

**PREVENTING MEDICARE FRAUD:
HOW CAN WE BEST PROTECT
SENIORS AND TAXPAYERS?**

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WEDNESDAY, MARCH 26, 2014

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 2:00 p.m., Room 562, Dirksen Senate Office Building, Hon. Bill Nelson, Chairman of the Committee, presiding.

Present: Senators Nelson, Casey, Donnelly, Warren, Walsh and Collins.

Also present: Senators Carper and Coburn.

**OPENING STATEMENT OF SENATOR
BILL NELSON, CHAIRMAN**

The CHAIRMAN. Good afternoon. Welcome to this hearing of the Committee on Aging.

We have had to improvise here because our normal start time was another half-hour from now, but you have to be flexible in this place because suddenly there are going to be five votes in a row, starting at 2:30, so we wanted to go ahead and get most of the testimony on the record ahead of time, and because Senator Collins is in a commitment she could not change, she will join us at the regular start time.

This past Sunday we marked the four-year anniversary of the Affordable Care Act, and, while there may be pieces of the ACA that there is a lot of controversy here on Capitol Hill, I think we can be supportive of the new tools that it gave to CMS, the Centers for Medicare and Medicaid Services, to use in the fight against fraud.

This Senator had a little bit to do with that in attaching some language as we were writing the ACA about going after Medicare and Medicaid fraud.

Now CMS now has more authority than ever before to keep bad providers out of the system and to find fraudulent providers through sophisticated data analysis. We are going to hear today how CMS is using those tools to prevent fraud in Medicare and trying to stop the theft of billions of dollars every year.

Despite all efforts and despite these tools, this country continues to lose as much as \$60 to \$90 billion a year to Medicare fraud. We cannot, obviously, afford this, and it is clear that we cannot just arrest our way out of the problem of this magnitude.

The Inspector General's Office will talk about their efforts to fight Medicare fraud and particularly with some reference to Florida, where, interestingly, too many of the bad actors are concentrated, in particularly South Florida, and prey on our senior citizens.

While we often think of fraud in terms of dollars and cents, it can obviously have a greater cost, and we are going to hear first-hand from a lady who has received unnecessary and potentially dangerous treatment she did not need just so that her doctor could bill Medicare for those so-called treatments, and we will hear from a Medicare Senior Patrol Coordinator who counsels seniors with similar stories every day.

When Senator Carper gets here, I want to focus on some of the things that he has done against Medicare fraud.

As we come out of this hearing, I hope we have a new appreciation for the human cost of this kind of fraud and what we are going to have to do in the future to try to nip as much of this in the bud as we can, and so we have a distinguished panel.

First, we are going to hear from Ms. Bettie Hughes, and she is the Senior Medicare Patrol Coordinator for the Area Agency on Aging in Wayne, Michigan. Then she is joined by Ms. Patricia Gresko from Romeo, Michigan, who was a victim of the Medicare fraud.

Then we are going to hear from Mr. Brian Martens, the Assistant Special Agent in Charge of the Miami Office of Investigations for the Department of HHS and their Inspector General, and then hear from Mr. Louis Saccoccio, the CEO for the National Health Care Anti-Fraud Association, and then hear from Dr. Shantanu Agrawal, who serves as Deputy Administrator and Director of Program Integrity at CMS.

Your full statement will be put in the record. Let's take each of you, see if you can condense it down given the time constraint that we have, and let's start with you, Ms. Hughes.

**STATEMENT OF BETTIE HUGHES, SENIOR MEDICARE
PATROL COORDINATOR, THE SENIOR ALLIANCE
(AREA AGENCY ON AGING 1-C)**

Ms. HUGHES. Chairman Nelson, on behalf of the Medicare beneficiaries, the people with disabilities, their families and caregivers of Michigan, I want to thank you for giving us this opportunity to come and speak to you about Medicare fraud and what we experience in Michigan.

I began working with seniors as a result of being a caregiver for my husband. He had gone in for a CAT scan and had an anaphylactic shock. This left him completely legally impaired, and with that, lots of things happened with billing.

I was encouraged to put him into a nursing home, but instead, I brought him home so that I could care for him. I quit my job at that point, after 21 years in retail management, and began to take care of him.

I did not really think too much of it at the time, but we did have a number of people coming into the home—physical therapy, occupational therapy; kind of strange to have occupational therapy for someone who is completely bedridden and is unable to move.

I saw firsthand just exactly how unnecessary medical treatments can cost a family thousands and thousands of dollars, so, on his passing, I decided to do something, and that is when I began working with the Senior Alliance Area Agency on Aging and immediately became very involved with the Senior Medicare Patrol and later became the Regional Coordinator for that program.

The Senior Medicare Patrol is a volunteer program, and it is funded by the Administration on Aging, and what we do is we provided education, counseling and outreach to those Medicare beneficiaries. We educate beneficiaries on what to look for and empower them to be able to report that back to us.

Today, the Senior Medicare Patrol program nationwide has received more than one million inquiries regarding potential fraud, waste and abuse, and it is estimated to have saved Medicare and Medicaid about \$106 million.

I am proud to serve as the Regional Coordinator for the Senior Medicare Patrol. I have the responsibility of managing 46 volunteers and counselors.

In the past seven years, our SMP program has identified and reported many cases of beneficiaries receiving unnecessary treatments, such as Ms. Gresko, tests such as MRIs and CAT scans similar to unnecessary treatment. We have also seen beneficiaries being billed for services that they did not receive.

We had a gentleman who suffered a massive heart attack and then had triple bypass surgery. During the time he was in the hospital for six weeks, he was scheduled for, and billed for, outpatient physical therapy treatments.

In another case, we have people that are soliciting and bearing gifts of televisions, video games, video equipment, having pizza parties and Bingo games at different senior housing. They have solicited our Meals On Wheels volunteers, followed them, taking addresses, only to return later to the beneficiary's and bring them a basket of food, saying that this is a gift from Medicare so that they can solicit the services.

We need to find a better way to identify these fraudsters and keep them from marketing their schemes to some of our most vulnerable seniors.

I know that there are many honest doctors, nurses, physical therapists. Not everyone is out to commit a crime or to defraud someone. We need to let more of the good people into the program while keeping some of these bad ones out.

We need to think how we can work together—government, private industry, beneficiary and provider—to stop this Medicare fraud.

We, in the Senior Medicare Patrol, have been doing our part. We have worked with our state health insurance program counselors to reach as many beneficiaries as we can. We have worked with the Office of the Inspector General in Wayne County to instruct service coordinators working in government housing on how they can protect the residents of their buildings from health care fraud.

Every day, we hear different stories from these beneficiaries. We need to try and find solutions.

We ask you to do what you can to give the Medicare program better tools to fight health care fraud. We need to keep the

fraudsters out of our program. We need to crack down on abusive marketing practices, and, we need to find a way to all work together to reduce the billions of dollars that we now have in Medicare fraud.

I thank you very much for letting me speak to you today about our experiences.

The CHAIRMAN. We want to thank you.

Before we hear one such example from Ms. Gresko, let me say before Senator Collins makes a statement that we are very pleased that Senator Carper has joined us because he has been involved in this fight against Medicare fraud. He is a former member of this Committee, and he is the Chairman of the Homeland Security and Governmental Affairs Committee.

I am a co-sponsor of additional anti-fraud legislation which will encourage the reporting of Medicare fraud and impose tougher penalties.

Ms. Gresko, if you can just hold one minute, let me turn to our Ranking Member, Senator Collins, for her statement.

Senator COLLINS. Thank you, Mr. Chairman.

In light of the fact that we have votes coming up, I will forego my opening statement and just submit it for the record. I am very interested in hearing from our witnesses, and I think the time would be better spent listening to them rather than having them listen to me, and so, with your permission, I will put it in the record.

The CHAIRMAN. Well, thank you, Senator Collins, and thank you for being a great partner in running this Committee.

Ms. Gresko—and then we will get to you, Senator, as well. I want to get on through the panelists.

Ms. Gresko.

STATEMENT OF PATRICIA GRESKO, MEDICARE FRAUD VICTIM

Ms. GRESKO. Chairman Nelson, Ranking Members of the Committee, distinguished Senators, I am honored to be here today to give you my story as a victim of Medicare fraud.

I live in Romeo, Michigan, where I worked for the school system for 25 years. My favorite part of the job was working with adult and alternative education programs. Getting students to stay in school and get their diploma was a very fulfilling accomplishment.

I will also count it as a great accomplishment if in sharing my story today I can prevent other seniors on Medicare from going through what I did.

I saw a doctor in Michigan for the first time several years ago, who told me I had a problem with my immune system and that I needed monthly IV medication. The doctor was personable and dignified. I trusted him, so I began these infusions in January of 2013.

During my first treatment, I had side effects of chest pains and was worried that it was my heart. The doctor told me that he needed to slow down the rate of the infusion, so I continued to get these treatments for seven months, each of these treatments taking seven hours.

I was shocked when I heard that my doctor had been arrested and taken into custody for Medicare fraud. The newspaper said he

had diagnosed people with cancer who did not have it just so he could bill Medicare for the treatments.

I started worrying about my own treatments and did some research. The deficiency my doctor said I had in my immune system, a low level of something called IgM, could not be replaced, so I went to see two different doctors, one of them a specialist, but both agreed I did not need these treatments.

Over the course of seven months, I paid this doctor \$1,500 in co-pays. I later found out he had received over \$14,000 for giving me these treatments.

I have three grown children—two sons and a daughter—who will one day be on Medicare. I do not want them to experience what I went through.

I hope that by telling you my story you will take action to prevent doctors like this one from getting into Medicare and ensure that the program will be there for many generations to come.

Thank you.

The CHAIRMAN. Ms. Gresko, it is an outrage what you just described. Is this doctor in jail?

Ms. GRESKO. Yes.

Senator COLLINS. Good.

The CHAIRMAN. Well, Mr. Martens, tell us what you all are doing to crack down on what is one of the highest rates of Medicare fraud in the country—in South Florida.

**STATEMENT OF BRIAN MARTENS, ASSISTANT SPECIAL
AGENT IN CHARGE, MIAMI OFFICE OF INVESTIGATIONS,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
OFFICE OF THE INSPECTOR GENERAL**

Mr. MARTENS. Good afternoon, Chairman Nelson, Ranking Member Collins and distinguished members of the Committee.

I am Brian Martens, an Assistant Special Agent in Charge from South Florida. I appreciate the opportunity to describe how our special agents are fighting Medicare fraud and protecting seniors and taxpayers.

We are making a positive impact in Florida and across the Nation. Criminal prosecutions and financial recoveries have increased while payments for services in certain fraud schemes have decreased, and the OIG efforts, together with those of our law enforcement partners, have led to a record-setting return on investment—over \$8 to \$1.

Despite our successes, South Florida continues to be a hot spot for health care fraud. Miami is ground zero.

In Florida, fraud schemes evolve quickly and can be both viral and migratory in nature. We see fraud schemes moving from Medicare Part B to Medicare Part C. Prescription drug fraud now involves non-narcotic, high-cost drugs. Home health schemes are transitioning to unnecessary physical and occupational therapy services.

Organized criminal enterprises steal money from Medicare by creating sham companies or complex networks. Health care fraud criminals are dangerous, and we often find weapons when we execute warrants. These criminals target the most vulnerable in our society—our seniors and the disabled.

When Medicare fraud is committed, the health of beneficiaries can be compromised. Take for example an HIV-positive beneficiary who lived in a boarded-up mobile home in South Florida. A professional patient recruiter paid him to go to a clinic that billed Medicare for expensive treatments that the patient never received. That beneficiary willingly chose to accept cash kickbacks and receive low-cost vitamin infusions instead of the appropriate medical treatment.

A local doctor complained to us that the patients at that clinic were using the cash kickbacks to buy drugs and alcohol, and those habits only made the patients more sick.

Thankfully, the majority of cases do not involve direct harm to patients that we have in Florida, but beneficiaries can be harmed by the Medicare fraud in other ways. For example, when a patient's Medicare number is stolen and used to bill false claims, the patient's medical record can be permanently distorted. This may cause complications or delays in treatment. Also, if a Medicare number is compromised and the patient cannot get a new number, the patient is susceptible to identity theft.

In Florida, beneficiaries play a role in Medicare fraud in three ways:

One, they are unknowingly involved and are likely the victims of identity theft.

Two, some are unwitting beneficiaries who may have received a medical service but did not realize that the provider improperly billed Medicare, usually for a more expensive service than the one they actually received.

