CUTTING WASTE, FRAUD, AND ABUSE IN MEDICARE AND MEDICAID

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

SECOND SESSION

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WITNESSES

SUBMITTED MATERIAL

CUTTING WASTE, FRAUD, AND ABUSE IN MEDICARE AND MEDICAID

WEDNESDAY, SEPTEMBER 22, 2010

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The Subcommittee met, pursuant to call, at 10:08 a.m., in Room 2322 of the Rayburn House Office Building, Hon. Frank Pallone [Chairman of the Subcommittee] presiding.

Members present: Representatives Pallone, Dingell, Green, DeGette, Gonzalez, Christensen, Castor, Sarbanes, Braley, Waxman (ex officio), Shimkus, Burgess, Blackburn, and Gingrey.

Staff present: Karen Nelson, Deputy Committee Staff Director for Health; Andy Schneider, Chief Health Counsel; Ruth Katz, Chief Public Health Counsel; Brian Cohen, Senior Investigator and Policy Advisor; Katie Campbell, Professional Staff Member; Tim Gronniger, Professional Staff Member; Alvin Banks, Special Assistant; Brandon Clark, Professional Staff Member, Health; and Sean Hayes, Counsel, O&I.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. I call the meeting of the Health Subcommittee to order. Today we are having a hearing on Cutting Waste, Fraud, and Abuse in Medicare and Medicaid. And I will recognize myself initially for opening statement. What we are doing is examining how the Department of Health and Human Services is using available statutory tools to reduce waste, fraud, and abuse in the Medicare and Medicaid programs. While estimates of the total cost of health care fraud are difficult to obtain, it is estimated that all health care fraud costs patients, taxpayers, and health care providers billions annually. For every dollar put into the pockets of criminals a dollar is taken out of the system to provide much needed care to millions of patients, including our nation's most vulnerable populations, children, senior, and the disabled.

Fraud schemes come in all shapes and sizes. We heard just last week in this subcommittee about how durable medical equipment companies set up sham store fronts and appear as legitimate providers. They bill Medicare for millions and then close up their stores only to find a new location and do it all over again. And then there are the legitimate businesses that bill for services that were never provided and pay kickbacks to physicians which treat crimi-

nals trafficking in illegally obtained drugs. In the end, it all has the same result undermining the integrity of our public health system and driving up health care costs.

I think we can all agree that health care fraud is a serious long-standing problem that will take aggressive long-term solutions to reverse. We made a strong commitment to combat these issues when Congress passed and President Obama signed the Affordable Care Act earlier this year. That bill contained over 30 anti-fraud provisions to assist CMS, the OGI, and the Justice Department in identifying abusive suppliers and fraudulent billing practices. The most important provisions change the way we fight for it by heading up the bad actors before they strike and thwarting their enrollment into these federal programs in the first place, and this way we aren't left chasing a payment once the money is already out the door. Some other important measures in the legislation include significant funding increases to the health care fraud and abuse fund, the creation of a national health care fraud and abuse data base, and new and enhanced penalties for fraudulent providers.

CMS and OIG have important roles to fulfill and along with the Justice Department and state and local Medicaid programs they are better equipped today because of the Affordable Care Act to safeguard the health and welfare of Medicare and Medicaid patients. I want to welcome Peter Budetti, a former staff member of this committee. I know that you are no stranger to these issues or our hearing proceedings. I also want to welcome or special welcome to Daniel Levinson, who had the lucky privilege of being in front of this subcommittee just last week and joins us again today. I am going to thank both of them again for their testimony.

And I would obviously like to thank our first panel, Representative Ron Klein and Representative Peter Roskam for joining us today. Your participation basically illustrates the importance of this issue within the Congress, so we look forward to your testimony on the first panel. But now I will recognize my ranking member, Mr. Shimkus, for an opening statement.

OPENING STATEMENT OF HON. JOHN SHIMKUS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. SHIMKUS. Thank you, Mr. Chairman. We have long struggled with combating the issue of waste, fraud, and abuse in the Medicare and Medicaid debate. Criminals take billions of dollars out of the system that could be spent on patient care and reducing cost. And with entitlement programs growing at an unsustainable rate, we simply cannot afford to let these taxpayer dollars go to waste any longer. I am glad to see the progress that HHS and the Department of Justice have made in recent years with additional resources but we can and must do more. Thanks to the efforts from our colleagues, Mr. Klein, from Florida, and my good friend, Peter Roskam, from Illinois, attention remains on new innovative ways to improving the system. In Peter Roskam's case, H.R. 5546 address an issue that I have talked about in the committee a long time, addressing the issue prior to sending the checks. That is what we do a very poor job at.

We would rather address the issue before that money goes out the door than trying to gather up the dollars after they have gone

fraudulently to places for years, numerous, numerous years. And so that is why I am very excited about it. And I know that Peter has done a good job engaging the Administration and has received pretty good feedback from the Administration. We all know he is a close friend with the President, former Illinois Senate buddies in the days gone by. This also, for Mr. Levinson, I apologize. He gets a chance to hear my rant and rave about the inability to get the Secretary to testify before us on the health care law. We are now close to 6 months. I guess 6-month anniversary will be tomorrow. She is already engaged in the debate on premium increases, and I think now would be the time to bring her to the committee, Mr. Chairman, so we can have a full and fair and free debate about the good, the bad, and the ugly on the health care law and move in a direction and try to fix some of the major provisions.

We know the high risk pools are at risk themselves. We know premium increases are going up. We know the cost curve was not bent down but it is bent up. We will continue to raise these issue until we all leave for the election break, which we are trying to figure out when that might be. Thank you for this time. Before I yield back, I have, I think they have been shared with your majority staff, 4 letters for submission to the record that I ask unanimous consent to insert.

Mr. PALLONE. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. PALLONE. I am shocked that you are actually handing me paper now that I see your computer device there.

Mr. SHIMKUS. I am trying to be as cool as you, Mr. Chairman.

Mr. PALLONE. Without objection, so ordered.

I will now recognize the chairman of the full committee, Mr. Waxman.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you very much, Chairman Pallone, for calling this hearing, and I am pleased to welcome our 2 colleagues who have introduced legislation. We all want to stop the Medicare-Medicaid waste, fraud, and abuse, those of us who support those 2 programs, and we know that millions of Americans rely on them. We want to make sure that the money we spend for Medicare and Medicaid services are going for those services and not for waste, fraud, or abuse. This is an important hearing. The Medicare and Medicaid programs, if there is fraud against them they are bilking taxpayers and they are undermining public health, and whether it is a street corner criminal illegally trafficking in pharmaceutical drugs or a large multi-national corporation paying illegal kickbacks to health providers the bottom line is the same. Billions of dollars are stolen from the taxpayer-funded programs that provide health care to seniors, children, and the disabled.

This kind of fraud costs more than money. It corrodes the quality of care. It weakens Medicare and Medicaid. And I must say that I have heard from providers over the years that a lot of them feel that trying to figure out how to game the system becomes very much part of what they do because everybody else is doing it. The

rationale isn't very comforting when we hear it from our kids, but I have heard it over and over again throughout the years. We want to hear from the Administration, and I am glad that Mr. Budetti who once served on the staff of this committee and the Oversight Committee when I chaired it is here to talk about the Administration's effort as well as Mr. Levinson who is the Inspector General at HHS. You both play a very important role in combating waste, fraud, and abuse. I hope this hearing today will lead to a greater commitment and realistic provisions to stop the fraud, waste, and abuse before it takes place and not try to wait till afterwards to collect the money back. Thank you, Mr. Chairman. I yield back my time.

[The prepared statement of Mr. Waxman follows:]

Statement of Rep. Henry A. Waxman
Chairman, Committee on Energy and Commerce
"Cutting Waste, Fraud, and Abuse in Medicare and Medicaid"
Subcommittee on Health
September 22, 2010

I want to thank Chairman Pallone for convening today's important hearing.

Anyone who has followed my career in Congress knows how deeply I care about the Medicare and Medicaid programs. I have spent almost 40 years building, protecting, and expanding Medicare and Medicaid because I believe that the health care they provide for the aged, the poor, and the disabled is a critical right of all citizens and a crucial government responsibility. These programs work well, and they provide quality health care to millions of Americans who would otherwise be uninsured.

Of course, the vast majority of Medicare and Medicaid providers are honest and compassionate. But criminals do exist. That's why part of standing up for Medicare and Medicaid means supporting the constant work that must be done to cut waste, fraud, and abuse in these programs.

Having served as Chairman of both the House Oversight Committee and the House Energy and Commerce Committee, a vital part of our work on both Committees has been reducing health care fraud.

The individuals and institutions that commit fraud against Medicare and Medicare are bilking taxpayers and undermining public health. Whether it is a street corner criminal illegally trafficking in pharmaceutical drugs or a large multinational corporation paying illegal kickbacks to health care providers, the bottom line is the same: billions of dollars are stolen from these taxpayer-funded programs that provide health care to seniors, children, and the disabled.

Health care fraud does more than cost money. It corrodes the quality of care, and weakens the Medicare and Medicaid programs.

That's why I'm proud of the provisions to help reduce Medicare and Medicaid fraud in the health care reform law that Congress passed and President Obama signed in March.

This new law contains dozens of provisions that amount to the most important reforms to prevent Medicare and Medicaid fraud in a generation.

The health care reform law contains new tools to prevent fraudulent providers from enrolling in or taking advantage of Medicare and Medicaid.

It shifts the prevailing fraud prevention philosophy from "pay and chase" – where law enforcement authorities only identify fraud after it happens – to "inspect and prevent."

The Affordable Care Act requires enhanced background checks, new disclosure requirements, and on-site visits to verify provider information.

It requires that health care providers create their own internal compliance programs.

And it allows CMS to impose moratoria on enrolling new providers if the Secretary believes that such enrollments will increase fraud risks. In short, it lets the HHS Secretary close the barn door before the horses have left.

But the new law does more than that. It contains several new requirements specifically aimed at preventing fraud in the high-risk home health and Durable Medical Equipment areas.

It contains new and enhanced penalties for fraudulent providers.

It contains new data sharing and data-collection provisions, providing additional access to anti-fraud databases for DOJ, the Inspector General, and states.

And it contains new funding – almost $500 million extra – to fight Medicare and Medicaid fraud. The Congressional Budget Office tells us that these new fraud provisions will save billions of dollars for taxpayers.

Even before passage of the Affordable Care Act, the Obama Administration asked for and received extra money to fight fraud in 2009 and 2010, increasing fraud recoveries by $600 million. They expanded use of interagency strike forces to attack Medicare and Medicaid fraud in hot spots like Miami, Detroit, and Brooklyn. And they reorganized CMS to better coordinate fraud-prevention and enforcement efforts.

Now, thanks to the health care reform law, the Administration will be able to do even more.

Just last week, CMS released a proposed rule to implement the most significant Affordable Care Act anti-fraud provisions.

I am pleased that Peter Budetti – who many years ago worked as staff on this Committee – will be here to tell us about fraud-fighting efforts at CMS.

I also appreciate the HHS Inspector General, Daniel Levinson, appearing before this Committee for the second time in a week. Mr. Levinson, we appreciate all the hard work your office is doing to fight fraud, and look forward to hearing your perspective on the Affordable Care Act's new fraud-fighting tools.

Mr. PALLONE. Thank you, Chairman Waxman. Next is the gentleman from Georgia, Mr. Gingrey. It is nice to see so many members here today. I was afraid that since we didn't go in until this evening we wouldn't get that many, so it is good to see so many.

OPENING STATEMENT OF HON. PHIL GINGREY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. GINGREY. Mr. Chairman, I am glad to be here. Each year at least 3 percent of our country's annual health care spending, that would be $68 billion, is lost to fraud. In fact, the FBI estimates that the number is much higher, as much as 10 percent or 226 billion, so clearly this is a problem in need of a fix, and an immediate fix if at all possible. On the one hand, I am pleased to see that Medicare fraud is not a partisan issue. The members who will testify here today before us, both Republican and Democrat, they symbolize that bipartisan interest, and I applaud them for their efforts, both Representative Klein and Representative Roskam, and we look forward to their testimony on their specific bills that they have introduced.

American taxpayers deserve to know that their money is being safeguarded here in Washington and preventing Medicare waste, fraud, and abuse is one way to protect their precious resources. While I may support many of these efforts to curb Medicare waste and fraud, including in Obama Care Patient Protection and Affordable Care Act of 2010, March 23, it is unfortunate that these provisions were enacted in the bill that I think is proving so harmful to both patients and businesses here at its 6-month anniversary. The legislation promised to reduce the cost of health care on patients by an average of $2,500 a year. This, some proponents argue, was worth the cost of turning the health care system over to the federal government and spending almost a trillion dollars in the process.

The bill proponents spent about 18 months blaming insurance companies for the high cost of care and they told the American people that Obama Care could fix the problem. Here we are 6 months later and insurance costs are going up by as much as 20 percent. The reason for these increases, Patient Protection and Affordable Care Act of 2010. I have asked this committee repeatedly to call a hearing in order to find out what in the world is going on. To support this request, Secretary Sebelius has taken the unusual step of publicly denouncing these costs, as she says, unjustified rate increases. If that is the case, Mr. Chairman, then I believe that the Secretary should come before this committee and explain her reasons. The American people certainly deserve answers.

Another promise was that every American would have health care if the bill was passed, which when you read the fine print means the federal government can now tax and penalize any American who doesn't buy insurance regardless of whether they have the ability to pay for it. With the 6-month anniversary of Obama Care tomorrow, I think it is safe to say the early news is not good. The 18 months the President and your majority, Mr. Chairman, spent on selling Obama Care instead of getting people back to work has not only let many Americans without jobs but with higher health care costs as well. Put simply, Obama Care has been proven

to be no way to solve a health care crisis. Mr. Chairman, with that, I am going to yield back. I do look forward to both panels, and thank you for calling this hearing.

Mr. PALLONE. Thank you, Mr. Gingrey. Next is the gentlewoman from Colorado, Ms. DeGette.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. DEGETTE. Thank you very much, Mr. Chairman. Mr. Chairman, I think I never met a politician who believed in waste, fraud, and abuse, and I think that it is great that we are having this hearing on how we can continue efforts to cut waste, fraud, and abuse in Medicare and Medicaid. I, frankly, can't believe that actually we are having such partisanship in some of these opening statements because I think we can all agree on a bipartisan basis that we should eliminate waste, fraud, and abuse, and as proof we have 2 of our colleagues from both sides of the aisle here to testify this morning. Eliminating these issues is an important goal and it sounds like it should be easy to do, but, in fact, these fraudulent practices are becoming increasingly more sophisticated. And what I would like to do today is really sit down and talk about how we can put together sophisticated responses to address the sophisticated fraudulent practices.

Let me give you an example. In Denver, we had a woman who was arrested by the HHS DOJ strike force in 2009. It was a nationwide sweep that involved a Medicare kickback scheme in Michigan. So the woman was from West Virginia. She was arrested in Denver for a kickback scheme in Michigan, and this was the level of sophistication that we are dealing with with this fraudulent activity. This is why we really have to put together some sophisticated responses. I am looking forward not just to hearing from our colleagues today but also from the experts who can talk to us about really what we can do to actually cut waste, fraud, and abuse instead of just talking about it in an election year. And I will yield back.

Mr. PALLONE. Thank the gentlewoman. Next is the gentlewoman from Tennessee, Ms. Blackburn.

OPENING STATEMENT OF HON. MARSHA BLACKBURN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Mrs. BLACKBURN. Thank you, Mr. Chairman. I thank you for the hearing, and it is an important issue, one that we need to focus on. I welcome our colleagues, and I want to especially commend Mr. Roskam for a bill that takes a proactive approach and looks at how we address this issue before the payments are out the door. I think that is important, you know. One of the things we have to realize when we look at the Medicare component of this is that our seniors have pre-paid their access to Medicare. The government has been taking that money out of their paycheck for years, and they do expect to get the services that are there. And Mr. Waxman and I actually agree on something, which may surprise some of you who are regular attendees in this room, and we have to make certain

that we look at the delivery systems but that the services are there for the people who are entitled to those services, to our nation's seniors.

The Medicaid component of this, I would like to highlight with this committee that in '03 we did a field hearing, one of the first field hearings on Medicaid fraud. This was in Bartlett, Tennessee. It was done on the TennCare Program, and many of you have heard me talk about TennCare, which was the experiment for the Clinton health care program, for Hillary Clinton's health care program in the preamble to Obama Care. What we found was rampant waste, fraud, and abuse in this program, so much so that TennCare has its own investigative bureau in trying to capture and quantify and then recapture those dollars, so it is a problem, and we know it is a problem.

I want to say a little bit about Obama Care since this is the 6-month anniversary of that passage, and I think that right now we are beginning to see the aftermath or maybe it is the lack of math, if you will. The law is costing Americans and families with children undue hardships and is a financial burden. We are beginning to see this. There has not been a single oversight hearing in this committee. There is no transparency in the budgetary operations and processes. Americans are losing coverage. They are losing patience. Our focus need to be turned to that. The real cost of Obama Care goes much deeper than the government's pockets. We are seeing estimates that it is going to cost hard-working citizens who are hanging on to their jobs on average $899 per year in premium contributions, an increase of more than 15 percent than last year. The percentage paid by workers for individual and family coverage rose for the first time in over a decade.

Individual premiums average over $5,000 and family premiums average nearly $14,000. Additionally, Obama Care will lead to a 51 percent reduction in current health coverage for the American work force over the next 3 years. To keep American workers employed and healthy, this is an absurd statistic. Nine regulations are included in the health care reform that will, in fact, raise premium cost for individuals and employers. These facts are alarming for a country facing uncertain times and economic hardships. Prominent health insurance have even stopped issuing, they are stopping issuing the child-only plans instead of meeting the new requirements of accepting children with pre-existing conditions. What happened to the promise that if you like what you have, you can keep it? Now the most vulnerable are losing their coverage. We should be focusing on this. There were a lot of lessons to be learned from TennCare. We in my state have been down this road. Mr. Chairman, we need to be putting some oversight and some attention on this. I yield back.

Mr. PALLONE. Thank you. Next is the gentleman from Texas, Mr. Gonzalez.

OPENING STATEMENT OF HON. CHARLES A. GONZALEZ, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GONZALEZ. Mr. Chairman, you can stop my practice of generally not to make opening statements but I am going to have to agree with Ms. DeGette. We can take up an hour on campaign

rhetoric. I would simply like to reserve that for the time that we are not trying to conduct hearings and listening to witnesses. We go back and forth. The truth is the health care bill passed. Its major provisions will not take effect for another couple of years. If anyone on the other side of the aisle wants to basically rescind what has already taken place and the benefits that are being enjoyed by millions of American families, then say so. Don't speculate on what may or may not happen in a year or two or so. But what about the immediate benefits? Do you really want to deny families the ability to obtain health insurance for their child who may have a pre-existing condition? Do you really want the insurance companies to be able to rescind your policy when you get sick?

Those are the benefits, and we will go on and on with this. The only thing is I am hoping that we can get to an issue that we should all have some concurrence and that is not let the taxpayers of this country lose money due to fraud. And with that, I yield back.

Mr. PALLONE. Thank you. Next is another gentleman from Texas, Mr. Burgess.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. Thank you, Mr. Chairman. Of course, it is my policy to make opening statements in this committee and I will do so. I don't think the federal government has done enough to address the issue of inappropriate transfer of funds for several years, even as reports indicate that our nation's government-run systems needlessly waste hundreds of billions of dollars each year through these activities. So eliminating the problems that cause the hemorrhage of billions of dollars in our country's government-run health care programs should have been a priority actually before we began to think about expanding the role of the federal government in health care, but we didn't do that. Fraud analysts and law enforcement officials estimate that 10 percent of the total health care expenditures are lost to fraud on an annual basis. If we are serious about bringing down the cost of health care and protecting the patient, not just reducing but eliminating fraud is where we need to go.

In Medicare, the government pays providers in practically an automatic fashion without review or scrutiny of the claims submitted. In north Texas, Fox channel 4, Becky Oliver, an investigative reporter, reported on a home health agency operator who is now behind bars. The records show that Medicare paid her over $8 million in 2 years time to care for home bound patients. The woman's patients included a man seen moving furniture, a lady seen running errands, and a man seen enjoying a barbecue. Even worse than that, she had multiple provider numbers, and after they shut down one provider number they continued to pay other provider numbers to the same post office box. This is unacceptable. Currently, the Center for Medicare and Medicaid services oversees a network of private contractors that conduct various program integrity activities in conjunction with the Office of Inspector General at Health and Human Services and the Department of Justice that were still losing billions of dollars annually to fraud.

We must improve oversight of these contractors and the Center for Medicare and Medicaid Services needs to take a more proactive role in assuring that contractors are using the utmost scrutiny in reviewing their activities. Further, I will raise a point that I raised numerous times. How much fraud are we willing to tolerate? The answer should be none but in reality the lack of prosecutors with a background in health law cripples our ability to go after everyone or in fact anyone. Are we comfortable with that, and, if not, this committee should work with our colleagues in Judiciary to correct it.

Under the Patient Protection and Affordable Care Act, and I would submit that affordable should be stricken from the title, but our current system is to prevent improper payments and we know it is inadequate. How can you assure that millions of dollars in funding in the PPACA and the Reconciliation Act will solve the problem. If more needs to be done, and it does, it should be a priority in this committee. I have introduced several fraud-fighting amendments during the consideration of our health care bill 3200. As ranking member of Oversight and Investigations, I am working with ranking member Barton to build off these suggestions for forthcoming legislation. As health care expenditures continue to rise developing new and innovative approaches to fight fraud becoming increasingly important, and I look forward to the testimony of our colleagues today as well as the representatives of the federal agencies, and I yield back.

Mr. PALLONE. Thank you, Mr. Burgess. Next is the gentlewoman from Florida, Ms. Castor.

OPENING STATEMENT OF HON. KATHY CASTOR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Ms. CASTOR. Thank you, Chairman Pallone, very much for calling this hearing, and I would like to welcome my colleagues, Congressman Roskam and Congressman Klein. Ron Klein especially has been a real leader for our Florida delegation when it comes to Medicare and fighting fraud, and rightfully so because south Florida often has many shady dealers down there. So, Ron, thank you very much for your terrific leadership on the issue. In Florida, Medicare and Medicaid is a real life line for our families and our seniors, and folks simply expect that the folks in charge of administering these initiatives keep a close eye on fraudulent practices, and I think we are going to continue to improve when it comes to that.

I am also very sensitive to the issue just in 2007. The FBI raided a major health insurance company in Tampa and that provider had stolen over $600 million from Medicaid and Medicare through fraudulent claims to CMS and ripping off the State of Florida. Subsequent to that, the Obama Administration thankfully cited one of their new health care fraud, prevention, and enforcement teams, the HEAP teams, in Tampa and our local U.S. Attorney's Office is very appreciative of the new tools that will allow us to continue to weed out these fraudulent practices in Medicare.

I am also very optimistic over the new robust commitment to anti-fraud in the Affordable Care Act. The Affordable Care Act clearly outlines a strategy to combat fraud in Medicare and Med-

icaid, and these new tools are really going to help us prevent shady practices and recoup billions of dollars that rightfully belong to the health services of families across the country. So this is a good news week when it comes to health care because not only are we going to highlight the robust new commitment to weeding out Medicare fraud, we can celebrate a lot of important consumer protections that are taking effect just this week. No longer will health insurance companies be able to say to families with children with diabetes or asthma that they can't get coverage. That is fundamental in this great country. Also, I know many of you are hearing from families like I am back home. They are so appreciative that kids can stay on their parent's insurance policies until the age 26. That takes effect this week.

Also, this week the law will prevent health insurance companies from cancelling coverage when you get sick or if you made a mistake on your application. And one of the things we have been fighting for for years is a new emphasis on wellness and preventative care, and this week families across America will receive their preventative care without having to pay significant out of pocket expenses for services like mammograms and colonoscopies, immunizations, and prenatal and well baby care. This is something we have been working on for a long time that is going to help us save money just like fighting Medicare fraud will. Also, on Monday I hope you saw Blue Cross and Blue Shield announce that thanks to the Affordable Care Act over 200,000 customers will receive refunds totaling over $150 million, and just yesterday we learned, and Congressman Klein is going to like this because he has been such a champion for making sure Medicare Advantage works, we learned yesterday that on average premiums for seniors enrolled in Medicare Advantage will decrease.

So this is a good news week when it comes to health care, and again thank you, Mr. Chairman, for convening this hearing. I look forward to hearing from our witnesses.

Mr. PALLONE. Thank you. The gentlewoman from the Virgin Islands, Mrs. Christensen.

OPENING STATEMENT OF HON. DONNA M. CHRISTENSEN, A REPRESENTATIVE IN CONGRESS FROM THE VIRGIN ISLANDS

Mrs. CHRISTENSEN. Thank you, Chairman Pallone, for this hearing where we get a chance to focus on the improvements that the Patient Protection and Affordable Care Act is making on reducing waste, fraud, and abuse in CMS programs, and potentially all government-run health care programs. The willful fraud and abuse and the waste that we often see in this program costs not just the taxpayers but all who depend on this system for care immeasurable damage. And the savings that will be realized from reducing or eliminating them will serve to improve and expand services to the beneficiaries and others. I also want to thank my colleagues, Congressman Roskam and Congressman Klein for the legislative offerings to make the Affordable Care Act provisions even stronger. As a physician who struggled with then HCFA, I have to say that also an important part of the CMS armamentarium ought to be fair and adequate reimbursement, and the Affordable Care Act does make some important steps in that regard.

