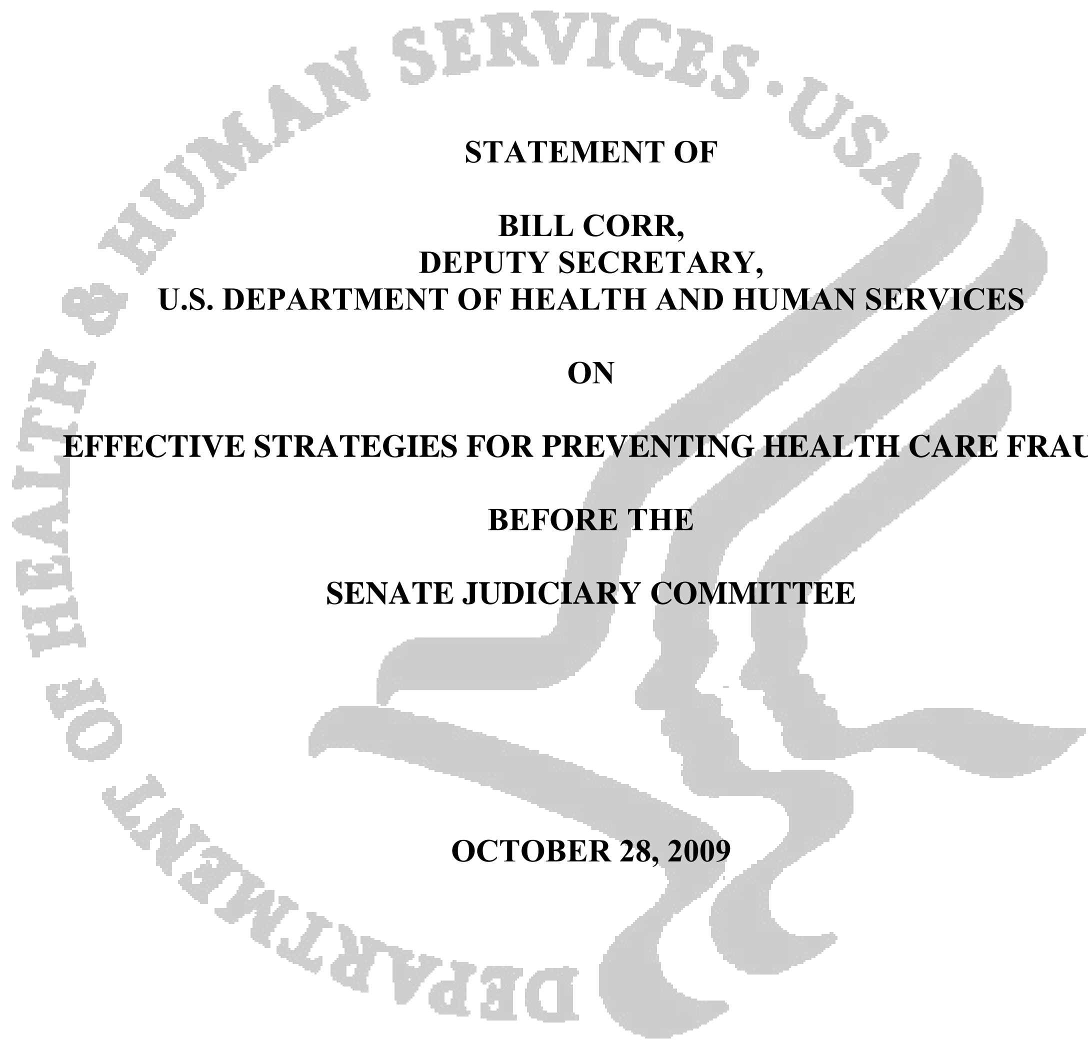

STATEMENT OF

BILL CORR,
DEPUTY SECRETARY,
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

ON

EFFECTIVE STRATEGIES FOR PREVENTING HEALTH CARE FRAUD

BEFORE THE

SENATE JUDICIARY COMMITTEE

OCTOBER 28, 2009

Chairman Leahy, Senator Sessions and Members of the Committee. I am Bill Corr, the Deputy Secretary of the Department of Health and Human Services (HHS). Thank you for the opportunity to join with my colleague from the Department of Justice (DOJ) to testify about the joint DOJ-HHS Task Force on Health Care Fraud, and in particular, HEAT, one of the Administration's signature initiatives. The Health Care Fraud Prevention and Enforcement Action Team (HEAT) is a joint effort by HHS and DOJ to marshal our resources, expertise and authorities to prevent fraud and abuse in Medicare and Medicaid. The HEAT task force was established by Secretary Sebelius and Attorney General Holder on May 20, 2009.