Three, unfortunately, in some cases, beneficiaries choose to participate in the fraud. They sell their Medicare numbers in exchange for cash or other benefits. Beneficiaries can make around \$1,500 in cash per month for participating in Medicare fraud.

Health care providers and beneficiaries can serve as a front line of defense by refusing to participate in Medicare fraud and reporting any suspected fraud to us, and I would like to thank those that already do, such as you, ma'am.

Senator Collins, Maine is not immune to these fraud schemes. I have spoken with my colleagues, and examples of their Medicare work include prescription drugs, medical identity theft, home health fraud, although most of the case work is in Medicaid.

I started today by telling you about some of our progress, but it is also important to tell you that OIG's missions is challenged by our declining resources at a time when health care fraud is on the rise. Our Medicare Fraud Strike Force Teams are not operating at full strength due to funding shortfalls and hiring freezes, and, in Florida, over the past two years, we have closed over half of our investigative complaints due to a lack of resources.

Among other things, the additional funding in OIG's 2015 budget request could support additional boots on the ground in places like Florida and elsewhere across the country. We appreciate this Committee's support.

In conclusion, I would like to thank our agents in Florida and throughout the country for their dedication and hard work.

Thank you for the opportunity to testify, and I am happy to answer any questions.

The CHAIRMAN. Thank you, Mr. Martens.

When we get to questions, we want to know also about what used to be so rife, where somebody would open up a storefront that did not provide anything and bill Medicare.

Mr. Saccoccio.

STATEMENT OF LOUIS SACCOCCIO, CHIEF EXECUTIVE OFFICER, NATIONAL HEALTH CARE ANTI-FRAUD ASSOCIATION

Mr. SACCOCCIO. Thank you. Good afternoon, Chairman Nelson, Ranking Member Collins and other members of the Committee.

My name is Lou Saccoccio, and I am the CEO of the National Health Care Anti-Fraud Association, or NHCAA, and I appreciate the opportunity to discuss with you this afternoon how to best protect seniors and taxpayers from health care fraud in Medicare.

On a national level, health care fraud hampers our health care system and undermines our Nation's economy. On an individual level, no one is left untouched by health care fraud.

It is a serious and costly problem that affects every patient and every taxpayer across our Nation. The extent of the financial losses due to health care fraud in the United States, while not entirely known, is estimated to be in the range of tens of billions of dollars.

To be sure, the financial losses are considerable, but the losses are compounded by numerous instances of patient harm, as evidenced by Ms. Gresko's case, which are an unfortunate, insidious side effect of health care fraud and which impact patient safety and diminish the quality of our medical care. Health care fraud is not just a financial crime, and it certainly is not victimless.

Fraud does not discriminate between different types of medical coverage. The same schemes used to defraud Medicare and Medicaid migrate to private insurance, and schemes perpetrated against private insurance make their way to Federal programs. The providers of health care services and products who commit fraud bill multiple payers, both private and public.

In this environment, dishonest providers bank on the assumption that payers are not working together to collectively connect the dots and uncover the true breadth of a scheme. It is precisely this reason why the sharing of anti-fraud information and data among payers is crucial for successfully identifying and preventing health care fraud. Payers, whether private or public, who limit the scope of their anti-fraud information to data from their organization are taking an uncoordinated and piecemeal approach to the problem.

The private-public anti-fraud information sharing sponsored by NHCAA routinely helps our private side members and our government safeguard and recover funds that would otherwise be lost to fraud.

Seeing that this coordinated approach is critical to anti-fraud success, NHCAA and other organizations and government agencies saw the need to improve and expand the cooperation and anti-fraud information-sharing between the private and public sectors. As a result, after more than two years of discussions, the Healthcare Fraud Prevention Partnership was formally announced in July 2012 at the White House.

The Partnership is a joint initiative of the Department of Health and Human Services and the Department of Justice. It is a vol-

untary public-private partnership between the Federal Government, state officials, private health insurance organizations and health care anti-fraud associations like NHCAA, which aims to foster a proactive approach to detect and prevent health care fraud across all public and private payers.

However, despite the proven effectiveness of anti-fraud information and data-sharing, many health insurance plans are reluctant to fully participate in anti-fraud sharing activities for fear of possible litigation brought by health care providers who may be the subject of the shared data or information.

This reluctance is demonstrated by the fact that only 40 percent of the 82 NHCAA health insurance company members enter information about their fraud investigations into NHCAA'S SIRIS database, which is a database containing information on health care fraud investigations opened by private payers. This 40 percent rate is in stark contrast to the 95 percent of the same members who search the database for information entered by other companies.

Clearly, the interest in receiving anti-fraud information exists. However, the willingness of a company to share its own information is clearly hampered by the perceived risks involved. Although the decision to avoid this risk may seem to make sense to a particular company, the decision results in a negative impact on the overall fight against health care fraud.

While several states provide some limited form of immunity for fraud reporting, there exists no Federal protection for insurers that share information about suspected health care fraud. NHCAA believes that providing protections for organizations that share information and data concerning suspected health care fraud is a reasonable and prudent step to take and would encourage this essential activity.

There is no silver bullet for defeating health care fraud. A winning fraud prevention strategy from Medicare must be multifaceted.

Just as importantly, health care payers, including Medicare, cannot work in isolation and expect to be successful in detecting and preventing health care fraud. The establishment of Federal protections for these organizations engaged in anti-fraud information and data-sharing would be a major step in encouraging this essential activity and also would lend strong support for the growth and success of the Healthcare Fraud Prevention Partnership. In our view, this partnership signals a new era of private collaboration and holds great promise as a significant step in preventing fraud in Medicare.

Thank you very much for allowing me to speak this afternoon, and I would be happy to answer any questions you may have.

The CHAIRMAN. Thank you.

Dr. Agrawal.

**STATEMENT OF SHANTANU AGRAWAL, M.D., DEPUTY
ADMINISTRATOR AND DIRECTOR, CENTER
FOR PROGRAM INTEGRITY, CENTERS FOR
MEDICARE AND MEDICAID SERVICES**

Dr. AGRAWAL. Thank you. Chairman Nelson, Ranking Member Collins and members of the Committee, thank you for the invitation to discuss the Centers for Medicare and Medicaid Services'

program integrity efforts. Enhancing program integrity is a top priority for the Administration and an agencywide effort at CMS, and we have made important strides in reducing waste, abuse and fraud, with the strong support of this Committee and Congress.

Before proceeding, I did want to take a moment to introduce myself. I started as Deputy Administrator for Program Integrity and Director of the Center for Program Integrity at CMS about three weeks ago, but prior to that, I was Chief Medical Officer of the Center.

I am a board-certified emergency medicine physician, and for the last several years I have been working concurrently with other physicians as an emergency medicine doctor, both in large academic centers and a small community hospital in the area.

I view program integrity through the lens of these experiences and as a physician who fundamentally cares about the health of patients.

CMS is committed to protecting taxpayer dollars by preventing or recovering payments for wasteful, abusive or fraudulent services and is helping to extend the life of the trust fund, but the importance of program integrity efforts extends beyond dollars and health care costs alone. It is fundamentally about protecting our beneficiaries, our patients, and ensuring we have the resources to provide for their care.

Numerous experts have cited the waste endemic to our system caused by multiple factors, from inefficiencies in care delivery to outright fraud.

Underlying the issues and numbers are real patients. Even everyday, common sources of waste have consequences. A patient presenting to an emergency department today may get the same testing she received at another facility because the results are simply unavailable. She may be exposed again to radiation or other unnecessary risks from excessive or duplicative diagnostics and procedures despite the best intentions of her providers.

Unfortunately, waste can transition to abuse. Providers can make clinical decisions, as in the case of Ms. Gresko, to prescribe a particular medication, order a specific test, perform a procedure, influenced by their own financial interests or incentives. These same interests can lead to up-coding or other gaming of the reimbursement system.

A few providers will go a step further to commit fraud. Fraud is not merely deception for dollars through falsified claims. It threatens beneficiary health through blatantly unnecessary services, substandard or nonexistence care, dangerous prescribing through pill mills and a host of other schemes.

CMS is changing the program integrity paradigm toward a focus on prevention and collaboration to identify and combat waste, abuse and fraud in our system and in partnership with other stakeholders. As Deputy Administrator, I will continue to lead CMS on this course with three main areas of attention—coordination across the agency and the broader health care system, excellence in our operations, and a clear view towards improving the cost and appropriateness of care.

First, coordination. The Center for Program Integrity is responsible for leading agency efforts to reduce waste, abuse and fraud.

Our work connecting Medicare and Medicaid is especially important. For example, the Affordable Care Act enabled us to protect beneficiaries from bad actors that cross programs by requiring removal from Medicaid if a provider had been removed from Medicare or another Medicaid program.

CMS also considers information received from states in its provider enrollment decisions.

Collaboration with stakeholders external to the agency is vital as well to the identification of vulnerabilities and increasing our impact.

We work with our law enforcement colleagues through active data-sharing, collaborative investigations and, ultimately, enforcement actions.

We also continue to build on existing partnerships with private sectors, health care organizations such as the NHCAA, and providers through our public-private partnership.

Second, operational excellence. Over the last several years, medicine has increasingly placed performance measurement at its core, and this principle has really become part of my DNA.

CMS has robust measures of the return on investment of program integrity appropriations, the result of audit and investigation activities, and the impact of advanced data analytic systems, all of which show strongly positive returns on investment. I intend to build on this foundation by managing performance and strategic decision-making based on the areas of greatest risk and return.

In particular, CPI's work on provider enrollment and screening, also strengthened by the Affordable Care Act, has enhanced program integrity while lowering burden for providers. We work with the provider community to close program integrity loopholes, devise new initiatives and, ultimately, produce more impact for our activities.

Finally, the cost and appropriateness of care. CMS has a comprehensive program integrity strategy that includes multiple tools and interventions that are used individually and in tandem to tackle specific vulnerabilities. By applying these tools across Medicare and Medicaid in a coordinated way, CMS can impact the overall cost of care. We can and should aim to do even more.

As just one examples, CMS uses predictive analytics technology to identify potentially fraudulent providers for investigation and is working to expand that focus to providers that may not reach the threshold of fraud but are billing inappropriately and may require education or medical review. The goal is to target the right intervention for the right situation to impact the overall cost of care.

Thank you for your time and this opportunity. I look forward to working together as we continue to focus on beneficiaries and strive every day to protect their health and well-being, and I am happy to take any questions.

The CHAIRMAN. Well, thanks to all of you.

Given the fact that we are racing the clock, I am going to defer questions. You can see the interest of this Committee in the subject matter. I will call on the Senators in the order in which they arrived.

Senator Collins.

Senator COLLINS. Thank you, Mr. Chairman.

Ms. Gresko, I want to start by saying that I am just horrified about what happened to you. I think when we contemplate Medicare fraud we tend to think of it in terms of dollars lost, but in your case you were subjected to grueling, unnecessary infusions that could have really harmed your health had they continued, so I think it is really important that we keep that side of the equation in mind as well.

Dr. Agrawal, I must say that I felt a sense of great frustration when I heard your testimony. Back in 1998, 16 years ago, when I was Chair of the Permanent Subcommittee on Investigations, I held a series of hearings on Medicare fraud in which we heard the Inspector General testify that there were billions of dollars lost to Medicare fraud.

Now I am encouraged to learn that CMS has now revoked the ability of more than 17,000 providers and suppliers to bill Medicare, but it begs the question of why it has taken so long for a crackdown to occur and how do these individuals get certified to receive payments from Medicare in the first place. How did 17,000—and, undoubtedly, there are many more—bogus providers and suppliers get certified to receive Medicare?

Let me just say one more as part of my rant on this, and that is that the IG's Office and GAO have been telling us for years that Medicare was a high-risk agency, extremely vulnerable to fraud.

Dr. AGRAWAL. Thank you for your question, Senator.

I will say that since the passage of the Affordable Care Act we have had a lot more tools at our disposal, which I believe Senator Nelson referred to as well, that really allow us to take significantly more steps in enrolling and screening our providers prior to them being able to bill Medicare.

I think some of those important steps include being able to risk-stratify providers based on their provider type, which was a specific authority provided to us by the ACA, that allows us to subject higher-risk provider categories to greater amounts of screening.