As a provider physician, I also want to thank both the Inspector General and the Deputy Administrator for including a statement, either this particular statement, or one similar, that the vast majority of health providers are honest people who seek to do the right thing and provide critical care services to millions of CMS beneficiaries, and I would add others, every day. Too often that is not the message that we hear or the premises that guides legislation. It is a daunting task or set of tasks that the law has set out and you have before you. I am glad that you see providers as well as beneficiaries as your partners, and the key here are clear guidelines and appropriate education on how we can best be that.

These and all the other provisions of the Affordable Care Act provide a strong blueprint for turning what despite all the wonderful technological, pharmaceutical, and biotech advances is a dysfunctional and inequitable system into a world class system that would be the envy of the world. I look forward to all of the testimony and the discussion to follow, Mr. Chairman, and I yield back the balance of my time.

Mr. PALLONE. Thank you. Next is our Chairman Emeritus, the gentleman from Michigan, Mr. Dingell.

OPENING STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. DINGELL. Mr. Chairman, thank you. I want to commend you for this hearing. The topic before us is a very important one. Each year the taxpayers are losing billions of dollars because of intentional fraud to the Medicare and Medicaid systems. Criminals who defraud these programs not only steal from the taxpayers but they do it at the expense of American seniors and families. The Administration has taken many positive steps to fight fraud. This committee has been immediately involved in many of these, and the fight goes back a long way. These actions show why it is a very much needed government action. People in Michigan have seen first hand the work of the Medicare Fraud Strike Task Force. Their work led in July to the arrest of 94 people who had defrauded the Medicare system. Two of these scam artists were from Detroit and were convicted in a $2.3 million fraud scheme.

These people not only broke the law but they took advantage of the most vulnerable members of our society, the elderly and poor, and they harmed programs that are vital to that particular community and to this country. This is only a beginning, and the health care reform law does a number of good things, but some of the lesser known benefits of it included the unprecedented set of tools it gives the Administration to squeeze out waste, fraud, and abuse. Because of the Affordable Care Act, the Administration can now move from a pay and chase model of fighting fraud to a much better one, one that prevents fraud from happening in the first place. Now criminals will not be accepted into these programs in the first place, and those that slip in will not get paid.

For example, the new law requires stronger rules and sentences for people who commit health care fraud, better screening tools to prevent fraud from happening, requirements for providers and suppliers to establish plans on how they will prevent fraud and en-

hance data collection that allows CMS, the Department of Justice, and the states and other federal health programs to share information. The new law does something else that is also important. It creates enhanced oversight of private insurance abuses. Waste, fraud, and abuse are not confined exclusively to Medicare and Medicaid. In fact, some of the most egregious examples of waste of beneficiary dollars happen in the private sector. Beginning tomorrow, it will be illegal for insurance companies to rescind policies once a person gets sick. Children with pre-existing conditions can no longer be denied coverage. Young adults up to age 26 can remain on their parent's health care plan, and lifetime limits on health care coverage will be a thing of the past.

Furthermore, insurance companies will be required to publicly disclose and justify minimum increases. They will have to provide rebates to customers if their non-medical costs exceed 15 percent of the premium cost in the group market or 20 percent in the small group and individual market. Despite all the doomsday predictions that we have heard during the health care reform debate these waste, fraud, and abuse provisions are proof that the new law is working and is in the interest of the American people. Mr. Chairman, again I thank you for recognizing me, and I commend you for your leadership in this matter and yield back the balance of my time.

Mr. PALLONE. Thank you, Chairman Dingell. Our next member for an opening statement is the gentleman from Iowa, Mr. Braley.

OPENING STATEMENT OF HON. BRUCE L. BRALEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA

Mr. BRALEY. Thank you, Mr. Chairman. Since I joined this subcommittee, I have focusing on the importance of addressing the enormous problem of waste, fraud, and abuse not only in Medicare and Medicaid but also in the private sector as the Chairman Emeritus noted. The problem of fraud gets the lion's share of public attention, and that 60 Minutes program on October 28 of last year is a good example of that. It showed people who were leaving careers as drug dealers in Florida because they could make more money in Medicare fraud. And they talked in that program about the enormous financial cost of Medicare fraud, and they use the figure of $60 billion a year. But the real elephant in the room, pun intended, is the problem of waste in health care delivery, and one of the most important books ever given to me was by a doctor in Cedar Falls, Iowa named Jim Young, and the book is Over Treated by Shannon Brownley, why too much medicine is making us sicker and poorer.

And in this groundbreaking publication she cites many health care researchers including many medical economists, and she speaks specifically of the work done at the group at Dartmouth Atlas where they estimated that as much as 30 percent of medical care paid by Medicare as well as private insurers is useless, unneeded, a waste. As of 2006 when the total health care budget reached $2 trillion, Americans were spending as much as $700 billion a year on health care that not only did them no good but caused unnecessary harm. And one of the biggest driving factors in this waste and over utilization problem is the provision of unneces-

sary care. One of the biggest problems we have is the enormous cost of prescription drugs in this country.

Americans consume about $200 billion worth of prescription drugs a year, and it used to be that the drug industry itself advocated against direct consumer marketing. In fact, our Chairman Emeritus held hearings on this in 1985 and had the leading pharmaceutical manufacturers testify in response to his questions, and they were on record as saying direct to consumer advertising would make patients extraordinarily susceptible to product promises. We believe direct advertising to consumers introduces a very well possibility of causing harm to patients and advertising would have the objective of driving patients into doctor's offices seeking prescriptions. Guess what? That is exactly what is happening. The drug industry has completely changed their position on direct to consumer and direct to physician marketing.

So we have an enormous challenge, and that is why I commend both of my colleagues. We need to make this a bipartisan focus of our work in Congress because the American taxpayers can't afford to continue to sustain wasteful and fraudulent spending with their tax dollars. And I yield back the balance of my time.

Mr. PALLONE. Thank the gentleman. And I think our last member is the gentleman from Texas, Mr. Green.

OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GREEN. Thank you, Mr. Chairman. Hearing so many opening statements, my opening statement is basically the same as other members. None of us support fraud or abuse in the Medicare-Medicaid programs. It is so important to our constituents to have this option. But following my Republican colleagues, I would say in 2003 a number of us on our side didn't vote for the prescription drug bill because of the flaws in it, but I don't remember saying we were going to defund it. We wanted to fix it. And there are things I would like to fix in the health care bill that I would hope we could work across the aisle and do it, but to start out every hearing we have on trying to deal with health care to say that the health care bill that is now the law, it is the law of the land, and we are going to work to make it happen because it is something that has been needed for at least my whole lifetime. So with that, Mr. Chairman, I would like to place my full statement in the record and look forward to hearing from our witnesses.

Mr. PALLONE. Thank the gentleman. Any member who seeks to put their statement in the record is certainly entitled to do so and so ordered. I think we have heard from all the members, so we will now go to our witnesses, and our first panel is, of course, the congressional panel. We have the Honorable Peter Roskam from Illinois, and the Honorable Ron Klein from Florida. And I appreciate you taking your time today to appear before us, and I guess it shows us this is an important issue the fact that you are here. So we will start with Congressman Roskam.

STATEMENTS OF HON. PETER ROSKAM, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS; AND HON. RON KLEIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

STATEMENT OF HON. PETER ROSKAM

Mr. ROSKAM. Thank you, Mr. Chairman, and Ranking Member Shimkus. I really do appreciate the opportunity to just spend a couple minutes with you. I want to tell you a quick story. Ten years ago or so, my wife and I were traveling overseas, and I decided to save a couple of bucks and we were going to take the subway in Budapest, which upon reflection is a very foolish thing to do. So I am in a Budapest subway and I get pick-pocketed. Now from the time that I got out of the subway to the time I got back to the hotel room, I had gotten a notice from the credit card company that said there is $10,000 that is poised on your card. Did you put stereo equipment on the street an hour ago? And, of course, I didn't, and they shut it off.

Now Chairman Pallone in his opening statement said a phrase that I think really encapsulates this whole drama, and the question is he said what we need to do is to concentrate on heading off bad actors before they strike. Now I understand the drama, the back and forth about the current health care law. One of the things that I think that is in the current health care law that is a gesture in the right direction even though I opposed it is some of the things, some of the anti-fraud elements of it, some of the enhanced penalties, and so forth, and that is an area where there is really a lot of common ground. My hunch is that based on these very, very large numbers that we are talking about that we need a larger gesture.

And let me walk through a piece of legislation that I have introduced. It got sort of a favorable mention by Nancy Ann DeParle in the White House. We had a good conversation and meeting about it. It was in President Obama's outline that he sent up to the Hill. It didn't make it through on final passage. But I think it is an area where there is a lot of interest and a lot of common ground, and even with meetings that I have had with HHS, I haven't sensed any defensiveness. It is more a sense of how do we actually implement something like this and how do we go about doing it? Let me just go back one quick second. The Administration reports that about a little over 7 percent or $24 billion in improper payments in Medicare fee for service is paid out, and that is sort of in the range of all your analysis that you have been talking about. But I think there is a weakness in the analysis in that it is really only looking at overpayments and underpayments. It is not looking at the type of fraud that you were all addressing in your opening statements.

So I think the President to reach this goal that he set out, which is an excellent goal of cutting fraud in half by 2012, he is going to need more tools, and I think that we can help to get more tools. The increased data sharing, some of the things that Mr. Dingell mentioned, the reorganization of program integrity efforts, greater compliance efforts, additional funding for enforcement efforts, every dollar that goes in on the enforcement side comes out as about $17

saved so this is an area that is ripe for investment. But my bill is H.R. 5546, which is called the Fighting Fraud with Innovative Technology Act, and it uses this predictive modeling, and essentially it doesn't wait for the bills to go out the door but it uses the same type of technology that the credit card companies have used. Let us put this into context. Credit card companies right now within the global economy, there is $11 trillion of credit card transactions every year. Just let that number sink in for a second.

The type of fraud that they are dealing with is .047 percent. Contrast that with the type of numbers we have been talking about this morning on the order of 10 percent. OK. CMS currently uses a limited application of prepayment screening, editing, and selector review of claims conducted by Medicare administrative contractors. Most resources are utilized on post-payment review activities by zone program integrity contractors and recovery audit contractors. But the fraudsters continue to be one step ahead of our current ruled and edits-based automated claims processing. Predictive modeling this approach can detect fraudulent claims that traditional rule-based edits simply can't identify. CMS is currently developing an integrated data repository that will eventually contain all provider data that can be mined but this will still be post-payment. Predictive modeling scores a claim to identify claims that have a high probability of fraud.

A predictive model creates an estimated score on claims using historical data, and that estimate is then applied to new claims that are being submitted. The predictive model is always evolving, improving, and adapting to provider and patient behavior. So, in other words, highly suspicious claims are subject to manual review to provide false positive and to provide self audit appeal process, which is encouraged. Following successful implementation to the Medicare program you could contemplate rolling this out for other elements of federal health care claims but my suggestion is let us creep and crawl and walk and let us start with focusing in on Medicare. That is basically this bill in a nutshell. And my sense is that there is an opportunity for us to come together and really to give the Administration the tools they need, to give a whole host of folks the tools they need because the approach that we have taken up until now has just under performed, and I think even in the health care law there are things that are going to be beneficial from an ant-fraud point of view but I think it is going to be beneficial on the margins.

I think the heart of this is to change the entire paradigm and to change that entire paradigm we need to do the type of predictive modeling. And it is not like it is open field running. In other words, it is not as if this hasn't been tried and this is a fool's errand. This is something that has been tried and demonstrated, and I think toward that end I submit my bill for your consideration as you are moving forward for possible solutions. Thank you.

[The prepared statement of Mr. Roskam follows:]

Statement of Congressman Peter Roskam
Energy and Commerce Health Subcommittee Hearing on Cutting Waste, Fraud and Abuse in Medicare and Medicaid

September 22, 2010

Chairman Pallone, Ranking Member Shimkus, and Members of the Energy and Commerce Health Subcommittee, thank you for holding this important hearing on cutting fraud, waste and abuse in the Medicare and Medicaid programs. Fraud in Medicare and Medicaid is a pervasive and problematic epidemic that necessitates an aggressive treatment remedy. A bipartisan dilemma, fraud infuriates taxpayers and Members of Congress alike. As a guardian of taxpayer dollars and the federal healthcare programs, I feel a responsibility to offer an innovative policy idea to attempt to mitigate fraud in Medicare and Medicaid. I will advocate for a deliberative move towards better prospective technologies to detect fraud before payments are made – including the use of predictive modeling analytics – to augment existing detection and enforcement efforts. I want to focus on this idea as an opportunity where we can work together.

One significant problem is that Medicare adjudicates and reimburses claims without verifying their legitimacy the way the financial services industry does with credit cards. A quick anecdote – my wife and I were traveling through Hungary when my wallet was stolen. Before I even realized my Hungarian forints were lifted, my credit card company notified me that a scammer attempted to purchase $10,000 worth of stereos and speakers on the streets of Budapest, which is very uncharacteristic of my consumer behavior. The claim was processed but halted in the twinkle of an eye before the reimbursement made it across the Atlantic Ocean.

Secretary Sebelius described a similar analogy at the last Healthcare Fraud Summit on August 26th, "It is what credit card companies have been doing for decades: If 10 flat screen TV's are suddenly charged to my card in one day, they know something's not quite right. So they put a hold on payment and call me right away... We should be able to take the same approach when one provider submits ten times as many claims for oxygen equipment as a similar operation just down the road.. It's about spotting fraud early before it escalates and the cost grows." These may sound overly simplistic but allow me to demonstrate how it could be effective.

This technology could have detected a fraudulent suburban Chicago physician who had billing privileges at three hospitals. According to the New York Times, the physician used two codes and "sent over 14,800 billings over five years to Medicare alone, billing for 24 hours or more of work every day of the year. His use of the codes represented a disproportionate use of them in the entire United States, and more than all the doctors in some states.. It allowed the purchase of multiple homes, numerous bank accounts and investments, nothing especially covert or overseas." This behavior would have been detected and prevented before nearly $7 million in reimbursement that was lost.

Another major setback is the lack of accurate measurement of Medicare and Medicaid fraud. Estimates vary widely, and reliable estimates of actual dollar value lost to Medicare fraud are limited. The Washington Post, 60 Minutes, ABC World News, the Wall Street Journal, National Public Radio, and many other media outlets have reported about fake patients, deceased doctors, fly-by-night storefronts, and multi-state criminal rings bilking $60 billion or more annually from seniors and taxpayers. The FBI estimates that healthcare fraud accounts for up to 10 percent of total health spending, or up to $250 billion per year. Thomson Reuters estimates healthcare fraud and abuse accounts for $125 to $175 billion per year. In August of 2009, the Health and Human Services Office of Inspector General wrote that the Medicaid Statistical Information System had not captured data that was useful in detecting and measuring fraud, waste and abuse in the Medicaid program.

The Administration reports 7.8 percent or over $24 billion in improper payments in Medicare fee-for-service, but this metric measures over-payments and under-payments and not fraud specifically. In June, President Obama announced an initiative to slash Medicare fraud in half by 2012, but the metrics for the measurement change too often to get a firm estimate. I share his commitment to reducing the improper payment rate. In order to accomplish this goal, I believe Medicare must utilize more advanced prospective analysis of claims prior to reimbursement. Predictive modeling can provide a more accurate estimate of highly suspicious claims.

HIPAA defined healthcare fraud as any scheme to obtain payment by means of misrepresentation from any healthcare benefit program. Fraud plagues both private and public programs, but Medicare and Medicaid are especially vulnerable to fraudsters ranging from petty thieves to organized criminals. Lewis Morris of Health and Human Services Office of Inspector General has said, "Building a Medicare fraud scam is far safer than dealing in crack or dealing in stolen cars, and it's far more lucrative." Since 1990, GAO has annually declared Medicare at high risk for improper payments and fraud due to its size, scope and decentralized administrative structure. Medicaid has been included on the high risk list since 2003 and involves a patchwork of fifty separate program integrity efforts. Fraud in both federal programs robs upwards of one hundred billion of taxpayer dollars from the public healthcare systems without any benefit society's most vulnerable populations.

Analysis of the Patient Protection and Affordable Care Act anti-fraud provisions shows enhanced penalties for convicted fraudsters, increased data sharing, re-organization of program integrity efforts, greater compliance programs, and additional funding for enforcement efforts. Increased enforcement and screening efforts are positive steps towards augmenting our fraud efforts and will inevitably catch more fraud. The Office of Inspector General returns $17 for every $1 invested for investigative and enforcement activities. While these well-intentioned provisions will help, I fear these efforts could only expose more of the iceberg that is Medicare and Medicaid fraud. Also, enforcement could potentially squeeze the balloon from the HEAT strike force zones to other areas of the country and create a wild goose chase scenario. U.S. Attorney Wilfredo Ferrer

described the pursuit, "This is like a game of whack a mole. The numbers are off the charts."

During the Ways and Means Committee markup of the health bill, I offered an amendment to move the way Medicare verifies claims from current policy towards the way the financial services industry authenticates purchases – more diligence before payments are made to remedy our current "pay and chase" pursuit of fraudsters. My amendment has been developed and modified since last summer. I offered it again before the Rules Committee in November. I introduced the amendment as legislation this June – HR 5546 the Fighting Fraud with Innovative Technology Act – that I believe will both measure the amount of Medicare fraud more accurately and protect the Medicare trust fund from doling out billions of dollars in fraud. My legislation has been supported by AARP, Citizens Against Government Waste, AAHomecare, and National Health Care Anti-Fraud Association.

My legislation would reform the way Medicare pays claims by directing the Centers for Medicare and Medicaid Services (CMS) Office of Program Integrity to design a comprehensive pre-payment predictive modeling system to be applied prior to reimbursing claims, preventing improper payments from being made. Strengthening claims at the front end of the payment system will prevent suspect claims from being reimbursed. CMS currently uses a limited application of pre-payment screening, editing and selective review of claims conducted by Medicare Administrative Contractors (MACs). Most resources are utilized on post-payment review activities by Zone Program Integrity Contractors (ZPICs) and Recovery Audit Contractors (RACs). Fraudsters continue to be one step ahead of our current rules- and edits-based automated claims processing. Predictive modeling can detect fraudulent claims that traditional rule-based edits cannot identify. CMS is currently developing an integrated data repository that will eventually contain all provider data that can be mined, but this will still be post-payment pursuit of fraud.

Predictive modeling "scores" a claim to identify claims that have a high probability of fraud. A predictive model creates an estimated score on claims using historical data. That estimate is then applied to new claims that are submitted. The predictive model is always evolving, improving and adapting to provider and patient behavior. Highly suspicious claims are subject to manual review to avoid false-positives and a provider self-audit appeal process is encouraged. Following successful implementation to the Medicare program, the predictive modeling system could be developed for all Federal Health Programs like Medicaid and CHIP.

Predictive modeling is a process used in analytics to create a statistical model of future behavior that is used in industries such as financial services, direct mail, utility companies and retail for multiple applications including probability scoring assessments. Predictive modeling was utilized by the financial services industry in the early 1990s to model consumer behavior. Initially, there was a cultural resistance to implement predictive modeling throughout the industry. However, within five years, 80 percent of financial services institutions had implemented predictive modeling. Fraudsters were

flocking to institutions that had not adapted a predictive modeling strategy. The industry, which handles $11 trillion in transactions yearly, suffers only 0.047 percent in fraud thanks to a predictive modeling system that stops fraud and abuse at the point of sale. The Lewin Group conservatively estimates that a comprehensive application of predictive modeling can save Medicare $65 billion. Another analysis by TerraMedica, a healthcare technology firm, finds between $18.6 billion and $42.2 billion in annual suspicious claims that could be subject to fraud, abuse or overutilization patterns. In 2009, Medicare was able to recover $2.5 billion in improper payments, so predictive modeling could dramatically increase the amount of fraudulent payments detected and savings to the Medicare Trust Fund. Pre-payment predictive modeling would mitigate fraud and deter future criminals from attempting to defraud taxpayer dollars and strengthen the Medicare program for seniors.

Last fall, I spoke with Nancy-Ann DeParle over the phone and she displayed interest in the proposal. President Obama then included the amendment in his health outline. I have since met in person with Ms. DeParle, CMS Legislative Affairs and the new CMS Center for Program Integrity. Again, interest was exhibited and a Request for Information (RFI) was issued in late August. It is my hope that CMS will seriously adapt innovative technologies that can significantly hamper the advantage that fraudsters have over Medicare.

There is a real opportunity here. I believe Congress can come together, put donkeys and elephants aside, and utilize and deploy the technology that is available to us for the benefit of taxpayers and seniors we are here to protect. Again, thank you for the opportunity to testify before the subcommittee today. I look forward to answering any questions for the record.

Mr. PALLONE. Thank you. Congressman Klein.

STATEMENT OF HON. RON KLEIN

Mr. KLEIN. Thank you, Mr. Chairman. And I would like to thank the ranking member and Chairman Waxman and Chairman Emeritus, Mr. Dingell, for leadership in Medicare over the years as well. I join Mr. Roskam and all of you in trying to find some solutions to this big issue. The bill that I am submitting for your consideration is drawn up with Ileana Ros-Lehtinen from Miami. It is H.R. 5044. It is called Medicare Fraud Enforcement and Prevention Act. As Ms. Castor mentioned, she and I both represent large areas of south Florida and west Florida, which include large numbers of Medicare participants. And, unfortunately, in particular there have been large concentrations of Medicare fraud. You know the story about go where the money is, and this seems to be one of those areas that it absolutely follows through.

I think we all have had constituents, and I can share with you the stories of constituents that come to my office with sheets of billing which is just outrageous, repetitive, false information, all sorts of things, and literally just pages and pages of the same services in some cases billed over and over again. I am not suggesting this is the norm but we know that there are lots of cases and the billions and billions of dollars which add up to this, and the question is why and how can we address it. I think we know it is deplorable for all of us to allow our seniors to be preyed upon by these criminals. And, by the way, they are not all small time criminals. There is organized crime behind this. It is large scale in this type of approach. We know who loses from Medicare fraud. It is obviously the people who provide the services whether they be doctors, hospitals, legitimate providers, people who are on the receiving end who want to get the best benefit for the dollars that they have contributed, and taxpayers. All of us are taxpayers. We are all paying in every year with a view that Medicare will be there for us.

So in short we all are losers when a criminal commits Medicare fraud and we have an obligation to fight back. Our bill takes a comprehensive approach at attacking criminals who seek nothing more than ripping off Medicare, as I said, and preying on seniors. And the way we are approaching it picks up on some of the things that Mr. Roskam said. We had a chance to meet with a number of the strike force people down in Florida. We met with the FBI, we met with law enforcement, we met with the Inspector General's Office, we met with committee staff to try to really get a comprehensive view on what are the specific things that can be done. And what we have come up with are a number of things. Number one, on the law enforcement side to make much more significant the criminal penalties for committing these acts. That is a very commonsense approach here but a slap on the wrist is unacceptable.

If someone is going to commit this kind of fraud, obviously, it is fines and criminal penalties, but for the same reason we know that many of the people who commit the fraud many times are gone, and those of us who live in areas where they are bordering under parts of other countries they are out of here. I mean once they collect their checks, they are leaving the country or they are going

somewhere else. So, yes, it is good to have a deterrent factor in place and have a much more substantial way of setting out a deterrence and saying if you do this you will be in prison for a long time and you will pay significantly. That is appropriate, and that is part of this bill. But the second part of it is what we all know is the pay and chase issue and that is what we have been talking about, and that is people get this Medicare provider number in a very simple way.

The due diligence, the checking, the verification is unfortunately not what it should be. So what we have done is we have put a number of things in place in our proposal which gets to the point of providers and suppliers before they can get their Medicare number and go off to the races of having a much more thorough prescreening measure through use of technology and a lot of other things. And this is the way to stay ahead of the criminals. Once they get the number, they are getting the checks. And even to the point where our bill makes it a much more significant crime to be a part of this whole process by selling your number to others. Unfortunately, in south Florida you have heard the cases where lots of senior citizens are getting paid to have their number used. And, again, 20, 30 bucks, and obviously that individual number is being used for a significant multiplier.

Another issue that we found is a flaw in the system, the unnecessary gaps in time when a fraudulent claim is submitted and when the law enforcement agency is alerted. That is a time squeeze that needs to be reduced down to nothing. We met with a local Medicare administrator contractor for Florida and though they chose to have some sophisticated computer system to check for anomalies, they only download this information once a week. Well, only downloading once a week it goes to the point of credit card information, this isn't rocket science. This can be done. It can be done in real time. It is all technology-based and it can be done in real time. So, again, it is just another specific solution to the problem.

And, of course, this whole notion of providing law enforcement with more resources, more persons on the ground, I am a big believer in this case to spend a little more money to save substantially more money I think is an appropriate investment here. So these are some of the ideas in our bill that we would ask you to take a look at. Time is of the essence. Every day that passes millions more goes out the door into criminals' hands, and, more importantly, it doesn't go the people who need to provide those services and to the people who are paying for them. As we said before, this is a bipartisan issue. I am very proud to work with Ileana Ros-Lehtinen, Mr. Roskam. And many of you I know have already talked about in your opening statements and you have lots of ideas from back home. So we look forward to working with you, Mr. Chairman, and the whole committee in working and creating some legislation whether it is mine or his or anybody else's to pass something as we are going to pass a piece of our bill and a piece of these bills this week on dealing with Medicare, and we are very proud to be participating in that. But we look forward to working with all of you on this.

