report).

The overall estimated error rate for Medicare fee-for-service payments (according to the same report) was 7.8%. The error rates among commercial payors vary depending on a host of factors. The error rate may reach approximately three (3) per cent in the commercial sector.

As far as future goals are concerned, CMS's long term, steady-state goal should be to bring down the claim payment error rate to 3.0%. With regard to recoupment of claim payment errors, for 2011, 3.5% of the 7.8% error rate is a reasonable starting point (note that the RACs will have 3 years of data in 2011). As mentioned previously, due to time constraints in the claims payment process (the impracticality of conducting a complex review of the

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clinical record prior to payment), as well as the sheer complexity of the system, there will always be a need for retrospective reviews.

12. Right now RACs are limited to requesting 1% of the detailed claims records and the rationale for this is that providers need reassurance that they're not going to spend all of their time filling data requests from RACS instead of taking care of their patients. Given that RACs can audit 100% of the high-level claims data, can you find errors without the detailed record audits? If so, then what effect does the 1% detailed record retrieval limitation have?

It is important to note that providers are adequately compensated by the RAC contractors (12 cents per page) for providing copies of requested medical records. The clerical or administrative personnel at provider facilities that collect and respond to record requests (records which have already been created and for which services have already been provided) have absolutely no connection with or impact on patient care. In addition, as previously stated, the majority of the major vulnerabilities and significant claim payment errors in the Demonstration Project were identified as a result of complex reviews that necessitated a review of medical records. Automated reviews of claim data simply will not identify a material amount of vulnerabilities or claim payment errors. The permanent program results to date are a testament to that fact. Provider concerns regarding being "overwhelmed" by record requests have no basis in fact.

On the first point, rather than adhering to an arbitrary limit (1%), the number of permitted record requests should be increased, as warranted, by the RACs' factual analysis, on a hospital-by-hospital basis. Given that the Medicare CERT error rate is 7.8% and the RACs are limited to requesting 1% of the records, the government is severely limiting its ability to identify vulnerabilities and identify claim payment errors.

Clearly, the 1% record request limit has a very significant negative impact on the ability of the RACs to identify claim payment errors and system vulnerabilities. The vast majority of the claim payment errors and vulnerabilities, over $1 billion, were the result of complex reviews of all types that required review of a patient record.

Notwithstanding the critical importance of complex reviews, HDI does have technology to conduct "automated" reviews without requesting a patient record. Duplicate billings are perhaps the simplest example of an error that HDI identifies without complex review. But again, the key point is that "complex" reviews absolutely drive the identification of significant and material vulnerabilities and claim payment errors and **we strongly recommend a careful examination of the current record request limits.** We fully understand and appreciate the need for provider sensitivity, and as it pertains to frivolous record requests, the RACs' interests are fully aligned with those of the provider. As a contingent fee contractor that incurs a significant cost for review of each chart in addition to

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the 12 cents per page paid to the provider, it is clearly in the RACs' interest to request only records that have a very high probability of containing errors.

Unfortunately, over one and one-half years (April 2009) into the launch of the permanent program, the RACs have been unable to conduct many of the more material complex types of reviews that the RACs were able to conduct in the Demonstration Project. These complex reviews resulted in the identification of some of the more significant vulnerabilities and identification of claim payment errors. We question whether the permanent program will be able the achieve the success of the Demonstration Project given the slow ramp-up of the permanent program and the restrictions placed on the RACs and the lack of identified metrics and recoupment goals. **Based on the estimated Medicare CERT error rate of 7.8%, the annual claim payment errors exceed $28 BILLION dollars based on annual paid claims. At the recent Senate hearing on the RAC program, CMS testified that as of June 2010, it had recouped less than $35 MILLION dollars in overpayments in the permanent RAC program.** That does not even take into account the fact that the RACs have access to three years of paid claim data. The identification of vulnerabilities and identification of erroneous claim payments is inextricably inter-related. More claims reviewed will simply result in the identification of more vulnerabilities.

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Post-Hearing Questions for the Record
Submitted to Robert Rolf
From Senator Claire McCaskill

"Preventing and Recovering Government Payment Errors"
July 15, 2010

Questions:

1. With regards to Medicare Administrative Contractor (MAC) and Recovery Audit Contractor (RAC) Relationships, could you rate how close your relationship is with the MACs in your regions, and what could be done to improve them? Do MACs have the right incentives to help you recover payments?

   ANSWER: CGI has a good relationship with the Fiscal Intermediaries, Carriers and Medicare Administrative Contractors in Region B. We have Joint Operating Agreements in place that spell out the guidelines we both follow to exchange information and we conduct weekly operation calls to discuss open issues and action items for follow up. At the beginning of the RAC contract the claims adjustment process was cumbersome to all parties. Recent changes implemented by CMS have increased the automation of these processes which, in turn, has increased the volume of claims that can be adjusted on a monthly basis.