For example, now—which is a change from prior to the Affordable Care Act—all providers are subjected to certain screening that is automated, very efficient and leverages databases across the Federal Government in order to ensure that they meet the basic requirements of enrolling in Medicare.

For example, we leverage licensure data to make sure that providers, like physicians, are appropriately licensed to provide care. We utilize GSA debarment data, felony conviction data, and that is a whole new level of consistent, automated screening that was not in place prior to the statute.

Senator COLLINS. Well, let me just say that there was nothing that would have prevented CMS from implementing those provisions prior to the passage of the ACA. You had plenty of authority to do so and as did the previous administration. There was just nothing preventing that kind of data-sharing and screening and automation from happening.

I only have one more minute because there are so many of us, so I want to quickly go to Mr. Martens.

One of the things we discovered back when I held these hearings 16 years ago was that millions of Medicare dollars were sent to durable medical equipment providers that provided absolutely no

goods or services whatsoever, and I remember vividly that one of the companies listed an address that would have been in the middle of the runway at the Miami airport had it existed.

It is my understanding that Medicare contractors now conduct onsite visits of DME suppliers to make sure that they are legitimate, that they are not just a post office box. How effective have these onsite inspections been for DME providers in detecting businesses that are not legitimate from your perspective?

Mr. MARTENS. From my perspective, in Miami, you are absolutely right. For years, you had that going on.

Then in about 2006–2007, there was active push to go out and do onsites. It was a collaborative effort between OIG, CMS and the contractors, and they did all these onsites of these various DME suppliers.

At the time, we were actually out going to financial institutions and just collecting money back that was sitting in bank accounts that was where people had left and disappeared who had owned DME companies.

Since that time, we saw a significant reduction in the amount of DME billing, especially as a boots-on-the-ground person in South Florida, and there has been a significant reduction in that. Obviously, there are still fraud schemes, and there are still times they do it.

We have had significant effect, and I would like to say one example where we ensured that not a dollar was lost to the Medicare program, and that was a case that happened in Florida, and it was specifically where we identified early through a complaint of a beneficiary, in part, who lived in a different geographic area, had not gotten the service.

We worked with the historical owner of the company. We were able to get to the company, work with the CMS contractors to make sure that the automatic payments that occur with 15 days did not go out. Within 30 days, we were able to arrest the people, and not a dollar went out, and we charged them with \$1.5 million in fraud.

There is a lot of efforts moving forward to stop that. We do see durable medical equipment fraud, but that is not the primary thing we are seeing anymore in the State of Florida as a top thing.

Senator COLLINS. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Walsh, Montana is a long way from ground zero of Miami, but you have Medicare fraud in Montana.

Senator WALSH. We do. Thank you, Mr. Chairman.

I would ask this question to any of, I guess, the three members to the center and to the right of the table that is prepared to answer.

My question would be that last year Montana was part of a \$2.6 million settlement with Kmart over Medicare and Medicaid fraud. Kmart was alleged to have overcharged for partial filling of prescriptions for seniors and low-income Montanans.

What are we doing to prevent and detect this type of fraud from happening in the future?

Can we have—do we have any idea?

Dr. AGRAWAL. I am happy to take the question. Thank you, Senator.

Part D fraud is an extremely important priority for the agency, and we are taking a number of steps to help secure the program. While not speaking specifically to the details of that case, I can tell you that we do look at pharmacy.

We conduct, in conjunction with Part D plan sponsors, pharmacy stock audits in order to prevent just that situation, where we have billing of a certain amount of medications but sort of purchasing of supplies of a different and lower amount of medications. Should those audits reveal anything, the Part D plan sponsors work with us to provide that information to law enforcement so action can be taken.

We do work with Part D plan sponsors in other ways, sharing information and data, so that we can help to identify vulnerabilities for each other and help to identify courses of action.

Beyond that, we are further trying to build in further safeguards, additional safeguards, in the Part D program. Earlier this year, we did publish a proposed rule that would bring a whole new level of control and oversight to Part D that, thus far, has not existed.

One element to that proposed rule is to require all prescribers in Part D to actually enroll in Medicare. Currently, if you just prescribe in Medicare, you do not necessarily have to be enrolled, which allows you to escape the screening and enrollment processes that we have in place. It would also prevent us from taking action against you if, for example, a provider that has been revoked continues to prescribe in Part D.

The provisions in that rule will do, I think, a lot to help us curtail abuse prescribing and take action against that kind of behavior.

Senator WALSH. Okay. Thank you.

One additional question. In Montana, we have extremely rural areas served by Medicare. Montana has 53 rural health clinics. In addition, a dozen other hospitals in Montana are considered frontier hospitals for purposes of the Medicare wage index.

My question is I am wondering, from the witnesses, what special characteristics you may have come across that make Medicare fraud more difficult to identify and prosecute in rural areas as opposed to the larger cities.

Dr. AGRAWAL. I will take that, Senator. Thank you.

I would say there is a certain consistency, actually, that we bring to fraud investigation and fraud detection that takes into account some of the particular practice patterns or differences that you see across the country but really allows us to look at the country as a whole.

For example, our provider enrollment processes are consistent, and actually, that is a change from before, and I think it is important because it allows us to perform our job efficiently but also decrease provider burden, so it should be the case that a physician or a provider in Montana does not experience a different process than one in Miami.

I should also mention that our predictive modeling approach is national in scope. It looks at 4.5 million claims a day regardless of where they originated, and it subjects those claims to sophisticated analytics.

We will take account in those analytics to geographic differences that might actually be appropriate patterns of care. We do not want to flag care that is very reasonable in a more rural area but unusual in a more urban area.

I think the consistency is actually one of the more important things that I would highlight, and beyond that, I think it is sort of working with providers and working with beneficiaries to make sure that they are also acting as a surveillance network for us, as Ms. Gresko did in a smaller part of Michigan actually.

Senator WALSH. Thank you, Doctor.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Coburn.

Senator COBURN. Mr. Chairman, first of all, thank you for the honor of being able to sit on your dais and be able to ask questions.

Thank you, Ranking Chairman Collins.

I have been working on Medicare fraud since 1995, and Dr. Agrawal, I think it is great that you chose to come in and try to tackle this. My hope is that you are given the flexibility to do what you really need to.

Most of my questions are going to deal with the FPS system because the GAO was pretty unimpressed with the last data that came out.

One, I would like to know where you are on that. What percentage of Medicare claims are actually looking at it? Your last only detected two-tenths of 1 percent of Medicare fraud at its last formal rollout of what you told the Congress.

The second question I would have for you is, are you now using the Death Master File daily? Are you coordinating? Are you still paying for dead doctors and dead patients?

Dr. AGRAWAL. Thank you for your question.

Let me just say, Senator Coburn, that I am deeply appreciative, and the agency is deeply appreciative, of your work on program integrity issues and your support of the agency's activities here.

To answer your questions, the FPS system has continued to develop. As you know, from the first year of report, our initial investment in that system returned a three to one return, so, for every dollar invested, we—

Senator COBURN. Let me just interrupt for a minute. GAO does not agree with that because they said not all the costs were associated with your numbers, so where you said 330, they said, time out, not accurate numbers.

Accurate numbers are important. That is the business that you are in, and so my hope is when GAO gives us the next report on this that they will not have that caveat.

Dr. AGRAWAL. I agree, Senator.

We are working very closely with the OIG as required in the statute to obtain certification for our next report. I can tell you that work has been diligent, and we are very optimistic that we will achieve certification as the next report comes out.

Senator COBURN. When will that be?

Dr. AGRAWAL. I cannot give you an exact date, sir, but I can tell you that we are working on it, and we hope to release the report soon.

I can also tell you that I am optimistic about the savings numbers that were identified in that report. I think the system has continued to develop in the right direction, where we are implementing far more models and refining the models that are already there.

I can tell you that the system is both identifying new cases of fraud as well as augmenting leads that we have had before.

Just one example to make this more concrete for folks who may not know as well as you do. There is, for example, a case that was on a program integrity contractor screen for about a year where they were investigating it. When an FPS model suddenly triggered for that provider, it actually provided new information that in the course of just a few months prompted a site visit and allowed us to revoke that provider.

Even in augmenting leads, I think the system has produced a real efficiency.

Senator COBURN. How about the Death Master File?

Dr. AGRAWAL. We do update all of our data sources routinely.

The Death Master File from the Social Security Administration is a very important data source. There are some inherent, I think, lag times built into that where there has to be reporting that goes to the SSA for them to incorporate it and then that data to come to CMS.

That lag time is there. We are looking at other opportunities for trying to eliminate that lag, utilizing claims data, but it is firmly integrated in our systems and into our modeling.

Senator COBURN. All right. Just one other comment, Mr. Chairman, and if I may, I would love to submit questions for the record for these witnesses.

The CHAIRMAN. Absolutely.

Senator COBURN. The history is CMS is doing the right thing, trying to get a prospective system in, and I applaud them for doing it.

The insurance industry has had one for years, and it is never pay and chase with the insurance industry. If there is a question, we do not pay.

My final question to you is, where are you on that, where we are raising it and, even if there is a suspicion, no payment until the suspicion is gone? Where are you on that?

Dr. AGRAWAL. Well, I think we are taking a few steps, sir.

First of all, we have been implementing the payment suspension authority given to us both by the ACA and prior to that.

We have, I think, far more streamlined processes that, working in conjunction with law enforcement and obtaining leads from FPS and other sources, allow us to get to payment suspension quicker.

We also—and that, obviously, as you know, prevents payments from going out the door.

We are also able to implement in the fraud prevention system, and have, as you saw in the first year report, algorithms, auto denial edits—I do not want to get too wonky in sort of the payer vernacular, but edits that essentially allow us to deny a claim and prevent a payment.

Those, I think, are real examples of things that stop payment from going out the door.

In addition, sir, to your comment about the private sector, that is one of the main objectives of the public-private partnership—is to be able to work with the private sector, teach them what we know, which I think is ample, and we can certainly teach them but also learn from them what some best practices are and what else we could be doing differently to help improve our efforts.

Senator COBURN. Well, once again, thank you for your service.

Dr. AGRAWAL. Thank you, sir.

The CHAIRMAN. All right. We have Senator Donnelly, Senator Warren and Senator Casey, and as you can see, the first vote has started.

I am going to call on Senator Donnelly. If you would go vote—now we are going to have a little lag time between this first vote and the second vote, but the last four votes are going to be 10-minute votes, so let's see if you all can come back, get your questions in, and then I will submit my questions for the record.

Okay, Senator Donnelly.

Senator DONNELLY. Thank you, Mr. Chairman.

Thank you all for being here. We greatly appreciate.

Mr. Martens and Mr. Saccoccio, if you could tell me, what do you ballpark and estimate is the amount of Medicare fraud per year right now?

Mr. SACCOCCIO. There has never been a very clear answer as to what—how much fraud is in the system. The estimates range from anywhere from a low of three percent up to 10 percent of overall expenditures.

For Medicare, you are talking about in the range now of \$600 billion a year, so, if you take 10 percent of that, you are in the \$60 billion—

Senator DONNELLY. A high of \$60 billion, a low of \$28 billion.

Mr. SACCOCCIO. [continuing]. \$70 billion range, and that is probably much more accurate, I would think, than the three percent range.

Mr. MARTENS. As a boots-on-the-ground individual in Miami, Florida—

Senator DONNELLY. Right.

Mr. MARTENS. I do not know that I am in a position to give you an answer on that. We can probably get something from our headquarters back to provide to you, sir.

Senator DONNELLY. What do you—as a boots-on-the-ground person in ground zero, what do you figure the percentage is down there, about? Any idea, of claims?

Mr. MARTENS. I do not know how I could quantify it.

I do know that with the types of cases we work there is a significant number or amount of health care fraud dollars that are down there, you know, but when you go across all lines of business, I am not sure where that number would be.

Senator DONNELLY. Okay.

Mr. MARTENS. It is not something I have ever attempted to quantify.

Senator DONNELLY. Thank you for all your hard work down there, too. The American—all of us appreciate everything you are doing on this.

What would you say is the highest impact thing you can do or that we can do to help you stop this? Like when you look, what is the most immediate action that could have significant impact?

Mr. MARTENS. Well, I would like to give you a couple, if I could. Senator DONNELLY. Yes.

Mr. MARTENS. I think the provider enrollment screening because part of this is before it ever gets to us is critical, and so if that stuff happens and that can be done at the CMS level, that is critical.

The second part for us is that, I mean, from a resource perspective for agents on the ground right now, especially in our area, we do not have the staff that we need with the amount of fraud that goes on there.