[The prepared statement of Mr. Klein follows:]

Testimony Before the Energy and Commerce Subcommittee on Health
Hearing On Cutting Waste, Fraud, And Abuse In Medicare And Medicaid
H.R. 5044, the "Medicare Fraud Enforcement
The Honorable Ron Klein
September 22, 2010

I want to thank the distinguished chairman and ranking member of the subcommittees on health for holding this important and timely hearing, and for allowing me testify in support of my bipartisan legislation, the "Medicare Fraud Enforcement and Prevention Act."

I represent a congressional district in South Florida that is on the front lines of the battle to fight Medicare fraud. I have constituents who have sent me copies of their Medicare statements. It's absolutely ridiculous. Literally pages and pages of the same services billed over and over again, totaling thousands of dollars that were fraudulently billed to Medicare.

It's deplorable to think that there are people out there preying on our seniors, but as everyone here knows, it's true. Some estimates say that Medicare fraud totals $60 billion a year. That's money taken out of the system to line the pockets of criminals and thieves.

Who loses from Medicare fraud? Seniors who face rising out of pocket costs for prescription drugs and other services, doctors and hospitals who provide medical services, and most of all, taxpayers, who are footing the bill at an absolutely staggering cost with every fraudulent claim. In short, we are all losers when a criminal commits Medicare fraud, and we must fight back.

That's why I teamed up with my good friend from Miami, Congresswoman Ileana Ros-Lehtinen, to put together the common-sense ideas that both build on the important provisions in the Patient Protection and Affordable Care Act, and bring new, innovative ideas to the table to fight Medicare fraud.

We take a tough, comprehensive approach at attacking criminals who seek nothing more than ripping off Medicare and preying on unsuspecting seniors by addressing both the front-end and back-end of fraud enforcement. This two-step approach involves instituting tough punishment and penalties to deter people from getting involved in fraudulent activities and putting in place tough safeguards to prevent fraudulent suppliers and providers from enrolling into Medicare, along with Medicaid, in the first place.

Specifically, H.R. 5044 doubles the penalties for the two cornerstone provisions used in the criminal code to fight Medicare fraud: the false statements and anti-kickback provisions in the Social Security Act. These penalties have not been updated since 1977 even though criminal conspiracies have dramatically advanced during that time.

HR 5044 will double the criminal penalties to a maximum of 10 years of imprisonment and up to $50,000 in fines. It will also create a new offense for illegally distributing a Medicare or Medicaid beneficiary ID and establishes a maximum penalty of 3 years in prison and a fine up to the amount that was stolen from the government.

We also provide the HHS Office of Inspector General with new powers to fight fraud. In particular, we close a loophole in current law that allows corporate executives to avoid exclusion from Federal health care programs if they have been convicted of health care fraud. With the assistance of the Inspector General, we have worked in a bipartisan manner with the Ways and Means Committee to improve this provision, and we will now have a stand-alone bill addressing this loophole on the House floor later this week. I am proud of the bipartisan work we've done and look forward to passing this important piece into law.

While these tough new penalties will send a clear signal that health care fraud doesn't pay, penalties alone are not enough. Too often, Medicare fraud enforcement relies on a "pay-and-chase" model where criminals get paid before law enforcement officials can catch them. We must take strong actions to stop fraudulent people from enrolling in Medicare in the first place. As everyone on this distinguished committee knows, once someone gets a billing number, it's off to the races. This is simply not acceptable.

My legislation would prevent high-risk providers and suppliers from enrolling in Medicare in the first place through tougher pre-screening measures and through the latest technologies, so Medicare can stay one step ahead of the criminals. It will also force better data sharing among the agencies and contractors tasked with processing payment claims and the law enforcement agencies who, by law, must go after these criminals. One of the biggest flaws in our system is the unnecessary gaps in time when a fraudulent claim is submitted, and when the proper law enforcement agency is alerted.

For example, I recently met with the local Medicare Administrative Contractor for Florida. While they have some sophisticated computer systems to check for anomalies, they only download this information once a week. By that time, a criminal may have bilked Medicare for millions. We need to have the proper law enforcement officials alerted immediately, and our provision would shrink this critical gap in time.

These are some of the common-sense, bipartisan proposals in the Medicare Fraud Enforcement and Prevention Act. As you can see, Congresswoman Ros-Lehtinen and I put this legislation together with one goal in mind, and that's to strengthen and protect Medicare for the millions of men and women who depend on this critical program. We didn't look at any idea as being a Democrat idea or a Republican idea. We were just interested in what could work, and what could keep the criminals and thieves from robbing taxpayers and seniors of one of the best bedrock safety-net programs in our country's history.

Thank you again for the opportunity to testify, and I yield back my time.

Mr. PALLONE. I want to thank both of you, and certainly going to keep your legislative initiatives in mind as we move forward. That is what this is all about, and so I appreciate your coming today. Our practice is not to have questions of members, so I am going to proceed. Thank you for being here. I really appreciate it.

And we will ask the next panel to come forward. Thank you both. Let me introduce the two of you. On my left is the Honorable Daniel Levinson, who is Inspector General, Office of the Inspector General, U.S. Department of Health and Human Services, and to my right is Dr. Peter Budetti, who is Deputy Administrator for Program Integrity at the Center for Medicare and Medicaid Services, again with the U.S. Department of Health and Human Services. I want to welcome you. Thank you for being here today. We try to have you limit your comments to 5 minutes, if possible, and then we will take some questions. I will start with Mr. Levinson.

STATEMENTS OF HON. DANIEL LEVINSON, INSPECTOR GENERAL, OFFICE OF THE INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND PETER BUDETTI, M.D., DEPUTY ADMINISTRATOR FOR PROGRAM INTEGRITY, CENTER FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DANIEL LEVINSON

Mr. LEVINSON. Good morning, Chairman Pallone, Ranking Member Shimkus, and members of the subcommittee. Thank you for the opportunity to testify about those tools in the Affordable Care Act that will help to combat fraud, waste, and abuse in the Medicare and Medicaid programs. OIG has been leading the fight against health care fraud, waste, and abuse for more than 30 years in collaboration with the Department of Justice and our colleagues at CMS. Although there is no precise measure of health care fraud, we know that it is a serious problem demanding an aggressive response. Over the past fiscal year, OIG has opened over 1,300 health care fraud investigations and obtained over 500 convictions. OIG investigations also have resulted in nearly $3 billion in expected civil and criminal recoveries. Despite such successes there is more to be done. Those intent on breaking the law are becoming more sophisticated and the schemes more difficult to detect.

Fraud is migratory and adaptive. Criminals quickly modify and relocate their schemes to evade enforcement efforts. In response, the government is working to stay ahead of these schemes. Fraud will never be completely preventable so we must investigate and prosecute before the criminals and stolen funds disappear. New tools and resources provided in the Affordable Care Act will help us to do just that. My written testimony describes more fully how provisions in the Act will support the government's efforts. For example, OIG's work has demonstrated that it is too easy to obtain billing privileges and defraud the system. Anyone who wants to keep their home safe begins by doing something very simple, locking the front door.

We need to do the same with Medicare. The Affordable Care Act strengthens the screening process to prevent criminals from enrolling as Medicare providers and suppliers. It also provides OIG new

authority to respond to enrollment fraud. For example, entities that provide false information on an application to enroll or participate in a federal health care program are now subject to monetary penalties and exclusion from the federal health care programs. When criminals make it through the front door and suspected theft occurs the action of payment suspension authority strengthens Medicare's ability to curb taxpayer losses. In addition, the Act authorizes longer prison terms and stiffer penalties for health care fraud. Put simply, criminals who commit health care fraud are going to be cut off from the Medicare trust funds faster, face longer prison terms, and be subject to larger criminal fines.

The Act includes new transparency requirements that will shine light on financial relationships and potential conflicts of interest. Public disclosure of ties between drug and device manufacturers and physicians will help the government and the public monitor financial relationships and should deter kickbacks. The Act also requires nursing facilities to report ownership and control relationships. This will make it harder for unscrupulous corporate owners to avoid responsibility for substandard care in their nursing homes. The Act also empowers honest providers to do the right thing. Under the Act providers and suppliers will adopt compliance programs that meet a core set of requirements. Well-designed compliance programs can be an effective tool for preventing fraud and abuse. OIG has provided compliance guidance to providers for more than a decade. We will also conduct compliance training programs for providers, compliance professionals, and attorneys across the country in 2011.

The training will empower well-intentioned providers to identify fraud risk areas and best practices to avoid fraud schemes that may be targeting their communities. Finally, the Affordable Care Act provides new funding, $350 million over the next 10 years, that will expand and strengthen the government's program integrity efforts. Thank you for your support of OIG's mission, and I would be happy to answer your questions.

[The prepared statement of Mr. Levinson follows:]

Testimony before the United States House of Representatives

Committee on Energy and Commerce

Subcommittee on Health

"Cutting Waste, Fraud, and Abuse in Medicare and Medicaid"

Testimony of:

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

September 22, 2010
10:00AM
2322 Rayburn House Office Building

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

Good morning, Chairmen Waxman and Pallone, Ranking Members Barton and Shimkus, 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 discuss new tools in the recently enacted Patient Protection and Affordable Care Act (Affordable Care Act or ACA) that will help to combat fraud, waste, and abuse in the health care system. My testimony will describe OIG's strategy for strengthening the integrity of the health care system and ways in which the Affordable Care Act significantly bolsters that effort.

Health Care Fraud, Waste, and Abuse: Serious Issues That Must Be Addressed Trhough Concentrated and Sustained Efforts

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 exacerbated by the growing number of people served by these programs and the increased strain on Federal and State budgets. With new and expanded programs under the Affordable Care Act, it is critical that we strengthen oversight of these essential health care programs.

Although there is no precise measure of health care fraud, we know that it is a serious problem that demands an aggressive response. For example, over the past fiscal year, OIG has opened over 1,300 health care fraud investigations and obtained over 500 convictions. OIG investigations also have resulted in nearly $3 billion in expected civil and criminal recoveries. While the majority of health care providers are honest and well-intentioned, a minority of providers who are intent on abusing the system can cost taxpayers billions of dollars.

Health care fraud schemes commonly include billing for services that were not provided or were not medically necessary, purposely billing for a higher level of service than what was provided, misreporting costs or other data to increase payments, paying kickbacks, and/or stealing 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 trafficking 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 appear to be legitimate providers, fraudulently bill Medicare for millions of dollars, and then close up shop and reopen in a new location under a new name and repeat the fraud. The criminals often pay kickbacks to physicians, nurses, and even patients to recruit them as participants in the fraud schemes.

The Medicare program is increasingly infiltrated by violent and organized criminal networks. For example, an individual in southern California led a Medicare DME fraud ring that established various fraudulent DME companies, primarily using street gang members to pose as nominee owners of his sham companies. He paid each gang member $5,000 to establish bank accounts and to fill out the Medicare paperwork. The nominee owners submitted claims for reimbursement to Medicare for power wheelchairs and orthotic devices that were not medically necessary or legitimately prescribed by a physician. To date, nine of the gang members and associates have been indicted for charges including health care fraud and providing false statements to Government agencies. The gang members involved in this fraud had previously been convicted of charges ranging from assault on a peace officer to numerous narcotics violations.

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

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. OIG has a strong record of investigating these corporate and institutional frauds, which often involve complex billing frauds, kickbacks, accounting schemes, illegal marketing, and physician self-referral arrangements. In addition, we are seeing an increase in quality of care cases involving allegations of substandard care.

Waste of funds and abuse of the health care programs also cost taxpayers billions of dollars. In fiscal year (FY) 2009, the Centers for Medicare & Medicaid Services (CMS) estimated that overall, 7.8 percent of the Medicare fee-for-service claims it paid ($24.1 billion) did not meet program requirements. Although these improper payments do not necessarily involve fraud, the claims should not have been paid. For our part, OIG reviews claims for specific services, based on our assessments of risk, to identify improper payments. For example, an OIG audit uncovered $275.3 million in improper Medicaid payments (Federal share) from 2004 to 2006 for personal care services in New York City. As another example, an OIG evaluation of payments for facet joint injections (a pain management treatment) found that 63 percent of these services allowed by Medicare in 2006 did not meet program requirements, resulting in $96 million in improper payments.

OIG's work has also demonstrated that Medicare and Medicaid pay too much for certain services and products and that aligning payments with market costs could produce substantial savings. For example, in 2007, 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. Similarly, we found that in 2007, Medicare allowed, on average, about $4,000 for standard power wheelchairs that cost suppliers, on average, about $1,000 to acquire. These pricing disparities also affect

beneficiaries, who are responsible for 20 percent copayments on items and services covered under Medicare Part B.

OIG's Five-Principle Strategy Combats Health Care Fraud, Waste, and Abuse

Combating health care fraud requires a comprehensive strategy of prevention, detection, and enforcement. OIG has been engaged in the fight against health care fraud, waste, and abuse for more than 30 years. Based on this experience and our extensive body of work, we have identified five principles of an effective health care integrity strategy.

1. Enrollment: Scrutinize individuals and entities that want to participate as providers and suppliers prior to their enrollment or reenrollment in the health care programs.

2. Payment: Establish payment methodologies that are reasonable and responsive to changes in the marketplace and medical practice.

3. Compliance: Assist health care providers and suppliers in adopting practices that promote compliance with program requirements.

4. Oversight: Vigilantly monitor the programs for evidence of fraud, waste, and abuse.

5. Response: Respond swiftly to detected fraud, impose sufficient punishment to deter others, and promptly remedy program vulnerabilities.

OIG uses these five principles in our strategic work planning to assist in focusing our audit, evaluation, investigative, enforcement, and compliance efforts most effectively. These broad principles also underlie the specific recommendations that OIG makes to HHS and Congress. The Affordable Care Act includes provisions that reflect these principles and that we believe will support the fight against fraud, waste, and abuse in Medicare and Medicaid.

The Affordable Care Act Enhances Health Care Oversight and Enforcement Activities

The breadth and scope of health care reform alter the oversight landscape in many critical respects, and as a result OIG will assume a range of expanded oversight responsibilities. The ACA provides us with expanded law enforcement authorities, opportunities for greater coordination among Federal agencies, and enhanced funding for the Health Care Fraud and Abuse Control (HCFAC) program. In addition, new authorities for the Secretary and new requirements for health care providers, suppliers, and other entities will promote the integrity of the Medicare, Medicaid, and other Federal health care programs. The following examples illustrate how the ACA will strengthen our oversight and enforcement efforts.

Effective use of reliable data is critical to the Government's anti-fraud efforts.

Section 6402 of the Affordable Care Act will enhance OIG's effectiveness in detecting fraud, waste, and abuse by expanding OIG's access to and uses of data for conducting oversight and law enforcement activities. For example, section 6402 exempts OIG from the administrative

requirements of matching data across programs in the Computer Matching and Privacy Protection Act and authorizes OIG to enter into data-sharing agreements with the Social Security Administration (SSA).

The law also requires the Department to expand CMS's integrated data repository (IDR) to include claims and payment data from Medicaid, the Departments of Defense and Veterans Affairs, SSA, and the Indian Health Service and fosters data-matching agreements between Federal agencies. These agreements will make it easier for the Federal Government to help identify fraud, waste, and abuse.

Further, the ACA recognizes the importance of law enforcement access to data. Access to "real-time" claims data – that is, as soon as the claim is submitted to Medicare – is especially critical to identifying fraud as it is being committed. Timely data is also essential to our ability to respond with agility as criminals shift their schemes and locations to avoid detection. We have made important strides in obtaining data more quickly and efficiently, and the Affordable Care Act will further those efforts.

In addition to claims data, access to records and other information is of critical importance to our mission. Pursuant to section 6402 of the ACA, OIG may, for purposes of protecting Medicare and Medicaid integrity, obtain information from additional entities, such as providers, contractors, subcontractors, grant recipients, and suppliers, directly or indirectly involved in the provision of medical items or services payable by any Federal program. This expanded authority will enable OIG to enhance Medicare and Medicaid oversight. For example, OIG audits of Part D payments can now more effectively follow the documentation supporting claims all the way back to the prescribing physicians.

Ensuring the integrity of information is also crucial, and the Affordable Care Act provides new accountability measures toward this end. For example, section 6402 authorizes OIG to exclude from the Federal health care programs entities that provide false information on any application to enroll or participate in a Federal health care program. The ACA also provides new civil monetary penalties for making false statements on enrollment applications; knowingly failing to repay an overpayment; and failing to grant timely access to OIG for investigations, audits, or evaluations.

The Affordable Care Act provides the Secretary with new authorities and imposes new requirements that are consistent with OIG's recommendations.

In addition to promoting data access and integrity, health care reform includes numerous program integrity provisions that support an effective health care integrity strategy. Consistent with OIG's five-principle strategy, these include authorities and requirements to strengthen provider enrollment standards; promote compliance with program requirements; enhance program oversight, including requiring greater reporting and transparency; and strengthen the Government's response to health care fraud and abuse.

Section 6401 of ACA requires the Secretary to establish procedures for screening providers and suppliers participating in Medicare, Medicaid, and the Children's Health Insurance Program

(CHIP). The Secretary is to determine the level of screening according to the risk of fraud, waste, and abuse with respect to each category of provider or supplier. At a minimum, providers and suppliers will be subject to licensure checks. The ACA also authorizes the Secretary to impose additional screening measures based on risk, including fingerprinting, criminal background checks, multi-State database inquiries, and random or unannounced site visits. These statutory provisions address significant vulnerabilities that OIG has identified in Medicare's enrollment standards and screening of providers and are consistent with recommendations that we have made to prevent unscrupulous providers and suppliers from participating in Medicare.

Health care providers and suppliers must be our partners in ensuring the integrity of Federal health care programs and should adopt internal controls and other measures that promote compliance and prevent, detect, and respond to health care fraud, waste, and abuse. OIG dedicates significant resources to promoting the adoption of compliance programs and providing guidance to health care providers on incorporating integrity safeguards into their organizations as an essential component of a comprehensive antifraud strategy. For example, OIG is planning a Provider Compliance Training Initiative to bring together representatives from a variety of government agencies to provide compliance training at no cost to local provider, legal, and compliance communities. The training sessions are scheduled to roll out in 2011 in several locations across the country. We aim to educate communities about fraud risk areas uncovered by OIG's work and to share compliance best practices so that providers can strengthen their own compliance efforts and more effectively identify and avoid illegal schemes that may be targeting their communities. This initiative will supplement OIG's extensive written guidance that is available on our Web site. We believe these efforts to educate provider communities can help foster a culture of compliance and protect the Federal health care programs and beneficiaries.

The Affordable Care Act require providers and suppliers to adopt, as a condition of enrollment, compliance programs that meet a core set of requirements, to be developed in consultation with OIG. In addition, the ACA separately requires skilled nursing facilities and nursing facilities to implement compliance and ethics programs, also in consultation with OIG. These new requirements are consistent with OIG's longstanding view that well-designed compliance programs can be an effective tool for promoting compliance and preventing fraud and abuse. These provisions are also consistent with recent developments in States that have made compliance programs mandatory for Medicaid providers.

Consistent with OIG recommendations, the ACA also facilitates and strengthens program oversight by increasing transparency. The new transparency requirements will shine light on financial relationships and potential conflicts of interest between health care companies and the physicians who prescribe their products and services.

Specifically, section 6002 requires all U.S. manufacturers of drugs, devices, biologics, and medical supplies covered under Medicare, Medicaid, or CHIP to report information related to payments and other transfers of value to physicians and teaching hospitals. This information will be made available on a public web site. The types of payments subject to disclosure have been the source of conflicts of interest and, in some cases, part of illegal kickback schemes in many of OIG's enforcement cases. OIG already includes similar disclosure requirements in our corporate

integrity agreements with pharmaceutical manufacturers as part of the settlement of these cases. The requirement of public disclosure of these payments will help the Government, as well as the health care industry and the public, to monitor relationships and should have a sentinel effect to deter kickbacks and other inappropriate payment relationships.

The quality of care in nursing homes also may improve with the increased transparency required by the Affordable Care Act. Section 6101 requires nursing facilities and skilled nursing facilities to report ownership and control relationships. Disclosure of these relationships is critical to facilitating better oversight of and response to quality-of-care and other issues. Historically, law enforcement has struggled to determine responsibility within an organization's management structure. We have had to resort to resource intensive and time-consuming investigative and auditing techniques to determine the roles and responsibilities of various management companies that are affiliated with a single nursing facility. Establishing accountability is challenging in part because corporations sometimes intentionally construct byzantine structures that obscure responsible parties from view. OIG has seen a variety of methods used to conceal true ownership, including establishing shell corporations, creating limited liability companies (LLC) to manage operations of individual homes, creating LLCs for real estate holdings, and creating affiliated corporations to lease and sublease among the various inter-owned corporations. The new requirements for disclosure of ownership and control interests will help ensure that corporate owners and investment companies that own nursing homes will no longer be able to provide substandard care, deny responsibility, and leave underfunded shell companies to take the blame.

Additional transparency provisions in the ACA will shine light on the administration of the Medicare and Medicaid programs. Section 6402 will require Medicare and Medicaid program integrity contractors to provide performance statistics, including the number and amount of overpayments recovered, number of fraud referrals, and the return on investment (ROI) of such activities, to the Inspector General and the Secretary. This latter requirement is consistent with OIG's call for greater accountability in the performance and oversight of CMS's program integrity contractors.

In addition to strengthening the Government's ability to detect fraud and abuse, the Affordable Care Act strengthens the Government's ability to respond rapidly to health care fraud and hold perpetrators accountable. For example, it expressly authorizes the Secretary, in consultation with OIG, to suspend payments to providers based on credible allegations of fraud. Significantly, the ACA also increases criminal penalties under the Federal Sentencing Guidelines for Federal health care offenses and expands the types of conduct constituting Federal health care fraud offenses under Title 18 of the United States Code. Put simply, criminals who commit health care fraud are going to be cut off from the Medicare Trust Funds faster, face longer prison terms, and be subject to larger criminal fines.

Each of these integrity provisions advances the fight against fraud, waste, and abuse. Further, we expect that the combined impacts of these new program integrity measures will be greater than the sum of the parts. Preventing unscrupulous providers and suppliers from gaining access to the health care programs and beneficiaries is the first step in an integrated integrity strategy. Requiring compliance programs and providing guidance helps to ensure that those permitted to

participate in the programs do not run afoul of the law or program requirements. Expanded oversight and reporting requirements will help the Government, industry, and the public monitor the programs and identify potential fraud, waste, and abuse more quickly and effectively. In combination, the ACA's new enforcement authorities and tools will help change the calculus undertaken by criminals when deciding whether to target Medicare and Medicaid by increasing the risk of prompt detection and the certainty of punishment.

Funding of the Health Care Fraud and Abuse Control Program is vital to the fight against fraud, waste, and abuse.

In addition to providing new authorities and enforcement tools, the Affordable Care Act provides critical new funding that will enable OIG to expand and strengthen current enforcement and oversight efforts to combat fraud, waste, and abuse.

The HCFAC program is a comprehensive effort, under the joint direction of the Attorney General and the Secretary of HHS, acting through OIG, designed to coordinate Federal, state and local law enforcement activities with respect to health care fraud and abuse. The HCFAC program provides OIG's primary funding stream to finance anti-fraud activities such as:

- Support of Criminal and Civil False Claims Act investigations and enforcement;
- Support of administrative enforcement activities;
- Evaluations of Medicare contractor operations, Medicare and Medicaid reimbursement for prescription drugs and DME, and other issues;
- Audits of payments to hospitals, home health agencies, Medicare Advantage plans, and Medicare Part D plans;
- Expansion of our use of technology and innovative data analysis to enhance our oversight and enforcement activities;
- Monitoring of providers under corporate integrity agreements;
- Issuance of advisory opinions and other guidance to the health care industry; and
- Establishment of Medicare Fraud Strike Force teams.[1]

From its inception in 1997 through 2009, HCFAC Program activities have returned more than $15.6 billion to the Federal Government through audit and investigative recoveries, with a ROI of more than $4 for every $1 invested in OIG, DOJ, and FBI investigations, enforcement, and audits.[2] HCFAC-funded activities have a further sentinel effect, which is not captured in this ROI calculation. HCFAC-funded activities are a sound investment, and HHS and DOJ are receiving vital new HCFAC funding – $10 million per year for 10 years in FYs 2011–2020 under the ACA, and an additional $250 million total allocated across FYs 2011–2016 under the Health Care and Education Reconciliation Act of 2010. With our share of this new funding, OIG will expand our Medicare and Medicaid investigations, audits, evaluations, enforcement, and compliance activities to support our efforts toward improving health care program integrity.

[1] Medicare Fraud Strike Forces are a joint OIG-Department of Justice (DOJ) initiative used to fight concentrations of Medicare fraud in specific geographic "hot spots." Strike Force teams include special agents from OIG and the Federal Bureau of Investigation (FBI), DOJ prosecutors, and oftentimes State and local law enforcement officials.
[2] The $4 to $1 return on investment is a 3-year rolling average from 2006-2008, which is used to help account for the natural fluctuation in returns from investigative, enforcement, and audit activities.