As a result of the priority given to combating health care fraud by President Obama, the government has been able to achieve a more rapid response to fraudulent schemes and increase its recovery of more funds lost to fraud than in previous years. For example, HHS Office of Inspector General investigations have resulted in $4.0 billion in receivables for FY 2009, an increase from $3.2 billion in OIG investigative receivables in FY2008.[1] Strike force cases typically are indicted and litigated faster than traditional criminal health care fraud cases.

[1] OIG investigative receivables, include monies resulting from criminal and civil judgments, settlements, forfeitures, and administrative recoveries. The number includes restitution, fines, penalties, forfeitures, and administrative recoveries. The figures are recorded at the time of judgment or settlement and do not represent the amount collected.

Since March 2007 strike force cases that included HHS agents have obtained 189 convictions, 443 indictments, and total an estimated $227 million in expected recoveries.[2] During this time, the Department of Justice also secured the largest health care fraud settlement in history against a pharmaceutical company for Medicare and Medicaid fraud and for violating the Food, Drug and Cosmetic Act. I refer to the $2.3 billion settlement with Pfizer to resolve criminal and civil liability arising from the illegal promotion of certain pharmaceutical products.

We are identifying perpetrators of fraud, recovering the money they stole, and removing them from federal health programs providing health care coverage to elderly, low income, and disabled beneficiaries. In the process, we are 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. Using this new information, we are pursuing policy changes and developing innovative methods of preventing fraud.

[2] This conviction figure includes only those subjects who have been sentenced. There may be additional subjects who have pled guilty or been convicted at trial but have not yet been sentenced and are not reflected in this figure. Expected recoveries include payments that have been court-ordered or agreed to be paid upon sentencing, settlement, or seizure.

For example, as a result of the strike force prosecutions in Miami focusing on fraudulent claims for durable medical equipment (DME), the Centers for Medicare and Medicaid Services (CMS) detected the potential for fraud and initiated new efforts to prevent fraudulent claims. These prevention efforts, together with the deterrent effect of the strike force prosecutions, resulted in a 63 percent reduction in DME claims in South Florida during the first 12 months of the strike force (March 2007 to February 2008). This represents a decrease in claims of $1.75 billion compared to the year before the intervention of the strike force.

HHS has a multi-faceted role in the HEAT task force, involving three of our most important components: the Office of Inspector General (OIG), CMS and the Food and Drug Administration (FDA). The OIG provides essential support by analyzing data for patterns of fraud, conducting independent investigations, supporting federal prosecutions of providers who commit criminal and civil fraud and pursuing administrative remedies, including civil monetary penalties and program exclusions. In FY 2009 alone, OIG investigations resulted in $4 billion in receivables, 671 criminal actions, 394 civil actions, and 2556 exclusions.

Since 2004, CMS has had field offices in high fraud areas of the country such as Miami, New York City and Los Angeles, providing an “on-the-ground” presence

to fighting fraud in the Medicare program. In addition to conducting its own data analysis to identify fraud trends, CMS provides significant data and analytical support to OIG and DOJ investigators and refers potential fraud cases for investigation to law enforcement entities.

FDA supports investigations of Food, Drug and Cosmetic Act violations and false claims act cases involving the illegal use of medicines for unapproved promotion. The aforementioned case against Pfizer involved significant support from FDA.

Fraud and abuse is not limited to federal health insurance programs. Health care fraud is a national problem that requires collaboration among public and private health entities. While there is no hard number for the costs of health care fraud, the National Health Care Anti-Fraud Association estimates that approximately 3 percent of total health care expenditures, or $60 billion, is lost to fraud by both the private and public sectors each year. Criminals who commit health care fraud are becoming more sophisticated and are often organized crime enterprises. They are preying on both providers and beneficiaries by illegally obtaining their provider or enrollment information and using it to submit fraudulent billings to Medicare and Medicaid. They are sullying the reputation of the overwhelming majority of providers, who are not only honest, but are providing essential health care to

Medicare and Medicaid beneficiaries. Strike forces are aggressively pursuing these criminal organizations and individuals.

