STATEMENT OF

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DEPUTY DIRECTOR FOR POLICY

CENTER FOR PROGRAM INTEGRITY

CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

PROTECTING MEDICARE AND MEDICAID:

EFFORTS TO PREVENT, INVESTIGATE, AND PROSECUTE HEALTH CARE FRAUD

BEFORE THE

UNITED STATES SENATE COMMITTEE ON THE JUDICIARY

SUBCOMMITTEE ON CRIME AND TERRORISM

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U.S. Senate Committee on the Judiciary
Subcommittee on Crime and Terrorism

Hearing on Protecting Medicare and Medicaid:
Efforts to Prevent, Investigate, and Prosecute Health Care Fraud

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Chairman Whitehouse, thank you for the invitation to discuss how the Centers for Medicare & Medicaid Services (CMS) has improved program integrity and is continuing to reduce fraud, waste, and abuse in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

Fraud, waste, and abuse in our health care system is a problem that affects both public and private payers, draining critical resources from our health care system, and contributing to the rising cost of health care for all. Taxpayer dollars lost to fraud, waste, and abuse harm not just the Federal government, but everyone, and, particularly some of our most vulnerable citizens. While most health care providers and suppliers who work with Medicare, Medicaid, and CHIP are honest, we are targeting those who are not legitimate providers and suppliers that seek to defraud taxpayers and the Trust Funds. Thanks to recent legislation passed by Congress giving CMS new resources and tools to fight fraud, CMS is using new technology to make significant improvements to the twin pillars of CMS' program integrity efforts: fraud detection and provider enrollment.

CMS is using many of the new anti-fraud authorities provided in the Affordable Care Act (P.L. 111-148 and P.L. 111-152) and the Small Business Jobs Act of 2010 (P.L.111-240) to strategically combat fraud, waste, and abuse, and is integrating additional tools into our current program integrity efforts. This is part of our comprehensive strategy to prevent and detect fraud and abuse, and requires working closely with States, our law enforcement partners, the private sector, and health care providers. I am confident that the improvements we have put in place over the past year will provide increasingly greater protections to Medicare, Medicaid, and CHIP for a long time to come.

Preventing Fraud, Waste, and Abuse in Medicare and Medicaid

CMS processes about 4.5 million Medicare FFS claims every day, or more than $1.3 billion daily, and is statutorily required to pay claims promptly, usually within 14 to 30 days. In Medicare Parts C and D, all private plans are required to have programs in place to combat fraud, waste, and abuse. CMS is working closely with our Compliance and Enforcement Medicare Drug Integrity Contractor (MEDIC) to prevent fraud in Parts C and D and has recently taken steps to strengthen our efforts to combat prescription drug trafficking and diversion. However, preventing fraud in Medicare involves maintaining an important balance: carrying out our core responsibility to protect beneficiary access to necessary health care services and reducing the administrative burden on legitimate providers, while identifying and thoroughly investigating suspect claims and reducing fraud, waste, and abuse.

Preventing fraud and abuse in Medicaid presents different challenges and requires a different approach. Medicaid is a shared Federal-State program. States design, implement, administer, and oversee their own Medicaid programs within broad Federal guidelines. The Federal government and States share in the cost of the program. Each State has a great deal of programmatic flexibility to tailor its Medicaid program to its unique health care, budgetary, and economic environment. As a result, there is variation among the States in eligibility, services, reimbursement rates to providers and health plans, and approaches to program integrity. CMS operates the Medicaid Integrity Program and administers the national Medicaid audit program in order to enhance Federal oversight of State Medicaid programs. The Medicaid Integrity Program accomplishes this by providing States with technical assistance and support that enhances the Federal-State Partnership.

