

STATEMENT OF

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ON

**“FOSTERING INNOVATION TO FIGHT
WASTE, FRAUD, AND ABUSE IN HEALTH CARE”**

**BEFORE THE
UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH**

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Chairman Pitts, Ranking Member Pallone, and members of the subcommittee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services (CMS) program integrity efforts for the Medicare and Medicaid programs, and as part of those efforts, our collaborations with our law enforcement partners and the private sector. Enhancing program integrity is a top priority for the administration and CMS, and the administration has made important strides in reducing fraud, waste, and abuse across the government.

Thanks to new authorities and resources provided by the Affordable Care Act and the Small Business Jobs Act of 2010, CMS has new powerful anti-fraud tools to shift the agency beyond a “pay and chase” approach to preventing fraud before it happens. CMS is also collaborating in an unprecedented way with the private sector, law enforcement, and our State partners to develop best practices in our fight against health care fraud. These efforts are paying off. Earlier this month, the government announced that in fiscal year (FY) 2012 its fraud prevention and enforcement efforts in the Health Care Fraud and Abuse Control (HCFAC) program resulted in the record-breaking recovery of \$4.2 billion in taxpayer dollars from individuals trying to defraud Federal health care programs serving seniors and taxpayers. Over the last three years, the average return on investment of the HCFAC program is \$7.90 for every dollar spent. Since 2009, the HCFAC program has collected \$14.9 billion.

Preventing Fraud in the Medicare and Medicaid Programs

Preventing fraud in Medicare and Medicaid involves striking an important balance: protecting beneficiary access to necessary health care services and reducing the administrative burden on legitimate providers, while ensuring that taxpayer dollars are not lost to fraud, waste, and abuse. Every workday, the fee-for-service Medicare program pays out more than \$1 billion from some 4.64 million claims, and is statutorily required to pay claims quickly, usually within 14 to 30 days. States administer the Medicaid program within the bounds of Federal law, and CMS

partners with each State Medicaid program to support program integrity efforts. The 56 separate State-run Medicaid programs process 4.4 million claims per day. In order to protect taxpayer dollars in the Medicare and Medicaid programs, CMS has a comprehensive program integrity approach centered on prevention and detection, innovative anti-fraud technologies, provider risk-based strategy, and greater collaboration with our fraud fighting partners in the private sector and law enforcement.

Fraud Prevention System

A key component of this effort is the Fraud Prevention System (FPS), which was launched on June 30, 2011 pursuant to the Small Business Jobs Act of 2010. The FPS analyzes all Medicare fee-for-service claims using risk-based algorithms developed by CMS and the private sector, prior to payment, allowing CMS to take prompt action where appropriate. CMS uses the FPS to target investigative resources to suspect claims and providers, and swiftly impose administrative action when warranted. The system generates alerts in priority order, allowing program integrity analysts to quickly investigate the most egregious, suspect, or aberrant activity. CMS and our program integrity contractors use the FPS information to stop, prevent, and identify improper payments using a variety of administrative tools and actions, including pre-payment review, claim denials, payment suspensions, revocation of Medicare billing privileges, and referrals to law enforcement.

Early results from the Fraud Prevention System show significant promise and CMS expects results to improve as the system matures over time. As reported in our first year Report to Congress,¹ in its first year of implementation, the Fraud Prevention System:

- Stopped, prevented or identified an estimated \$115.4 million in improper payments;
- Achieved a positive return on investment, saving an estimated \$3 for every \$1 spent in the first year;
- Generated leads for 536 new fraud investigations;
- Provided new information for 511 existing investigations; and

¹ Report to Congress: Fraud Prevention System First Implementation Year 2012
<http://www.stopmedicarefraud.gov/fraud-rtc12142012.pdf>

- Triggered 617 provider interviews and 1,642 beneficiary interviews regarding suspect claims or provider activity.

Integrated Data Repository and One Program Integrity

To complement this work, CMS continues to enhance the Integrated Data Repository (IDR) to provide a comprehensive view of Medicare and Medicaid data including claims, beneficiary data, and prescription drug event (PDE). CMS is using the IDR to provide broader and easier access to data for our partners while strengthening and supporting CMS's analytical capabilities. The IDR contains Medicare provider, supplier, beneficiary and claims data for Medicare Parts A, B, and D back to January 2006. In FY 2012, CMS expanded the IDR to include shared systems data, providing access to Part B physician, supplier, and durable medical equipment (DME) claims data from both before and after final payment has been made. This permits testing of prepayment analytics on historical data that can be used to develop analytic models that can be used in the FPS. CMS is working to integrate new data sources into the IDR. CMS is now requiring Medicare Advantage organizations to submit encounter data for dates of service January 3, 2012 and later. CMS is also working to incorporate State Medicaid data into the IDR, while working with States to improve the quality and consistency of the data from each State.