2. Do you also have commercial clients? If you do, how does working for CMS differ from working for private insurance companies and what can we learn from private industry? What is a typical payment error rate in the private sector and what is your rate of error detection? Does the private sector do a better job fixing systemic vulnerabilities?

   ANSWER: CGI has performed recovery audits for commercial clients for 20 years. Our experience has been that over time the error rate for commercial clients has declined due in part to the sentinel effect of performing comprehensive audits. We have found that the addressable errors account for 3-5% of a commercial plans total medical expense. The nature of improper payments changes continuously. As changes occur to reimbursement rules, medical practice guidelines and the coding systems that support claim billing, the nature of improper payments changes as well.

   The private sector does an uneven job of identifying and correcting improper payments. Commercial payers that have mature processes in place are better equipped to implement preventative steps based on the findings of a recovery audit. In the case of complex reviews, continued recovery audit is the most common corrective action whereas issues that are more black and white are implemented as pre-payment edits to prevent future payout.

3. There is currently a relatively high rate of erroneous payments in Medicare. Ideally, the RAC program will identify common problems and once providers have to return payments

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for the same mistakes, the lessons learned would be realized and the problem would diminish over time. RACs are also charged with communicating systemic flaws to CMS and MACs so that regulatory or administrative fixes can be enacted to lessen waste. If this system performs as promised then each year the percentage of erroneous payments should go down and the RACs are going to have to work harder to make the same return on investment. First of all, do you believe that this slow but steady reduction in error rate will happen? If not, how can we make this happen? Secondly, does this affect the long-term sustainability of this program as constructed? Do MACs and CMS have a good system in place for fixing systemic errors?

ANSWER: CGI has many clients for which it has provided recovery audit services for over ten years. For these clients we are not identifying the same issues today that we identified ten years ago. With the constant change in the healthcare system the nature of errors changes as well. We do see over time that a sentinel effect takes place in which providers develop more of a culture of compliance due to the financial impact of audits and that they will correct past errors in future billing.

CGI is committed to identifying major findings to CMS for the purposes of implementing corrective actions and preventing future payout of known vulnerabilities. In any comprehensive approach to improper payments it is critical to have continuous quality improvement based on retrospective audit findings that are then corrected through policy and system changes. However, without ongoing backend audits you never know how effective your front end processes truly are.

4. It has been argued that you may actually have reason to not stop systemic improper payments since it would eliminate a source of steady income. Do you feel that is true? Please explain.

   ANSWER: CGI is an active participant in the ongoing major findings calls sponsored by CMS. We understand the importance of corrective action on known vulnerabilities and take our role in this process very seriously. CGI views its role as a RAC as one part in a comprehensive approach to improper payments that includes policy and prevention. The role of the RACs are to continuously monitor for new areas of vulnerabilities to the healthcare system and make them known to CMS while recovering those payments already made in error.

5. Related to question number 2 above, if the error rate in the private sector is lower, does your error discovery process work differently in the private sector?

   ANSWER: CGI follows the same process for the discovery of improper payments in both the private and public sectors. The original mandate of the RAC program was to bring commercial approaches to government.

6. As an experienced RAC could you provide a few suggestions on how to best construct the recovery programs that we'll be rolling out soon for state Medicaid programs and Medicare Parts C and D? How should it be constructed differently than for Parts A and B? Does the capitated nature of these programs create challenges? Is there going to be unhealthy overlap between the role of MEDICs and RACs in Part D?

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ANSWER: The RAC approaches to Medicare Parts C and D will be different due to the inherent differences between a fee for service program and a managed care program. CGI does see the opportunity for greater synergies when a common contractor is able to analyze the data from across all Medicare and Medicaid programs. Although a scenario that segregates the audits would have success in each program individually, far greater success could be achieved through an integrated approach that links the data and allows for the identification of improper payments that result from program overlap and from inconsistencies between pharmacy and medical claims.

The MEDICS in Medicare Part D are focused on fraud and abuse much in the same way as the ZPICs and PSCs are for Medicare Parts A and B. As long as there are clear delineations of scope between the RACs and the MEDICS we do not see an unhealthy overlap. CMS combats this in the current RAC program through the use of the RAC data warehouse which allows all claim review entities to identify claims they are reviewing thus preventing overlap.

7. The Affordable Care Act is going to steer Medicare away from fee-for-service and toward bundled reimbursements. What is this going to do to both the numbers of claims as well as the potential for waste, fraud and abuse? Will your job get easier or harder with this bundling?