The New "Twin Pillars" Strategy - Medicare

As we continue the traditional program integrity work of past years, our recent innovations on the Medicare side include a new twin-pillar strategy. The first pillar is our Fraud Prevention System (FPS), the predictive analytic technology mandated by the Small Business Jobs Act. It detects potential fraud, and can prevent potentially fraudulent claims from being paid. The FPS uses predictive analytics to detect aberrant billing patterns and other vulnerabilities by running predictive algorithms against all Medicare Part A, Part B, and Durable Medical Equipment

(DME) claims before payment is made. The second pillar is our new Automated Provider Screening (APS) system. The APS does rapid and automated screening of all providers and suppliers seeking to enroll or revalidate their enrollment in Medicare. These two systems are designed to constantly interact and feed information into one another regarding suspect providers or claims, creating a truly integrated data management and analysis capability. For example, by analyzing characteristics of known fraud, we are continuously improving the predictive algorithms in the FPS that are used to screen the providers in APS. Similarly, if a provider is flagged as risky by APS, we can watch this provider even closer in FPS. Together these pillars represent an integrated approach to program integrity – preventing fraud before payments are made, while at the same time keeping out bad providers in the first place, and knocking wrongdoers out of the program quickly once they are detected.

The Fraud Prevention System

The Small Business Jobs Act required CMS to adopt predictive modeling technology, similar to that used by credit card companies, to identify and prevent fraud, waste, and abuse in the Medicare fee-for-service program by July 1, 2011. CMS implemented this provision aggressively and efficiently only nine months after the President signed the bill into law. The FPS has been using predictive analytic technology to screen Medicare fee-for-service claims nationwide since June 30, 2011, putting CMS well ahead of the statutory schedule of phasing in the technology in an initial ten States over a three year period. Nationwide implementation of the technology maximizes the benefits of the predictive models and also helps CMS efficiently integrate the technology into the Medicare fee-for-service program and train our anti-fraud contractors.

With the FPS, CMS is using our investigative resources to target suspect claims and providers before claims are paid and taking swift administrative action when warranted. The technology does this by identifying providers who exhibit the most egregious, suspect, or aberrant activity. Program integrity analysts begin swift and thorough investigations of such individuals almost as soon as the system generates the top-priority alerts. The FPS has enabled CMS and its program integrity contractors to stop, prevent, and/or identify improper payments using a variety of administrative tools and actions, including claim denials, payment suspensions, revocation of

Medicare billing privileges, and referrals to law enforcement. Since the inception of the FPS, 846 active Zone Program Integrity Contractor (ZPIC) investigations have resulted – 510 that are the direct result of the FPS and 336 existing investigations that are being supported by the real-time FPS data. ZPICs are local private investigators that CMS contracts with to investigate potential fraud.

The FPS has also led to 417 direct interviews with providers suspected of participating in potentially fraudulent activity, and over 1,200 interviews with beneficiaries to confirm they received the services for which the Medicare program had been billed. Information CMS learns from these beneficiary interviews is used along with historical claims data and beneficiary complaints submitted to 1-800-MEDICARE to help identify the characteristics of potentially bad actors, and that information is loaded directly into the FPS. Additionally, if a beneficiary has submitted a complaint or suspicion of fraudulent activity to 1-800-MEDICARE about a specific provider, that information is also incorporated into the FPS and becomes an important data point that feeds into our analytics.

The FPS provides a national view in near "real-time" of fee-for-service Medicare claims for the first time, and has enabled our program integrity contractors to expand their analysis beyond designated regions to reveal schemes that may be operating with similar patterns across the country. This comprehensive view allows our investigators to see and analyze billing patterns as claims are submitted, instead of relying primarily on review of post-payment data. CMS is evaluating strategies for expanding predictive modeling to Medicaid and CHIP. CMS is currently identifying the range of performance metrics that will fully capture the success of the FPS, and these will be reported in the first implementation year report due to Congress this fall.