The last part is in something we have here with SMP. When you look at the education of seniors and getting people to look at their MSNs, their Medicare Summary Notices, and hopefully, we can empower them to call in and make sure when they see something that does not match up to let us know about it so we can get on things quicker. We have numerous examples of cases where those things have happened and those calls from seniors have been extremely beneficial and allowed us to do our job and put people in jail for it.

Senator DONNELLY. Okay. Dr. Agrawal, by the way, when you talk about resources, the figure that has been discussed today is for every dollar that is spent in trying to find it, we get \$8 back, I guess.

Dr. AGRAWAL. Correct.

Senator DONNELLY. That is a pretty good rate of return by any imagination that I could think of.

Dr. AGRAWAL. I would like to think so. I would like to think that we are a positive return to the American taxpayer.

Senator DONNELLY. Well, my guess is if you tell everybody around this town that you will give them \$8 for every dollar you give them, you would be a very popular guy is my guess.

Dr. Agrawal, when we look at the way Medicare is being run now and the things that are being done—and Dr. Coburn talked about learning from the insurance company, the different insurance companies out there—do you know what kind of fraud insurance companies are experiencing they pay for not just Medicare but across the spectrum for medical care that they pay for?

Dr. AGRAWAL. Thank you for the question.

I would echo Mr. Saccoccio's comment that there is not really an accepted universal fraud methodology for knowing the rate of fraud, either in the public or private sector. There are estimates.

I can tell you in working with the partners, with the private plans through the public-private partnership, that they face many of the similar issues that we do. Fraud does tend to cross the public-private divide, which I think in and of itself is an important lesson for folks to know—that fraud is not either just a Medicare or Medicaid problem.

As far as the volume of fraud, what I can say is that there are some tools that the private plans have at their disposal that we can learn from and indeed are. One example I would highlight is prior authorization, which we instituted recently in a demonstration for powered wheelchairs, and that actually has shown a good impact.

Senator DONNELLY. I am about out of time, so let me ask this last one real quick, and that is in regards to a number of the insurance companies who provide Medicare Advantage programs and others.

Are you sitting down with them and saying, what are your best practices, and then finding out the best practices from this one and from this one and from this one—because number one and most important is we can make sure that Ms. Gresko and the rest of our seniors never have to deal with this kind of fraudulent and criminal and, more than anything else, painful and heartbreaking conduct by these people, but number two is that all of a sudden you look up and the United States Government has saved \$40 billion each year and at the same time we have made it so that these businesses operate more effectively.

Have you talked to them, and are there any plans to sit down individually with each one to see what we can do?

Dr. AGRAWAL. Yes, sir. Thank you.

I would highlight that many of the members in the Healthcare Fraud Prevention Partnership, while they have their purely private side, are also MA plans, and so in that regard we do work with MA through that partnership. We work with MA plans directly. We ensure that they have compliance programs in place so that their efforts in fighting fraud are also robust.

Yes, we do get best practices from them as well. Not only, actually, do we get qualitative information from them about best practices; we are actually engaged in data-sharing with them so that we can identify bad actors together.

Senator DONNELLY. Well, to all of you, thank you. You are doing amazing work on behalf of every citizen.

Ms. Gresko, our goal is to make sure it does not happen to anybody else ever again. Thank you so much for being here.

I am from Indiana, right next door to your home state of Michigan, and we are still angry about you beating us up in basketball this year.

The CHAIRMAN. Senator Carper, have you already voted?

Senator CARPER. I have not.

The CHAIRMAN. You have not?

Senator CARPER. No.

The CHAIRMAN. Well, we are down to about six minutes to vote.

Senator CARPER. Okay.

The CHAIRMAN. Do you want to go and vote and come back?

Senator CARPER. I am happy to. Are there six minutes on the clock?

The CHAIRMAN. Yes. We are down to—

Senator CARPER. If there are six minutes on the clock, I would like to go ahead and talk. If there is not—that would mean we have eleven minutes.

The CHAIRMAN. Okay. You are recognized.

Senator CARPER. Oh, thanks so much.

The CHAIRMAN. Would you recess the Committee?

Senator CARPER. I will. I will. I am happy to.

The CHAIRMAN. Then members will come back.

Senator CARPER. Good. Thanks so much.

All right, everybody, thanks so much.

This is sort of a crazed atmosphere today. We have all these votes that have been crammed into a regular already busy schedule, and it looks like these started at 2:33, and it will run 20 minutes, so it will be 2:53.

I would just ask, Peter, just make sure I am out of here at 2:48.

STAFF. Yes, sir.

Senator CARPER. Thanks, pal.

I went to Ohio State, so most people would think I would not care much about Michigan.

I am a huge Detroit Tigers fan, and I have been watching them closely in spring training all the season, so I hope our Tigers do well.

They let me throw out one of the last opening game pitches at Tiger Stadium the week they closed Tiger Stadium, so, a huge fan and sat in the broadcast booth with Ernie Harwell, a Hall of Fame sports announcer, and used to do play by play with him.

I love the Tigers and have a great affection for that part of your State.

I am going to ask—thank you all for being a part of this and for bearing with us as our schedules are pulled and twisted.

I want to ask a question. Is it Dr. Agrawal? How do you pronounce your last name?

Dr. AGRAWAL. It is Agrawal, sir.

Senator CARPER. Agrawal. Agrawal, okay.

Dr. Agrawal, I think this is the first time we have had a chance to meet. We spent a lot of time with Peter Budetti and enjoyed working with him. We look forward to working with you and your team as well.

Dr. Coburn, who has been here—I think he has been here and gone. He and I have teamed up to introduce legislation. He probably mentioned it—the PRIME Act, and the idea is to do even more to try to reduce where we can improper spending and improper payments but also fraudulent payments as well.

We saw an uptick in the Medicare numbers, about a \$5 or \$6 billion uptick from 2012 to 2013, which was a matter of some concern for us, but I am delighted we have this opportunity to collaborate with Senator Nelson and Senator Collins on this area and also with you and the folks that you lead.

I am not going to spend much time talking about our legislation, the PRIME Act, other than to say what I said. The bill includes some improvements to the Senior Medicare Patrol.

I would just ask, what are your priorities, Dr. Agrawal, to work to improve program integrity? More specifically, how do you plan on reducing the level of Medicare improper payments?

I understand the level of improper payments, as I said earlier, went up significantly, about \$5 or \$6 billion, from year to year.

Just take a shot at that just for a couple of minutes, and I will be on my way. Thank you.

Dr. Coburn and I are hugely interested in these issues, so are Senator Collins and Nelson, but we just do not have time, unfortunately, to drill down like I would like to, but we want to have plenty of chances to talk to you later on.

Dr. AGRAWAL. That would be great, Senator. Thank you.

I do, and I know the agency does, very much appreciate your longstanding support on these issues.

Specifically, to talk about the improper payment rate, obviously, you are absolutely correct that the improper payment rate did go up. What I would ask is sort of just to remember the context—that the rate went up and primarily it was driven by improper payments in certain institutional providers like SNFs and home health agencies.

What we are finding is that is actually the outcome, most likely, of actually more specific regulation, more specific policy for those providers to respond to, which I think is obviously good from a program integrity standpoint, but it does create sort of a requirement that those providers be aware of the policies and respond appropriately to them. One, for example, is the face to face requirement for home health services.

The policies are clearly important. The policies clearly do help program integrity, but, if the providers are not educated about them well enough and have not gotten up to speed, then it is very possible that they will fail to submit the appropriate documentation or take some appropriate steps which will then drive up the improper payment rate.

I do think the improper payment rate is a symptom of that.

What we can do, I think, to work on it more is rather than backing away from real program integrity measures and initiatives is to do more and do better about educating providers, working with them, communicating with them, which we already do, and certainly I think that can help.

I think other activities, like the prior authorization demo, have shown that even an area like power mobility devices, which can be somewhat complex from a regulatory standpoint, can be clarified for providers if they know on the front end what they have to submit, and, indeed, we work with them to make sure that they submit things correctly on the front end, and therefore, they sort of get a guarantee on the back end that they will not be audited and the improper payment rate will not rise as a result.

I think we can—and there is some language in the President's budget to do more and take additional measures like that I think would help on the rate.

Senator CARPER. Good.

I am going to run.

I like to say whenever I talk to people who have been married a long time they always say the secret to—not always, but a lot of people say the secret to a vibrant, long marriage is the two Cs—communicate and compromise. Pretty good, huh? Communicate and compromise.

The third C would be collaborate, and what we need here is collaboration, communication as well and probably some compromise, but especially collaboration.

We are pleased to see our Committees here collaborating.

We very much look forward to collaborating with you and your folks and with others as well.

Welcome here, and we will look forward to see you at the ball game.

Thank you.

With that, the hearing is recessed for a few minutes.

They are not leaving.

Now, Senator Warren.

Senator WARREN. Thank you.

I realize we are kind of a tag-team here. Thank you very much for bearing with us.

This means we are very efficient. We are getting our votes done and able to address this really important question.

I want to think some more about Medicare fraud. Part of preventing fraud is deterrence. The government can invest billions of dollars in identifying fraud, but if major wrongdoers only get a slap on the wrist, then it does not mean much in terms of deterrence and there is not much incentive to quit doing it.

Let's examine how much real deterrence there is. I have pulled some examples here.

Last year, the Department of Justice convicted 718 people of health care fraud. CMS has more thoroughly scrutinized about a third of current Medicare providers and revoked over 17,000 providers' ability to bill Medicare—I think this is what you were talking about—since the passage of the ACA.

Those are very impressive raw numbers, and it is a lot better than the track record of many other enforcement agencies, so, good work on that.

Most of these cases involve individual actors or small and mid-sized companies. When major health care entities are accused of defrauding Medicare, the cases seem to end in a settlement and a corporate integrity agreement, which is an alternative to being excluded from Medicare participation, where big companies are accused of breaking the law and are asked only to set up internal fraud prevention controls.

I want to start out by asking, do CMS, the HHS Inspector General and DoJ have policies that guide them about when to pursue prosecution and when to bar Medicare participation versus when to just settle and write up a corporate integrity agreement?

Mr. Martens, could I start with you?

Mr. MARTENS. Absolutely, ma'am.

For us—and I will just start with an example in Florida.

I mean, currently, right now there is a huge corporation, WellCare, which was an HMO. We took over 200 Federal agents when we had information and executed search warrants on their facility in Tampa. Subsequently, we charged the executives, they went through a long trial, and they were convicted. We were actually onsite that day the trading on Wall Street was shut down on that stock ticker.

The more important thing there is that we have to have the proof to get there. We have to have the information, so, in a lot of cases, we need to have witnesses that can specifically show the intent, and we are able to prove that in conjunction with DoJ and our other law enforcement partners, so many times, when you see these settlements and things, I think what happens is we have not gotten to the point in those matters to be able to get inside and prove the direct intent on a specific individual, not necessarily the corporation.

Senator WARREN. Yes, but it is a corporation we are talking about here and the corporation that should be held responsible, and you are telling me that it was easy to do for little tiny providers, but you have these large providers that have many employees and millions of dollars that are churning through in activities, and the reason you ended up with so many settlements was because you could not prove your case?

Mr. MARTENS. Well, no, we are—I mean, we are proving the case, right, just in a civil perspective that we know there are false claims, right, or there is some sort of false claim, and, when we move it into the justice arena to go through with that, we may not have been able to get to the level to prove the criminal intent.

Senator WARREN. That is what I am just trying to understand.

The policy is that if you think you can prove criminal intent you actually would charge and take to trial to pursue banning them from further Medicare participation?

Mr. MARTENS. In the case of WellCare, just as an example there, the corporation—

Senator WARREN. What I am trying to ask about is whether or not you have a policy in place for when it is that you make the decision that you are just going to settle and tell them to clean it up internally, or you are actually going to pursue it—you are going to pursue criminal remedies or you are going to pursue keeping them out of the Medicare system altogether.

Mr. MARTENS. There is not a policy.

Senator WARREN. Okay. That was my question.

Mr. MARTENS. I mean, when we investigate a case, we are looking to find the evidence and wherever the evidence takes us, and, if we can get the evidence to prove the intent and work with DoJ to get that prosecuted, we do it.

Senator WARREN. Well, but that is the question I am asking about, what the level of prosecution is.

Maybe Dr. Agrawal, could you speak to that a little bit?