Innovative Uses of Data Are Central to OIG's Program Integrity Efforts

Health care fraud schemes have become more sophisticated and better able to morph quickly in response to anti-fraud initiatives. Innovative uses of information technology have dramatically enhanced OIG's ability to respond to this challenge. For example, OIG is capitalizing on technology to process and review voluminous electronic evidence obtained during our health care fraud investigations. Using Web-based investigative software, OIG can efficiently analyze large quantities of email or other electronic documents and identify associations among emails contained in multiple accounts based on content and metadata. This technology is enabling investigators to complete in a matter of days analysis that used to take months with traditional investigative tools. Recently, OIG expanded the impact of this cutting-edge technology by making it available to our law enforcement partners for use in joint investigations.

Efficient and effective analysis of claims data to detect fraud indicators also is shaping how we deploy our law enforcement resources. OIG is using data to take a more proactive approach to identifying suspected fraud. In 2009, OIG organized the multidisciplinary, multiagency Advanced Data Intelligence and Analytics Team (Data Team) to support the work of the Health Care Fraud Enforcement and Prevention Action Team (HEAT). The Data Team, composed of experienced OIG special agents, statisticians, programmers, and auditors and DOJ analysts, combines sophisticated data analysis with criminal intelligence gathered from special agents in the field to more quickly identify health care fraud schemes, trends, and geographic "hot spots." For example, the Data Team has identified locations where billing for certain services is more than 10 times the national average. The Data Team's analyses inform the deployment of Strike Force resources and selection of new locations to focus and leverage Government resources in the areas with concentrations of health care fraud. Medicare Fraud Strike Forces have been established in seven fraud hot spots – Miami, Los Angeles, Detroit, Houston, Brooklyn, Tampa, and Baton Rouge.

We are committed to enhancing existing data analysis and mining capabilities and employing advanced techniques, such as predictive analytics and social network analysis, to counter new and existing fraud schemes. As part of that commitment, we are developing a consolidated data access center, which will integrate business intelligence tools and data analytics into our fraud detection efforts. It will also provide the opportunity to access, analyze, and share data – consistent with applicable privacy, security, and disclosure requirements – with our law enforcement partners. This will enhance the efficiency and coordination of our collective efforts by giving law enforcement agents an opportunity to put the pieces together and see the totality of the fraud scheme.

Through this data-enhanced collaboration, law enforcement will be able to increase the numbers of credible investigative leads, recoveries, and avoidances of improper Medicare and Medicaid payments and detect emerging fraud and abuse schemes and trends. In addition, these tools will support our effective targeting of audits and evaluations to identify program vulnerabilities and recommend systemic solutions.

Conclusion

Health care fraud, waste, and abuse cost taxpayers billions of dollars every year and require focused attention and commitment to solutions. The Affordable Care Act provides additional

authorities and resources that will significantly enhance our effectiveness in fighting health care waste, fraud, and abuse in the Medicare and Medicaid programs. 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. Thank you for your support of this mission. I would be happy to answer any questions that you may have.

Mr. PALLONE. Thank you, Mr. Levinson. Dr. Budetti.

STATEMENT OF PETER BUDETTI, M.D.

Dr. BUDETTI. Chairman Pallone, Ranking Member Shimkus, Chairman Emeritus Dingell, and other distinguished members of the subcommittee, I am Peter Budetti, and I am privileged to hold the new position at the Centers for Medicare and Medicaid Services as the Deputy Administrator for Program Integrity where I have the opportunity to address many of the issues that have been raised this morning. The Centers for Medicare & Medicaid Services is very pleased to have the new tools to fight fraud and reduce waste and abuse in the Medicare and Medicaid programs that were given to the Secretary, to the Department of Health and Human Services in the Affordable Care Act of this year, and I am delighted to be here to discuss those with you. I am very pleased to share this panel with my distinguished colleague in fighting health care fraud, the Honorable Dan Levinson, Inspector General of the Department of Health and Human Services. We are committed to enhancing the collaborative working relationship between CMS and the Office of the Inspector General, and I believe we have made significant progress in doing so since we embarked on this endeavor.

On a personal note, I am honored to be appearing before the subcommittee that I had the distinct privilege of serving as counsel for some 6 years. The Affordable Care Act is the most far-reaching health care law since the inception of Medicare and Medicaid. We greatly appreciate the new and expanded authorities and are excited about using the tools that Congress has provided to CMS in the Affordable Care Act. Most important, with the implementation of these provisions that were provided by Congress is that CMS is looking, as many of you have mentioned this morning, to fundamentally shift program integrity activities beyond pay and chase to fraud prevention.

Even as we apply new technologies and methods to detecting and pursuing the fraudulent activities of dishonest or phony providers or suppliers, and as we continue our efforts to recover overpayments made for false claims, CMS is focused on preventing either of these events from ever occurring in the first place. Our goal is to turn off the pipeline of fraudulent activity before it develops. We will do this in 2 ways, working with legitimate providers and suppliers to ensure compliance with the program requirements and taking new measures to keep dishonest ones out of the programs and to avoid paying fraudulent claims. Our fraud prevention initiatives stem from our first priority which is to help provide our beneficiaries with the health care that they need. Precious public resources must not be diverted from that core purpose.

To that end, working with states and law-abiding providers and suppliers to protect beneficiary access to needed health services, medicines, and supplies is the number one goal of our program integrity work. With beneficiary interests in mind as we continue the process of implementing these authorities and improving our program integrity, we must do so in a way that is fair and transparent to health care professionals, other providers and suppliers who are our partners in caring for beneficiaries. Maintaining this partner-

ship is an important aspect of our program integrity work. As we implement these new authorities, we have a significant opportunity to build on our existing efforts to combat waste, fraud, and abuse. The new authorities offer more front-end protections to keep those who are intent on committing fraud out of the programs and new tools for determining wasteful and fiscally abusive practices, identifying and addressing fraudulent payment issues promptly, and ensuring the integrity of the Medicare and Medicaid programs.

We also now have the flexibility to tailor our resources and activities in previously unavailable ways which we believe will greatly support the effectiveness of our work. As an example of this, on September 17, CMS posted a Notice of Proposed Rulemaking that will implement several of the key anti-fraud authorities in the Affordable Care Act that go a long way towards enabling us to keep the bad actors out and to avoid paying fraudulent claims. This includes new measures to screen providers and suppliers before they are allowed into the program to build the programs, new authorities to declare a temporary moratorium on enrollment for high risk areas of fraud in our program, authority to suspend Medicare and Medicaid payments for providers and suppliers pending investigation of credible allegations of fraud.

Since this is a proposed rule, we look forward to receiving comments and feedback from all interested stakeholders and to working with the providers, suppliers, beneficiaries, law enforcement, and other key groups as we work to finalize this rule. This proposed rule builds on existing authorities and also on the rulemaking that we issued earlier this year that implemented the Affordable Care Act requirement for physicians and other professionals who order or refer Medicare-covered items or services to be enrolled in the Medicare program. Health care fraud is a national problem. The loss of taxpayer dollars through waste, fraud, and abuse diverts those funds from supporting needed health care and drives up health care costs. Reversing this problem will require a sustained approach, which brings together federal and state and local governments and law enforcement, beneficiaries, health care providers, and the private sector in a collaborative partnership effect relationship.

This Administration is strongly committed to minimizing waste, fraud, and abuse in federal health care programs. The President demonstrated this commitment with his executive order in setting a target to reduce improper payment rates in half by 2012, and we are committed to meeting the President's goal. The Administration has made a firm commitment to reigning in fraud and wasteful spending and with the Affordable Care Act we have more tools than ever to implement important and strategic changes. CMS thanks the Congress for providing us with these new authorities, and we look 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. Thank you, and I look forward to answering your questions.

[The prepared statement of Dr. Budetti follows:]

STATEMENT OF

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

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

ON

CUTTING WASTE, FRAUD, AND ABUSE IN MEDICARE AND MEDICAID

BEFORE THE

U.S. HOUSE COMMITTEE ON ENERGY & COMMERCE
SUBCOMMITTEE ON HEALTH

SEPTEMBER 22, 2010

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

House Committee on Energy & Commerce
Subcommittee on Health
Hearing on "Cutting Waste, Fraud, & Abuse in Medicare and Medicaid"
September 22, 2010

Chairman Pallone, Ranking Member Shimkus, and Members of the Subcommittee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) efforts to reduce waste, fraud, and abuse in the Medicare and Medicaid programs and the new tools and authorities given to the Secretary of the Department of Health & Human Services (HHS) and CMS in the Affordable Care Act of 2010.

Health care fraud is a national problem. This Administration is strongly committed to minimizing waste, fraud, and abuse in Federal health care programs. While improper payments are not necessarily fraudulent, we are also focused on reducing the Medicare fee-for-service error rate in half by 2012. CMS' program integrity mission encompasses the operations and oversight necessary to ensure that public funds are not diverted from their central purpose of making accurate payments to legitimate providers and suppliers for appropriate, reasonable, and necessary services and supplies for eligible beneficiaries of Medicare and Medicaid.

The Affordable Care Act is the most far reaching health care law since the inception of Medicare and Medicaid. We greatly appreciate the new authorities and are excited about using the new tools that Congress provided to CMS in the Affordable Care Act, which will better ensure the integrity and fiscal security of Medicare and Medicaid.

As CMS works to implement the new authorities in the Affordable Care Act, we have a significant opportunity to build on existing efforts to combat waste, fraud, 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 the Medicare and Medicaid

programs. CMS is pursuing an aggressive program integrity strategy that prevents fraudulent transactions from ever occurring, rather than simply tracking down fraudulent providers and chasing fake claims. CMS also now has the flexibility needed to tailor resources and activities in previously unavailable ways, which we believe will greatly support the effectiveness of our work.

Last week, CMS put on display proposed rule CMS-6028-P that details the initial steps the Agency is taking to implement certain provisions in the Affordable Care Act, including new provider enrollment screening measures and requirements, new authority to issue a temporary moratorium enrollment for high risk areas of fraud in our programs, and authority to suspend Medicare and Medicaid payments for providers or suppliers subject to credible allegations of fraud. This proposed rule builds on existing authorities and on earlier rulemaking that implemented the Affordable Care Act requirement for physicians and other professionals who order or refer Medicare-covered items or services to be enrolled in the Medicare program.

CMS recognizes the importance of having strong program integrity initiatives that will deter criminal activity and attempts to defraud Medicare or Medicaid. I share your commitment to ensuring taxpayer dollars are being spent on legitimate items and services. As we continue the process of implementing these authorities and improving our program integrity, 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 health care services or medicines is not impeded. CMS' first priority is to our beneficiaries, and working with States and law-abiding providers and suppliers to protect their interests is an important goal in our program integrity work.

Strategic Principles for Program Integrity Operations

CMS program integrity work operates under several broad principles that will guide all current and future program integrity operations. These principles include: shifting our focus to the prevention of improper payments while continuing to be vigilant in detecting

and pursuing problems when they occur; targeting, tailoring, and prioritizing initiatives to focus on high risk areas, while reducing the burden on those that are compliant; leveraging and sharing best-in-class knowledge, practices, and technology to prevent, detect, and address waste, fraud, and abuse; sharing information and performance metrics broadly to engage key stakeholders around the common goal of reducing waste, fraud, and abuse; and engaging internal and external stakeholders with a shared interest in improving the integrity of Medicare and Medicaid.

The Affordable Care Act provides CMS with additional tools to help the Agency tailor interventions to address areas of the most significant risk. Enhanced screening requirements for providers and suppliers to enroll in Medicare, along with oversight controls such as a temporary enrollment moratorium and pre-payment review of claims in high risk areas, will allow the Agency to better focus its resources on addressing the areas of greatest concern and highest dollar impact. Additionally, the face-to-face encounter requirement in Section 6407 of the Affordable Care Act will further enable appropriate payment for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) and home health services, as will the new requirement in Section 6405 that providers who order or refer such items or services be enrolled in Medicare.

CMS is also working to better coordinate program integrity policies and operations for Medicare and Medicaid. CMS is pursuing this through an overhaul of specific contractor functions relating to our program integrity efforts. For example, seven zones were created for the Zone Program Integrity Contractors (ZPICs) based on the newly established Medicare Administrative Contractor (MAC) jurisdictions. These zones address fraud "hot spots." This strategy achieves best value for CMS by leveraging economies of scale and concentrating in high fraud areas.

In addition, CMS has taken several administrative steps to better meet the Agency's future needs and challenges. A realignment of CMS's internal organizational structure, announced on April 11, 2010, consolidated the bulk of Medicare and Medicaid program integrity activities under a new CMS Center for Program Integrity (CPI). This

centralized system enables CMS to pursue a more strategic and coordinated approach between Medicare and Medicaid and forms a bridge that facilitates collaboration on anti-fraud initiatives with our law enforcement partners, such as the HHS Office of Inspector General (OIG), the Department of Justice (DOJ) and the States through State Medicaid Fraud Control Units (MFCUs) who also have program integrity related functions. Furthermore, this new organizational structure with senior leadership positions will allow the Agency to build upon and strengthen existing program integrity programs and operations to combat fraud while also investing new resources and technology to reduce waste, fraud, and abuse before it occurs.

The Affordable Care Act builds on these organizational changes by providing CMS with the ability to improve and streamline its program integrity capabilities in important ways. For example, many Affordable Care Act provisions, such as screening, apply across Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) and the new structure within CMS allows us to ensure that there is consistency in how CMS approaches fraud prevention across our programs. In addition, the Affordable Care Act requires Medicare and Medicaid's program integrity contractors to assemble and track performance statistics. The HHS Secretary is also required to conduct evaluations of CMS' program integrity contractors at least once every three years.

Shifting our focus to the prevention of improper payments, while continuing to be vigilant in detecting and pursuing problems when they occur, involves reexamining our claims and enrollment systems. Due to prompt pay requirements in Medicare, our claims processing systems were built to quickly process and pay claims. CMS pays 4.8 million Medicare claims each day, approximately 1.2 billion Medicare claims each year. Nevertheless, with the new tools provided to CMS under the Affordable Care Act, we are steadily working to better incorporate fraud prevention activities into our claims payment and provider enrollment processes where appropriate.

One of the first steps to ensuring claims are properly paid is to screen providers who are enrolling in Medicare (and also those who revalidate their enrollment) so that claims are

only paid to legitimate providers and companies who meet our new screening standards. In the proposed screening rule published earlier this month, CMS seeks to implement additional enrollment screening procedures and require certain higher risk providers to undergo additional screening measures. Our goal is to keep those individuals and companies that intend to defraud Medicare and Medicaid out of these programs in the first place. CMS will focus additional screenings using a risk-based strategy that will help to identify – and prevent enrollment of – those new and existing suppliers or providers who pose the greatest risk to the Medicare program.

The Affordable Care Act also provides for data sharing between Federal entities to monitor and assess high risk program areas and better identify potential sources of fraud. CMS will soon expand its Integrated Data Repository (IDR) to include claims and payment data, and intends to enter into 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 programs. Also, the Affordable Care Act requires States to report an expanded set of data elements to the Medicaid Management Information System (MMIS) that will strengthen CMS' program integrity work within State Medicaid programs.

CMS currently has and is already using its authority to examine predictive analytics and modeling concepts through several pilots that will utilize new technologies supporting a combination of behavioral analysis, network analysis, and predictive analysis to identify fraud. While these technologies may hold great benefit in identifying and combating fraud, we plan to test them in a series of pilot programs to determine which of the myriad of approaches holds the most promise for Medicare before moving broadly to a wholesale application or system-wide changes. Therefore, CMS expects to conduct a number of pilots that will focus on identifying fraudulent providers on the front-end and recognizing complex patterns of fraud in improper claims and billing schemes.

CMS is very excited about the potential of these new data analysis and prediction tools to improve the Agency's ability to prevent payment of fraudulent claims from ever entering taking place in our system. Before CMS expands predictive analytic tools to prepayment claims application, we are applying predictive analytics and modeling on a post-payment basis. This will allow us to do three things. First, it will help us ensure these technologies will not result in false positives – disrupting payments and business for legitimate providers. It is imperative the predictive models are developed and tested prior to implementation to avoid a high rate of false positives – we want to ensure that claims are paid for legitimate providers without disruption or hassle. Second, given there are many different types of predictive analytics and modeling technologies, it will allow CMS to determine which ones are best suited to Medicare's unique needs. We first want to identify the predictive analytics that are cost-effective and will produce more successful fraud detection than other types of fraud detection measures. Third, incorporating this approach to our pre-payment processes will require significant systems changes. We want to ensure effective use of taxpayer funds; before making a significant investment of CMS resources in complex system changes, we want to ensure we are on the right track.

Additionally, the Affordable Care Act requires both Medicare and Medicaid program integrity contractors to assemble and track performance statistics, including the number of overpayments identified, the number of fraud referrals, and the return on investment (ROI), and to provide such statistics to the Secretary and OIG as requested. In addition, the Affordable Care Act grants the Secretary new flexibility to utilize Health Care Fraud and Abuse Control (HCFAC) funds to hire and train Federal employees for pursuing waste, fraud, and abuse in Medicare, rather than relying exclusively on contractors. All of these new authorities and analytical tools will help move CMS away from its historical "pay and chase" mode towards a closer alignment with strong fraud deterrents and increased enrollment screenings, new disclosure and transparency guidelines, and early identification of high-risk providers and suppliers.

Sharing information and performance metrics broadly and engaging internal and external stakeholders involves establishing new partnerships with government and private sector groups. Because the public and private sectors have common challenges in fighting fraud and keeping fraudulent providers at bay, it makes sense that we should join together in seeking common solutions. HHS' partnerships with the private sector have grown since the launch of the inter-Departmental initiative known as the Health Care Fraud Prevention and Enforcement Action Team, or Project HEAT. In addition to Project HEAT, HHS, CMS, OIG, and DOJ co-hosted the first National Summit on Health Care Fraud in January of this year, bringing together Federal and State officials, law enforcement experts, private insurers, health care providers, and beneficiaries for a comprehensive meeting to discuss and identify the scope of fraud, weaknesses in the current Federal, State and private health care systems, and opportunities to move towards new collaborative solutions.

Building on the momentum generated by the National Summit, HHS, along with its Federal partners, held two Regional Health Care Fraud Prevention Summits across the country this summer. These summits, held in Miami and Los Angeles, provided more opportunities to bring together a wide-array of Federal, State and local partners, beneficiaries, providers, insurers, and other interested parties 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 both providers 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 additional 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.

CMS recognizes that our efforts to implement these strategic principles will be an incremental process. As we seek to reduce waste, fraud, and abuse in Medicare and Medicaid, 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 in need. At their core, Federal health care programs are designed to provide affordable health care to families in need, people with disabilities, and aging Americans. We do not want to prevent beneficiary access to important health care services or needed medications. Furthermore, the vast majority of health care providers are honest people who seek to do the right thing and provide critical health care services to millions of CMS beneficiaries every day.

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 waste, fraud, and abuse in Medicare and Medicaid. The Senior Medicare Patrols (SMP) program, led by the HHS Administration on Aging (AoA), empowers seniors to identify and fight fraud through increased awareness and understanding of Federal healthcare programs. This knowledge helps seniors protect themselves from the economic and health-related consequences of Medicare and Medicaid waste, fraud, 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. Over the last decade, nearly 2.6 million beneficiaries have been educated through approximately 67,500 group education sessions led by SMP staff or SMP projects. On a one-time basis, HHS plans to expand the size of the SMP program in the coming year 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 Summaries Notices (MSNs) are sent to beneficiaries every 90 days. Additionally, beneficiaries can now check their claims within days of the processing date by using either the "MyMedicare" secure website or the 1-800-MEDICARE automated system. A fact sheet and informational card has 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 summits and have been shared with both State Health Insurance Plans (SHIPs) and SMPs.

Also, CMS has improved our processes for reporting, analyzing, and investigating fraud complaints. One of these improvements involves modifications to the 1-800-MEDICARE call center procedures. Previously, if a caller reported that they did not recognize the physician or provider listed and did not receive the service on their MSN form, they were asked to contact the provider prior to 1-800-MEDICARE filing a fraud complaint. Now, when our beneficiaries report that they do not recognize the provider and did not receive a service that Medicare or Medicaid has been billed for, 1-800 MEDICARE will file a complaint regardless of whether or not the caller has attempted to first contact the provider. Also, CMS has created a weekly "fraud complaint frequency analysis report" that analyzes and categorizes providers with high numbers of fraud complaints for the past month and past 12 months.

CMS is in the process of developing a "fraud heat map." As calls come into 1-800-MEDICARE, data will be geographically displayed, which will allow CMS to quickly see shifts in fraud calls over time and to drill down by various parameters such as claim type, geographic location, and fraud type, and to listen to the actual call if necessary. 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. These updated processes will help CMS to more quickly and efficiently examine and address waste, fraud, and abuse issues.

In addition, on June 8, 2010, senior leadership from HHS, CMS, and AoA launched a national fraud prevention campaign to protect Medicare Part D beneficiaries who receive a one-time $250 prescription drug rebate check as a result of the Affordable Care Act. Beneficiaries were proactively informed about potential fraud in order to ensure that they did not mistakenly give out any personal information to scam artists. To date, the fraud

prevention and education campaign has included national TV, radio, and print media advertising running concurrently with the timeframe that the rebate checks are mailed out to eligible seniors each month, and targeted in areas with high percentages of Medicare recipients who will receive the rebate checks, as well as advertising on ethnic radio channels to communicate with groups of seniors who are particularly targeted by fraudsters. The goal of this campaign is to use traditional media avenues, emerging technologies, and existing tools to promote the message of how to protect Medicare from fraud and also ensure that beneficiaries who receive a rebate check do not fall prey to criminals and identity thieves.

In Medicaid, we are actively working to give our State partners the tools to implement important provisions of the Affordable Care Act. On July 13, 2010, CMS issued a letter to State Medicaid Directors on State recovery of Medicaid overpayments. This letter provides initial guidance on how States can move forward in implementing Section 6506 of the Affordable Care Act, which became effective March 23, 2010. Under Section 6506, States now have up to one year from the date of discovery of an overpayment for Medicaid services to recover, or to 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 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 may help encourage States to be more aggressive in rooting out fraud and overpayments. CMS continues to provide technical assistance to States' to support their Medicaid program integrity efforts.

CMS' Efforts to Implement the Affordable Care Act

Initial Steps – CMS-6010-IFC

CMS published an interim final rule with comment (CMS-6010-IFC) in the Federal Register on May 5, 2010 that began the process of implementing the new authorities and provisions of the Affordable Care Act. This rule had an effective date of July 6, 2010. This rule 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 and on all claims for payment submitted under Medicare and Medicaid. This rule also requires physicians and eligible professionals who order and refer covered items and services for Medicare beneficiaries to be enrolled in Medicare. In addition, it adds requirements for providers, physicians, and other suppliers participating in the Medicare program to provide documentation on referrals to programs at high risk of waste and abuse -- specifically, DMEPOS, home health services, and other items or services as specified by the Secretary.

In order to be considered "enrolled" for the purposes of these new statutory requirements, CMS is requiring providers to enroll in the Provider Enrollment, Chain and Ownership System (PECOS). However, in order to accommodate legitimate providers who were still trying to enroll in PECOS when the July statutory deadline arrived, CMS has not yet implemented changes that would automatically reject claims based on orders, certifications, and referrals made by providers that had not yet had their applications approved by July 6, 2010. While more than 800,000 physicians and other health professionals have enrolled and have approved applications in the PECOS system, some providers have encountered problems. CMS is continuing to update and streamline the process, and more providers have been enrolled in the interim. The Agency will take into account the efforts taken by providers to attempt to enroll in Medicare when finalizing the rule early next year.

New Actions – CMS-6028-P

On September 17, 2010, proposed rule CMS-6028-P went on display at the Federal Register. This proposed rule includes a 60-day comment period and seeks comments on CMS' approach to implementing provisions in the Affordable Care Act relating to: establishing procedures to determine the enrollment screening necessary for providers and suppliers; the application fee that will be collected from institutional providers enrolling and revalidating in Medicare, Medicaid, and CHIP; the temporary enrollment moratoria that the Secretary may impose to prevent or combat waste, fraud, and abuse under Medicare and Medicaid; payment suspensions under Medicare and Medicaid; and

the requirement that States must terminate provider participation agreements when providers are terminated by Medicare or another State Medicaid program. The proposed rule also solicits comments on, but does not propose requirements for, core elements of compliance plans. CMS is confident that the new authorities will strengthen the Agency's strong approach to fighting fraud, and looks forward to receiving and reviewing comments from all interested parties during the comment period.

Enrollment Screening and Controls

The Affordable Care Act provides several specific authorities that CMS seeks to implement through the recently released proposed rule. Section 6401 of the Affordable Care Act requires the Secretary, in consultation with the HHS OIG, to establish procedures under which pre- and post-enrollment screening is conducted for Medicare, Medicaid, and CHIP providers and suppliers, including eligible professionals. For purposes of Medicaid and CHIP, States are required to comply with the screening procedures developed for Medicare.