Automated Provider Screening

The second pillar of our strategy is APS for providers and suppliers seeking to enroll or revalidate their enrollment in Medicare. The APS technology is complemented by enhanced screening requirements enacted in the Affordable Care Act, and has strengthened the enrollment process and improved the controls that assist in the identification of providers and suppliers that do not meet enrollment requirements. When CMS identifies such providers and suppliers, it

results in the denial of an enrollment application or revocation of billing privileges for those already enrolled. This new screening strategy is not one-size-fits-all, but rather is tailored to both categorical and individual provider risk.

The new APS technology was launched on December 31, 2011; it validates enrollment information against thousands of public and private data sources prior to enrollment and monitors for changes in information on a continuous basis. The APS has replaced the time- and resource-intensive manual review process of multiple data sources. CMS anticipates that the new process will decrease the application processing time for providers and suppliers, while enabling CMS to continuously monitor the accuracy of its enrollment data, and to assess applicants' risk to the program using standard analyses of provider and supplier data.

Effective March 25, 2011, CMS promulgated final rules[1] pursuant to requirements of the Affordable Care Act, and established levels of risk for categories of providers and suppliers. Providers and suppliers designated at the lowest level, or "limited" risk, are subject to the same screening requirements for enrollment as they were prior to the Affordable Care Act. CMS established new requirements for categories of providers and suppliers designated as moderate or high risk, including home health agencies and durable medical equipment (DME) suppliers.

Providers and suppliers in the moderate level of risk are now required to undergo an onsite visit prior to enrolling or upon revalidation of their Medicare billing privileges. This new requirement expanded physical on-site inspections to many providers and suppliers that were previously not subject to such site visits as a condition of enrollment into the Medicare program. CMS has estimated that approximately 50,000 additional inspections will be conducted to ensure providers and suppliers are operational and meet all regulatory enrollment requirements. CMS has completed the procurement of a national site visit contractor to increase efficiency and standardization of the site visits and the contractor has recently started performing these site visits.

[1] http://www.gpo.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf

In addition to announced and unannounced site visits, providers and suppliers who are designated in the high-risk level will be subject to fingerprint-based criminal background checks. Individuals with a five percent or more ownership interest in newly enrolling home health and DME companies and providers and suppliers that hit certain triggers (such as a prior Medicare or Medicaid payment suspension or termination from a State Medicaid program) will also be required to submit fingerprints for completion of a Federal Bureau of Investigation (FBI) criminal background check.

CMS has embarked on an ambitious project to revalidate the enrollments of all existing 1.5 million Medicare suppliers and providers by 2015 under the new Affordable Care Act screening requirements. Since revalidation began in September 2011, CMS has enrolled or revalidated enrollment information for approximately 217,340 providers and suppliers under the enhanced screening requirements of the Affordable Care Act. These efforts will ensure that only qualified and legitimate providers and suppliers can provide health care items and services to Medicare beneficiaries.

The FPS and the APS work in tandem with each other. For example, based on FPS leads, we have identified specific providers and suppliers as top priorities for the revalidation effort. As a result of screening providers and suppliers that pose an elevated risk as identified by the FPS, CMS has begun to revoke or deactivate providers and suppliers who do not meet Medicare enrollment requirements. CMS is also sharing information on revoked providers with State Medicaid programs.

The Affordable Care Act

While these efforts are already helping CMS to stop potentially fraudulent or otherwise inappropriate payments, we recognize that they cannot prevent every instance of fraud. In addition to the enrollment safeguards in the APS and data analytics in the FPS system, new tools included in the Affordable Care Act will also allow us to remove bad actors from our programs. We are working in collaboration with our State partners to ensure that those who are caught defrauding Medicare will not be able to defraud Medicaid. The Affordable Care Act requires States to terminate from Medicaid providers or suppliers who have been revoked by Medicare, or

terminated by another State's Medicaid or CHIP program. Similarly, Medicare may also revoke providers or suppliers who have been terminated by State Medicaid agencies.

