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NEW TOOLS FOR CURBING WASTE AND FRAUD IN MEDICARE AND MEDICAID

HEARING

BEFORE THE

FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT INFORMATION, FEDERAL SERVICES, AND INTERNATIONAL SECURITY SUBCOMMITTEE

OF THE

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS UNITED STATES SENATE

OF THE

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

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NEW TOOLS FOR CURBING WASTE AND FRAUD IN MEDICARE AND MEDICAID

WEDNESDAY, MARCH 9, 2011

U.S. SENATE,
SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT,
GOVERNMENT INFORMATION, FEDERAL SERVICES,
AND INTERNATIONAL SECURITY,
OF THE COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2:33 p.m., in room 342, Dirksen Senate Office Building, Hon. Thomas R. Carper, Chairman of the Subcommittee, presiding.

Present: Senators Carper, Begich, Brown, Coburn, and Klobuchar.

OPENING STATEMENT OF SENATOR CARPER

Senator CARPER. I always rap my gavel like that and say that the hearing will come to order, but this one is already in order. This is a remarkably well behaved panel and audience, as well. The press is in line over there. It is nice to see all of you. Welcome. Thanks for coming today.

Sometimes our hearings are fairly timely, sometimes less so. But this is actually a hearing that is more timely than most. We are going to be voting, starting in about 30 minutes, on a Republican proposal, H.R. 1, to reduce budget deficits in the next half-year or so and even beyond and a Democratic alternative to that proposal. So this is something that we are focused on a great deal. And what we are going to be talking about here today is Medicare and Medicaid and our ability to get better outcomes for less money. How does that actually affect our debate in the Senate today and the folks that are served by Medicare and Medicaid?

We still face in this country considerable economic challenges. The economy is coming back. We added about 230,000 private sector jobs last month and we are encouraged by that. That is the good news. The bad news is our national debt stands at about $14 trillion. It has pretty much doubled in the last decade or so.

One of the things we look at is debt as a percentage of Gross Domestic Product (GDP), and if you look at our debt as a percentage of GDP, it is about 65 percent. I think the last time it was that high was maybe the end of World War II. That is the highest it has ever been, so we are on treacherous, treacherous ground.

Some other countries that run very high debt as a percentage of GDP are places like Greece and Ireland, and we are reminded what

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happened to them and their economy. So we are on some thin ice here. We need, clearly, to work on that, and hopefully we will find a way today to help out.

A wide variety of ideas have been put forward on how to reduce our budget deficit and begin whittling down our debt. Last fall, a majority of the bipartisan Deficit Commission appointed by the President—and it is known as the Bowles-Simpson Commission for Erskine Bowles and former Senator Alan Simpson—provided us with a road map to reduce the cumulative Federal deficits over the next decade or so by about $4 trillion. A number of the steps that we would need to take to accomplish this goal are going to be painful. And while most Americans want us to reduce the deficit, determining the best path forward is not going to be easy.

Many Americans believe that those of us here in Washington are not capable of doing some of the hard work we were hired to do, and that is to effectively manage the tax dollars with which we have been entrusted. They look at the spending decisions we made in recent years and question whether the culture here is broken. They question whether we are capable of making the kind of tough decisions that they and their families—our families—have to make on a regular basis for their own budgets. I do not blame people around the country for being skeptical.

I think we need to establish a different kind of culture here in Washington when it comes to spending. A lot of people think what we have here is a culture of spendthrift. We need to replace that with a culture of thrift. We need to look in every nook and cranny of Federal spending, whether it is domestic programs, defense programs, entitlements, oh, gosh, tax expenditures, tax credits, tax deductions, we need to look at all of that and ask the question, is it possible to get better results for less money? And if that is not possible, is it possible to get better results for the same amount of money?

Today, we are here to examine the steps that have been taken and should be taken to save literally billions of dollars in waste and fraud in Medicaid and Medicare. Medicare and Medicaid are, two vital programs that provide health care for a lot of our Nation's seniors, people with disabilities, low-income children, among others.

I was surprised to learn a number of years ago that the majority of money that we spend in Medicaid is not just for largely mothers and their children. The majority of money spent in Medicaid is for folks that spend down the value of their money, their assets, and they are, in many cases, folks who are going to end up in a nursing home, and a lot of money that we put into Medicaid helps to pay for those bills.

But last year, Medicare paid about $509 billion, over half-a-trillion dollars, to care for some 47 million beneficiaries. Think about that. Over half-a-trillion dollars to pay for almost 50 million beneficiaries. Medicaid expenditures for the Federal Government and our States was an additional $381 billion, almost $400 billion. Those numbers are expected to grow as our population grows older.

Americans' increasing reliance over time on Medicare and Medicaid presents another opportunity for criminals to take advantage of lax anti-waste and anti-fraud controls, and they do try to take

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advantage, as we know all too well. Medicare made an estimated $47.9 billion in improper payments in fiscal year 2010. We have a chart that indicates that.

One of our new laws that we passed last year, signed into law by President Obama, is one that says all Federal agencies have to keep track of improper payments, mostly overpayments. They have to report improper payments. They have to reduce improper payments. And they have to go out and recover the money from those improper payments.

How much in Medicare last year alone? Almost $48 billion. How much in Medicaid last year alone? About $22.5 billion. So we are talking about real money here. And this does not even include an estimate for the Medicare prescription drug program. I think this is Medicare A, B, and C. I do not believe it includes Medicare Part D, which I am told could add even maybe another $5 billion to that total for improper payments. For Medicaid, the improper payments, again, totals about $22.5 billion.

Moreover, Attorney General Eric Holder estimates that Medicare fraud totals as much as $60 billion each year—$60 billion just from fraud, criminal activities, largely—and Medicare and Medicaid continue to be on the Government Accountability Office's (GAO's) list of government programs at risk. The new At-Risk List has come out again just recently. They do it every year. But at risk for waste, fraud, and abuse. They have been on the list—Medicare, I think, and Medicaid have been on the list for maybe 20 years.

As improper payments occur, as most of you know, when an agency pays a vendor for something it did not receive or maybe even pays them twice. It can occur when a doctor is reimbursed by Medicare for a procedure that never took place or perhaps one that was not necessary and should not have taken place at all. These kinds of mistakes occur every day across the country. What disturbs me about the problem here in the Federal Government is that we seem to make expensive, often avoidable mistakes at a rate much higher than a business or the average family would tolerate or could afford.

So it is easy to see how urgent it is that we step up the pace of our efforts with Medicare and Medicaid, that we sharpen our pencils and eliminate to the best of our abilities the problems that lead to waste and fraud. Success in doing so will help us get closer to our deficit reduction goals.

It will also lengthen the life of the Medicare Trust Fund, now forecast to run out of money, I think, in 2029. The changes we made in the health care reform law actually extended, if you will, the date that the Medicare Trust Funds run out of money by about another 8 years, I am thinking from 2017 to 2029, but we will get some confirmation of that.

The good news is that we are seeing renewed commitment to curb waste and fraud in Medicare and Medicaid. President Obama and Secretary Sebelius have set a goal of reducing the Medicare fee-for-service improper rate by, get this, 50 percent by 2012. That is pretty ambitious, very aggressive. It represents the kind of goals that we need and we applaud that.

Congress has also put Medicare waste and fraud in its sights. The Affordable Care Act, which was enacted about a year ago, in-

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cludes a number of provisions aimed at enhancing our efforts to fight waste, fraud, and abuse in Medicare and Medicaid. Central to the new law is a goal to obtain better results in health care for less money. Eliminating avoidable mistakes and cracking down on fraudsters will be an important element in achieving that goal.

The new Affordable Health Care law calls for dramatically improving screening of Medicare providers. The measure also aims to stop payment to providers before payment is made when there is credible allegations of fraud. This ends a practice often called pay and chase in which a provider is paid and then chased down later once an error or fraud was detected. So the idea is to do something before we actually make that payment and have to begin the chase.

The new law also extends Recovery Auditing Contracting (RAC), which involves the use of private contractors who comb agency books for improper payments and then seek to recover them. CMS has had considerable success with this tool in the past, recovering roughly $1 billion in Medicare fee-for-service improper payments in just five States, I believe, during a pilot project. That effort is now being expanded to all of Medicare and Medicaid and to all 50 States.

CMS is also working to implement other program changes, such as increased support for the Senior Medicare Patrol (SMP) and the strengthening of controls over the Medicare prescription drug program. The men and women who run Medicare and Medicaid are making strides in fixing many of the problems in those programs that lead to waste and fraud, but we have a long way to go.

Today, we have been joined by a number of witnesses—five of them, in fact—who are each trying to do their part in the efforts underway. We have witnesses from law enforcement to describe how we catch fraudsters. We have witnesses to describe how we can prevent waste and fraud before it happens. We are also pleased to welcome this afternoon someone who works directly with seniors in Delaware to identify fraud through the Senior Medicare Patrol.

We are here today in large part because I believe that we have a moral imperative to ensure that our Medicare and Medicaid beneficiaries have access to quality care and at the same time that the scarce resources that we put into those programs are well spent. Eliminating waste and fraud is the right thing to do, as well, both for the health of those two programs and for our Federal budget as a whole. Each and every one of us can agree on that point, and I hope on a great deal more.

Now, with that having been said, let me turn, if I may, to Senator Brown, our Ranking Member on this Committee, for any comments that he would like to make. Senator Brown, welcome. Thanks for joining us.

OPENING STATEMENT OF SENATOR BROWN

Senator BROWN. Thank you, Mr. Chairman. I appreciate the opportunity to be here again and look forward to the hearing.

Just looking at your chart, it is just amazing to me that we can have that amount of improper payments, because when you look at—I mean, just an example, you take the credit card industry, which has over $2 trillion in transactions per year, which is nearly the size of the health care sector, and there are more than 700 mil-

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lion credit cards in circulation, there are millions of vendors and countless items that can be purchased with a credit card, yet the credit card fraud is a fraction of one percent.

And I am shocked that the government cannot do it better. I mean, in doing the research and being on the Committee with Senator McCaskill, we dealt with a lot of these things and you hear—if you go through the historical records, you actually see that we are doing the same thing, like, 10 years later. There has been no change, really, substantial change. The numbers are bigger, and now here we are. We are expanding the program to the point where the opportunity for improper payments and waste, fraud, and abuse is just so much greater, it is scary.

I have very deep concerns that—and we just keep talking and talking and talking about this stuff instead of somebody putting their foot down and saying, oh, yes, before we send the money out the door, we are going to find out if they are actually entitled to it. Oh my goodness. Is that not a novel idea.

And I want to thank you for your leadership on this because I intend to make the oversight of our entitlement programs the primary objective of my tenure here on the Subcommittee. And as waste, fraud, and abuse undercuts the vitality of these programs. The people that need it most are not getting the money. I mean, just that alone—and that is just the tip of the iceberg.

And I want to thank you, as we have spoken privately on this issue. I know how dedicated you are on these, and Senator Coburn and others. We care very deeply, Senator Klobuchar. That is why we are here to kind of bang away at this problem and fix it, especially when the dollars are so sparse.

And experts estimate that there are potentially upwards of $100 billion in fraud, waste, and abuse in Medicare and Medicaid combined. This is more than the Gross Domestic Product of three-quarters of the world's countries, to put it in perspective, and with any large government program, Medicare and Medicaid are prime targets for those who want to commit waste, fraud, and abuse, and health care fraud is not a victimless crime, either. It inevitably translates into higher premiums and costs for everybody.

The Patient Protection and Affordable Care Act (PPACA) expands Medicaid coverage, as we all know, by over 16 million people by 2019. That is a 32 percent increase over the current enrollment, and the cost of Medicaid expansion is expected to exceed $430 billion over the next 10 years. Well, if that happens, what happens to those numbers, Mr. Chairman? Are they going to stay the same? Are they going to go down? When does it get better? When do we start to focus on these things?

I know there are a lot of good people here. They are new. But that is the problem. We just keep kicking the can down the road a little bit. It is very frustrating.

I know the administration has introduced a variety of new program integrity measures into the law and I am greatly appreciative of that and it is intended, obviously, to reduce the amount of fraud in the health care program. Yet while an improvement, they are only a drop in the bucket in light of the incredible wave of health care spending, and the history of lax oversight in these programs

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does not give me much confidence right now and I believe that more needs to be done, and quite frankly, done very quickly.

These issues, for example, the previous expansions of government health care benefits, such as those for Medicare Part D, also included new integrity measures for the Centers for Medicare and Medicaid Services (CMS). Unfortunately, their track record for implementing these new measures on a timely basis, I feel, and others, as well, that they are spotty, at best. Congress has extended the Part D prescription drug benefit in 2003, yet the GAO reported as recently as last year that the oversight of the $51 billion program was limited. I mean, we are talking billions.

When I go back home and I say the numbers that we throw around here, they are just shocked that a billion is like a hundred bucks. Sometimes we lose track of what real money is. And when we are talking about cutting—what are we talking, Tom, about, $61 billion? Is that the House number? Well, it is right there, folks. It is right there. That is it right there. I mean, to put it into perspective, we would not have to do A if we could get B under control.

Senator COBURN. We have to do both.

Senator BROWN. Yes, thank you. I knew you would say that. We have to do both. I do not disagree with that. But before we can do one, can we not do the other? We can do something.

The 2010 Department of Health and Human Service (HHS) Financial Audit revealed shortcomings in both the Department's information technology (IT) and the financial systems. Now, there is a question whether they will be able to actually handle the robust increase of new demands placed on it by the Health Care Act. We cannot afford this wait and react approach any more. We have to be proactive, before the money gets out the door. I have never seen anything like it. Not only do we give them the money, then we have to pay someone to go chase the money. And then sometimes we will not only do that, we will renew their contracts and give them a bonus. What a job, if you can get it.

So the implementation of an effective program integrity system must ensure effective deterrence against these potential criminals while also protecting providers from overly burdensome regulations. And this expansion of the government's role is already straining our Nation's already dire financial situation.

I know that we have a lot of problems, folks, but I really do not want to hear today the same type of stuff. I mean, I have the historical records. I went down, and I am anxious to see what your testimony is so I can say, yes, back in 1992, they said the same thing, based on the previous report.

So I appreciate the opportunity to speak and look forward to participating.

Senator CARPER. Yes. I am just grateful that you are sitting here and that we are going to work on this together.

One of the things that was different, in 1992, we did not know how much the improper payments were from agency to agency across the Federal Government. In 2002, we did not know what they were, either. Today, we know that improper payments for last year in the whole Federal Government, as best we could tell, without the Department of Defense (DOD), without Medicare Part D,

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was about $125 billion. We know from Medicare, it was about $48 billion. That is not counting Part D. For Medicaid, it is $22.5 billion. We actually know that now.

One of the things that is different, I would say to Senator Brown, my colleague——

Senator BROWN. Is you are here.

Senator CARPER. No, that we are here. And Tom Coburn is here and Senator Klobuchar is here.

But the thing that is different now, the Federal Government, agency by agency, is required to report their improper payments. They are required to stop them. We are going to evaluate the performance of managers within these Departments by the kind of job that they do in reducing improper payments. We are going to evaluate by what kind of job they do in going out and recovering improper payments.

And finally, we have had the Administration come here and say on the record, and the President has already said this on the record, we want to reduce, cut in half, improper payments. Cut this number in half by 2012. That is encouraging.

And the other thing that I hope is encouraging is we are going to be providing whatever help we can to enable you to meet that goal. We are also going to be here to make sure that you do meet the goal to the best of your ability. Senator Klobuchar.

OPENING STATEMENT OF SENATOR KLOBUCHAR

Senator KLOBUCHAR. Thank you very much, and I wanted to thank you, Chairman, for inviting me into this Subcommittee.

Senator CARPER. It is almost like you are a Member. We like that.

Senator KLOBUCHAR. Well, I feel quite at home, because looking at that fugitive chart, I feel like I am back in Judiciary, where we often have those charts, and I really appreciate the leadership you have shown in these areas.

As we all know and as Senator Brown so strongly pointed out, one of the greatest contributors to wasteful government spending is fraud and abuse, and law enforcement authorities estimate that Medicare fraud costs about $60 billion every year. Last year, $4 billion was stolen from Federal health care programs, and that was recovered.

As a former prosecutor, this really bothers me, and I also look at it as coming from a State that, while we have had some prosecutions—I actually worked on one where we secured the conviction of a woman for bribing a county official and fraudulently billing Medicaid for services that were never provided—but coming from a State that has a well-organized health care system with high quality, lower cost care, one of the things I know is that some of the hot spots—and I learned this term in Judiciary from some of our Justice Department people—the hot spots tend to be in areas where they have less organized health care systems. I know Florida has some hot spots down there.

And that the answer to all of this is the work that we are going to be doing with Senator Carper and others, but it is also about doing a better job of having more organized health care systems, some of which we started out with in the health care bill, but a lot

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more work has to be done with how these delivery systems coordinate with each other so there are other watchdogs besides just the government. I believe that is why we have less fraud in Minnesota than in some of the other States.

Another tool to use is that CMS must take steps to consolidate its databases, allowing for more data sharing and efficient use of technology. Creating these types of claims databases will help us better identify potential sources of fraud.

I also introduced the Improve Act with Senator Snowe that requires electronic payments for Medicare and Medicaid. We were able to include this requirement for Medicare in the health care reform bill, but still more work needs to be done with the Medicaid bill, because you all know that if you have these electronic payments, you are not going to have these checks go to storefronts. Then you have to watch where the electronic payments go, but you can greatly reduce fraud with the electronic payments.

So I want to thank the witnesses for being here. I look forward to hearing this update and look forward to working with Senator Carper and Senator Brown and others on this very important issue. Thank you.

Senator CARPER. Always happy to welcome you. Thank you for your good work.

Senator Coburn, you have been working these vineyards for at least 6 years here and I have been pleased to work with you on a bunch of that stuff. We are always delighted to have you here, Tom. Welcome.

OPENING STATEMENT OF SENATOR COBURN

Senator COBURN. Well, it is an appropriate time, Mr. Chairman, to have the hearing. I have seen Dr. Budetti and Inspector General Levinson more than I have my wife in the last week. [Laughter.]

I saw them before the Finance Committee, as well.

I would mention to you that Senator Carper and I are working on a very substantive addition on fraud, and we have been working on it for about 5 months, I think, and hopefully we will put that in front of the GAO and get their comments and in front of you before we release it. But we all know there are areas to go.

My big problem is Medicare as it is currently designed is designed to be defrauded. I mean, if you just set at it, you could not set up much of a better system than this one to defraud it. I applaud some of the changes the administration is making. I applaud the Justice Department, where they have been aggressive in going after some of this. The more aggressive we are and the greater the consequences for defrauding or abusing or wasting Medicare dollars will send a signal.

So I am pretty pleased with the direction we are going. I think you still need some more tools and look forward to working with you and thank you for being here.

Senator CARPER. Dr. Coburn, thanks very, very much.

Let me just briefly introduce our witnesses, if I may.

Dr. Peter Budetti, no stranger to a bunch of us, is our first witness today. Dr. Budetti is the Deputy Administrator and Director for Program Integrity at the Centers for Medicare and Medicaid Services. He is responsible for program integrity policies and oper-

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ations in both the Medicare and Medicaid programs. Dr. Budetti has a long history in the health care arena as a pediatrician, in government, and as Chairman of the Board of Directors of the Taxpayers Against Fraud, as well as a professor at the University of Oklahoma. We thank him for being with us today.

I went to Ohio State. I understand you have an OSU in Oklahoma, too.

Dr. BUDETTI. We have the real OSU. [Laughter.]

Senator CARPER. The guy who used to be President of Ohio State is now the President of Oregon State University. I like to tell him he has one more to go, OSU and U State, and he would have the hat trick, so we will see.

Greg Andres, our second witness, is from the Department of Justice (DOJ) and the Acting Deputy Assistant Attorney General in the Criminal Division. Mr. Andres oversees the Fraud Section, the Appeals Section, the Capital Case Unit, and the Organized Crime and Racketeering Section. You are a busy man. Mr. Andres has been involved in prosecuting many of the bad guys we will talk about today regarding Medicare fraud during his distinguished career at the Department of Justice. I would also note that Mr. Andres served in the Peace Corps in West Africa, and we thank you for that and we thank you for joining us today and for your service.

Inspector General Daniel R. Levinson. Mr. Levinson is the Inspector General of the Department of Health and Human Services. Mr. Levinson has been Inspector General of Health and Human Services for nearly 7 years, leading the important work overseeing Medicare and Medicaid and other Department programs. Mr. Levinson has a long history of public service. We appreciate very much your being with us here today.

And next is Kathleen King. Ms. King is a Director of the Health Care Team at the U.S. Government Accountability Office, affectionately known as GAO. Ms. King is responsible for leading various studies of our health care system, specializing in Medicare management and prescription drug coverage. Ms. King has over 25 years of experience in health policy and administration. I am happy to note that we learned in a previous hearing that Ms. King grew up in Wilmington, Delaware, graduated from Ursuline Academy High School. We thank her for being here today. You could only turn out well with that kind of background.

Finally, we are delighted to welcome Ms. Helen Carson, who is a Volunteer Coordinator and Case Manager at the Delaware Senior Medicare Patrol. Ms. Carson came to work at the Senior Medicare Patrol after first seeking help from the program, then decided to work as a volunteer and was later hired on to help other volunteers. She is one of the people on the front lines fighting fraud in Delaware, and there are a lot of people like her around the country—not enough, though, I would say. But I note that her home town, again, is Wilmington, and she now resides near New Castle, a place where I bought my first home when I was just a pup coming out of the Navy. Ms. Carson, we are pleased to have you here today.

All of you, welcome. Your entire testimony is going to be made part of the record. Feel free to summarize. If you go much more than 5 minutes, we will try to rein you in. We will start voting

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probably around 3:00, but we will finish a couple of testimonies and then run and vote and come right back.

Dr. Budetti, why do you not lead off. We are happy you are here. Thanks.

TESTIMONY OF PETER BUDETTI,[1] M.D., DEPUTY ADMINISTRATOR AND DIRECTOR, CENTER FOR PROGRAM INTEGRITY, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Dr. BUDETTI. Thank you very much, Chairman Carper, Senator Brown, Senator Klobuchar, Dr. Coburn, for this opportunity. I appreciate this opportunity to come and discuss with you what we are doing in the Centers for Medicare and Medicaid Services.

Ever since I had the privilege of taking this job a little over a year ago, I have been asked two questions. Why do you let crooks into the programs? And why do you pay their claims when you think they are fraudulent? I am very pleased to be able to tell you that, with the tools that we have now and that we are putting into place under the Affordable Care Act and through other legislation, we are going to do things that will put a stop to both of those. We are going to keep out the bad guys without making things worse for the honest providers, and we are going to cut off payments that should not be made.

Under the leadership of Secretary Sebelius, she reorganized the Centers for Medicare and Medicaid Services, realigned them into four Centers, one of which is the Center for Program Integrity. This consolidated Medicare and Medicaid Program Integrity together for the first time. This is a very important step, I believe, both organizationally and symbolically because it speaks to the seriousness of our anti-fraud efforts and it also provides notice to would-be fraudsters that we do, in fact, take this very seriously.

Also, this reorganization has provided new opportunities for us to collaborate with our law enforcement partners, and so I believe we are indeed on the road that many of you alluded to, to making things different.

I would like to draw your attention to our chart. I think you have copies of this. But this tells you exactly what we are doing in terms of moving from where we have been to where we are going.

First of all, we want to move from what you mentioned, Mr. Chairman, the pay and chase mode, into preventing fraud, and the way that we are going to move to preventing fraud is to keep the people out of the program who should not be there and to cut off payments that we should not make.

Second, we do not want to take a monolithic approach, a one-size-fits-all approach. We want to target our resources to the real problems, to identify the real problems, and to be focusing our efforts on the bad actors.

Third, we are taking advantage of new technology and we are going to be moving quickly to take administrative action as well as referrals to law enforcement.

Fourth, consistent with this administration's commitment to transparency and accountability, we are developing performance measures that will spell out what we hope to achieve, what we will

[1] The prepared statement of Mr. Budetti appears in the appendix on page 48.

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achieve, and will lay out what our goals are and what we are going to accomplish.

And five, we are actively engaging the private sector, our private partners, to work with us across the spectrum because we know that although the public programs are certainly targeted by scams and scam artists, so, too, are the private programs and we need to join together to fight against this.

And finally, we are committed to coordinating and integrating the program activities across the Centers for Medicare and Medicaid Services in order to get more effective and more coordinated activities underway.

To do this, we need to focus on several things. We need to do a better job of preventing bad actors from enrolling in Medicare. We need to act quickly in concert with our law enforcement partners to cut off payments that are fraudulent. And we need to do this—and I would stress this point—that as we crack down on those who would commit fraud, we are mindful of the necessity to be fair to health care providers and suppliers who are our partners in caring for beneficiaries, and to protect beneficiary access to necessary health care services. This requires striking the right balance between preventing fraud and other improper payments, but without impeding the delivery of critical health care services to beneficiaries.

We will always respect the fact that the vast majority of health care providers and suppliers are honest people who provide critical health services every day to millions of beneficiaries and we are going to target our anti-fraud efforts on the people who would commit fraud while reducing the burden on legitimate providers and saving public funds.

As this has proved to be a very good investment over the years. The Health Care Fraud and Abuse Control program (HCFAC) has had very substantial returns on investment over time. We know that the more that we look for fraud, unfortunately, the more we find, but the return on that investment has been very substantial and this year reached a new high.

I appreciate this opportunity to discuss what we are doing with you and I look forward to working with you in the future. Thank you very much.

Senator CARPER. Great. Thanks, Dr. Budetti.

Mr. Andres, please. And what we will probably do is, once you have completed your testimony, three or four of us will run and vote, make two votes, and come right back. Please proceed.

TESTIMONY OF GREGORY ANDRES,[1] ACTING DEPUTY ASSISTANT ATTORNEY GENERAL, U.S. DEPARTMENT OF DEFENSE

Mr. ANDRES. Chairman Carper, Senator Brown, and distinguished Members of the Subcommittee, thank you for inviting me to speak to you today about the Department of Justice's efforts to combat health care fraud. I am privileged to appear before you on behalf of the Department of Justice. The Department of Justice is grateful to the Subcommittee for its leadership in this area and we appreciate the chance to testify here today.

[1] The prepared statement of Mr. Andres appears in the appendix on page 67.

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Health care fraud is a significant law enforcement problem. The Federal Government spends billions of dollars every day to fund Medicare and other government health care programs, and taxpayers rightly expect these funds to be used to provide health care to seniors, children, the poor, and the disabled. Most medical professionals work hard to comply with the rules, but too many doctors, nurses, and others in the health care industry devote their energies elsewhere, to schemes that cheat taxpayers and patients alike and defraud Medicare and other government programs.

At the Justice Department, together with our colleagues at the Department of Health and Human Services, we are fighting back. We investigate, we prosecute, and we secure prison sentences for hundreds of defendants each year, and we are recovering billions of dollars in stolen funds. With the additional resources provided to us by Congress over the past 2 years, we are making significant strides in this battle.

In fiscal year 2010, we collectively recovered a record $4.02 billion on behalf of taxpayers, $2.86 billion of which was deposited back into the Medicare Trust Fund. This represents a $1.47 billion, or 57 percent increase over the amount recovered in fiscal year 2009, which was itself a record at that time. Indeed, over the past 3 years, we have collectively recovered an average of $6.80 for every dollar of funding that Congress has appropriated for health care fraud enforcement.

The Justice Department has a multifaceted litigation approach to fighting health care fraud with the Criminal Division, the Civil Division, the Civil Rights Division, the U.S. Attorneys Offices, and the Federal Bureau of Investigation (FBI) all contributing substantial resources to this effort. Allow me for a moment to focus on our criminal enforcement efforts.

Criminal health care fraud enforcement is aimed at holding accountable doctors, nurses, health care providers, and others who conspire to cheat government health care programs, including Medicare and Medicaid. Today, our criminal enforcement efforts are at an all-time high. In fiscal year 2010, we brought criminal charges against 931 defendants, the most in any single fiscal year since the HCFAC program began, and approximately 16 percent more than in fiscal year 2009. Moreover, we secured 726 criminal health care fraud convictions, also the most in any year of the HCFAC program, and approximately 24 percent more than in fiscal year 2009. In short, the Justice Department is working hard and with great success to investigate and prosecute health care fraud wherever we find it.

We have been fortunate to receive important new tools for fighting health care fraud. In the Patient Protection and Affordable Care Act of 2010, Congress made several important revisions and additions to Federal statutes that the Justice Department uses in health care fraud cases. These changes are likely to have and are already having a significant impact on our health care fraud enforcement efforts.

For example, the Act clarifies that a defendant need not have been aware of a specific statutory provision in order to be convicted of violating the health care fraud statute or the Medicare anti-kickback statute. In addition, the Act directs the U.S. Sentencing Com-

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mission to make certain important changes to the Sentencing Guidelines that will increase sentences for health care fraud offenders. Finally, the Act provides significant additional funding for our collective health care fraud enforcement efforts.

Prosecuting health care fraud is a high priority for the Department of Justice. Every day, every single day, Federal prosecutors and law enforcement agents at the Federal, State, and local levels are working hard to investigate and prosecute those intent on defrauding Medicare and Government health care programs, and we have been successful.

Thank you for the opportunity to provide the Subcommittee with this overview of the health care fraud enforcement efforts. I look forward to answering any questions you may have.

Senator CARPER. Good. Thanks so much.

Mr. Levinson, go ahead and give us your testimony and then we will run to the vote. Thanks. Please proceed.

TESTIMONY OF DANIEL R. LEVINSON,[1] INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. LEVINSON. Good afternoon, Chairman Carper and Members of the Subcommittee. Thank you for the opportunity to testify about the efforts of OIG and our partners to combat health care fraud, waste, and abuse. I appreciate your support for OIG's mission to protect the integrity of HHS programs and their beneficiaries.

OIG has been leading the fight against health care fraud for more than 30 years in collaboration with the Justice Department and CMS. Thanks in part to the HEAT Initiative, we are making strides in preventing fraud, catching and prosecuting criminals more quickly, and assisting well-intentioned providers in complying with the law. Our efforts will be bolstered by the additional funding provided through the Affordable Care Act for the Health Care Fraud and Abuse Control, or HCFAC, program.

The HCFAC program is a prudent investment of taxpayer dollars. In fiscal year 2010, this program's activities returned an unprecedented $4 billion in fraudulent and misspent funds. Over the past 3 years, for every dollar spent on the HCFAC program, the government has returned an average of $6.80. The Affordable Care Act further augments our program integrity efforts by addressing vulnerabilities, strengthening enforcement, and encouraging greater coordination among Federal agencies.

Despite our successes, there is more to be done. Those intent on breaking the law are becoming more sophisticated and their schemes are more difficult to detect. Some fraud schemes go viral and they replicate quickly. They also migrate. As law enforcement cracks down on a particular scheme, the criminals may design it or relocate to a new city. When detected, some perpetrators have become fugitives, fleeing with stolen Medicare funds.

To combat this fraud, the government's response must be swift, agile, and well organized. My written statement describes in more detail our collaboration with CMS and DOJ, enhanced program integrity tools in the Affordable Care Act, and OIG fraud fighting ini-

[1] The prepared statement of Mr. Levinson appears in the appendix on page 79.

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tiatives. This afternoon, I will highlight just a few of those initiatives.

Our Medicare fraud strike forces are cracking down on criminals and fraud hot spots around the country. Since 2007, strike force operations have charged almost 1,000 individuals, involving more than $2.3 billion in Medicare billing. Just last month, strike force teams engaged in the largest Federal health care fraud take-down in history. The teams charged more than 100 defendants in nine cities, including doctors, nurses, and health care company owners and executives for fraud schemes involving more than $225 million in Medicare billing.

OIG has referred credible evidence of fraud to CMS to implement payment suspensions, helping to turn off the spigot to prevent dollars from being paid for fraudulent claims. OIG excludes fraudulent or abusive providers from Federal health care programs, cutting them off from Federal funds. We are now focusing on holding responsible those individuals who are responsible for corporate misconduct. This exclusion authority is a powerful deterrent to corporate fraud.

However, enforcement alone is not enough. We are also engaging health care providers to help prevent fraud and abuse. For example, we are conducting free training seminars in six cities this spring to educate providers on fraud risks and share compliance best practices. We recently published a Roadmap for New Physicians. It provides guidance on how doctors should comply with fraud and abuse laws in their relationship with payers, vendors, and fellow providers.

We are also asking the public to help us track down Medicare fraud fugitives. We have posted online OIG's Ten Most Wanted health care fraud fugitives, including photographs and details on their fraud schemes, and you can see our current "Most Wanted" list on display here today. We hope the public will help us bring these individuals to justice by reporting any information about their whereabouts to our Web site or fugitive hotline.

In conclusion, OIG is committed to building on our successes, employing all oversight and enforcement tools available to us, and maximizing our impact to protect our health care programs, the people served by them, and American taxpayers.

Thank you for your support, Mr. Chairman, and I welcome your questions.

Senator CARPER. Thank you so much.

We will take a break here. We will be back in about 15 minutes and, Ms. King, you will be on. You are the batter on deck. Thanks so much. [Recess.]

All right. I think that is the voting for a while. We will hopefully have a chance to maybe complete this hearing. I sure hope so.

We are back in session, and Ms. King, you are recognized. Please proceed. Thank you.

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TESTIMONY OF KATHLEEN KING,[1] DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Ms. KING. Mr. Chairman, thank you for inviting me to speak with you today about provisions of recently enacted laws and agency actions that may help to reduce fraud, waste, and abuse in Medicare and Medicaid.

Fraud represents intentional acts of deception with knowledge that the action or representation could result in an inappropriate gain. Waste includes inaccurate payments for services, while abuse represents actions inconsistent with the acceptable business or medical practices. An improper payment is any payment that should not have been made or was made in an incorrect amount and includes both overpayments and underpayments.

I was asked to address whether recently enacted laws could help CMS in preventing fraud, waste, and abuse. Congress has recently passed a few laws, as you mentioned, the Improper Payments Elimination and Recovery Act, the Patient Protection and Affordable Care Act, and the Small Business Jobs Act, which provide additional authority and resources and impose new requirements designed to help CMS reduce improper payments.

In previous work, we have identified five strategies to reduce improper payments. They are: strengthening provider enrollment and standards; improving prepayment review of claims; focusing postpayment review on those most vulnerable areas; improving oversight of contractors; and developing a robust process for addressing identified vulnerabilities.

The provisions in PPACA, if properly implemented, could aid CMS's efforts to reduce improper payments. We also note that CMS has not implemented some of our recommendations in this area, which we believe merit continued consideration.

With respect to provider enrollment, the law contains multiple provisions designed to strengthen the enrollment process. It requires the Secretary of HHS to establish procedures for screening providers enrolling in Medicare, including assessing their potential risk levels. Moderate and high-risk providers may be subject to unannounced site visits. CMS has categorized home health agencies (HHA) and durable medical equipment (DME) suppliers as high-risk providers, which we believe is appropriate given our work in this area.

The law also requires all providers to be subject to licensure checks, including across State lines, and it also authorizes the Secretary and the States to impose a moratorium on enrollment if they believe it is necessary to prevent fraud, waste, and abuse.

With respect to prepayment review of claims, our work has shown that such reviews are essential to help ensure that Medicare pays correctly the first time. Conducting these reviews is challenging because of the volume of claims. Medicare pays approximately 4.5 million claims every business day and less than one percent of these claims are subject to review by trained medical personnel.

The Small Business Jobs Act requires CMS to use predictive analytic technologies both to identify and prevent improper payments.

[1] The prepared statement of Ms. King appears in the appendix on page 88.

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By analyzing Medicare provider networks and billing patterns and beneficiary utilization patterns, these technologies may help CMS detect potentially fraudulent activity and conduct additional reviews before making payment.

In addition, CMS is implementing a 2010 Presidential memorandum known as the "Do Not Pay" list, that directs agencies to consult these lists before making payments to ensure that payments are not made to providers who are dead or entities who have been excluded from Federal payment.

We have also found that post-payment review is critical to identifying payment errors. Steps could be taken to improve post-payment review, including focusing these reviews on the most vulnerable areas and by adding recovery auditing. The law directed that CMS expand its Recovery Audit, or RAC program, to Medicare Parts C and D and to Medicaid.

