United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510–6400
(202) 224–5364

March 12, 2024

The Honorable Gene Dodaro
Comptroller General
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Comptroller General Dodaro:

As members of the Senate Special Committee on Aging, we write regarding the alarming increase in Medicare fraud. In 2022, the Government Accountability Office (GAO) estimated improper payments cost Medicare $47 billion, while other estimates put Medicare fraud at over $60 billion annually.[1] In fiscal year 2022, only $1.7 billion was reclaimed from Medicare fraud, representing a mere 2.8 percent recovery rate.[2] This fraud poses a substantial financial threat to older Americans, undermines our healthcare system's integrity, and contributes to the nation's $34 trillion deficit. In the private sector even a minor level of fraud would lead to an immediate audit of one's finances. We request that GAO audit the Centers for Medicare and Medicaid Services' (CMS) internal oversight reforms, such as adopting machine learning and other innovative solutions, to enhance fraud prevention and minimize the significant financial losses currently being experienced.

Recent investigative reports by The New York Times[3] and The Washington Post,[4] highlighted an alleged Medicare fraud scheme uncovered by the National Association of Accountable Care Organizations (NAACOS). Using federal data,[5] NAACOS found that over two years, 10 companies went from billing just 15 patients for catheters to an astonishing 515,000 patients,[6]

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[1]CMS Needs to Address Risks Posed by Provider Enrollment Waivers and Flexibilities, GAO-23-105494. December 2022 https://www.gao.gov/assets/d23105494.pdf

[2] Department of Health and Human Services, Office of Inspector General. "Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2022." Last modified 2022. https://oig.hhs.gov/publications/docs/hcfac/FY2022-hcfac.pdf.

[3] Sarah Kliff and Katie Thomas. "Scammers Exploit Medicare Loophole, Billing for Unneeded Catheters." The New York Times. Last modified February 9, 2024. https://www.nytimes.com/2024/02/09/health/medicare-billing-scam-catheters.html.

[4] Dan Diamond, Lauren Weber, and Dan Keating. "Medicare Alleged Fraud Scheme Targets Catheter Supplies, Costing Millions." The Washington Post. Last modified February 9, 2024. https://www.washingtonpost.com/national-security/2024/02/09/medicare-alleged-fraud-catheters/.

[5] The association's allegations come from a review of two billing codes for Medicare claims data from the Centers for Medicare & Medicaid Services (CMS) Virtual Research Data Center.

[6] "Despite the relatively low reimbursement rates for each catheter — Medicare pays out about $8 per curved tip and sterile kit catheter — ample profits can be made when the products are ordered in bulk. The health department's own watchdog warned that Medicare's payment rates for the products were too high and should be lowered" (Dan Diamond, Lauren Weber, and Dan Keating. "Medicare Alleged Fraud Scheme Targets Catheter Supplies, Costing

marking an increase of 50,000 from the previous year and accounting for an estimated $2.7 billion increase in taxpayer spending.[7] This represents approximately 23.7 percent of Medicare's total medical supply expenditures for the year, leading to the group's conclusion that a significant portion seems to be related to fraudulent activities. Both news reports reviewed the analysis and found additional evidence supporting the suggestion that the rise in catheter bills represents a severe case of Medicare fraud.

Medicare has increasingly become a target for highly sophisticated fraud schemes, including online phishing, data breaches, and international fraud rings. For instance, in 2023, there was also a significant increase in COVID-19 test kit fraud, leading to estimated losses of over $200 million dollars from the Medicare Trust Fund.[8] These criminals exploit the communication channels between patients and providers to submit fraudulent reimbursement claims. A striking example of the ease with which these frauds are carried out was provided by a Miami individual involved in Medicare theft, who stated, "It's just so easy. It's unbelievable."[9]

CMS's defense against this abuse is what is commonly referred to as the *Medicare Fraud Strike Force*: a specialized team composed of analysts, investigators, and law enforcement agents from various agencies, including the Department of Health and Human Services (HHS), the Office of Inspector General (OIG), the Federal Bureau of Investigation (FBI), and various local partners. Its primary mission is to detect, prevent, and prosecute Medicare fraud across the United States. Yet, despite acknowledgement that "CMS program integrity must keep pace to address emerging challenges" and boasting an eight to one return on investment in "program integrity activities,"[10] the alleged $2.7 billion catheter scheme points to critical vulnerabilities within CMS and the Medicare Fraud Strike Force which must be addressed immediately.