Medicare currently conducts several types of screenings: pre-enrollment licensure verifications; Social Security Number verifications of eligible professionals, owners, Authorized Officials (AOs), Delegated Officials (DOs), and managing employees; checks against the OIG Exclusions Database to determine exclusions imposed on any eligible professional, provider or supplier; and pre-enrollment and/or post-enrollment site visits to high-risk providers, suppliers, or geographic regions. We will continue to expand these types of screenings and add new types of screenings, such as fingerprinting and background checks, for providers identified as higher risk. Additionally, the Affordable Care Act permits the Secretary to impose temporary enrollment moratoria on categories of newly enrolling providers or suppliers if necessary to prevent or deter waste, fraud, and abuse in Medicare, Medicaid, and CHIP.

Suspension of Providers or Suppliers

The Affordable Care Act gives CMS the authority, after consultation with the HHS OIG, to suspend payments to a provider of services or supplier under Title XVIII pending an

investigation of a credible allegation of fraud against the provider or supplier, unless good cause exists not to suspend payments. The law also prohibits a State from spending Federal Medicaid funds on non-emergency services or supplies furnished by an individual or entity under investigation for a credible allegation of fraud. This prohibition, however, is enforceable only if a State has failed to suspend payments already to the individual or entity under the State Medicaid plan. Also, the law provides an exception to ensure a State need not suspend payments to such entities or individuals for good cause, such as beneficiary access to care.

Compliance Programs

The Affordable Care Act also requires that a provider or supplier, as a condition of enrolling in Medicare, Medicaid, or CHIP, establish a compliance plan that contains several specific core elements. The law requires the Secretary, in consultation with the HHS OIG, to establish the core elements for particular industries or categories, and allows the Secretary to determine the date by which providers and suppliers must establish the core elements. As required under the Affordable Care Act, the Secretary must consider the extent to which the adoption of compliance programs is widespread in a particular industry sector or provider/supplier category in determining the date by which providers and suppliers must meet the new requirement.

Other Program Integrity Tools

In addition to the new authorities provided by Congress, CMS has new financial resources at its disposal thanks to the Affordable Care Act. We appreciate the additional $350 million for the HCFAC account and the Medicare Integrity Program over the next 10 years provided by Congress and this Committee in particular. This new infusion of funds, along with the Consumer Price Index for all Urban Consumers (CPI-U) adjustment to the base funds, will provide additional resources for the HCFAC program over the next decade. This investment will allow HHS and CMS to implement and exercise the new authorities in the Affordable Care Act that strengthen the Medicare program through a demonstrable shift toward preventative activities, stricter provider and supplier

enrollment requirements, and expanded oversight controls, such as pre-payment review of claims for high risk items and services.

The $250 million discretionary increase CMS seeks in the President's FY 2011 budget request will support initiatives of the newly established, joint HHS-DOJ HEAT Task Force. Currently, there are HEAT Strike Forces in Miami, Los Angeles, Houston, Detroit, Brooklyn, Baton Rouge, and Tampa. If provided by Congress, this additional discretionary funding would be used to establish up to 13 new Strike Force cities to combat fraud and abuse on the front lines, bringing the total number of Strike Force cities to 20. Funds would also be used to increase our data capabilities and ensure law enforcement has access to our data, which would help stop fraudulent schemes and practices before they take root and expose systemic vulnerabilities being exploited by fraudulent providers. The additional dollars would also fund the implementation of the legislative and administrative program integrity proposals in the President's budget that, if fully enacted and funded, are projected to save about $14.7 billion over the next 10 years.

Conclusion

Health care fraud and improper payments undermine the integrity of Federal health care programs. The loss of taxpayer dollars through waste, fraud, and abuse drives up health care costs. Reversing the problem will require a long-term, sustainable approach that brings together Federal, State, and local governments, Federal, State and local law enforcement agencies, beneficiaries, health care providers, and the private sector in a collaborative partnership effort.

This Administration has made a firm commitment to reigning in fraud and wasteful spending, and with the Affordable Care Act, we have more tools than ever to implement important and strategic changes. CMS thanks the Congress for providing us with these new authorities, 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.

Mr. PALLONE. Thank you both, and now we will have some questions, and I will start with by recognizing myself. In the health care reform bill there is provision, you know, to improve Medicare and Medicaid's fight against fraud, as both of you said, in many different ways. Dr. Budetti, in your testimony you described the shift in fraud-fighting tactics that will come about as a result of these new approaches as moving away from pay and chase towards a more preventive approach. And, of course, the hallmark of health care reform is prevention. So I wanted to ask each of you in Dr. Budetti's case, what do you mean when you talk about shifting away from the pay and chase approach to reducing or towards a more preventative approach?

Dr. BUDETTI. Mr. Chairman, the 2 questions I have been asked most frequently since I took this position are the ones that I am sure that will come as no surprise to anyone, which is why do you let those crooks in the program and why do you pay them when their claims are fraudulent? And our approach to moving away from pay and chase recognizes the fact that we now have people getting into the program, billing the program who disappear before they can be chased and who have no assets when we track them down. Pay and chase evolved from the core purpose of the Medicare and Medicaid programs which was, and is, to provide services to beneficiaries and to do that we need to get providers into the program quickly and we need to pay them promptly, but that speaks to legitimate providers and legitimate claims for the correct services.

What we need to recognize now is that not everyone who is getting into the program and who is billing the program will be there when we chase after them. So moving from the traditional approach, which is always going to be necessary, to go beyond that to preventing the problems in the first place will mean two things in particular. Number one, keeping people out, and to do that we are implementing new screening techniques, new screening measures. The Notice of Proposed Rulemaking that we just published speaks to this by putting providers and suppliers following the terms of the statute into different categories of risk and applying different levels of screening to different levels of risk, and that is an important step forward.

And then in terms of not paying fraudulent claims, we are implementing the—proposing to implement, the new authority that allows us to withhold payments when there is a credible allegation of fraud, which we work closely with the Inspector General on determining what a credible allegation of fraud is. So moving away from pay—moving beyond pay and chase, I should say, to preventing these problems in the first place is an important aspect of what we are doing at the Center for Medicare and Medicaid Services.

Mr. PALLONE. Let me ask Mr. Levinson, can you tell us about some of the benefits you expect to see when these provisions are put into effect?

Mr. LEVINSON. Mr. Chairman, I think it is going to be especially helpful to strengthen the enrollment standards. As I said in my opening statement, to lock the front door. So much of the problem that we have experienced in so many parts of the country have to

do with the ease with which historically you have been able to get a provider number. And I would only elaborate on Dr. Budetti's answer just by noting that my understanding is that historically when the program was much smaller and simpler, perhaps the government even knew who it was doing business with, there was an emphasis on ensuring prompt payment to providers to make sure that doctors and others would want to participate in the Medicare program. And what has occurred over time is that the government has not kept pace with the enormous change, the explosion in size of the program, the increased sophistication of health care delivery and services, and certainly in the modern era too often the government doesn't know who it is doing business with.

And it has been an interesting experience for us in south Florida, just to give you one example, in the year following our anti-fraud strike force work in the south Florida area, DME billing dropped $1¾ billion in south Florida alone just by virtue of people getting the signal that the government was actually watching. So the strengthening of enrollment standards, it would be hard to exaggerate the importance that that will play, I think, in making sure that those masquerading as health care providers don't get in the program in the first place. It is not a panacea. And there are many other fraud, waste, and abuse issues that occur in other aspects of the system. But I would certainly emphasize first and foremost the importance of strengthening the enrollment standards that is included in the ACA.

Mr. PALLONE. I appreciate this. I think it is interesting because I was talking about prevention and preventative care in the context of health care reform. I hadn't thought about prevention in terms of the fraud aspect so much but obviously that is really crucial, and so I am glad to hear that what we are doing has the real potential to make a difference. Thank you both. Mr. Shimkus.

Mr. SHIMKUS. Thank you, Mr. Chairman. I appreciate our panel today. It is a very important issue. Before I go on to this, let me just again put on the record 6-month anniversary, no Secretary Sebelius, no CMS Administrator Berwick, no CMS actuary to give us an analysis on the new health care law. We are more than willing to talk about the good and the bad, the good policies. Republicans repeal and replace, does talk about a lot of the positive things that went on through the law. But we still have to continue to make the point that we are 6 months into a new law without a hearing on the law. Maybe some specific provisions like this one so that is why it is important, but this is our only venue. So people have to understand. Other than 1-minute speeches or 5-minute speeches or special orders, which is not really the venue for talking policy. I know my colleagues get frustrated but we are just doing our job.

This is a really great discussion, and it is a great discussion because it really highlights the health care debate in the aspect of—let me just ask a simple question first. If we go after this process and try to clean it up before the checks go out the door, do our admin costs go up? I am just talking about the administrative costs to be able to have a cleaner system to protect the system for sending fraudulent checks out the door. Mr. Levinson?

Mr. LEVINSON. Mr. Shimkus, I think you have put your finger on a very important question concerning the whole role of IT in being able to really master the system as opposed to simply respond to it, and our office will certainly be looking very closely as this more consolidated and integrated system actually unfolds over the course of the next year or the next 2 years. We certainly have been able to use real time data just by coordinating better with CMS, with the Department of Justice. Our strike force teams have been operating in multiple cities now——

Mr. SHIMKUS. Let me interrupt because my time is real short, but administrative costs are going to go up. New IT programs, new surveillance. I mean there is a higher cost for this on the admin side, is that safe to say?

Mr. LEVINSON. Well, I mean from an audit side, which is certainly part of our office, we will look back to see, you know, exactly how costs have been accounted for but——

Mr. SHIMKUS. But we got to change the way we are doing business now because we don't have the folks to audit on the front end. Dr. Budetti.

Dr. BUDETTI. Thank you, Mr. Shimkus.

Mr. SHIMKUS. It is not a trick question.

Dr. BUDETTI. No, I understand. I think it is very important, I think, for us to keep in mind that the expenditures that have been made over the years since the health care fraud and abuse control program was established have been wise investments by the Congress.

Mr. SHIMKUS. The question is to clean up the system, is there more admin cost?

Dr. BUDETTI. I am not sure whether——

Mr. SHIMKUS. Here is my point. I only have a minute left or 2 minutes left. Here is my point. In this whole health care debate we have always demagogued the health insurance companies because they do what you want to get to. They have higher administrative costs which is what has been demagogued for years here. Why do they have higher admin costs? Because they are trying to make sure that the checks don't go out the door. We send the checks out the door and then we take a 3 or 4 or 5-year process of trying to figure out who stole the money. So what we are saying in reforms here, and I am with you, OK, we have to spend more money. We are going to have to update our IT. We have to have a process to stop the checks before they go out the door and, guess what, this is part of the opening statement, what is going to happen?

And I agree, it is because we pushed prompt payment and we want early enrollment. We don't want anybody—every time we spend money fast here whether it is Iraq, whether it is Katrina, any time we are throwing money at a problem we find fraud and abuse. So we want to have a quick response to get people their money because it is a fee for service system but this is how we responded. We may end up withholding payments until we have an idea of whether—that is what happens now in the insurance industry and people are frustrated to heck because they are saying, oh, the evil insurance. I can't get my payment. Well, they are doing it to make sure that—so now part of our reforms will probably take some of the practices that the profitable evil insurance companies

are doing and roll it into government services to make sure we are not ripped off. So that is my take away. I think it is important to do. My time has expired, Mr. Chairman, and I yield back.

Mr. PALLONE. Thank you. Chairman Dingell.

Mr. DINGELL. Thank you, Mr. Chairman. Gentlemen, we appreciate your testimony here. These questions relate to funding to fight fraud. The Affordable Care Act increased mandatory funding for the health care fraud and abuse control fund by $300 million and index funding for the health care fraud and abuse control fund and the Medicare and Medicaid integrity programs to make sure it keeps up with inflation. Overall funding to fight fraud will increase by about $500 million over the next decade. Gentlemen, can you each discuss the need for the increased funding to fight fraud and can you give us some examples of how you will spend these new resources.

Mr. LEVINSON. Mr. Dingell, it has been exceedingly helpful to see a rise in funding for the health care fraud, anti-fraud control program after many years of essentially plateau expenditures for this vital program that really partners our office with the Department of Justice and with CMS to fight health care fraud in both the Medicare and the Medicaid program.

Mr. DINGELL. When will you be able to spend these additional funds and what benefit will that occur to the public?

Mr. LEVINSON. Some of the dollars we are looking to enhance and expand the strike force operations, some of which you actually spoke to in your statement earlier this morning. In Detroit, the July strike force operations, just to give an example, resulted in 94 indictments in 5 cities, including Detroit that involved $250 million in false billing for DME, home health, infusion, physical and occupational therapy. These strike force operations require resources. They require resources at the investigative end——

Mr. DINGELL. Which they have not had till now.

Mr. LEVINSON. Well, as the programs have expanded over the course of the last 10 or 15 years, and Congress was well aware of the need to structure a program to fight health care fraud when in the mid-1990s as part of HIPA the health care fraud account was established, that account simply did not take into account, if you will, the explosion of dollars, the much larger programs that we have seen since the mid-1990s. So this is important both catch up to be able to devote resources at both the investigative and prosecutorial end as well as take into account the added cost of being able to handle this in a sophisticated, technologically savvy way that the 21st century really requires.

Mr. DINGELL. Thank you. Dr. Budetti, what comments do you have, sir?

Dr. BUDETTI. Yes, Chairman Dingell. We are going to be spending this—we are very grateful to the Congress for making this investment in fighting fraud. This is an important step forward, an important increment over the monies that were already scheduled to be in the health care fraud and abuse control program. We are going to be spending it responsibly to improve our enrollment and screening activities and processes to consolidate many of our contracting activities. We are going to be coordinating Medicare and Medicaid policies to the maximum extent that we can. And we will

be implementing many of the advanced data and analytic techniques that have been discussed this morning as well as improving our data system so we view this as an important step forward in terms of being able to support the kinds of activities it will take to move beyond pay and chase to prevention.

Mr. DINGELL. Thank you, Doctor. Now, Mr. Levinson, it allows the Inspector General to exclude affiliates and officers of affiliates if a parent or sister company is found guilty of health care fraud. What advantage is this going to confer on you and the taxpayers and why is it necessary?

Mr. LEVINSON. Mr. Dingell, it has been problematic for us to be able to actually pursue those who have engaged in wrongdoing in defrauding the system. It has been simply too easy for corporate officials to simply resign, to leave their corporate office. The laws right now are in the present tense so that the ability to exclude those found to have defrauded the system only work when they actually stay in place. Once they leave, we are not really able to pursue them. The ability to actually exclude and go beyond any particular corporate entity allows us in effect to pursue those who actually have engaged in the defrauding of the program and therefore will strengthen our ability to actually capture the people who are taken advantage of.

Mr. DINGELL. Thank you. Just do this, would you, please? Submit to the committee about other legislative changes or additions that you in your agency, and, you, Dr. Budetti, need to address the problems of fraud. For example, piercing the corporate veil of subsidiaries or affiliate companies, being able to seize assets of these corporations, being able to address the officers as opposed to just the corporation because getting the officer makes paying where it is most necessary and most needed, so if you would submit that to the record, I would appreciate it. Mr. Chairman, I thank you for your courtesy to me.

Mr. PALLONE. Mr. Dingell, you asked them to follow up with some written comments? I didn't hear you. Absolutely, any member who wishes to do so. The gentleman from Georgia, Mr. Gingrey.

Mr. GINGREY. Mr. Chairman, thank you. I think we can all agree that there is no room for waste, fraud, and abuse in the Medicare program and to put taxpayer dollars at risk. It jeopardizes the integrity of our seniors' health care program. However, it seems that President Obama and the Democratic majority have a different view about what constitutes waste, fraud, and abuse. On July 30, 2009, President Obama promised that the health plan was funded by eliminating, and I quote, this is his quote, "the waste that is being paid for our of the Medicare trust fund." And then on September 10, 2009, Speaker Pelosi said that Congress will pay for half of Obama Care by "squeezing Medicare and Medicaid to wring out waste, fraud, and abuse." I want to ask the Inspector General, Mr. Levinson, do you feel that the $137 billion cut in Medicare Advantage in the bill is rooting out waste and combating fraud in the Medicare fund?

Mr. LEVINSON. Mr. Gingrey, that is beyond my portfolio to opine on.

Mr. GINGREY. Let me ask you to opine on one other then. The CMS actuary says those cuts will cost 7.5 million seniors to lose

their Medicare plan by 2017, and the benefit reductions that will result are expected to cost seniors on average $250 in extra cost per month. Is charging seniors $250 more a month on average for their Medicare ending waste or combating fraud?

Mr. LEVINSON. I would be happy to defer to Dr. Budetti if he wants to answer that question.

Mr. GINGREY. Well, let us let you do that. I will be happy to seek a response from Dr. Budetti on that particular question.

Dr. BUDETTI. I believe comments by the actuary are also not part of my portfolio.

Mr. GINGREY. All right. Well, let me shift back to Mr. Levinson then. Hospital reimbursement for Medicare seniors are being slashed by $155 billion. This is to the hospital. The CMS actuary projected those cuts could drive about 15 percent of the hospitals and other institutions into the red and jeopardizing access to care for seniors. Is slashing hospital payments to the point where you threaten their ability to stay open and you are threatening seniors' ability to be able to find more that will treat them, is this ending waste or combating fraud, either Mr. Levinson or Dr. Budetti?

Dr. BUDETTI. Speaking to our efforts to reduce waste and combat fraud, I mentioned in my opening remarks that our core commitment is to our beneficiaries, and to do that we need to have the legitimate providers and suppliers in the system as partners with us. We need to work with them and we need to support them. So our approach at our end of the spectrum working on the fraud, waste, and abuse is certainly to keep in mind the critical importance of beneficiary access and the fact that——

Mr. GINGREY. I understand. My time is limited. I will ask one more question, and I will just ask it rhetorically because I understand what the answer would be from both Mr. Levinson and Dr. Budetti. The President and Speaker Pelosi also slashed billions of dollars for home health care and hospice. Hospice, as you know, provides the patients in the last 6 months of their life, those who are suffering in many cases from metastatic cancer. These cuts threaten the quality of health care for patients in the last stages of their lives. And, again, I would ask in your opinion is cutting hospice payments ending waste or combating fraud in the Medicare program, and our witnesses have already said to the previous questions this is not really in their jurisdiction.

But, Mr. Levinson, this question, I think, is in your jurisdiction. These 30 provisions in Obama Care that result in $6 billion, and this is the Congressional Budget Office estimate, not mine, $6 billion in savings over 10 years, that is about half of one percent, and we are estimating here that we are wasting $68 billion a year. In fact, the FBI says $226 billion a year. We got 30 provisions in the bill that saves $6 billion. Mr. Levinson, didn't you make recommendations to the Senate Finance Committee and indeed maybe even to this Committee on Energy and Commerce regarding the bill as it was being developed a lot more recommendations in regard to cutting waste, fraud, and abuse that would amount to much more than $6 billion a year in savings, and why weren't they included in the bill?

Mr. LEVINSON. Mr. Gingrey, it is certainly true that our office has provided technical assistance to both the House and the Senate

over the course of the last year or year and a half as the legislation went through, and that is a very important part of our job. We report to the Secretary but we also report to the Congress, and we endeavor to try to provide the best technical assistance. That assistance was directed towards the health care fraud provisions, Title 6 mostly, although perhaps not entirely. I think there might be elements in other titles, but primarily Title 6, title assistance, and it was a matter of responding to member requests on how to handle, how to phrase, how to craft particular initiatives. And if there are added questions from Congress and certainly we will be looking at how the law unfolds over the course of the next couple of years much as we did with MMA when it was passed in 2003. Our office has done significant work on Part D to try to understand where the possible problems are there. We certainly will be doing the same with the Affordable Care Act.

Mr. GINGREY. Mr. Chairman, I yield back. I realize I have gone beyond my time and I thank you for your patience, and I request that Mr. Levinson would submit his annual recommendations in combating waste, fraud, and abuse to the committee. I would appreciate that for the record.

Mr. PALLONE. Is that something that is already out? OK. Thank you. We ask you to do so. Chairman Waxman.

Mr. WAXMAN. Thank you, Mr. Chairman. The Affordable Care Act included a series of program integrity provisions that CBO estimates will save federal taxpayers $6 billion over the next 10 years. The Act provides CMS and the Inspector General with dozens of new tools to prevent fraud and keep fraudulent providers out of Medicare and Medicaid. It has new civil and criminal penalties. It has new data-sharing requirements and it provides $500 million in new funding to fight fraud. Dr. Budetti, some have called for repealing the Affordable Care Act. What effect would repeal have on your agency's ability to detect, stop, and prosecute fraud against Medicare and Medicaid?

Dr. BUDETTI. Mr. Chairman, the Affordable Care Act has so many strong provisions in it that are the central part of our initiative to move forward to keep people out of the program who don't belong in the program and to avoid paying claims that are fraudulent. It also provides the support for us to do that——

Mr. WAXMAN. Keep people out of the program, are you talking about beneficiaries or providers?

Dr. BUDETTI. To keep fraudsters out of the program, to keep scam artists, to keep people who would enter the program simply to be able to submit bills and not provide legitimate services, to keep those people, the bad guys, out of the program. And the Affordable Care Act provides us new and expanded authorities that are absolutely central to our ability to do that going forward. It also provides the increased financial support that is important to us. It provides a new level of flexibility in how we go about this so that we can be nimble and adapt to the changing problems that we see all the time. These are very important provisions in terms of the ability to protect Medicare and Medicaid resources, Mr. Chairman.

Mr. WAXMAN. Well, some have called for repealing the Act but others have called for defunding the agencies that implement the

Affordable Care Act. What effect would defunding have on CMS' ability to fight fraud?

Dr. BUDETTI. The activities that we are doing to implement the Affordable Care Act, the new provisions, are on top of a very, very large array of activities that have been going on for some time. All of those are demanding on staff and on our resources. Any serious limitations on our ability to carry out these programs would mean that the likelihood of getting a return on investment would go down. The less we invest in fighting fraud the less of return on that investment that we would see over time.

Mr. WAXMAN. Mr. Levinson, what is your view, would eliminating and defunding the new anti-fraud provisions in the health care reform bill impact the work of the Inspector General to reduce fraud?

Mr. LEVINSON. Mr. Chairman, that is beyond my portfolio to opine on. We take the law as passed by Congress and we try to make the laws most effective and——

Mr. WAXMAN. If you didn't have this law, do you think that your anti-fraud efforts or the Department's anti-fraud efforts would be weakened?

Mr. LEVINSON. Well, we think that many of the provisions, especially in Title 6 that strengthen the enrollment standards, are very helpful in being able to create much greater controls over the program so that fraudsters are not able to gain entry. We think that mandated compliance programs, which also is included in the Act, will be very helpful in getting so many of the lawful providers the kind of assistance and the kind of incentives to structure their program so that they are not either advertently or inadvertently in violation of Medicare and Medicaid rules and guidance. So unquestionably there are many features of this Act that I included in my opening statement that are very beneficial to ensuring that the programs will run with far less exposure to fraud, waste, and abuse.

Mr. WAXMAN. Mr. Chairman, there are plenty of good reasons why repealing the Affordable Care Act is a terrible idea including the fact that repeal would increase Medicare and Medicaid fraud. I just want to make that statement very clear because when we hear people on the other side of the aisle complain they don't like the Act, they want to repeal it, they want to stop the agency from getting funded, what they are in effect saying as it relates to today's hearing is that they are going to increase Medicare and Medicaid fraud when the policeman on the beat, which is the department, and others in this area are not given the tools to fight fraud and abuse. I think it is clear that fraud and abuse would be increased rather than decreased. I yield back the balance of my time.

Mr. PALLONE. Thank you, Mr. Chairman. Next is the gentleman from Texas, Mr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman. Just to reference the chairman of the full committee's remarks, I would submit that the bill itself is a fraud that has been perpetrated on the American people but it is what it is, and we got to make the best of it. So the Patient Protection and Affordable Care Act predicts a drastic cost savings from fraud prevention to cover the $500 billion in cuts to Medicare, as well as allocating 10 million annually for the fiscal

years 2011 through 2020. The Reconciliation Act that was passed right after the bill provides an additional $250 million for the period 2011 through 2016 for health care fraud and abuse program. In order to combat fraud and use the money in the most effective manner, do you think—I will actually direct this question to either or both of you, in order to combat fraud and use the money in the most effective manner, do you believe it would be beneficial to hire more federal prosecutors as I referenced in my opening statement with a background in health care fraud to combat this problem as opposed to hiring prosecutors with no previous health care experience?

Mr. LEVINSON. Mr. Burgess, we have had over the course of years a very, very good and productive relationship with the Department of Justice, the civil division, the criminal division, United States Attorneys in all 94 districts. Unquestionably, I think there is more focus on health care fraud in some parts of the country and in some districts than in others. We certainly want to encourage as much expertise to be imbedded in the Department of Justice as possible. We know that they rely upon the expertise of our investigators, our agents, for a lot of the work that we do as well as the FBI.

Mr. BURGESS. I don't mean to interrupt, but we had this discussion, of course, last week as well. In my area in Texas, in the north Texas area, I asked people from HHS, Office of Inspector General, as well as Department of Justice to come and talk to me about some of the problems we were having with foreign nationals who were setting up sham operations and literally just ripping the government off. The figure I reported was over a million dollars from one individual who is now in jail thankfully. But I was told by both your folks in the Office of Inspector General and as well as the Department of Justice that they lack prosecutorial manpower to go after. In fact, there were certain levels where they wouldn't even bother to bring a case. I forget what the level was, but I was startled by the size of the number. And I recognize that terrorism is important and I recognize that there are lots of other places we need to spend our money but this is important as well.