The best efforts of the public and private sectors will be required to substantially reduce health care fraud. Therefore, one of the initiatives being considered by the HEAT task force is a national summit on health care fraud that would include participants from every affected group, including private insurers, beneficiaries, law enforcement and providers. A summit of this nature will bring fresh ideas and collaborations that we believe will result in more effective methods of preventing and detecting fraud. Collaboration and innovation are essential in the fight against fraud. They are the key factors in the success of HEAT. The collaboration between HHS and DOJ is rooted in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which established a joint Health Care Fraud and Abuse Control (HCFAC) Program. HCFAC activities are supported by a dedicated funding stream within the Hospital Insurance Trust Funds as well as annual discretionary appropriations.

Since its inception, HCFAC has resulted in the return of $13.1 billion to the Medicare Trust Fund. The investigative and prosecutorial activities performed by OIG and DOJ with HCFAC resources have a return on investment averaging over

$6 for each $1 spent from 2006 to 2008. In fact, their work yielded a nearly $8 to $1 return in FY 2008 alone, as shown in the FY 2008 HCFAC Annual Report which was published on-line just last week. The cost avoidance activities performed by the Medicare Integrity Program under HCFAC, such as prepayment edits and claims audits, have a return on investment averaging $14 for each $1 spent over the last three years.

Experts agree that the most effective way to eliminate fraud is to stop it before it ever starts. **S**ome of the most important work of the HEAT task force and its partners is focused on enhancing the fraud prevention programs in Medicare and Medicaid.

The Administration is making program integrity and fiscal oversight a high priority at CMS. We will build on existing prevention activities at CMS, such as enrollment and claims review processes, to detect and prevent fraud and abuse. We will provide more rigorous screening of new provider applications and greater scrutiny of existing providers. Our goal is to ensure that Medicare and Medicaid are not easy targets for unscrupulous individuals and criminal elements whose intent is to perpetrate fraud.

CMS is currently in the final stages of building an integrated data repository (IDR) which will for the first time in Medicare's history bring all Medicare claims data together in one centralized data repository. Using the IDR, CMS will go beyond the current practices of application and claims review by using sophisticated new technology to identify aberrations in claims data, such as unusual, clinically inconsistent, or high volume billings. This will allow CMS to go beyond the current standard of reviewing just the paperwork. For example, using the CMS field offices and benefit integrity contractors, CMS conducts additional inspections of providers, interviews beneficiaries and visits physicians to ensure that services are being provided in accordance with Medicare laws and regulations. The IDR will enhance these existing program integrity activities.

The President has made increased HCFAC funding a strong priority by requesting $311 million in total discretionary resources in his FY 2010 Budget Request. This request represents a $113 million increase over the $198 million in new discretionary funding Congress provided for HCFAC in the Omnibus Appropriations Act of 2009. As indicated in our budget request, we will use this funding to strengthen HHS and DOJ efforts to combat health care fraud and abuse, predominantly in the Part D drug benefits program, Medicare Advantage, and the Medicaid program. In addition, this funding will be used to improve real-time data

analysis between HHS and DOJ, as well as increase our on-the-ground field presence across the country to more quickly detect and investigate fraud and abuse.

A complement to HCFAC is the Medicaid Integrity Program (MIP) created by the Deficit Reduction Act of 2005 (DRA). The Deficit Reduction Act provided dedicated federal funding to enhance Medicaid integrity efforts through four defined activities: 1) the review of provider actions; 2) the auditing of claims; 3) the identification of overpayments; and 4) the education of providers, managed care entities, beneficiaries, and others on payment integrity and healthcare quality.

CMS has completed the process of awarding Medicaid Integrity review and audit contracts, which now cover the entire country. Over 600 provider audits are now underway. In addition, we have identified over $120 million of potential overpayments through data analysis and mining for five states. The states involved are now verifying these findings. We continue to identify further potential overpayments and errors through our national program of algorithm development and testing.

The Deficit Reduction Act also supports the national expansion of the Medicare-Medicaid (Medi-Medi) Data Match Pilot Program. Matching Medicare and

Medicaid claims data to find patterns of fraud, previously undetectable to the programs individually, has provided State and Federal law enforcement and program integrity units with dramatic insights into the overall practices of providers who are exploiting both programs. In FY 2008, 30 Medi-Medi cases were referred to law enforcement, over $27 million in overpayments were referred for collection, and $7 million in improper payments were caught before erroneous payments were made.