   ANSWER: The Affordable Care Act creates a national pilot program designed by the Secretary for up to eight medical conditions. Services provided for these conditions within the designated episode of care will be bundled as one payment to a single entity. The impact of eight medical conditions during the proposed pilot phase will not have a significant impact on the number of claims being reviewed by the RAC and will constitute additional areas requiring review. CGI has reviewed episode of care claims for clients as these are typical arrangements for transplant procedures. In a transplant episode of care it is typical that the harvest of the donor organ as well as all services relating to the transplant procedure itself including hospital, surgeon and aftercare are included in one payment to the hospital who performs the transplant. It is the hospitals responsibility to coordinate payments to the participating entities. If these other entities bill the payer directly and those services are not indentified clearly as related to a bundled transplant then the claims would pay separately constituting a duplicate or unbundled payment. Unbundling of services for increased payment is a very common issue in fee for service claims today.

   During the pilot phase these claims should not be restricted from review by a RAC as the potential for error is high.

8. In the next ten years the Medicare population is expected to increase by 15 million (32%) and the growth over 20 years will be 32 million (68%). Right now we're experimenting with ways to fix problems of waste and fraud with our existing beneficiaries and claims in an efficient way; meanwhile we've got a potentially new problem of sheer capacity. How do you see the growth of Medicare affecting the current claims process and likelihood of improper payments?

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ANSWER: Increased numbers of recipients means increased claims for services which will put an even greater burden on legacy claim systems to keep up with the processing requirements. The primary function of these systems is to pay the claims in a timely manner. These increased pressures will make it even more difficult to keep up with the identification of improper payments before payment is made. This situation creates a greater need to review payments retrospectively to ensure that any improper payment is identified and recovered to protect the Medicare trust fund. The role of the RAC will continue to be an increasingly necessary one.

9. CMS approves each audit area before RACs can run queries. As I understand it right now there have been no complex reviews allowed yet in 2010. How do you prioritize which areas to audits and do you have a master plan?

   ANSWER: We are currently authorized to perform automated and complex reviews including complex medical necessity reviews. CGI prioritizes its reviews based on our past experience of known vulnerabilities as well what we see in the data. By analyzing the data and applying clear Medicare policies to our analysis we determine which issues have the highest recovery potential and those are the issues we submit first to CMS for approval.

10. Do you have data on where (i.e. Durable Medical Equipment (DME) or inpatient hospitals) the most overpayments are in Medicare? If so, where are they and what are the figures? Is the relative error rate in certain areas driving your decisions on which audits you seek approval for?

    The program is still in the early stages and the data are not yet developed enough to make accurate conclusions. Much of what has been recovered to date is based on the order in which CMS has approved issues submitted and the order in which RACs have submitted those issues to CMS as well as the speed with which individual claims processors have recovered the improper payments. As the program continues to mature we expect to see errors distributed in a similar fashion to the CERT error rates.

11. What is the estimated error rate for Part A and B payments and what is the goal that you are aiming to reduce improper payments to? How does this compare to the error rate of private insurers and what is realistically the lowest rate we can hope to practically achieve?

    It is still too early to estimate the addressable error rate for Parts A and B. However we expect to see results similar to what we have experienced on past contracts which is 3-5% of the total medical expense.

12. Right now RACs are limited to requesting 1% of the detailed claims records and the rationale for this is that providers need reassurance that they're not going to spend all of their time filling data requests from RACS instead of taking care of their patients. Given that RACs can audit 100% of the high-level claims data, can you find errors without the detailed record audits? If so, then what effect does the 1% detailed record retrieval limitation have?

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ANSWER: RACs are permitted to perform both automated reviews as well as complex reviews that require a medical record. The automated reviews typically are looking at clear evidence in the claim record that an error was made, such as a duplicate payment, unbundled service or excessive units billed. We estimate automated reviews will account for approximately 10% of the recovered dollars. Complex reviews requiring a medical record review will account for a significant portion of the recovered dollars. CGI utilizes data analysis and our experience to target those claims that have the highest potential of being improper. This targeting ensures that we are only requesting those records that need to be reviewed which reduces provider burden. The current limits in place should be evaluated each year to ensure that the RACs are able to identify improper payments where they find them while respecting provider rights.

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Post-Hearing Questions for the Record
Submitted to Romil Bahl
From Senator Claire McCaskill

"Preventing and Recovering Government Payment Errors"
July 15, 2010

Questions:

1. **With regards to Medicare Administrative Contractor (MAC) and Recovery Audit Contractor (RAC) Relationships, could you rate how close your relationship is with the MACs in your regions, and what could be done to improve them? Do MACs have the right incentives to help you recover payments?**

   As a RAC subcontractor in three RAC regions, PRGX has one of the broadest exposures to the MAC community in the recovery audit program. While this makes our work a little more complicated than that of the other RACs, it also provides us with better insight across the entire RAC program, insight that we are able to leverage across multiple MACs and multiple regions to better serve CMS and the American taxpayer. We have formed very collaborative relationships with our MACs and will often apply lessons learned from one MAC region to other regions to help improve performance and efficiency.