Dr. AGRAWAL. Sure, and I appreciate the question.

We have pursued administrative, I should say, authorities against institutional providers on the CMS side. Obviously, we hand off cases in terms of to law enforcement to take them to trial or other kinds of law enforcement activities, but we have had revocations against institutional providers, hospitals, skilled nursing facilities.

Senator WARREN. Again, the question, Dr. Agrawal, is not whether or not you have ever taken anyone forward. The question is whether there is a policy in place that distinguishes why sometimes these things settle out and do not.

I just want to turn to a couple of examples on this—HCA, the largest for-profit hospital chain in the country. In 2000, HCA paid \$840 million after pleading guilty to charges of fraud and illegal kickbacks. Then in 2003, it paid \$631 million to settle the associated civil claims. At the time, this was the largest health care fraud settlement in U.S. history.

Despite the guilty pleas, HCA was not barred from Medicare. Instead, it entered into an eight-year corporate integrity agreement that required the company simply to improve its compliance efforts.

What happened? Two years ago, HCA got in trouble again, this time over allegations that one of its subsidiaries was again engaged in an illegal kickback scheme that dated back to 2007, the time when they were operating under this corporate integrity agreement. The next time now, HCA's punishment was a \$16.5 million settlement and another corporate integrity agreement for the subsidiary. All of this was in a year when HCA made \$1.6 billion in profits.

The question I am trying to ask is about whether or not we really have enough punishment associated with violating the law to act as an effective deterrent, Dr. Agrawal.

Dr. AGRAWAL. I do appreciate what you are asking, and I understand the case.

We do not get involved nor do we have authority to levy exclusions or corporate integrity agreements. Those are actions taken by law enforcement. We are happy to provide assistance and support wherever we can, but ultimately, those decisions are not made at CMS.

What I can tell you is that we do have significant administrative authorities which are preventive and deterrent in nature, and when the bar for those administrative authorities is met, we do take action, whether it is revocation or payment suspension or whatever the authority.

Senator WARREN. I understand this is not strictly within your authority.

Perhaps I could ask the question just slightly differently, and that is, do you think that these settlements and the corporate integrity agreements are working as an effective deterrent?

Dr. AGRAWAL. I appreciate the question.

Unfortunately, I do not have the appropriate expertise to be able to address that. I do think that needs to be a question that is addressed by law enforcement or the folks that actually administer those remedies.

The CHAIRMAN. Senator, I can answer the question—

Senator WARREN. Please, Mr. Chairman.

The CHAIRMAN. [continuing]. Because the fine was actually \$1.7 billion.

Senator WARREN. Yes.

The CHAIRMAN. Guilty in the corporation, but nobody in the corporation went to jail.

Where is the example of this is a no-no and people should not be doing this?

Senator WARREN. You know, I am just very concerned, Mr. Chairman, that Medicare fraud has become a game of catch-me-if-you-can.

If you do catch me, it is just the price of doing business. You pay a few million. Shoot, maybe even a billion dollars, but, pay a fine and move on and alter your business practices only to the extent of figuring out where to minimize the odds of being caught.

If that is the case, we are always going to be behind on Medicare fraud. We are never going to do much to shut it down.

Like I said, I started out with the good numbers, but they mostly were small-time operators, so you go after the small-time operators, but you let the big guys continue to keep everybody in business and

continue in the same operations. It just seems to me that is not going to be a very effective deterrent.

Mr. Chairman, do I have time for one more question?

The CHAIRMAN. Of course.

Senator WARREN. Oh, thank you because there is another one I want to ask you about, and that is when we talk about the settlements it seems like many, if not most, that we are talking about here, of these Medicare and Medicaid fraud cases, involve both large health care corporations and they result in settlements, so, if there is going to be this much reliance on settlements, then we need to look closely at the information that is available to the American public about the settlements.

I want to think about—you mentioned, Mr. Martens, about the False Claim Act.

We have a lot of cases brought under the False Claim Act. Department of Justice recently reported that \$2.6 billion was recovered from the False Claims Act settlements of health care fraud cases in fiscal year 2012.

Accordingly to the IRS audit guidelines, here are the quotes they used: Experience has shown that almost every defendant deducts the entire amount of a False Claims Act settlement as a business expense.

When the government announces one of these settlements and trumpets a large sticker price, I think they ought to tell us whether or not the taxpayers are going to end up picking up a substantial amount of the tab.

Dr. Agrawal, my question for you is, do you agree that more clarity around the details of these settlements would be beneficial?

Dr. AGRAWAL. I think there are a number of initiatives to make various parts of health care more transparent. CMS is implementing transparency initiatives where we can, where we have both the requisite data and the transparency is sort of in our arena. I could give you examples of that.

This is not an area that falls within CMS's bailiwick, so I could not comment on the likelihood or potential impact of that kind of transparency, but I would be happy to give you transparency initiatives that we do control.

Senator WARREN. Well, I appreciate that.

I will put it this way. I have introduced with Senator Coburn, who was here earlier, a truth in settlements bill that would require that whenever settlements are done, whether it is here in Medicare fraud or it is somewhere else, when settlements are made with the government, that the details are made clear and that the financial implications, including whether or not these are going to be tax-deductible and the taxpayer is going to end up picking up part of the tab, be made clear at the time that the settlement is announced.

I just want to be clear on this part of it, though, while we have introduced this as legislation and would like to make it apply to all of the agencies, there is no reason that those who are negotiating the settlements cannot adopt that level of transparency on their own and with each one of these settlements make it clear what the details are and who is paying how much, in truth.

I think it is an important thing to do, and I ask for help on that.

The CHAIRMAN. Dr. Agrawal, we want you all to crack down on this.

Senator Warren, let me give you another example. In Florida, a man by the name of Armando Gonzalez pled guilty to a conspiracy to defraud Medicare of \$63 million. He was a convicted cocaine dealer before he entered the Medicare program.

Now the question is, how did he get into the Medicare program?

One of the things that we did in the ACA that I mentioned at the outset, that this Senator did when we marked up the ACA in the Finance Committee, was that we wanted the requirement to perform background checks on Medicare providers.

I am getting ready to get to my question about the vacant storefronts that used to be rampant—nothing, but they would bill, or they would have a post office box.

I think if we are going to do this we are going to have to do these background checks.

Now I know you have limited budgets. I agree with you on all your plea for additional funds and so forth, but, you want to comment on that?

Dr. AGRAWAL. Sure, sir. Thank you.

We are performing criminal background checks. As you know, from the ACA, we have the ability to utilize new screening resources, and for our highest-risk providers, which include new DME companies as well as home health agencies, we have implemented criminal background checks for them.

We have also, in addition, conducted those site visits that you have mentioned. We have conducted literally tens of thousands of site visits, and that has helped to lead to the over 17,000 revocations that you heard about and—I think an important number to keep in mind also—over 200,000 deactivations from failing to report or communicate with CMS.

The CHAIRMAN. Okay. We passed the ACA in 2009. It became law that year. The background checks were mandated within the confines of your budget.

This guy is a convicted cocaine dealer, and he still gets through and rips off \$63 million.

Of course, Medicare equipment suppliers receive improper payments, and then some of them are accused of abusive telemarketing practices.

It is just hard to understand how somebody like this can get through the system at the expense of the taxpayer.

I would ask you, since you are saying that you have already testified you are doing the background checks on the high-risk providers, how do you decide which providers are high-risk?

Dr. AGRAWAL. That is a great question. Thank you.

We were given the authority to decide that certain provider groups were high-risk or moderate-risk or limited. What we did was we worked very closely with our law enforcement colleagues actually to help make that determination.

Currently, in the high-risk categories are new entrants who are DME suppliers or home health agencies and also folks that have exemplified themselves and earned the credit to be high-risk by being revoked before or having some other kind of program integrity action taken against them. All of those folks are now subject

to our highest level of scrutiny, which includes the automated checks, the site visits, the criminal background checks.

In addition, we have provider groups in the moderate category that are subject to a great number of screenings.

If you have a question about that, I am happy to answer it.

As far as the improper payment rate, sir, with respect to DME, one thing I would ask you to keep in mind is that improper payments are not the same as fraud. Most of the improper payments that Medicare makes and that we are able to assess on an annual basis are due to documentation errors or medical necessity issues. The vast majority of the time those services would have been appropriate in another setting or with appropriate documentation.

The CHAIRMAN. Mr. Martens, have you seen storefronts, post office boxes that offer nothing, and they still rip off the taxpayer?

Mr. MARTENS. Obviously, that was something that was historical and was there.

You know, there are different potential schemes and ways to try to move around, and as things are created they will morph into different methods of doing that. We are not really seeing the storefront issue specifically right now, but there are some methods and means to try and move around that.

Hopefully, that answers it. We do not really see them now in that sense relating to Medicare Part A and Part B kind of services.

The CHAIRMAN. All right. I want to thank everybody.

We are going to have to adjourn the hearing because we are down to five minutes with no give time at the end for this next vote and then a series of votes, one right thereafter, and I do not want you all sitting here until we could get back in another hour after all of these votes.

We will submit for all the members of the Committee additional questions. I have a number here that will be submitted for the record.

We want to thank you for lending your expertise and time as we go after this very significant question of Medicare and Medicaid fraud. Thank you very much.

The meeting is adjourned.

[Whereupon, at 3:07 p.m., the Committee was adjourned.]

APPENDIX

Prepared Witness Statements

**Prepared Statement of Bettie Hughes, Senior Medicare Patrol
Coordinator, The Senior Alliance (Area Agency on Aging 1-C)**

Chairman Nelson, Senator Collins, ranking members of the Committee, and distinguished senators, on behalf of older adults, people with disabilities and their families and caregivers of Michigan, I thank you for this opportunity to be here today to share with you some of our first hand experiences with detecting and reporting Medicare fraud.

My inspiration for working with older adults came from my own experiences as a caregiver for my husband. My husband had just retired when he was shot in the leg during an armed robbery. He had some persistent pain in his abdomen and back, so the doctors ordered a CAT scan. He went into anaphylactic shock from the dye used in the CAT scan, and stopped breathing. Even though the doctors tried to resuscitate him, he wound up with significant brain damage. They tried to get me to put him in a nursing home, but I said "no". I had one daughter in college and the other in high school—how could I put their father in a nursing home? I took him home on a ventilator.

I had to quit my job of 21 years in retail management to take care of him. I didn't think anything of it at the time, but I paid for a bed bound man to have occupational therapy; and to be on a ventilator doctors later said he didn't need. I saw firsthand how unnecessary medical treatments can cost a family thousands of dollars.

I decided to do something. In Michigan, I began working at the Senior Alliance area agency on aging, and quickly became involved with the Senior Medicare Patrol. The Senior Medicare Patrol is a volunteer program funded by the Administration on Aging which provides education, counseling, and outreach to Medicare beneficiaries on how to protect themselves against Medicare fraud. To date, the Senior Medicare patrol program nationwide has received more than one million inquiries regarding potential fraud, waste and abuse in the program, and is estimated to have saved Medicare and Medicaid about \$106 million. I am proud to serve as Regional coordinator for the Senior Medicare Patrol, with the responsibility for managing and training 46 volunteers and counselors.

In the past seven years, our SMP program has identified and reported cases of beneficiaries receiving unnecessary treatments or tests like MRI and CAT scans, similar to what happened to Ms. Gresko. We have also seen beneficiaries being billed for services they did not receive, and we have seen organizations that bill Medicare target vulnerable seniors with abusive marketing practices. In one case, an elderly man was billed for outpatient physical therapy services on the same day he was having triple bypass surgery after having a heart attack. He remained in the hospital for six weeks, and then went to a rehabilitation facility. While he was in the hospital, Medicare was billed for 12 outpatient physical therapy visits that he never received. In other cases, Seniors have been offered gifts of television and video games, weekly pizza parties and bingo games have been arranged, and solicitors from these organizations have even followed our Meals-On-Wheels volunteers to find out where Medicare beneficiaries live so that they can return with gifts as incentives to sign up for care from that organization. In one case, a home health representative followed a volunteer driver and was able to record all the addresses the driver delivered to and then returned later to the beneficiaries' homes with baskets of food, saying it was a gift from Medicare.

We need to find better ways of identifying who these fraudsters are, and keep them from marketing their schemes to some of our most vulnerable seniors. I know that there are many honest doctors, nurses, physical therapists, and home health aids which every day help Seniors to live healthy and productive lives. We need to let more of the good ones into the program, while keeping out the bad. We need to think about how we can all work together, government and private industry, beneficiary and provider, to stop Medicare fraud.