While tamping down on frauds and improper payments for CMS programs has been a long-standing effort, the December 2022 GAO Report, "CMS Needs to Address Risks Posed by Provider Enrollment Waivers and Flexibilities," identified particular vulnerabilities during the public health emergency. During this period, CMS provided new Medicare waivers and flexibilities to help people maintain access to Medicare services, but without proper safeguards, opened the door for fraudsters to exploit benefits intended for seniors in need. The GAO report provided four recommendations for CMS to strengthen safeguards and protect services for seniors, and the agency concurred with the recommendations. The alarming new fraud data, however, raises questions regarding the extent to which CMS' safeguards are working to prevent fraud.

Millions." The Washington Post. Last modified February 9, 2024. https://www.washingtonpost.com/national-security/2024/02/09/medicare-alleged-fraud-catheters/).

[7] An analysis of 2021- 2023 Medicare claims data by the National Association of ACOs showed a significant spike in national DME billing for urinary catheters beginning in late 2022. Since the news reports were published, NAACOS has found additional potentially fraudulent activity accounting for the increase in companies, patients, and taxpayer spending.

[8] Department of Health and Human Services, Office of Inspector General. "2023 COVID-19 Takedown." Last modified 2023. https://oig.hhs.gov/newsroom/media-materials/2023-covid-takedown/.

[9] Popken, Ben. "How Medicare and Medicaid Fraud Became a $100B Problem for the US." CNBC. Last modified March 9, 2023. https://www.cnbc.com/2023/03/09/how-medicare-and-medicaid-fraud-became-a-100b-problem-for-the-us.html.

[10] Centers for Medicare & Medicaid Services. "FY2022 Medicare and Medicaid Report to Congress." https://www.cms.gov/files/document/fy2022-medicare-and-medicaid-report-congress.pdf

For these reasons, we call for a comprehensive assessment of CMS' fraud prevention measures and Medicare Fraud Strike Force's performance, with a specific emphasis on the period from December 2022, when the GAO last reported on CMS's fraud risks, to March 2024, when the alleged urinary catheter scheme became public news. We ask that this investigation address the following questions:

1. NAACOS reported the estimated $2.7 billion increase in spending on urinary catheter suppliers to CMS. It is unclear if CMS was previously aware of this potential fraud or immediately acted on this information. Since CMS did not comment on the issue, NAACOS bought it to national attention.
    a. What is GAO's estimation of the total Medicare fraud and improper payments in 2023? How much of this was fraudulent urinary catheter billing?
    b. Does CMS communicate with key stakeholders when concerning fraud trends are suspected? If so, how can CMS improve collaboration with providers without jeopardizing the integrity of any ongoing or future investigations?
    c. What is the HHS- OIG procedure for ensuring that fraud reports are taken seriously and acted upon quickly? Please provide recommendations on how actors submitting and receiving reports of fraud in the CMS network can coordinate most effectively.

2. The Fraud Prevention System (FPS) at CMS, initiated in June 2011 by the *Small Business Jobs Act of 2010*, employs predictive analytics to prevent Medicare fraud.
    a. How is CMS updating its detection tools to stay ahead of sophisticated fraud attempts? Please provide detailed updates including timelines of completed and planned updates and make recommendations on how CMS can adopt advanced technological solutions.
    b. Please share how improvements to fraud detection tools impact Medicare Fraud Strike Force performance.