Mr. LEVINSON. Absolutely, and I am not trying to dodge the question. The question really is best posed in the first instance to the Justice Department because they are the ones who need to take responsibility for their resources. I can say though clearly that it is a testament to how hand in glove we work with out partners at DOJ that you can meet with folks from both of these departments and get whatever picture they are giving you about your neighborhood and what is going on and what needs to be done. And it is absolutely true that no matter how many investigators you have if you don't have the prosecutorial backup then you have cases that are simply lingering and really not doing enough for the system.

Mr. BURGESS. I understand. And you referenced in your opening statement about you have to lock the front door. You know, we go after a lot of this stuff for post-payment review and the figure I have here that fewer of 700 of the 8.7 million claims were reviewed. That is a pretty small number. Is there any way to prospectively—we never hear of Aetna, United Health Care, Blue Cross/Blue Shield having these types of problems. Sure, there is

probably improper utilization with those payers as well but it is never to the order of magnitude that it is with the public programs. Is there a way to do it prospectively?

Mr. LEVINSON. Mr. Burgess, I think that the National Health Care Anti-Fraud Association, those who actually deal with anti-fraud efforts in the private sector, might be able to provide some useful detail on what is going on on the other side of the ledger, and health care indeed is a hybrid system in the country where you have both robust, private and public sector involvement. We deal at the IG's office with the system that we have, and we certainly try to encourage our partners in the department to try to clarify and make more transparent what is going on so that we can do our job better and indeed they can do their job better.

Mr. BURGESS. That figure of 10 percent, if you think of any company, any private company, publicly held company in this country that had a 10 percent loss rate due to theft would certainly try to get its arms around that. Two things that do concern me, the anti-kickback statute and the health provisions of the criminal mail fraud statute. I am concerned that we may turn innocent coding errors into federal cases. What are you doing to kind of protect what may be simply an innocent mistake from someone who then receives the full force of the federal prosecutorial force?

Mr. LEVINSON. Yes. That is a very important question, and indeed I think just looking at the improper payment problem is kind of a good macro example of what we are talking about because the programs do suffer from a lot of improper payments. In many cases, that has to do with documentation that for one reason or another is not fully exposed on the record. It simply is a failure of documentation. That might be hiding fraud. But in many cases, probably in most cases, it isn't. There is something else going on. There is still a failure to document but improper payment does not equate with fraud and proper payment doesn't equate with lack of fraud.

It is very possible to get the payment system looking right and indeed what it is doing is it is masquerading some fraudulent scheme. So when it comes to health care and some of the sophisticated kinds of scams that are occurring it really requires an information technology system and the cooperation of a lot of different parties to be able to tease out the kinds of very serious issues that you are raising and that need to be done as a result certainly of the added dollars that are being provided now for health IT. Those dollars need to be focused in significant part, in my opinion, on making sure that we don't fall into those kinds of problems where you do have genuine providers who are then being questioned on a very fair record because we have gotten the IT piece wrong.

Mr. PALLONE. We are over time here. Thank you. Next is the gentlewoman from Florida, Ms. Castor.

Ms. CASTOR. Thank you, Chairman Pallone, very much. Dr. Budetti, on October 1 the private health insurance companies will begin to market to seniors all across the country for private Medicare plans. I have been concerned for many years about some of the marketing practices and have direct experience with this with some insurance company sending agents to assisted living facilities or nursing homes to try to sign up seniors. Often times if they were

on traditional Medicare they would lose access to their trusted doctor. I have seen them camped out in front of senior apartment complexes to try to get them to sign up and use high pressure sales tactics. The problem is a few years ago the Medicare Modernization Act took away the authority of our state insurance commissioners to go after these fraudulent practices so now the burden is wholly on HHS and the federal government.

In the House version of the health reform bill, I had an amendment, it was a bill I had, to restore the authority of our state insurance commissioners and consumer advocates to go after those practices. And that didn't make it in the final package unfortunately, but these abusive tactics remain, and I am very concerned because they prey on seniors that often lack the wherewithal to withstand the high pressure tactics or may suffer from dementia or Alzheimer's. And what can you do, what tools do you have where you can work with the states to make sure that you are taking action against those type of marketers and what—I really want to understand what you can do, what authorities you have, what else do you need? Obviously, we have got to return some authority to the state insurance commissioners. Consumer advocates are strongly behind this proposal, but in the mean time until we do that, what can you do to work with states to make sure we are going after those folks?

Dr. BUDETTI. Thank you for that observation and question. One of our priorities at the Center for Program Integrity has been to expand our work with beneficiaries to help them become, really, partners in spotting and preventing scams from occurring in the first place. We are working closely with the Administration on Aging to expand the Senior Medicare Patrol, which trains seniors to review their Medicare statements. We have been rewriting those Medicare summary notices so that they are more user friendly. We have been encouraging people to use My Medicare system so that they can review their claims on an immediately up-to-date basis, and we have had a lot of outreach and consumer education that we have been doing.

I think you are aware that we have been holding regional fraud prevention summits around the country. We held one in south Florida, the first one in south Florida. In fact, at that summit a major piece of it was to work with beneficiaries and interact with beneficiaries on how they could help in preventing and fighting fraud. So one major aspect of what we are doing is to get the beneficiary community more aware and give them more tools to work on this. In south Florida, in fact, we have established a separate hotline specifically for that purpose because of the problems that we see, but also because we are promoting the awareness down there. So beneficiary outreach and involvement in education is a very big piece of what we are doing.

We also, of course, have our oversight of the Part C Medicare Advantage plans. And we do have our responsibilities to oversee them and to look closely at whether they are complying with the requirements that are imposed on them and also with respect to the way that their funding is working.

Ms. CASTOR. Mr. Levinson, do you have a comment and what happens if someone gets caught, if the company gets caught with

these high pressure tactics or coming into a nursing home when they are not allowed? What is the penalty?

Mr. LEVINSON. Well, I wouldn't want to speculate, I will put it that way, Ms. Castor, on exactly what would happen given that we have 400 investigators who really follow up very conscientiously on health care fraud allegations of a wide variety and depending upon the particular facts of what happened there could be very serious penalties.

Ms. CASTOR. I just think that this should be a shared responsibility, that our states have additional tools that can help protect seniors from these high pressure tactics that often result in seniors not being able to see those other doctors. And under the Medicare Advantage plan oftentimes you are signed up, you can't get back out. It is a pain to try—if there has been some fraud committed to actually switch back out of a private plan back to the coverage you had.

Mr. PALLONE. I have to ask the gentlewoman—we are a minute over.

Ms. CASTOR. OK. Thank you.

Mr. PALLONE. Thank you. The gentlewoman from the Virgin Islands, Mrs. Christensen.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman, and, thank you, Dr. Budetti and Mr. Levinson. Dr. Budetti, CMS is requiring providers to enroll in the provider enrollment chain and ownership system, and the deadline has effectively passed although you haven't started rejecting the claims. In your testimony you said that over 800,000 providers have enrolled. Do you have any idea how many of those are minorities or how well those practicing in poor or rural areas are represented? Many minority doctors, for example, practice in poor communities, and Medicare and Medicaid make up a large part of the patient's payment form. So what special outreach, if any, has been done or is being planned and do you plan to track enrollees by racial, ethnic, geographical or any other data? The Affordable Care Act has placed a lot of emphasis on diversifying our work force reaching out to under represented minorities and making sure that the programs reach rural areas.

Dr. BUDETTI. Dr. Christensen, I am not aware that we have any data on the backgrounds, demographic backgrounds, of the enrollees to that extent. I do know that we are making major efforts to conduct outreach to all the providers who are required to enroll and to improve our systems to be able to handle the enrollments more efficiently, and I will be delighted to look into that issue and see whether there is an opportunity for us to do exactly what you suggest.

Mrs. CHRISTENSEN. My office will be working with MMA and some of the other organizations to try to make sure that they understand some of the provisions and are able to take advantage of the benefits. Mr. Levinson, as a physician who interacts with pharmaceutical reps during my practice, although it was a while ago, I am interested to know what would be considered a transfer of value, transfer of value, sample meds which we use to help poor people get their medications, pens, trinkets, CMEs with a meal, none of those really influenced me and I am sure don't influence the majority of providers who are really just trying to do what is

best for their patients and help them to get a better health outcome. So what do you think would be considered a transfer of value which is required to be reported under Section 6002?

Mr. LEVINSON. I would respectfully ask that my counsel provide you a legal definition, and I say that in part because some of the examples that you were alluding to based on your own practice and experience don't strike me as the kinds of things that are actually being targeted by that law, so I think it would be helpful to get not my off the cuff, off the top of my head, definition of that but for you to get our counsel's explanation of what exactly that includes.

Mrs. CHRISTENSEN. Thank you. And I guess, Mr. Budetti, you talked a little about the outreach to beneficiaries, and I remember beneficiaries getting their notices of information from Medicare and coming in and my having to sit down and interpret them for them. Again, you have a lot of people who don't have a lot of education working in low level jobs who are now Medicare beneficiaries and are going to have a lot of difficulty not only understanding the information that is sent out but even going through their bills. And they have such an important role to play along with both of your offices and the Department of Justice so how do you plan to help these beneficiaries understand what their role is and how do you plan to reach them?

Dr. BUDETTI. Dr. Christensen, when I first started thinking about how we were going to go about this, I asked my colleagues if any of them had tried to read their explanation of benefits recently.

Mrs. CHRISTENSEN. It hasn't changed.

Dr. BUDETTI. And I was reassured that that was a challenging task to put it mildly. So one of the first things that we did was to start working with Medicare beneficiaries to have focus groups and specifically work with them on how to make the Medicare summary notices more user friendly and more readable, and we also want to highlight in the summary notices what we are looking for, what we want them to look for by way of potential problems. So we are working on it on that end to try to get the documents that we are sending to them to be more usable, but we are also working, as I mentioned, with the programs that are in place, the Senior Medicare Patrol, who educate beneficiaries, and it is a train the trainer approach where they will go out. So we are addressing this, I think, on 2 fronts and I am optimistic that this will pay off.

Mrs. CHRISTENSEN. Thank you. Thank you for your answers. Thank you, Mr. Chairman.

Mr. PALLONE. The gentleman from Maryland, Mr. Sarbanes.

Mr. SARBANES. Thank you, Mr. Chairman. There is a good piece of legislation on the floor today, H.R. 6130, the Strengthening Medicare Anti-Fraud Measures Act of 2010, which will give you all some additional tools in terms of combating fraud. In particular, this would provide more clarity on the rules for excluding individuals and companies from the program based on findings of fraud and associations they have with companies that have been fraudulent, and I just wanted to make sure for the record I assume you all are very supportive of this additional set of tools.

Mr. LEVINSON. Mr. Sarbanes, we don't explicitly endorse bills but I do want to note that 6130 closes a statutory loophole that allows

corporate officials to escape liability simply by resigning their job. And current law is written in the present tense so an executive of a corporation that engaged in criminal fraud can evade exclusion simply by resigning before the corporation is convicted. And 6130 would hold responsible those individuals that are ultimately in charge of the corporations that defraud the health care programs and taxpayers. The legislation would also help in the shell game in which large corporations resolve criminal liability by pleading guilty through a shell subsidiary. Under current law if a single entity within a chain of entities is sanctioned our office can exclude the sanctioned entity's subsidiaries but cannot exclude its parent or sister corporations regardless of whether they are related entities or operator-owned by the same people. So by reaching affiliated entities the legislation will provide new incentives to corporations to promote compliance and police the activities within their corporate families.

Mr. SARBANES. Great. Thank you for those comments. Let me ask you this question. There was a discussion about administrative overhead and I assume that when it comes to combating fraud both prevention measures would be part of administrative overhead as well as the pay and chase or really, I guess, the chase element of it, right, is going to be counted as administrative overhead, would it not?

Dr. BUDETTI. I think that is an important consideration, Mr. Sarbanes. We have to take a look at the entire spectrum of what it will take on the one hand to implement these provisions and on the other hand where the savings will be in terms of things that we might not have to do down the road.

Mr. SARBANES. So it is conceivable that the administrative costs, the net administrative costs, could go down if you are more effective in the prevention side of things and have to spend less money chasing folks after they have been paid. That is, I guess, the point I was making. The other thing was Congressman Shimkus raised an interesting point which is, you know, comparing the overhead and administrative costs on the private side with the public side in Medicare, and, you know, noted that there is sort of the evilness of the insurance companies in terms of their administrative costs as often pointed to by the critics as the way the insurance companies operate. My own sense, and I am not asking you to necessarily respond to this, but my own sense is that the evilness is not so much that they have got good warranted prevention efforts on the front end that may add something to their administrative costs, it is that with respect to providers that have already been vetted and are providing legitimate services and are legitimate providers that there is a whole part of the operation that is dedicated to denying payment and wearing those folks down, and that actually consumes a tremendous amount of administrative costs that don't have to be part of the equation.

I am going to run out of time in about a minute, so let me ask you something else. What amount of the fraud, would you say, is attributable, saying you can quantify it at all, to providers that are just completely non-existent? In other words, it is just a paper provider, right, who managed to get hold of a provider number and has figured out a way to completely create out a whole cloth of doc-

umentation and other things that get submitted to be paid versus—and in that case you are talking about harming the system and harming beneficiaries in an indirect way and the huge amount of dollars that could be going for legitimate services are going to non-existent providers, so there is that category of fraud and abuse. Versus situations where the provider exists but they really set up shop to push through services that are unnecessary in which case you are talking about a direct effect on the patient as a result of that fraudulent activity because they are being put through tests and other things that they don't need. Do you have sense of kind of the percentage in each of those areas?

Mr. LEVINSON. Quite honestly, Mr. Sarbanes, I cannot give you percentage. Health care fraud is perpetrated on the street, in corporate 500 offices, by doctors, by pharmacies, by beneficiaries, but of course the great majority of all of those categories are not engaging in health care fraud, but we see it pop up in such a wide variety of context it is rather difficult to be able to sort out given that——

Mr. SARBANES. Well, I am out of time.

Mr. LEVINSON. But I would like to finish by noting that when, and I made allusion to this earlier, during the year after our strike force work in south Florida DME billing went down by 63 percent, and it is so crucial to get control of enrollment because enrollment fraud is the kind of problem where people masquerading as health care providers are getting into the program. Take care of the enrollment issue and unquestionably you have resolved a certainly important percentage. I can't give you the number but a significant problem has been eliminated.

Mr. SARBANES. Thank you.

Mr. PALLONE. Thank you. Let me thank both of you. I mean, obviously, this has been very helpful to us.

Mr. SHIMKUS. Mr. Chairman.

Mr. PALLONE. Yield to the gentleman.

Mr. SHIMKUS. This has been vetted to the majority, another letter in support of Peter Roskam's bill. If we could submit that for the record, I would appreciate it.

Mr. PALLONE. Without objection, so order.

[The information appears at the conclusion of the hearing.]

Mr. PALLONE. I just wanted to thank you because I think this has been very helpful, not only in terms of what you are doing under the health care reform bill but other ideas that might be useful. We had the two members of Congress testify before and they have some legislation. I guess Ron Klein's or part of it is actually on the floor today. That is what Mr. Sarbanes was talking about, so this is helpful to us as we move forward. Thank you very much. As you notice, some members had asked some questions and you may get additional ones within the next 10 days, and we would ask you to try to get back to us with a response as soon as possible.

But without any other objection, this hearing of the subcommittee is adjourned.

[Whereupon, at 12:10 p.m., the Subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Opening Statement of the Honorable Joe Barton
Ranking Member
Committee on Energy and Commerce

Subcommittee on Health Hearing
Cutting Waste, Fraud, and Abuse in Medicare and Medicaid
September 22, 2010

Thank you, Chairman Pallone, for holding this hearing today on waste, fraud, and abuse in Medicare and Medicaid.

As we know and have known, Medicare and Medicaid are permeated with problems and the cost is absolutely staggering, with dollar figures almost beyond comprehension.

In 2005, *The New York Times* published a eye-opening series of reports on the New York Medicaid program, finding that over 10 percent of the taxpayers' dollars going into the medical welfare program there paid off claims that were criminally fraudulent. According to state's chief investigator for Medicaid fraud, "40 percent of all claims are questionable." Since the New York State Medicaid program spends $50

billion per year, this means that up to $20 billion in taxpayer funds appear wasted in just one program, in just one state, and in just one year.

These findings were backed up by a comprehensive study produced by Thomson Reuters in October of 2009. It estimates that between $600 billion and $850 billion of what taxpayers spend on government health programs each year is wasted. That's about a third of every dollar spent.

Mr. Chairman, President Obama has told us over and over that half of the costs of his health program would be paid for by reductions in waste, fraud, and abuse. Unfortunately, the Congressional Budget Office says he's almost completely wrong. The CBO projects that ***all*** of the so-called integrity provisions for Medicare, Medicaid, and SCHIP that are in the ObamaCare legislation will ***only*** reduce federal spending by about $6 billion between 2010 and 2019. So in nearly a trillion dollars worth of programs that are known to be rife with abuse, the Obama Administration will manage to save $600 million. $600 million

seems like a lot of money, and it is, but in this case it amounts to a fraction of one percent of the ObamaCare spending extravaganza. That's like a raindrop in a hurricane. .

Still, baby steps are better than none. While I do applaud the Majority for at least acknowledging the existence of waste, fraud, and abuse in taxpayer-funded health care programs, clearly we must do better. And it is my sincere hope that we will use this hearing as an opportunity to focus on how we can travel the miles we still have left to go to achieve our goals instead of applauding ourselves for the small steps we have already taken.

I would also like to note that tomorrow is the six-month anniversary of the Democrats' ObamaCare package being signed into law, and just as Republicans, independents, and a few brave Democrats predicted, insurance premiums are rising and people are losing their current health insurance coverage as a direct result of the flawed provisions in that legislation.

Reports of problems in ObamaCare abound, but has this Committee held a hearing on its implementation? No. In fact, this Subcommittee has held 15 hearings since its passage, but not dealt with the most radical change to every American's health care in generations. The same is true of the subcommittee on Oversight and Investigations: seven hearings since passage—not one on Obamacare.

As all of us have noticed lately, people back home are experiencing the unhappy reality of the federal government's health care takeover. And as many news reports indication, many people seem to prefer a Congressional Majority that wants to get the truth from the Obama Administration about what's gone wrong. I know the seniors in my district are completely clear about their desire to have us look into the Administration's plans to cut $575 billion from Medicare. They also want to know about statements by the Chief Actuary of Medicare that providers "could find it difficult to remain profitable" and might "end their participation in the program."

And any American concerned about the disastrous spending policies of this Administration and the current Majority would want oversight over recent revelations that after passage of ObamaCare, health care spending is projected to increase *more* than CMS had projected before passage.

During the run-up to passage, miracles were promised day in and day out. Seniors were told the law would strengthen Medicare, only to see reductions to the program spent on new entitlements. Everyone was told the cost curve would be bent down, only to see the Administration's own actuaries report it will continue to go up.

Families were told that if they liked their current coverage they could keep it, only to learn that the law encourages employers to drop coverage, that health insurers will pass along increased costs through increased premiums, and that every plan will be subject to a host of costly new federal rules and restrictions.

Where is the oversight? Where are the hearings? As the election nears, I would like to note that the American people seem to want a new kind of Congress, one that is willing to find its mistakes and to fix them.

Again, Mr. Chairman, I thank you for holding this hearing, and I look forward to hearing the testimonies of our witness. With that, I yield back the balance of my time.

Caring that Feels Right at Home

September 20, 2010

The Honorable Peter J. Roskam
U.S. House of Representatives
507 Cannon House Office Building
Washington, DC 20515

Dear Congressman Roskam:

On behalf of the American Association for Homecare (AAHomecare), I would like to thank you for introducing H.R. 5546. AAHomecare is pleased to support this important legislation, which will improve the tools and resources available to prevent fraud and abuse in Medicare through the use of predictive modeling technologies. These technologies are far more effective at protecting Medicare funds than the "pay and chase" method and will reduce the number of unnecessary and burdensome audits that CMS and its contractors are now pursuing.

H.R. 5546 will create a system that mirrors one of the key recommendations from AAHomecare's anti-fraud proposals: implementation of real-time data monitoring technologies to analyze and detect fraudulent Medicare claims before they are paid. The Association would like to work with Congress and CMS to ensure that the predictive modeling system is appropriately designed to target fraud while neither increasing the regulatory burden on providers who file legitimate claims nor inhibiting timely payment of legitimate claims.

AAHomecare has been on record for many years in support of new measures designed to root out fraudulent activity within Medicare. We are very pleased that you have demonstrated leadership in proposing an aggressive, proactive approach to stopping fraud.

The Association looks forward to continuing to work with you, Congress, and the Administration to reduce fraud and abuse in the Medicare program.

Sincerely,

Tyler J. Wilson
President
American Association for Homecare

2011 Crystal Drive, Suite 725, Arlington, VA 22202-3709
tel: 703.836.6263 fax: 703.836.6730 www.aahomecare.org

Statement of Mary Kay Owens
President, Southeastern Consultants, Inc.
Clinical Associate Professor, University of Florida College of Pharmacy,
Department of Pharmaceutical Outcomes and Policy
For the
Committee on Energy and Commerce/Subcommittee on Health
U.S. House of Representatives
Hearing on "Cutting Waste, Fraud, and Abuse in Medicare and Medicaid"
September 22, 2010

Chairman Pallone, Ranking Member Shimkus and Members of the Subcommittee,

I submit this testimony for the record because it addresses one of the greatest causes of waste and inefficiency in Medicare, Medicaid and health care in general. That cause is variation in utilization and practice caused by extreme, uncoordinated care. The Nation has tens of trillions of dollars of unfunded obligations it must find a way to pay for. Much of that comes from health care costs. Having some families pay for the costs of other families does not address the waste in the health care system or the poor quality that comes from uncoordinated care. The key insight is that there is a tremendous variation in costs and utilization of services based on the level of uncoordinated care; the costs posed from waste by uncoordinated care is, by our estimate, over $240 billion a year. The good news is there are steps we can take to reduce this waste.

Below I will summarize an analysis of the extent of uncoordinated care, its features, and its costs to the country. There are many more insights. This study has been reviewed by the Institute of Medicine and will be published in the near future. One of the keys to the approach in the study is using algorithms that identify indicators of uncoordinated care which can be applied to any claims level healthcare data base. This allows us to provide a score of uncoordinated care and to gauge the variations in practice, utilization, and cost based on such a score.

While the study and methodology provides great insights, the methodology can also be used in a system to reduce uncoordinated care, focus care coordination resources, save money and improve quality. Specifically, this methodology can provide actionable information to payers and providers who can follow protocols that identify the problem, focus resources, and correct the problem. We should not tolerate hundreds of billions of dollars being wasted each

year or the poor quality and sometimes harmful inconsistencies that result from uncoordinated care.

This same approach can provide us a metric to measure the performance of a care system and the effects of steps to improve it. Positive actions should reduce the amount of uncoordinated care over time. Certain population characteristics and insights can also help with development and validation of Medicare and Medicaid payment models and policies.

I note that H.R. 5546 which is a subject of this hearing has mechanisms of using statistical analysis of data which can be modified to accommodate uncoordinated care analyses for the Medicare and Medicaid populations. I support this approach in H.R. 5546 and would like to work with the Committee to improve the bill explicitly to address uncoordinated care.

With respect to the study, Southeastern Consultants, Inc. (SEC) performed comprehensive claims analyses on over 9 million Medicaid-only enrolled patients and Medicaid/Medicare dually enrolled patients for five large states, which included utilization and expenditure analyses of drugs and medical services, a disease profile of the population, and the identification of access patterns indicative of uncoordinated care in a subset of the population. SEC examined drug and medical utilization and costs attributed to these extremely uncoordinated care patients in an effort to supply policy makers addressing health care reform at the state and federal levels with compelling new data as to the importance of improving the coordination of care. In addition, SEC conducted statistical-based, predictive modeling to estimate future expected costs and created matched comparison groups to further evaluate estimated program savings following a multiple intervention approach to better coordinated care using a patient-centered, primary care medical home model with enhanced health information technology applications and provider incentive payment models.

Using the claims data, patients were separated into Medicaid only, Medicare dual eligibles and long term care subgroups and screened for patterns of uncoordinated episodes of care and the absence of a medical and pharmacy home. Patterns identified included utilizing excessive numbers of prescriptions, therapeutically duplicative drugs, frequently changing drug therapies, using multiple prescribers and multiple pharmacies concurrently and in random patterns, accessing the ER frequently and/or for non-emergent care, and numerous other access patterns indicative of uncoordinated care. The vast majority of identified uncoordinated care patients had at least one chronic condition.

