

**Questions for Bill Corr, Deputy Secretary  
U.S. Department of Health and Human Services  
Submitted by Senator Specter**

1. Mr. Corr, you note that “The Health Care Fraud Prevention and Enforcement Action Team (HEAT)” was “established by Secretary Sebelius and Attorney General Holder on May 20, 2009.” I chaired a Crime and Drugs Subcommittee hearing on “Criminal Prosecution as a Deterrent to Health Care Fraud” that very same day. On May 21, 2009, I wrote to General Holder and Secretary Sebelius to encourage their consideration of recommendations we received from Dr. Malcolm Sparrow, a criminologist from Harvard. Dr. Sparrow recommended that HHS “Require a review of the adequacy of the Medicare and Medicaid programs’ operational responses to claims submitted that are clearly implausible. Auto-rejection of claims involving dead patients, dead doctors, or previously deported persons is a terribly weak response . . . .” On July 24, 2009, HHS Inspector General Daniel R. Levinson responded to my letter that OIG “will consider for inclusion in our fiscal year 2010 work plan a review of CMS’s<sup>[1]</sup> operational response to implausible claims.” **To your knowledge, Mr. Corr, has the OIG included a review of CMS’s operational response to implausible claims in its FY 2010 work plan? Do you agree with Dr. Sparrow that it should?**

**Response:**

Yes, OIG has several audits and evaluations in its FY 2010 work plan that relate to CMS payments for and operational responses to implausible claims. These audits and evaluations will identify possible overpayments and vulnerabilities in internal controls and recommend safeguards to avoid these types of incorrect payments in the future. OIG’s planned and ongoing work in this area includes reviews of:

- Medicare and Medicaid payments for claims for services ordered or referred by:
  - deceased physicians,
  - excluded providers, and
  - other providers with invalid or inactive provider identification numbers;
- Medicare payments for claims involving deceased beneficiaries;

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<sup>1</sup> CMS stands for the Centers for Medicare and Medicaid Services.

- Medicare payments for physician claims with inaccurate information about the setting in which the service was provided. Medicare reimburses physicians at a lower rate for services provided in an outpatient facility such as an ambulatory surgical center than in the physician's office, so inappropriate coding for place of service on a claim can result in overpayments. If a physician submits a claim indicating that a service was provided in his/her office and an outpatient facility submits a claim for the same beneficiary for the same date indicating that the service was provided at the facility, this could indicate an inaccurate claim.
2. Mr. Corr, you testified that “We are putting criminals who fraudulently billed Medicare for equipment like wheelchairs behind bars, while at the same time ensuring our beneficiaries get the right services and the ones they pay for.” (Corr Stmt. at 12). **Do you think that jail time is the best deterrent when it comes to highly profitable white collar frauds?**

**Response:**

Criminal prosecution is a critical component of an overall law enforcement strategy designed to detect and prevent health care fraud – a strategy that also includes civil fines and penalties, administrative sanctions such as exclusion from participation in Federal health care programs, periodic financial audits, industry guidance, beneficiary outreach, and evaluations that identify and recommend corrective action for program vulnerabilities. Recently, an OIG investigation resulted in convictions of three executives of the Purdue Frederick Company based on their positions of responsibility at Purdue during the time of the fraudulent misbranding of OxyContin. After these convictions, OIG excluded the three executives from participation in Federal health care programs. The exclusions have been upheld administratively and are on appeal in Federal court.

We believe that criminal prosecutions (and subsequent exclusion) have a marked sentinel effect. Though deterrence is difficult to quantify, we have empirical evidence that our Strike Force model for investigating and prosecuting health care fraud has resulted in reductions in improper claims to Medicare. Medicare claims data showed that during the first 12 months of the Strike Force (March 1, 2007, to February 29, 2008), claim amounts submitted for Durable Medical Equipment (DME) in south Florida decreased by 63 percent to just over \$1 billion from nearly \$2.76 billion during the preceding 12 months.

3. Mr. Corr, you mention that HHS is “using new methods of data analysis and intelligence gathering to detect patterns of criminal activity, including regions of the country where they are most prevalent, and the types of payments from Medicare and Medicaid that are most vulnerable to fraud.” (Corr Stmt. at 2). **What types of new methods of data analysis is HHS generally, and CMS in particular, using to detect fraud? For the Record, what is the “Integrated Data Repository” (Corr Stmt. at 7) and what are “Benefit Integrity Contractors”? How do these new tools facilitate beneficiary and physician interviews to nail down suspect claims?**

**Response:**

CMS has been working to consolidate claims information, with the first phase of an integrated data repository (IDR) already complete and targeted for initial use by the end of the year. An integral part of the CMS data warehouse strategy, the IDR ensures a consistent, reliable, secure, enterprise-wide view of data supporting CMS and its partners in more effective delivery of quality health care at lower cost to CMS' beneficiaries through state-of-the-art health informatics.

The IDR will allow CMS to:

- Transition from a claim-centric orientation to a multi-view orientation that includes beneficiaries, providers, health plans, claims, drug data, clinical data and other data as needed.
- Create an analytic and reporting platform.
- Retain operational data stores such as Common Working File (CWF) and those in shared systems.
- Provide database scalability to meet current and expanding volumes of CMS data.
- Provide uniform privacy and security controls.
- Provide users the capability to analyze the data in place instead of relying on data extracts.
- Integrate claims data from diverse sources such as Medicare and Medicaid in a meaningful way.

The vision of the IDR includes providing greater information sharing, broader and easier access, enhanced data integration, increased security and privacy and strengthened query and analytic capability by building a unified data repository for reporting and analytics.

Benefit integrity activities at CMS are performed by designated benefit integrity contractors, the Program Safeguard Contractors (PSCs) which are being replaced by new Zone Program Integrity Contractors (ZPICs), who identify and track fraud, waste & abuse in the Medicare program, impose administrative actions such as suspensions, overpayment collections and sanctions, and work as a liaison to make referrals to CMS' law enforcement partners. Within the last two years, CMS' benefit integrity contractors have suspended nearly \$23 million in payments, referred nearly \$2 billion in overpayments for collection, and made more than 700 referrals to law enforcement.

As part of the HEAT initiative, the OIG and DOJ have formed a cross-discipline, cross-department data intelligence team to examine Medicare claims for fraud and aberrant patterns in claims and billing. The team is comprised of Investigators, Auditors, and Evaluators from OIG as well as a Senior Health Care Program Analyst from DOJ. Together the team brings a wealth of experience in utilizing sophisticated data analysis tools combined with criminal intelligence gathered directly from OIG Investigators in the field in order to more quickly identify ongoing health care fraud schemes and trends.

The HEAT initiative has also expanded the Medicare Fraud Strike Forces. Strike Forces are law enforcement specialty teams that conduct criminal investigations and prosecutions and execute enforcement operations in areas identified as being at high risk for and having high concentrations of health care fraud. DOJ and HHS are implementing a new paradigm in fighting fraud by using data analysis to swiftly identify, investigate, and prosecute health care fraud perpetrators. Strike Force investigations are data driven and target individuals and groups that are actively involved in ongoing Medicare fraud schemes.

OIG is also capitalizing on cutting edge electronic discovery tools to maximize investigative efficiency in the processing and review of electronic evidence obtained during the course of our health care fraud investigations. This technology allows OIG Investigators and Computer Forensics Examiners to cull through Gigabytes, or even Terabytes, of electronic mail and other documents in a matter of days as opposed to months of manual investigative analysis. The OIG is also providing access to these tools to our law enforcement partners allowing a much more collaborative approach to reviewing electronic evidence than has been done up to now.