The Affordable Care Act also enhances our authority to suspend Medicare payments to providers or suppliers during the investigation of a credible allegation of fraud. This allows CMS to halt claims payment before funds go out the door, and helps moves us beyond the old pay-and-chase paradigm to a more prevention-focused approach to fighting fraud. CMS suspended over $27 million in payments to suspect providers in calendar year (CY) 2011. In addition, States are now similarly required to suspend payments to Medicaid providers against whom there is a credible allegation of fraud.

It is important to remember that payment suspensions are just one of CMS' tools to prevent losses from fraud, waste, and abuse. We also use a variety of prepay edits that automatically deny claims when the submitted bills are implausible or inappropriate. In CY 2011, CMS saved $208 million in Medicare through the use of such edits. In addition to suspensions, CMS revoked billing privileges from thousands of Medicare providers and suppliers last year, cutting off fraudulent billing directly at its source. In CY 2011, CMS revoked or deactivated 19,139 providers and suppliers.

Engaging beneficiaries to combat fraud, waste, and abuse

Beneficiary involvement is a key component of all of CMS' anti-fraud efforts. Alert and vigilant beneficiaries, family members, and caregivers are some of our most valuable partners in stopping fraudulent activity. In CY 2011, over 49,000 beneficiaries reported complaints of fraud to 1-800-MEDICARE.

CMS also encourages our beneficiaries to review their Medicare billing statements and other medical reports in order to spot unusual or questionable charges. To that end, I am pleased to report that on March 7, 2012, Medicare announced the redesign of the quarterly Medicare Summary Notices (MSN) so that beneficiaries can more easily spot potential fraud or

irregularities on claims submitted for their care.[2] Beneficiaries are encouraged to report fraud to 1-800-MEDICARE, and this is promoted in the new MSN. This MSN redesign is part of a new CMS initiative, "Your Medicare Information: Clearer, Simpler, At Your Fingertips," which aims to make Medicare information clearer, more accessible, and easier for beneficiaries and their caregivers to understand. Starting in March, the redesigned MSN has been available to beneficiaries on www.mymedicare.gov, and starting in early 2013, paper copies of the redesigned MSN will replace the existing mailed version.

Additional educational resources, including tip sheets on protecting against fraud, are available on www.mymedicare.gov and www.stopmedicarefraud.gov.

Senior Medicare Patrols

In addition, CMS has been partnering with the Administration on Aging (AOA) to operate the Senior Medicare Patrol (SMP) program - groups of senior citizen volunteers that educate and empower their peers to identify, prevent, and report health care fraud. The SMP program empowers seniors through increased awareness and understanding of health care programs. SMP projects also work to resolve beneficiary complaints of potential fraud in partnership with State and national fraud control/consumer protection entities, including Medicare contractors, State Medicaid fraud control units, State attorneys general, the Department of Health & Human Services (HHS) Office of Inspector General (OIG) and the AOA. To support this work, CMS provided grant funding to SMP projects in recent years.[3] The increased funding levels have supported additional targeted strategies for collaboration, media outreach, and referrals for States identified with high-fraud areas.

The SMP has produced important results; since the SMP program's inception in 1997, more than 68,000 volunteers have been trained to educate their peers in local communities. Since inception, the program has educated over 3.84 million beneficiaries in group or one-on-one counseling sessions and has reached an estimated 24 million people through SMP-led community education outreach events. Over 267,000 Medicare, Medicaid and other complaints

[2] http://www.cms.gov/apps/media/press/release.asp?Counter=4298

[3] http://www.hhs.gov/news/press/2011pres/11/20111122b.html

of potential health care fraud have been resolved by SMPs or referred for further investigation. In Rhode Island, 49 volunteers provided education and assistance to 1,438 beneficiaries in 2010. Further, over the life of the program, the OIG has documented approximately $106 million in savings attributable to the SMP program resulting from beneficiary complaints.[4] However, this almost certainly understates the real impact of the program due to difficulties in quantifying the impact of the robust education and awareness efforts of the SMPs.