With respect to improving oversight of contractors, the law included new requirements for CMS to evaluate contractors receiving Medicare and Medicaid Program Integrity funding every 3 years, and for these contractors to provide performance statistics to the OIG and HHS on request.

One area where more progress is needed is having a robust process for identifying vulnerabilities that lead to improper payments. Our work on the Medicare RAC program found that CMS had not established an adequate process to address these vulnerabilities.

In conclusion, the enactment of these laws as well as agency actions gives CMS new tools for fighting fraud, waste, and abuse, but effective implementation of them is critical.

Mr. Chairman, this concludes my prepared statement. I would be happy to answer any questions. Thank you.

Senator CARPER. Great. Thanks so much. Thanks for your good work on this and all your help.

Ms. Carson, welcome, Helen Carson.

TESTIMONY OF HELEN CARSON,[1] VOLUNTEER COORDINATOR AND CASE MANAGER, DELAWARE PARTNERS OF SENIOR MEDICARE PATROL

Ms. CARSON. Good afternoon, Senator Carper and staff. Thank you for convening these hearings for the opportunity to present my testimony today.

The National Senior Medicare Patrol has been very busy since its inception in the mid-1990s. In Delaware, the Senior Medicare program began in 1999. Today, there are 54 Medicare Patrol programs, one in every State as well as the District of Columbia. Senior Medicare Patrol programs recruit and train senior volunteers and Medicare beneficiaries to conduct outreach and education to their peers, caregivers, and professionals about Medicare and Medicaid fraud prevention.

The goals of Senior Medicare Patrol are twofold. First, to educate and motivate consumers on how to prevent, detect, and report health care fraud, errors, and abuse, and second, to receive and prepare to refer appropriate complaints of potential health care fraud.

[1] The prepared statement of Ms. Carson appears in the appendix on page 118.

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I would like to begin with my health care victimization story. After a history of cardiac issues, my husband had a heart attack in 2004 and was hospitalized. It was discovered he had a defective device controlling his heart. Costly errors by the hospital resulted in an original 2-day stay turning into 30 days of multiple testing, a serious operation, and intensive care. As a result of this situation, the impact of our lives amounted to my husband not being able to work, leaving us with large copayments, private hospital bills, and costly medication. We had no other choice but to refinance our home and use credit cards with minimal payments. Another major decision I made during this time period was to personally forego a year without medication for chronic conditions so that my husband could get life-saving medication.

It was this experience that inspired me to learn about billing, to read Medicare Summary Notice (MSNs), and to help others with issues of health care error, fraud, and abuse. Medicare Summary Notice is a quarterly statement of service and supplies that providers and suppliers bill to Medicare. While trying to cope with this situation, I watched a Senior Medicare Patrol segment on television on how to address some health care issues.

As a result, I became a Senior Medicare Patrol volunteer and now a part-time Volunteer Service Coordinator Case Manager for Delaware Partners of Senior Medicare Patrol. I became a self-advocate and now assist others in recognizing hospital billing errors and questionable medical service. I used to be one of those seniors who threw away the Medicare Summary Notice because I thought my insurance would take care of anything. Now, I know better and realize that the Medicare Summary Notice can be a big help in assisting with cases of potential Medicare fraud.

There are many Medicare rules that are complicated and, therefore, seniors often do not understand the Medicare system. That is why the Senior Medicare Patrol reaches out to Medicare beneficiaries to inform and educate so seniors can be self-advocates, and report questionable health care issues back to the program.

In Delaware, we are working on many complaints involving durable medical equipment providers. A senior resident contacted us about a durable medical equipment provider who was putting up flyers which advertised free durable medical equipment in a senior apartment building. The provider then came in and educated the seniors, pressuring at least one Medicare beneficiary to get an electric wheelchair for the future. This provider manipulated the individual to give out his Medicare number and supplementary insurance. As a result, this Medicare beneficiary has an electric wheelchair and fears that if he speaks with us, he may lose the wheelchair. This is potential fraud to the taxpayer and Medicare and a harm to the senior who feels caught in the fraudulent process.

In another case, an assisted living beneficiary was billed for Medicare services not provided by a facility physician. These services included office visits to the physician and foot surgery. All the services were billed to Medicare and secondary insurance and the beneficiary. The beneficiary kept a log of services he received. He was then able to reconcile his record against the monthly Summary Notice. The beneficiary was fearing retaliation and charges from the assisted living facility and did not report the fraud until inter-

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vention by Senior Medicare Patrol staff. The case was referred to law enforcement for investigation.

Working with Senior Medicare program as a volunteer, and now as a team member, is the most rewarding job I have ever had. I help people who suffer the same problems that I faced, and some are much greater than mine. But the greatest gift is to see the smile on their face after you have helped a Medicare beneficiary who was victimized by health care fraud, abuse, or waste. I should know, because I have been a victim and have felt that sense of hopelessness.

SMP volunteers know they do this work for satisfaction and not pay, and the impact of these volunteers' efforts nationally has been impressive. Since it started in 1997, the Senior Medicare Patrol program has trained over 6,000 volunteers, handled over 141,000 beneficiary complaints, and educated 2.9 million people to be self-advocates. In addition, the program has saved Medicare, Medicaid, and beneficiaries close to $106 million through referral and resolution of beneficiary complaints.

Thank you for inviting me to be a part of this panel.

Senator CARPER. Great. Ms. Carson, thank you so much for sharing that with us.

I just want to start my first question with you, if I may. How many people did you say have been trained to be part of the Senior Medicare Patrol? Did you say 6,000?

Ms. CARSON. Yes.

Senator CARPER. That is across the country?

Ms. CARSON. No, 60. Sixty.

Senator CARPER. Sixty-thousand? That is across the country?

Ms. CARSON. That is across the country.

Senator CARPER. Over the last, what, dozen or so years?

Ms. CARSON. Seven years.

Senator CARPER. Over these last 7 years.

Ms. CARSON. Yes.

Senator CARPER. OK. Do you think that is enough?

Ms. CARSON. No.

Senator CARPER. What might be enough? What should be our goal in terms of recruitment?

Ms. CARSON. Well, what is going on in our State—I can only talk about Delaware—our senior population is growing in the Sussex County of Delaware.

Senator CARPER. That is Southern Delaware for those who do not know.

Ms. CARSON. Yes. Because we are a tax-free State, what is happening is that a lot of seniors are moving to the Sussex area of Delaware, and because of that, we are the seventh, I think—we have the seventh largest population of seniors in the Nation.

Senator CARPER. Any idea how many—we have got 60,000 that we have trained. How many folks could we use to be part of the Senior Medicare Patrol? Could we use a couple hundred thousand across the country?

Ms. CARSON. I think we can use that and more.

Senator CARPER. Yes. And how would you suggest we go about recruiting them?

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Ms. CARSON. Well, first of all, actually putting our program more out there, that people are aware that we are there, and that we have volunteers that are lawyers. We have volunteers that were former chemists. We have volunteers that are former hairdressers. We have——

Senator CARPER. Any former Senators?

Ms. CARSON. Yes. [Laughter.]

Senator CARPER. You will take us, too?

Ms. CARSON. Yes, we will take you, too.

Senator CARPER. All right. It is all well and good that Dr. Budetti and his folks are taking advantage of the new laws we have, whether it is improper payments and the kind of resources that are provided in the Affordable Care Act. It is all well and good we have the Government Accountability Office, GAO, doing their oversight. We have the IG helping us out on this stuff, and we are trying to do oversight.

But boots on the ground—we need boots on the ground, as well, and one of our jobs is figuring out how to grow this operation to get more—we have tens of millions of senior citizens in this country and some of them are looking for things to do, worthwhile things to do with their time, and most of them do not even know this program was there. Maybe we could do a better job of acquainting them with that and making sure they have the opportunity to do what you have done with your life. Good. Thanks.

I have a question—we have been joined by Senator Mark Begich from Alaska, one of how many Marks in the U.S. Senate?

Senator BEGICH. There are five now.

Senator CARPER. Five. There are more Marks in the U.S. Senate, ladies and gentlemen, than any other name. If you are not sure what a Senator's name is, call him Mark and there is a pretty good chance you will nail it. [Laughter.]

Senator BEGICH. You can join the caucus. [Laughter.]

Senator CARPER. All right. We will see.

My next question, if I can, is for Dr. Budetti. I want to talk about our work with the Medicare prescription drug program. We have a big problem with folks who were not supposed to be writing prescriptions to folks who should not have been getting them for controlled substances, and we, I think, are doing a better job of stopping that.

Could you just talk about what we are doing? I think it is a success, something we have been very active in putting a spotlight on, and I think you all have reacted in a way that is appropriate. Would you just want to talk about it, please?

Dr. BUDETTI. Yes, Senator. Thank you for that question. In the Medicare prescription drug program, we make our payments directly to the drug plans and then, of course, they pay for filling the actual prescriptions, and then they report to us certain information, which is what we use to oversee what they have been doing. In the reporting of that information, there have been identified problems with the identifiers that were used to track who it was that wrote the prescriptions.

We have made a lot of progress in terms of shifting from less effective to more effective identifiers and we are very much interested in looking at making sure that we can track back to be sure

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who the prescriber was of the prescription that was filled and make sure that it was appropriately prescribed, because we are paying for it through the drug plan. And so we are actively considering a rule that would move towards requiring the National Provider Identifier (NPI) be provided to us for us to be able to track that back. We do recognize that this is an area that needs attention and we are working on it very diligently.

Senator CARPER. Good. Let me follow up by asking a related question to Mr. Levinson, if I could. Let me just ask you, do you believe that the new steps to control some of this fraud with respect to Medicare prescription use, do you think the things that Dr. Budetti has been talking about, are they on the right track? Are the things that he is talking about, are they the appropriate things that should be done? Are there other steps that ought to be taken?

Mr. LEVINSON. Mr. Chairman, we think those are important steps, and indeed, the Part D program has vulnerabilities that need to be aggressively monitored and in many cases corrected. A very important part of our work is now and in the near future to look at how Part D sponsors, as well as the contractors who are supposed to oversee those sponsors, how they are doing their anti-fraud work to ensure that we can actually track the money better.

Senator CARPER. All right. Have any of you ever worked for a credit card company? Did anybody ever work for a credit card company?

Ms. CARSON. I have.

Senator CARPER. Is there anything we can learn from credit card companies in the way that they go after fraud? I remember when MBNA was a big credit card bank in our State, now part of Bank of America, but I remember talking to the CEO of the company maybe 10 years or so ago and saying, why do you keep hiring all these folks from the FBI, people retiring from the FBI and other law enforcement services? And I said, what do they know about credit cards? And he said, they do not know a lot about credit cards, but they are pretty good on fraud.

One of the things that we talked about at another hearing where Dr. Budetti and Senator Coburn and I were at not long ago was the idea of maybe putting together what we call a roundtable, which is sort of a hearing but it is an informal hearing, and bring in folks from the credit card industry who actually do this stuff every day. This is what they do 24/7 and are pretty good at it, to see what lessons we can learn from them, share with them what we are doing. Might that be a good idea?

Ms. CARSON. I think it would be an excellent idea. Actually, I come from the credit card industry myself——

Senator CARPER. Do you?

Ms. CARSON [continuing]. But I find that Medicare fraud and Medicaid fraud are quite different than what we were dealing with. It is much bigger.

Senator CARPER. Yes. Maybe there are some lessons learned from the financial services, from the credit card industry that are transferable. We are going to try—Dr. Budetti, any comments, and then I am going to yield to Senator Brown.

Dr. BUDETTI. Yes, Senator. As we have discussed, we are actively engaged with different private sector industries. We have looked at

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activities to fight fraud in the banking industry and in telecommunications. We are certainly interested in—we have a pilot project underway in DME where we are using swipe cards that will rely on credit card-like technology. We intend to build on that pilot to see what the results are and to move into this area in a way that we actually learn lessons first and then build on it. So this is something that we are delighted to continue this dialogue with you on, yes.

Senator CARPER. Great. OK. Let us do that.

All right. Senator Brown.

Senator BROWN. Thank you, Mr. Chairman. It is good to be back.

So I will just start with Mr. Andres, if we could. So you indicated that you, through the Justice Department, collected $4 billion of fraud through your Department and a couple of billion went back to, obviously, back into the program. Where did the rest of the money go?

Mr. ANDRES. The difference between the $4 billion recovered and the $2.86 billion that went back to the Medicare fund is the question of how much has actually been collected. So the $2.86 billion is the amount. The $4 billion——

Senator BROWN. Oh, so you got judgments for $4 billion——

Mr. ANDRES. Exactly.

Senator BROWN [continuing]. And you only collected that amount.

Mr. ANDRES. That is correct.

Senator BROWN. So in looking at the chart that the Chairman provided, I mean, we have substantially more billions and we have only collected $4 billion. Where is the difference in terms of the collection versus the actual improper payments? How do we get a better return on our dollar?

Mr. ANDRES. Well, I mean, in terms of prosecuting additional people for fraud, at the Justice Department, unfortunately, we are more on the back end of the process, where the fraud has already occurred, and we are prosecuting people. We are seeking forfeiture to the extent possible. But as you can imagine, it is not as though criminals, once they are able to defraud the program, keep that money locked in a bank or place where we can necessarily get at it. A lot of times, the funds have been dissipated. So while judges order restitution and we seek forfeiture——

Senator BROWN. Yes, typical collection issues.

Mr. ANDRES [continuing]. We are not able to always collect after a prosecution.

Senator BROWN. So are you satisfied you have the tools and resources you need to continue on with your job? Is there anything that we in the Congress can do for you?

Mr. ANDRES. So two things, Senator, and thank you for the question. In the Affordable Care Act, one of the provisions in the Act directed the Sentencing Commission to look at and revise the Sentencing Guidelines——

Senator BROWN. The Sentencing Guidelines to make it more——

Mr. ANDRES. Exactly, to increase it, and the Sentencing Commission has since made proposals, and so we would ask Congress to support those proposals.

And the second——

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Senator BROWN. Have you reviewed those and you are satisfied with those?

Mr. ANDRES. Yes, Senator.

Senator BROWN. OK. I will look at them.

Mr. ANDRES. Just to give you an example, they raised the—they will raise the jail time that is available for offenders in that category. So if you take an example of somebody who, for example, was involved in $23 million, or $20 to $25 million in fraudulent billing, the fact that they were involved in that amount of billing does not necessarily mean that they got that amount of money that they were actually paid. The guidelines now allow us to use the amount that they billed——

Senator BROWN. Right.

Mr. ANDRES [continuing]. As opposed to the amount that they were paid——

Senator BROWN. OK.

Mr. ANDRES [continuing]. And that is significant.

Senator BROWN. So noted. OK. Number two?

Mr. ANDRES. The second thing is that in the President's budget, there is additional funding for our strike forces and for our health care fraud enforcement efforts. As one of the other witnesses mentioned, the return on investment is almost seven dollars for every dollar spent on health care fraud.

Senator BROWN. OK.

Mr. ANDRES. We are returning seven dollars. So to the extent that we are able to continue our current efforts in the strike force process and able to expand where appropriate, we think that the strategy we have in the strike forces is working, and as was mentioned, we have arrested almost a thousand people since the inception of the strike force program.

Over the last year, we have had significant national arrests, one in July 2010. We arrested almost 90—more than 90 people. And then recently, in February, we arrested over 100 people in nine different cities. The fraudulent billing related to those arrests was over $200 million. In that same week, we had made other arrests in Miami and arrested another 20-some-odd defendants. And so the total billing related to the enforcement actions in that week alone was $400 million. So we think the strike force efforts are having great success, and we would like to be able to continue those efforts?

Senator BROWN. Is there an opportunity for my office to meet with somebody in your office to get kind of briefed as to what you are doing?

Mr. ANDRES. Certainly, Senator.

Senator BROWN. All right. Thank you.

So, Dr. Budetti, looking at—as I said, I went back. In 1992, HCFA, now CMS, it was reported by the GAO, testified at the House hearing that the lack of vigilance over contractor payment safeguard activities has left the program funds inadequately protected from loss and waste. So that was back in 1992. And currently, Medicare is designated by the GAO as a high-risk program and it has been so since the 1990s.

Looking at the chart, once again, that I appreciate was brought forth, I mean, can you instill confidence that your organization will

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address these problems, and if so, like, what has been done that we can really—because we have four billion here, but is there not a mechanism—unless I am just totally lost here, is there not a mechanism to identify whether it is a legitimate claim and before it goes out the door so we are not chasing it? Is there not a way to do that?

Dr. BUDETTI. Senator, thank you. We certainly share your concern about the magnitude of the issues that we are facing here——

Senator BROWN. And may I just interrupt one second——

Dr. BUDETTI. Yes.

Senator BROWN [continuing]. And I will certainly let you answer.

Dr. BUDETTI. Go ahead. Sure.

Senator BROWN. We just voted on a budget over there to cut $51, $61 billion. It is right there. As I said earlier, I do not get it.

Dr. BUDETTI. So, Senator, we really need to address two aspects of this problem, and I will briefly describe them. One is the numbers you are looking at up there, improper payments. Improper payments really span a spectrum from honest billing mistakes to other kinds of reasons why a payment should not have been made, and that requires one set of activities to deal with and we are certainly actively pursuing those. The other——

Senator BROWN. In what way are you actively pursuing it?

Dr. BUDETTI. OK. Well, we are doing that on a variety of levels. One is to work with the provider community to make sure that when they submit a payment, it is submitted in the right way, it is documented, the service is provided at the right site. The vast majority of the improper payments that we have been measuring are—often involve services that a legitimate provider provided to an eligible beneficiary, but perhaps at the wrong site of service, perhaps as an inpatient instead of an outpatient. It might have lacked the appropriate documentation——

Senator BROWN. So you are saying that the amount here really is not—it is not illegal or fraudulent payments, they are just done improperly. We have to get the accounting squared away. So if that is what you are saying-——

Dr. BUDETTI. That is a big piece of——

Senator BROWN. All right. So how much out of that money is actually that scenario?

Dr. BUDETTI. That is the second prong of what we need to address, which is the real fraud, and that is a major issue that we are addressing in a number of ways, and I would just like to touch on one aspect of what I believe you were getting at, which is the fact that we are now moving to use modern technologies, advanced analytics, to look at not just claims data, but to look at a wide range of data in a way that will allow us to predict where the problems are and to stop payments before they are made. That is what we need to do to really——

Senator BROWN. No, I agree.

Dr. BUDETTI [continuing]. Put this to an end. We are in the process right now, and with the support that we got both from the Affordable Care Act and also the Small Business Jobs Act on the predictive analytics side, we are implementing programs and we are working with private contractors and using the best ideas from private industry, putting them into the context of the Medicare and

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Medicaid programs, Medicare at first, to be able to do exactly what you are getting at, Senator, which is to spot these problems and not to make the payments in the first place. That is the best way to stop an improper payment, is to not make it——

Senator BROWN. It has been almost 20 years. It has almost been 20 years that we have had this identified as high-risk designation by the GAO—20 years, and we are still talking about it.

Dr. BUDETTI. It is a long time and I think we are turning the corner. I——

Senator BROWN. All right. How are you turning——

Dr. BUDETTI. I have been here——

Senator BROWN. How are you turning the corner? Tell me how you are turning the corner so I can feel good tonight when I leave.

Dr. BUDETTI. I hope you will feel good about this, Senator. We are turning the corner because we are implementing the authorities in the Affordable Care Act that really give us new and expanded tools that we are going to use very diligently. For example, the advance screening to keep the bad guys out of the program; to spot them when they are in the program and to get rid of them; and, the new authority that when there is a credible allegation of fraud, and we do that in consultation with our law enforcement partners, we determine when an allegation is sufficiently credible, we can suspend payments. We have additional authorities to declare moratoria where there is no evident need for new suppliers or providers to come into the program. We are coordinating the Medicare and Medicaid screening processes and other tools together. We are expanding the Recovery Audit Contractor program into Medicare Parts C and D as well as into Medicaid.

And backing all of that up is our development of the application of modern predictive analytics, looking at many, many different aspects of a health care situation all at the same time in order to know which claims represent the highest risk of fraud and not to pay them, to make sure that the money is never paid. So we want to keep the bad guys out and we want to stop the payments before they are made.

We also have a variety of measures that we are taking specifically to cut the Medicare fee-for-service improper payment rate in half by 2012. That is a commitment the President has made and we are going to carry that out——

Senator BROWN. In half from this number right here?

Dr. BUDETTI. That is correct, from the Medicare fee-for-service components of those numbers. That was the commitment. We are also, of course, working to cut the improper payments in the rest of Medicare as well as in Medicaid. But we have the specific commitment to—and in 2012, we will be accountable for reaching that goal.

Senator BROWN. OK. I appreciate it. I will turn it back and then get back at you.

Senator CARPER. Those are good questions.

It is kind of confusing, because on the one hand we have the improper payments reports that come that are required under the legislation just passed and signed by the President last year while we have, I think, what Attorney General Holder says may be as much as $60 billion in fraud, criminal fraud. Improper Payments are not

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necessarily criminal fraud activity, maybe some element of it, but for the most part, that is not the case. So we are going here on two tracks.

I think our job, I would just say to my colleague, Senator Brown, our job is to ask what resources are needed, what authorities are needed to do the best that we can. The payoff is seven-to-one. For every dollar we invest, we get seven dollars in recovery. That is a pretty good return on the investment, to make sure that we are doing that, to ask our friends at GAO and our IGs to advise us and the agencies as we go forward in this area to recruit a whole lot of people like Ms. Carson to go out there and help us to identify this fraud and stamp it out as best we can.

And then our responsibility is oversight, oversight, oversight. We will be back here certainly before 2012 to see how we are doing. But as Senator Brown says, if we can cut that number, you all can cut that number in half, that is real money. That is real money, and that is one—people say, we cannot do anything to reduce the growth of entitlement spending. Well, maybe we can, and this is one of the ways we can do that.

All right. Senator Begich, and then back to Senator Klobuchar. Mark, nice to see you.

Senator BEGICH. Thank you very much, Mr. Chairman.

Let me ask, Mr. Budetti and Mr. Andres, let me, if I can, first ask two simple questions. If the Affordable Care Act was repealed, would it crimp the ability for you to do the work you need to do?

Mr. ANDRES. There are numerous benefits to our——

Senator BEGICH. I do not need the detail, just the yes or no.

Mr. ANDRES. Yes, and certainly in light of the changes to the sentencing and the funding.

Senator BEGICH. Excellent. We just had a House resolution in front of us to reduce $57-point-some billion out of the Federal budget. Would that amendment affect either one of your divisions in any negative way for you to do the work you need to do on fraud?

Mr. ANDRES. Senator, I do not know the specifics of that bill.

Senator BEGICH. OK.

Dr. BUDETTI. I would agree with that, but in commenting on the need for the Affordable Care Act provisions, Senator, certainly, as I have mentioned, those are very central to our efforts to fight fraud and abuse.

Senator BEGICH. Excellent. Could you, just for the record, on H.R. 1 that we just rejected, could you have whoever in your appropriate divisions report back to us if that bill would have had an impact to you in the sense of ability to go after fraud and abuse?

Mr. ANDRES. Certainly, Senator.

Senator BEGICH. OK. Let me go to this number, if I can. The improper payments, my understanding is that it does not include Medicare Part D also in this, or does it?

Ms. KING. It does not.

Senator BEGICH. It does not. OK. So let us assume—I do not know what that number is, but let me make sure I clearly define improper payments. Once you go through the process of determining that the paperwork is filled out for some of these, that is not necessarily recovered money, that is just clarification of the right—I mean, when it is improper payment, it could be like me,

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for example—not me, because I am not a provider, but when I go fill out my reimbursement to Aetna, they send back a form and say, you did not send us the right verification. Now, they may have sent me a check and still ask for the paperwork. That could be an improper payment on my end. But on the Medicare provider who may send in their information to get reimbursed but does not send in all the correct information, that is an example of a improper payment?

Ms. KING. Yes.

Dr. BUDETTI. That is——

Senator BEGICH. OK, either one.

Dr. BUDETTI. Go ahead.

Senator BEGICH. Yes. Nodding the head to say yes. So of this number, which may not be recoverable money because it is still paid, just they need to do their paperwork right, so it is not new money to the Treasury, but a percentage of this, if we go after the fraud that really is people who are abusing the system, what percentage would you guess of this number plus Medicare Part D is in that category of recoverable potential, knowing that some is—you can never squeeze it all out of someone when they have done it wrong because they have spent it. What is the percentage that you would estimate on this?

Dr. BUDETTI. Senator, I would draw a little distinction here, which is improper payments are recoverable if they are identified and if there are resources to collect them. But the way that we measure improper payments right now is not designed to measure fraud. Fraud is elusive. Fraud is secretive. Fraud is hidden. Fraud is something that requires different ways of identifying it. So it really is not a question of what proportion of the improper payments are fraud. If the auditors, in measuring the improper payments, detect signs of fraud, they are required and they do report that to our anti-fraud contractors——

Senator BEGICH. I understand. Here is the dilemma I am trying to solve, and that is we use these big numbers——

Dr. BUDETTI. Yes.

Senator BEGICH [continuing]. But that is not accurate.

Dr. BUDETTI. It——

Senator BEGICH. In other words, unless you are telling me that all of this is recoverable to the Federal Treasury——

Dr. BUDETTI. It may be recoverable, but it does not mean that it will be avoided to be paid. Let me tell you what I mean. If, for example, if a beneficiary who is eligible for the program receives appropriate services from a legitimate provider——

Senator BEGICH. Right.

Dr. BUDETTI [continuing]. But they get those services in the hospital and they could have been provided in the outpatient setting——

Senator BEGICH. Right.

Dr. BUDETTI [continuing]. That money that was paid is recoverable. However, had those services been provided in the outpatient department, in other words, had they been a proper payment instead of an improper payment, we would have been responsible for making that proper payment good. And so the difference, if any, be-

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tween the payment for the inpatient service and the payment for the outpatient service is what the net to the Treasury would be——

Senator BEGICH. Right. I have got you.

Dr. BUDETTI [continuing]. Or to the trust funds would be.

Senator BEGICH. I have got you. Again——

Dr. BUDETTI. We could still recover the amount if we went after it.

Senator BEGICH. Right, but you may have only a differential that you are requiring recoverable because you may have paid that inpatient——

Dr. BUDETTI. Under current rules, we recover the entire amount, but we are looking into exactly that and working on—our main thrust, though, is to make sure that the services are provided correctly in the correct setting——

Senator BEGICH. I understand that.

Dr. BUDETTI [continuing]. And the documentation and the billing is proper in the first place to support this.

Senator BEGICH. So let me—I am going to end this line, because——

Dr. BUDETTI. Sure.

Senator BEGICH [continuing]. Honestly, it is—then what we are going to still be using, just so we are clear, that there is $60 billion of recoverable money, because——

Dr. BUDETTI. Yes.

Senator BEGICH [continuing]. I think that is one of the struggles here for us, is what is—do we believe at the end of the day 30, 40 percent of this number is really the hard nut that we are going to crack and go after in the sense of returning back to the Treasury?

Dr. BUDETTI. What we need to focus on, Senator, is the fact that because some of that—a substantial amount of that—may be due to improper documentation, or a lack of documentation entirely, or provided in the wrong setting, we are still going to be providing the right services. So there may be a differential between what we could pay and what we would need to pay if the service were provided and billed for properly——

Senator BEGICH. The right way.

Dr. BUDETTI [continuing]. But having said that, there is still the world of real fraud that we need to take on, and that is a major challenge to us and that is what we are intent on, as well, what we are intent on preventing.

Senator BEGICH. You mentioned you are working with private contractors to try to go after the fraud and use new technology, which I think is great, and there is a ton out there. Credit card companies, as the Chairman indicated, they use a lot of it to figure out where there are situations occurring. What do you think your time table will be to really implement some of that new technology on the ground that has an impact, a real dollar impact?

Dr. BUDETTI. We are in the process right now of looking at the solicitations that were out. The bids are in. We will be implementing the kinds of solutions that come in this year and we will have them integrated into our claims payment system, in part, this year. We will be phasing it in this year and the target is no later than the middle of next year that we would have it thoroughly integrated. So we are not just waiting until we get all the results.

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Senator BEGICH. Understood.

Dr. BUDETTI. We are going to integrate the findings as we get them.

Senator BEGICH. So from a Committee perspective, when would you be able to say to the Committee, here is some update. Here is what we are seeing. Here is some positive news or here is some negative news, depending on how we look at it——

Dr. BUDETTI. Later this year, I think would be——

Senator BEGICH. Later this year?

Dr. BUDETTI [continuing]. Would be the first phase.

Senator BEGICH. OK. And I will just ask two quick questions. In regard to medical schools and the education that is going on, are you engaged in helping folks that are coming through the system now that will soon be providers how to deal with improper payments and Medicare fraud and those kinds of elements? Do you go to that level, or do you kind of——

Dr. BUDETTI. Senator, I think I will defer to my colleague, the Inspector General, on that count——

Senator BEGICH. OK.

Dr. BUDETTI [continuing]. Because I know they have a major initiative on that front, if he does not mind.

Senator BEGICH. OK.

Mr. LEVINSON. Yes, thank you. And indeed, we have published a Roadmap for New Physicians in which we actually provide a very good, succinct summary of the major laws that are implicated in the Federal health care programs, everything from the physician self-referral law, the Stark Law, the exclusion statute, to give the incoming medical profession a sense of what is at stake, how to go about conducting their business in a way that conforms with our requirements. It has been very well received in the medical schools in which it has already been presented and before the medical associations, and it is part of our Health Care Fraud Summits that we have conducted this past year and we continue to do so this year, in which we do this kind of outreach to the medical community. It is a very important initiative and I am pleased to say it has been very well received.

Senator BEGICH. Very good. And I will just end, Mr. Chairman, and say I do not know whose Web site it was, but when I was able to review the Top Ten Most Wanted in the fraud of Medicare, I want to commend whoever did that, I do not know if it is—there we go—I think it is a great thing to do. I know as a former mayor, one of the things we did with people who did not pay their bills, we put them on the web. It actually was so popular, it crashed the system three times over a weekend—not that people wanted to see if they were on it, they wanted to see who else was on it. But of $20 million, we collected almost $9 million in the first year, because people are not happy when other people are cheating the system.

And so I thank you for that. I think that is a great system. I think you should continue to do whatever you can to put those "Most Wanted" up, because people actually are intrigued by that and probably would be your best allies and your best enforcement arm.

Thank you very much.

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Senator CARPER. Thanks, Senator Begich. Senator Klobuchar.

Senator KLOBUCHAR. Thank you very much, Mr. Chairman, and thank you to the witnesses.

Dr. Budetti, many States are taking the initiative to set up all-payer claim databases similar to CMS's integrated data repository, and I am working on legislation that actually would create a standard for the process for these other States so that we can expand the use of these databases. Do you feel that having databases combined with predictive analytics and other tools are a good way to combat fraud and abuse in the health care system?

Dr. BUDETTI. Yes, Senator, and certainly working with the States to enhance the Medicaid data and to enhance the use of those data is a priority for us and we would be very interested in talking to you about that.

Senator KLOBUCHAR. OK. Very good. Mr. Andres, you mentioned in your testimony that the average prison term for defendants convicted of health care fraud is over 40 months. How recent is that, over what span of time?

Mr. ANDRES. I believe that is fairly recent, Senator.

Senator KLOBUCHAR. Mm-hmm, because I remember at a previous hearing that most people convicted were not sent to jail and I think they served less than 3 years, and I think it has gone up by a few months. Do you feel that the current sentencing limits are enough of a deterrent?

Mr. ANDRES. As I mentioned earlier, Senator, the Affordable Care Act directs the Sentencing Commission to examine the sentences for health care offenses and those proposals have now come through and will significantly increase sentences, and we believe that—or we would ask Congress to support the Sentencing Commission's recommendations.

If I could just address the 40-month issue in two ways. First, the average of 40 months may be a little misleading because the types of health care fraud cases that are included in that figure could vary widely——

Senator KLOBUCHAR. Mm-hmm.

Mr. ANDRES [continuing]. From the beneficiary who was abusing the system to a health care provider who was billing $20 or $30 or $40 million. So there is a wide range there, and so that number may be misleading.

Let me say this. Our prosecutors are asking for jail time in appropriate cases, and I believe in many cases, we are getting significant jail sentences. To give you an example, in November 2010, a defendant and owner/operator of a Miami clinic was sentenced to 10 years in prison for her role in a $22 million fraud. A doctor in Detroit was sentenced to 72 months in prison for writing prescriptions for unnecessary and non-rendered services. Another doctor was sentenced to 14 years in prison and ordered to pay $9.4 million in restitution for a scheme involving $18.3 million.

So in appropriate cases, judges are certainly sending defendants to jail and they are sending them to jail for significant periods of time.

Senator KLOBUCHAR. And I, in my former life as a prosecutor, I found, especially with these types of white collar crime cases, that sometimes the best thing you can do is just the example and that

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you may not know of some other fraud going on, but then people get very nervous and either pay back money or change their ways, so thank you for that.

Inspector Levinson, the OIG and DOJ's Medicare Strike Force has expanded to include nine total hot spots of health care fraud, leading with Miami, Los Angeles, Detroit, Houston, Brooklyn, Baton Rouge, Tampa, Dallas, and Chicago. Could you talk about what makes a city a hot spot, and does the mention that I made of coordination of care, does that have anything to do with the low incidence of fraud?

Mr. LEVINSON. Well, I think that over time, through our own experience as well as that of the Justice Department, it is clear that there are concentrated areas around the country where either ethnic groups, organized sense a vulnerability in a particular part of the program—very often it is within the area of DME, infusion therapy, home health is becoming a popular scam area—where the same kind of scheme is hatched and becomes very, in a sense, viral.

And, of course, South Florida several years ago emerged as the hottest of hot spots and we concentrated on South Florida years ago to try to especially focus on the DME area with tremendously good results, not only in terms of investigation and prosecution, but billings for DME are way down as a result of that activity, indicating that there is real value to getting the word out, even as you do the work-——

Senator KLOBUCHAR. How about the question I asked on coordination of care? And this is related to delivery system reform, where you know what is happening with a patient. You have maybe one primary care provider and you have a group that works together. This is the model we tend to use in Minnesota. And my argument is that in itself, outside of the government and the work that Mr. Andres and others are doing, that it polices itself some. You need the government, as well, but it polices itself because there are other private sector people that are working with a group of people.

Mr. LEVINSON. I am not sure whether any examination or study has been done about the impact of that in terms of the fraud area. Again, I am talking about those who really do not belong in the program in the first place. The fraud part of this exercise has so much to do with cleansing the program, and then the next step, of course, is strengthening the program, and I think there are important provisions in the Affordable Care Act on coordination that perhaps my colleague, Dr. Budetti, can speak about.

Senator KLOBUCHAR. Right. I just—I want to point out that some of the areas that have the more coordinated care in our country are not included in your hot spot list, and there is more of a check on the system.

Mr. Levinson, you mentioned the use of exclusion from Federal programs as a disincentive for executives and providers to commit fraud and corporate misconduct. In the consideration of whether or not someone should be excluded from the programs, are stronger civil and criminal charges also considered in addition to the exclusion?

Mr. LEVINSON. Well, they do play a very, very important part in whether permissive exclusion goes forward. There are mandatory exclusions if someone is convicted of a felony, for example. But

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within the context of permissive exclusions, the record of executives, of managers, is very important.

Senator KLOBUCHAR. And your testimony also highlighted the steps CMS and OIG are taking to move away from the pay and chase model, focusing more on preventing fraud from occurring in the first place. How will CMS and OIG prevent a person who is denied payment in one area simply from relocating and doing it in another area? That is what we see with, like, Web sites and piracy. Do you want to answer that, Mr. Budetti?

Dr. BUDETTI. I would be happy to, Senator. One of the provisions in the Affordable Care Act requires that if someone is excluded—is thrown out of the Medicaid program in one State, they also have to be similarly treated in all States. And, of course, if they are tossed out of the Medicare program, provided that the reasons for them being tossed out are the kinds of things that we are concerned about. If they just resigned without being under a cloud or they just decided to move from one State to another, that is not going to count. But if they are terminated in one State for cause, they are going to be terminated everywhere, and if they are terminated in Medicare, they are going to be terminated in all the States.