Users may access the IDR through One Program Integrity ("One PI"), CMS's centralized portal that provides CMS contractors and law enforcement with a single access point to Medicare data as well as analytic tools to review the data. In FY 2012, CMS trained 275 contractors and 44 law enforcement staff to effectively use One PI, and since October of 2010, a total of 886 program integrity contractors and CMS staff, including 108 law enforcement personnel, have been trained. Additionally in FY 2012, CMS offered mobile, on-site training on One PI for our program integrity contractors, training large groups of contractor staff while reducing travel costs related to this training.

Enhanced Provider Screening

As part of our enhanced program integrity efforts, CMS has implemented a risk-based screening process for newly enrolling and revalidating Medicare providers and suppliers. This screening

process requires certain categories of providers and suppliers that have historically posed a higher risk of fraud to undergo greater scrutiny prior to their enrollment or revalidation in Medicare. In 2012, CMS began the implementation of the Automated Provider Screening System (APS). The APS is designed to verify the data submitted on enrollment applications against independent commercial and health care data to establish eligibility for enrollment or revalidation in the Medicare program. CMS has embarked on an ambitious project to revalidate the enrollments of all existing 1.5 million Medicare suppliers and providers under the new Affordable Care Act screening requirements. Since March 2011, CMS validated or revalidated enrollment information for nearly 410,000 Medicare providers and suppliers under the enhanced screening requirements of the Affordable Care Act. Because of revalidation and other proactive initiatives, CMS has deactivated 136,682 enrollments and revoked 12,447 enrollments.² These efforts will ensure that only qualified and legitimate providers and suppliers can provide health care items and services to Medicare beneficiaries. These initiatives complement the traditional program integrity work and additional provider enrollment enhancements that CMS performs.

CMS is collaborating with our State partners to ensure that those caught defrauding Medicare will not be able to defraud Medicaid, and those identified as fraudsters in one State will not be able to replicate their scams in another State's Medicaid program. Specifically, the Affordable Care Act and CMS's implementing regulations require States to terminate from Medicaid and the State Children's Health Insurance Program (CHIP) those providers whose Medicare billing privileges have been revoked for cause, those providers whose Medicare billing privileges have been revoked for cause, or that another State's Medicaid or CHIP agency has terminated for cause. Similarly, under current authority, the Medicare program may also revoke the billing privileges of its providers or suppliers that were terminated by State Medicaid or CHIP agencies.

To support State efforts to share such information, CMS implemented a web-based application, which allows States to share information regarding providers who have been terminated for cause and view information on Medicare providers and suppliers who have had their billing privileges revoked for cause. This tool for States is the beginning of a smarter, more efficient

² "Deactivate" means that the provider or supplier's billing privileges were stopped, but can be restored upon the submission of updated information. Revoke means that the provider or supplier's billing privileges are terminated and cannot be reinstated.

Federal-State partnership, integrating technology solutions to routinely share relevant program information in a collaborative effort.

CMS Collaboration with States on Medicaid Program Integrity

To address Medicaid's structure as a Federal-State partnership, CMS has developed initiatives specifically designed to assist States in strengthening their own efforts to combat fraud, waste, and abuse. The Medicaid Integrity Institute (MII) is one of CMS's most significant achievements in Medicaid program integrity. The MII provides for the continuing education of State program integrity employees, including specific coursework in specialized skills in Medicaid fraud detection, investigative data collaboration, and on predictive analytics, as examples. At the MII, CMS has a unique opportunity to offer substantive training, technical assistance, and support to States in a structured learning environment. From its inception in 2008 through the end of FY 2012, CMS has continually offered MII courses and trained more than 3,383 State employees from all 50 States, D.C., and Puerto Rico through 82 courses at no cost to the States. These State employees are able to learn and share information with program integrity staff from other States on a variety of program integrity topics. In FY 2012, CMS trained 919 State staff in 19 courses at the MII.