We in the Senior Medicare Patrol have been doing our part. We have worked with our State health insurance program counselors to reach as many beneficiaries as we can. We have worked with the Office of Inspector General to instruct service coordinators working in government housing on how they can protect the residents of their buildings from health care fraud. Every day we hear these stories, and try to find solutions.

We ask you to do what you can to give the Medicare program better tools to fight health care fraud. We need to keep fraudsters out of the program; we need to crack down on abusive marketing practices; and we need to find a way to all work together to reduce the billions of Federal dollars lost each year to health care fraud.

Thank you for letting me share my experiences with you.

Prepared Statement of Patricia A. Gresko, Medicare Fraud Victim

Chairman Nelson, Ranking members of the Committee, distinguished senators, I am honored to be here today to give you my story as a victim of Medicare Fraud.

I live in Romeo, Michigan where I worked for the public school system for 25 years. My favorite part of that job was working with adult and alternative education programs. Getting students to stay in school and get their diploma was a very fulfilling accomplishment. I will also count it a great accomplishment if in sharing my story today, I can prevent other Seniors on Medicare from going through what I did.

I saw a doctor in Michigan for the first time several years ago, who told me I had a problem with my immune system, and that I needed IV medication monthly. This doctor was personable and dignified, and I trusted him. I thought, like all doctors, he would have my best interests at heart.

I began these infusions in January 2013. During my very first treatment, I had side effects. I had chest pains, and was worried that it was my heart. The doctor told me that he needed to slow down the rate of the infusion, so, I continued to get these treatments for seven months. Each of these treatments took seven hours.

I was shocked when I heard that my doctor had been arrested and taken into custody for Medicare fraud. The newspapers said he had diagnosed people with cancer who didn't have it, just so he could bill Medicare for the treatments.

I started worrying about my own treatments, and did some research. The deficiency my doctor said I had in my immune system, a low level of something called IgM, couldn't be replaced, so I went to see two different doctors, one of which was a specialist. Both agreed that I did not need the IV medication.

Over the course of seven months, I had paid this doctor over \$1500 in co-pays. I later found out he had received over \$14,000 for giving me these treatments.

I have three grown children (two sons and a daughter) who will one day be on Medicare. I don't want them to ever experience what I went through, and, if there are doctors out there like this one, I worry that Medicare will not be there for my children.

I am hopeful that by telling my story, you will take action to prevent doctors like that from getting into Medicare, and ensure that the program will be there for many generations to come.

Thank you.

**Prepared Statement of Brian Martens, Assistant Special
Agent in Charge, Miami Office of Investigations, Department
of Health and Human Services, Office of the Inspector General**

Good morning, Chairman Nelson, Ranking Member Collins, and distinguished Members of the Committee. I am Brian Martens, an Assistant Special Agent in Charge based in the Miami Region with the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG). I appreciate this opportunity to describe the work of our Special Agents in South Florida to fight Medicare fraud and protect seniors.

We are having a positive impact in Florida and across the country. As reflected in the most recent Health Care Fraud and Abuse Control Program (HCFAC) Report,¹ OIG efforts, together with those of our law enforcement partners, have led to a record setting return on investment of over \$8 to \$1. Through coordinated enforcement efforts across the country, including those of the Medicare Fraud Strike Force teams, criminal prosecutions and monetary recoveries have increased while we have seen a measurable decrease in payments for certain medical services targeted by fraud schemes. One such example is the drop we have seen in Community Mental Health Center (CMHC) Medicare payments. Following targeted enforcement activities, nationwide Medicare CMHC payments fell from an annual \$273 million to \$31 million over a four-year period. Florida is an area where CMHCs were geographically concentrated. Despite our measurable successes in combating fraud, South Florida continues to be a hot spot of health care fraud and Miami is considered “ground zero.”

In Florida, we are seeing fraud schemes quickly evolve. As enforcement efforts target certain schemes, new permutations of those schemes arise. Not only are fraud schemes mutating, they are migrating—geographically and even between parts of the Medicare program. We are seeing an evolution of beneficiaries’ roles in health care fraud—including unknowing victims and complicit participants. We also continue to see organized criminal networks operating in a systematic approach to steal money from Medicare. The criminals committing these crimes are often dangerous and we regularly encounter stockpiles of weapons when we execute arrests and enforcement operations. These criminals are taking advantage of those most vulnerable in our society—the elderly and the disabled.

Medicare fraud is not a typical white collar financial crime, and it is not a victimless crime—it can affect patients, their families, the health care system and all taxpayers, and it’s not just about the money—when fraud is committed, Medicare beneficiaries can suffer physical harm.

Take for example the case of an HIV-positive beneficiary who lived in a socio-economically depressed area in South Florida. He lived in a boarded up mobile home and was being paid cash by a professional patient recruiter to go to a specific clinic for his HIV treatment. Only instead of getting the expensive HIV drug treatment he needed and paid for by Medicare, he willingly accepted a vitamin mixture in exchange for cash. During our investigation, a medical doctor in the community complained that the patients in that clinic were using the cash kickbacks to purchase drugs and alcohol, yet those habits only made the HIV-positive patients sicker.

Thankfully, the majority of our cases don’t involve direct physical harm to patients. However, Medicare fraud can create hardships for beneficiaries in many ways:

- Medicare fraud can distort a patient’s medical history when false records are created to support false claims. If a patient’s identification number is stolen and used for false claims, that patient may be denied necessary equipment or care because Medicare’s records indicate that patient already received those services. For instance, if a patient needs a wheelchair, but a fraudulent claim has already been submitted for one, what is the patient to do?
- If a Medicare beneficiary number is compromised, there is currently no way for the patient to get a new number, which leaves the patient vulnerable to identity theft. We had a recent case in Tampa in which stolen Medicare numbers and personally identifiable information were used to file tax returns and the criminals received fraudulent tax refunds.

Beneficiaries are vulnerable and can be adversely affected by Medicare fraud, but it is important that I tell you today about another role that beneficiaries play in Medicare fraud, particularly in Florida.

¹ Report produced annually by the Department of Health and Human Services and the Department of Justice, available at <http://oig.hhs.gov/reports-and-publications/hcfac/index.asp>.

Medicare fraud needs at least two elements to succeed: (1) health care providers who bill Medicare; and (2) patients, or “beneficiaries,” on whose behalf Medicare is billed. Beneficiary roles can be categorized into three types:

1. Unknowing victims—for example, victims of medical identity theft.
2. Unwitting beneficiaries—for example, beneficiaries who have received some type of medical service or product but were not aware that it was medically unnecessary or was billed improperly to Medicare. Some of these beneficiaries suffer physical harm from the medical service.
3. Complicit participants—for example, beneficiaries who use their Medicare numbers for personal financial gain. This can take the form of beneficiaries selling their Medicare number to be used in fraud schemes, or receiving payments to obtain unnecessary or inappropriate medical treatment solely for the purpose of defrauding Medicare. Beneficiaries can make around \$1,500 in cash per month plus other benefits for participating in such schemes. Unfortunately, we see complicit beneficiary participants involved in a lot of our Medicare fraud cases in South Florida.

Fraud schemes can be both viral and migratory. For example, we first saw the HIV fraud scheme in Miami. Through aggressive targeted prosecution and increased enforcement efforts in Miami, we saw the decrease of those services billed under Medicare Part B in Miami and saw the fraud scheme surface in Detroit, Michigan. In Detroit, the schemes were even organized by some of the relatives and co-conspirators of the Miami perpetrators.

Now, the HIV scheme is again resurfacing in Miami; however, it is now being billed under Medicare’s managed care program, Part C, perhaps in part because of fraud prevention measures implemented in Medicare Part B.

Medicare Part D, specifically pharmacy fraud, is an area where we are seeing the largest increase in our South Florida case work. Prescription drug fraud is a complex crime that can involve many co-conspirators—drug distributors and traffickers, health care professionals, patient recruiters, drug-seeking patients, and pharmacies may all play a role. Criminal enterprises are also becoming an increasing presence in prescription drug fraud.

It is important to note that OIG prescription drug fraud cases are not limited to investigating schemes involving only controlled substances. Our work is increasing in matters involving high-cost, noncontrolled, name brand prescription drugs such as respiratory, anti-psychotic, and HIV/AIDS medications.

Another area in which the schemes continue to evolve is home health services. Although we have seen a decrease in home health payments, the area remains rife with fraud and is one of our top priorities. Home health schemes were initially characterized by billing Medicare for expensive long term skilled nursing visits to administer insulin injections to diabetics. However, the scheme has changed and now involves billing for physical therapy and occupational therapy.

To combat these and other schemes, we strategically leverage partnerships with other law enforcement agencies, CMS, and the private sector. For example, in Maine where we have only four agents, our partnerships are extremely important. Our agents in Maine have successfully worked Medicare cases involving prescription drugs, medical identity theft, and home health fraud as we see in Florida; however, Medicaid fraud comprises the majority of our work in Maine.

Health care providers and beneficiaries can serve as the front line of defense by refusing to participate in these schemes and reporting suspected fraud.

I began my testimony by telling you about some of the outstanding results of our Medicare fraud enforcement efforts. However, it is important to note that OIG’s mission is challenged by declining resources at a time when prescription drug fraud and other schemes are on the rise. Our Part D investigative caseload has almost quadrupled over the past five years, while at the same time, Strike Force teams are not operating at full strength due to funding shortfalls and hiring freezes. The additional funding in OIG’s 2015 budget request would, among other things, support additional boots on the ground in Florida and in other high health care fraud areas across the country. We appreciate this Committee’s support.

Thank you for the opportunity to testify. I would be happy to answer any questions.



Testimony of:

Louis Saccoccio

Chief Executive Officer

National Health Care Anti-Fraud Association

Good afternoon, Chairman Nelson, Ranking Member Collins and other distinguished Members of the Committee. I am Louis Saccoccio, Chief Executive Officer of the National Health Care Anti-Fraud Association (NHCAA). I appreciate the opportunity to discuss with you how to best protect seniors and taxpayers from Medicare fraud.

Established in 1985, NHCAA is the leading national organization focused exclusively on combating health care fraud and abuse. NHCAA has remained as a private-public partnership since its founding, making it uncommon among associations. Our members comprise more than 80 of the nation's most prominent private health insurers, together with nearly 120 federal, state and local government law enforcement and regulatory agencies that have jurisdiction over health care fraud who participate in NHCAA as law enforcement liaisons.

The NHCAA mission is straightforward: To protect and serve the public interest by increasing awareness and improving the detection, investigation, civil and criminal prosecution and prevention of health care fraud and abuse. Our commitment to this mission is the same regardless of whether a patient has private health care coverage or is a beneficiary of Medicare, Medicaid, or any other federal or state program. In my testimony today I draw upon our organization's nearly 30 year history of combating health care fraud.



On a national level, fraud hampers our health care system and undermines our nation's economy. The United States is projected to spend \$3.1 trillion¹ dollars on health care in 2014 and generates billions of claims from health care service and product providers every year. Medicare alone accounts for \$635 billion² in annual spending. On an individual level, no one is left untouched by health care fraud; it is a serious and costly problem that affects every patient and every taxpayer across our nation. The extent of financial losses due to health care fraud in the United States, while not entirely known, is estimated to range in the tens of billions of dollars or more. To be sure, the financial losses are considerable, but those losses are compounded by numerous instances of patient harm -- unfortunate and insidious side effects of health care fraud that impact patient safety and diminish the quality of our medical care. Health care fraud is not just a financial crime, and it is certainly not victimless.

Health care fraud is a complex crime that can manifest in countless ways. There are many variables at play. The sheer volume of health care claims makes fraud detection a challenge. Medicare Parts A and B alone pay 4.5 million claims every day. Add to that the fact that fraud can conceivably be committed by any one of the 1.5 million providers of services and products in Medicare, and that those committing fraud have the full range of medical conditions, diagnoses, treatments and patients on which to base false claims. Plus, detecting health care fraud often requires the application of knowledge of medical and clinical best practices and terminology, along with a proficiency in arcane coding systems including CPT, CDT and HCPCS codes, DRGs, ICD-9 codes, and the forthcoming ICD-10 codes.

¹ National Health Expenditure Projections 2012-2022, Centers for Medicare and Medicaid Services, Office of the Actuary.
<http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2012.pdf>

² Ibid.