And so we are working with the States to set up a system that will allow the identity of the people who are subject to this provision to be securely identified so that the right person will be identified across the country, so aimed at exactly what you are getting at.

Senator KLOBUCHAR. OK. And thank you, Ms. King—my time is done here—for your testimony, and also, Ms. Carson, for telling your story. And if I could just ask one question, it would be how do you think we can help seniors and Medicare beneficiaries become more aware of potential fraud schemes?

Ms. CARSON. Actually getting out and publicizing it, and also letting the seniors know that they do have forces on the ground that will help them. A lot of them that are in high-rises and nursing homes are not aware of what is going on unless we come out. We do presentations and we are educating them on the frauds that are happening around the country and also in our State.

Senator KLOBUCHAR. Thank you very much.

Senator CARPER. Thanks so much for those questions and for your work, good work in a lot of areas, really, a lot of areas.

I want to come back to, if I can, a question for you, Ms. King, before too long, but not yet. I want to come back to Dr. Budetti. On the issue of Recovery Audit Contracting, and for folks that are not familiar with that, I actually used to do this, at the time I was Governor of Delaware, we had people who worked in the Division of Revenue. Their job in Delaware was to collect revenues that were owed to the State. And some cases, particularly for difficult monies to collect that were owed to the State of Delaware, we would hire contractors and their job was to go out and collect the money. They kept a percentage of that which they collected and that was their compensation. It worked well, and the Division of Revenue, rather than providing worse service, ended up providing, I think, better service and won the Quality Award for the State of Delaware my last year as Governor, so we are very proud of that.

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I am going to go back in time 4 or 5 years when the idea of using a similar approach with contractors doing recovery with respect to Medicare, and I think the idea was to do a demonstration focused on three States, I want to say California, maybe Florida, maybe New York. I think those are the initial three States that we did the demonstration for a couple of years, and then I think we expanded to a couple more States, maybe five, and then before the demonstration was over, I think we might have gone to 19 States.

Then I think we had like what we used to call in the Navy a stand-down. We used to have a safety stand-down in our Navy air squadrons and we would not fly for a day or a couple of days, just focus on safety. For recovery Audit Contracting we had what I would call a stand-down for, I think for a year, to do sort of lessons learned. What did we learn from the demonstration that would enable us to collect more money, that would enable us to cause less intrusion, less confusion among the provider community.

And then we went back and said, we are going to do this in all 50 States. Now that we have learned from this demonstration, we are going to do it in all 50 States. My recollection was in the last year that we did the demonstration before the stand-down, we collected, or contractors collected over $300 million. I think it was over $300 million. And for the 4 years, I think they collected about maybe a billion dollars.

And we are told that in the first year coming back, doing this in all 50 States that we can expect to collect less than $100 million. That just seems strange to me. And as we look at your improper payments of $48 billion, in order for us to get close to half of that, we are going to have to do a whole lot more, than the $100 million or $200 million. And I know that your focus is on prevention, so we do not pay and chase. But it seems to me we ought to be able to do a whole lot better in 50 States, looking at improper payments, Medicare Part A, Part B, Part C, Part D. The numbers just do not add up.

Dr. BUDETTI. Senator, we certainly appreciate your leadership in this area, and I think, the program was just expanded to the Nation as a whole in 2010. That was the first full year, and a lot of that year was spent in implementing many of the lessons that were learned from the pilot program, getting feedback from the provider community, doing exactly what you said, which was standing down in some ways long enough to make sure that the program was implemented in a way that benefited from the pilot.

So much of 2010 was spent with the initial stages of improving operations, of working with our partners, making sure that the program was up and running. So we do see that the recoveries are going back up again and we believe that we will be on track to reach the goals that were established. We are also in the process of——

Senator CARPER. And what were the goals? Could you just talk about the goals that were established?

Dr. BUDETTI. I do not have the numbers in front of me, Senator——

Senator CARPER. Just roughly.

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Dr. BUDETTI. They are in the—I believe they were in the—for 3 years, in the $300 to $500 million a year range, and we believe that we are on track to getting there.

We also believe, as you said, that as we implement—we have already signed a contract for a Recovery Audit Contractor to look at overpayments and underpayments in the Part D program. We are right now finished collecting public comments on how to implement the other aspects that were in the Affordable Care Act on the Part C and Part D programs. And we have also been working very closely and diligently with the States to implement the Medicaid RACs in the States.

So we are on track, I think, to get the full benefit out of the Recovery Audit Contractor program and we will be happy to keep tabs with you on how successful we are.

Senator CARPER. We have had this conversation before, and I do not mean to beat a dead horse, but this is a lot of money. If we can collect through Recovery Audit Contracting a billion dollars in roughly 4 years out of anywhere from three to five States, and that was not Medicare Part A, Part B, Part C, Part D, but it was just maybe A and B, if we are adding C and D to that and we are adding another 45 States, we ought to be able to do a whole lot more than $300, $400, $500 million in the next several years. It just—it does not add up.

Dr. BUDETTI. I certainly appreciate that, Senator. I think that some of the changes that were made in the program will take a while to be fully in place and to be implemented properly. And also, we are working with the provider community to correct many of the problems that led to the identification of an improper payment that could be recovered. Certainly, everybody's goal is to eliminate that problem in the first place, not just to recover the funds after the fact. But we will be happy to, as I said, keep tabs on this with you.

Senator CARPER. And we will keep tabs on it, as well.

You mentioned Medicaid. Let me just touch bases on that. My understanding was that CMS will no longer require that States have Medicaid Recovery Audit Contractors in place by April 1 of this year. That is what I am told. And that the Medicaid program final rule will establish a new deadline, not April 1, but a new deadline. I am told that CMS has also dropped the March target for publishing the final rule and there has been no announcement of a new target date for the final rule. And I would just ask, when do you expect to see the final rule for Medicaid Recovery Audit Contracting?

Dr. BUDETTI. Senator, we did publish the Notice of Proposed Rulemaking last fall and we did get a lot of feedback from both the States and from the provider community, in particular, on the way that the program would be implemented across the States and trying to assure that the Recovery Audit Contractors under Part A and B of Medicare, for example, were not completely different than the way that they are implemented under Medicaid. So we are taking a lot of considerations seriously as we design the program.

But we are on track. We are working diligently, and although I can never talk about the exact date of a regulation that has not yet

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been published, I can tell you that we are working on getting this in final form very diligently and it will be forthwith.

Senator CARPER. And I would like to take more comfort. I am not sure, but is the beauty in the eye of—

Dr. BUDETTI. It will be in the short term, Senator——

Senator CARPER. OK.

Dr. BUDETTI [continuing]. But since we are in the process of rulemaking, I am just not in a position to specify exactly what the content or timing would be just yet.

Senator CARPER. Well, sooner rather than later. I hope you feel that sense of urgency and reflect it.

Dr. BUDETTI. I feel that sense of urgency, sir.

Senator CARPER. All right. Let me yield to Senator Brown. I have a couple more questions, and then we will come back to—I have at least one question for you, Ms. King, so do not go away. Senator Brown.

Senator BROWN. Thank you, Mr. Chairman. I have been listening back at another meeting. The Chancellor of UMass-Lowell came out.

Mr. Budetti, just to kind of reengage a little bit, the GAO designated Medicaid a high-risk program, in 2003, and under the Affordable Care Act, the cost of the Medicaid expansion is $430 billion over the next 10 years and the Federal Government is going to be responsible for 90 percent of that.

On page ten of your testimony, you state that the return of the ROI for the Medicare Integrity program is 14 to one. Do you know what the ROI will be for the Medicaid Integrity program?

Dr. BUDETTI. Senator, the Medicare Integrity program is something that we operate fully at the Federal level and the collections and the data are all something that is entirely under our purview. The activities in the Medicaid Integrity program itself and the various Medicaid activities that are designed to combat fraud and go after these kinds of problems are really a partnership between us and the States. We operate a number of activities. For example, we run the Medicaid Integrity Institute, which has trained a couple of thousand State employees in program integrity. And so that is one kind of activity that we do at the Federal level that is not really designed for us to have a direct return on investment like we can measure in the Medicare Integrity program. We also have, of course, auditors that do audit and do those audits based upon data that we collect from the States, but we do not have direct access to the kind of claims data that we do on the Medicare side.

So it is really a partnership, and there are funds that are coming back to the States that we may or may not actually be able to identify easily for calculating our return on investments. But we are working on this. This is an issue before us. We are looking at the best way to go about calculating the return on investment on the Medicaid side. We firmly believe that what we have done is effective and is leading to recoveries, but it is much more complicated in the sense that it is a partnership with the States and there are a variety of activities that go on at the State level that we are not directly responsible for.

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Senator BROWN. So do you think you are effectively able to figure out if the money is effectively being spent or not and if it is being allocated in the right integrity activities?

Dr. BUDETTI. Well, that for sure. We certainly believe that we are engaging with our States. We are moving to get the States and ourselves, as Senator Klobuchar referred to, to have better data available for this process. We are working with them on looking to the ways to use the data. We are working with the States on clusters of States working on issues that are important to them. We are revisiting this entire issue because we believe that the States are effective partners.

States have a variety of activities that go on that we are not directly overseeing. For example, the Medicaid Fraud Control Units that generally are in the Attorneys Generals' offices in the States are something that, although they are funded out of Medicaid operations, they are not directly controlled by us.

Senator BROWN. That being said, have you noticed any differences, because, for example, in Massachusetts, we have 98 percent of our people already insured. Have you noticed any difference between the States like ours that are already kind of dealing with those issues and already have a health care plan in effect and, quite frankly, I think it is better than the Federal plan? Have you noticed a difference between our State and maybe other States that are not where we are?

Dr. BUDETTI. I do not have any State-specific data at hand, Senator, but I would be happy to see whether we can find something for you——

Senator BROWN. No, just—not looking for anything. It is just a general, do you notice a difference, that is all. But if you cannot answer, that is fine.

Dr. BUDETTI. I do not think I have anything to add to that, Senator.

Senator BROWN. All right. I was looking for an "atta boy" for Massachusetts. [Laughter.]

Man, I cannot give any more softballs than that. Simply, "Yes, Massachusetts is doing great, Senator." OK. [Laughter.]

Dr. BUDETTI. I am sure Massachusetts is doing great in many——

Senator BROWN. Oh, it is too late. [Laughter.]

And just to follow up again, HHS's fiscal year 2010 agency financial report estimates the national improper payment rate for Medicaid is 9.4 percent, with the Federal share being an estimated $22.5 billion. The same report stated that CMS faced challenges with State payment systems that had paper-only and aggregate claims. Changes in information systems, IT, obviously, at the State level during the course of the measurement cycle and wide variations of system designs and capabilities vary, from State to State.

I know CMS is working with the States to modernize their IT. How long and how much money do you think it will take before the States achieve and kind of get on the same sheet of music when it comes to dealing with these types of issues?

Dr. BUDETTI. Well, Senator, as I am sure you are aware, some States are far more advanced than others——

Senator BROWN. Like Massachusetts. [Laughter.]

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I have you flustered, do I not? [Laughter.]

Senator BROWN. Good. I am trying to throw you off, so—I am obviously teasing. I am glad everyone has a sense of humor.

Dr. BUDETTI. I am looking for something here, Senator.

Senator BROWN. All right. Good.

Dr. BUDETTI. The States—the way that the States are running their programs does vary from State to State, and the way that the improper payments are measured in the States is on a three-year rotating cycle, so that 17 programs are studied and reported on annually. So when we reported the figure for this year, for the first time that we had 3 years of data to get a comprehensive national figure, that set the target for us for what we want to reduce.

Now, what that means is that States typically have 2 years before the next time that they will be studied, because it is a three-year rolling cycle. So that is the cycle that we expect the States to implement their improvement plans in, and it is in that kind of a cycle that we will know whether the States are improving. So——

Senator BROWN. May I interrupt for one second?

Dr. BUDETTI. Yes, sir.

Senator BROWN. So it is clear to me that the States are all different. It has been 40 years, basically, and we still do not have, like, a uniform national claims system where you can all be on the same sheet of music, same type of "keep it simple, stupid" type of philosophy where we just do it all the same and there is no miscommunication, there is no misunderstanding, there are no improper classifications. I mean, what type of problem, I guess, would it be to have a lack of uniform national claims kind of data system? Is there something you guys talk about at all, or——

Dr. BUDETTI. Well, Senator, as I said, the Medicaid program is a partnership with the States and the States have substantial flexibility. They are the ones who end up paying the claims and having the claims data to analyze. So we do need to work individually with all of the States and to make sure that we are doing something that is appropriate for a given State.

On the other hand, as you mentioned, we do want the States all to get the maximum possible return on their program integrity investments and that is why we do things like our Medicaid Integrity Institute. We also do a variety of ways of communicating with the States so that they know what each other is doing and can learn from each other best practices.

Senator BROWN. I have one final question. Thank you for your sense of humor. I appreciate it. It is not easy to come here. I appreciate everyone else laughing, too.

So, Ms. King, I want to just touch base very quickly, because I know the Chairman has a question or two left. The expanded prescription Part D drug benefit program began in 2006, but it was not until 2010 that GAO indicated that CMS has made progress in the $51 billion program for waste, fraud, and abuse. Due to the nature and size and complexity, how confident are you that CMS will be able to implement in a timely manner a vastly more complex system to make sure that we are not having any of the fraud, waste, and abuse that we are kind of discussing here today in that program?

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Ms. KING. Well, if I could elaborate a little bit on the Medicare Part D situation, CMS, before Part D went into effect, required the sponsors and the plans to have compliance programs, and in effect, that is sort of self-policing. CMS put forth elements that you have to have in your required compliance plan, so the plan is supposed to police themselves and they were, in effect, and they were checked. But what CMS did not do as soon as they said they would do is audit whether the compliance plans were working.

Senator BROWN. Right.

Ms. KING. So there is a little bit of a nuance there.

Senator BROWN. No, I understand——

Ms. KING. And in the Affordable Care Act, there are requirements for providers to have compliance plans. So going forward, I think that there is going to be more on the provider community and providers as a group to take those things into account on the front end, so to share more in the responsibility.

Senator BROWN. Thank you, Mr. Chairman.

Senator CARPER. Thanks for all those questions and for helping, and your staff, as well, for helping us with this issue.

This is not a partisan issue. We all know we have a huge debt. We need to bring it down. We have a problem with Medicare. We are running out of money somewhere down the line. We want to make sure that does not happen. And we want to put bad guys in jail and put the white hats, we want to make sure they get some credit. We appreciate the work that is being done on this.

When I get to the end of my questions, the last question I will ask is for you to come back to us and give us advice and maybe one thing, and I will start maybe with you, Ms. Carson—not now, but in 7 or 8 minutes—come back and say, if the Congress could do one thing, the Legislative Branch, what can we do? What should we do to try to make sure that we do a better job with respect to these issues? Just be thinking about that, everybody here.

All right. A question, if I could, for Mr. Andres, if I could. I think our Attorney General, Eric Holder, has been quoted as saying maybe the fraud on Medicare is as much as $60 billion. Let us just say it is half that. Let us just say it is, like, $30 billion. I do not think anybody knows what it is, but let us say it is only half that number, $30 billion.

Last year, we reached a high-water mark, I think, the most recent year, where we recovered, what, about $4 billion, or we tried to recover as much as $4 billion, reported that. That would be the biggest recoveries we have ever made. Going forward, obviously, we want to stop the incidence of fraud in the first place, but can we expect next year—I think we have seen this growth, these recoveries grow from maybe $1 billion to $2 billion to $4 billion. Given the fact that there is a lot more out there, can we expect to see that number continue to rise?

Mr. ANDRES. Senator Carper.

Senator CARPER. And what can you do, what can we do to make sure that happens? I think one answer might be, if you are getting seven bucks back for every dollar that you have to invest, maybe we need to make sure that you can get those one dollars so you can get to seven. Maybe we ought to double that. But what can we

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do, what do you need to do to make sure that we continue to increase that number of recoveries?

Mr. ANDRES. Certainly support the President's budget, which asks for additional funding for the Department of Justice. A lot of the money on the recovery side comes from the tremendous work from the Civil Division. The Civil Division is involved in False Claims Act and other related lawsuits in which they are suing pharmaceutical companies and going after a variety of different actors in the field. So a lot on the recovery side comes from the civil side as opposed to on the criminal side.

Our recovery numbers on the criminal side, as I mentioned earlier, are a little harder because, again, we are involved in the arrest and prosecution and jailing of these individuals, but it is harder for us to actually collect money in many instances because the money is simply gone or we cannot get to it.

Senator CARPER. All right. Ms. King, I have been saying I am going to ask you a question and the moment has come. Let me just see how I lead into this. I think—Dr. Coburn is gone now. He was instrumental in having GAO conduct a review, I think, that led to the release of a report that identified numerous duplicative government programs as well as ways that the Federal Government could cut costs and save money. I think we all realize that identifying duplication in the agency and improvements are critical at this time of economic challenge, at this time of high deficits, as well as trying to be better stewards.

As an old recovering Governor, I understand the serious challenges that come along with running a major program like Medicare and Medicaid. We all know that our Medicare and Medicaid systems are not perfect. We have to find ways to make them better.

So my question is basically this. We have discussed a number of the changes that are being made at CMS to fight fraud. As we look forward to the next steps, can you identify some best practices or other activities that CMS should consider to further prevent fraud, waste, and abuse in these programs? So beyond what is being done, how about some additional steps, next steps, to do even better? And are there additional statutory authorities that you need from Congress that would enable you, or enable them to do an even better job?

Ms. KING. I think one thing that we would suggest that they could do a better job on at the moment is, and especially following up on the RAC program, to aggressively identify a process to look at what happens with the vulnerabilities so that they do not happen again. When we evaluated the RAC pilot program, we found out that they did not have a process like that in place, and going forward in the national program, I think that would be important.

In terms of additional authorities——

Senator CARPER. Dr. Budetti, would you briefly respond to that comment, please?

Dr. BUDETTI. Yes, Senator. We appreciate the comment from GAO and we are looking to do exactly that, to follow up on the vulnerabilities. We believe that we should learn from the findings of the Recovery Audit Contractors to correct those problems.

Senator CARPER. All right. Thanks.

Go ahead, Ms. King.

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Ms. KING. I think in terms of new authorities, I think CMS has a really full plate at this point, so——

Senator CARPER. Is that true, Dr. Budetti? [Laughter.]

Ms. KING [continuing]. And they have testified before that they feel like they have the tools necessary. But effective implementation of those authorities is going to be really important.

The other thing that I think that was pointed out in the Coburn Report is, as you probably know, the Congress sets a lot of the payment policies in Medicare in law and I think it is important to look carefully at those policies to see that they are providing the right incentives to provide care effectively.

Senator CARPER. All right. Thank you.

Let me go to an issue involving contractor conflict of interest. Mr. Levinson, I think this involves some of the work that you all have been doing. But we are always trying to identify ways to incentivize government contractors for better performance as well as to try to remove some of the hindrances that they face. About a week or so ago, Senators Baucus, McCaskill, and I sent a letter to your office asking to review contracting oversight by CMS. The issues involved potential organizational conflicts of interest among the contractors hired, on one hand, to perform the Medicare claims reimbursements and those hired to oversee the process. I would just ask, is your office going to be able to examine the questions and the issues that we raised, and if you could respond to that, I would be very pleased.

Mr. LEVINSON. Thank you, Mr. Chairman. We have received the letter and, indeed, we have ongoing work in the conflicts area that we believe overlaps to a certain degree with what the request is, and we look forward actually to working with your staff to see how we can align our work that was started some time ago with this fresh request, which we think in many respects will be very helpful, actually, in filling out our own work. So the answer is a very enthusiastic yes.

Senator CARPER. All right. Good.

And a follow-up, if I could, Dr. Budetti. Do you have any thoughts on the steps that CMS could take to improve the oversight of your Program Integrity contractors?

Dr. BUDETTI. Senator, we certainly, just as you do, we take any conflict of interest issues very seriously. We do have processes in place to screen for conflicts of interest before contracts are awarded. We are always willing to take a second look at something so important and we look forward to continuing to do so. So we do take this very seriously. We believe we have good processes in place, but if we need to learn something, we are open to learning it.

Senator CARPER. OK. Thank you.

All right. Ms. Carson, I indicated I would have one last question for the whole panel and it is basically the same question. What can we do on the legislative side? This Federal Government, three branches, executive, judicial, and legislative, and we try to work together. I am actually quite pleased, in preparing for this hearing, to know as we try to reduce improper payments and try to reduce the incidence of fraud, as we try to recover additional monies that

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have been defrauded from these programs, my sense is we are actually working as a team. The team works actually pretty good.

We have GAO out there being a watchdog and coming up with a bunch of recommendations and telling us maybe some things that we need to be doing or some things that the folks at CMS need to be doing.

We have the Department of Justice chasing the bad guys, putting them in jail, fining them, sending out a real strong message to people who are doing this stuff that if they keep it up, we will catch you. You will not be happy. And that is an important message, as well.

And for Ms. Carson over here to say we have not just tens of thousands of our senior citizens out there, but maybe hundreds of thousands we can put out on the beat, some new cops on the beat, and they are all 65 or over, but if we got them out on the beat and helping us to beat back the bad guys.

But what I really want to hear from you is what more—not so much what should the folks at the table and those you represent be doing, but is there anything, any advice, good advice you have to close with what more the Legislative Branch, the Congress, can be doing to help us do a better job on this front?

Ms. CARSON. Well, when I was in banking, we had a tracking system called an Excessive Transaction Report.

Senator CARPER. Excessive transaction?

Ms. CARSON [continuing]. Report that we had, and what is going on in a day in which an alert is transmitted, with the fraud that is—and the new scams that are coming out in other cities? If we were alerted, we can educate the seniors to what is going on so that they can be best prepared to actually—they can be best prepared and we can be best prepared in educating them on what to look out for and also not to be taken in by any of the new scams that are coming about.

Senator CARPER. All right. Thanks. I think we are going to want to follow up with you back in Delaware and figure out how—maybe we can be a model in getting a whole lot more folks involved in this.

During the time I served as Governor for 8 years, we focused a lot on recruiting mentors. I wanted to recruit 10,000 mentors to work in our schools with kids on a voluntary basis and we hit the target. We actually still have thousands of people who mentor. I still mentor. That is something where we actually made a big difference in terms of quality of the education, students doing better in school, less disruption, just simply doing better academically. It did not cost really much money at all and we got a great return on that investment. Maybe we can figure out a way to leverage and get more of our seniors to sign up for the Patrol. Thank you.

All right. Ms. King, I am always happy to work with all you folks at GAO. I had a nice chat with your new Comptroller General yesterday and it was very encouraging—a very encouraging conversation. But what else can we do at our end to help on this front?

Ms. KING. I think effective oversight is really critical at this juncture, such as you are doing now. The Congress has taken a really active role in oversight of late and I think that is critical going forward, as well.

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Senator CARPER. All right. Thank you. Mr. Levinson.

Mr. LEVINSON. Mr. Chairman, of course, it would be very helpful to have strong continuing support for the HCFAC program.

Senator CARPER. Talk about that.

Mr. LEVINSON. Well, over the course of its history, it has been able to recover $14 billion, and as was pointed out earlier, those dollars are continuing to increase. The stakes are much larger and the HCFAC program really presents a very, very important vehicle for DOJ, OIG, CMS to work in a coordinated fashion to attack the fraud problem. So continued support of HCFAC, I would——

Senator CARPER. For the folks who are monitoring and following this hearing intently across the country, why do you not tell them what HCFAC actually means in words that they can understand.

Mr. LEVINSON. It is the Health Care Fraud Account program that was established as part of the Kennedy-Kassebaum HIPAA law in the mid-1990s, and it created this dedicated account that is shared between the Departments of Justice and Health and Human Services to coordinate a multi-prong attack against health care fraud. And as I have said, it has produced very, very significant results. The return on investment continues to look even better.

Senator CARPER. Good.

Mr. LEVINSON. As a second more particular matter, on (b)(15) exclusion authority——

Senator CARPER. Say that again?

Mr. LEVINSON. On (b)(15) exclusion authority that OIG exercises, there is bipartisan interest in Congress now on giving us additional authority under (b)(15) that would allow us to pursue, in the context of sanctioned entities, to pursue parent or sister corporations that, in effect, control or are working with the entity that has been excluded for—as a part of the sanction.

Senator CARPER. OK.

Mr. LEVINSON. We need to be able to pursue those who, in effect, are in or connected with the corporation that we have identified as committing a serious health care infraction. Giving us that authority would allow us to go up the corporate chain or be able to pursue other corporations in which individuals basically are working together.

Senator CARPER. Good. That is one that—I think that is new to me. That is not something I have thought about before, so we appreciate that idea.

Mr. LEVINSON. Thank you.

Senator CARPER. Thanks. Mr. Andres, what can we do to help you guys do a better job?

Mr. ANDRES. Chairman Carper, the President's budget seeks an additional $63 million in discretionary funding for the Department of Justice, and we would use those funds to continue our law enforcement efforts. As we have testified here today, investment in health care fraud enforcement is a sound one, one that generates revenue, and we believe that supporting the budget would be instrumental to us continuing those efforts.

Senator CARPER. All right. Thank you.

Dr. Budetti, before you respond, let me just say, my colleagues and I have, frankly, asked a lot of questions, not easy questions, in some cases difficult questions. I am sure as we go forward there

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are going to be even more tough questions. But having said that, I just want to note that a very good and important step that you described. CMS implementing new requirements and controls will help curb waste and fraud from the Medicare prescription drug program. We are mindful of that. These steps directly address the findings of the IG that I released. That is just one of several in a series of solid progress. I just would like to say that.

It is not enough just to pull somebody before a Committee and just say, well, why do you not do a better job? The important thing is, well, we have asked you to do a better job. We have provided the resources. We have asked you, how can we help you. We have provided the resources. And then we say we expect you to do a better job, and on a number of fronts, you are, and we want to make sure that continues and we are keeping up our share of the bargain.

But any closing comment in terms of how we can help more?

Dr. BUDETTI. Thank you very much for those kind words, Senator. I truly anticipate that we will be in the position to give you more reason to feel good about the investments that you have made.

As far as going forward, well, first of all, we certainly appreciate everything that you and your colleagues in the Senate and in the Congress have done with providing us with the authorities and the expanded funding in the Affordable Care Act and other new authorities. Those are absolutely critical to what we are doing.

Going forward, as my colleagues have said, the President's budget for 2012 does propose additional spending that promises to save another $30 billion or more over the coming decade. So we continue to believe that it would be an ongoing wise investment to make, for the Congress to make. So if there is any one thing that I would mention, it would be for you to support the President's budget request for 2012.

But I also want to thank you, sir, for your leadership in this area and look forward very much to continuing to work with you.

Senator CARPER. We look forward to it, as well.

My thanks to each of you for joining us today, for preparing today, for the good work that you and your teams are doing. Let us just keep it up.

I will close with this. I say this probably once or twice every day. Everything I do, I know I can do better. The same is probably true for all of us. And if it is not perfect, we need to make it better, and while we are doing better, better yet, I know we can all do better still. Let us just make sure that we do.

Thank you so much. This hearing is adjourned. [Whereupon, at 5:02 p.m., the Committee was adjourned.]

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APPENDIX

FOR IMMEDIATE RELEASE

TOM CARPER

UNITED STATES SENATOR · DELAWARE

FOR RELEASE: March 9, 2011
CONTACT: Emily Spain (202) 224-2441

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT INFORMATION, FEDERAL SERVICES, AND INTERNATIONAL SECURITY

HEARING: "New Tools for Curbing Waste and Fraud in Medicare and Medicaid"

Delawarean Testified on the Delaware Senior Medicare Patrol Program's Success in Reducing Fraud

WASHINGTON – Today, Sen. Tom Carper (D-Del.), Chairman of the Senate Subcommittee on Federal Financial Management, held the hearing, "New Tools for Curbing Waste and Fraud in Medicare and Medicaid."

For more information on the hearing or to watch the webcast of the hearing, please click HERE.

A copy of Sen. Carper's remarks, as prepared for delivery, follows:

"Today's hearing will focus on two of our nation's health care programs, Medicare and Medicaid, and steps that have been taken and should be taken to curb waste and fraud in those programs.

"As we hold this hearing today, our nation still faces considerable economic challenges. Partly as a result of those challenges, we've faced record budget deficits in recent years. In addition, our national debt stands at more than $14 trillion, well over double what it was just ten years ago. The debt as a percentage of GDP has risen to 63 percent – up from 33 percent a decade ago. The last time it was this high was at the end of WWII. That level of debt was not sustainable then, and it is not sustainable today.

"A wide variety of ideas have been put forward on how to reduce our budget deficit and begin whittling down our debt. Last fall, a majority of the bi-partisan deficit commission appointed by President Obama provided us with a roadmap to reduce the cumulative federal deficits over the next decade by some $4 trillion. A number of the steps we would

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need to take to accomplish this goal will likely be painful.

"While most Americans want us to reduce the deficit, determining the best path forward will not be easy. Many Americans believe that those of us here in Washington aren't capable of doing the hard work we were hired to do – that is to effectively manage the tax dollars they entrust us with. They look at the spending decisions we've made in recent years and question whether the culture here is broken. They question whether we're capable of making the kind of tough decisions they and their families make with their own budgets. I don't blame them for being skeptical.

"We need to establish a different kind of culture in Washington when it comes to spending. We need to establish a culture of thrift to replace what some would call a culture of spendthrift. We need to look in every nook and cranny of federal spending – domestic, defense and entitlements, along with tax expenditures – and ask this question, 'Is it possible to get better results for less money? If not, is it possible to get better results for the same amount of money we're spending today?'

"Today, we are here to examine the steps that have been taken and should be taken to save billions of dollars in waste and fraud in Medicare and Medicaid. Medicare and Medicaid are two vital programs that provide health care for our nation's seniors, people with disabilities, and low income children, among others. Last year, Medicare paid out about $509 billion to care for 47 million beneficiaries. Medicaid expenditures for the federal government and our states were an additional $381 billion, covering over 68 million people. And these numbers are expected to grow as our population becomes older.

"Americans' increasing reliance over time on Medicare and Medicaid presents another opportunity for criminals to take advantage of these programs. And they do try to take advantage. Medicare made an estimated $47.5 billion in improper payments in fiscal year 2010. And this does not even include an estimate for the Medicare prescription drug program, which I'm told could add more than $5 billion to the total. For Medicaid, the improper payments figure is $22.5 billion.

"Moreover, Attorney General Holder estimates that Medicare fraud totals as much as $60 billion dollars each year. And Medicare and Medicaid continue to be on the Government Accountability Office's list of government programs at "high risk" for waste, fraud and abuse—as they have been since 1990.

"An improper payment occurs, as most of you probably know, when an agency pays a vendor for something it didn't receive or, maybe, even pays them twice. It can occur when a doctor is reimbursed by Medicare for a procedure that never took place or, perhaps, one that wasn't necessary and shouldn't have taken place at all. These kinds of mistakes occur every day in the private sector and across government. But what disturbs me about the problem here in the federal government is that we seem to make expensive, often avoidable mistakes, at a rate much higher than a business or the average family would

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tolerate or could afford.

"So it's easy to see how urgent it is that we step up the pace of our efforts with Medicare and Medicaid, that we sharpen our pencils, and eliminate to the best of our abilities the problems that lead to waste and fraud. Success in doing so will help us achieve our deficit reduction goals. It will also lengthen the life of the Medicare trust fund, now forecast to run out of money in 2017.

"The good news is that we are seeing renewed commitment to curb waste and fraud in Medicare and Medicaid. President Obama and Secretary Sebelius have set a goal of reducing the Medicare fee-for-service improper payment rate by 50 percent by 2012. That is very aggressive and represents the kind of goals we need. Congress also has put Medicare waste and fraud in its sights.

"The Affordable Care Act, which was enacted almost a year ago, includes a number of provisions aimed at enhancing our efforts to fight waste, fraud, and abuse in Medicare and Medicaid. Central to the new law is also a goal to obtain better results in health care for less money. Eliminating avoidable mistake and cracking down on fraudsters will be an important element of achieving that goal.

"The new law calls for dramatically improved screening of Medicare providers. The measure also aims to stop payments to providers before payment is made when there is credible evidence of fraud. This ends a practice often called "pay and chase" in which a provider was paid and then chased down later for a refund once an error or fraud was detected.

"The new law also extends Recovery Audit Contracting, which involves the use of private contractors who comb agency books for improper payments and then seek to recover them. CMS has had considerable success with this tool in the past, recovering roughly $1 billion in Medicare fee-for-service improper payments in just five states during a pilot project. The pilot project also gave CMS important feedback to address the concerns of patients and health care providers by improving the program. That improved effort is now being expanded to all of Medicare and Medicaid.

"CMS is also working to implement other program changes, such as increased support for the Senior Medicare Patrol and a strengthening of controls over the Medicare prescription drug program. The men and women who run Medicare and Medicaid are making strides in fixing many of the problems in those programs that lead to waste and fraud, but we have a long way to go.

"Today, we have been joined by several witnesses who are each doing their part in the efforts underway. We have witnesses from law enforcement to describe how we catch fraudsters. And we have witnesses to describe how we can prevent waste and fraud before it happens. We are also pleased to welcome this afternoon someone who works

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directly with seniors in Delaware to identify fraud through the Senior Medicare Patrol.

"We are here today in large part because I believe that we have a moral imperative to ensure that our Medicare and Medicaid beneficiaries have access to quality care and, at the same time, that the scarce resources we put into those programs are well spent. It is the right thing to do, as well, both for the health of those two programs and for our federal budget as a whole. Each and every one of us can agree on that point and, I hope, on a great deal more."

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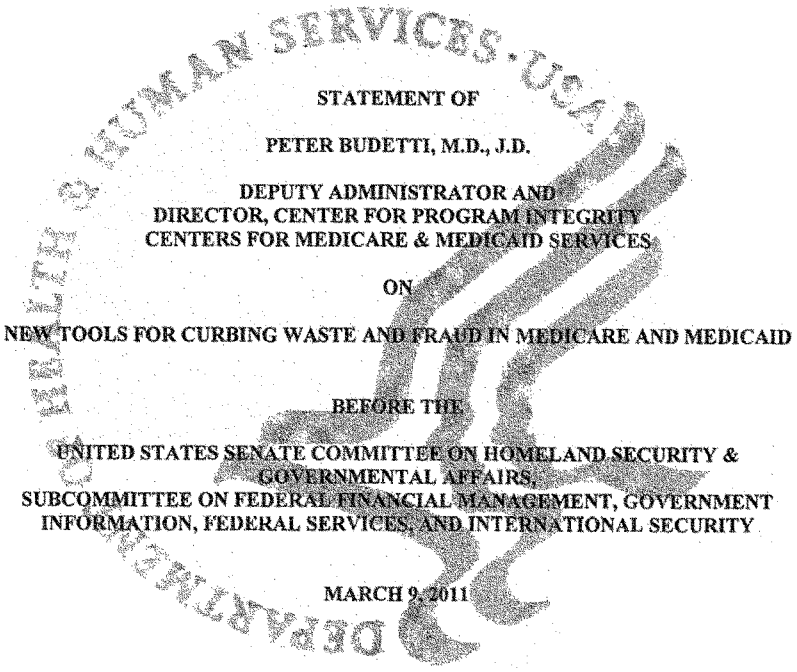
Brown Holds Hearing on Combating and Preventing Medicare and Medicaid Fraud

WASHINGTON, DC—Today, U.S. Senator Scott Brown (R-MA) held a hearing called *"New Tools for Curbing Waste and Fraud in Medicare and Medicaid"*. As Ranking Member of the Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security, Senator Brown partnered with Chairman Tom Carper (D-DE) to assess the progress of the Centers for Medicare and Medicaid Services (CMS) in implementing programs for combating and preventing fraud in America's two most important health care programs.

"It's outrageous that $100 billion of taxpayer dollars spent on Medicare and Medicaid is being consumed by waste, fraud and abuse," Brown said after the hearing. "It's time that CMS put in place strong anti-fraud measures that ensure taxpayer dollars are actually being used to help senior citizens and other worthy recipients. We must tackle this problem now, and a failure to act immediately threatens the very existence of these important programs."