   We believe that the incentives for the MACs to prioritize recoveries can and probably should be improved. It is the responsibility of the MACs to process the millions of first-time Medicare claims – not just the small number of claims that constitute the RAC claim universe. While we are not privy to the specifics of the contracts between the MACs and CMS, we understand that the MACs are paid for correcting and processing an erroneous RAC claim in much the same manner as a regular Medicare claim coming from the provider for the first time. We believe that Congress's goal of reducing wasteful spending and errors in our healthcare system would be well-served by giving MACs a greater incentive to re-process any erroneous claims before and ahead of new provider claims for payment. This would send a clear message to the provider community that errors will not be tolerated and that the fastest way to have new claims paid is to have no erroneous RAC claims in the system.

2. **Do you also have commercial clients? If you do, how does working for CMS differ from working for private insurance companies and what can we learn from private industry? What is a typical payment error rate in the private sector and what is your rate of error detection? Does the private sector do a better job fixing systemic vulnerabilities?**

   PRGX performs recovery audit services for some of the largest insurance companies and Medicaid agencies in the country. The main difference we see between our government and commercial clients is the degree of emphasis placed by the payer on pre-payment approval

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and pre-screening processes. Most private companies pre-authorize high volume and high dollar services and procedures as a way to contain costs before they are paid. Private insurance companies also screen their provider networks closely and eliminate providers who do not conform to established payment and quality standards.

PRGX does not calculate error rates for any of its commercial healthcare clients because we are not hired by clients to conduct statistically-significant, random sampling of claims across all possible types and categories. Instead we focus specifically on locating errors and recovering our clients' hard-earned dollars. Our recovery audits for private insurance companies differ from our work in the Medicare RAC program in a few ways. Contract compliance reviews comprise a larger part of a private insurer's recovery audit since these clients maintain separate contracts with many provider groups instead of one over-arching set of payment policies. Also, audits on high dollar procedures and outlier payments are more a common part of our recovery audits for private insurers.

There are also a number of similarities between private insurance and Medicare recovery audits. Coding and billing errors found by complex reviews - where a record is ordered and obtained from a provider in order to substantiate an improper payment - are similar in both arenas. These issues are typically caused by the way providers document, code, and bill for their services and are not easily detected by Medicare or private insurance companies without ordering the record and conducting a post-payment audit.

In addition to our years of healthcare-specific experience, PRGX pioneered the recovery audit industry forty years ago and today serves hundreds of private sector clients. We work with the most complex of procure-to-pay business processes in the world, and systemically bring recovery audit best practices to bear in every situation, including our work with CMS. We have found that across the private sector, or even within a single industry segment, clients' degree of success in correcting root causes to systemic issues varies as some of our clients are more adept than others at achieving an improved operating environment as an outcome of our work. In many cases, we are actively engaged with our clients to help resolve systemic improper payments, and we believe it is a real competitive differentiator that we at PRGX proactively offer this service to our clients. Few companies are so favorably positioned to help their clients fix systemic gaps and vulnerabilities as PRGX is, given our audit recovery background.

3. **There is currently a relatively high rate of erroneous payments in Medicare. Ideally, the RAC program will identify common problems and once providers have to return payments for the same mistakes, the lessons learned would be realized and the problem would diminish over time. RACs are also charged with communicating systemic flaws to CMS and MACs so that regulatory or administrative fixes can be enacted to lessen waste. If this system performs as promised then each year the percentage of erroneous payments should go down and the RACs are going to have to work harder to make the same return on investment. First of all, do you believe that this slow but steady reduction in error rate will happen? If not, how can we make this happen? Secondly,**

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does this affect the long-term sustainability of this program as constructed? Do MACs and CMS have a good system in place for fixing systemic errors?

PRGX believes there should and will be a steady decline in the Medicare error rate, but that it may take several years to experience a meaningful error rate reduction across the Medicare program. There are several reasons for this. First is the fact that claims audited today can be up to three years old. That means changes made today by providers may not be reflected in reduced error rates until new/current claims are audited sometime in the future. Also, the RAC roll-out has been slow, deliberate, and methodical so as not to disrupt the provider community. While this approach is probably warranted to minimize provider abrasion levels, it may not drive immediate, comprehensive changes in provider practices. However, it is likely to produce a sentinel effect that will help ensure error rate trends continue to move in the right direction.