The landscape I describe demands that anti-fraud efforts be multi-faceted. There is no single solution that will solve the problem. A wide range of tools is necessary to wage an effective and comprehensive battle against health care fraud -- methods such as the use of data analytics and predictive modeling; the application of rigorous provider screening processes; the development of innovative investigative methodologies; the maintenance of a skilled and sufficient anti-fraud workforce; and the education of consumers and providers are all necessary components of an effective anti-fraud program.

In addition to the methods listed above, there is another concept that is essential to being able to successfully fight health care fraud. The remainder of my comments will concentrate on this concept -- one that has been the focus of the work of NHCAA for nearly three decades and that offers our best chance of success at preventing fraud. This concept is anti-fraud information sharing. NHCAA is convinced that the exchange of anti-fraud information between and among public and private payers of health care is critical to the success of anti-fraud efforts and should be encouraged and strengthened.

Health care fraud does not discriminate between types of medical coverage. The same schemes used to defraud Medicare and Medicaid migrate to private insurance, and schemes perpetrated against private insurers make their way into government programs. Government entities, tasked with fighting fraud and safeguarding public programs, and private insurers, responsible for protecting their beneficiaries and customers, can and should work cooperatively on this critical issue of mutual interest.

The vast majority of providers of health care services and products bill multiple payers, both private and public. For example, a health care provider may be billing Medicare, Medicaid, and



several private health plans in which it is a network provider, and may also be billing other health plans as an out-of-network provider. However, when analyzing this provider's claims for potential fraud or abuse, each payer is limited to the claims it receives and adjudicates and is not privy to claims information collected by other payers. Currently, there exists no single repository of all health care claims similar to what exists for property and casualty insurance claims.³ The complexity and size of the health care system, along with understandable concerns for patient privacy, likely make such a database impracticable. Nevertheless, the absence of such a tool limits the effectiveness with which health claims (housed in the discrete databases of individual payers) can be analyzed to uncover potential emerging fraud schemes and trends.

In this environment, fraudsters bank on the assumption that payers are not working together to collectively connect the dots and uncover the true breadth of a scheme. It is precisely this reason why the sharing of preventive and investigative information among payers is crucial for successfully identifying and preventing health care fraud. Payers, whether private or public, who limit the scope of their anti-fraud information to data from their own organization or agency are taking an uncoordinated and piecemeal approach to the problem. Our experience as a champion and facilitator of anti-fraud information exchange has taught us that it is very effective in combating health care fraud.

For example, NHCAA hosts several anti-fraud information sharing roundtable meetings each year during which private health plans and representatives of the FBI, the Investigations Division of the Office of the Inspector General for the Department of Health and Human Services (HHS-OIG-OI), State Medicaid Fraud Control Units, the Centers for Medicare and Medicaid Services (CMS), TRICARE, and other federal and state agencies come together to share information

³ See <https://claimsearch.iso.com>



about emerging fraud schemes and trends. Other information sharing methods employed by NHCAA include fraud alerts, NHCAA's SIRIS database of health care fraud investigations, and our Request for Investigation Assistance (RIA) process which allows government agents to easily query private health insurers regarding their financial exposure in active health care fraud cases as a means to strengthen developing investigations. NHCAA-coordinated private-public anti-fraud information sharing routinely helps our private side members and our government partners safeguard and recover funds that would otherwise be lost to fraud.

The Department of Justice (DOJ) has also recognized the benefit of private-public information sharing. For example, many U.S. Attorney Offices sponsor health care fraud task forces that hold routine information-sharing meetings, and when invited to do so, private insurers often participate in these meetings to gather and offer investigative insight. In fact, eighty-nine percent of respondents to NHCAA's 2011 Anti-Fraud Management Survey⁴ (a biennial survey of our private-sector members that aims to assess the structure, staffing, funding, operations and results of health insurer investigative units) report that they share case information at law enforcement-sponsored health care fraud task force meetings.

Additionally, DOJ developed guidelines for the operation of the Health Care Fraud & Abuse Control Program (HCFAC) established by HIPAA which provide a strong basis for information sharing. The "Statement of Principles for the Sharing of Health Care Fraud Information between the Department of Justice and Private Health Plans"⁵ acknowledges the importance of a coordinated program, bringing together both the public and private sectors in the organized fight against health care fraud.

⁴ The National Health Care Anti-Fraud Association, *The NHCAA Anti-Fraud Management Survey for Calendar Year 2011* (Washington, DC, NHCAA, July 2012) p. 44.

⁵ See <http://www.usdoj.gov/ag/readingroom/hcarefraud2.htm>



Despite DOJ's recognition of information sharing as an anti-fraud tool, NHCAA, along with other organizations, saw the need to improve and expand the cooperation and anti-fraud information sharing between the private and public sectors. This concept was a topic of focus during the National Health Care Fraud Prevention Summit hosted by the Department of Justice and the Department of Health & Human Services in January, 2010, in which NHCAA and numerous private insurers participated. This summit set into motion a determined and steady effort to develop and establish a more formalized partnership between government agencies and private sector health insurers. It was envisioned that such a partnership would facilitate anti-fraud information exchange by creating a process to exchange not just investigative information, but to allow the exchange of private and public payer data in a way that could lead to earlier and more effective detection and prevention of fraud.

After more than two years of discussions and meetings involving several interested parties, including NHCAA, the Healthcare Fraud Prevention Partnership (HFPP) was formally announced on July 26, 2012, at the White House. The HFPP is a joint initiative of the U.S. Department of Health & Human Services and the Department of Justice. It is a voluntary public-private partnership between the federal government, state officials, private health insurance organizations, and health care anti-fraud associations, like NHCAA, which aims to foster a proactive approach to detect and prevent health care fraud across all public and private payers. NHCAA believes that HFPP is the necessary next step that takes the information sharing work NHCAA has done, and will continue to do, to a higher level of complexity and effectiveness through the sharing of actual payer data in designated studies.



The HFPP has an Executive Board that provides strategic direction and input for the partnership and shares information with the leadership of member organizations. In addition there are two committees:

- The Data Analysis and Review Committee (DARC) focuses on the operational aspects of data analysis and review and the management of the data analytics.
- The Information Sharing Committee (ISC) focuses on sharing the aggregated results and the individual best practices of the participants both internal to the partnership and to external stakeholders.

The partnership and its committees employ a “study-based” approach for data sharing, whereby studies are proposed, planned, executed and analyzed. Smaller, more targeted groups of partners are typically convened to conduct specific studies.

At present, the HFPP has more than 30 partners, including several private insurers. Formal steps are being taken to expand the partnership and ideally the HFPP will foster a national scope by encouraging the participation of eligible public and private entities in the health care industry that are willing and able to meaningfully contribute health care data.

While the HFPP does not intend to create a national-level all-claims database, it has established several principles and goals that hinge significantly upon the concept of information and data sharing. HFPP partners will work together to combat fraud by:

- Engaging in value-added data-exchange studies between the public and private sector partners.
- Leveraging analytic tools and technologies against this more comprehensive data set.



- Providing a forum for business and government leaders and subject matter expert members to share successful anti-fraud practices and effective methodologies and strategies for detecting and preventing health care fraud.

The HFPP has already conducted a few initial studies, including one on misused codes and fraud schemes. Misused codes included those claim codes, or claim code combinations, that partners had assessed to be frequently associated with fraud, waste or abuse in the last 6 to 12 months, and associated with large-dollar claims or high utilization. Fraud schemes referred to descriptions of major fraud schemes in the last 6 to 12 months with an associated high-dollar amount. The resulting data exchange proved successful. Schemes and codes that were not thought to be problematic by certain partners were highlighted in the exchange results. The process also confirmed known schemes and misused codes. Further analysis will be conducted and sharing of the results will continue.

An important aspect of the HFPP is the use of a Trusted Third Party (TTP) to serve as a data-exchange entity. As envisioned, the TTP will conduct HFPP data exchanges, research, data consolidation and aggregation, reporting and analysis. The TTP will not share the source of the data during an exchange in order to keep the identity of the data source confidential. This concept is similar to one that has been employed successfully for many years through the Federal Aviation Administration's (FAA) Aviation Safety Reporting System (ASRS). The ASRS is a voluntary system run by the National Aeronautics and Space Administration (NASA) that allows pilots and other airplane crew members to confidentially report near misses and close calls in the interest of improving air safety. The confidential and independent nature of the ASRS is vitally



important. Reports that are submitted are stripped of identifying information and an immunity policy is in place that encourages submission of all safety incidents and observations.

While NHCAA and the HFPP work to promote and improve the effectiveness of data and anti-fraud information sharing, many NHCAA members remain reluctant to fully participate in anti-fraud sharing activities for fear of the potential legal risk such sharing raises. For example, some health insurers are hesitant to share data or information that could lead to litigation brought by health care providers who may be the subject of the shared data or information. This reluctance is demonstrated by the fact that only 40% of NHCAA health insurance company members enter information about their open fraud investigations into NHCAA's SIRIS database. This 40% rate is in stark contrast to the 95% of the same members who search the database for information entered by other companies. Clearly, the interest in receiving anti-fraud information exists; however, the willingness of a company to share its own information is clearly hampered by the perceived risks involved.

While many states provide immunity for fraud reporting (typically to law enforcement and regulatory agencies, although protections, as well as reporting requirements, vary by state), there exists no federal protection for insurers that share information with one another about suspected health care fraud. As demonstrated by the percentages mentioned above, the absence of such protection creates a chilling effect that leads some organizations to determine that the risk of sharing information outweighs the potential benefit. Although the decision to avoid the risk may seem to make sense to a particular company, the decision results in a negative impact on the overall fight against health care fraud.



For many years, NHCAA has supported immunity protections for the sharing and reporting of health care fraud-related information (when provided in good faith and without malice). In May of 1996, the Government Accountability Office (GAO) conducted a study titled, “Health Care Fraud: Information-Sharing Proposals to Improve Enforcement Efforts.”⁶ The study examined the issue of immunity and includes NHCAA’s views and recommendations. The GAO found broad support among federal and state officials, as well as insurers and state insurance commissioners, for a federal immunity statute. Several federal officials interviewed for the report recommended immunity for insurers sharing fraud-related information with other insurers. It’s worth noting that this report also examined the idea of establishing a centralized health care fraud database to enhance information sharing and support enforcement efforts.

Based on this report, there seemed to be wide support for federal protections for sharing anti-fraud information. However, the legislation that would have implemented these ideas was not enacted (S. 1088, 104th Congress⁷). Now, nearly 20 years later, we remain essentially in the same situation with regard to immunity. However, the difference is that rather than spending \$1 trillion⁸ annually on health care as we did 20 years ago, today we spend \$3.1 trillion.

NHCAA believes that we should remove unnecessary obstacles that inhibit fraud fighting efforts, and that providing protections for individuals and entities that share information and data concerning suspected health care fraud is a reasonable and prudent step to take. The GAO report discussed above remains relevant to this discussion and may offer worthwhile models to consider.

⁶ Health Care Fraud: Information-Sharing Proposals to Improve Enforcement Efforts, the Government Accountability Office, May 1996. <http://www.gpo.gov/fdsys/pkg/GAOREPORTS-GGD-96-101/html/GAOREPORTS-GGD-96-101.htm>

⁷ Senate Bill 1088, 104th United States Congress. “Health Care Fraud and Abuse Prevention Act of 1995,” Sponsor: Senator William Cohen. <http://www.gpo.gov/fdsys/pkg/BILLS-104s1088is/pdf/BILLS-104s1088is.pdf>

⁸ National Health Expenditure Data, historical 1960-2012, Centers for Medicare and Medicaid Services, Office of the Actuary. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf>



Conclusion

There is no silver bullet for defeating health care fraud. A winning fraud prevention strategy for Medicare must be multi-faceted. We believe one of the most important aspects of health care fraud prevention is anti-fraud information and data sharing among private and public payers of health care, which should be encouraged and strengthened. Health care payers, including the Medicare program, cannot work in isolation and expect to be successful in detecting and preventing health care fraud. The establishment of federal protections for those individuals and entities engaged in anti-fraud information and data sharing would be a major step in encouraging this essential activity, and also would lend strong support for the growth and success of the HFPP as it moves forward. In our view, the HFPP signals a new era of private-public collaboration and holds great promise as a significant step in preventing fraud in Medicare.

Thank you for allowing me to speak to you today. I would be happy to answer any questions that you may have.