We recognize that preventing health care fraud and abuse will require relentless effort and constant dedication to protect Medicare and Medicaid. Through the joint task force, DOJ and HHS are training lawyers to have the necessary skills to prosecute health care fraud, and training FBI and OIG agents and local law enforcement personnel on methods of investigation. We are investing in data analysts, to identify patterns of fraud so that we can target our efforts for maximum effectiveness.

Additional training is being provided directly to state governments by the Medicaid Integrity Institute (MII), which was established in September 2006 to provide quality education on program integrity to State Medicaid employees free of cost. Through an interagency agreement with the National Advocacy Center of the DOJ

Office of Legal Education, CMS supports training in all aspects of program integrity. Since February of 2007, more than 1,300 State employees have been trained at the MII.

In addition to the MII, CMS conducts comprehensive management reviews of each State's Medicaid program integrity procedures and processes on a triennial basis. Through these reviews, CMS assesses the effectiveness of State program integrity efforts and determines whether a State's policies and procedures comply with Federal regulations. CMS also uses the reviews to identify and disseminate effective practices.

The most common performance problems cited in these reviews include: the failure to collect required ownership, control, and criminal conviction disclosures; the failure to require disclosure of business transaction information; and the failure to report adverse actions on providers to the HHS' Office of Inspector General (OIG). The most common vulnerabilities, which can place State program integrity at greater risk than performance violations include: inadequate protections in the provider enrollment process; lack of exclusion checking after initial enrollment; undocumented program integrity procedures; failure to disenroll inactive

providers; inadequate oversight of Medicaid managed care organizations; and ineffective relationships with State Medicaid Fraud Control Units (MFCU).

The States have responded positively to the reviews, indicating that they will implement corrective actions in response to the findings identified in the reviews. CMS has posted an annual summary of effective practices, findings, and vulnerabilities on its website.[3] CMS has also identified States with effective practices by name so State Medicaid agencies may consult each other and collaborate on what may work in their State.

Home medical equipment—Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS or "DME")—is an industry that has historically high risk for fraud. In South Florida and Los Angeles, where Medicare billing is disproportionately high, the number of DME suppliers spiked by increasing nearly 20 percent between 2005 and 2007.

This is an example where our efforts have culminated in a successful approach to addressing fraud in federal health programs. As I briefly mentioned earlier, we are employing new methods of analysis by personnel trained to use claims data to

[3] http://www.cms.hhs.gov/FraudAbuseforProfs/Downloads/2008pireviewannualsummaryreport.pdf

identify fraud, using investigators trained in health care fraud, working with DOJ prosecutors, and implementing new prevention techniques.

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. We are vigilant when we see spikes in DME claims. We are screening DME providers and keeping bad actors out of the Medicare program. As a result, we are seeing substantial drops in DME claims in high-risk pockets of the country.

One important tool to help fight DME fraud is competitive bidding for suppliers, first authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Bidding began for DME suppliers recently and we anticipate the competitive bidding program to be implemented in Round 1 for suppliers in nine areas of the country by January 1, 2011.

In conjunction with the move to competitive bidding, effective in early October 2009, most DME suppliers participating in the Medicare program were required to have both a surety bond and accreditation from a deemed accrediting organization. Most non-physician suppliers of durable medical equipment are required to obtain

a $50,000 or higher surety bond, thus deterring illegitimate suppliers from enrolling in Medicare. The combination of the surety bond and accreditation requirements is an important step to ensure that CMS is only doing business with legitimate and high quality partners and will allow CMS to expel fraudulent suppliers from the program and keep them out.

The new accreditation requirements include onsite visits, detailed reviews of staff credentials, business records, insurance and license requirements, and other information necessary to ascertain that the supplier is a valid business entity that meets Medicare requirements. The combined impact of these two policies is expected to decrease significantly the number of unscrupulous DME suppliers participating in the Medicare program, even before competitive bidding is launched.

Until DME competitive bidding is fully operational, CMS is focusing on Medicare fraud in seven high-risk areas across the country. This "stop-gap program" increases pre-payment reviews of medical equipment suppliers and will also single out the highest-billed claims—continuous positive airway pressure (CPAP) devices, oxygen equipment, glucose monitors and test strips, and power wheelchairs—which are the most lucrative items for suppliers and thus, at the

greatest risk of fraud. The program adds background checks on new suppliers and increases scrutiny of claims submitted by the highest ordering physicians and the highest utilizing beneficiaries.