Another countervailing factor is that our healthcare system is constantly changing due to numerous factors including advances in medical technology (e.g. new therapeutic procedures, diagnostic techniques and equipment, lab tests and pharmaceuticals) and the associated challenges of establishing fair and appropriate coverage and payment policies around these advances. When the coverage provisions, rules, and regulations that apply to government health programs change, it is necessary for payers to adjust their processes accordingly. We also acknowledge that there is often a "Balloon Effect" when attempts are made to control health care costs.[1] Providers of health care services are very adept at expanding into new sources of revenue when price controls or tight coverage policies reduce their reimbursement for certain other services or procedures. These issues work against a decline in error rate, and diligence will be needed to ensure that new errors and improper payments caused by these new practices are found and eliminated. Without the services of the RACs, it is unlikely that CMS could effectively overcome all the factors tending to increase the likelihood of payment errors.

We feel that CMS and MACs have a good system in place for fixing some errors. As part of CMS's Major Findings telephone conference calls, top issues are discussed with CMS and MAC representatives, and claim system parameters are added or fine-tuned. This solution does not work as well for issues that are based far upstream in a provider's documentation, coding, and billing practices. For correction of these deeply rooted issues, MACs offer provider education, but sufficient motivation must be present for providers to enact these changes. The penalties in place, speed of recovery audit implementation across all claim types and provider areas, and amount of providers' records that can be ordered and audited all have an impact on motivation for providers to change their behavior and improve billing practices.

Drawing again upon PRGX's forty years of pioneering work in the recovery audit industry, it should be noted that even in the private sector, and certainly with each new major era and innovation in technology and automation, there has always been the potential for recovery auditors to "work themselves out of a job" by eliminating all known sources of error.

[1] On Squeezing Balloons — Cost Control Fails Again, New England Journal of Medicine 1991; 325:1099-1100 October 10, 1991)

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Recovery auditing has instead turned out to be a dynamic, growing industry as indicated by the increase in total recoveries experienced by our major clients. Through creativity and innovation we continually identify broader categories of errors and introduce audit concepts which address these new and more complex error sources, and we expect the same trend to occur in the government healthcare recovery audit space as well.

4. **It has been argued that you may actually have reason to not stop systemic improper payments since it would eliminate a source of steady income. Do you feel that is true? Please explain.**

No, we do not believe the above statement represents a true and complete picture of the recovery audit industry. PRGX has been providing recovery audit services to our clients for over forty years. We are still in business because we are constantly innovating and improving our services to meet the needs of our clients – who in turn, are constantly changing to keep pace with technological advances, population growth, and changes in global economic conditions. Our clients look to us to identify root causes of erroneous payments and to help fix these issues and process gaps. This is increasingly the price of entry into the recovery audit market place. By putting our clients' needs above all other factors, we are able to partner with our clients in focusing on those problem areas that our clients may not have the resource capacity or the expertise to examine. Our commitment to clients' needs have led us to expand our service offerings to include analytics and advisory services aimed specifically at helping clients determine how to improve processes and reduce overpayments and other errors.

Our commercial clients include over 70 percent of the Global 50 retailers, and a large number of the Fortune 500 companies in the United States. When we started in the recovery audit business, three claim categories comprised over 90% of our clients' payment errors. Today, the same three categories account for less than 10% of all the payment errors we identify. As the world of business changes, PRGX's services adapt to meet clients' needs and to identify new sources of error and waste.

5. **Related to question number 2 above, if the error rate in the private sector is lower, does your error discovery process work differently in the private sector?**

Our error discovery process is the same for both the private (commercial insurance) sector and for Medicare and Medicaid recoveries with CMS and other government agencies. In both, our proprietary algorithms and data analyses are used to identify the highest sources of recoverable errors for our clients. For commercial insurance clients, we review all applicable provider contract terms and payment policies to ensure claims are valid and authorized for payment. In some cases, we request medical records to substantiate a claim error.

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We utilize continuous quality improvement techniques and incorporate valuable lessons learned across our entire client base in order to ensure that our services are indeed world-class and provide the greatest recoveries and audit efficiency to our clients.

6. **As an experienced RAC could you provide a few suggestions on how to best construct the recovery programs that we'll be rolling out soon for state Medicaid programs and Medicare Parts C and D? How should it be constructed differently than for Parts A and B? Does the capitated nature of these programs create challenges? Is there going to be unhealthy overlap between the role of MEDICs and RACs in Part D?**

Our interpretation of the legislation is that the states will procure and contract for Medicaid RAC services independently, which we feel will best meet the needs of each individual state's processes, policies, and payment systems. Likewise, because Medicare Part C and Part D audits will greatly increase the scope of the total RAC program and will have significant differences from the existing Part A and Part B audits, we believe that CMS must solicit new competitive bids as a first and necessary step to finding the right recovery audit partners to achieve CMS's goals within the aggressive time frames established. By virtue of our experience, capabilities, and extensive auditing presence, PRGX is in a position to offer a competitive proposal, and, if selected, to start work well within the time frame set forth by the legislation.