How Beneficiaries Can Report Fraud

If a beneficiary discovers a suspicious claim, there are a variety of places that Medicare and Medicaid fraud tips can be reported for further action: beneficiaries can contact the Medicare call center at 1-800-MEDICARE, call the OIG tip line at 1-800-HHS-TIPS, or call 1-877-808-2468 to find the SMP in their local area. As a reminder, any beneficiary whose tip leads to the uncovering of fraud is eligible for a reward of up to $1,000 of the recovered funds. To report a lost or stolen Medicare card, beneficiaries can call the Social Security Administration at 1-800-772-1213 for a replacement card. To report suspected misuse of personal information, beneficiaries can call the Federal Trade Commission at 1-877-ID-THEFT.

Engaging the Provider Community

As CMS implements many of the new tools in the Affordable Care Act, including the enrollment enhancements discussed above, we are working closely with our partners in the provider community to promote their active participation in efforts to cut fraud, waste, and abuse in Medicare. The American Medical Association and other organizations have participated in our periodic "Power Users Group" meetings designed to collect ongoing provider feedback from heavy users of our enrollment systems before and as those systems are developed, instead of after roll-out. This partnership has proven valuable, and because of CMS' proactive outreach to the provider community, we have been able to implement significant changes in our enrollment systems (such as an online enrollment option) with widespread provider acceptance. These groups also are collaborating with CMS to implement new methods to prevent and detect fraud, waste, and abuse.

[4] Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2011. Page 68

Engaging State Medicaid Programs in Program Integrity Efforts

The Medicaid Integrity Institute (MII) is one of CMS' most significant achievements in fighting Medicaid fraud, in partnership with our State colleagues. In its four years of operations, the MII has offered numerous courses and trained more than 2,464 State employees at no cost to the States. Courses have included teaching enhanced investigative and analytical skills, Medicaid program integrity fundamentals, and a symposium to exchange ideas, create best practice models, and identify emerging fraud trends. I encourage Rhode Island and all States to continue taking advantage of this opportunity to reduce fraud, waste, and abuse in Medicaid.

Fraud Summits

Building on the momentum generated by the National Health Care Fraud Summit in January 2010, regional health care fraud prevention summits have been held across the country in six cities since 2010. CMS and the OIG collaborated with the Department of Justice (DOJ), and the FBI to convene Regional Health Care Fraud Summits in Miami, Los Angeles, Brooklyn and Boston in 2010 and in Detroit and Philadelphia in 2011. These summits have brought together Federal and State officials, law enforcement experts, private insurers, beneficiaries, caregivers, and health care providers to discuss innovative ways to eliminate fraud within the nation's health care system. These summits have also featured educational panels that discussed best practices for providers, beneficiaries, government agencies, and law enforcement in preventing health care fraud. Our next Fraud Summit, scheduled for the spring of 2012, is intended to highlight our public-private partnership efforts, with presentations from the private sector on their efforts in predictive modeling.

CMS has hosted well-attended Provider Interaction Sessions at these regional health care fraud prevention summits, as well as multiple Open Door Forums and other professional outreach activities to discuss the impact of new Affordable Care Act requirements with physicians and other medical professionals. The responses received by CMS at these events have demonstrated physicians' and other practitioners' strong interest in working with CMS and the HHS in eliminating fraud, waste, and abuse in the federal health care programs. CMS has demonstrated its commitment to continuing and improving these conversations; the Center for Program

Integrity recently hired a Medical Officer to be a liaison for providers on program integrity issues and activities.

Collaboration with Law Enforcement and Public-Private Partnerships

CMS is working closely with key partners to reduce fraud. These partners include the OIG, the DOJ, State Medicaid offices, and partners from the health care sector of private industry. Sharing information and performance metrics broadly and engaging internal and external stakeholders requires establishing new partnerships with government and private sector groups. Because the public and private sectors have common challenges in fighting fraud and keeping fraudulent providers at bay, it makes sense that we work together to develop common solutions and share information about emerging and migrating scams, and we intend to highlight our strengthened public-private partnership at future summits.