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STATEMENT OF

PETER BUDETTI, M.D., J.D.

DEPUTY ADMINISTRATOR AND
DIRECTOR, CENTER FOR PROGRAM INTEGRITY
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

NEW TOOLS FOR CURBING WASTE AND FRAUD IN MEDICARE AND MEDICAID

BEFORE THE

UNITED STATES SENATE COMMITTEE ON HOMELAND SECURITY & GOVERNMENTAL AFFAIRS,
SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT INFORMATION, FEDERAL SERVICES, AND INTERNATIONAL SECURITY

MARCH 9, 2011



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U.S. Senate Committee on Homeland Security & Governmental Affairs, Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security

Hearing on "New Tools for Curbing Waste and Fraud in Medicare and Medicaid" March 9, 2011

Chairman Carper, Ranking Member Brown, and Members of the Subcommittee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) efforts to reduce fraud, waste, and abuse in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) and the new tools and authorities provided in the Affordable Care Act.

As CMS implements the new authorities in the Affordable Care Act, we have a significant opportunity to enhance our existing efforts to combat fraud, waste, and abuse in Federal health care programs. These new authorities offer more front-end protections to keep those who are intent on committing fraud out of the programs and new tools for deterring wasteful and fiscally abusive practices, identifying and addressing fraudulent payment issues promptly, and ensuring the integrity of Medicare, Medicaid, and CHIP. CMS is pursuing an aggressive program integrity strategy that seeks to prevent payment of fraudulent claims, rather than chasing fraudulent providers after a payment has been made. CMS now has the flexibility to proactively tailor resources and quickly initiate activities in a transformative way. We believe the Affordable Care Act provisions will greatly support the effectiveness of our work. This historic moment also presents CMS with a valuable opportunity to partner with the private sector and collaborate on fraud detection efforts based on tools and methods that are already succeeding in other sectors.

CMS recognizes the importance of having strong program integrity initiatives that will deter and end criminal activity that attempts to defraud Federal health care programs. I share your commitment to ensuring taxpayer dollars are being spent on legitimate items and services, which is at the forefront of our program integrity mission.

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Bringing Activities Together into the Center for Program Integrity

CMS has taken several administrative steps to better meet the Agency's future needs and challenges. CMS realigned its internal organizational structure last year, consolidating the Medicare and Medicaid program integrity groups under a unified Center for Program Integrity (CPI). This centralized approach has enabled CMS to pursue a more strategic and coordinated set of program integrity policies and activities across the Federal health care programs and has formed a bridge that facilitates collaboration on anti-fraud initiatives with our law enforcement partners, such as the Health and Human Services Office of Inspector General (OIG), the Department of Justice (DOJ), and State Medicaid Fraud Control Units. We are also working closely with our colleagues in the Office of the Secretary at HHS, as they implement the Secretary's program integrity initiative across the department. We are actively sharing best practices and lessons learned as we move forward together.

The Affordable Care Act enhances this organizational change by providing CMS with the ability to improve and streamline its program integrity capabilities by providing us with an opportunity to jointly develop Medicare, Medicaid and CHIP policy on these new authorities. For example, many Affordable Care Act provisions, such as enhanced screening requirements for new providers and suppliers, apply across the programs. The new integrated operation of program integrity activities within CMS ensures that there is better consistency in CMS' approach to fraud prevention across all of our programs.

Strategic Principles for Program Integrity Operations

As we continue the process of implementing these authorities and strengthening the integrity of the Federal health care programs, we are mindful of the impact our new rules have on health care providers and suppliers, who are our partners in caring for beneficiaries and have the awareness needed to assist us in continuing to protect beneficiary access to necessary health care services, supplies or medication. CMS is committed to improving care for our beneficiaries and engaging States and law-abiding providers and suppliers to ensure our activities reflect their interests. As we seek to reduce fraud, waste, and abuse in Medicare, Medicaid, and CHIP, we are mindful of striking the right balance between preventing fraud and other improper payments without impeding the delivery of critical health care services to beneficiaries. At their core, Federal

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health care programs are designed to provide affordable health care to families in need, people with disabilities, and aging Americans. Additionally, the vast majority of health care providers are honest people who abide by their legal and professional duties and provide critical health care services to millions of CMS beneficiaries every day. CMS is committed to providing health care services to beneficiaries, while reducing the burden on legitimate providers, targeting fraudsters and saving taxpayer dollars.

This Administration is committed to minimizing fraud, waste, and abuse in Federal health care programs. While improper payments are not necessarily indicative of fraud, CMS is committed to reducing all waste within our programs. In order to focus on the prevention of improper payments while remaining vigilant in detecting and pursuing problems when they occur, we have increased provider education on proper documentation and are reexamining our claims payment and enrollment systems. With these efforts and others, we are confident that we will meet the President's goal to reduce the Medicare fee-for-service error rate in half by 2012. Moreover, we are implementing a number of measures that will shift our enforcement and administrative actions from a "pay and chase" mode to the prevention of fraudulent and other improper payments. This shift involves many different activities, which we are carrying out with the powerful new anti-fraud tools provided to CMS and our law enforcement partners under the Affordable Care Act.

We are steadily working to incorporate targeted screening and prevention activities into our claims and enrollment processes where appropriate. Our goal is to keep those individuals and companies that intend to defraud Medicare, Medicaid, and CHIP out of these programs in the first place, not to pay fraudulent claims when they are submitted, and to remove such individuals and companies from our programs if they do get in. The first step to preventing fraud in the Federal health care programs is to appropriately screen providers and suppliers who are enrolling or revalidating their enrollment to verify that only legitimate providers and suppliers who meet our stringent enrollment standards are providing care to program beneficiaries.

CMS' Efforts to Implement the Affordable Care Act

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New Actions – Medicare, Medicaid, and CHIP Screening and Fraud Prevention Rule (CMS-6028-FC)

On January 24, 2011, HHS and CMS announced rules that implement new Affordable Care Act tools to fight fraud, strengthen Federal health care programs, and protect taxpayer dollars. This rule puts in place prevention safeguards that will help CMS move beyond the "pay and chase" approach to fighting fraud.

Enhanced Screening and Enrollment Protections: The Affordable Care Act requires providers and suppliers who wish to enroll in the Medicare, Medicaid, or CHIP programs to undergo a level of screening tied to the level of risk of fraud, waste, or abuse such providers and suppliers present to the programs. This new rule will require high-risk providers and suppliers, including newly enrolling suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) and home health agencies, to undergo a higher level of scrutiny based on CMS' and law enforcement's experience with these provider and supplier types. CMS has also established certain triggers that would move a provider or supplier into the highest screening level.

In addition, CMS-6028-FC implements the Affordable Care Act provision that authorizes CMS to require that providers who order and refer certain items or services for Medicaid beneficiaries be enrolled in the State's Medicaid program; this is similar to the new Medicare requirement included in an interim final rule published this past spring, CMS-6010-IFC, described in more detail below.

This new rule implements the statutory authority for CMS to impose a temporary enrollment moratorium if the Secretary determines such a moratorium is necessary to prevent or combat fraud, waste, or abuse. We will assess the impact of any proposed moratorium on beneficiary access and take this into consideration. We will publish a notice of the moratorium including a rationale for the moratorium in the *Federal Register*. Other preventive measures include new levels of coordination between Medicare and State Medicaid agencies. For example, State Medicaid programs are now required to terminate a provider that has been terminated by Medicare or terminated for cause by another State Medicaid agency or CHIP program.

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Stopping Payment of Suspect Claims: CMS-6028-FC allows Medicare payments to be suspended from providers or suppliers if there is a credible allegation of fraud pending an investigation or final action. The law also requires States to suspend payments to Medicaid providers where there is a credible allegation of fraud. This enhanced authority will help prevent taxpayer dollars from being used to pay fraudulent providers and suppliers.

New Resources to Strengthen Program Integrity: The Affordable Care Act provides an additional $350 million over 10 years, plus an inflation adjustment, to ramp up program integrity efforts in HHS' Health Care Fraud and Abuse Control program (HCFAC) account, including the Medicare Integrity Program, as well as the Medicaid Integrity Program. These dedicated Affordable Care Act funds provide important financial resources for government-wide health care fraud and abuse efforts for the next decade, which will be used along with discretionary funding sought in the President's Budget to pursue critical new prevention-focused activities, place more "feet on the street" by hiring more law enforcement agents, and facilitate other efforts to reduce improper payments and address emerging fraud schemes in the health care system.

Other Implementation Steps – CMS-6010-IFC

CMS published an interim final rule with comment period (CMS-6010-IFC) in the *Federal Register* on May 5, 2010 that implemented some new anti-fraud authorities and provisions of the Affordable Care Act. This rule, which took effect July 6, 2010, requires all providers of medical or other items or services and suppliers that qualify for a National Provider Identifier (NPI) to include their NPI on all applications to enroll in Federal health care programs and to also include their NPI on all claims for payment submitted to Medicare and Medicaid. CMS-6010-IFC also requires that physicians and eligible professionals who order or refer home health services or most Medicare Part B-covered items and services for Medicare fee-for-service beneficiaries be enrolled in Medicare. In addition, it adds requirements for providers, physicians, and suppliers participating in the Medicare program to provide access and maintain documentation on orders or requests for payments for items or services at high risk of fraud, waste, and abuse, such as DMEPOS, home health services, and certain other items or services as specified by the Secretary.

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Other Affordable Care Act Authorities

There are many other Affordable Care Act program integrity provisions that we will also be busy implementing this year. For example, CMS will be issuing additional surety bond requirements under the Affordable Care Act for DMEPOS suppliers and home health agencies and potentially for certain other providers of services and supplies. These surety bonds are a condition of enrollment and may help ensure that DMEPOS suppliers and home health agencies, and potentially certain other providers of services and supplies, are legitimate and financially solvent.

In addition, providers and suppliers will be required to establish compliance plans that contain certain anti-fraud requirements and reflect good governance practices. Such plans will help ensure that providers and suppliers have incorporated anti-fraud protections into their operations. Other preventive measures focus on certain categories of providers and suppliers that historically have presented concerns to our program including DMEPOS suppliers, home health agencies, and Community Mental Health Centers (CMHCs). For example, as an additional safeguard to address longstanding concerns with CMHCs, such facilities will be required to provide at least 40 percent of their items and services to non-Medicare beneficiaries.

Expanded Use of Recovery Audit Contractors

CMS is drawing from the lessons learned from the Medicare Fee-For-Service (FFS) Recovery Audit Contractor (RAC) Program to implement the new statutory authority given in the Affordable Care Act to expand the program to Medicare Parts C and D and Medicaid. In order to address the fundamental differences in payment structure between FFS, Medicare Part C (managed care), Medicare Part D and State-run Medicaid programs, CMS has taken a multi-pronged approach to implementation of the new Affordable Care Act authorities. In January 2011, CMS awarded a contract to identify incorrect payments and recoup overpayments in Medicare Part D. Additionally, we are seeking public comment through a solicitation issued on December 27, 2010 in the Federal Register on innovative strategies for review of additional Medicare Parts C and D data, including the effectiveness of sponsors' anti-fraud plans.

In the Medicaid program, CMS issued a State Medicaid Director letter in October 2010 that offered initial guidance on the implementation of the Medicaid RAC requirements and published

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a Notice of Proposed Rulemaking on November 10, 2010. CMS has provided significant technical assistance to States through all-State calls and webinars and has begun the coordination with States that have RAC contracts in place, as required by the statute. CMS will also work to ensure that States and their Medicaid RACs coordinate recovery audits with other entities to minimize the likelihood of overlapping audits. On February 17, 2011, CMS launched a Medicaid RACs At-A-Glance web page on the CMS website. The page provides basic State RAC information to the public and interested stakeholders about each State's RAC program. As States fully implement their programs and additional elements are added to the site in the future, the site will help States to monitor the performance of their own RAC program and find information on other States' programs that may assist them.

Increased Flexibility in Medicaid Recovery Rules

CMS issued a State Medicaid Director letter in July 2010, providing initial guidance on the recovery of Medicaid overpayments as required by the Affordable Care Act. States now have up to one year from the date of discovery of an overpayment in Medicaid to recover, or attempt to recover, such overpayment before being required to refund the Federal share of the overpayment. Prior to passage of the Affordable Care Act, States were allowed only up to 60 days from the date of discovery of an overpayment to recover such overpayment before making the adjustment to the Federal share. CMS appreciates this new flexibility for States. The additional time provided under the Affordable Care Act will enable States to more thoroughly root out fraud and overpayments. However, for overpayments resulting from fraud, if an ongoing administrative or judicial process prevents a State from recovering an overpayment within one year of discovery, the State has an additional 30 days after a final judgment is made to recover the overpayment before making the adjustment to the Federal share.

Guidance on Self-Disclosure of Actual or Potential Violations of Physician Self-Referral Statute

In September 2010, CMS published the Voluntary Self-Referral Disclosure Protocol (SRDP) on its website to enable providers and suppliers to disclose actual or potential violations of the physician self-referral statute (Section 1877 of the Social Security Act). The SRDP contains instructions for providers and suppliers who make self-disclosures, and advises that the Affordable Care Act gives the Secretary the discretion to reduce the amount due and owing for a

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violation of the physician self-referral statute. The SRDP states the factors CMS may consider in reducing the amounts due and owing, including: (1) the nature and extent of the improper or illegal practice; (2) the timeliness of the self-disclosure; (3) the cooperation in providing additional information related to the disclosure; (4) the litigation risk associated with the matter disclosed; and (5) the financial position of the disclosing party.

Fraud Detection and Reporting

CMS has improved the processes for fraud detection by our contractors and for reporting, analyzing, and investigating complaints of potential fraud from beneficiaries.

In order to take a more holistic approach to detecting and addressing fraud, CMS has worked to integrate the activities of the Program Safeguard Contractors (PSCs) into more comprehensive Zone Program Integrity Contractors (ZPICs). Before these reforms, each PSC focused on benefit integrity in limited parts of the Medicare program, making it possible for providers and suppliers to continue to submit fraudulent claims to one part of the Medicare program even after questionable claims had been identified in another part of the program. Instead, CMS is currently in the process of contracting with one ZPIC in each of seven separate geographic zones, with an emphasis on designated high fraud areas. Unlike PSCs, ZPICs perform program integrity functions for all parts of Medicare. These contracting reforms have allowed CMS to break down silos in program integrity work and better identify potentially fraudulent behavior across all parts of the Medicare program.

Another of these fraud detection improvements involves modifications to the 1-800-MEDICARE call center procedures. In the past, if a caller reported that they did not recognize a provider or did not receive the service documented on their Medicare Summary Notice form, they were asked to follow up with the provider prior to filing a fraud complaint. However, now 1-800-MEDICARE will review the beneficiary's claims records with them and if the discrepancy is not resolved, we will take action and file a complaint immediately, regardless of whether the caller has attempted to contact the provider. Also, CMS is using the information from beneficiaries' complaints in new ways. For instance, CMS is generating weekly "fraud complaint frequency analysis reports" that compile provider-specific complaints and flag providers who have been the

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subject of multiple fraud complaints for a closer review. This is just one example of CMS shifting our use of available data in more intuitive ways.

As part of our commitment to applying innovative analytics to existing data sources to prevent fraud, CMS has developed the capability to map shifts and trends in fraud allegations reported to 1-800-MEDICARE over time using geospatial maps and sophisticated data tools. These tools will allow CMS to gather more information from 1-800-MEDICARE calls for data analysis. The various parameters include claim type, geographic location, and fraud type. CMS is also exploring new options for streamlining the process and timeframe for investigating fraud complaints, while seeking to preserve the efficiencies and cost-effectiveness of a single call center like 1-800-MEDICARE.

Fiscal Year 2012 Budget Request

To continue the Administration's focus on fraud prevention and to build on the new authorities and resources provided by the Affordable Care Act, the President's Fiscal Year 2012 Budget Request includes a package of program integrity legislative proposals across Medicare, Medicaid and CHIP that will save $32.3 billion over 10 years. These proposals, if enacted, would provide CMS with additional tools to reduce and prevent improper payments and ensure that those committing fraud are held responsible and cannot easily discharge their debts or reenter our programs to commit additional offenses.

In addition, the FY 2012 Budget Request also includes a little over $1.85 billion for the HCFAC account, including mandatory and discretionary sources, divided between CMS' programs and our law enforcement partners at the OIG and DOJ. The FY 2012 discretionary HCFAC request is $581 million, a $270 million increase over the FY 2010 enacted level. Described in more detail below, these new HCFAC resources would support and advance the goals of the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative, a joint Cabinet-level effort established by the President and led by Secretary Sebelius and Attorney General Holder. The Budget Request is necessary to continue expanding the Medicare Fraud Strike Force—an integral part of HEAT—to as many as 20 areas, as well as civil health care fraud enforcement activities. Further, if provided by Congress, this discretionary HCFAC funding will allow us to

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expand prevention and detection activities and work to reduce improper payments with aggressive pre-payment review, increased provider education, and the development of a national pre-payment edit module.

HCFAC Program Successes

HCFAC has been steadily growing since it began in 1997 and, as shown in the recently released FY 2010 HCFAC report, this investment in fraud fighting resources is paying dividends. The HCFAC report demonstrates the value of this program; since its inception and through FY 2010, HCFAC has resulted in the return of $18 billion to the Medicare trust funds. In FY 2010 alone, $2.8 billion was returned to the Medicare trust funds and $683 million was returned to the Federal Treasury from Medicaid recoveries. The HCFAC return-on-investment (ROI) is currently the highest it has ever been; the 3 year rolling ROI (FY 2008- FY 2010) averaging all HCFAC activities is $6.8 to $1; this is $1.9 more than the historical average. Additionally, the ROI for the Medicare Integrity Program's activities is 14 to 1.

HCFAC funds support HEAT and many complementary anti-fraud initiatives, including:

- **DOJ-FBI-HHS-OIG-Medicare Strike Forces:** This coordinated effort is needed in order to focus enforcement resources in geographic areas at high risk for fraud. Strike Force cases are data driven, using technology to pinpoint fraud hot spots through the identification of unusual billing patterns as they occur.
- **Increased Prevention and Detection:** CMS is committed to working with law enforcement to efficiently use existing systems and collaborate on future improvements, and has provided numerous training sessions for law enforcement personnel on CMS data analytic systems. Further, CMS will do rapid response projects as well as long-term in-depth studies.
- **Expanded Law Enforcement Strategies:** HCFAC will further expand existing criminal and civil health care fraud investigations and prosecutions, particularly related to fraud schemes in areas such as pharmaceutical services, medical devices, and durable medical equipment, as well as newly emerging schemes. It will allow the use of cutting-edge technology in the analysis of electronic evidence to better target and accelerate

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enforcement actions. Finally, the increase will expand Medicare and Medicaid audits and OIG's enforcement, investigative, and oversight activities.

- **Oversight:** HCFAC will help to further strengthen oversight in Medicare, Medicaid, and CHIP.

We are excited about the tools and resources available to CMS through HCFAC. In particular, because of changes in the Affordable Care Act, we will now have flexibility to utilize HCFAC funds to enhance our own expertise for pursuing fraud, waste, and abuse in Medicare.

Engaging Our Beneficiaries and Partners

Meanwhile, HHS and CMS continue to work with and rely on our beneficiaries and collaborate with our partners to reduce fraud, waste, and abuse in Medicare, Medicaid and CHIP. The Senior Medicare Patrol (SMP) program, led by the Administration on Aging (AoA), empowers seniors to identify and fight fraud through increased awareness and understanding of Federal health care programs. This knowledge helps seniors protect themselves from the economic and health-related consequences of Medicare and Medicaid fraud, waste, and abuse. In partnership with State and national fraud control/consumer protection entities, including Medicare contractors, State Medicaid Fraud Control Units, State Attorneys General, the HHS OIG, and CMS, SMP projects also work to resolve beneficiary complaints of potential fraud. Since the program's inception, the program has educated over 3.84 million beneficiaries in group or one-on-one counseling sessions and has reached almost 24 million people through community education outreach events. CMS is partnering with AoA to expand the size of the SMP program and put more people in the community to assist in the fight against fraud.

In addition to working with AoA on expanding the SMPs, CMS is implementing a number of new mechanisms to better engage beneficiaries in identifying and preventing fraud. As part of that effort, CMS encourages its beneficiaries to check their Medicare claims summaries thoroughly. Medicare Summary Notices (MSNs) are sent to beneficiaries every 90 days; CMS is working with beneficiaries to redesign the MSNs to make them easier to understand so beneficiaries can spot potential fraud or overpayments on claims submitted for their care. Additionally, some 10 million beneficiaries are enrolled into www.mymedicare.gov, a secure

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website, and can now check their claims within 24 hours of the processing date. This information is also available through the 1-800-MEDICARE automated system. A fact sheet and informational card have been developed to educate and encourage beneficiaries or caregivers to check their claims frequently and to report any suspicious claims activity to Medicare. These materials are being used at the regional fraud prevention summits, described below, and have been shared with both State Health Insurance Plans and SMPs.

Further, CMS is implementing a number of new educational and awareness initiatives in identifying and preventing fraud among those Americans who receive services under the Medicaid program.

Collaborating with Law Enforcement Partners

HEAT Task Force

CMS is committed to working with our law enforcement partners, who take a lead role in investigating and prosecuting alleged fraud. CMS provides support and resources to the Strike Force, which investigate and track down individuals and entities defrauding Medicare and other government health care programs. Strike Force prosecutions are "data driven" and target individuals and groups actively involved in ongoing fraud schemes. These efforts started in Miami in 2007 and expanded to Los Angeles in 2008. In 2009 and 2010 under the HEAT initiative, we continued expanding the Strike Force to Detroit, Houston, Brooklyn, Tampa and Baton Rouge using the additional discretionary funding that Congress provided in response to the President's budget requests. On February 17, 2011, we announced further expansion of Medicare Fraud Strike Force operations to Dallas and Chicago. HEAT has enhanced coordination of anti-fraud efforts of DOJ's Civil and Criminal Divisions and U.S. Attorneys' Offices, FBI, HHS/OIG and CMS. The HEAT task force is working to identify new enforcement initiatives and areas for increased oversight and prevention, including how to increase efficiency in pharmaceutical and device investigations.

The Strike Force model has been very successful. Since its inception, Strike Force operations in nine cities have charged more than 990 individuals who collectively have falsely billed the Medicare program for more than $2.3 billion. This figure includes the Medicare Strike Force's

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latest successes, announced on February 17, 2011, charging 111 individuals with more than $225 million in false Medicare billing.

Health Care Fraud Prevention Summits

Because the public and private sectors have common challenges in fighting fraud and keeping fraudulent providers at bay, it makes sense that we should work together to develop common solutions. In addition to the HEAT initiative, agencies including HHS, CMS, OIG, and DOJ have co-hosted a series of regional summits on health care fraud prevention.

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. These summits, held to date in Miami, Los Angeles, New York, and Boston with plans for additional cities, 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 also featured educational panels that discussed best practices for providers, beneficiaries and law enforcement in preventing health care fraud. The panels included law enforcement officials, consumer experts, providers and representatives of key government agencies. CMS looks forward to continuing these summits in 2011 as well as more opportunities to bring these stakeholder communities together in other cities to continue this important dialogue and strengthen our cooperative efforts across the Federal government and with the private sector.

Resolving Invalid Prescriber Identifiers

Sharing information and performance metrics broadly and engaging internal and external stakeholders requires establishing new partnerships with government and private sector groups. Another one of our key partners in this effort has been the OIG. In June 2010, the OIG issued a report: "Invalid Prescriber Identifiers on Medicare Part D Drug Claims" which found that in 2007, CMS accepted more than 18 million Medicare Part D claims, worth $1.2 billion, that contained invalid prescriber identifiers.[1] While these claims accounted for 2 percent of all

[1] "Invalid Prescriber Identifiers on Medicare Part D Drug Claims", June 2010, OEI-03-09-00140, http://oig.hhs.gov/oei/reports/oei-03-09-00140.pdf.

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prescription drug event (PDE) records submitted by plans to CMS in 2007, 98 percent of the PDE records with invalid prescriber identifiers reflect pharmacy submission of invalid DEA numbers (numbers assigned by the Drug Enforcement Administration). CMS took the results of the OIG report seriously, and issued a memorandum in August 2010 instructing Part D plans to submit a valid prescriber identifier on all PDE records.

On February 2, 2011, the OIG issued another report looking at CMS' oversight of prescriber identifiers for Schedule II controlled substance drugs.[2] The report found that in 2007, $20.6 million in claims (about 1.3 percent) for Schedule II drugs did not have a valid prescriber identifier.

CMS agrees with the OIG that invalid prescriber identifiers hinder efforts to monitor prescribing practices of specific providers. However, an invalid prescriber identifier does not automatically indicate that the prescription is invalid. Since 2007, there has been a substantial shift toward using the NPI as the standard prescriber identifier, which has resulted in a reduction in the percentage of invalid identifiers. Invalid NPIs accounted for less than 2 percent of all claims with invalid prescriber identifiers found in the OIG report. Therefore, CMS has worked to encourage providers to utilize the NPI format. Based on its own review, CMS has found that, as the percentage of prescriber NPIs on pharmacy claims has increased, the incidence of invalid prescribers has decreased.

CMS's current practice is to allow plans to submit one of four types of identifiers on Part D claims: a valid NPI, DEA number, Unique Physician Identification Number (UPIN) or State license number as a prescriber identifier. However, taking into account the OIG's findings, CMS believes that mandating the use of the NPI on all Part D claims may be the best way to ensure that a valid prescriber identifier is present on all Part D claims, including claims for Schedule II drugs. CMS is reviewing and building on prior guidance to Part D plans. As part of that process, CMS is considering proposing a requirement for 2013 that all Part D claims include a

[2] Oversight of the Prescriber Identifier Field in Prescription Drug Event Data for Schedule II Drugs, February 2, 2011, A-14-09-00302, http://oig.hhs.gov/oas/reports/other/140900302.pdf.

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valid NPI, which would be enforced by system checks on claims data CMS receives from Medicare drug plans.

In the meantime, we have proposed enhanced safeguards for 2012 in the draft 2012 Call Letter for Part D plan sponsors, which CMS released on February 18, 2011.[3] CMS intends to begin systems checks in 2012 that validate the NPI format on claims data it receives from drug plans. In addition, effective January 1, 2012, we have proposed to require that Part D plan sponsors confirm the validity of DEA numbers on Schedule II drug claims or map NPIs on these claims to the prescriber's DEA number. Sponsors would also be required to confirm that the controlled substance is within the prescriber's scope of practice to prescribe.

Data Analytics

The Affordable Care Act also requires increased data sharing between Federal entities to monitor and assess high risk program areas and better identify potential sources of fraud. CMS is expanding its Integrated Data Repository (IDR) which is currently populated with five years of historical Part A, Part B and Part D paid claims, to include near real time pre-payment stage claims data; this additional data will provide the opportunity to analyze previously undetected indicators of aberrant activity throughout the claims processing cycle. CMS intends to develop shared data models and is pursuing data sharing and matching agreements with the Department of Veterans Affairs, the Department of Defense, the Social Security Administration, and the Indian Health Service to identify potential waste, fraud, and abuse throughout Federal health care programs. Also, the Affordable Care Act requirement that States report an expanded set of data elements from their Medicaid Management Information System (MMIS) will strengthen CMS' program integrity work both within State Medicaid programs and across CMS. This robust State data set will be harmonized with Medicare claims data in the IDR to detect potential fraud, waste and abuse across multiple payers.

CMS will implement an innovative risk scoring technology that applies effective predictive models to Medicare. Innovative risk scoring technology applies a combination of behavioral

[3] Advance Notice and Draft Call Letter for CY 2012 for Medicare Advantage and Medicare prescription drug plans, http://www.cms.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2012.pdf.

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analyses, network analyses, and predictive analyses that are proven to effectively identify complex patterns of fraud and improper claims and billing schemes. CMS is integrating the advanced technology as part of an end-to-end solution that triggers effective, timely administrative actions by CMS as well as referrals to law enforcement when appropriate. Prior to applying predictive models to claims prepayment, CMS will rigorously test the algorithms to ensure a low rate of false positives, allowing payment of claims to legitimate providers without disruption or additional costs to honest providers; confirm that the algorithms do not diminish access to care for legitimate beneficiaries; and identify the most efficient analytics in order to appropriately target resources to the highest risk claims or providers. Given the changing landscape of health care fraud, any successful technology will need to be nimble and flexible, identifying and adjusting to new schemes as they appear.

As we pursue and test new technology, CMS is working to involve the private sector and State partners to incorporate strategies that have already proven successful. As the first phase of partnership building with private sector entities, CMS held an industry day in October 2010 that was attended by approximately 300 industry representatives. This event highlighted CMS' strategic goals, priorities, and objectives in the use of information technology solutions for fraud prevention in our programs and provided an opportunity for attendees to determine whether their firm's services, methods and products fit with CMS' mission and vision. In December 2010, CPI issued a Request for Information asking vendors to identify their capabilities in the areas of provider screening/enrollment and data integration. CMS will review the responses and incorporate innovative ideas into the strategy for integrated, automated, providers screening and data integration.

Further, the Small Business Jobs Act of 2010 provided $100 million, beginning in FY 2011 to phase-in the implementation of predictive analytics in Medicare FFS, Medicaid, and CHIP over four years. The new predictive modeling technology will incorporate lessons learned through pilot projects. For example, in one pilot, CMS partnered with the Federal Recovery Accountability and Transparency Board (RATB) to investigate a group of high-risk providers. By linking public data found on the Internet with other information, like fraud alerts from other payers and court records, we uncovered a potentially fraudulent scheme. The scheme involved

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opening multiple companies at the same location on the same day using provider numbers of physicians in other states. The data confirmed several suspect providers who were already under investigation and, through linkage analysis, identified affiliated providers who are now also under investigation.

Delivery System Reforms

Beyond the traditional program integrity initiatives, the delivery system reforms created by the Affordable Care Act will further help to deter and prevent fraudulent activities within Medicare. When there are large disparities between the cost of goods and services, as compared to the allowed reimbursement, we know that these excessive payments often make Medicare a more attractive and lucrative target for those attempting to commit fraud. For instance, OIG, the Government Accountability Office (GAO), and other independent analysts have repeatedly highlighted that the fee schedule prices paid by Medicare for many DMEPOS items are excessive, as much as three or four times the retail prices and amounts paid by commercial insurers or cash customers. These inflated prices in turn increase the potential profits of those intending to defraud the Medicare program. To that end, CMS implemented supplier contracts and new payment rates based on the Round 1 rebid of DMEPOS competitive bidding on January 1, 2011 in nine Metropolitan Statistical Areas. The Office of the Actuary estimates that once fully implemented this program is projected to save more than $17 billion in Medicare expenditures over ten years. Outside of DMEPOS, CMS is working to redesign our Medicare payment systems and institute delivery system reforms that will realign Medicare payments with market prices and thereby reduce the incentive for "bad-actors" to target Medicare.

All of these new authorities and analytical tools will help move CMS beyond its historical "pay and chase" mode to a prevention-oriented approach with strong fraud deterrents and increased enrollment screenings, new disclosure and transparency guidelines, and early identification of high-risk providers and suppliers.

Conclusion

Health care fraud and improper payments undermine the integrity of Federal health care programs. Taxpayer dollars lost to fraud, waste, and abuse harm multiple parties, particularly

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some of our most vulnerable seniors, not just the Federal government. Eliminating the problem requires a long-term, sustainable approach that brings together beneficiaries, health care providers, the private sector, and Federal, State, and local governments and law enforcement agencies, in a collaborative partnership to develop and implement long-term solutions. New authorities in the Affordable Care Act offer additional front-end protections to keep those who intend to commit fraud out of Federal health care programs, as well as new tools for deterring wasteful and fiscally abusive practices, and promptly identifying and addressing fraudulent payment issues, which will ensure the integrity of Medicare, Medicaid, and CHIP.

This Administration has made a firm commitment to rein in fraud and wasteful spending, and with the Affordable Care Act, we have more tools than ever before to implement important and strategic changes. CMS thanks the Congress for providing us with these new authorities and resources, the Subcommittee for its ongoing oversight, and looks forward to working with you in the future as we continue to make improvements in protecting the integrity of Federal health care programs and safeguarding taxpayer resources.

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Statement of
Greg Andres
Acting Deputy Assistant Attorney General
Criminal Division
Department of Justice

Before the
Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security
Committee on Homeland Security and Governmental Affairs
United States Senate

Entitled
"New Tools for Curbing Waste and Fraud in Medicare and Medicaid"

Presented on
March 9, 2011

I. INTRODUCTION

Chairman Carper, Ranking Member Brown, and distinguished Members of the Subcommittee: Thank you for inviting me to speak with you today about the Department of Justice's efforts to combat health care fraud through criminal prosecution. I am privileged to appear before you on behalf of the Department of Justice, along with my colleagues Deputy Administrator and Director Budetti, Director King, Inspector General Levinson, and Volunteer Coordinator Carson. The Department is grateful to the Subcommittee for its leadership in this area, and we appreciate the chance to testify here today.

Health care fraud is a significant law enforcement problem. The federal government spends hundreds of billions of dollars every year to fund Medicare and other government health care programs, and taxpayers rightly expect these funds to be used to provide health care to seniors, children, the poor, and the disabled. Most medical professionals work hard to comply with the rules. But too many doctors, nurses, and others in the health care industry devote their

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energies elsewhere – to schemes that cheat taxpayers and patients alike, and defraud Medicare and other government programs.

At the Justice Department, together with our colleagues at the Department of Health and Human Services ("HHS"), we are fighting back. We investigate, prosecute, and secure prison sentences for hundreds of defendants every year, and we are recovering billions of dollars in stolen funds. With the additional resources provided to us by Congress over the past two years, we are making significant strides in this battle. In FY 2010, we collectively recovered a record $4.02 billion on behalf of taxpayers, $2.86 billion of which was deposited back into the Medicare Trust Fund. This represents a $1.47 billion (or 57 percent) increase over the amount recovered in FY 2009, which was itself a record amount at the time. Indeed, over the past three years, we have collectively recovered an average of nearly $7 for every dollar of funding that Congress has appropriated for health care fraud enforcement. Furthermore, in FY 2010 the Justice Department brought criminal health care fraud charges against 931 defendants – the most ever in a single fiscal year – and we secured 726 convictions, also a record.

II. BACKGROUND

Before focusing more closely on our criminal law enforcement efforts, I would like to provide you with a brief overview of the Justice Department's successful return on investment in fighting health care fraud, and of the different Department components involved in that effort. In the Health Insurance Portability and Accountability Act of 1996, Congress created the Health Care Fraud and Abuse Control Program ("HCFAC Program" or "Program"). The Program was established under the joint direction of the Justice Department and HHS to coordinate federal, state, and local law enforcement activities with respect to health care fraud and abuse. Our enforcement efforts have never been stronger than they are today. Since the HCFAC Program

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was established, the two Departments have returned more than $21.3 billion to the federal government, of which over $18 billion has been returned to the Medicare Trust Fund. Over the life of the HCFAC Program, this amounts to an average return on investment ("ROI") of $4.90 for every $1.00 expended. The average ROI over the past three years has been even higher. As reported in the HCFAC Program's annual report for FY 2010, the average ROI for the period 2008-2010 was $6.80 for every $1.00 expended, nearly $2.00 higher than the historical average.

This increased ROI is the result of a significant expansion of enforcement efforts at both the Justice Department and HHS. On May 20, 2009, Attorney General Holder and HHS Secretary Sebelius announced the creation of the Health Care Fraud Prevention and Enforcement Action Team ("HEAT"), an interagency effort created to tackle all aspects of the health care fraud problem. With the creation of HEAT, the Justice Department and HHS committed to making the battle against health care fraud a Cabinet-level priority, and the results have been extremely strong. HHS' Office of the Inspector General ("HHS-OIG") and the Centers for Medicare & Medicaid Services ("CMS") have closely partnered and provided significant investigative and administrative support to the HEAT effort.