Analysis Findings

1. **For the Medicaid only enrolled group, patients exhibiting patterns of extreme uncoordinated care represent a small percentage of all patients (10%), yet account for a significant percentage of program costs (30%).**

   - Uncoordinated care patients represented less than 10% of patients yet accounted for an average of 46% of drug costs, 32% of medical costs, and 36% of total costs for the population. **(Figure 1)**

2. **For the Medicaid only enrolled group, extreme uncoordinated care patients have significant differences in all cost service components, including lab, outpatient, emergency room, pharmacy, practitioner, and hospital services.**

   - Uncoordinated care patients had average annual total costs of $15,100 Vs $3,116 for those with better coordinated care in the remaining population. **(Figure 2)**

Figure 1

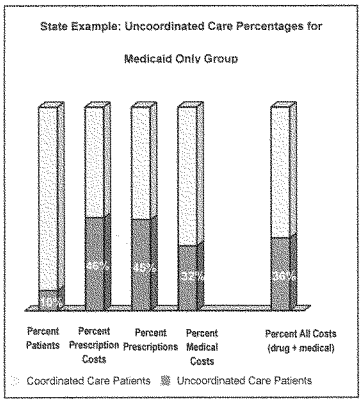
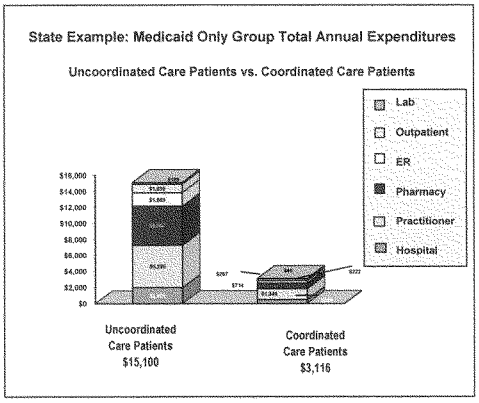


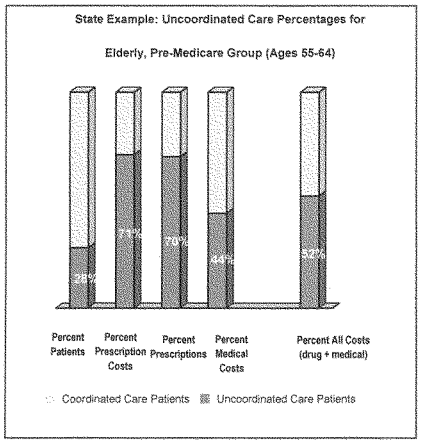
Figure 2



3. **For the subset of elderly (Pre-Medicare) patients aged 55-64 years old, those exhibiting patterns of extreme uncoordinated care represented about 28% of patients, yet accounted for a very large percentage of costs (52%).**

   - Uncoordinated care patients represented 28% of patients in that age group yet accounted for an astounding 71% of drug costs, 44% of medical costs, and 52% of total costs for that population. **(Figure 3)**

Figure 3



National Cost Savings Estimates

SEC analyses support average overall savings estimates of approximately 9% of the total direct medical and drug costs incurred per year.

The subset of the population with the most savings opportunities are those that are receiving extremely fragmented care and are accessing the system in a very inefficient and uncoordinated manner which in turn creates unnecessary costs and compromises quality of care for the entire system. These patients account for a disproportionate share of costs which averages approximately 30% of total plan costs. Based on multiple analyses completed, an average of 35% of the costs contributed by patients with extremely uncoordinated care should be avoidable with improved efforts of care integration, enhanced and targeted interventions,

and coordination of care between providers. SEC extrapolated projected savings for the entire U.S. healthcare system by using National Health Expenditure (NHE) data for annual total health expenditure projections for the periods 2010 through 2018. The categories of NHE spending that were used mirrored the cost service categories used by SEC in the state level data and included direct care expenditures for hospital, professional, home health care, and medical products including drugs and excluded expenditures for administrative, nursing home care, structures and investments.

The projected annual savings were calculated using the NHE 2009 released data for the period 2010 through 2018. The total NHE annual projected expenditures were multiplied by a factor of 0.3 to obtain the total NHE annual expenditures attributed by patients with extreme uncoordinated care and then that total annual amount was multiplied by a factor of 0.35 to obtain the annual estimated savings to be achieved by reducing the excessive costs due to uncoordinated care. A phase in savings factor of 0.25, 0.50 and 0.75 was applied in each of the first 3 years (2010-2012) to allow for implementation of a program to identify and target these uncoordinated care patients and create the processes, procedures and financial incentives needed by plans and providers to cooperatively achieve the savings objectives.

Public Program Savings Estimates

SEC used the above methods and data sources from NHE to estimate the annual public program savings (Medicaid and Medicare**). The public program savings were calculated to be $133.5 billion on average per year for each year in the period 2010-2018.**

Total Public and Private Plan Program Savings

SEC used the above methods and data sources to also extrapolate the total national savings for both public and private health care spending. **The average savings for both public and private spending combined were calculated to be $240.1 billion on average per year for each year in the period 2010-2018.**

Methods

Various methods have been tested for calculating and estimating potential cost savings from better coordination of care. SEC has performed multiple regression analyses to test specific variables for their independent contribution to the overall cost. These included variables such as age, gender, severity of illness, number and type of chronic conditions. Other variables studied included numbers of prescribers, treating providers, dispensing pharmacies, and number and type of prescriptions utilized. Surprisingly, the variables that seem to be predictors of higher than expected total cost and thus are markers for identifying patients with

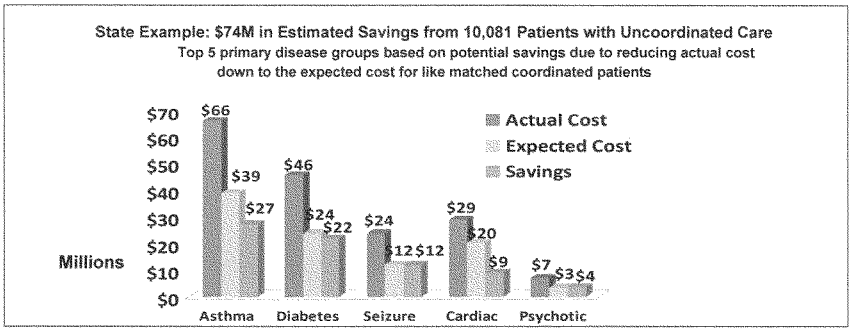
the greatest savings opportunities were those that were correlated with episodes of uncoordinated care and treatment.

Variables with high significance included using excessive numbers of prescriptions, high numbers of different prescribing and treating physicians, utilizing a high number of different pharmacies, accessing the ER frequently and/or for non-emergent care, all of which contribute to unnecessary costs due to resulting usage of therapeutically duplicative drugs, inappropriate drug usage, drug compliance problems, frequently changing drug therapies, excessive and duplicative lab and diagnostic tests, excessive office visits and excessive and inappropriate utilization of all types of services.

In addition, SEC also created matched comparison groups with thousands of patients matched by age, gender, severity of illness scores, primary disease, and major co-morbid conditions to further evaluate the cost savings potential for patients that are extremely uncoordinated in their care and treatment when compared to like patients that are receiving better coordinated care. The results of these matched comparisons indicate there is significant potential savings available in the system if patients are provided more consistent and coordinated care from their providers.

- **Estimated cost savings for a Medicaid only matched comparison group of 10,081 uncoordinated care patients matched to 37,873 coordinated care patients by age, gender, primary disease, primary co-morbid disease and severity score (CCI) is $74M (43% of the total actual cost of $172M) or $7,340 per patient annual savings. (Figure 4)**

Figure 4



Recommended Strategies for Improving the Coordination of Care

Conduct baseline analysis

Private and commercial health plans should conduct a baseline claims analysis to identify patterns of uncoordinated episodes of care using defined criteria driven algorithms, create a disease profile of the entire population, and examine drug/medical utilization and cost components to risk stratify and characterize uncoordinated care patients by the specific contributing factors identified, such as therapeutic duplication, diagnostic service duplication, narcotic usage, ER frequency and types of visits, multiple treating providers, multiple prescribers, and multiple pharmacies providing care. Additional activities of the baseline analysis include mapping identified patients into geographic regions and to existing care providers to assist with planning and implementation of care coordination activities.

Evaluate and retool existing systems and programs

Plans should periodically evaluate and modify current technology, system edits, existing utilization review program criteria, and existing disease and care management programs to assess the efficiency and effectiveness of these programs and systems. Current utilization review programs, care management and audit/investigative programs are often not well coordinated with each other in terms of common criteria applied, procedures for referrals and follow-up, and a shared focus and intervention strategy specifically for an identified subset of patients that will generate the greatest return on investment.

Target and expand existing intervention programs for identified patients to improve care coordination

- Implement patient-centered "medical and pharmacy home" programs with focused and enhanced care management and medication therapy management programs
- Enhanced on-line utilization edits and real time claims monitoring systems for providers
- Disease and care management program interventions specifically for targeted uncoordinated care patients
- Patient education/incentive programs to improve compliance with treatment plans and coordination goals
- Emergency room diversion programs to redirect access to primary care providers

Integrate technologies to improve efficiency and patient outcomes

Technologies that are currently being implemented in many plans, such as electronic health information exchange systems, e-prescribing, and other web-based provider monitoring and communication tools, offer the best return on investment for patient and provider monitoring of service utilization, costs, and quality of care. Patients that are identified in the claims analysis as receiving uncoordinated care should be prioritized to receive focused interventions and their providers could be prioritized to receive allocations of new technologies and resources first, as part of a plan-wide effort or in regional pilot programs to expand medical and pharmacy home models of integrated care.

Develop new provider delivery and payment models

There must be a concerted effort to engage providers to be active participants in assisting patients with achieving coordinated care via new models such as medical and pharmacy homes. Engage stakeholders, such as hospitals, physician groups, pharmacists, patient advocates, and others to design care delivery and reimbursement models that create incentives for providers to assume enhanced patient management activities in a multidisciplinary team approach. Initially, resources should be focused on the identified, targeted uncoordinated care patients. Providers should be adequately compensated and encouraged to perform these added responsibilities, such as through increased care management fees, shared savings arrangements, medication therapy management fees, receiving enhanced practice management technology tools, pay for performance, and other appropriate incentives.

Conclusion

The findings from these comprehensive claims analyses provide compelling evidence that effective cost avoidance measures are readily available and should be implemented within existing state, federal and commercial program structures. Healthcare reform efforts must recognize and address the problem and significant costs of uncoordinated care if there are going to be "real" and "meaningful" changes to the healthcare delivery and payment systems. Public and private health plans can reduce unnecessary expenditures due to uncoordinated care, preserving valuable resources without reducing appropriate access to care or needed services. These preserved resources can also be used for funding expansion programs for the uninsured and underinsured populations and improving the quality of healthcare for all citizens.

I would be pleased to provide Members of the committee a further briefing or answer any questions regarding this work.

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The Honorable Frank Pallone
Chairman
Subcommittee on Health
237 Cannon House Office Building
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The Honorable John Shimkus
Ranking Member
Subcommittee on Health
2452 Rayburn House Office Building
Washington, DC 20515

Dear Gentlemen,

Chairman Henry Waxman, Health Subcommittee Chairman Frank Pallone, Ranking Member Joe Barton, Health Subcommittee ranking member John Shimkus and Members of the Subcommittee, thank you for taking the time to hear our thoughts. Waste and abuse in government health care spending is a major problem with some clear solutions. We are pleased to see legislation being drafted to address the serious problems of overpayment, fraud and abuse in government medical reimbursements. We wish to ensure that payments from government health programs go to pay for citizens care, not into the pockets of crooks. Based upon what we see in our day to day business we believe we could cut 20–30% of Medicare and Medicaid spending without needing to eliminate a single legitimate reimbursement.

The amount of money being stolen from the system is staggering, Health and Human Services Secretary Kathleen Sebelius stated "Today, Medicare, Medicaid and private insurance companies pay out billions of dollars in fraudulent claims, and charge taxpayers higher premiums for it." in her speech at the "National Summit on Health Care Fraud" on January 28, 2010. She added that "We believe the problem of healthcare fraud is bigger than government, law enforcement or private industry can handle alone."

The sentiment expressed by Secretary Sebelius is corroborated by research. In October 2009 Thomson Reuters released a study showing that between $600 and $850 billion of health care spending each year is wasted (about one-third of overall health care spending). The report goes on to suggest that between $125 and $175 billion of that is pure fraud.[1]

[1]Thomson Reuters, "Healthcare Reform Starts with the Facts," October 27, 2009. http://thomsonreuters.com/content/corporate/articles/healthcare_reform.

Eliminating health care fraud is obviously important from a policy perspective, and has significant proponents from both sides of the political spectrum. Additionally polls show that the majority of Americans would place a higher priority on "eliminate fraud" (85%) than on "standardize administrative forms" (77%) or "reduce medical errors" (72%).[2]

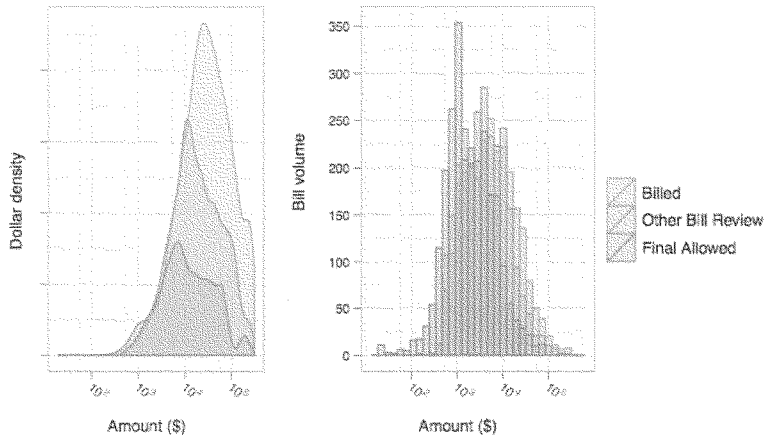


Figure 1: This figure shows how severe the problem of over billing is. The green area represents the amount of money charged by providers in a real group of medical bills received from a client. The blue area is what is paid after a standard bill review process done by our client and the red area shows how much was ultimately paid by Qmedtrix's client for this data set.

Qmedtrix is a medical bill review company based in Portland, Oregon. For over a decade we have worked to identify patterns of overpayment, fraud and abuse and correct those errors prepayment. We have made substantial investments in the creation of predictive modeling tools (like those described in the draft of HR 5546) and using those systems we currently return millions of dollars of overpayments to our private sector clients. It should be noted that across the board all bill sets need to be audited since no large collection of medical bills is ever free of abusive billing. Even the less impressive bill review systems produce astounding savings (see figure 1).

[2]Zogby International/University of Texas Health Science Center poll of 3,862 adults, June 2009. `http://www.zogby.com/news/ReadNews.cfm?ID=1722`.

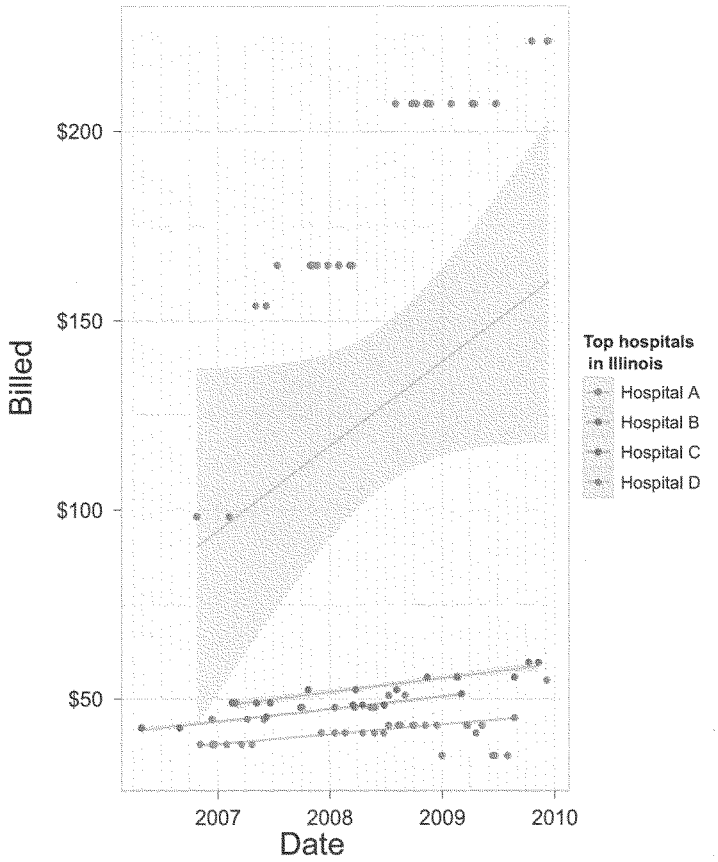


Figure 2: This figure shows the actual amount billed by four different hospital emergency rooms for a standard tetanus shot over several years in the state of Illinois. The lines show what the general trend of pricing for each hospital seems to be by way of a linear model.

While many providers bill reasonably there are enough abusive facilities that a comprehensive audit is required to ensure optimal cost containment. See figure 2 for an example of the kind of rampant abuse we see across all states and types of bills.

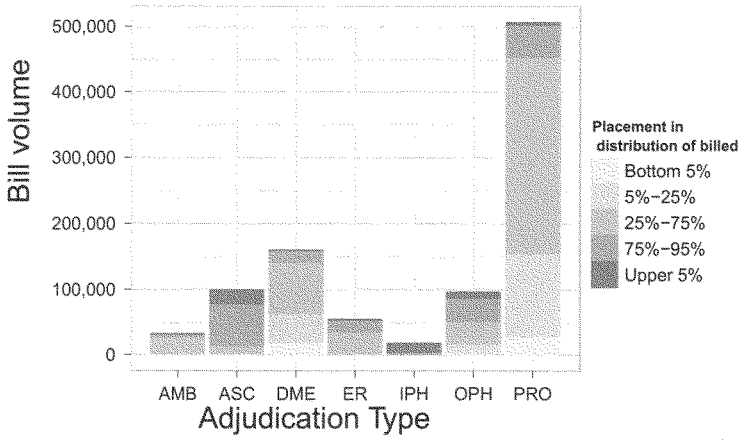


Figure 3: This figure shows the breakdown of bill type in a large set of medical bills. The histogram bars are colored to show where the most expensive bills are. The darker the color, the more expensive. In the scheme showed here a bill can originate form an ambulance (AMB), ambulatory surgery center (ASC), durable medical equipment supplier (DME), emergency room (ER), inpatient hospital (IPH), outpatient hospital (OPH) or doctor's office/professional services (PRO).

It should be noted that facilities, generally produce more expensive bills than doctors offices or medical equipment (see figure 3). Additionally, reimbursement methodology is especially complex for facilities (as compared with doctors or medical supplies) creating huge opportunities for fraud and abuse. Specialized tools need to be built to help the Medicare and Medicaid administrators validate facility bills. Most bill review platforms focus on professional bills and medical equipment. We are in a unique position to understand the difficulties faced by Medicare and Medicaid administrators since Qmedtrix is a company specializing in cost containment for facility medical bills.

Each type of reimbursement scheme has unique ways in which it is gamed. Figure 3 shows that inpatient hospital bills are by far the most concentrated group of expensive bills. Qmedtrix has found significant levels of upcoding in inpatient hospital bills. In a recent internal study done on a set of bills originating from Southern California over 50% of the bills were upcoded.

Upcoding occurs when erroneous diagnoses are added to an inpatient hospital bill to cause the DRG payment system to flag the bill as one where complications occurred. This can result in tens of thousands of additional payment dollars *per bill.* DRG codes can be altered to produce higher payments by doing as little as changing the order of the diagnosis codes. The automation to detect this sort of abuse successfully is not commercially available and needs to be developed.

From our experience at Qmedtrix we believe that as much as 20–30% of Medicare and Medicaid spending could be eliminated if proper billing were enforced. For this to happen, however, the audits must be exhaustive, meaning that every bill should be checked. This requires a robust automated system since the volume of medical claims passing through CMS is far too large to allow manual audits to scale reasonably in a cost effective manner.

Qmedtrix has been involved in an ongoing research and development operation for over five years to bring advanced machine learning and pattern recognition tools to bear on the problem of medical fraud and billing abuse. This project has spawned a NIH grant[3], a patent, academic papers, and many new tools. Our goal is to build systems that can learn the complex and labor intensive tasks of medical bill review and allow computers to do the bulk of the labor, increasing speed and accuracy.

Qmedtrix reviews and audits large data sets of medical bills using automated methods while ensuring quality and accuracy using human-computer interaction where doctors, nurses and bill review experts *teach* our automated engines to identify suspicious patterns. Medical experts specify appropriate actions when the system has inconclusive data yet never need to look at bills which can be processed automatically with a high degree of confidence. While the system is currently being trained to work in our current domain of workers compensation this technology could be tuned to work with the rules governing various federal or state programs such as the Office of Workers' Compensation (OWCP), Medicare, Medicaid or Tricare. This is because the payment methodology for most of these programs uses the Medicare coding standards.

It should also be noted that not all bill review companies or platforms are created equal. Any competitive bid should factor in the quality of the services rendered and optimally such a process should involve requiring competing entities to perform test runs to show what their systems are capable of producing. The current systems are not sufficient for this extremely complex task. Qmedtrix has spent substantial resources over the last half decade developing sophisticated fraud detection tools and we can testify to the difficulty of such a task. Discovering patterns of unbundling[4] double billing[5] and upcoding is a nontrivial task which can not be

[3] SBIR National Library of Medicine Grant #1R41LM009190-01A2 "The Use of Mathematic Algorithms in the Prevention of Improper Medical Payments"

[4] If payment for procedure X should include supplies A and B unbundling, is when a provider charges full price for X, A and B.

[5] Double billing occurs when a provider bills multiple times for the same procedure.

completed by manual auditors or rule based systems. Rule based engines to apply fee schedules will always be a necessary component of an automated payment system, but without machine learning algorithms to mine patterns of fraud there will continue to be billions of dollars of wasted taxpayer money.

Of course this process should also factor in the bill review company's track record of defense of the reimbursement decision. Some bill review companies have tried to gain market share by finding savings which do not really exist and then fail to defend their payment decisions in court. Qmedtrix has always stood behind its audits and defends such audits in court and we would expect nothing less from whatever vendor CMS ultimately uses.

We would like to close by offering a few policy suggestions:

- Implement comprehensive pre-payment audits for all future bills instead of recovery of overpayments.
- Institute penalties for reoccurring inappropriate billing practices (not individual errors) leading to overpayments – there are currently no good incentives to bill properly.
- Initiate comprehensive audits of the past ten years of Medicare and Medicaid payments taking credits towards future medical expenses rather than trying to recover the overpayments. Federal and state collection laws clearly allow government entities to take credits rather than costly and timely recoveries.
- When releasing paid bills for an audit allow multiple companies to do side-by-side audits and allow CMS to assess their success, forcing competition on quality as well as price.

We thank the committee for their time and hope our comments have been useful.

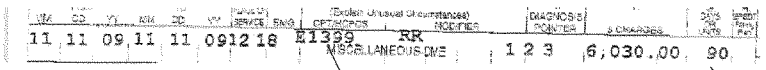
Dr. Merrit Quarum M.D.
President & CEO
Qmedtrix

Noah Pepper
Director, Research & Development
Qmedtrix

Appendix A

Attached on the following page is a real world example of abusive medical billing.

Medical Supply company billing:



11 11 09 11 11 0912 18 A1399 RR MISCELLANEOUS DME 1 2 3 6,030.00 90

Misc.Medical Supply code.

This is for 90 Days of rental.

In this case the Supply is for:

11/11/2009 Saunders
Lumbar Traction Unit (RENTAL)
Actively Moving Treatment Surface
Patented Pump/Gauge
Effectively Applies Up To 200 lbs of Traction. Friction-Free Surface Ensures Smooth Motion
Comfortable Thoracic and Pelvic Belts

Looked up online:

THE SAUNDERS GROUP INC

The **Saunders Lumbar Traction** is one of the most effective devices on the market today for treating back pain from a variety of conditions. Simply put, it is considered the gold standard by which all others are judged. Designed with the patient in mind, this Saunders HomeTrac unit utilizes an expandable fold out design to provide a stable stable, smooth surface for the torso straps to apply precise traction to the lumbar vertebrae. Saunders has made the harness easy to adjust for both patients and clinicians. It also has a non-slip surface to effectively grab onto the torso to provide an effective pull. Foam wedges for the head and legs are included to make application of traction more comfortable for the lumbar region. The enclosed pneumatic hand pump is designed to apply up to 200 lbs of traction. This Saunders h[illegible]el is manufactured in the USA and is used by physical therapists, chiropra[illegible]tion professionals - perfect for home use as well!

Sells NEW for 499

Note to consumers: This is [illegible]nders unit; if you see a cheaper price for this product anywhere, it will most likely [illegible]ished unit with the indicator sticker being removed and sold as "NEW". Buyer beware. We cannot publish the price for this item because we sell it for less than the recommended manufacturer's price of $499. Please call us at 877-721-7701 and we'll place your order manually to be shipped out today!

Basically, this person rented something for 3 months at a price of $6000 they could buy for $500.00

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The Honorable John Shimkus
Ranking Member
Subcommittee on Health
2452 Rayburn House Office Building
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September 22, 2010

Dear Gentlemen:

In response to a recent request for input into fighting fraud in Medicare and Medicaid, FIS would like to offer the following complementary, detection measures to impact the broad area of healthcare fraud and waste, whereby the end consumer or patient is actively involved. In the commercial market, people are rapidly assuming the role of 'healthcare consumer' as more of the liability for healthcare is falling directly to them rather than to their insurer or employer. The market is responding by offering educational and support resources to facilitate this shift. We would propose steps in a similar direction as a way to combat fraud, waste and abuse for the Medicare and eventually for Medicaid populations as well.