With respect to Medicaid recovery auditing, CMS should create a manual, or "playbook" as it's referred to in the commercial sector, to which states can refer for implementation of a RAC program, consistent with the national Medicare RAC program. CMS should document its already-tested exclusion and suppression methodologies for determining the universe of claims a RAC is authorized to audit. This playbook can also include guidelines for appeal processes that can be utilized by states. Audit types and concepts that have been approved for the national Medicare RAC program should be automatically approved in each state in order to fast-track a library of Medicaid audit concepts, and to ensure a faster ramp time for the program. These guidelines will minimize provider confusion and substantially lower the duplication of effort and cost to implement new state programs.

In order for it to be effective we believe that recovery auditing of Medicare Part C and Medicare Part D should focus on audits of the transactions between the Medicare Advantage and Prescription Drug plans (Plan Sponsors) and the providers. This is where the complexity lies and where the majority of errors occur.

PRGX believes that the capitated nature of Medicare Part C and Part D will present unique challenges for the RAC program. For Part C we recommend that RACs be required to analyze risk adjustment data submitted to CMS by Medicare Advantage (MA) Plans and to conduct audits based upon this data analysis in order to identify overpayments made to MA Plans, based upon the submission of inaccurate information through the Medicare Risk Adjustment Processing System (RAPS).

We would not anticipate a problem with overlap between the roles of MEDICs in Part D and RACs. Similar to the role of ZPICs (Zoned Program Integrity Contractors) today in Part A

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and Part B, MEDICs focus on fraud and abuse, which tends to be a very focused and narrow set of providers and claims. The RACs analyze large amounts of claim data to find broad error categories. The RACs' analysis can help MEDICs and ZPICs alike determine what providers and claims are outliers which deserve closer scrutiny for potential fraud or abuse.

7. **The Affordable Care Act is going to steer Medicare away from fee-for-service and toward bundled reimbursements. What is this going to do to both the numbers of claims as well as the potential for waste, fraud and abuse? Will your job get easier or harder with this bundling?**

We do not have sufficient information at present to provide a definitive answer to this question, because the implementation of the Affordable Care Act is incomplete as of this date, and there are many unanswered questions. However, PRGX strongly believes that the error rate and the recoverable dollars associated with this error rate will be directly correlated to the breadth and depth of policy change. Given that the Affordable Care Act is going to introduce changes to healthcare payment policy across a broad spectrum of claims and claim types, one can reasonably expect it to have a broad and far-reaching impact on the error rate. We understand that one potential consequence of the Affordable Care Act could be that services will be bundled, potentially reducing the number of claims, but increasing the dollar amounts and complexity of such claims. For example, patients could be assigned to a physician (or physician practice) that will serve as a "Patient Centered Medical Home" (PCMH), and payment for the care provided to such patients might not be based upon payment for individual services. Rather, a single payment might be made for all physician care provided during a particular time period to the patients assigned to a given physician (or practice). Any change to the way providers must file claims with Medicare likely results in an increase in payment errors, and the greater the change, the higher the likelihood that errors will increase in both number and dollar amount.

8. **In the next ten years the Medicare population is expected to increase by 15 million (32%) and the growth over 20 years will be 32 million (68%). Right now we're experimenting with ways to fix problems of waste and fraud with our existing beneficiaries and claims in an efficient way; meanwhile we've got a potentially new problem of sheer capacity. How do you see the growth of Medicare affecting the current claims process and likelihood of improper payments?**

With the projected growth in the Medicare population, it is more important than ever to squeeze every dollar of waste out of the system and return it to the Trust Fund. The Patient Protection and Accountability Act of 2010 coupled with the expected increase in the size of the beneficiary population will significantly increase payment throughput and complexity in the system. It is a fact in the recovery audit industry that the error rate is a function of complexity and the number of transactions. Complexity in this situation will be a function of Transaction Volume, Cost per Claim, New Technology, and Changes in Policy and Process. We can reasonably expect that the projected increases in the size of the Medicare program will be accompanied by impacts from all the variables mentioned above, and can thereby state with reasonable certainty that Medicare program complexity and error rates will be

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significantly impacted. Stated simply, as payments increase, the potential for errors increases as well, and as new systems and procedures are implemented, complexity will grow. This will require careful orchestration of all the waste and fraud tools in the CMS arsenal to ensure that closing one gap does not open another. Current claims processors (MACs) will, by necessity, have to primarily focus on processing and paying every claim, in order to ensure that the system continues to work. RACs offer the only self-sustaining and self-funded solution for effectively ensuring that improper payments are identified and that future improper payments are prevented, through feedback to the MACs with resultant implementation of appropriate front-end edits.