The Justice Department has a multi-faceted litigation approach to fighting health care fraud, with the Criminal Division, the Civil Division, the Civil Rights Division, the U.S. Attorneys' Offices, and the Federal Bureau of Investigation (FBI) all contributing substantial resources to the effort. The Civil Division aggressively pursues civil enforcement actions aimed at rooting out waste, fraud, and abuse in the health care industry, often through use of the False Claims Act, 31 U.S.C. §§ 3729-3733. Through its Office of Consumer Protection Litigation ("OCPL"), the Civil Division also invokes the Food, Drug and Cosmetic Act ("FDCA"), which authorizes both civil and criminal actions. Since 2000, the Civil Division, working closely with

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the FBI, HHS-OIG, U.S. Attorneys' Offices around the country, and other law enforcement agencies, has recovered over $1 billion every year on behalf of defrauded federal health care programs; in FY 2010 the Department secured approximately $2.5 billion in civil health care fraud recoveries, more than in any other previous year.

The Civil Rights Division also plays an important role in the Department's efforts to protect the nation's health care system. The Special Litigation Section of the Civil Rights Division is responsible for enforcing the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997, *et seq.* CRIPA authorizes the investigation of conditions of confinement at state and local residential institutions and the initiation of civil actions for injunctive relief to remedy a pattern or practice of Constitutional or federal statutory violations at such institutions.

The Justice Department's primary investigative and enforcement arm is the FBI. Working closely with U.S. Attorneys' Offices across the country and DOJ litigating components, the FBI serves to identify, investigate, and aid in the prosecution of health care fraud. With over 750 FBI personnel dedicated solely to health care fraud investigations, the Justice Department is able to aggressively address fraud not only in Strike Force locations, but also in any of the over 450 locations where the FBI has investigative personnel stationed. The FBI leverages these resources and works collaboratively with HHS-OIG investigative personnel and other agencies to address significant health care fraud through coordinated investigations targeting the most egregious offenders and fraudsters.

Finally, the Criminal Division, together with the U.S. Attorneys' Offices, the FBI, and OCPL, is responsible for the Department's criminal health care fraud enforcement efforts. These efforts, which I will focus on in more detail below, have been a tremendous success. Since the

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inception of the HEAT initiative, we have aggressively prosecuted health care fraudsters, leading, in FY 2010, to the largest number of criminal health care fraud convictions since the HCFAC Program was created.

III. CRIMINAL HEATLH CARE FRAUD ENFORCMEMENT

Criminal health care fraud enforcement is aimed at holding accountable doctors, nurses, health care providers, and others who conspire to cheat government health care programs, including Medicare and Medicaid. Today our criminal enforcement efforts are at an all-time high. In FY 2010, we brought criminal charges against 931 defendants, the most in any single fiscal year since the HCFAC Program began, and approximately 16 percent more than in FY 2009. Moreover, we secured 726 criminal health care fraud convictions, also the most in any year of the HCFAC Program, and approximately 24 percent more than in FY 2009. In total, last fiscal year the Justice Department opened 1,116 new criminal health care fraud investigations involving 2,095 potential defendants.

The strong performance of our criminal enforcement efforts is due in large part to the strategic thinking behind our response. In 2007, the Criminal Division launched the Medicare Strike Force in collaboration with the U.S. Attorney's Office for the Southern District of Florida and the Miami Divisions of the FBI and HHS-OIG, to root out fraud and abuse among durable medical equipment ("DME") suppliers and Human Immunodeficiency Virus ("HIV") infusion therapy providers in South Florida. The Strike Force uses data analysis techniques to identify aberrational billing patterns in Strike Force cities, permitting law enforcement teams to target emerging or migrating schemes along with chronic fraud by criminals operating as health care providers or suppliers. Federal agents and analysts review Medicare data and other intelligence to identify potential targets who may be billing for fictitious or medically unnecessary services.

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In March 2008, the Criminal Division expanded the Strike Force to Los Angeles, another health care fraud hot spot; in May 2009, as the HEAT initiative was announced, we expanded the Strike Force to Houston and Detroit; in December 2009, we added Brooklyn, Tampa, and Baton Rouge; and just last month, we expanded the Strike Force to include Chicago and Dallas, bringing the total number of Strike Force cities to nine.[1]

The Strike Force has been an unqualified success. In FY 2010, the Strike Force secured 240 convictions (217 guilty pleas and 23 trial convictions), more than in any other year of Strike Force operations. One goal of the Strike Force is to identify targets using the "data-driven" approach described above, and then bring those cases as expeditiously as possible. This model is working. Cases are initiated and brought to conclusion quickly, and defendants are going to prison for substantial periods. In FY 2010, the average amount of time from indictment to sentencing in Strike Force cases was approximately 9 months; more than 94 percent of Strike Force defendants were convicted; and over 86 percent were sentenced to prison terms. Since HEAT's inception, the average prison term for Strike Force defendants is over 40 months.

During FY 2010, we also carried out what was then the largest federal health care fraud takedown in history. In July 2010, Attorney General Holder, Secretary Sebelius, and FBI Director Mueller announced charges against 94 defendants – including doctors, medical assistants, health care executives, and others – in Strike Force cities Miami, Baton Rouge, Brooklyn, Detroit, and Houston. These defendants were charged with collectively submitting more than $251 million in false claims to the Medicare program.

This was followed, just last month, by what now stands as the largest federal health care fraud takedown ever. On February 17, 2011, Attorney General Holder and Secretary Sebelius

[1] With funds requested in the President's FY 2012 Budget, the Department has plans to expand the Strike Force to additional cities.

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announced charges against more than 110 defendants in all nine Strike Force cities. Doctors, nurses, health care company owners and executives, and others were charged with defrauding the Medicare program of over $240 million. Typical of Strike Force cases, many of the defendants charged in the February takedown participated in alleged schemes to submit claims to Medicare for treatments that were medically unnecessary or never provided. In addition, the indictments and complaints allege that patient recruiters, Medicare beneficiaries, and other co-conspirators were paid cash kickbacks in return for supplying beneficiary information to providers so that those providers could submit false Medicare claims.

In addition to prosecuting defendants for health care fraud, we are also seeking and receiving substantial prison sentences for those convicted. For example:

- On December 14, 2010, defendant Bernice Brown, the president of a Detroit-area clinic, and defendant Daniel Smorynski, the clinic's vice president, were sentenced in the Eastern District of Michigan to 151 months and 109 months in prison, respectively. They had previously been convicted at trial of charges relating to a $23 million fraudulent physical and occupational therapy scheme.
- And on November 23, 2010, defendant Flor Crisologo, the owner and operator of a Miami clinic, was sentenced in the Southern District of Florida to 120 months in prison for her role in a $22 million HIV infusion fraud scheme. Crisologo's clinic billed Medicare for providing hundreds of medically unnecessary infusion treatments to HIV-positive Medicare beneficiaries who were recruited to visit the clinic in exchange for cash kickbacks.

Indeed, in just the first five weeks of 2011, more than 20 defendants were sentenced on their health care fraud convictions:

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- On February 10, defendant Guy Ross, a medical assistant, was sentenced in the Eastern District of Michigan to 36 months in prison for participating in a Medicare fraud scheme operated out of two Detroit-area companies that purported to provide in-home health services.
- The day before, on February 9, two other defendants – Grant Johnson and Elizabeth Egan – were sentenced in the same district on their guilty pleas to Medicare fraud.
- On February 4, eight Miami-area nurses were sentenced in the Southern District of Florida to prison for their roles in an $18.7 million home health care Medicare fraud scheme, and a ninth was sentenced to two years' probation.
- On January 28, defendant Lissbet Diaz, a nurse, was sentenced in the Southern District of Florida to 18 months in prison for participating in a fraudulent Medicare home health care fraud scheme.
- Two days before that, on January 26, defendant Melvin Young, a patient recruiter for Ritecare LLC, was sentenced in the Eastern District of Michigan to 40 months in prison for participating in a Medicare fraud scheme.
- On January 18, defendant Darrell Nichols, a patient recruiter, was sentenced in the Eastern District of Michigan to 15 months in prison for participating in a Detroit-area Medicare fraud scheme involving fraudulent claims for diagnostic testing.
- One week earlier, on January 11-12, defendant Basil Obasi Kalu, an employee of Onward Medical Supply, a Houston-area DME company, was sentenced to 70 months in prison for his role in a Medicare fraud scheme. Kalu was sentenced

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along with three patient recruiters, one of whom received a 46-month sentence, and one delivery driver.

- And on January 4, defendant Howard Grant, a doctor, was sentenced to 41 months in prison on his guilty plea to participating in the Onward Medical Supply DME Medicare fraud scheme. Grant was sentenced along with defendant Obisike Nwankwo, a delivery driver, and defendant John Lachman, Onward Medical Supply's manager.

In addition to ensuring that health care fraudsters go to prison, the Strike Force seeks to identify and stop ongoing frauds and to recover public funds lost to health care fraud schemes. In October 2010, for example, the Criminal Division, the U.S. Attorney's Office for the Southern District of Florida, the FBI, and HHS announced the unsealing of a 13-count indictment against two Miami health care companies, American Therapeutic Corporation ("ATC") and Medlink Professional Management Group, Inc., as well as four owners and senior managers of the companies, for engaging in a $200 million fraud scheme involving billing for purported mental health services. At the same time, the Civil Division announced that it had filed a civil action for injunctive relief against these same defendants and two other companies and obtained a temporary restraining order to freeze the assets of the indicted companies and individuals. Last month, the Criminal Division, the U.S. Attorney's Office for the Southern District of Florida, the FBI, and HHS announced the unsealing of a 38-count superseding indictment in this case that charges an additional 20 individuals, including three doctors, with various criminal health care fraud offenses. The ATC case is perhaps the largest Medicare Strike Force case ever brought, and represents the first time that the Strike Force has indicted a corporation.

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Further, I want to mention the important work of the Civil Division's OCPL, which, together with U.S. Attorneys' Offices around the country, is authorized to bring civil and criminal actions for violations of the FDCA. OCPL pursues the unlawful marketing of drugs and medical devices, fraud on the Food & Drug Administration, and the distribution of adulterated products, among other violations. In FY 2010, OCPL's efforts yielded more than $1.8 billion in criminal fines, forfeitures, restitution, and disgorgement, the largest health care-related one-year recovery under the FDCA in Department history.

In short, prosecutors in the Criminal Division's Fraud Section, the Civil Division's OCPL, the nation's U.S. Attorneys' Offices, and the FBI are working hard – and with great success – with federal, state, and local law enforcement agents to investigate and prosecute health care fraud wherever we find it.

IV. AFFORDABLE CARE ACT PROVISIONS

Finally, I would like to address certain key provisions in the Patient Protection and Affordable Care Act of 2010 ("ACA" or "Act"), Pub. L. 111-148. The Act made several important revisions and additions to federal criminal and civil statutes that the Justice Department uses in health care fraud cases. These changes are likely to have – and are already having – a significant impact on our health care fraud enforcement efforts.

For example, the ACA clarifies that neither the health care fraud statute, 18 U.S.C. § 1347, nor the anti-kickback statute, 42 U.S.C. § 1320a-7b, requires the government to prove that the defendant had actual knowledge of the specific statute or the specific intent to violate that statute. This is an important clarification that effectively abrogates judicial constructions of the phrase "knowingly and willfully" in both statutes that had made it harder for the government to prove health care fraud violations.

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The ACA also expands the definition of "federal health care fraud offense" in 18 U.S.C. § 24 to include violations of the anti-kickback statute and other offenses. As a result of this change, the proceeds of these crimes are now subject to criminal forfeiture under 18 U.S.C. § 982(a)(6) and the offenses now qualify as "specified unlawful activity" under the money laundering statutes.

In addition, the Act directs the U.S. Sentencing Commission to amend the U.S. Sentencing Guidelines to clarify that, when calculating the loss attributable to a health care fraud offense, the total amount that the defendant billed to a federal health care program comprises prima facie evidence of the defendant's intended loss; and to increase the guideline ranges for health care fraud schemes involving a loss of $1 million or more. In January, the Sentencing Commission published proposed amendments to the sentencing guidelines to implement these directives, and last month it held a public hearing on the amendments. These proposed amendments, if they become law, will subject health care fraud defendants to the possibility of even greater prison time than they already face, a prospect that we believe will be a more effective deterrent.

The ACA also makes several significant changes to the law governing employee group health benefit plans subject to title I of the Employee Retirement Income Security Act of 1974 and multiple employer welfare arrangements ("MEWAs") regulated by ERISA. First, the ACA prohibits false statements in the sale or marketing of employee health benefits by MEWAs. Second, the ACA adds that new offense and other ERISA offenses governing employee health care benefits generally to the definition of "federal health care offense."

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In addition, the Act confers new subpoena power on the Attorney General for the investigation of claims under CRIPA. Finally, the Act provides significant additional funding for our collective health care fraud enforcement efforts.

The ACA's statutory revisions and the additional funding provided by the Act will strengthen the Justice Department's criminal and civil enforcement efforts, and we look forward to taking advantage of these and other new tools as we continue the fight against health care fraud.

V. CONCLUSION

Prosecuting health care fraud is a high priority for the Department of Justice. Every day, in Strike Force cities and elsewhere around the country – from New York to Los Angeles, and cities in between – federal prosecutors, and law enforcement agents at the federal, state, and local levels are working hard to investigate and prosecute those intent on defrauding Medicare and other government health care programs. Our efforts over the last two years, since the inception of the HEAT initiative, have been remarkably successful. The number of people charged with health care fraud and the number of criminal convictions are both higher than they have ever been. We are poised to continue these efforts in the months and years ahead, and look forward to continuing to work closely with the FBI, HHS-OIG, CMS, and others toward that end.

Thank you for the opportunity to provide the Subcommittee with this overview of our health care fraud enforcement efforts. I look forward to answering any questions you may have.

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Testimony of:
Daniel R. Levinson
Inspector General
U.S. Department of Health & Human Services

Good afternoon, Chairman Carper, Ranking Member Brown, and other distinguished Members of the Subcommittee. I am Daniel Levinson, Inspector General of the U.S. Department of Health & Human Services (HHS or the Department). Thank you for the opportunity to testify about the efforts of the Office of Inspector General (OIG) and our partners to combat waste, fraud, and abuse in Medicare and Medicaid. I also thank you for your continued commitment to furthering our shared goal of safeguarding the fiscal integrity of these programs.

Medicare and Medicaid fraud, waste, and abuse cost taxpayers billions of dollars each year and put beneficiaries' health and welfare at risk. The impact of these losses and risks is magnified by the growing number of people served by these programs and the increased strain on Federal and State budgets. Moreover, new and expanded programs under the Patient Protection and Affordable Care Act (Affordable Care Act or ACA) further heighten the need for robust oversight.

My testimony today describes the nature and scope of health care fraud, waste, and abuse; OIG's ongoing initiatives to fight these problems, including our highly productive collaboration with our colleagues in HHS and the Department of Justice (DOJ); and new tools and initiatives to prevent and detect fraud, waste and abuse and hold accountable those who engage in it. OIG is committed to building on our successes, employing all oversight and enforcement tools available to us, and maximizing our impact on protecting the integrity of government health care programs and the health and welfare of the people they serve.

OIG Work Highlighting the Nature and Scope of Health Care Fraud, Waste, and Abuse

Fraud is a serious problem requiring a serious response.

Although there is no precise measure of the magnitude of health care fraud, we know that it is a serious problem that demands an aggressive response. OIG has been leading the fight against health care fraud, waste and abuse for more than 30 years. Although the majority of health care providers are honest and well-intentioned, a minority of providers who are intent on abusing the system cost taxpayers billions of dollars. Over the past fiscal year, OIG has opened more than 1,700 health care fraud investigations. Additionally, our enforcement efforts have resulted in more than 900 criminal and civil actions and more than $3 billion in expected investigative recoveries in fiscal year (FY) 2010. OIG's total expected recoveries for FY 2010 also include more than $1 billion in audit receivables.

OIG investigations uncover a range of fraudulent activity. Health care fraud schemes commonly include purposely billing for services that were not provided or were not medically necessary, billing for a higher level of service than what was provided, misreporting costs or other data to increase payments, paying or receiving kickbacks, illegally marketing products, and/or stealing

U.S. Senate Committee on Homeland Security and Governmental Affairs, Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security
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providers' or beneficiaries' identities. The perpetrators of these schemes range from street criminals, who believe it is safer and more profitable to steal from Medicare than to traffic in illegal drugs, to Fortune 500 companies that pay kickbacks to physicians in return for referrals.

Many OIG investigations target fraud committed by criminals who masquerade as Medicare providers and suppliers but who do not provide legitimate services or products. The rampant fraud among durable medical equipment (DME) suppliers in south Florida is a prime example. In these cases, our investigations have found that criminals set up sham DME storefronts to create the appearance that they are bona fide providers; fraudulently bill Medicare for millions of dollars; and then close up shop, only to reopen in a new location under a new name and continue the fraud. The criminals often pay kickbacks to physicians, nurses, and even patients to recruit them as participants in the fraud schemes. When their schemes are detected, some of these perpetrators flee with the stolen Medicare funds and become fugitives.

The Medicare program is increasingly infiltrated by violent and organized criminal networks. For example, the Government recently charged 73 defendants with various health-care-fraud-related crimes involving more than $163 million in fraudulent billings. According to the indictments, the Armenian-American organized crime ring behind the scheme was the Mirzoyan-Terdjanian Organization, which has allegedly used violence and threats of violence to ensure payments to its leadership.

The scheme perpetrated by this crime ring involved subjects allegedly stealing the identities of thousands of Medicare beneficiaries from around the country, as well as the identities of doctors who were usually licensed to practice in more than one State. Other subjects leased office space and opened fraudulent clinics and bank accounts to receive Medicare funds—often in the name of the doctor whose identity they had stolen. Upon becoming approved Medicare providers, the subjects allegedly billed Medicare for services never provided, using the stolen beneficiary information. The funds they received from Medicare were quickly withdrawn and laundered, and sometimes sent overseas. Although Medicare identified and shut down some of the phony clinics, members of the criminal enterprise simply opened up more fraudulent clinics, usually in another State. The investigation uncovered at least 118 phony clinics in 25 States.

Health care fraud is not limited to blatant fraud by career criminals and sham providers. Major corporations, such as pharmaceutical and medical device manufacturers, and institutions, such as hospitals and nursing facilities, have also committed fraud, sometimes on a grand scale. For example, in August 2010, Allergan, Inc., agreed to plead guilty to misdemeanor misbranding and paid $600 million (including a $375 million criminal fine and forfeiture and a $225 million civil settlement) to resolve criminal and civil liability arising from the company's promotion of Botox®. Our investigations found that the company illegally marketed the drug for indications that, during the relevant time periods, had not been approved as safe and effective by the Food and Drug Administration (FDA). These unapproved indications included headache, pain, spasticity and juvenile cerebral palsy. In addition, the settlement resolved allegations that Allergan misled doctors about the safety and efficacy of Botox®, instructed doctors to miscode claims to ensure payment by Government health care programs, and paid kickbacks to doctors.

Despite our successes, there is more to be done. Those intent on breaking the law are becoming more sophisticated, and the schemes are more difficult to detect. Some fraud schemes are viral,

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i.e., schemes are replicated rapidly within communities. Health care fraud also migrates–as law enforcement cracks down on a particular scheme, the criminals may redesign the scheme (e.g., suppliers fraudulently billing for DME have shifted to fraudulent billing for home health services) or relocate to a new geographic area. To combat this fraud, the Government's response must be swift, agile, and well organized.

Waste and abuse cost taxpayers billions of dollars and must be addressed.

Waste of funds and abuse of the health care programs also cost taxpayers billions of dollars. In FY 2010, the Centers for Medicare & Medicaid Services (CMS) estimated that overall, 10.5 percent of the Medicare fee-for-service claims it paid ($34.3 billion) did not meet program requirements. Although these improper payments do not necessarily involve fraud, the claims should not have been paid. OIG's analysis of the Medicare error rate found that insufficient documentation, miscoded claims, and medically unnecessary services accounted for almost all of these errors.

For our part, OIG reviews specific services, based on our assessments of risk, to identify improper payments. For example, OIG reviewed high-utilization claims for blood-glucose test strips and lancet supplies. Our audits identified an estimated $270 million in improper Medicare payments for these supplies. OIG has also conducted a series of audits over the past decade identifying improper Federal Medicaid payments for school-based health services. Most recently, we found that Arizona was improperly reimbursed an estimated $21.3 million in Federal Medicaid funds for school-based services.

OIG's work has also demonstrated that Medicare and Medicaid pay too much for certain services and products and that better aligning payments with costs could produce substantial savings. For example, OIG reported that Medicare reimbursed suppliers for pumps used to treat pressure ulcers and wounds based on a purchase price of more than $17,000, but that suppliers paid, on average, approximately $3,600 for new models of these pumps.

OIG and its Partners Are Leading the Fight Against Health Care Fraud, Waste, and Abuse

Collaboration and innovation are essential in the fight against health care fraud. The collaborative antifraud efforts of HHS and DOJ are rooted in the Health Insurance Portability and Accountability Act of 1996, P. L. No. 104-191 (HIPAA), which established the Health Care Fraud and Abuse Control (HCFAC) Program. The HCFAC return-on-investment is at an all-time high. Over the past 3 years (FY 2008- FY 2010), for every $1 spent on the HCFAC Program, the Government has returned an average of $6.80. OIG's, HHS's and DOJ's HCFAC activities returned $4 billion in fraudulent and misspent funds to the Government in FY 2010 and have returned more than $18 billion to the Government since 1997.

On May 20, 2009, the HHS Secretary and the Attorney General announced the creation of the Health Care Fraud Prevention and Enforcement Action Team (HEAT). This initiative marshals significant resources across the Government to prevent health care waste, fraud, and abuse; crack down on those who commit fraud; and enhance existing partnerships between HHS and DOJ.

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Medicare Fraud Strike Forces are a proven success in fighting fraud.

Medicare Fraud Strike Forces are an essential component of HEAT and have achieved impressive enforcement results. Strike Forces are designed to identify and investigate fraud, and prosecute the perpetrators quickly. Strike Force teams are composed of dedicated prosecutors from DOJ and U.S. Attorneys Offices and Special Agents from OIG; the Federal Bureau of Investigation (FBI); and, in some cases, State and local law enforcement agencies. These "on the ground" enforcement teams are supported by data analysts and program experts. This coordination and collaboration have accelerated the Government's response to criminal fraud, decreasing by roughly half the average time from the start of an investigation to its prosecution.

OIG and DOJ launched their Strike Force efforts in 2007 in south Florida to identify, investigate, and prosecute DME suppliers and infusion clinics suspected of Medicare fraud. Building on the success in Miami, Strike Force teams have been established in eight more locations—Los Angeles; Detroit; Houston; Brooklyn; Baton Rouge; Tampa; and, most recently, Dallas and Chicago.

The Strike Force uses data analysis and a collaborative approach to focus enforcement resources in geographic areas at high risk for fraud. Strike Force cases are data driven to pinpoint fraud hot spots through the identification of suspicious billing patterns as they occur. To support this approach, OIG created a team of data experts composed of OIG special agents, statisticians, programmers, and auditors. Together, the team brings a wealth of experience in using sophisticated data analysis tools combined with criminal intelligence gathered directly from special agents in the field to identify more quickly ongoing health care fraud schemes and trends. To expand the coalition of data experts focused on this effort, OIG has garnered the support and participation of our law enforcement partners at DOJ and FBI. This model is particularly effective in detecting sham providers and suppliers who masquerade as bona fide providers and suppliers.

The Strike Force model has proven highly successful. Since their inception in 2007, Strike Force operations in nine cities have charged almost 1,000 individuals for fraud schemes involving more than $2.3 billion in claims.

Just last month, Strike Forces engaged in the largest Federal health care fraud takedown in history. Teams across the country arrested more than 100 defendants in 9 cities, including doctors, nurses, health care company owners and executives, and others, for their alleged participation in Medicare fraud schemes involving more than $225 million in false billing. The defendants are accused of various health-care-related crimes ranging from violating the anti-kickback statute to money laundering to aggravated identity theft. More than 300 special agents from OIG participated in partnership with other Federal and State agencies, including fellow Offices of Inspector General. With the approval of the Attorney General, the Council of the Inspectors General on Integrity and Efficiency (CIGIE) has established procedures to permit special agents from within the Inspector General community to work together on operations like the HEAT Strike Forces, thereby maximizing efficiency.

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The effectiveness of the Strike Force model is enhanced by our use of important tools. We refer to CMS credible allegations of fraud so that CMS can suspend payments to the perpetrators of these schemes. For example, during a July 2010 Strike Force operation, OIG worked with CMS to initiate payment suspensions and pre-pay edits on 18 providers and suppliers targeted in the investigation. The prompt action taken by OIG and CMS stopped the potential loss of more than $1.3 million in claims submitted by the defendants. During the February Strike Force operations discussed above, OIG and CMS worked to impose payment suspensions that immediately prevented a loss of more than a quarter million dollars in claims submitted by Strike Force targets.

OIG's work with CMS during these recent Strike Force operations reflects the multi-pronged, collaborative approach that is critical to success. OIG and our law enforcement partners investigate and prosecute those who steal from Medicare. Relying on our work, CMS "turns off the spigot" to prevent dollars from being paid for fraudulent claims.

OIG recommendations prevent fraud, waste, and abuse.

OIG has also recommended actions to remedy program integrity vulnerabilities and prevent fraud, waste, and abuse. We found, for example, that Medicare's average spending per beneficiary for inhalation drugs was five times higher in south Florida, an area rife with Medicare fraud, than in the rest of the country, and that a disproportionately high rate of these claims in south Florida exceeded the maximum dosage guidelines. OIG's recommendations included adding new claims edits to prevent fraudulent or excessive payments, including edits to detect dosages exceeding coverage guidelines. In another example, to prevent future improper payments for blood-glucose test strips and lancet supplies, we recommended that CMS contractors implement various payment edits, such as edits to identify claims with overlapping dates of service. We have also found that Medicare has paid for prescription drug and DME claims that did not include valid prescriber identifiers, and we have recommended that CMS verify the prescriber identifier on claims before they are paid. Many other recommendations to prevent fraud, waste, and abuse are described in our annual *Compendium of Unimplemented OIG Recommendations*; our latest edition will be published later this month.

Enhanced Tools and New Initiatives Further Support Our Mission

The Affordable Care Act enhances program integrity in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

The ACA, as amended by the Reconciliation Act, promotes program integrity by addressing program vulnerabilities, strengthening law enforcement resources and authorities, and encouraging greater coordination among Federal agencies. Consistent with OIG's recommended program integrity strategy, the ACA:

- strengthens provider enrollment standards;
- addresses payment vulnerabilities;
- promotes compliance with program requirements;
- enhances program oversight; and

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- fortifies the Government's arsenal of fraud-fighting tools and penalties.

The ACA includes numerous provisions that address vulnerabilities in CMS program operations and payment methodologies. To address the need for more upfront oversight, the ACA authorizes more robust provider and supplier screening procedures, temporary enrollment moratoria when the Secretary identifies fraud "hot spots," provisional periods of enhanced payment oversight for newly enrolled providers and suppliers, heightened disclosure and transparency requirements, and mandatory compliance programs.

The ACA also addresses particular fraud, waste, and abuse risks by altering program requirements. The following examples are illustrative. The law requires physicians to document that the physician (or a designated health professional) has had a face-to-face encounter with a patient for whom the physician is certifying the need for DME or home health services. The law requires community mental health centers that provide partial hospitalization services to provide at least 40 percent of their services to non-Medicare beneficiaries, which should help reduce fraud by centers that set up shop to prey on Medicare. The ACA addresses misaligned payments by, for example, rebasing home health payments, and the law will produce cost savings by increasing the Federal Medicaid rebate for generic drugs. The ACA addresses quality-of-care vulnerabilities through provisions that create incentives for hospitals to reduce readmissions and prevent hospital-acquired conditions.

The ACA strengthens the Government's ability to respond rapidly to health care fraud and hold perpetrators accountable. Increased HCFAC funding will support important fraud-fighting resources, including new technology for detecting suspected fraud more effectively and "boots on the ground" for our vital oversight and enforcement efforts. The ACA provisions that strengthen cross-agency collaborations and information sharing will aid our program integrity efforts. Enhanced authority to suspend payments pending the investigation of credible allegations of fraud will help ensure that the Government can effectively stop perpetrators from absconding with ill-gotten program funds. Important changes to the False Claims Act, the Federal anti-kickback statute, OIG's administrative authorities, and the Federal Sentencing Guidelines, among others, will help the Government more effectively prosecute those who defraud or abuse Federal health care programs.

OIG promotes program integrity by removing untrustworthy individuals from Federal health care programs.

Once we determine that an individual or entity has engaged in fraud or abuse or provided substandard care, OIG can use one of the most powerful tools in our arsenal: the authority to exclude that provider from participating in Federal health care programs. Program exclusions bolster our fraud-fighting efforts by removing from Federal health care programs those who pose the greatest risk to our programs and their beneficiaries.

No program payment may be made for any item or service that an excluded person or entity furnishes, orders, or prescribes. This prohibition applies regardless of whether the excluded person is paid directly by the programs (such as a physician) or whether the payment is made from the program to another person (such as payments to a hospital for services by its employed

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nurses and other staff or payments to a pharmacy for drugs manufactured by a pharmaceutical company). Those who employ the services of an excluded individual or entity for the provision of items or services reimbursable by Medicare or Medicaid may be subject to monetary penalties and program exclusion. Because of its scope and effect, the risk of exclusion creates a strong incentive to comply with the programs' rules and requirements.

In imposing discretionary exclusions, OIG must weigh the fraud and abuse risks to the programs and beneficiaries against the impact on patient access to care if the provider or entity is excluded from Federal health care programs. Some hospital systems, pharmaceutical manufacturers and other providers play such a critical role in the care-delivery system that they may believe that OIG would never exclude them and thereby risk compromising the welfare of our beneficiaries. We are concerned that these providers may consider engaging in fraud schemes, and paying civil penalties and criminal fines if caught, as a cost of doing business. As long as the profit from the fraud outweighs those costs, abusive corporate behavior is likely to continue. For example, some major pharmaceutical corporations have been convicted of crimes and paid hundreds of millions of dollars in False Claims Act settlements and continue to participate in Federal health care programs.

One way to address this problem is to attempt to alter the cost-benefit calculus of the corporate executives who run these companies. By excluding the individuals who are responsible for the fraud, either directly or because of their positions of responsibility in the company that engaged in fraud, we can influence corporate behavior without putting patient access to care at risk. To that end, in 2008, we excluded three executive officers of the pharmaceutical company Purdue Frederick based on their convictions for misbranding the painkiller OxyContin. Each of the executives was convicted based on his status as a responsible corporate officer.

OIG also has the discretionary authority to exclude certain owners and the officers and managing employees of a sanctioned entity (i.e., an entity that has been convicted of certain offenses or excluded from participation in Federal health care programs) even if the executive has not been convicted of a crime. This authority, section 1128(b)(15) of the Social Security Act, allows OIG to hold responsible those individuals who are accountable for corporate misconduct. OIG has used this exclusion authority in more than 30 cases since it was added to the statute in 1996. But until recently, we had typically applied this exclusion authority to individuals who controlled smaller companies, such as pharmacies, billing services, and DME companies and not to executives of large complex organizations such as a drug or device manufacturer.

Moving forward, we intend to use this essential fraud-fighting tool in a broader range of circumstances. For example, in addition to excluding the Purdue Frederick executives, we recently excluded an owner (and former executive) of Ethex Corporation Company under our section (b)(15) exclusion authority. Ethex operated manufacturing facilities in St. Louis. In March of last year, Ethex pled guilty to felony criminal charges after it failed to inform the FDA about manufacturing problems that led to the production of oversized tablets of two prescription drugs. The owner was excluded for a period of 20 years.

We are mindful of our obligation to exercise this authority judiciously, and we do not propose to exclude all officers and managing employees of a company that is convicted of a health care-

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related offense. However, when there is evidence that an executive knew or should have known of the organization's underlying criminal misconduct, OIG will operate with a presumption in favor of exclusion of that executive. We have published on our Web site guidance that sets out factors that we consider when evaluating whether a section (b)(15) exclusion should be imposed. This guidance alerts health care providers and executives to the standards of ethical conduct and responsibility to which they will be held accountable by OIG. Even if we decide exclusion of a major health care entity is not in the best interest of Federal health care programs and their beneficiaries, we may decide that executives in positions of responsibility at the time of the fraud should no longer hold such positions with entities that do business with the programs.

OIG is engaging health care providers and the public in the fight against fraud.

We recognize that the vast majority of health care providers and suppliers are honest and well-intentioned. Health care providers and suppliers are valuable partners in ensuring the integrity of Federal health care programs and preventing fraud and abuse. OIG seeks to collaborate with health care industry stakeholders to foster voluntary compliance.

OIG is using the Internet to enlist the health care industry and the public in the fight against fraud. Our Web site, http://oig.hhs.gov, offers extensive information to health care providers and patients about ways to reduce the risk of fraud and abuse. These extensive resources include OIG's voluntary compliance program guidance, fraud alerts, and advisory opinions on the fraud and abuse laws. OIG also offers a guide for patients to avoid becoming the victim of medical identity theft, a growing problem that can disrupt lives, damage credit ratings, and waste taxpayer dollars. We offer tips to Medicare beneficiaries and their caregivers on how to avoid medical identity theft and where to report misuse of personal information.

The Web site also includes information about the OIG's self-disclosure protocol, which offers a way for providers that uncover fraudulent billings or other misconduct within their organizations to self-disclose the problem and to work with OIG to the resolve the issue, including return of any inappropriate payments.

Another example of OIG's commitment to promoting compliance is the HEAT Provider Compliance Training Initiative. The initiative brings together representatives from a variety of Government agencies to provide free compliance training to local provider, legal, and compliance communities. The first of these seminars took place in Houston in February, and we have scheduled additional seminars in Tampa, Kansas City, Baton Rouge, Denver, and Washington, DC throughout the Spring of 2011. In May, OIG will provide a Webcast of the seminar for those unable to attend in-person training. Our aim is to educate providers about fraud risks uncovered by OIG and to share compliance best practices so that providers can strengthen their compliance efforts. We believe these efforts to educate provider communities will help foster a culture of compliance and protect Federal health care programs and beneficiaries.

In response to requests from physicians just beginning their practices, OIG recently published *A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse*. The *Roadmap* summarizes the five main Federal fraud and abuse laws and provides guidance on how

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physicians should comply with these laws in their relationships with payers, vendors, and fellow providers.

Finally, we also have posted OIG's list of the 10 most-wanted health care fraud fugitives, including photographs and details about the fugitives and their schemes. Our current most-wanted list includes 10 individuals who have allegedly defrauded taxpayers of approximately $136 million. We are asking the public to help us bring these fugitives to justice by reporting any information about their whereabouts to our Web site or fugitive hotline (1-888-476-4453).

Conclusion

Health care fraud, waste, and abuse cost taxpayers billions of dollars every year and require focused attention and commitment to solutions. Through the dedicated efforts of OIG professionals and our collaboration with HHS and DOJ partners, we have achieved substantial results in the form of recoveries of stolen and misspent funds, enforcement actions taken against fraud perpetrators, improved methods of detecting fraud and abuse, and recommendations to remedy program vulnerabilities. Finally, we have enhanced tools and authorities and have engaged in new initiatives aimed at achieving our mission. Thank you for your support of this mission. I would be happy to answer any questions that you may have.

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United States Government Accountability Office

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Testimony

Before the Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security, Committee on Homeland Security and Governmental Affairs, U.S. Senate

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MEDICARE AND MEDICAID FRAUD, WASTE, AND ABUSE

Effective Implementation of Recent Laws and Agency Actions Could Help Reduce Improper Payments

Statement of Kathleen M. King
Director, Health Care

Kay L. Daly
Director, Financial Management and Assurance



GAO-11-409T

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Highlights

Highlights of GAO-11-409T, a testimony before the Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security, Committee on Homeland Security and Governmental Affairs, U.S. Senate

March 9, 2011

MEDICARE AND MEDICAID FRAUD, WASTE, AND ABUSE

Effective Implementation of Recent Laws and Agency Actions Could Help Reduce Improper Payments

Why GAO Did This Study

GAO has designated Medicare and Medicaid as high-risk programs because they are particularly vulnerable to fraud, waste, abuse, and improper payments (payments that should not have been made or were made in an incorrect amount). Medicare is considered high-risk in part because of its complexity and susceptibility to improper payments, and Medicaid because of concerns about the adequacy of its fiscal oversight to prevent inappropriate spending.