As in Medicare, CMS's ultimate goals are to use predictive modeling and analytics to enhance our capabilities, and to increase information-sharing and collaboration among State Medicaid agencies. CMS is actively pursuing ways to apply advanced analytics technology, including predictive analytics, to the Medicaid program. CMS is currently exploring ways to identify specific FPS algorithms applicable to Medicaid and is performing an analysis of one State's Medicaid claims data using the identified algorithms. The FPS pilot with State Medicaid data will also provide more collaboration between Medicare and Medicaid. CMS is also supporting States' use of predictive analytics through technical assistance and education. In an effort to foster information sharing and collaboration, CMS assessed States' current capabilities and facilitated joint presentations at various venues to share progress in their development. These presentations also shared information on how States can secure enhanced Federal financial participation (FFP) for a major information technology (IT) planning and implementation effort related to predictive analytics support software and systems related to the Medicaid Management

Information System (MMIS). CMS brought State program integrity staff together for a *Data Experts Symposium* at the MII in July 2012, which included presentations about predictive analytics from speakers representing CMS, States that have developed their own systems, and States that have contracted with vendors. CMS also sponsored 10 sessions that covered predictive modeling and analytics during six different MII courses held in FY 2012.

CMS also provides States assistance with “boots on the ground” for targeted special investigative activities. Since October 2007, CMS has participated in 12 projects in three States, with the majority occurring in Florida. CMS assisted States in the review of 654 physicians and other prescribers, 60 home health agencies and DME suppliers, 52 group homes, and 231 assisted living facilities. During those reviews, CMS and States interviewed 1,145 beneficiaries, and States took nearly 900 actions against non-compliant providers (including, but not limited to fines, suspensions, licensing referrals, and State MFCU referrals). Florida reported that five home health agency investigations undertaken with CMS between 2008 and 2010 have resulted in nearly \$40 million in savings to the Medicaid program through cost avoidance.

Medicaid RAC Programs

The Affordable Care Act expanded the Recovery Audit Contractors (RACs) to Medicaid. State Medicaid agencies are required to contract with RACs to identify and recover overpayments and identify underpayments made to Medicaid providers. As of February 15, 2013, 42 States and the District of Columbia have implemented Medicaid RAC programs. CMS developed the Medicaid RACs-At-A-Glance website³ to facilitate transparency and monitoring. In 2012, CMS enhanced RACs-At-A-Glance by including State-reported information on each State’s Medicaid RAC program, including contact information for the State Program Integrity Director; the name of each RAC vendor and Medical Director; contingency fee rates for the identification and recovery of overpayments; fee structure for the identification of underpayments; user-friendly charts and data; and State profile pages. The website will include performance metrics later this year. For FY 2012, the States have recovered a total Federal and State share combined amount of \$95.64 million and returned a total of \$57.57 million to the Department of Health and Human Services (HHS), through the State Medicaid RAC programs.

³ <http://w2.dehpg.net/RACSS/Map.aspx>

The Medicare-Medicaid Data Match Program

The Medicare-Medicaid Data Match Program (Medi-Medi) is another CMS initiative to improve the use and availability of better quality Medicaid data. The Medi-Medi program began as a pilot project with the State of California in 2001; nine other States joined the Medi-Medi program between 2003 and 2005, followed by further expansions. The Medi-Medi program enables participating State and Federal Government agencies to collaboratively analyze billing trends across the Medicare and Medicaid programs to identify potential fraud, waste, and abuse. Currently, CMS is partnering with the 19 States that account for most of the expenditures in Medicaid. We are also exploring additional opportunities to collaborate with States as well as working directly with States to match Medicare and Medicaid data for specific collaborative projects. In addition, we will be providing more opportunities for sharing lessons learned from States that have made successful referrals to law enforcement and recouped improper Medicaid expenditures.

Collaboration to Detect and Prevent Fraud and Waste in Medicare and Medicaid

CMS's approach to program integrity once involved stand-alone programs with siloed communications that did not engage other Federal partners or allow for shared best practices. Now, however, thanks to a variety of efforts, Federal, State, and local law enforcement health care fraud activities are being coordinated to a greater extent than ever before.

Command Center

CMS is using new and innovative ways to collaborate to improve health care fraud detection and investigation. CMS has established collaboration between program officials and law enforcement as a critical cornerstone in improving health care fraud detection and investigation. The Command Center provides the advanced technologies and collaborative environment for a multi-disciplinary team of experts and decision makers to more efficiently coordinate policies and case actions, reduce duplication of efforts, and streamline fraud investigations for more immediate administrative action. From the opening of the Command Center on July 31, 2012, the Command Center conducted 61 missions that included over 450 unique participants from CMS and its partners, including the HHS Office of Inspector

General (OIG) and the Federal Bureau of Investigations (FBI). The Command Center's collaborative activities will strengthen CMS's ability to take administrative actions, such as revocations of Medicare billing privileges and payment suspensions, more quickly and efficiently.