We are supporting our efforts against fraud and abuse by adding staff in high fraud risk areas of the country. CMS has opened program integrity field offices in Los Angeles, Miami and New York to coordinate our fraud and abuse efforts at the local level. They conduct data analysis to proactively identify targets, connect the dots among various contractors and agencies to identify local, field level issues and vulnerabilities with national or regional impact and to serve as CMS' "eyes & ears" in the field. They implement administrative actions such as suspensions, auto-denial edits, deactivations, and revocations.

In our Miami field office, CMS has worked with law enforcement to address a Medicare drug infusion scam that involves sham clinics recruiting HIV/AIDS patients, paying them kickbacks and then billing Medicare for astronomical amounts of infusion services. To curb these fraudulent practices, CMS pursued front-end prevention strategies including more vigorous claims review and editing. Simultaneously, on the back-end, law enforcement is prosecuting cases. To date these efforts have resulted in more than $1.8 billion dollars in Medicare savings

based on cumulative efforts by CMS, OIG, DOJ in South Florida to address infusion therapy fraud, and in 20 criminal cases being made against 42 defendants. Overall field office efforts for the three offices, excluding the infusion scam, have resulted in combined savings of billions of dollars.

Our work in Florida includes a new pilot program initiated in August, 2008, to test the effectiveness of sending out monthly, rather than quarterly Explanation of Benefits (EOBs) to beneficiaries and providing them with a regional fraud hotline to call in order to report problems identified while reviewing those EOBs. To date the Florida hotline alone has received more than 5,200 calls, and 840 of those calls have led to open investigations. In addition, the following actions have been taken:

- Eight providers have been suspended from the Medicare program;
- Nineteen providers have been placed on prepayment edits;
- Seven provider numbers have been revoked from Medicare; and
- Over $6.3 million in overpayments have been requested.

We will remain steadfast in our efforts and continue to find new ways to fight fraud, waste, and abuse. In addition to the programs I have described in my testimony, CMS has just completed two promising demonstrations involving strengthening initial provider and supplier enrollment and revalidation of

enrollment to prevent unscrupulous DME and HHA providers from entering the program. The demonstrations also incorporated criminal background checks of providers, owners and managing employees into the provider enrollment process. Additionally, CMS has completed a third demonstration that waived authorities related to the payment of claims for infusion therapy.

Preliminary reporting has shown proven results. Over 1,139 suppliers' billing privileges have been revoked as of January 2009 and total reimbursement to the L.A. demonstration suppliers has decreased significantly. Other demonstration results indicate that thirty-seven HHAs' provider numbers have been revoked. These providers had received approximately $6.1 million in Medicare payments in CY 2007.[4]

Results of the infusion therapy demonstration include 24 referrals to law enforcement, 138 provider deactivations/revocations and $254 million in savings based on edits that resulted in claims denials between November 2007 and January 2009, with a cumulative savings and costs avoided totaling $327.6 million.

[4] Both DME and HHA demonstration figures are based on internal communications with CMS contractor, National Supplier Clearinghouse.

The health reform bills moving through Congress all include substantial new requirements and authorities to aid in our efforts to reduce fraud. The bills include provisions such as: (1) Requiring the Secretary of Health and Human Services to institute an enhanced screening process for all providers and suppliers before granting Medicare billing privileges, which can include criminal background checks and licensure checks; (2) Requiring providers and suppliers to implement compliance programs as a condition of enrolling in Medicare and Medicaid; and (3) Establishing new penalties for submitting false data on applications, false claims for payment, or for obstructing audit investigations related to Medicare and Medicaid.

I have described a reinvigorated and focused Federal Government that is taking measured steps to prevent health care fraud. .In summary, we are adding resources to existing programs and evaluating funding needs for the future; coordinating efforts across the government, led by the joint DOJ-HHS HEAT task force, with great initial success; building new prevention programs to stop fraud before it happens; and using new analytical techniques to identify and then strike against individuals and criminal organizations who have targeted Medicare and Medicaid. With the continued support of the President, this Committee and the

entire Congress, and joining forces with the private sector, we will continue our success and ultimately prevail in the war against health care fraud.