In fiscal year 2010, the Centers for Medicare & Medicaid Services (CMS)—the agency that administers Medicare and Medicaid—estimated that these programs made a total of over $70 billion in improper payments.

This statement focuses on how implementing prior GAO recommendations and recent laws, as well as other agency actions, could help CMS carry out five key strategies GAO identified in previous reports to help reduce fraud, waste, and abuse and improper payments in Medicare and Medicaid. It is based on 16 GAO products issued from April 2004 through June 2010 using a variety of methodologies, such as analyses of Medicare or Medicaid claims, review of relevant policies and procedures, and interviews with officials. In February 2011, GAO also received updated information from CMS on agency actions.

View GAO-11-409T or key components. For more information, contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov or Kay L. Daly at (202) 512-9095 or dalykl@gao.gov.

What GAO Found

The amount of improper payments creates urgency for CMS to effectively implement prior GAO recommendations, provisions in recently enacted laws, and recent guidance related to five key strategies to help reduce fraud, waste, abuse, and improper payments in Medicare and Medicaid.

1. **Strengthening provider enrollment standards and procedures.** Strengthening the standards and procedures for provider enrollment can help reduce the risk of enrolling entities intent on defrauding the program. The Patient Protection and Affordable Care Act as amended (PPACA) strengthens aspects of provider enrollment in Medicare and Medicaid. CMS is implementing these provisions, which include designating providers by levels of risk and providing more stringent review of high-risk providers.

2. **Improving prepayment review of claims.** Prepayment reviews of claims help ensure that Medicare pays correctly the first time. CMS is implementing a PPACA provision requiring states to add automated prepayment controls in their Medicaid programs. In addition, CMS is seeking contractors to apply predictive modeling analysis to claims as a way to develop new prepayment controls to add to Medicare; however, CMS has not implemented certain GAO recommendations related to prepayment review.

3. **Focusing postpayment claims review on most vulnerable areas.** Postpayment reviews are critical to identifying payment errors and recouping overpayments. CMS is instituting recovery audit contractor (RAC) programs in Medicare and Medicaid to increase postpayment review. However, CMS contractors generally choose their focus for claims review, and GAO continues to contend that CMS should make it a priority to focus claims administration contractors' postpayment review on the most vulnerable areas.

4. **Improving oversight of contractors.** CMS's oversight of contractors' activities to address fraud, waste, and abuse is critical. CMS has taken action to address GAO recommendations to improve oversight of prescription drug plan sponsors' fraud and abuse programs and to comply with other contractor oversight provisions in PPACA.

5. **Developing a robust process for addressing identified vulnerabilities.** Having mechanisms in place to resolve vulnerabilities that lead to improper payment is critical, but CMS has not developed a robust corrective action process for vulnerabilities identified by Medicare RACs, and has not fully implemented GAO recommendations to improve it. Further, CMS's guidance to states on Medicaid RAC programs did not include steps to address vulnerabilities through a corrective action process.

Effective implementation of these recommendations, provisions of law, and guidance will be a key factor in helping to reduce future improper payments.

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Mr. Chairman, Ranking Member, and Members of the Subcommittee:

I am pleased to be here today to discuss provisions in recent laws and agency actions that may help reduce fraud, waste, and abuse[1] in the Medicare and Medicaid programs.[2] Fraud, waste, and abuse and improper payments put programs at risk. An improper payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements.[3]

We have designated both Medicare and Medicaid as high-risk programs.[4] Medicare, a federally financed program, was designated as high risk because its complexity and susceptibility to improper payments, added to its size, have made it vulnerable to serious management challenges. The Centers for Medicare & Medicaid Services (CMS)—the agency in the Department of Health and Human Services (HHS) that administers Medicare and oversees Medicaid—has estimated improper payments for Medicare of almost $48 billion for fiscal year 2010.[5] This estimate does not include improper payments in Part D, the Medicare prescription drug

[1]Fraud represents intentional acts of deception with knowledge that the action or representation could result in an inappropriate gain. Waste includes inaccurate payments for services, such as unintentional duplicate payments. Abuse represents actions inconsistent with acceptable business or medical practices.

[2]Medicare is the federally financed health insurance program for persons age 65 or over, certain individuals with disabilities, and individuals with end-stage renal disease. Medicaid is the federal-state program that covers acute health care, long-term care, and other services for low-income people and consists of more than 50 distinct state-based programs. In fiscal year 2009, Medicaid covered about 65 million people. The federal government matches states' expenditures for most Medicaid services using a statutory formula based on each state's per capita income.

[3]This definition includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except where authorized by law), and any payment that does not account for credit for applicable discounts. Pub. L. No. 111-204, § 2(e), 124 Stat. 2224, 2227 (2010) (codified at 31 U.S.C. § 3321 note).

[4]In 1990, we began to report on government operations that we identified as "high risk" for serious weaknesses in areas that involve substantial resources and provide critical services to the public. See GAO, *High-Risk Series: An Update*, GAO-11-278 (Washington, D.C.: February 2011). http://www.gao.gov/highrisk/risks/insurance/medicare_program.php.

[5]HHS, "Improper Payment Reduction Outlook FY 2009 through 2013," in *Fiscal Year 2010 Agency Financial Report* (Washington, D.C.: Nov. 15, 2010). The Secretary of HHS has delegated administration of the Medicare program to the Administrator of CMS. See Appendix I for abbreviations used in this statement.

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benefit, for which the agency has not yet estimated a total amount. Medicaid, a federal-state program, was designated as high risk in part due to concerns about the adequacy of fiscal oversight, which is necessary to prevent inappropriate spending. Medicaid also has significant improper payments. HHS estimated that the federal share of improper payments in the Medicaid program in fiscal year 2010 was $22.5 billion.[6] Since 2004, we have issued 16 products containing strategies we have identified for reducing fraud, waste, abuse, and improper payments in Medicare and Medicaid. My statement today updates our previous work in light of certain provisions affecting Medicare and Medicaid in PPACA;[7] the Small Business Jobs Act of 2010;[8] and pertinent agency actions.

Over the years, the Congress has worked to address fraud, waste, and abuse, and improper payments in the Medicare and Medicaid programs. Beginning in 1997, the Congress provided funds specifically for activities to address fraud, waste, and abuse in federal health care programs. In addition, Congress created the Medicare Integrity Program to conduct activities designed to reduce fraud, waste, abuse, and improper payments in Medicare. The Deficit Reduction Act of 2005 created the Medicaid Integrity Program and included specific appropriations to reduce fraud, waste, and abuse in Medicaid. In 2010, PPACA provided further funding for such efforts and set new requirements specific to Medicare and Medicaid that are designed to address fraud, waste, and abuse. In the same year, the Improper Payments Elimination and Recovery Act of 2010 (IPERA) amended the Improper Payments Information Act of 2002 and established additional governmentwide requirements related to accountability, recovery auditing, compliance and noncompliance determinations, and reporting.[9] However, owing to the size and scope of

[6]In its *Fiscal Year 2010 Agency Financial Report*, HHS calculated and reported the 3-year (2008, 2009, and 2010) weighted average national payment error rate for Medicaid of 9.4 percent. See *Department of Health and Human Services FY 2010 Agency Financial Report* (Washington, D.C.: Nov. 15, 2010).

[7]Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, 124 Stat. 1029, which we refer to collectively as PPACA. The program integrity provisions discussed in this statement are generally located in sections 6401 through 6411 and 10603 and 10605 of PPACA as well as section 1304 of HCERA. For our previous work, see a list of related products at the end of this statement.

[8]Pub. L. No. 111-240, § 4241, 124 Stat. 2504, 2599.

[9]Implementing guidance has not been issued, and therefore it is too early to assess the implementation of these requirements.

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Medicare and Medicaid, reducing improper payments and addressing fraud, waste, and abuse in these programs are continuing challenges for CMS—despite progress made by the agency that we have recognized since the programs were first designated as high risk.

CMS contractors play an important role in preventing improper payments in Medicare. Within Medicare Parts A and B—also known as Medicare fee-for-service (FFS)[10]—CMS contractors process and pay approximately 4.5 million claims per work day, enroll providers, respond to beneficiary questions, and investigate potential Medicare fraud. In addition, in Medicare Advantage (Part C) and the Medicare prescription drug benefit (Part D),[11] CMS contracts with private health plans and drug plan sponsors that administer Medicare benefits and in that capacity are responsible for helping to ensure Medicare program integrity.

With more than 50 distinct state-based programs that are partially federally financed, Medicaid creates complex challenges for CMS and states. CMS is responsible for overseeing the program at the federal level, while the states administer their respective programs' operations. Within broad federal requirements, each state operates its Medicaid program in accordance with a state plan. Differences in program design can lead to differences in state programs' vulnerabilities to improper payments and state approaches to protecting the program. States play a critical role in implementing strategies to reduce improper payments and address fraud, waste, and abuse. However, CMS also has a critical role in ensuring that adequate controls are in place and states' actions to help reduce improper payments are effective. Like Medicare, the state Medicaid programs also rely on contractors to help manage payments or services, but they vary in their use of contractors.

My testimony today focuses on how implementing recent laws and our prior recommendations, as well as other agency actions, could help CMS carry out five key strategies we identified in previous reports to help

[10]Medicare Parts A and B are known as original Medicare or Medicare FFS. Medicare Part A covers hospital and other inpatient stays. Medicare Part B is optional, and covers hospital outpatient, physician, and other services.

[11]Medicare beneficiaries have the option of obtaining coverage for Part A and B services from private health plans that participate in Medicare Advantage—Medicare's managed care program—also known as Part C. All Medicare beneficiaries may purchase coverage for outpatient prescription drugs under Part D.

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reduce fraud, waste, and abuse and improper payments in Medicare[12] and Medicaid.[13] This statement discusses past agency actions, actions in progress, and actions that are still needed to implement certain recommendations that we continue to consider important. The five key strategies, and recommendations designed to facilitate them, are taken from the 16 products mentioned above. Twelve of these products, which we issued from April 2004 through June 2010, focused on fraud, waste, abuse, and improper payments in Medicare. Because Medicaid faces a similar challenge to reduce its improper payments, these Medicare strategies can also be helpful when tailored to Medicaid. The other 4 products, which we issued since July 2004, focused on reducing fraud, waste, abuse, and improper payments in Medicaid.[14]

The products on which this statement is based were developed by using a variety of methodologies, including analyses of Medicare and Medicaid claims, review of relevant policies and procedures, interviews with agency officials and other stakeholders, and site visits.[15] We also received updated information from CMS in February 2011 on its actions related to the laws, regulations, guidance, and open recommendations that we discuss in this statement. Our work was performed in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[12]These strategies were identified in our June 2010 testimony as critical to helping prevent fraud, waste, and abuse in Medicare. See GAO, *Medicare Fraud, Waste, and Abuse: Challenges and Strategies for Preventing Improper Payments*, GAO-10-844T (Washington, D.C.: June 15, 2010).

[13]This statement deals with the challenge of reducing improper payments to providers and plans, but Medicaid has additional areas of concern, such as supplemental payments to providers that can lead to inappropriate federal payments to states. For a discussion of these areas, see GAO, *High Risk Series: An Update*, GAO-11-278 (Washington, D.C.: February 2011).

[14]A list of both sets of products appears at the end of this statement.

[15]For more detailed information on the methodologies used in our work, please consult the products listed at the end of this statement.

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Implementation of Our Prior Recommendations and Recent Laws, as Well as Other Agency Actions, Could Help CMS Reduce Medicare and Medicaid Fraud, Waste, and Abuse

The implementation of specific recommendations made in our prior reports[16] and provisions in PPACA and the Small Business Jobs Act of 2010, as well as other agency actions, could help in reducing fraud, waste, and abuse in Medicare and Medicaid. In reports we have issued from 2004 through 2010, we have identified five key strategies as important to reducing Medicare and Medicaid fraud, waste, and abuse, and ultimately improper payments:[17]

- strengthening provider enrollment standards and procedures,
- improving prepayment review of claims,
- focusing postpayment claims review on the most vulnerable areas and adding new recovery audit contractors,
- improving oversight of contractors, and
- developing a robust process for addressing identified vulnerabilities.[18]

PPACA has a number of provisions that could also aid CMS in its efforts to minimize improper payments, and CMS has issued final rules implementing some of these provisions. Furthermore, the Small Business Jobs Act of 2010 and the Presidential Memorandum, "Enhancing Payment Accuracy through a Do Not Pay List," focus on preventing, reducing, and recovering improper payments, which could also help CMS in reducing improper payments in Medicare and Medicaid.

[16]For a list of recommendations that we made that CMS has not implemented, see appendix II.

[17]See GAO, *Medicare Fraud, Waste, and Abuse: Challenges and Strategies for Preventing Improper Payments*, GAO-10-844T (Washington, D.C.: June 15, 2010). While the June 2010 statement specifically focused on the Medicare program, the strategies it presented are also applicable to the Medicaid program.

[18]Vulnerabilities are service-specific errors that result in improper overpayments and underpayments. An example of a vulnerability that leads to improper payments is providers billing for more than one blood transfusion in a hospital outpatient setting for a Medicare beneficiary in a day, which Medicare policy does not allow.

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Strengthening Provider Enrollment Procedures for Medicare and Medicaid Could Reduce the Risk of Enrolling Providers Intent on Defrauding or Abusing the Program

Our work on Medicare indicates that strengthening the standards and procedures for provider enrollment could help reduce the risk of enrolling providers intent on defrauding or abusing the program.[19] CMS has previously identified two types of providers whose services and items are especially vulnerable to improper payments—home health agencies (HHA) and suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). In our 2009 report on HHAs, we found problems with the enrollment procedures—for example, CMS's contractors were not requiring HHAs to re-submit enrollment information (including information about key officials, operating capital, and practice location) for re-verification every 5 years as required by CMS.[20] In a 2005 report on DMEPOS suppliers, we found that CMS had not taken sufficient steps to prevent entities intent on defrauding Medicare from enrolling, and we reported that more effective screening and stronger enrollment standards were needed to ensure that new suppliers were legitimate businesses.[21] Partly in response to our recommendation to improve the provider enrollment process, CMS took steps to implement new supplier quality standards as part of an accreditation rule issued in August 2006 and proposed new supplier enrollment standards in January 2008. Suppliers were required to meet these new accreditation standards in 2009; however, the new supplier enrollment standards were not finalized until August 2010. Prior to the implementation of the new supplier enrollment standards, we exposed persisting weaknesses when we created two fictitious DMEPOS suppliers, which were subsequently enrolled by CMS's contractor and given permission to begin billing Medicare.[22] As an enrollment requirement, suppliers must, upon request, show that they have contracts for obtaining inventory if the suppliers do not produce their own inventory. Review would have shown that the contracts provided by our fictitious companies had been fabricated.

[19]Enrolling as a provider in Medicare and Medicaid allows a provider to provide services to beneficiaries and bill for those services.

[20]See GAO, *Medicare: Improvements Needed to Address Improper Payments in Home Health*, GAO-09-185 (Washington, D.C.: Feb. 27, 2009). CMS's contractors began to revalidate HHA enrollment during the course of our work on that engagement.

[21]See GAO, *Medicare: More Effective Screening and Stronger Enrollment Standards Needed for Medical Equipment Suppliers*, GAO-05-656 (Washington, D.C.: Sept. 22, 2005).

[22]See GAO, *Medicare: Covert Testing Exposes Weaknesses in the Durable Medical Equipment Supplier Screening Process*, GAO-08-955 (Washington, D.C.: July 3, 2008).

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For Medicaid, states have adopted requirements to check providers' backgrounds before enrollment or during re-enrollment; however, these enrollment procedures have not been sufficient to protect Medicaid. For example, in September 2009, we reported that in five states Medicaid paid over $2 million in controlled substance prescriptions during fiscal years 2006 and 2007 that were written or filled by 65 medical practitioners and pharmacies that were barred, excluded, or both from federal health care programs, including Medicaid, for such offenses as illegally selling controlled substances.[23] As a result, we recommended that CMS consider issuing guidance to state Medicaid programs to provide assurance that their program requirements and systems prevent the processing of claims from providers and pharmacies that were barred from federal contracts or excluded from Medicare and Medicaid. We also recommended that CMS periodically identify deaths of Medicaid providers and prevent the approval of claims associated with providers who had died.

Implementation of PPACA provisions related to provider enrollment could protect Medicare and Medicaid from making improper payments and address some of our previous concerns and recommendations. PPACA requires the Secretary, in consultation with the HHS Office of Inspector General (OIG), to establish procedures for screening providers enrolling in Medicare and Medicaid,[24] including assessing the risk levels of fraud, waste, and abuse by categories of providers. At a minimum, PPACA requires all providers to be subject to licensure checks, which may include checks across state lines. Depending on the risks presented by the type of provider, CMS may require additional screening procedures, such as criminal history checks.[25] Further, PPACA provides for enhanced oversight for specific periods for new providers and of initial claims of DMEPOS suppliers. In addition, PPACA directs HHS to promulgate a regulation requiring providers to include their National Provider Identifier on all Medicare and Medicaid enrollment applications and claims for payment.

[23]See GAO, *Medicaid: Fraud and Abuse Related to Controlled Substances Identified in Selected States*, GAO-09-957 (Washington, D.C.: Sept. 9, 2009). The five states whose claims we reviewed for this report were California, Illinois, New York, North Carolina, and Texas.

[24]This law also applies to certain provisions related to Medicaid or to the state Children's Health Insurance Program (CHIP), which is the joint federal-state program that provides health coverage to children whose families have incomes that are low, but not low enough to qualify for Medicaid. This statement does not address how PPACA will affect CHIP.

[25]The enhanced screening procedures that PPACA provided for will apply to new providers beginning 1 year after the date of enactment and to currently enrolled providers 2 years after that date.

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On February 2, 2011, CMS and the HHS OIG published a final rule to implement these new screening procedures.[26] The rule is designed to institute a consistent set of enrollment procedures for Medicare and Medicaid, but not to abridge CMS's established screening authority or diminish the screening that providers currently undergo. Therefore, if states have additional Medicaid screening procedures, they will be able to maintain them.[27]

For Medicare, CMS designated three levels of risk—high, moderate, and limited—with different screening procedures for providers at each level. Based in part on our work and that of the HHS OIG and its own experience, CMS designated newly enrolling HHAs and DMEPOS suppliers as high risk and designated other providers at the lower levels.[28] Providers in all risk levels are to be screened to verify that they meet specific requirements established by Medicare. This includes checking providers' licenses, including checks across state lines; and checking certain databases, to verify items such as Social Security numbers, on a pre- and post-enrollment basis to ensure that they continue to meet enrollment criteria.[29] Moderate- and high-risk providers are also subject to unannounced site visits. All individuals who own a 5 percent or greater interest in high-risk providers are subject to fingerprinting and criminal

[26]*Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers*, 76 Fed. Reg. 5862 (Feb. 2, 2011).

[27]In discussing the final rule, CMS noted that Medicare already employs a number of the screening practices described in PPACA to determine if a provider is in compliance with federal and state requirements to enroll or to maintain enrollment in the Medicare program.

[28]CMS considered issues such as past levels of improper payments and occurrences of fraud among different provider types to determine risk levels. The moderate level comprises re-enrolling HHAs and re-enrolling DMEPOS suppliers; ambulance suppliers; community mental health centers; comprehensive outpatient rehabilitation facilities; hospice organizations; independent diagnostic testing facilities; independent clinical laboratories; and physical therapists, including physical therapy groups and portable X-ray suppliers. Other providers, such as physicians and ambulatory surgical centers, are in the limited risk level.

[29]The database checks may include verification of the following: Social Security number; National Provider Identifier; National Practitioner Databank licensure; whether the provider has been excluded from federal health care programs by the OIG; taxpayer identification number; and death of an individual practitioner, owner, authorized official, delegated official, or supervising physician.

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background checks.[30] CMS's implementation of fingerprinting and criminal history checks would address our 2009 recommendation for CMS to assess the feasibility of verifying the criminal history of all key HHA officials named on the provider enrollment applications.

In its discussion of the February 2, 2011 final rule, CMS indicated that the agency intended to review the criteria for its screening levels on a consistent and ongoing basis and would publish changes if the agency decided to update the assignment of screening levels for Medicare providers. This may become necessary, because fraud is not confined to newly enrolling HHAs and DMEPOS. As more scrutiny is given to these two types of providers, the types of providers that CMS is classifying as moderate risk, such as physical therapy practices, may begin to attract more individuals who are intent on defrauding Medicare or Medicaid. In their 2010 annual report on the Health Care Fraud and Abuse Control Program, DOJ and HHS reported convictions or other legal actions, such as exclusions or civil monetary penalties, against several types of Medicare providers other than DMEPOS suppliers and HHAs, such as medical clinics and physical therapy practices.[31] CMS has also established triggers for adjustments to an individual provider's risk level. For example, if an individual limited- or moderate-risk provider has been excluded from Medicare by the HHS OIG, that individual provider would move to the high-risk level.

For Medicaid, one requirement in CMS's February 2011 rule is that state Medicaid agencies are to establish categorical levels of risk for their providers. For the moderate- and high-risk providers, a state Medicaid agency must conduct site visits, and for high-risk providers, it must conduct fingerprinting and criminal background checks.

[30]In February 2011, CMS told us that the agency had requested additional comments on how best to implement the fingerprinting and criminal history record check requirements and might adopt some of the comments in implementing this provision. CMS will not implement fingerprinting and criminal history record checks until after subregulatory guidance is published that explains how the agency plans to ensure that privacy rights are respected and that addresses other operational concerns.

[31]*The Department of Health and Human Services and the Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2010* (Washington, D.C.: January 2011).

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In addition to enhancing screening procedures, PPACA includes two provisions that strengthen other aspects of provider enrollment for Medicare and Medicaid. CMS implemented these provisions in its February 2011 final rule. First, PPACA allows CMS to declare a moratorium on enrollment of new Medicare and Medicaid providers when the agency determines such a moratorium to be necessary to prevent or combat fraud, waste, and abuse. State Medicaid agencies may also authorize such a moratorium. Second, PPACA also requires state Medicaid programs to terminate providers that have been terminated from Medicare or other state Medicaid programs.

PPACA also imposes new requirements on Medicare and Medicaid providers, including a requirement for establishing compliance programs that adhere to standards established by the Secretary in consultation with the OIG.[32] CMS sought public comment on establishing such compliance programs in a proposed rule on September 23, 2010.[33] The agency indicated in explaining its February 2011 final rule that it intended to conduct further rulemaking on compliance program requirements and would advance specific proposals in the future. In addition, PPACA imposes specific requirements for providers to disclose any current or previous affiliation with a provider that has uncollected debt; has been or is subject to a payment suspension under a federal health care program; has been excluded from participation under Medicare, Medicaid, or CHIP; or has had its billing privileges denied or revoked. The law allows CMS to deny enrollment to any such provider whose previous affiliations pose an undue risk. In February 2011, CMS told us that it was drafting a proposed rule to implement this authority. Further, providers that order home health services must have a face-to-face encounter with the beneficiary before the services can be ordered. CMS issued a final rule regarding this requirement in November 2010.[34] Finally, providers that order DMEPOS or

[32]In general, a compliance program is the internal set of policies, processes, and procedures that a provider organization implements to help it act ethically and lawfully. In this context, compliance plans help provider organizations prevent and detect violations of Medicare laws and regulations.

[33]*Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers*. 75 Fed. Reg. 58204 (Sept. 23, 2010).

[34]*Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices*. 75 Fed. Reg. 70,372 (Nov. 17, 2010).

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home health services for beneficiaries will have to be enrolled in Medicare or Medicaid and maintain documentation on the services or items ordered, and the claims for these services and items must contain their National Provider Identifier number.

Before PPACA, CMS had taken other steps over the past 3 years regarding the legitimacy of providers, and PPACA has provisions that are consistent with some of these steps. First, the agency implemented a statutory requirement for DMEPOS suppliers to post a surety bond to help Medicare recoup erroneous payments that result from fraudulent or abusive billing practices.[35] PPACA extended CMS's authority to impose surety bonds consistent with billing volume to all Medicare providers.[36] Second, as directed by law, CMS required that all DMEPOS suppliers be accredited by a CMS-approved accrediting organization to ensure that they meet minimum standards. In June 2010, CMS told us that approximately 9,000 DMEPOS suppliers were dis-enrolled as result of these surety bond and accreditation requirements. Third, CMS began to implement a Medicare competitive bidding program for durable medical equipment and supplies with prices that took effect in January 2011 from the first round of bidding. This program could also help reduce fraud, waste, and abuse because it requires CMS to select DMEPOS suppliers based in part on new scrutiny of their financial documents and other application materials, among other things. The program took effect initially in nine metropolitan areas. PPACA built upon some of these efforts. It required CMS to speed up implementation of the competitive bidding program, expanding the number of areas to be included in the second round of bidding from 70 to 91 by the end of 2011.

[35]Social Security Act §1834(a)(16)(B). As of October 2009, DMEPOS suppliers were required to obtain and submit a surety bond in the amount of at least $50,000. A DMEPOS surety bond is a bond issued by an entity guaranteeing that a DMEPOS supplier will fulfill its obligation to Medicare. If the obligation is not met, Medicare will recover its losses via the surety bond. Medicare Program; Surety Bond Requirement for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), 74 Fed. Reg. 166 (Jan. 2, 2009).

[36]Before PPACA, the Social Security Act also required CMS to impose surety bonds on HHAs and permitted the imposition of surety bonds on certain other Medicare providers. PPACA requires any surety bond imposed to be commensurate with the provider's billing volume. CMS officials stated that the agency is drafting a rule to implement this authority, in which the agency will propose imposing surety bonds on additional providers.

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Improving Prepayment Review of Claims Could Prevent Improper Payments from Being Made

Our work on Medicare has shown that prepayment reviews of claims are essential to help ensure that Medicare pays correctly the first time. Conducting these reviews is challenging due to the volume of claims. Overall, less than 1 percent of Medicare's claims are subject to a medical record review by trained contractor personnel. Therefore, having robust automated payment controls—called edits—in place that can deny inappropriate claims or flag them for further review is critical. However, we have found weaknesses in these prepayment controls. For example, in 2007, we found that contractors responsible for reviewing DMEPOS claims did not have automated prepayment controls in place to identify questionable claims, such as those associated with atypically rapid increases in billing or for items unlikely to be prescribed in the normal course of medical care.[37] Lack of such prepayment controls has resulted in losses to Medicare.[38] As a result, we recommended in 2007 that CMS require its contractors to develop thresholds for unexplained increases in billing and use them to develop automated prepayment controls. Although CMS has not implemented that recommendation specifically, it has added edits to flag claims for services unlikely to be provided in the normal course of medical care. Additional prepayment controls, such as those based on thresholds for unexplained increases in billing, could further enhance CMS's ability to identify improper claims before they are paid.

PPACA requires state Medicaid agencies to add some specific prepayment edits. Beginning with claims submitted on October 1, 2010, PPACA requires states to incorporate into their Medicaid Management Information System compatible National Correct Coding Initiative (NCCI) methodologies in order to promote correct coding and to control improper coding leading to inappropriate payment.[39] These methodologies are in use

[37]See GAO, *Medicare: Improvements Needed to Address Improper Payments for Medical Equipment and Suppliers*, GAO-07-59 (Washington, D.C.: Jan. 31, 2007).

[38]For example, we found that from the first quarter of 2003 through the first quarter of 2005, due to an absence of such prepayment controls, 225 suppliers increased their billing to Medicare both by at least 500,000 and by at least 50 percent from at least one 3-month period to the next. In November 2004, the U.S. government won a default civil judgment against 16 of these suppliers for filing false claims against Medicare for services not rendered—after they were paid almost $40 million from January 2003 through September 2004.

[39]NCCI, a CMS program that consists of coding policies and edits, was initiated for Medicare in 1996 to help ensure correct payment for Medicare Part B for physician, laboratory, and radiology services claims. Under NCCI, CMS's contractors screen Medicare Part B claims with automated prepayment edits designed to detect anomalies that indicate a claim has incorrect information.

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in the Medicare program for edits related to certain practitioner services, ambulatory surgical center services, outpatient hospital services, and supplier claims for durable medical equipment. For example, NCCI edits can detect claims with duplicate services delivered to the same beneficiary on the same date of service, such as more than one excision of a gallbladder for the same beneficiary. CMS provided guidance on how to implement this requirement through a state Medicaid directors' letter issued on September 1, 2010.

The Small Business Jobs Act of 2010 also has a provision regarding claims review to prevent improper payments. It requires CMS to use predictive modeling and other analytic techniques—known as predictive analytic technologies—both to identify and to prevent improper payments under the Medicare FFS program.[40] The law requires these predictive analytic technologies to be used to analyze and identify Medicare provider networks, billing patterns, and beneficiary utilization patterns and detect those that represent a high risk of fraudulent activity. Through such analysis, unusual or suspicious patterns or abnormalities could be identified that could be used to prioritize additional review of suspicious transactions before payment is made. CMS published a solicitation in December 2010 for these technologies and a case management system to track findings. The law requires that the solicitation require contractors that are selected to begin using these technologies on July 1, 2011, in the 10 states identified by CMS as having the highest risk of waste, fraud, or abuse in Medicare FFS payments. After the initial year, based on the results of the predictive analytic technologies, their use will be expanded to other states. Based on the results after year 3, the technologies are to be expanded to Medicaid. In September 2010, CMS indicated that it was conducting pilots to test the ability of the technologies to identify potential fraud in paid claims. Agency officials told us that the experience from the pilot projects helped them develop the solicitation. CMS reported that it planned to incorporate the technologies for prepayment review after testing them through postpayment review to ensure that the new technologies work as intended and do not disrupt claims from legitimate providers or diminish access to care for legitimate beneficiaries.

[40]The law requires these predictive analytic technologies to be integrated into the Medicare FFS claims flow and prevent the payment of claims identified as potentially fraudulent, wasteful, or abusive until the claims can be verified as valid.

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In addition, a June 2010 Presidential Memorandum directed agencies to check certain databases—known as the "Do Not Pay List"—before making payments, to ensure that payments did not go to individuals who were dead or excluded from receiving federal payments or to entities that had been excluded from receiving federal payments. CMS officials stated that, in response to the Presidential Memorandum, the agency reviewed the databases that it and its Medicare contractors were using to determine payment eligibility for providers and took action to ensure that the agency's method of ensuring payment eligibility was consistent with the intent of the "Do Not Pay List". Specifically, CMS told us that it is currently reviewing the following databases: (1) the Social Security Administration's (SSA) Death Master File, (2) HHS OIG's Exclusions Database, (3) the Federal Payment Levy Program (FPLP), (4) the Treasury Offset Program, and (5) General Services Administration's Excluded Parties List System (EPLS).[41] CMS reported that it uses information from these databases to update its provider enrollment system. Specifically, provider enrollment information is checked monthly against the Medicare Exclusion Database, which contains information from the HHS OIG's Exclusions Database, the GSA's EPLS, and the SSA's Death Master File to update providers' enrollment status. Agency officials told us that CMS's contractors integrate updated provider enrollment information into CMS's payment system. Specifically, changes in CMS's provider enrollment system are downloaded nightly to the CMS contractors that pay claims.[42] Claims are then run through prepayment edits to check that providers are active and eligible for payment. With regard to Medicaid, CMS officials said that the state programs use some of these data sets, such as SSA's Death Master File, but that the states' abilities to complete checks consistent with the Presidential Memorandum would depend on whether they could obtain access to other databases, such as the FPLP, which has information on federal tax debt. The CMS officials added that they have encouraged states to review the databases available to them prior to making payments.

[41]See http://www.ntis.gov/products/ssa-dmf.aspx [SSA death master]; http://oig.hhs.gov/fraud/exclusions.asp [HHS OIG Exclusions] http://www.irs.gov/individuals/article/0,,id=100551,00.html [FPLP]; and http://fms.treas.gov/debt/top.html.

[42]These contractors include Medicare Administrative Contractors (MAC) and any fiscal intermediaries or carriers still administering claims. These MACs, carriers, and fiscal intermediaries are responsible for ensuring that they only pay claims to eligible providers.

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Focusing Postpayment Claims Review on the Most Vulnerable Areas and Adding New Recovery Audit Contractors Could Increase Identification of Improper Payments

We have found that postpayment reviews are critical to identifying payment errors to recoup overpayments in Medicare and that there are steps that could strengthen postpayment review. These steps involve focusing postpayment claims review on the most vulnerable areas and increasing the amount of postpayment review by using recovery audit contractors (RAC) for the Medicare and Medicaid programs.

CMS's claims administration contractors conduct limited postpayment reviews; therefore, it is important that they target their postpayment review resources on providers with a demonstrated high risk of improper payments.[43] For example, in 2009 we recommended that postpayment reviews be conducted on claims submitted by HHAs with high rates of improper billing identified through prepayment review.[44] To date, CMS has not implemented this recommendation; however, in February 2011 CMS told us that its contractors are developing medical review strategies that may include postpayment reviews on HHAs. We continue to believe that focusing postpayment claims review on the most vulnerable areas should be a priority.

Cross-checking claims for home health services with the physicians who prescribed them can be a further safeguard against fraud, waste, and abuse, but, as we reported in 2009, this is not routinely done.[45] For example, a physician must certify that a beneficiary needs home health services before services can be provided, but CMS does not routinely provide physicians with information that would enable a physician to determine whether an HHA was billing for services that the physician had not authorized or services that the physician would not consider necessary for the beneficiary's care. We recommended that CMS require that physicians receive a statement of services beneficiaries received based on the physicians' certification, but to date, the agency has not taken action. Taking such action also could be beneficial for other services and items susceptible to fraud and abuse that are not billed directly by physicians, such as DMEPOS. In February 2011, CMS indicated that it did not plan to implement this recommendation because agency officials thought that it would involve extensive resources to do so.

[43]We reported in 2009 that two contractors paying home health services claims conducted postpayment reviews on fewer than 700 of the 8.7 million claims they paid in fiscal year 2007. See GAO-09-185.

[44]See GAO-09-185.

[45]See GAO-09-185.

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Prior to PPACA, CMS had efforts focusing on postpayment review of claims, most recently its new national RAC program, which began in March 2009, after completion of a 3-year demonstration program in 2008.[46] The national program is designed to help the agency supplement the postpayment reviews conducted by contractors other than RACs. The RACs review Part A and B claims after payment, but because RACs are paid a contingent fee based on the dollar value of the improper payments identified, they have focused on claims from inpatient hospital stays, which are generally more costly services. We pointed out to CMS in our previous work that other contractors' postpayment review activities could be more valuable if CMS directed these contractors to focus on items and services where RACs are not expected to focus their reviews, and where improper payments are known to be high, such as home health services claims.[47]

PPACA expands Medicare's RAC program to Parts C and D. CMS published a request for comments on the development of Parts C and D RACs in December 2010. CMS awarded a Part D RAC task order for a 1-year base period that began January 2011 and 4 option years.

PPACA also requires state Medicaid programs to establish contracts, consistent with state law and similar to the contracts established for the Medicare RAC program, with one or more RACs. These state RACs are to identify underpayments and identify and recoup overpayments made for services provided by state Medicaid programs. In November 2010, CMS issued a proposed rule and guidance to states on establishing a Medicaid Recovery Audit Contractor program. CMS's proposed rule covered issues such as contingency fees and establishing a process for provider appeals of RAC determinations. States can ask CMS for an exception to the Medicaid RAC requirements. CMS officials told us that as of February 2011, 55 state Medicaid agencies have submitted their plans for addressing the Medicaid RAC PPACA provision, and 14 states have asked for

[46]The Medicare Prescription Drug, Improvement and Modernization Act of 2003 directed CMS to conduct a project to demonstrate how effective the use of RACs would be in identifying underpayments and overpayments, and in recouping overpayments in Medicare. Pub. L. No. 108-173, § 306, 117 Stat. 2066, 2256. Subsequently, in December 2006 the Tax Relief and Health Care Act of 2006 required CMS to implement a national RAC program by January 1, 2010. Pub. L. No. 109-342, div. B, title III, § 302, 120 Stat. 2924, 2991 (codified at 42 U.S.C. § 1395ddd(h)).