Aligning with the HEAT Task Force

One of the most visible examples of increased collaboration is the Health Care Fraud Prevention and Enforcement Action Team (HEAT) Task Force, a joint effort between HHS (OIG and CMS) and DOJ to fight health care fraud. CMS has actively collaborated with DOJ and the OIG by providing improved access to Medicare data to help identify criminals and fight fraud while protecting patient privacy. CMS and the OIG have partnered to train more than 600 law enforcement agents in Medicare data analysis using CMS systems. The HEAT initiative has engaged law enforcement and professional staff at the highest levels of HHS and DOJ to increase coordination, intelligence sharing, and training among investigators, agents, prosecutors, analysts, and policymakers. A key component of HEAT is the Medicare Strike Force: interagency teams of analysts, investigators, and prosecutors who can target emerging or migrating fraud schemes in high fraud areas, including fraud by criminals masquerading as health care providers or suppliers. In FY 2011, the total number of cities with Strike Force prosecution teams increased to nine- Miami, Los Angeles, Houston, Detroit, Brooklyn, Baton Rouge, Tampa, Dallas and Chicago.

On February 28, 2012, the DOJ and HHS, and the Texas Attorney General's Office, announced the arrest of a Dallas physician and the office manager of his medical practice, along with five

owners of home health agencies, on charges related to their alleged participation in a nearly $375 million health care fraud scheme involving fraudulent claims for home health services. On the same day as the indictment, CMS also announced the suspension of payments to 78 home health agencies associated with the physician based on credible allegations of fraud against them. These enforcement actions were the direct result of collaborations with the HEAT Task Force and the Medicare Fraud Strike Force operations. We want to highlight the unprecedented scale of this civil-criminal coordination that occurred in the Texas case. The coordinated, simultaneous indictment and large-scale suspension of payments in last month's operation will be a template for future operations. Not only does such coordination between prosecutors and program administrators stop the flow of money simultaneously with criminal prosecution, but it also signals robust coordination among the States and federal government, and enhances the sentinel effect of the entire federal government's anti-fraud effort, by sending a strong warning to bad actors across the country that the government is willing and able to prosecute even the most sophisticated fraudsters.

CMS supports law enforcement activities from beginning to end: its Zone Program Integrity Contractors develop and refer cases to law enforcement, provide support throughout these investigations, and implement administrative actions such as payment suspensions, revocation of Medicare billing privileges, implementation of prepayment edits, review of medical records and computation of overpayments.

FY 2013 Budget Request

Demonstrating the Administration's commitment to combating fraud, waste, and abuse in Medicare, Medicaid, and CHIP, the President's FY 2013 Budget requests $610 million in discretionary program integrity resources, as part of a multi-year investment to enable HHS and DOJ to detect, prevent, and prosecute health care fraud. This investment will support efforts to reduce the Medicare fee-for-service (FFS) improper payment rate and initiatives of the HEAT task force. The investment also supports Strike Force teams in cities where intelligence and data analysis suggest high levels of fraud; more rigorous data analysis; and an increased focus on civil fraud. These targeted efforts, as part of a multi-year investment, will save an estimated $11.3 billion over 10 years. The Budget also proposes a series of new legislative authorities to

strengthen program integrity for Medicare, Medicaid, and CHIP. Our Program Integrity legislative proposals yield an estimated $3.6 billion in savings over 10 years.

Conclusion

Thank you, Chairman Whitehouse for the opportunity to outline CMS' efforts to cut fraud, waste, and abuse in Medicare, Medicaid, and CHIP. With the tools Congress has provided and the coordinated efforts that I have outlined above, the Administration and CMS have been successful in combating health care fraud, waste, and abuse. We look forward to working with beneficiaries, providers, community partners, and Congress to continue our efforts to prevent and identify health care fraud, waste, and abuse.