9. CMS approves each audit area before RACs can run queries. As I understand it right now there have been no complex reviews allowed yet in 2010. How do you prioritize which areas to audits and do you have a master plan?

CMS does approve each audit concept (defined as a "New Issue" by CMS) prior to a RAC's initial audit activity. Complex reviews for DRG Coding have been approved since January, 2010 and are conducted by certified coding specialists. Complex reviews for Medical Necessity have only been recently approved by CMS, and the RACs are starting these audits on a limited basis.

Reviews are first prioritized according to a CMS-defined audit roll-out schedule. Secondly, data analysis is conducted against an internal library of audit concepts to optimize potential recoveries for each approved claim type. Finally, New Issue approval packets are developed and submitted to CMS for approval. These packets contain the audit description, all pertinent review criteria and documentation, and a data sample of claims meeting all criteria.

10. Do you have data on where (i.e. Durable Medical Equipment (DME) or inpatient hospitals) the most overpayments are in Medicare? If so, where are they and what are the figures? Is the relative error rate in certain areas driving your decisions on which audits you seek approval for?

PRGX participated in the Medicare RAC Demonstration program from March 2005 to March 2008. According CMS's published report on the RAC Demonstration, 85% of all overpayments collected were Inpatient Hospital claims. Other areas included Outpatient Hospital claims (4%), Physician claims (2%), Skilled Nursing Facility claims (2%) and DME claims (1%).

Because total savings to the RAC Program overall are maximized, RACs do have an economic incentive to focus audits in areas believed to contain the greatest amount of erroneous program dollars. This incentive also provides the greatest return on investment to the taxpayer and ensures that effort and resources are not utilized chasing claims that are paid improperly but offer very little in potential recovery back to the Trust Fund and ultimately to the American taxpayer.

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11. What is the estimated error rate for Part A and B payments and what is the goal that you are aiming to reduce improper payments to? How does this compare to the error rate of private insurers and what is realistically the lowest rate we can hope to practically achieve?

For 2009, CMS estimated the Fee for Services error rate (for Part A and B payments) to be 7.8%. As discussed in our response to Question #2, we do not independently calculate an error rate for our clients and do not have a specific error rate target that we work toward. Instead, we focus specifically on identifying errors and maximizing the recovery of our clients' hard-earned dollars. Because our compensation is contingency-based, as error rates improve we must continually become more adept and efficient at identifying and recovering payment errors. This is the nature of our business and it drives a level of efficiency and competitiveness into everything that we do.

We cannot, at this time, accurately predict the lowest error rate that the program can hope to achieve. RACs are only part of the equation that CMS has implemented to lower the error rate. It is the responsibility of the MACs to close systemic gaps in the process and to educate providers on the proper methods for billing, coding, and submitting correct claims. We strongly believe that the RAC program will have a sentinel effect on all providers. This sentinel effect should help to push the error rate lower year-over-year. This positive effect will be challenged by any action that increases the complexity of the payment system, including new technologies, new healthcare services for which coverage must be determined, and changes or updates to healthcare policy.

12. Right now RACs are limited to requesting 1% of the detailed claims records and the rationale for this is that providers need reassurance that they're not going to spend all of their time filling data requests from RACs instead of taking care of their patients. Given that RACs can audit 100% of the high-level claims data, can you find errors without the detailed record audits? If so, then what effect does the 1% detailed record retrieval limitation have?

The 1% detailed record retrieval limitation has a very large impact on the level of erroneous payments that can be recovered and returned to the Trust Fund. During the Medicare RAC Demonstration program, PRGX identified and corrected $330.5 million in improper payments. Only 5% of total improper payments identified were derived from high-level claims data. The remaining 95% were substantiated by audits of detailed medical records after review of related high-level claims data. Traditionally, high-level claims data audits uncover mostly low dollar-value errors. While important, these audits do not generate substantial recoveries back to the American taxpayer.

Further, as substantiated by PRGX's performance in the RAC Demonstration program, improper payments were found on 29% of the detailed medical records that were ordered by PRGX, at approximately $6,300 per improper payment. Moving the RAC program in a direction that only focuses on the high level claims data will substantially reduce the effectiveness of the program in two critical areas. First, the amount of dollars recovered will be substantially reduced, and second, the sentinel effect that is important for achieving long term error reduction goals will be severely hampered. Increasing the 1% limit will have a positive effect on the dollars recovered. PRGX recommends a gradual increase in the 1% number so that the RAC program can further increase its contribution to CMS's Medicare error rate reduction goals.