[47]See GAO, *Medicare Fraud, Waste and Abuse: Challenges and Strategies for Preventing Improper Payments*, GAO-10-844T (Washington, D.C.: June 15, 2010).

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exceptions in part or in whole. CMS plans to make public its decisions on any exceptions granted.

Improving Oversight of Contractors Could Help Ensure That Safeguard Activities Are Conducted

Overseeing the activities of contractors that provide services to Medicare beneficiaries is critical to addressing fraud, waste, and abuse and preventing improper payments. Over the years, we found areas where CMS's oversight had been insufficient to ensure that required program control activities were conducted and working well. For example, all Part D drug plan sponsors are required to have programs to detect, correct, and prevent fraud, waste, and abuse—also referred to as fraud and abuse programs. CMS is responsible for ensuring that sponsors are in compliance with this requirement; however, in 2008 we found that CMS's oversight of these programs had been limited.[48] We recommended that CMS conduct timely audits of sponsors' fraud and abuse programs. CMS agreed with this recommendation, and in March 2010 we reported that CMS had completed desk audits of selected sponsors' programs and was beginning to implement an expanded oversight strategy, including on-site audits to assess the effectiveness of these programs more thoroughly.[49] In November 2010, CMS officials reported that the agency had conducted on-site audits of 33 of the 290 sponsors in 2010, which covered 62 percent of the enrolled beneficiaries in 2010. As a result of the on-site audits, CMS had taken formal enforcement actions against several sponsors. In addition, CMS published a final rule in April 2010 to increase its oversight efforts and ensure that sponsors have effective programs in place.[50]

PPACA included new requirements for CMS to evaluate contractors receiving Medicare Integrity Program and Medicaid Integrity Program funding every 3 years. In addition, PPACA requires these contractors to provide performance statistics to HHS and OIG upon request. These statistics may include the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment of such

[48]GAO, *Medicare Part D: Some Plan Sponsors Have Not Completely Implemented Fraud and Abuse Programs, and CMS Oversight Has Been Limited*, GAO-08-760 (Washington, D.C.: July 21, 2008).

[49]See *Medicare Part D: CMS Oversight of Part D Sponsors' Fraud and Abuse Programs Has Been Limited, but CMS Plans Oversight Expansion*. GAO-10-481T (Washington, D.C.: March 3, 2010). A desk audit includes reviews of requested documents only, in contrast to site visits, which include other tasks, such as interviews with sponsor officials.

[50]*Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs*, 75 Fed. Reg. 19,678 (Apr. 15, 2010).

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activities. In February 2011, CMS officials told us that they are taking action to implement these requirements for Medicare and Medicaid. For Medicare, CMS reported that it is currently tracking performance statistics and is adding to and refining these statistics. CMS is also currently developing the specific performance statistics for its Part D integrity contractors and expects to finalize these statistics this year. For Medicaid, CMS also reported that it is requiring states to track performance statistics and anticipates finalizing the specific performance statistics to be tracked by March 2011.

Developing a Robust Process for Addressing Identified Vulnerabilities Could Help Reduce Improper Payments

Having mechanisms in place to resolve vulnerabilities that lead to improper payment is critical to effective program management, but our work has shown that CMS has not developed a robust process to specifically address identified vulnerabilities that lead to improper payments in Medicare. We have reported that an agency should have policies and procedures to ensure that (1) the findings of all audits and reviews are promptly evaluated, (2) decisions are made about the appropriate response to these findings, and (3) actions are taken to correct or resolve the issues promptly.[51] We have also stressed the importance of holding individuals accountable for achieving agency objectives.

As we reported in March 2010, CMS did not establish an adequate process during its recovery audit contracting demonstration or in planning for the national program to ensure prompt resolution of identified improper payment vulnerabilities in Medicare.[52] During the demonstration, CMS did not assign responsibility to agency officials or contractors for taking corrective action. According to CMS officials, the agency took corrective action only for vulnerabilities with national implications, and let the contractors that processed and paid claims decide whether to take action

[51]These are all aspects of internal control, which is the component of an organization's management that provides reasonable assurance that the organization achieves effective and efficient operations, reliable financial reporting, and compliance with applicable laws and regulations. Internal control standards provide a framework for identifying and addressing major performance challenges and areas at greatest risk for mismanagement. GAO, *Internal Control Standards: Internal Control Management and Evaluation Tool* GAO-01-1008G (Washington, D.C.: August 2001).

[52]GAO, *Medicare Recovery Audit Contracting: Weaknesses Remain in Addressing Vulnerabilities to Improper Payments, Although Improvements Made to Contractor Oversight*, GAO-10-143 (Washington, D.C.: March 31, 2010).

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for vulnerabilities that might occur only in certain geographic areas. Additionally, during the demonstration CMS did not specify in a plan what type of corrective action was required or establish a time frame for corrective action. The documented lack of assigned responsibilities impeded CMS's efforts to promptly resolve the vulnerabilities identified during the demonstration.

For the national Medicare RAC program, although CMS established a corrective action team to compile, review, and categorize identified vulnerabilities and discuss corrective action recommendations, the corrective action process is still incomplete. CMS appointed the Director of the Office of Financial Management to be responsible for the day-to-day operations of the program, and the CMS Administrator to be responsible for vulnerabilities that span agency components. However, the corrective action process still does not include any steps to either assess the effectiveness of the corrective actions taken or adjust them as necessary based on the results of the assessments. Further, the agency has not developed time frames for implementing corrective actions.

Because of these weaknesses, we recommended that CMS develop and implement a corrective action process that includes policies and procedures to ensure that the agency promptly (1) evaluates findings of RAC audits, (2) decides on the appropriate response and a time frame for taking action based on established criteria, and (3) acts to correct the vulnerabilities identified.[53] CMS concurred with this recommendation. Agency officials said they intended to review vulnerabilities on a case-by-case basis and were considering assigning them to risk categories to help prioritize their actions. However, to date, this recommendation has not been implemented. In February 2011, CMS reported that the agency is still working to address the vulnerabilities identified during the demonstration program. Specific to corrective actions, CMS told us that it now requires its contractors to consider and evaluate vulnerabilities identified by various entities, including the RACs.

For the Medicaid RAC program, CMS's proposed rule for state Medicaid programs does not include any steps to collect information on vulnerabilities to improper payment and develop a corrective action process to address them. Lessons learned from the Medicare RAC program indicate that collecting information on vulnerabilities and having an

[53]GAO-10-143.

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adequate corrective action process are important to address vulnerabilities. In turn, this suggests that having Medicaid RACs report to state Medicaid agencies and CMS on the vulnerabilities they identify and having a corrective action process to address those vulnerabilities would be important to reduce Medicaid improper payments. State Medicaid agencies are required to have a corrective action process as part of their activities to reduce their Medicaid error rates. Information from the Medicaid RAC program could be incorporated into these processes. Although its guidance was silent on this issue, in February 2011, CMS told us that state Medicaid programs will be responsible for addressing RAC-identified vulnerabilities and that it will monitor and assist states in implementing corrective actions.

Concluding Observations

The amount of improper payments in the Medicare and Medicaid programs creates urgency for CMS to act decisively to reduce them. Identifying the nature, extent, and underlying causes of improper payments is an essential prerequisite to reducing them, as is implementing our prior recommendation to develop an adequate corrective action process to address vulnerabilities. CMS could also take other actions to help better address the issue of fraud, waste, abuse, and improper payments in the Medicare and Medicaid programs. For Medicare, these include (1) developing thresholds for unexplained increases in billing and using them to develop automated prepayment controls, (2) conducting postpayment reviews on claims submitted by HHAs with high rates of improper billing identified through prepayment review, (3) cross-checking claims for home health services with the physicians who prescribed them, and (4) focusing claims administration contractors' postpayment reviews on items and services where RACs are not expected to focus their reviews, and where improper payments are known to be high. For Medicaid, other actions include ensuring that states develop adequate corrective action processes to address vulnerabilities to improper Medicaid payments to providers and issuing guidance to states to better prevent payment of improper claims for controlled substances.

As it implements PPACA provisions concerning Medicare and Medicaid, CMS has an opportunity to address fraud, waste, abuse, and improper payments in the two programs. CMS has made progress in rulemaking and issuing guidance to implement this law, the Small Business Jobs Act, and the "Do Not Pay List" memorandum. CMS's implementation efforts are in process, so it is too early to gauge their effects. As these requirements become part of Medicare and Medicaid operations, additional evaluation and oversight will help determine whether they are implemented as

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intended and have the desired effect on better ensuring proper payment. As the implementation process proceeds, we are continuing to monitor these issues. Notably, we are beginning new work to assess CMS's efforts to strengthen the standards and procedures for Medicare provider enrollment to reduce the risk of enrolling providers that are intent on defrauding or abusing the program. We also plan to examine the effectiveness of different types of prepayment edits in Medicare and of CMS's oversight of its contractors in implementing those edits to help ensure that Medicare pays claims correctly the first time. The level of importance placed on effectively implementing our recommendations and the requirements established by recent laws and guidance will be a key factor in reducing improper payments in the Medicare and Medicaid programs and ensuring that federal funds are used efficiently and for their intended purposes.

Mr. Chairman, this concludes my prepared statement. I would be happy to answer any questions you or other members of the subcommittee may have.

Contacts and Acknowledgments

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Appendix I: Abbreviations

CHIP	Children's Health Insurance Plan
CMS	Centers for Medicare & Medicaid Services
DMEPOS	durable medical equipment, prosthetics, orthotics, and supplies
EPLS	General Services Administration's Excluded Parties List System
FFS	Medicare fee-for-service
FPLP	Federal Payment Levy Program
HCERA	Health Care and Education Reconciliation Act of 2010
HHA	home health agencies
HHS	Department of Health and Human Services
NCCI	National Correct Coding Initiative
OIG	Office of the Inspector General
PPACA	Patient Protection and Affordable Care Act
RAC	Recovery Audit Contractor
SSA	Social Security Administration

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Appendix II: Open Recommendations

GAO report title and number		GAO recommendation	Centers for Medicare & Medicaid Services (CMS) implementation status
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)			
Medicare: Improvements Needed to Address Improper Payments for Medical Equipment and Supplies, GAO-07-59	1.	The Administrator of CMS should require the Program Safeguard Contractors to develop thresholds for unexplained increases in billing—and use them to develop automated prepayment controls as one component of their manual medical review strategies.	CMS has not implemented our recommendation specifically, but has added edits to flag claims for services that were unlikely to be provided in the normal course of medical care. CMS told us they are in the process of awarding contracts to implement advanced fraud detection and some contract awardees may have the ability to include increases in billing as part of those fraud detection efforts.
Home Health Agencies (HHA)			
Medicare: Improvements Needed to Address Improper Payments in Home Health, GAO-09-185	2.	To strengthen the controls on improper payments in the Medicare home health benefit, the Administrator of CMS should assess the feasibility of verifying the criminal history of all key officials named on an HHA enrollment application.	The Patient Protection and Affordable Care Act requires CMS to establish additional screening procedures for providers enrolling in Medicare and Medicaid. CMS has published a final rule that subjects high-risk providers in Medicare to fingerprinting and criminal background checks. Implementation of these efforts would address our recommendation.
	3.	To strengthen the controls on improper payments in the Medicare home health benefit, the Administrator of CMS should give physicians whose identification number was used to certify or recertify a plan of care a statement of services the HHA provided to that beneficiary based on the physician's certification.	CMS has no plans to implement this recommendation. The agency indicated that doing so would require extensive resources and funding.
	4.	To strengthen the controls on improper payments in the Medicare home health benefit, the Administrator of CMS should direct CMS contractors to conduct postpayment medical reviews on claims submitted by HHAs with high rates of improper billing identified through prepayment review.	CMS has not implemented this recommendation, but CMS reported that its contractors are developing medical review strategies that may include postpayment reviews on HHA claims. We believe there is an opportunity to further strengthen controls on improper payments if CMS were to direct its contractors to specifically conduct postpayment medical reviews on claims submitted with high rates of billing identified through prepayment review.

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GAO report title and number		GAO recommendation	Centers for Medicare & Medicaid Services (CMS) implementation status
	5.	To strengthen the controls on improper payments in the Medicare home health benefit, the Administrator of CMS should amend current regulations to expand the types of improper billing practices that are grounds for revocation of billing privileges. Grounds for revocation could include a pattern of submitting claims that are falsified, for persons who do not meet Medicare's coverage criteria, or are for services that are not medically necessary.	CMS has not implemented this recommendation.
Controlled Substances			
Medicaid: Fraud and Abuse Related to Controlled Substances Identified in Selected States, GAO-09-957	6.	To establish an effective fraud prevention system for the Medicaid program, the Administrator of CMS should evaluate our findings and consider issuing guidance to the state programs to provide assurance that claims processing systems prevent the processing of claims from providers and pharmacies debarred from federal contracts (i.e., on the Excluded Parties List System (EPLS)), excluded from the Medicare and Medicaid programs (i.e., on the List of Excluded Individuals/Entities (LEIE)), or both.	CMS told us it has taken various steps to implement this recommendation. It issued guidance to state Medicaid directors regarding the frequency with which states should check for excluded parties and directing them to provide guidance to enrolled providers and managed care organizations regarding checking for excluded employers, contractors, agents, etc. CMS also conducts triennial comprehensive program integrity reviews of states, in which they examine a sample of providers to determine if they contained excluded individuals.
	7.	To establish an effective fraud prevention system for the Medicaid program, the Administrator of CMS should evaluate our findings and consider issuing guidance to the state programs to provide assurance that Drug Utilization Review and restricted recipient program requirements adequately identify and prevent doctor shopping and other abuses of controlled substances.	CMS has taken some steps to address this recommendation. Beginning in fiscal year 2011, as part of the triennial comprehensive program integrity reviews, CMS staff reviewed states' recipient restriction programs. CMS also made efforts to educate providers, beneficiaries, and others on related payment integrity and quality assurance issues.
	8.	To establish an effective fraud prevention system for the Medicaid program, the Administrator of CMS should evaluate our findings and consider issuing guidance to the state programs to provide assurance that effective claims processing systems are in place to periodically identify both duplicate enrollments and deaths of Medicaid beneficiaries and to prevent the approval of claims when appropriate.	CMS has begun to take steps to address aspects of this recommendation. The agency is in the process of working with states to validate their processes to prevent the approval of claims for deceased Medicaid beneficiaries.

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GAO report title and number		GAO recommendation	Centers for Medicare & Medicaid Services (CMS) implementation status
	9.	To establish an effective fraud prevention system for the Medicaid program, the Administrator of CMS should evaluate our findings and consider issuing guidance to the state programs to provide assurance that effective claims processing systems are in place to periodically identify deaths of Medicaid providers and prevent the approval of claims when appropriate.	CMS has taken some steps to improve how deceased provider information is incorporated into claims processing in the Medicaid program. Specifically, CMS told us that it is currently implementing steps to access Medicare's provider enrollment system, which is updated monthly to reflect excluded and deceased providers, in order to inform Medicaid's provider data.
Recovery Audit Contracting			
Medicare Recovery Audit Contracting: Weaknesses Remain in Addressing Vulnerabilities to Improper Payments, Although Improvements Made to Contractor Oversight, GAO-10-143	10.	To help reduce future improper payments, the Administrator of CMS should develop and implement a process that includes policies and procedures to ensure that the agency promptly: (1) evaluates findings of recovery audit contractors (RAC) audits, (2) decides on the appropriate response and a time frame for taking action based on established criteria, and (3) acts to correct the vulnerabilities identified.	Although CMS has not implemented our recommendation specifically, it has taken some steps to address vulnerabilities identified by the RAC demonstration program. For example, CMS has developed provider-specific reports related to the demonstration program and established a team to facilitate the corrective action process. In addition, CMS told us that it now requires its contractors to consider and evaluate vulnerabilities identified by various entities, including the RACs.

Source: GAO and GAO analysis of CMS information.

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Related GAO Products

Medicare Fraud, Waste, and Abuse: Challenges and Strategies for Preventing Improper Payments. GAO-10-844T. Washington, D.C.: June 15, 2010.

Medicare Recovery Audit Contracting: Weaknesses Remain in Addressing Vulnerabilities to Improper Payments, Although Improvements Made to Contractor Oversight. GAO-10-143. Washington, D.C.: March 31, 2010.

Medicare Part D: CMS Oversight of Part D Sponsors' Fraud and Abuse Programs Has Been Limited, but CMS Plans Oversight Expansion. GAO-10-481T. Washington, D.C.: March 3, 2010.

Medicare: CMS Working to Address Problems from Round 1 of the Durable Medical Equipment Competitive Bidding Program. GAO-10-27. Washington, D.C.: November 6, 2009.

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DELAWARE HEALTH AND SOCIAL SERVICES

Division of Services for Aging and Adults with Physical Disabilities



Statement of

Helen Carson

Volunteer Service Coordinator, Case Manager
Delaware Partners of Senior Medicare Patrol

State of Delaware Department of Health and Social Services

Division of Services for Aging and Adults with Physical Disabilities

On

"New Tools for Curbing Waste and Fraud in Medicare and Medicaid"

Before the

Subcommittee on Federal Financial Management, Government Information,
Federal Services and International Security

Committee on Homeland Security and Governmental Affairs

United States Senate

March 9, 2011

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My name is Helen Carson and I am a Volunteer Service Coordinator/Case Manager of the Delaware Senior Medicare Patrol, at State of Delaware Department of Health and Social Services, Division of Services for Aging and Adults with Physical Disabilities. We are a State Unit on Aging, with a mission to improve or maintain the quality of life for Delawareans who are at least 18 years of age with physical disabilities or who are elderly.

Good afternoon Senator Carper, members of the Subcommittee and staff. Thank you for convening these hearings and for the opportunity to present my testimony today.

Senior Medicare Patrol

The national Senior Medicare Patrol (SMP) has been very busy since its inception in the mid-1990's. In Delaware, the Senior Medicare Patrol program began in 1999 and continues with a strong network of partners both in the state and nationally. Today there are 54 Senior Medicare Patrol programs, one in every state as well as the District of Columbia, Guam, U.S. Virgin Islands and Puerto Rico. These programs are well supported by the national Senior Medicare Patrol Resource Center. Health care fraud is a serious problem. The General Accounting Office (GAO) recently reported that in 2010, the federal government lost an estimated $48 billion on fraudulent claims and other improper payments.

Senior Medicare Patrol programs recruit and train senior volunteers and Medicare beneficiaries, to conduct outreach and education to their peers, caregivers, and professionals about Medicare and Medicaid fraud prevention. The primary message here is that there is something that beneficiaries can do about preventing healthcare fraud.

The goals of Senior Medicare Patrol are twofold: first, to educate and motivate consumers on how to prevent, detect and report healthcare fraud, errors, and abuse; and second, to receive and prepare to refer, as appropriate, complaints of potential healthcare fraud. So why is this important? Indeed, the billions lost to Medicare fraud each year - represents a massive financial loss to the government and beneficiaries. Fraud also can cause people to lose access to care, suffer inappropriately, receive low quality of care, lose benefits, and receive unnecessary or faulty durable medical equipment, the wrong drugs or other things they do not need - all affecting their health and quality of life.

Health Care Fraud Experience Stories

I would like to begin with my health care victimization story. After a history of cardiac issues, my husband had a heart attack in 2004 and was hospitalized. It was discovered that he had a defective device controlling his heart. Costly errors by the hospital resulted in an original 2 day stay turning into 30 days of multiple testing, a serious operation, and intensive care. As a result of this situation, the impact on our lives amounted to my husband not being able to work, leaving us with large co-payments, private hospital bills, and costly medication. We tried various agencies, though we were denied help due to our middle class income. We had no other choice but to refinance our home and use credit cards with minimal payments. Another major decision I made during this time period was to personally forgo a year without medication for chronic conditions, so that my husband could get his life-saving medications.

These were some of the many challenges that we faced in paying for high priced medications and abusive medical services. It was this experience that inspired me to learn about billings, to read Medicare Summary Notices and to help others with issues of health care error, fraud and abuse.

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Medicare Summary Notice (MSN) is a quarterly statement of services and supplies that providers and suppliers bill to Medicare.

While trying to cope with this situation, I watched a Senior Medicare Patrol segment on television, on how to address some healthcare issues. As a result, I became a Senior Medicare Patrol Volunteer and am now a part-time Volunteer Service Coordinator / Case Manager for Delaware Partners of Senior Medicare Patrol. I became a self-advocate and now assist others in recognizing hospital billing errors and questionable medical services. Most importantly, I'm now able to read and understand my Medicare Summary Notice. I used to be one of those seniors who threw away the Medicare Summary Notice because I thought my insurance would take care of anything. Now I know better, and realize that the Medicare Summary Notice statement can be a big help in assisting with cases of potential Medicare fraud.

There are many Medicare rules that are complicated and therefore seniors often don't understand the Medicare system. That is why the Senior Medicare Patrol reaches out to Medicare beneficiaries: to inform and educate, so seniors can be self-advocates and report questionable health care issues back to the program. Each case referred from a Medicare beneficiary may be a case that will necessitate gathering further information and/or referring the case for investigation. One such case involved services with Medicare Outpatient Services, Durable Medical Equipment, Prescription Medication, and private billing with a Medicare beneficiary who went into a nursing home for physical rehabilitation. Medicare and Supplemental Insurance were billed and paid for about a year's worth of services. These services were also billed to, and paid for, by the family member. With intervention from the Senior Medicare Patrol, the family member was reimbursed. Other issues, such as questionable Part D prescription medication billed over time, are still under assessment.

In Delaware, we are working on many complaints involving Durable Medical Equipment providers who visit residents in both long term care facilities and in the community, pretending to be educators. In facilities, these providers may present themselves as doctors and staff, and proceed to assist the residents by measuring and fitting them with medical supplies and equipment. Medicare pays for some supplies and equipment because Medicare beneficiaries are being pressured into getting them. We get issues all over the state where the provider has indicated, "It's free from Medicare"; in that Medicare will pay for the supplies or equipment.

One such case we are working on is with "Voice of the Community." A senior resident contacted us about a Durable Medical Equipment provider, who was putting up flyers which advertised "Free Durable Medical Equipment" in a senior apartment building. The provider then came in and "educated" the seniors, pressuring at least one Medicare beneficiary to get an electric wheel chair for the future. This provider manipulated the individual to give out his Medicare number and Supplemental Insurance. As a result, this Medicare beneficiary has an electric wheel chair and fears that if he speaks with us, he may lose the wheel chair. This is a fraud to the tax payers and Medicare; and a harm to the senior who feels caught in the fraudulent process.

In another case, an assisted living beneficiary was billed for medical services not provided by facility physician. These services included office visits to the physician and foot surgery. All the services were billed to Medicare, secondary insurance, and the beneficiary. Interestingly, the beneficiary kept a log of services he received. He was then able to reconcile his record against the Monthly Summary Notice. The beneficiary, fearing retaliation and discharge from the assisted living facility, did not report the fraud until intervention by the Senior Medicare Patrol staff. The case was referred to law enforcement for investigation. These are but examples of similar fraud-related cases handled by the Delaware Senior Medicare Patrol Program.

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Volunteer Impact

Some of the stories I shared with you today do not have successful endings, as volunteers are still diligently assisting in the resolution of these issues. Working with the Senior Medicare Patrol program, as a volunteer and now as a team member, is the most rewarding job I've ever had. I help people just like me, a senior. I help people who suffer the same problems that I faced, and some are much greater than mine. But the greatest gift is to see the smile on their face, after you have helped a Medicare beneficiary who was victimized by healthcare fraud, abuse, or waste. I should know because I have been a victim and have felt that sense of hopelessness. SMP volunteers know they do this work for satisfaction and not pay. We owe volunteers a great deal of appreciation for the work that they do and for actually giving up their time, sharing their passion, and using their expertise from a past career to fight health care fraud.

And the impact of these volunteer efforts nationally has been impressive. Since it started in 1997, the Senior Medicare Patrol program has trained over 60,000 volunteers, handled over 141,000 beneficiary complaints, and educated 2.9 million people to be self-advocates. In addition, the program has saved Medicare, Medicaid and beneficiaries close to $106 million through referral and resolution of beneficiary complaints.

Conclusion

In conclusion, it is my opinion as a former credit card investigator and a senior victim, that Medicare should have a reward system in place to encourage people and others like "Whistle Blowers" to speak up. Also, we need tougher laws and stiffer sentences implemented for fraud violations. By combining our efforts, we will combat Medicare fraud, abuse, and waste.

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Additional Written Questions for the Record
From
Senate Homeland Security & Governmental Affairs Committee
On
"New Tools To Curb Waste and Fraud in Medicare and Medicaid"

March 9, 2011

FOR DR. PETER BUDETTI OF CMS *(Chairman Tom Carper)*

1) **RECOVERY AUDIT CONTRACTING**

Dr. Budetti, I would like to ask some questions involving Recovery Audit Contracting (RAC). As your testimony described, the Affordable Care Act requires expansion of the Medicare RAC program to all of parts of Medicare, as well as Medicaid.

A) **Dr. Budetti, has CMS considered modifying the contracts of the Medicare Administrative Contractors (MACs) to incentivize its role in these recoveries? Are there any restrictions or limits to the work of the MACs in performing their RAC related efforts? For example, are the MACs restricted to the quantity of recoupment actions in a given time period?**

Answer: CMS expects the MACs to conduct all work related to their contracts with CMS. The MAC associated recovery auditing tasks, such as claim adjustment, appeal adjudication, validation and customer service have been added to all MAC contracts. CMS has worked with each MAC and each Recovery Auditor to determine appropriate workload levels in each jurisdiction. This is important so that the MAC can staff accordingly. CMS believes the MACs and Recovery Auditors have a very good working relationship. Any limitations that currently exist, such as a workload number, are put into place by CMS to help ensure consistent workload as well as to help ensure cost efficiencies. The workload numbers are flexible and if a workload number needs to be increased it can be increased by MAC jurisdiction.

B) **Dr. Budetti, I understand that CMS will no longer require that states have Medicaid RACs in place by April 1st of this year, and that the Medicaid program final rule will establish a new deadline. However, CMS also dropped the March target for publishing the final rule, and there has been no announcement of a new target date for the final rule. When will we see the final rule for Medicaid RACs?**

Answer: The Affordable Care Act included many program integrity provisions with aggressive implementation timelines, and CMS has worked expeditiously to meet all statutory deadlines within the Affordable Care Act in a timely fashion. CMS is mindful of burdens on providers and we will continue to work with providers to make sure that they are informed on the status of all new program integrity provisions. In regards to the

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Medicaid Recovery Audit program, in line with our interpretation of the statute, States were required to submit a State Plan Amendment to CMS to establish their recovery audit programs by December 31, 2010. This is an important program and we intend to promulgate final regulations as expeditiously as possible.

2) PRESCRIBER IDENTIFIER VERIFICATION POLICY

You mentioned in your testimony that CMS recently issued new guidelines in regards to Medicare prescription drug program prescriber identifier verification. Those important and very useful guidelines will go into effect in 2012. With billions of taxpayer dollars at stake, what is CMS doing *right now* to verify prescriber IDs? Is CMS considering interim steps to address potential fraud in the Medicare prescription drug program, such as voluntary steps by Medicare prescription drug sponsors? Is it possible for CMS or the Office of Inspector General to check prescription drug records to identify potential fraud? Under the new guidelines, will the current Medicare prescription drug oversight contractors, or another entity, perform the reviews of the Medicare prescription drug sponsors to ensure that they are checking for valid prescriber identifiers? How will CMS determine that no valid prescription drug claims with invalid prescriber identifiers were reimbursed? Who will determine and review that sponsors have adequate controls to check for valid controlled substance prescriber identifiers?

Answer: CMS recognizes the importance of having strong program integrity initiatives that will deter criminal activity and attempts to defraud the Medicare and Medicaid programs. I share your commitment to ensuring taxpayer dollars are being spent on legitimate items and services. We must make sure to do this in a way that is fair and transparent to plans and providers, who are our partners in caring for beneficiaries, and also work to ensure that beneficiary access to necessary medicines is not impeded. Starting in 2012, CMS Part D plans will validate that prescriptions for Schedule II drugs are within the prescriber's scope of practice by ensuring the National Provider Identifier (NPI) on pharmacy claims maps to, or includes a valid DEA number.

Over the longer term, CMS believes that mandating the use of the NPI on all Part D claims is the best way to ensure that a valid prescriber identifier is present on all Part D claims, including claims for Schedule II drugs. Next year, CMS will begin systems checks in 2012 that validate the NPI on claims data it receives from drug plans. We are considering proposed regulations to be issued later this year that would require that all Part D claims include a valid NPI, effective 2013, to be enforced by system checks on claims data CMS receives from Medicare drug plans. In the interim, CMS has issued guidance to Part D plan sponsors clarifying that, while CMS continues to accept any of four prescriber identifiers (NPI, DEA number, State license number or unique provider identification number) on prescription drug event data, plans must only submit valid identifiers.

3) UPIN PRESCRIBER IDENTIFIER NOT UPDATED SINCE 2007

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My understanding is that the UPIN database, 1 of the 4 prescriber identifiers CMS says it accepts, has not been updated since June 2007. Also, I understand that CMS is considering a proposal to restrict the acceptable prescriber identifiers to only the National Provider Identifier in 2013. However, this proposal will, at best, require that the UPIN usage will stop about two years from now. Why is CMS continuing to accept the UPIN prescriber identifier since we know that this database information is at best nearly 4 years old? Will this continued use of the UPIN create substantial opportunities for people trying to commit fraud under the Medicare prescription drug program? Are there steps under consideration to address the problems of continued usage of the UPIN by those trying to commit prescription drug fraud.

Answer: CMS stopped issuing UPINs in 2007, however the database is available and current as of the final June 2007 update. CMS has permitted the use of one of four identifiers to accommodate instances when pharmacies are unable to obtain the prescriber NPI at the time of dispensing and to prevent Part D enrollees from experiencing service interruptions. In a February 18, 2011 call letter, CMS notified plans that it is considering proposing a requirement through its next rulemaking that all Part D claims include a valid NPI, which would be enforced by system checks on claims data CMS receives from Medicare drug plans. CMS also detailed plans to validate the format of all prescriber identifiers on PDEs that are coded as an NPI and assess each sponsor's performance regarding NPI use and validity.

DUAL ELIGIBLE BENEFICIARIES AND IMPROPER PAYMENTS

4) **Dr. Budetti, when CMS identifies improper payments to a provider involving a dual-eligible beneficiary (i.e. a person eligible for both Medicare and Medicaid), is this information shared with the state Medicaid offices? How many states receive this information, and are there plans by CMS to increase the number of states receiving this information? Do these state Medicaid offices typically collect the identified overpayments, or is this an area that needs some attention?**

Answer: Medicare has a process called the national Coordination of Benefits Agreement (COBA) claims crossover process. In this process, Medicare transmits electronically claim information to State Medicaid claims processors. If a State has elected to receive adjustment claims or, if a claim was paid and then is adjusted upon post payment review (e.g., by a Recovery Auditor), that information is shared with the State, unless it has specified that it does not wish to receive these kinds of claims. The same process also exists with commercial supplemental payers, such as employee retiree plans, FEHBP, TRICARE, or Medigap insurers.

At this time, 32 of the 49 participating State Medicaid Agencies that receive Medicare crossover claims accept adjustment claims. States elect to receive claim adjustments. States can modify their election to meet their needs.

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Currently, through the COBA crossover process, State Medicaid Agencies have the option to exclude claims on which they have no cost sharing responsibilities as well as adjustment claims. There are no immediate plans to change this practice of allowing State Medicaid Agencies the option to either accept or exclude receipt of adjustment claims.

Questions for Dr. Budetti (*Senator Coburn)*

1. **Last June, President Obama set a goal of reducing the Medicare fee-for-service improper payment rate to half of its current level by 2012. You have said this goal will be met. To ensure the goal posts are not moved, is CMS committed to on measuring the improper payment rate with the same methodology next year as it was this year? What happens if the President's goal is NOT met? Are you the accountable federal official for this goal? Are you willing to have a percentage of your salary indexed to the degree of CPI's success in meeting this goal?**

   Answer: The agency accountable official is Ellen Murray, the Assistant Secretary for Financial Resources for the Department of Health and Human Services. As the Deputy Administrator for Program Integrity at CMS, I am the program accountable official. Payment policies and guidelines for all government employees are established by the Office of Personnel Management. However, as the program accountable official at CMS, the Agency's efforts to reduce fraud and improper payments is a component within my annual performance evaluation.

2. GAO has a list of more than 30 significant recommendations, based on reports they have done, that would enhance program integrity. These recommendations have not been implemented. Have you reviewed this list? The Inspector General's Office publishes a compendium of unimplemented recommendations each year. These recommendations have not been implemented. Have you reviewed this list? Which recommendations from both lists will CMS implement and which recommendations you think Congress should give CMS the tools or authority to implement?

   Answer: CMS is working steadily to implement the new authorities provided by the Affordable Care Act and has identified additional tools to enhance these efforts in the President's budget. Additionally, not all of the recommendations from GAO fall under my direct area of supervision, so I cannot comment on all of the recommendations. However, CMS agrees in general with these recommendations, and is working to reduce improper payments and fraud in the Medicare and Medicaid programs. For example, CMS is working to implement the GAO recommendation from a 2009 report titled "Improvements needed to address improper payments in Home Health" by conducting FBI criminal history checks for all key owners of newly enrolling home health agencies. CMS is implementing criminal background checks for all high risk providers, including newly enrolling DMEPOS suppliers, as authorized by ACA section 6401(a)(3). We appreciate GAO's acknowledgement of our efforts to reduce improper payments and are working to address their recommendations as we continue to implement the Improper

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Payments Elimination and Recovery Act of 2010 (IPERA) and expand the Recovery Audit program.

3. **Last year's financial audit of the Department found that CMS does not perform a claims-level detailed analysis for certain Medicaid bills (Entitlement Benefits Due and Payable) to determine the reasonableness of the various state calculations of unpaid claims. This pot of money was about $27 billion as of September last year. The auditors said it is "a significant liability on the financial statements." Has your office taken any steps to rectify this situation? If so, please detail. If not, do you have a timeframe or process for implementing a detailed claims look-back analysis?**

Answer: The CMS annual financial statements include the calculation of the Medicaid Entitlement Benefits Due and Payable (EBDP) liability to ensure the agency reports all of its liabilities owed in accordance with generally accepted accounting standards. This liability is an estimate of the net Federal share of Medicaid expenses that have been incurred by the States and Territories but have not yet been reported to CMS, i.e., Medicaid services have been provided, but the claim has not been submitted for payment. The CMS develops this estimate using specific audited financial data provided by the States and Territories who attest to the validity and accuracy of the information provided.

While the independent auditors did report that CMS' FY 2010 financial statements, including the $27 billion Medicaid EBDP estimate, were fairly stated, they did note that we do not perform a claims-level look back analysis that would determine the reasonableness of the estimate. In order to do this analysis, CMS would need to have access to all the States and Territories' Medicaid claims level detail. Currently, the CMS receives claims level data from States through the Medicaid Statistical Information System (MSIS). However, this information is not comprehensive for all States and Territories which precludes us from conducting the reasonableness test.

The CMS has several initiatives in progress to move us toward a timely, and more comprehensive data feed from the States, including comprehensive Medicaid and CHIP claims and eligibility data that will allow us to conduct an additional reasonableness test. Under one pilot project currently underway, we will attempt to bring 10 selected pilot States onboard with this new data submission methodology by the end of this fiscal year. We intend to bring onboard the remaining 40 States thereafter, and to be operational, nationwide, using this new submission process following the conclusion of the pilot.

The pilot initiative is to test implementation of sections 6402(c) and 6504(a) of the Affordable Care Act. Section 6402(c) requires enrollee encounter data to be submitted by the States to the MSIS in order for States to receive federal matching payments for the amounts expended for each individual enrollee and section 6504(a) requires States to submit data elements from their automated data systems that CMS determines to be necessary for program integrity, program oversight and administration. Currently, data extraction is different in each State, but if it could be standardized across States with tools being developed in the pilot that would result in a reduction from numerous feeds to one

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feed. The data feed would expand from around 350 data elements to around 800. CMS will also create a database using States' data for States to access.