A Prevention System is most effective if initiated at the point of service, the genesis for the creation of a claim. The member's eligibility card is currently the mechanism that enables the provider to transact with the member's insurer, including providing proof of insurance and establishing a direct payment relationship with the patient. We would suggest several possible options for using the card for tighter control of personal identity verification that leverages existing business processes. Consider:

- Utilizing a more "intelligent" member eligibility card design that would be enabled with an additional layer of validation (i.e. photo, bio metric, personal identification number). This validation could be made a requirement before the eligibility and claim submission transactions are initiated/affirmed. Biometrics or other personal authentication options are also evolving for mobile applications, which is where POS eligibility verification is heading in the future.

- Physical and near-real-time analysis of the member's identity through private, public and government data sources, in concert with the eligibility card. Similar process to current credit/debit card authentication and verification.
- Requiring eligibility transactions to be performed for each member visit in combination with the member identification verification. (H.R. 3590 will cover the electronic eligibility transaction and receipt requirements.) Validation of these steps could be required as part of the claim submission process.

Complexity in the United States healthcare system fosters a breeding ground for criminal activity and an environment where the member is neither well informed, nor engaged in verification and validation of services rendered. The following enhancements would aid in the member's transformation into a true healthcare consumer, empowering them to take control and responsibility of their healthcare:

- Post visit, provide the patient/member with a "bill of services". This 'receipt' would detail in easily understandable terms the services rendered, the estimated provider billed charges, likely Medicare reimbursement and potential member liability.
- Post visit, but before claim adjudication, require the member to authorize and approve that the claim submission is factually consistent with the services rendered and the billed amount(s) are directionally equivalent to the "bill of services".
- Offer online data to the member in the form of a Personal Health Record that reflects services rendered, associated charges and discounts, and organized in a meaningful way that enables better understanding of the purpose and results from healthcare services.
- Provide for the creation of a Medicare call center, staffed with nurse and billing advocates, to assist members with any questions regarding the claim authorization and approval requirements. Enact a penalty and loss of benefits for members knowingly authorizing and approving invalid claims.

The two main areas of detection described above, in addition to the measures described within H.R. 5546, need to be interconnected and provide for regular feedback loops to create an optimal Prevention System solution whereby the member/patient/consumer is actively engaged. A combination of initiatives is the best way to provide complete detection assurance or reduce the approximately $60Bn of Medicare fraud, waste and abuse. Engaging the consumer in the process has the added value of eventually bending the cost curve as well.

Sincerely,

John Reynolds
President, FIS Government, Education & Healthcare

Submission for the Record
Hearing on
Cutting Waste, Fraud and Abuse in Medicare and Medicaid
Before the House Committee on Energy and Commerce,
Subcommittee on Health
September 22, 2010

Statement of Dino Martis, President, On-e Healthcare

Chairman Pallone and Ranking Member Shimkus, I am pleased to provide my thoughts on combating fraud, waste and abuse in the Medicare and Medicaid programs and throughout our health system. Too many resources are wasted to criminals who game our inadequate program integrity systems. Equally important, and a point that is missed too often in the fraud and abuse debate, is that we spend a great deal of resources on law enforcement and chasing crooks rather than leveraging technology to prevent fraud before it bears fruit. This point cannot be overstated: our fraud and abuse laws do not reflect the advances in technology that will protect taxpayer assets and consumer resources.

Despite the recent, well intentioned and useful changes in Federal laws to provide more tools and to create disincentives to defraud Federal health programs, including modernizations included in the Patient Protection and Affordable Care Act, Congress needs to deploy all tools at its disposal to protect program integrity. One step would be to prevent fraud through use of technologies that identify patient and provider, label durable medical equipment for tracking purposes and make use of electronic health records to track services and claims by provider and patient.

Fraud and Abuse is Pervasive

As a society, we are experts when it comes to keeping our possessions safe. We have home security systems, car alarms, surveillance cameras in our businesses, PIN numbers, passwords, and dozens of other methods. Why is it then that our large investment in healthcare does not receive the same level of security?

The U.S. spends more than $2.5 trillion on healthcare annually. According to the National Health Care Anti-Fraud Association, at least 3 percent of that spending — or $68 billion — is lost to fraud each year. The FBI estimates at least 10 percent – or $226 billion --- is annually lost to health care fraud. These numbers are staggering. Think of the benefit to people that might be provided if those dollars were captured.

Medicare and Medicaid made an estimated $23.0 billion in provider overpayments in 2009. While not necessarily fraudulent, they highlight program vulnerabilities that need to be addressed. One example of this problem is the Medicare program paid 16,548 to 18,240 deceased physicians 478,500 claims totaling more than $92 million from 2000 to 2007 according to the U.S. Senate Permanent Committee on Investigations.

Unfortunately, the US trails behind most of the world in leveraging technology to keep up with the latest health crime schemes. To combat healthcare fraud, countries across the world invest in IT to save money. According to the Council on Foreign Relations, the U.S. government invests $0.43 annually per capita on IT whereas the Canadian government, by contrast, spends $31 per capita. Other industries, particularly in financial services, have adopted predictive modeling and sophisticated data analytics and program rules to detect new fraud schemes,

prevent them from being implemented and to stop them in their tracks. This is largely done through the application of technology and information systems not widely adopted in the health care marketplace or by federal agencies.

A Path Forward

Our experience is that we can keep people from stealing and wasting our healthcare dollars with data. On-ē is a company dedicated to eliminating healthcare waste and fraud and improving healthcare outcomes through its information products and through advocacy. The company's services are built on the principle that the recovery philosophy governing how fraud is addressed is outdated, inefficient and expensive. While recovery can identify large clear spikes in fraudulent claims, it is woefully inadequate at eliminating everyday fraud.

To this end, On-ē offers software, hardware, and information transfer and analysis solutions. Unlike other Electronic Medical Records (EMR) providers, On-ē is dedicated to assisting healthcare institutions and services in communicating with each other. On-ē solutions allow existing EMR systems to interact and interoperate easily with other non-compatible EMR systems.

Specific Recommendations

We support the Subcommittees' efforts in highlighting this issue in the Medicare and Medicaid programs and note there are several bills before the Energy and Commerce Committee for its consideration. We suggest specific changes to these bills to fully leverage technology available in the market today to prevent fraud.

Specifically, we make the following legislative suggestions and encourage the Committee to move quickly this year to strengthen Medicare and Medicaid program integrity.

Biometric Identifiers

> **Recommendation:** Biometric Identification should be required for patients and providers. Requiring that a static biometric characteristic of a health care provider and recipient be electronically acquired and used for subsequent biometric identification of providers and recipients and authentication of healthcare transactions is critical in addressing fraudulent claims for services not rendered.

Current legislative proposals (H.R. 5044, Klein) suggest a biometric identity for patients be acquired as part of a healthcare transaction. We believe this is inadequate without an authenticated provider biometric identifier. As noted in prior hearings on H.R. 5044, some provider schemes encourage false patient registration and sign-in logs that are then used for proof of services delivered to secure Medicare payment. A biometric patient identifier will do nothing to prevent this type of scheme unless it is combined with a provider biometric identifier. We suggest adding this component to H.R. 5044, or other proposals this Committee may

consider, to further strengthen the good thoughts behind using biometric identifiers to combat fraud.

> **Recommendation:** Congress should identify the parameters of a biometric characteristic used for identification purposes while granting the Secretary sufficient leeway to evolve standards over time to reflect technological improvements in the market.

To be meaningful, we believe a biometric characteristic used for identification should be:

(i) unique to a specific healthcare provider or recipient;
(ii) repeatable each time it is measured during a healthcare transaction; and
(iii) unalterable by the healthcare provider or recipient or others.

We also suggest that HHS require an association between the acquired biometric identities of providers and beneficiaries and a photograph in a manner that ensures the photograph and the static biometric identity were taken simultaneously and are from the same individual. We believe this holds vast potential to dramatically reduce cases of medical identity theft and false claims. We also note that the Drug Enforcement Administration adopted a similar approach in requiring biometric identities for electronic prescriptions of controlled substances. We encourage a similar approach in Medicare and Medicaid for items and services at risk to these types of schemes.

Biometrics and Secure Electronic Transactions

> **Recommendation:** Congress should require or test the use of, and as a precondition to the payment of a claim for a healthcare services, the acquisition in unalterable electronic format of sufficient information to verify that all reimbursable aspects of the healthcare transaction occurred. In addition, we suggest that such information be sufficient to verify all reimbursable aspects of the healthcare transaction and be acquired simultaneously through a single or integrated system that includes verified biometric identification of the qualified provider and patient.

Electronic Prescriptions

> **Recommendation:** Congress should require as a precondition of participating in the Part D incentive program for electronic prescribing that physicians use technologies that track and leverage information exchange methodologies that:

1. acquire prescription information at the time it is created by the prescriber in an unalterable format, including the biometric identity of the patient and the biometric identity of the prescriber, and
2. either (i) securely transmits the acquired information from the prescriber to the party filling the prescription directly, or (ii) unalterably embeds the information

acquired at the time it is created by the prescriber in a media for delivery to the party filling the prescription.

Electronic Labeling for Durable Medical Equipment

Recommendation: Congress should test the use of non-duplicable and verifiable electronic labels for DME products.

Hundreds of millions, if not billions of dollars are lost annually to fraud associated with durable medical equipment. One common scheme is to bill for the same wheel chairs and other equipment multiple times for multiple patients who may never receive the equipment. The Government Accountability Office has noted that to adequately address DME fraud, paper claims review is not sufficient.

Sufficient technology exists to begin deploying a non-duplicable, verifiable electronic label at the source of manufacture to a targeted list of DME equipment most susceptible to fraud. We suggest that the electronic labels contain sufficient attributes for claim verification and for identification of the product and its location at any point in the supply chain. Exceptions could be made for existing products already in use, or for low cost items where an electronic label might be more expensive than the cost of the equipment itself. To prevent tampering, we suggest an electronic label should contain information on a product's attributes necessary for claim verification and that it be unalterably embedded in the label.

Conclusion

Our experience suggests that no single solution will address all the issues generated by determined and skillful criminals who are determined to defraud taxpayers. This is especially true in Medicare and Medicaid, where large sums of money are at stake. But our experience also suggests there are multiple tools the Administration and Congress have not explored and that are available to deploy in the battle against unscrupulous individuals.

We stand ready and willing to assist the Administration and Congress address these issues by leveraging technology to prevent health care fraud. Considering the large sums of taxpayer and beneficiary dollars at stake, we encourage Congress to act this year on a bill to achieve this goal. On-e healthcare is happy to provide our thoughts on this critical issue.

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hci HealthCare Insight®

COMMITTEE ON ENERGY AND COMMERCE
Subcommittee on Health

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The Honorable John Shimkus
Ranking Member
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September 22, 2010

Gentlemen:

It is with intense interest that we have studied the content of H.R. 5546, precisely because it calls for implementation in Medicare and Medicaid of the fraud, waste and abuse (FWA) preventive services which our company, HealthCare Insight (HCI), has been providing to health care claims payors for the last 12 years. We have proven across many health care payor segments, including risk-bearing group health organizations, TPA's, Taft Hartley plans, Medicaid MCO's and self insured plans of all sizes, that the HCI's process works: pre-payment detection and clinical validation of potentially fraudulent claims and providers stops payment of FWA suspected claims, without adversely affecting provider relations or breaching prompt payment regulations. HCI has clients with as few as 25,000 members, to as many as 6+ million members; our process operates efficiently irrespective of claims volume.

THE CHALLENGES OF PRE-PAYMENT FWA DETECTION

It is important to note the primary concerns generally raised from any discussion of pre-payment FWA processes are that 1) these procedures could potentially delay payments of all claims, and 2) that fraud-prevention software technologies - as advanced as they are - still have high rates of false positives. Irrespective of technology advancements such as predictive analytics, intelligent software (software that learns) and complex scoring logic can help flag potential fraud, the fact remains that correctly interpreting actual FWA in health care claims vs. legitimate submissions is a complex task because of the incredible number of variables in the correct payment equation of any health care claim. There are vast numbers of coding rules that govern the submission of a medical bill. That, in combination with the complexities and the evolving nature of medical care, makes it difficult to scrutinize and accurately determine which claims may be improper representations of services provided - or worse yet, may be totally false claims where no services

were ever provided. Software-enabled rules systems are a critical element to any efficient fraud prevention program, but software-only solutions cannot address concerns about false positives. HCI's operations model significantly reduces false positives by using licensed clinicians to analyze and validate system-detected suspect claims *before* they are reported to the payor for payment adjustment/denial or a suspect provider is identified for investigation to the client's SIU.

Couple complexity issues with the need to render a decision on any given claim in a time sensitive scenario and we have the ideal situation for fraudsters to prey on the current public systems and have nearly free reign to rob our programs of billions annually. While it is popular to point to the professional - yet not always skilled - criminals who commit health care fraud, we at HCI know that there are also licensed, seemingly legitimate providers who are also taking advantage of the system: a system which historically pays now and may ask questions later, if the level of abuse is egregious enough to attract the attention of an auditor at some later time. The fact that the Medicare and Medicaid systems now have the opportunity to pause the payment process when a suspect claim is identified is a step in the right direction. H.R. 5546 now calling for preventing the payment of suspect claims is the next necessary step in that direction.

The practicality of implementing such a process will undoubtedly be raised by many whose thinking is grounded in the murky world of legacy systems and processes. The purpose of this communication is to demonstrate clearly that pre-payment fraud, waste and abuse detection and the prevention of payment of suspect claims is practical at large scale and currently operational for several years across the significant client base of HealthCare Insight customers. HCI is preventing the payment of suspect claims and saving millions of dollars annually for our customers. Our Medicaid MCO clients alone will save over $37 million dollars this year due to these pre-payment approaches and techniques. These approaches are proven and can be applied to any claims stream. What is even more important is that the use of the HCI approach can be accomplished at virtually no marginal cost: it does not necessitate system replacements or the addition of large numbers of staff members to implement the process and capture the savings.

Commercial health care payors are relying more and more on the use of vendors to provide services that augment their current claims payment processes as well as other support services. Various forms of outsourcing and the use of software as a service (SAAS) vendors have become practical and cost effective ways to avoid the daunting costs in both time and capital to take advantage of new technologies. It is crucial that state and federal procurement processes embrace new technical models if government health care programs are to keep pace with growing administrative demands, particularly prevention of fraud, waste and abuse. Technologies and processes such as HCI's can be implemented almost immediately with no adverse effects on timely claims payments or on the costs of personnel that staff the Medicare and Medicaid plans.

HOW HCI'S PRE-PAYMENT MODEL WORKS

We at HCI believe we can make a substantial and immediate impact that will save hundreds of millions of dollars and preserve valuable financial assets being wasted. We can do this by simply applying already proven processes and systems that are currently in daily use, saving our

existing clients millions of dollars every month. Our systems use predictive analytics *and* clinically derived fraud detection logic, along with a complex and dynamic scoring system that assigns risk to both claims and the providers that submit those claims. This process facilitates an efficient and practical method which prevents the payment of aberrant and questionable claims and identifies suspect providers for further scrutiny. HCI systems and processes begin with a robust historical analysis of paid claims data that examines each provider's billing patterns within the context of local, regional and national norms of all peer providers in that specialty. When deviations from expected billing behaviors are encountered and a provider or claim is flagged as an outlier, our technology allows the comparison of that claim and the services and intensity of services billed to what would normally be expected based upon best practice guidelines for management of that particular patient's illnesses. Additional technology scores the risk of the patient being managed and addresses the potential issue that a provider may be managing a "sicker" population of patients.

What really makes interference-free, pre-payment processes work with the efficiency and timeliness of claims payment is our combination of technology and clinical review of the output of our systems. HCI has added uniquely this all important layer of professional clinical evaluation of system flagged potential problems in order to produce a highly accurate and actionable inventory of incorrectly billed claims that should not be paid as submitted. Client acceptance rates routinely exceed 90% of claims identified by HCI as coding and billing violations. Likewise, when a claim or provider is tagged by our systems and validated by our clinicians as potentially fraudulent, our clients open investigations on upwards of 80% of the reported cases.

There is a functioning pre-payment fraud prevention solution currently in use in the health care space and HCI supports this timely and important bill. It is our hope that its passage will enable our company to demonstrate the incredible savings that can be had with virtually no inconvenience to anyone but the fraudsters.

Respectfully,

Dr. Barry L. Johnson
President HCI

Additional Written Questions for the Record
From Peter Budetti's Hearing
on
"Fraud Provisions in ACA"
Before the
House Energy & Commerce Health Subcommittee

September 22, 2010

The Honorable Michael C. Burgess

1. Last year the GAO conducted a study on Medicaid and fraudulent activities related to the abusive purchases of controlled substances in five States – including my home state of Texas. The study discovered $63 million in fraudulent Medicaid payments not including the costs incurred from doctors' office visits. This was only in 5 States. PPACA will add 16 million Americans to the Medicaid system. If we cannot prevent this type of fraudulent activity in only 5 States, how do you propose we do it when 16 million more people are added to the system?

A: The Administration and the Centers for Medicare & Medicaid Services (CMS) are strongly committed to combating prescription waste and abuse in public programs. Fraud and abuse is not unique to public health care programs; private sector payers are frequently subject to the same kinds of problems. The Affordable Care Act took the historic step of extending health insurance coverage to millions of uninsured Americas. However at the same time this legislation greatly enhanced CMS' fraud fighting ability with new authorities and tools. These new authorities will greatly assist CMS in working with the States to improve program integrity operations and recoveries.

In particular, related to the area of controlled substances, we are continuing our role in assisting States in their ongoing monitoring of prescription drug abuse. The President's Budget Request for FY 2011 includes a CMS legislative proposal to boost our efforts on this issue by requiring States to monitor and remediate high-risk prescription drug Medicaid billing activity to improve program integrity.

Beyond this proposal, we have several ongoing Medicaid monitoring activities and improvements that will help CMS better prevent fraud, waste and abuse in Medicaid, including working with State Surveillance and Utilization Review programs, working with the Drug Enforcement Administration and States on controlled substance prescriber files, and implementation of the tamper resistant prescription pad requirement.

The expansion of our program integrity authorities and reporting requirements in the Affordable Care Act will provide CMS with better data on a more frequent basis that will allow us to work closely with the States in this area. The new data sharing requirements that we are implementing now will be important in our broader work to ensure that only proper payments are made, and that fraudulent actors are removed from the program or

sanctioned. Medicaid data will be included in this new data sharing regime, which we believe will help ensure that proper and accurate payments are made in the program. We are optimistic that these new tools will help ensure the accuracy of Medicaid payments as we expand Medicaid eligibility under the Affordable Care Act.

2. What steps are you taking with States to ensure Medicaid vendors review claims before they are paid?

A: Generally, State Medicaid programs are responsible for certain pre-payment screening and other requirements relating to claims processing.

The vast majority of Medicaid claims are screened through system edits within the State's Medicaid Management Information System (MMIS), which is certified by CMS. Claims are screened for many factors and States have the flexibility to add additional edits to respond to particular localized concerns that data indicate may need attention. In addition, States are required to perform post-payment claims review. CMS continues to encourage States to increase their focus on pre-payment, preventive screening efforts while continuing post-payment reviews as well. Section 6507 of the Affordable Care Act requires States to use the National Correct Coding Initiative to improve coding practices in Medicaid. CMS issued a State Medicaid Director (SMD) letter on September 1 to advise States on how to implement programs to meet these requirements.

Further, the expansion of our program integrity authorities and reporting requirements in the Affordable Care Act will provide CMS with better data on a more frequent basis that will allow us to work closely with the States to ensure Medicaid managed care plans are in compliance with Medicaid requirements. The new data sharing requirements in Section 6504 of the Affordable Care Act will be important in our broader work to ensure that only proper payments are made and that fraudulent actors are removed from the program or sanctioned. Managed care data will be included in this new data sharing regime which we believe will further help assure that proper and accurate payments are made in the program.

In addition, we will use our authority to suspend payments for fraudulent billing, continue and expand our collection of performance statistics, exclude entities that have control over affiliated entities or individuals that have been sanctioned or excluded from the Medicaid program, and better identify those that are fraudulently seeking to bill the program for services.

3. The sharing of information was mentioned as a necessary and important factor in fighting fraud. How do you propose we integrate both private sector and public sector records to ensure a thorough examination of all providers?

A: The Affordable Care Act builds on CMS' existing efforts to integrate data, and provides for enhanced data integration across our programs and data sharing among Federal entities to monitor and assess high risk program areas and better identify potential sources of fraud. As required by the Affordable Care Act, CMS is expanding its Integrated

Data Repository (IDR) to include claims and payment data from other Federal agencies, and intends to enter into 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 programs.

In addition to expanding the IDR, the Affordable Care Act requires the Secretary to consolidate all information in the Healthcare Integrity and Protection Data Bank (HIPDB) with the National Practitioner Data Bank (NPDB). This revamped NPDB, run by the Health Resources and Services Administration, is designed to maintain a national health care fraud and abuse data collection program for reporting certain final adverse actions against health care providers, suppliers, or practitioners. Also, the Affordable Care Act requires States to report an expanded set of data elements to the Medicaid Management Information System (MMIS) that will strengthen CMS' program integrity work within State Medicaid programs.

Because the public and private sectors have common challenges in fighting fraud and keeping fraudulent providers at bay, it makes sense that we should join together in seeking common solutions. HHS' partnerships with the private sector have grown since the launch of the inter-Departmental initiative known as the Health Care Fraud Prevention and Enforcement Action Team, or Project HEAT. CMS is partnering with the HHS Office of Inspector General (OIG), the Department of Justice (DOJ) and the Secretary to coordinate several Regional Fraud Summits. These summits provide a space for providers, hospitals and law enforcement to discuss shared concerns and strategies for collaboration in the fight against fraud. We will continue to work with all our private partners to implement the best mechanisms possible to address the problems of fraud, waste, and abuse in our health care system.

4. As health care fraud schemes become more sophisticated, how do you plan to stay ahead of their activities and combat fraud?

A: With the implementation of the new authorities provided by Congress in the Affordable Care Act, CMS is looking to achieve a fundamental shift in its approach to program integrity by going beyond "pay and chase" to fraud prevention. We will do this in two ways: working with legitimate providers and suppliers to ensure compliance with program requirements, and taking new measures to keep dishonest providers out and to avoid paying fraudulent claims. Our new measures are also designed to address programmatic vulnerabilities identified by other CMS program integrity efforts.

The 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 the Medicare and Medicaid programs.

CMS has also begun to explore using more sophisticated data tools that will identify and prevent fraud from occurring in the first place. To that end, CMS is conducting a series of

pilot projects looking at how data analytics, including predictive modeling, may be useful to our fraud prevention efforts. CMS' goal is to maximize the return on our investments in new technologies while minimizing the risk of implementing an automated system generating "false positives," which could result in improper denials of care or services. These pilots are helping CMS identify key lessons, such as the importance of scalability in developing predictive analytic models. All of the information CMS learns from these pilots will help the Agency refine future models for potential expansion across all types of claims and providers. To better assess what private contractors can offer CMS, the agency held a "Vendor Day" on October 15, 2010, with over 200 vendors attending to learn more about CMS' data technology needs. CMS intends to continue conversations to determine how private sector solutions may have transferrable lessons for Medicare and Medicaid.

5. Do you believe by bringing in so many agencies and contractors that the sheer number of people and organizations working simultaneously is impeding the progress and by streamlining this approach we could act faster and recover more funds?

A: CMS is working to better coordinate program integrity policies and operations for Medicare and Medicaid. As a part of this effort, CMS is nearing completion of a transition from 15 Program Safeguard Contractors (PSCs) to 7 Zone Program Integrity Contractors (ZPICs) whose geographic boundaries are based on the newly established Medicare Administrative Contractor (MAC) jurisdictions. We anticipate the common boundaries will promote more immediate communication and coordination. In addition, the ZPICs are responsible for analysis of the full range of care for Medicare beneficiaries rather than isolated specific instances of irregularity in particular service areas.

In addition, CMS has taken several administrative steps to streamline operations and enhance the Agency's ability to meet future needs and challenges. The consolidation of Medicare and Medicaid program integrity activities under a new CMS Center for Program Integrity (CPI) will enable CMS to pursue a more strategic and coordinated approach between Medicare and Medicaid; form a bridge that facilitates collaboration on anti-fraud initiatives with our law enforcement partners, such as the OIG, DOJ, and the State Medicaid Fraud Control Units (MFCUs); and allow the Agency to build upon and strengthen existing program integrity programs and operations to combat fraud while also investing new resources and technology to reduce waste, fraud, and abuse before it occurs.

6. Can you expand on the comments made that PPACA modified two separate statutes -- the Anti-Kickback Statute (AKS) and the health provisions of the criminal mail fraud statute. There has been significant concern that the changes make it possible for prosecution of innocent errors or mistakes. Do prosecutors continue to have the obligation to prove that violations were knowingly and willfully? Is the Department of Justice in agreement with this conclusion? / Is the agreement between the OIG / CMS and DOJ on this point?

A.: This question would be more appropriately addressed by the OIG. We have forwarded it to his office, and OIG will respond directly to you.

7. Can the government establish liability for violations of these statutes without proving and individual knowingly and willfully intended to perpetrate a fraud?

A.: This question would be more appropriately addressed by the OIG. We have forwarded it to his office, and OIG will respond directly to you.