3. In the most recent study on CMS' vulnerabilities, GAO concluded that: "Fingerprint-based criminal background checks for high-risk providers who enrolled without them would help identify providers who may have falsified their enrollment application. In addition, timely revalidations of provider enrollments, particularly for provider types who the agency considers a high-risk or moderate-risk, would help identify providers who are no longer eligible to deliver Medicare services."[11]
    a. Please investigate the use of fingerprint-based criminal background checks within the Medicare Fraud Strike Force, detailing which agencies or actors use these protocols, and how this has impacted their performance in fraud detection.
    b. What are the costs associated with increasing the use of criminal background checks? Please estimate both the annual expenditure and operational effects.

[11] CMS Needs to Address Risks Posed by Provider Enrollment Waivers and Flexibilities, GAO-23-105494. December 2022 https://www.gao.gov/assets/d23105494.pdf Page 29.

4. In the most recent study on CMS' vulnerabilities, GAO concluded that: "Fingerprint-based criminal background checks for high-risk providers who enrolled without them would help identify providers who may have falsified their enrollment application. In addition, timely revalidations of provider enrollments, particularly for provider types who the agency considers a high-risk or moderate-risk, would help identify providers who are no longer eligible to deliver Medicare services."[12]
    a. Please investigate the use of fingerprint-based criminal background checks within the Medicare Fraud Strike Force, detailing which agencies or actors use these protocols, and how this has impacted their performance in fraud detection.

5. The December 2022 GAO report makes two additional recommendations. The first one asks CMS to conduct provider enrollment "revalidations" to ensure providers are authenticated prior to the end of their 3-to-5-year revalidation cycles. The second one asks CMS to improve the security of waivers and flexibilities for provider enrollment.
    a. Regarding revalidation, CMS agreed to develop and implement a plan for conducting these revalidations and prioritizing higher risk provider types. What is the status of these reform efforts, and what improvements or successes in fraud detection can be drawn from such activities?
    b. Regarding flexibilities, CMS said that it is undertaking an agency-wide initiative to assess the lessons learned from the waivers issued during the COVID-19 pandemic to inform decision making for future emergencies. What is that status of this specific initiative, and what action will CMS now pursue in light of these findings?

6. With fraud estimated to represent nearly 10 percent of healthcare expenditures,[13] the focus should be on the bad actors committing fraud rather than auditing all providers.
    a. How is HHS OIG prioritizing the investigation of fraudulent actors instead of legitimate providers?
    b. What is the coordination of data and auditing by CMS and contractors for pre and post pay audits to identify legitimate providers verses potential fraudulent actors?
    c. Has there been an assessment to determine how provider audits affect smaller healthcare providers' ability to serve their communities? If not, please assess these risks.

7. Accountable Care Organizations (ACOs) are health care providers that come together voluntarily to serve Medicare patients with a goal of preventing duplicative services and medical errors.[14] This leads to savings for Medicare. However, ACOs can lose their hard-

[12] CMS Needs to Address Risks Posed by Provider Enrollment Waivers and Flexibilities, GAO-23-105494. December 2022 https://www.gao.gov/assets/d23105494.pdf Page 29.
[13] Caffrey, M., et al. "Costs of Care for Persons with Opioid Use Disorder in the 2 Years Following Diagnosis." PubMed Central (PMC). Last modified 2020. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7579458/.
[14] Centers for Medicare & Medicaid Services. "Innovation Models." Last modified [Access Date]. https://www.cms.gov/priorities/innovation/innovation-models/aco.

earned savings and face penalties from Medicare when bad actors bill for unnecessary medical supplies.

a. How does CMS protect ACOs from bearing the cost and performance burdens of external fraudulent activity? Please provide specifics.

Thank you for addressing these critical concerns.

Sincerely,

Mike Braun
U.S. Senator
Ranking Member, Special Committee on Aging

Rick Scott
U.S. Senator
Special Committee on Aging

JD Vance
U.S. Senator
Special Committee on Aging