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QUESTIONS FOR THE RECORD
From Chairman Tom Carper
Preventing and Recovering Medicare Payment Errors
Hearing of July 15th Before the U.S. Senate Subcommittee on Federal Financial Management

For Mr. Romil Bahl -

Question #1- RAC Expansion
The Patient Protection and Affordable Care Act greatly expands recovery audit contracting, including Medicare Parts C and D and Medicaid. Would you please provide the Subcommittee with your views on how this expansion can be best implemented to achieve the best results for CMS?

Our interpretation of the legislation is that the states will procure and contract for Medicaid RAC services independently, which we feel will best meet the needs of each individual state's processes, policies, and payment systems. Likewise, because Medicare Part C and Part D audits will greatly increase the scope of the total RAC program and will have significant differences from the existing Part A and Part B audits, we believe that CMS must solicit new competitive bids as a first and necessary step to finding the right recovery audit partners to achieve CMS's goals within the aggressive time frames established. By virtue of our experience, capabilities, and extensive auditing presence, PRGX is in a position to offer a competitive proposal, and, if selected, to start work well within the time frame set forth by the legislation.

With respect to Medicaid recovery auditing, CMS should create a manual, or "playbook" as it is referred to in the commercial sector, to which states can refer for implementation of a RAC program, consistent with the national Medicare RAC program. CMS should document its already-tested 'exclusion and suppression' methodologies for determining the universe of claims a RAC is authorized to audit. This playbook can also include guidelines for appeals processes that can be utilized by states. Audit types and concepts that have been approved for the national Medicare RAC program should be automatically approved in each state in order to fast-track a library of Medicaid audit concepts, and to ensure a faster ramp time for the program. These guidelines will minimize provider confusion and substantially lower the duplication of effort and cost to implement new state programs.

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conduct audits based upon this data analysis in order to identify overpayments made to MA Plans, based upon the submission of inaccurate information through the Medicare Risk Adjustment Processing System (RAPS).

The above recommendations for the RAC expansion are based upon our years of experience in both recovery auditing and in working with CMS. PRGX has developed certain basic principles by which we manage our company and approach every client engagement. First and foremost is our belief in the value of competing for the opportunity to provide world-class services. Our clients benefit the most from receiving the highest value at the most competitive price. We believe we're the best, and for forty years, our clients have upheld that notion by continuing to give us their business. If we are not innovative, if we are not continually improving our services and helping clients close the gaps that cause errors and waste, our clients let us know by choosing a different service provider. We are the best because we continually compete for and win the trust of our clients who vote with their hard-earned dollars. Our second guiding principle is our commitment to improving the efficiency of our clients' payment processes, thereby returning hard-earned dollars back to our clients. We continually strive to improve our clients' processes and to make them less vulnerable to errors and waste. Our third guiding principle is our dedication to maintaining the client's point of view when providing our services. This means we never maximize our own revenue to the detriment of our clients or their programs. For CMS, this means using our unique view across three RAC regions to identify and improve processes and drive efficiency across the entire program.

Question #2 -

Mr. Bahl, in your testimony you mentioned that the expansion of Medicare Recovery Audit Contracting required by the new health care law coupled with the enacted Improper Payments law "doubles the auditable federal spend." Could you describe what that means?

Before the recent legislation, there were a limited number of agencies using recovery auditing as a means to recover improper payments. Our best estimate of the prior auditable universe is $800 billion, comprised of Medicare Part A and Part B (approximately $308 billion) and direct payments made to vendors by the Departments of Defense, Agriculture, and Education (approximately $500 billion) which are included in the discretionary spending portion of the President's budget for 2010. The expanded auditable universe adds $127 billion for Medicare Part C and Part D, $376 billion in spend for Medicaid, and an estimated $340 billion in discretionary spending from the President's budget for 2010. This latter number is derived by estimating that at least 25% of the $1.36 trillion in discretionary spend would be able to utilize recovery audits. The Improper Payments Elimination and Recovery Act of 2010 expands the use of recovery audits beyond direct payments made by agencies to include areas such as grants, loan guarantees, and insurance subsidies. The expanded definition also enables the head of an agency to conduct recovery audits for any programs that spend over $1 million annually, which essentially makes the entire $1.36 trillion discretionary spending portion of the President's budget for 2010 available to utilize recovery audits. Since 100% of discretionary spending is an aggressive estimate, we conservatively estimated that only 25% of this budget would be able to utilize recovery audits (approximately $340 billion). Adding these new areas to the equation brings the new auditable universe to more than $1.6 trillion in spend and more than doubles the auditable universe available prior to recent legislation.



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