Health Care Fraud Prevention & Enforcement Action Team (HEAT)

The sustained success of HEAT demonstrates the effectiveness of the Cabinet-level commitment between HHS and Department of Justice (DOJ) to prevent and prosecute health care fraud. Since its creation in May 2009, HEAT, has played a critical role in identifying new enforcement initiatives and expanding data sharing to a cross-government health care fraud data intelligence sharing workgroup. A key component of HEAT is the presence of Medicare Strike Force Teams, interagency teams of analysts, investigators, and prosecutors, who target emerging or migrating fraud schemes such as criminals masquerading as healthcare providers or suppliers.

Medicare Strike Force Teams coordinated three major takedowns in 2012, and CMS took administrative action against 160 providers and suppliers associated with those law enforcement activities. Under the Affordable Care Act and implementing regulations, HHS is able to suspend payments for up to eighteen months and for longer periods under certain circumstances. The largest action was in May 2012, when the Medicare Strike Force teams charged 107 individuals, including doctors, nurses and other licensed medical professionals, in seven cities for their alleged participation in Medicare fraud schemes involving more than \$452 million in alleged false billing.

Since its inception:

- Strike Force prosecutors filed more than 724 cases charging more than 1,476 defendants who collectively billed the Medicare program more than \$4.6 billion;
- 918 defendants pleaded guilty and 105 others were convicted in jury trials; and
- 745 defendants were sentenced to imprisonment for an average term of more than 45 months.

Healthcare Fraud Prevention Partnership

In addition to collaborating with other agencies, CMS is partnering with the private sector in anti-fraud efforts. Last year, HHS and DOJ launched a voluntary, collaborative partnership between the Federal government, State officials, several leading private health insurance organizations, and other health care anti-fraud groups.⁴ The goal of the partnership is to improve fraud detection and prevent payment of fraudulent health care billings by finding and stopping schemes that cut across public and private payers. The partnership will enable those on the front lines of industry anti-fraud efforts to share information more easily with investigators, prosecutors, policymakers and other stakeholders. It will help law enforcement officials to more effectively identify and prevent suspicious activities and use the full range of tools and authorities provided by the Affordable Care Act and other essential statutes to combat and prosecute illegal actions.

CMS is also committed to engaging our beneficiaries because alert and vigilant beneficiaries are able to detect and prevent fraud as it occurs. Information from beneficiaries and other parties helps us to quickly identify potentially fraudulent practices, stop payment to suspect providers and suppliers for inappropriate services or items, and prevent further abuses in the program. CMS is making it easier for seniors to help us fight fraud. In March 2012, CMS redesigned the Medicare Summary Notices, the explanation of benefits for people with Medicare fee-for-service, to make it easier to spot fraud or errors. The redesigned notices are available online,⁵ and will be mailed quarterly later in 2013.

Moving Forward

Medicare and Medicaid fraud affects every American by draining critical resources from our health care system. The Administration has made stopping fraud and improper payments a top

⁴The following organizations and government agencies are among the first to join this partnership: America's Health Insurance Plans, Amerigroup Corporation, Blue Cross and Blue Shield Association, Blue Cross and Blue Shield of Louisiana, Centers for Medicare & Medicaid Services, Coalition Against Insurance Fraud, Federal Bureau of Investigations, Health and Human Services Office of Inspector General, Humana Inc., Independence Blue Cross, National Association of Insurance Commissioners, National Association of Medicaid Fraud Control Units, National Health Care Anti-Fraud Association, National Insurance Crime Bureau, New York Office of Medicaid Inspector General, Travelers, Tufts Health Plan, UnitedHealth Group, U.S. Department of Health and Human Services, U.S. Department of Justice, and WellPoint, Inc.

⁵ <http://www.medicare.gov/help-and-resources/mail-about-medicare/medicare-summary-notice.html>

priority. Today, we have more tools than ever before to move beyond “pay and chase” and implement strategic changes in pursuing and detecting fraud and abuse. We are focused on preventing fraud before it happens by stopping fraudsters from enrolling or maintaining enrollment in Medicare or Medicaid, using sophisticated analytics to identify improper billing before claims are paid, and by rapid pursuit and implementation of administrative actions that are appropriate to the behavior. Our comprehensive program integrity strategy implements innovative data technologies and draws on expertise from across the country. As we integrate strategies and engage our Federal, State, and private sector partners, Medicare and Medicaid will become stronger, more effective programs. I look forward to continuing to work with you as we make improvements in protecting the integrity of our health care programs and safeguarding taxpayer resources.