4. **If a Medicare provider or supplier submits a bill for services and that claim is denied, are subsequent claims from that same provider or supplier more closely examined or denied? Why or why not?**

Answer: Over the last two years, CMS has made significant progress in eliminating inappropriate payments to Medicare physicians who are not living, or payments made on behalf of dead beneficiaries. Since September 2008, CMS has received monthly updates of deceased individuals from the Social Security Administration, which we compare against our provider and beneficiary enrollment data. Based on this comparison and the subsequent verification by a CMS contractor, CMS has deactivated the National Provider Identifiers of more than 11,500 practitioners who were previously enrolled in Medicare.

As CMS continues its efforts to implement predictive modeling and data analysis in our claims payment process, we will be able to recognize aberrant patterns of billing, including patterns of billings for deceased patients. This is potentially one trigger that could escalate a provider into a high-risk category that would subject them to further scrutiny. If the provider is fraudulent, they will be referred to law enforcement for investigation and prosecution, and/or suspended or terminated from the Medicare program.

5. **Last year's Departmental audit found some Medicare contractors still use financial processes that are "subject to an increased risk of inconsistent, incomplete, or inaccurate information." According to the audit, the accuracy of these contractors' reports "remains heavily dependent on inefficient, labor-intensive, manual processes that are also subject to an increased risk of inconsistent, incomplete, or inaccurate information being submitted to CMS." Do you believe this kind of contractor problem could put taxpayer dollars at risk? What remedies are you exploring to streamline their data entry processes?**

Answer: The Medicare contractors' claims processing systems are operating effectively in adjudicating healthcare claims; however, they were not designed to meet the requirements of a dual entry, general ledger accounting system. As a result, the claims processing systems did not meet the provisions of the Federal Financial Management Improvement Act of 1996 (FFMIA).

To address this issue, CMS developed and implemented the Healthcare Integrated General Ledger Accounting System (HIGLAS), which is an Oracle based commercial off-the-shelf (COTS) product. Implementing HIGLAS has provided CMS with enhanced ability to oversee contractors' accounting and financial reporting processes, and allows contractors to provide high quality, timely financial data with minimal manual intervention. Nationwide implementation of HIGLAS began in 2005 and, to date, has been implemented at 14 traditional Medicare FFS contractor sites and 16 Medicare Administrative Contractor (MAC) sites. Currently 94 percent of completed Medicare benefit payments are processed via HIGLAS. CMS continues to transition

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MAC workloads to HIGLAS, with 10 additional MAC sites still left to transition. CMS expects that Part A and Part B MACs will be transitioned to HIGLAS by late 2012.

6. **The Department of Defense has a "common access card" that is used for identification purposes, that meets or exceeds requirements of privacy laws, and uses integrated chips, a magnetic stripe, and a bar code to enable a secure to log-on to networks. Are you aware of any of the challenges associated with that model? Has your office ever explored the utility of using smart card technology for program integrity in Medicare? Would you be willing to talk with DOD about the idea?**

Answer: We share your concerns about the importance of safeguarding and protecting Medicare beneficiaries from identity theft and safeguarding the Trust Funds with appropriate beneficiary identification.

As we have looked into the feasibility of altering the Medicare identification card, we have found that there are considerable costs associated with both changing the Medicare beneficiary identifier and/or switching to a "smart card," not only for CMS, but our public and private sector partners. The current Medicare Health Care Identification Number (which contains a beneficiary's Social Security Number) is the basis of eligibility for Medicare and is integrated in more than 50 CMS systems, as well as communications with the Social Security Administration, State Medicaid Departments, private Medicare health and drug plans, and over two million health care providers and suppliers. However, CMS will continue to consider various options and any technological advances in this area to the extent that such options protect beneficiaries' privacy, prevent identity theft, and protect the integrity of the Medicare Program in a cost-effective manner.

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Questions for the Record to
Greg Andres
Acting Deputy Assistant Attorney General
Criminal Division
U.S. Department of Justice

Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security
Committee on Homeland Security and Governmental Affairs
United States Senate

"New Tools for Curbing Waste and Fraud in Medicare and Medicaid"
March 9, 2011

Questions from Senator Thomas Carper

BETTER INFORMATION SHARING AND COOPERATION

1) **Mr. Andres, are there steps under discussion to allow better cooperation and information sharing between CMS, the state Medicaid offices and other law enforcement? Could you address if there are unmet needs or opportunities for better DOJ access to the databases of providers, beneficiaries and Medicare claims data that CMS maintains, including the Integrated Data Repository?**

The Department is currently involved in several efforts to ensure we coordinate effectively with our partners. For example, as part of the Healthcare Fraud Prevention and Enforcement Action Team (HEAT) initiative, DOJ and CMS are working together to enhance information sharing between HHS and DOJ agencies to facilitate and expedite data sharing and access for Medicare Fraud Strike Force and other federal criminal and civil health care fraud enforcement actions. CMS has provided access to the Services Tracking Analysis and Reporting System (STARS), a national repository for all Part A, B, and DME claims data that is updated on a monthly basis, to more than 100 DOJ and about 20 FBI personnel. CMS is also expanding law enforcement agency access to the "Next Generation Desktop" (NGD) system maintained by CMS in support of the 1-800-MEDICARE operation that is used to receive beneficiary calls, questions, and complaints. NGD claims information is updated daily and is the closest to "real-time" ongoing claims submission activity available. A HEAT "data sharing workgroup" also exists and is working to establish law enforcement access to the Integrated Data Repository which contains all Medicare claims data from Parts A (hospital), B (outpatient), , and D (prescription drug) to facilitate more comprehensive cross claims analysis of Medicare billings and services. In addition, the FBI works closely with CMS at the national level, particularly in the areas of data analysis, identification of fraud schemes, and training. The FBI also regularly contacts CMS contractors at the local level to obtain billing data and other information. Cooperation and information sharing are also

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enhanced through direct FBI liaison with state Medicaid offices and law enforcement partners and through joint participation on numerous task forces and working groups.

STATE BREAKDOWNS OF HCFAC RECOUPMENT NUMBERS

2) **Mr. Andres, your testimony described the successes of the Health Care Fraud and Abuse Control Program, including the recoupment of about $4 billion last year in recoveries of health care fraud related to federal health care programs. Do you have data showing state- by-state breakdowns of these figures?**

The Department does not collect or maintain the HCFAC report data on a state-by-state basis. First, the recoveries described in the HCFAC report, pursuant to the statute establishing the program and the annual reporting requirement, involve federal dollars that were returned to federal agencies whose programs were defrauded by the defendants prosecuted in the Department's criminal and civil cases, HHS audit disallowances and administrative penalties, and payments to relators. The Federal share of all Medicaid dollars recovered in DOJ litigation and HHS-OIG audit disallowances was returned to CMS, not to the states. Thus, state shares of Medicaid recoveries are not included in the $4 billion in recoveries reported in the FY 2010 HCFAC report to Congress.

Second, state Medicaid dollars that are recovered in federal health care fraud litigation are returned to the victim state/s, but the involvement of DOJ attorneys is usually limited to negotiating the overall settlement terms. For national health care fraud settlements that involve schemes victimizing multiple state Medicaid programs, the National Association of Medicaid Fraud Control Units (NAMFCU) usually works with the individual states to determine the respective shares of state Medicaid program funds that are to be transferred to each victim state Medicaid program.

Third, it would be difficult to determine exactly what portion of all recoveries may be attributable to each state. This is due in part to the fact that recoveries often come in cases where the offense has occurred in multiple states or nationwide. Since the statutory reporting requirements do not mandate reporting beyond a national level, the Department has not created the accounting systems or procedures to track or estimate recovery information at the state or local levels based on the numbers of beneficiaries who may have been victimized in each health care fraud scheme.

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Questions from Senator Tom Coburn

3) HHS and the Justice Department sent Sen. Grassley a letter in late January (2011) explaining the results from the Administration's much-publicized HEAT initiative, Health Care Fraud Prevention and Enforcement Action Teams. If I read the data correctly, in 2010, convictions in all but one city (Miami) decreased. Can you please explain this? How much taxpayer money did DOJ and HHS spend per conviction?

The number of convictions in each Strike Force city for which we have comparative data increased in FY 2010. The original table in our January 24, 2011 letter to Senator Grassley and the enhanced table below demonstrate that the numbers of HEAT convictions increased in all three locations where Strike Force prosecution teams produced convictions during FY 2009 and FY 2010. The table below shows the total number of convictions and specific counts of guilty pleas and guilty verdicts in each HEAT Strike Force location. We added the columns in italics to show the absolute and percentage changes in HEAT convictions during FY 2010 compared to FY 2009. According to our data, from FY 2009 to FY 2010 the number of HEAT/Strike Force convictions increased from 111 to 129 in Miami (+16%); from 16 to 25 in Los Angeles (+56%); and from 16 to 47 in Detroit (+194%).

For all Strike Force locations combined, total HEAT/Strike Force convictions increased from 143 in FY 2009 to 240 in FY 2010 (a nearly 68% increase). Since none of the defendants who were charged in the Houston Strike Force indictments announced in July 2009 had pleaded guilty or were convicted at trial until after October 1, 2009 (e.g., the beginning of FY 2010), and since Brooklyn, Tampa, and Baton Rouge were announced as new Strike Force sites during FY 2010, we cannot compute the changes in HEAT convictions for these four locations in FY 2010 compared to FY 2009.

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Medicare Fraud Strike Force: Convictions	FY 2007	FY 2008	FY 2009	FY 2010	*Change FY10/FY09*	*Pct Chg FY10/FY09*	Total (FYs 2007-2010)
Miami (Commenced in May 2007)							
Guilty Pleas	43	89	101	124	*23*	*22.8%*	357
Guilty Verdicts	4	7	10	5	*-5*	*-50.0%*	26
Subtotal MFSF Convictions	47	96	111	129	*18*	*16.2%*	383
Los Angeles (Commenced in May 2008)							
Guilty Pleas		2	13	22	*9*	*69.2%*	37
Guilty Verdicts		1	3	3	*0*	*0.0%*	7
Subtotal MFSF Convictions		3	16	25	*9*	*56.3%*	44
Detroit (Commenced in June 2009)							
Guilty Pleas			16	39	*23*	*143.8%*	55
Guilty Verdicts			0	8	*8*	*n/a*	8
Subtotal MFSF Convictions			16	47	*31*	*193.8%*	63
Houston (Commenced in July 2009)							
Guilty Pleas				23	*23*	*n/a*	23
Guilty Verdicts				7	*7*	*n/a*	7
Subtotal MFSF Convictions				30	*30*	*n/a*	30
Brooklyn (Commenced in December 2009)							
Guilty Pleas				2	*2*	*n/a*	2
Guilty Verdicts				0	*0*	*n/a*	0
Subtotal MFSF Convictions				2	*2*	*n/a*	2
Tampa (Commenced in January 2010)							
Guilty Pleas				7	*7*	*n/a*	7
Guilty Verdicts				0	*0*	*n/a*	0
Subtotal MFSF Convictions				7	*7*	*n/a*	7
Baton Rouge (Commenced in July 2010)							
Guilty Pleas				0	*0*	*n/a*	0
Guilty Verdicts				0	*0*	*n/a*	0
Subtotal MFSF Convictions				0	*0*	*n/a*	0

TOTAL Medicare Fraud Strike Force Conviction Statistics	FY 2007	FY 2008	FY 2009	FY 2010	*Change FY10/FY09*	*Pct Chg FY10/FY09*	Total (FYs 2007-2010)
Guilty Pleas	43	91	130	217	*87*	*66.9%*	481
Guilty Verdicts	4	8	13	23	*10*	*76.9%*	48
Total MFSF Convictions	47	99	143	240	*97*	*67.8%*	529

(Note: These statistics do not include all criminal health care fraud cases filed and defendants charged; they only include the subset of Strike Force prosecution statistics for each district.)

The Department of Justice does not track the cost per conviction related to our health care fraud prosecution activities. Our payroll and time-keeping systems do not collect sufficiently detailed information to accurately reflect the work time and related costs for employees who investigated, prosecuted, and provided support for each case and/or defendant who was convicted in a HEAT-related law enforcement action nor all associated non-personnel litigation and investigation expenses on a per case or per conviction basis.

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4) As a law enforcement agency, does DOJ know what states and cities are most vulnerable to gross Medicare fraud? So, does DOJ target its fraud detection and prevention efforts to vulnerable areas?

DOJ works closely with the HHS Office of Inspector General (HHS-OIG), the FBI, CMS and the agency's program integrity contractors to examine available claims and program integrity information, as well as available criminal intelligence information in order to target our fraud detection and prevention activities to geographic areas that appear to be the most vulnerable to fraud. Our analysts, agents and investigators begin by analyzing Medicare claims billing and payment data to identify geographic areas and types of services with aberrations that may be indicators of possible fraud. For example, prior to launching the Strike Force in 2007, we analyzed DME and HIV infusion billing levels and payment error rates by geographic areas and identified Florida, California, and Texas as states with a high likelihood of fraud involving billing for fictitious or medically unnecessary services. The next step in the process was to narrow our focus within these states to identify services and providers with aberrant billing patterns and develop targets for specific investigation. We later observed that a Miami infusion scheme migrated to Detroit and then discovered through our data analysis billing in Detroit for fictitious or medically unnecessary services involving physical and occupational therapy.

For our most recent expansion to Chicago and Dallas (and previously to Brooklyn, Baton Rouge, and Tampa in December 2009), we worked closely with HHS-OIG to conduct a similar analytical process to identify potential Medicare fraud "hot spots" in metropolitan areas. This process involved identifying geographic areas where billings for certain procedure codes were multiple times higher than the national average; DME suppliers that experienced extraordinary growth in claims volume over the previous year; and providers who were associated with beneficiaries whose claims histories showed Medicare had paid for services from 50 or more providers using the beneficiary's number during a one-year period.

The HEAT task force and data sharing workgroup are seeking to further refine our ability to review and assess Medicare claims and other information and improve our detection of potential fraud, and to use this information to identify new targets for investigation and for deploying additional Strike Force teams.

5) Currently, less than 1 % of all Medicare claims undergo a medical review by health professionals. Would it make sense for CMS to use medical reviews in areas known to be vulnerable to fraud? Do you think that would help decrease fraud?

Medical review looks at the supporting documentation associated with a claim for services or an episode of care to determine whether the services billed on the claim are consistent with the documentation in the medical records and with Medicare coverage policy and rules. Consequently, increased medical review would not itself be sufficient to prevent or decrease fraud significantly. Since false documentation can be prepared to support claims, additional resources are needed to conduct follow-up investigative work along with medical review to determine in fact whether the services billed were necessary, actually delivered by a legitimate provider or supplier, and billed appropriately, or whether they were fraudulent.

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That said, increased medical review could have a deterrent effect on potential Medicare fraudsters.

6) The National Insurance Crime Bureau is a non-profit that has a database that 1,100 property and casualty plans submit claims data information. They are interested in trying to help the federal government reduce health care fraud by sharing data with CMS and DOJ. Are you aware of this entity? Has your office engaged them to help reduce fraud in federal health care programs? Do you think it would benefit taxpayers for CMS to establish an information-sharing conduit with this group?

The National Insurance Crime Bureau (NICB) has been a longstanding private sector partner of the Federal Bureau of Investigation (FBI) for several years. The FBI regularly participates in NICB's Law Enforcement Advisory Committee meetings. The partnership has primarily focused on property and health insurance fraud arising out of staged auto accidents. Presently, the FBI and NICB are partnering in proactive health care fraud investigations in several regions of the country.

The FBI routinely engages NICB to assist in ongoing health care fraud investigations. The majority of these investigations involve unscrupulous health care providers that defraud NICB member companies (such as State Farm, GEICO and Allstate) by submitting false claims for personal injury protection benefits. The FBI and NICB have identified some cases where these providers have also defrauded government sponsored health care programs. For example, NICB assisted the FBI in the investigation of Dr. Arun Sharma and his wife who operated multiple clinics in the Southern District of Texas. In the Sharma case, the provider was defrauding both public and private health care plans by submitting false claims for a variety of pain management treatments. In 2010, Dr. Sharma was sentenced to a 15-year prison term.

NICB recently announced the rollout of its Aggregated Medical Database to which 16 member companies are contributing claim information. This database could be a beneficial source of information and data sharing.

NICB officials also have participated in the HEAT Regional Health Care Fraud Prevention Summits. An NICB executive served as a panelist in the "Using Technology and Sharing Data Among Private and Public Partners" session in the most recent regional summit held on June 17, 2011 in Philadelphia.

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HHS OIG Response to QFRs
3/9/11 HSGAC FFM Hearing
"New Tools for Curbing Waste and Fraud in Medicare and Medicaid"

QUESTION FOR MR. DANIEL LEVINSON from Senator Carper

IMPROVING LAW ENFORCEMENT ACTIONS

Mr. Levinson, are there steps under discussion to allow better cooperation and information sharing between CMS, the state Medicaid offices and other law enforcement? Could you address if there are unmet needs or opportunities for better OIG access to the databases of providers, beneficiaries and Medicare claims data that CMS maintains, including the Integrated Data Repository?

Answer:

OIG has published a notice of proposed rulemaking to permit Federal grant payments to State Medicaid Fraud Control Units (MFCUs) for the purpose of using Medicaid agency data to identify potential cases for investigation. OIG believes that allowing MFCU access to data for data mining purposes will improve the productivity and efficiency of MFCUs. We also continue to work successfully with CMS for access and training relating to the Integrated Data Repository.

OIG recognizes that private health care insurers have developed a tremendous wealth of experience and technological expertise in addressing our common goal of stopping health care fraud. It is axiomatic that most of the criminals who prey on the Nation's health care system are equal opportunity thieves – they defraud private health care insurance as well as the Federal health care programs.

Recognizing this fundamental principle, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) established and funds a program to combat fraud and abuse committed against all health plans, both public and private. This legislation required the Attorney General and the Secretary of Health & Human Services to establish a Health Care Fraud and Abuse Control (HCFAC) Program under the joint direction of the Attorney General and the Secretary (acting through the Inspector General). In furtherance of the goals of the HCFAC program, the Attorney General and Secretary issued a Program Statement and detailed set of Guidelines for joint HHS/Department of Justice (DOJ) activities to fulfill the dictates of HIPAA. One of the core concepts of the Statement and Guidelines is that "DOJ, HHS and other enforcement and program agencies will work together with the private sector to pursue a comprehensive enforcement approach to health care fraud. The foundation of this approach is coordinating and exchanging information in a regularized manner."

In furtherance of that core concept, the Program Statement and Guidelines outlines a rich menu of possible health care anti-fraud, program integrity, and information-sharing activities between the Federal Government and the private sector. Among the

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contemplated activities are: 1) the establishment of working groups to examine particular areas of the health care industry in order to develop recommendations on enforcement policy; 2) the creation of mechanisms for Government to alert the public, service providers, and consumers to fraud schemes; and 3) the development of mechanisms for identifying information concerning payment or record keeping policies, structures, or practices that make public or private health plans vulnerable to fraud, with OIG to compile and transmit reports on such vulnerabilities to the health plans so corrective action can be taken.

Since the creation of the HCFAC program, OIG, DOJ, and other law enforcement and program agencies have worked to carry out the objectives of the program. As part of that effort, United States Attorneys' Offices established Health Care Fraud Working Groups, which brought together Government agencies and private sector insurers united in the common goal of combating health care fraud. These work groups have proven highly effective in promoting collaboration. Our agents report receiving significant field intelligence on ongoing fraud schemes and many have engaged in joint public/private investigations in which their private sector counterparts provided active assistance or staffing for the case.

Among the private sector organizations participating in this effort is the National Health Care Anti-Fraud Association (NHCAA). NHCAA is a national organization focused exclusively on the fight against health care fraud, whose members represent more than 100 private health insurers. Its mission is to protect and serve the public interest by increasing awareness and improving the detection, investigation, civil and criminal prosecution, and prevention of health care fraud. OIG takes an active role in training conferences and conducts regular liaison meetings with NHCAA in order to share information about significant areas of health care fraud exposure and emerging trends. In addition, an OIG investigator sits on the NHCAA board as the law enforcement liaison.

Efforts currently are underway to further enhance collaboration with the private sector. For example, the recent Health Care Fraud Prevention and Enforcement Team (HEAT) fraud summit in Philadelphia emphasized the critical importance of public-private collaboration in the fight against health care fraud.[1] Because useful information sharing often occurs between investigators at a case level, we are working with our law enforcement partners to provide "best practices" guidelines that can promote appropriate information sharing with the private sector.

Questions for Inspector General Dan Levinson from Senator Coburn

1. Mrs. Carson testified with the Senior Medicare Patrol Project. According to one of your office's report from 2008, the program has resulted in recoveries averaging about $10 million each year, but has cost taxpayers slightly more than the $10 million each year. This means that, according to your office's report, the program has shown no significant *financial* return on investment over the course of the past decade. Do you still believe the program is important to

[1] http://www.stopmedicarefraud.gov/.

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maintain for *qualitative* reasons? If so, why? How could we improve it to get better return-on-investment for taxpayer dollars in this program?

Answer:

Evaluating the success of the Senior Medicare Patrol Project is not just a matter of comparing recoveries to the cost of the program. The number of beneficiaries who have learned from the Senior Medicare Patrol Projects to detect fraud, waste, and abuse and who subsequently call the OIG fraud hotline or other contacts cannot be tracked. Therefore, the projects may not be receiving full credit for savings attributable to their work. In addition, the projects are unable to track substantial savings derived from a sentinel effect whereby fraud and errors are reduced in light of Medicare beneficiaries' scrutiny of their bills. We defer to Congress and to program officials to determine whether the Senior Medical Patrol program is important to maintain.

How could we improve it to get better return-on-investment for taxpayer dollars in this program?

Answer:

OIG has not made specific recommendations on this issue. We are aware that AoA has initiatives underway to increase the program's impact, as well as plans to conduct a program evaluation that will assess performance measures to determine how to best measure the program's value, including return on investment.

2. In 2009, your office said that the Medicaid Statistical Information System does not provide "timely, accurate, or comprehensive information for fraud, waste, and abuse detection." Your office said CMS could "improve the documentation and disclosure of error tolerance adjustments and expand current State Medicaid data collection and reporting to further assist in fraud, waste, and abuse detection..." Do you believe that if this claims database were updated regularly with accurate information, it would help increase program integrity? Can this best be accomplished through administrative or legislative action? Do you think States have the resources to do this now?

Answer:

Program integrity relies heavily on the timeliness and accuracy of data available to CMS in administering its programs and to OIG in meeting its mission. Thus, regular claims database updates with accurate information would help to improve program integrity. Updating the MSIS database regularly, and ensuring the information in the database is accurate, would help. However, updating the information included in the database regularly does not necessarily translate to timely reporting. While States are required to report information for inclusion in MSIS on a quarterly basis, the information is not included in the MSIS database until it is passes data validation edits. OIG determined

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that during FYs 2004-2006, the most current data in the MSIS database was an average of 1½ years old. Furthermore, any adjustments to systems tolerance levels increase the possibility that the MSIS database will contain inaccurate information. While established error tolerance levels are publicized, data users must know the extent to which those levels have been adjusted beyond publicized rates to understand the accuracy of the data.

Can this best be accomplished through administrative or legislative action?

Answer:

CMS has the ability to reject information reported by States for inclusion in the MSIS database that does not meet publicized tolerance levels. While legislative authority now exists that enables CMS to impose sanctions against States that fail to report Medicaid managed care encounter data in MSIS, it would have to seek additional legislative authority to impose sanctions against States that fail to meet other MSIS report requirements.

Do you think States have the resources to do this now?

Answer:

The extent to which States currently capture some of the information related to the data elements that the CMS Medicaid Integrity Group (MIG), identified as assisting in fraud, waste, and abuse detection is unknown. The availability of State resources to capture this information is also unknown.

3. The Department of Defense has a "common access card" that is used for identification purposes, that meets or exceeds requirements of privacy laws, and uses integrated chips, a magnetic stripe, and a bar code to enable a secure to log-on to networks. Are you aware of any of the challenges associated with that model? Has your office ever explored the utility of using smart card technology for program integrity in Medicare? Would you be willing to talk with your counterpart at DOD about the idea?

Answer:

Making both provider and beneficiary IDs more secure would be valuable in curbing fraud, waste, and abuse, but OIG would need to review the specifics of any proposal to make any further comment. We have not evaluated any such initiatives and thus cannot opine regarding successes or challenges, but would welcome the opportunity to discuss best practices with our colleagues at DOD.

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4. In Medicare, are claims in Part A (Hospitals) and Part B (Physicians) and Durable Medical Equipment cross-checked against one another? Wouldn't this be a common-sense step to ensure the system is not being abused or dually billed?

Answer:

OIG has not assessed the extent or efficacy of such edits and defers to CMS as the programmatic agency for response.

5. The PECOS System—Provider Enrollment, Chain, and Ownership System—is an online provider database of Medicare providers. Once a provider enters his or her data, is this data ever verified? How regularly is it verified? Who verifies the data? How is this data verified, compared to other provider or supplier data? Would it make sense to verify this against other publicly available information – tax records, land records, business records, etc?

Answer:

OIG has not recently reviewed the PECOS system and thus defers to CMS for response. We do, however, have work underway evaluating the completeness, consistency, and accuracy of PECOS data. This work will likely not be completed for at least one year and we would be happy to brief the Committee upon completion. By way of background, OIG issued two reports in 2009 reviewing PECOS – *Inaccurate Data in the Provider Enrollment, Chain, and Ownership System Individual Global Extract File* and *Reassignment of Medicare Benefits* – available at http://oig.hhs.gov/oei/reports/oei-07-08-00181.pdf and http://oig.hhs.gov/oei/reports/oei-07-08-00180.pdf. We note that because of the 2009 issuance date the reports may not reflect the current status of PECOS.

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Questions for Kathleen King, GAO from Senator Coburn

1. **GAO has a list of more than 30 significant recommendations, based on reports they have done, that would enhance program integrity in Medicare or Medicaid. These recommendations, updated as of January 2011, and have not been implemented. Which of these recommendations would you suggest Sen. Carper and I consider for our bill? Which of these recommendations would you most strongly suggest this Committee consider?**

   In our reports, when we think legislative action might be necessary, GAO raises matters for the consideration of the Congress. When we think that agency action is needed, we make recommendations to the agency. The list of recommendations to enhance Medicare and Medicaid program integrity and help address fraud, waste, and abuse that you reference in your question are generally issues that we believe could be resolved by agency action, rather than legislation. However, agencies do not always take actions to respond and sometimes the Congress takes action through legislation instead.

   For Medicare, there is one recommendation that we have made that could require legislation to effect change. In part, this is because the Centers for Medicare & Medicaid Services (CMS) officials were uncertain about the agency's authority to implement the change. As discussed below, we recommended that CMS examine the feasibility of expanding its payment safeguard mechanisms by adding more front-end approaches to managing imaging services, such as prior authorization. Based on CMS's response, the agency is unlikely to implement our recommendation unless legislation specifically directs it to do so.

   For Medicaid, improved federal oversight of the program's fiscal and program integrity is needed, in addition to state actions. The Department of Health and Human Services (HHS) has indicated it is taking steps to implement several of our open recommendations, and we are working with HHS officials to monitor progress. We are planning to examine state and federal actions to reduce Medicaid improper payments to providers, which were an estimated $22.5 billion (federal share) in fiscal year 2010. Apart from ensuring that states are developing adequate corrective action processes to address vulnerabilities to improper Medicaid payments, HHS needs to improve the fiscal oversight and integrity of Medicaid demonstrations and of state Medicaid financing arrangements. One matter for Congressional consideration relates to HHS's criteria and process for reviewing and approving spending under comprehensive Medicaid demonstrations. These demonstrations by policy should not increase federal costs, and associated spending for a demonstration can be tens of billions of dollars. We have recommended that the Secretary of HHS clarify the waiver approval criteria and ensure valid methods were used in the process to demonstrate budget neutrality, but because HHS disagreed with the recommendation, we elevated it to the Congress to consider. (See Medicaid

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Demonstration Waivers: Recent HHS Approvals Continue to Raise Cost and Oversight Concerns, GAO-08-87 and related products.)

2. **One of the critiques of a recent GAO report was that postpayment claims are not focused on the most vulnerable areas. GAO has found CMS is not using evidence from prepayment review to reduce erroneous payments. Why has CMS not done that?**

In GAO-09-185, *Medicare: Improvements Needed to Address Improper Payments in Home Health*, we said that CMS's claims payment contractors are limited in the number of claims for which they can provide medical review by trained staff to ensure the claim was paid correctly. In 2007, two of the three contractors paying home health claims were conducting medical review on about 0.5 percent of claims on a prepayment basis and almost none on a post-payment basis. Our concern was that they were not doing postpayment review on claims from home health agencies with a pattern of improper billing. As a result, we recommended that CMS direct its contractors to conduct postpayment medical reviews on home health agencies with high rates of improper billing identified through prepayment reviews. CMS did not agree with this recommendation and indicated that contractors had to consider their costs and availability of resources when they prioritize their work. However, this might not lead to postpayment reviews of claims by home health agencies with high rates of improper billing or on other vulnerable areas. CMS allows its claims payment contractors to set their own priorities for medical review based on information, such as improper payments made in that jurisdiction.

Since we generally know what states and cities are most vulnerable to Medicare fraud, what do you think of the idea of allowing CMS to implement a mandatory prior authorization program in fee-for-service Medicare, targeted to high fraud areas?

Private health care plans use certain practices to manage spending growth that may have lessons for CMS, such as prior authorization, which requires physicians to obtain some form of plan approval to assure coverage before ordering a service. In our June 2008 report, *Medicare Part B Imaging Services: Rapid Spending Growth and Shift to Physician Offices Indicate Need for CMS to Consider Additional Management Practices* (GAO-08-452), we found that several plans that attributed substantial declines in the rates of increase in spending on imaging services to the use of prior authorization.

The private plans' experience suggests that such "front-end" management of these services could add to CMS's prudent purchaser efforts. In contrast, CMS employs an array of post payment safeguard activities focused on identifying fee-for-service medical claims that do not meet certain billing criteria. As a result, we recommended that CMS examine the feasibility of expanding its payment safeguard mechanisms by adding more front-end approaches to managing imaging services, such as prior authorization.

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CMS officials indicated implementing prior authorization would likely require significant administrative resources. In addition, they would have to evaluate whether they have the statutory authority to implement such approaches. Further, with regard to the recommendation, CMS raised concerns about the lack of independent data on the effectiveness of prior authorization, whether the public nature of Medicare was consistent with prior authorization to approve or withhold services, and whether denials due to failure to obtain prior authorization would be overturned on appeal.

If the Congress enacted legislation requiring prior authorization for certain services, it might be useful to implement it as a demonstration and include imaging services. Such a demonstration could test whether prior authorization could help constrain Medicare costs while providing reasonable and necessary care for beneficiaries, as well as testing whether it might be useful for services being billed abusively in high-fraud areas.

3. **Has your office ever done a comprehensive assessment of all of CMS' technology systems and internal data sharing with its contractors? Would your office be able to conduct a thorough assessment of data sharing with its contractors and make recommendations to this committee?**

We have not conducted a comprehensive assessment of all of CMS's technology systems and the agency's initiatives to share data with its contractors. However, since 2001, we have completed four studies and made recommendations regarding the agency's implementation of various information technology systems and related initiatives.

- In 2001, we studied the agency's efforts to modernize its information technology environment and identified shortcomings in planning and management processes intended to increase the likelihood that systems development and implementation would be cost-effective and successful. Among these, we noted that the agency had made only limited use of performance measures to ensure accountability and increase the likelihood of achieving results. We recommended that top management officials become more involved in IT planning and management efforts and that they take steps to, among other things, improve the agency's investment management processes for evaluating IT projects that includes cost, milestone, and performance data.[1] CMS officials agreed to take steps to address the weaknesses we identified.
- In 2005, we conducted case studies of four CMS systems and reviewed CMS's processes for monitoring Medicaid Management Information Systems that states use to support their Medicaid programs. We again found deficiencies in CMS's investment management practices and recommended that CMS develop and implement a plan to address the IT investment management weaknesses

[1] GAO, *Medicare: Information Systems Modernization Needs Stronger Management and Support*, GAO-01-824 (Washington, D.C., Sep. 20, 2001).

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we identified.[2] In response to our recommendations, CMS officials described actions they were taking to improve the agency's IT investment management processes.

- In 2006, we assessed the effectiveness of information security controls in the communications network CMS used.[3] We found that some controls were in place, but others were not or were not implemented correctly. We also found numerous vulnerabilities in various areas, such as user authorization and monitoring of security-related events. As a result, sensitive, personally identifiable medical data being transferred through the network was vulnerable. We recommended that CMS ensure that information security policies and standards were fully implemented. CMS concurred with our recommendations.
- Finally, next month we plan to release a report on the agency's efforts to develop and implement a data repository, the Integrated Data Repository, and application software, the One Program Integrity portal and tools, to support CMS's efforts to better detect improper payments in the Medicare and Medicaid programs.

Overall, the scope of these studies was limited to specific information technology systems or management issues; as such, the studies did not entail a comprehensive assessment of CMS's systems or the agency's practices for sharing its data with contactors.

GAO would consider any request from you or other members seeking an assessment of all of CMS's technology systems and its internal data-sharing with contractors and any recommendations to improve them. The thoroughness with which we could conduct such an assessment would depend on various factors, including the significance of the systems to CMS's mission, availability of agency and other related documentation on the extent to which CMS uses contractors to conduct its claims processing and other business functions, as well as any time and resource limitations that might impact the scope of the study.

4. **Medicare Administrative Contractors (MAC) process and pay claims and enroll and educate providers.**

Do you think the current model for MACs is working?

We have not conducted recent evaluations of every aspect of MAC performance. CMS measures aspects of MAC performance, for example, the agency has reported that the MACs continued to meet agency targets for timely claims processing. In a March 2010 report, *Medicare Contracting Reform: Agency Has Made Progress with Implementation, but Contractors Have Not Met All Performance Standards* (GAO-10-71), we found that CMS has a program to assess the performance of MACs against standards in accordance with their contracts and that the MACs whose assessments we reviewed did not meet all of the

[2] GAO, *Information Technology: Centers for Medicare & Medicaid Services Needs to Establish Critical Investment Management Capabilities*, GAO-06-12 (Washington, D.C.: Oct. 28, 2005).
[3] GAO, *Information Security: The Centers for Medicare & Medicaid Services Needs to Improve Controls Over Key Communication Network*, GAO-06-750 (Washington, D.C.: Aug. 30, 2006).

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standards set by CMS. However, their performance improved between the first and subsequent assessment period. We are currently evaluating the Medicare enrollment process and the extent to which MACs are using prepayment edits as a way to prevent improper payments. As part of these engagements, we will be reviewing MAC activities or CMS's oversight of them. We have not recently evaluated some aspects of MAC performance—for example, the full extent of MACs' provider education activities.

Do you have any concerns that they are stretched too thin/focused on too many tasks?

Over the past few years, CMS has removed certain tasks from MACs, in an effort to improve efficiency. For example, claims administration contractors were formerly responsible for helping to develop cases of potential Medicare fraud. CMS has transferred those tasks to Zone Program Integrity Contractors. Similarly, claims administration contractors were formerly responsible for collection of improperly paid claims where Medicare was the secondary payer. In response to our recommendation, CMS consolidated those responsibilities to a single contractor focused specifically on that task. The agency achieved savings as a result. There may be further areas where consolidating MAC responsibilities could lead to savings or other program benefits. For example, CMS is currently considering whether to remove many of the provider enrollment functions from MACs and consolidate them to a single contractor. There may be benefits to this consolidation, depending on how the contract is structured and how the contractor that is chosen performs.

However, as tasks formerly conducted by MACs are given to other contractors, coordination among them becomes crucial to ensure that the program operates efficiently. For example, as we reported in Medicare Recovery Audit Contracting: Weaknesses Remain in Addressing Vulnerabilities to Improper Payments, Although Improvements Made to Contractor Oversight (GAO-10-143), CMS took steps in its national Recovery Audit Contractor (RAC) program to resolve coordination issues that arose between the RACs and MACs during the initial demonstration that introduced RACs into the program.



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