SHANTANU AGRAWAL, M.D. , DEPUTY ADMINISTRATOR AND DIRECTOR, CENTER FOR PROGRAM INTEGRITY, CENTERS FOR MEDICARE & MEDICAID SERVICES

Chairman Nelson, Ranking Member Collins, and members of the Committee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) program integrity efforts. Enhancing program integrity is a top priority for the administration and an agency-wide effort at CMS. We have made important strides in reducing fraud, waste, and abuse across our programs with the strong support of this Committee and the Congress.

Thanks in part to the authorities and resources provided by the Affordable Care Act and the Small Business Jobs Act of 2010, CMS has powerful tools that help improve our efforts to detect and prevent fraud, waste, and abuse in Medicare. CMS's approach has two key components: prevention and collaboration. By shifting the agency beyond a "pay and chase" approach and by collaborating in unprecedented ways with our State partners, law enforcement, and the private sector, CMS is making great strides in protecting the integrity of CMS's programs, including Medicare.

Earlier this year, the government announced that in fiscal year (FY) 2013, its fraud, waste, and abuse prevention and enforcement efforts in the Health Care Fraud and Abuse Control (HCFAC) program resulted in the record-breaking recovery of \$4.33 billion in taxpayer dollars from individuals trying to defraud Federal health care programs serving seniors and taxpayers.¹ Over the last five years, the administration's enforcement efforts have recovered \$19.2 billion, up from \$9.4 billion over the prior five-year period. Over the last three years, the average return on investment of the HCFAC program is \$8.10 for every dollar spent, which is an increase of \$2.70 over the average ROI for the life of the HCFAC program since 1997.

Preventing Fraud in the Medicare Program

One of the most fundamental changes in the administration's approach to fraud-fighting is a focus on prevention. For far too long, CMS and our law enforcement partners were forced to

¹ <http://oig.hhs.gov/publications/docs/hcfac/FY2013-hcfac.pdf>

“pay and chase” by paying claims and then working to identify and recoup fraudulent payments. Now, CMS has a variety of tools to keep fraudsters out of our programs, and to uncover fraudulent schemes quickly, before they drain valuable resources from our Trust Funds.

Strengthening Provider Enrollment

The Affordable Care Act required CMS to implement categorical risk-based screening of providers and suppliers who want to participate in the Medicare and Medicaid programs, and CMS put these additional requirements in place for newly enrolling and revalidating Medicare providers and suppliers in March 2011. This enhanced screening requires certain categories of providers and suppliers that have historically posed a higher risk of fraud to receive greater scrutiny prior to their enrollment or revalidation in Medicare. Categories of providers and suppliers designated as limited risk undergo verification of licensure and a wide range of database checks to ensure compliance with any provider or supplier-specific requirements. Categories of providers and suppliers designated as moderate or high categorical risk are subject to all the requirements in the limited screening level, plus additional screening including unannounced site visits.

The Affordable Care Act also required CMS to screen all existing 1.5 million Medicare suppliers and providers under the new screening requirements. CMS embarked on an ambitious project to revalidate the enrollment information of all existing providers and suppliers, and these efforts will ensure that only qualified and legitimate providers and suppliers can provide health care items and services to Medicare beneficiaries. Since March 25, 2011, more than 770,000 providers and suppliers have been subject to the new screening requirements and over 260,000 provider and supplier practice locations had their billing privileges deactivated for non-response as a result of these screening efforts.² Since implementation of the Affordable Care Act’s requirements, CMS has also revoked 17,534 providers’ and suppliers’ ability to bill the Medicare program. These providers and suppliers were removed from the program because they had felony convictions, were not operational at the address CMS had on file, or were not in compliance with CMS rules, such as licensure requirements.

² Deactivated providers could reactivate over time with updated practice information or after showing evidence of proper licensing.

CMS is also aware of concerns related to fraud, waste, and abuse in the Medicare Part D program, as well as concerns that compliance with program requirements could be improved. CMS appreciates the thoughtful work of the Congress³ and the Department of Health & Human Services (HHS) Office of Inspector General (OIG)⁴ that highlights the potential for fraud, waste, and abuse in Part D. To address these concerns, we have proposed applying similar approaches for ordering by, and enrollment of, physicians and non-physician practitioners to the Medicare Part D program that were implemented for Medicare Parts A and B. Our proposal would require that physicians and non-physician practitioners who write prescriptions for covered Part D drugs to be enrolled in Medicare for their prescriptions to be covered under Part D. This requirement would help CMS ensure that Part D drugs are prescribed only by qualified individuals. We have also issued a proposal that would allow CMS to revoke a prescriber's enrollment based on abusive prescribing practices and patterns. This proposal would provide CMS the authority to revoke a physician's or eligible professional's Medicare enrollment if CMS determines that he or she has a pattern or practice of prescribing Part D drugs that is abusive and represents a threat to the health and safety of Medicare beneficiaries, or otherwise fails to meet Medicare requirements. Additionally, prescribing authority could be revoked if a prescriber's Drug Enforcement Administration (DEA) Certificate of Registration is suspended or revoked or the applicable licensing or administrative body for any State in which a physician or eligible professional practices has suspended or revoked the physician or eligible professional's ability to prescribe drugs.

Enrollment Moratoria

The Affordable Care Act provides the Secretary the authority to impose a temporary moratorium on the enrollment of new Medicare, Medicaid, or Children's Health Insurance Program (CHIP) providers and suppliers, including categories of providers and suppliers, if the Secretary determines the moratorium is necessary to prevent or combat fraud, waste, or abuse under these programs. States affected are required to determine whether the imposition of a moratorium

³ For example, <http://www.hsgac.senate.gov/subcommittees/Federal-financial-management/hearings/costs-of-prescription-drug-abuse-in-the-medicare-part-d-program>

⁴ HHS OIG has a large body of work examining Part D billing including: OEI-02-09-00603, OEI-02-09-00608, OEI-02-09-00140, OEI-03-11-00310, OEI-07-09-00150, OEI-07-10-06004

would adversely affect Medicaid beneficiaries' access to medical assistance and notify the Secretary if there would be an adverse effect. When a moratorium is imposed, existing providers and suppliers may continue to deliver and bill for services, but no new applications will be approved for the designated provider or supplier-types in the designated areas, allowing CMS and its law enforcement partners to continue efforts to remove bad actors from the program while blocking provider entry or re-entry into markets that CMS has determined have a significant potential for fraud, waste or abuse. CMS is required to re-evaluate the need for such moratoria every six months.

In the last year, CMS has used this authority to fight fraud, waste, and abuse, and to safeguard taxpayer dollars while ensuring patient access to care is not interrupted. In July 2013, CMS announced temporary moratoria on the enrollment of new home health agencies (HHAs) and ambulance companies in Medicare, Medicaid, and CHIP in three "fraud hot spot" metropolitan areas of the country: HHAs in and around Miami and Chicago, and ground-based ambulance suppliers in and around Houston.⁵ In January 2014, CMS announced new temporary moratoria on the enrollment of HHAs in four metropolitan areas (Fort Lauderdale, Detroit, Dallas, and Houston), and a new temporary moratorium on the enrollment of ground ambulance suppliers in the metropolitan Philadelphia area.⁶ CMS also extended for six months the existing moratoria for HHAs in and around Chicago and Miami, and ground ambulance suppliers in the Houston area.

Before taking these actions, CMS consulted with HHS OIG, the Department of Justice (DOJ), and the relevant State Medicaid Agencies, and found that fraud trends warranted moratoria on certain types of providers in these geographic areas. CMS also reviewed key factors of potential fraud risk including a disproportionately high number of providers and suppliers relative to the number beneficiaries, and extremely high utilization. All the geographic areas included in the moratoria ranked as high-risk in these fraud risk factors.

⁵ <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-07-26.html>

⁶ <http://cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-01-30-2.html>

CMS carefully examined Medicare beneficiary access to services in all of these areas, and concluded that the moratoria will not affect access to care. The Agency also worked closely with each of the affected states to evaluate patient access to care, and these states reported that Medicaid and CHIP beneficiaries will continue to have access to services. During the moratoria period, CMS and the affected states will continue to monitor access to care to ensure that Medicare, Medicaid, and CHIP beneficiaries are receiving the services they need.

Fraud Prevention System

Our prevention efforts in Medicare and Medicaid strike an important balance: protecting beneficiary access to necessary health care services and reducing the administrative burden on legitimate providers and suppliers, while ensuring that taxpayer dollars are not lost to fraud, waste, and abuse. CMS quickly implemented the requirements of the Small Business Jobs Act of 2010, which calls for the use of predictive modeling and other analytic technologies to identify and prevent fraud, waste, and abuse, just nine months after the President signed the bill into law. Since June 30, 2011, when CMS launched the Fraud Prevention System (FPS), CMS has been applying advanced analytics to Medicare fee-for-service (FFS) claims on a streaming, national basis. When FPS predictive models identify egregious, suspect, or aberrant activity, the system automatically generates and prioritizes leads for review and investigation. The FPS helps CMS target fraudulent providers and suppliers, reduce the administrative and compliance burdens on legitimate ones, and prevent fraud so that funds are not diverted from providing beneficiaries with access to quality health care. These important tools help protect the Medicare Trust Funds by preventing funds from being spent on these questionable providers and suppliers.

The FPS is used by CMS's Zone Program Integrity Contractors (ZPICs) and the HHS OIG Office of Investigations. When suspect behavior or billing activity is identified, the ZPICs perform specific program integrity functions for the Medicare FFS program. Complementing the ZPICs' traditional activities, ZPICs are now using the FPS as a primary source of leads to prevent, identify, and investigate fraud. The FPS screens claims data before payment is made, allowing CMS to rapidly implement administrative actions, such as revocation, payment suspension, or prepayment review, as appropriate. The FPS generates a prioritized list of leads

for ZPICs to review and investigate Medicare fraud in their designated region. The FPS also gives CMS a provider-level view of ZPIC activities and administrative actions, making it a useful management tool.

Early results from the FPS show significant promise and CMS expects increased returns as the system matures over time. As reported in the FPS FY 2012 Report to Congress,⁷ in its first year of implementation, the FPS stopped, prevented or identified an estimated \$115.4 million in improper payments. The FPS achieved a positive return on investment, saving an estimated \$3 for every dollar spent in the first year; CMS anticipates that the ability of FPS to identify bad actors and focus investigative resources on most egregious schemes will continue to expand.

National Correct Coding Initiative

CMS has developed the National Correct Coding Initiative (NCCI), which consists of edits designed to reduce improper payments in Medicare Part B and Medicaid. This program was originally implemented with procedure-to-procedure edits to ensure accurate coding and reporting of services by physicians.⁸ In addition to procedure-to-procedure edits, CMS established the Medically Unlikely Edit (MUE) program to reduce the paid claims error rate for Medicare Part B claims as part of the NCCI program.⁹ NCCI edits are updated quarterly and, prior to implementation, edits are reviewed by national healthcare organizations and their recommendations are taken into consideration before implementation. Since October 2008, all procedure-to-procedure edits and the majority of MUEs have been made public and posted on the CMS website.¹⁰ The use of the NCCI procedure-to-procedure edits saved the Medicare program \$483 million in FY 2012, and the NCCI methodology procedure-to-procedure edits applied to practitioner and outpatient hospital services have prevented the improper payment by Medicare of over \$5 billion since 1996 based on savings reports from claims-processing contractors.

⁷ <http://www.stopmedicarefraud.gov/fraud-rtc12142012.pdf>

⁸ Procedure-to-procedure edits stop payment for claims billing for two procedures that could not be performed at the same patient encounter because the two procedures were mutually exclusive based on anatomic, temporal or gender considerations.

⁹ MUEs stop payment for claims that are beyond the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service.

¹⁰ Certain edits are not published because of CMS concerns that they may be used or manipulated by fraudulent individuals and entities.

Coordination and Collaboration to Detect Fraud, Waste, and Abuse

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

CMS uses a variety of different contractors to administer and oversee the Medicare FFS program. Each of these contractors has different roles and responsibilities. Some contractors specifically assist CMS in combating fraud and identifying improper payments, while others assist CMS's fraud fighting efforts as part of their broader responsibilities as FFS contractors that process claims and recover overpayments.

CMS is working to integrate the program integrity functions for audits and investigations across Medicare and Medicaid from work currently performed by several existing contractors, including ZPICs, Program Safeguard Contractors, and the Medicaid Integrity Contractors. CMS has begun market research into the creation of Unified Program Integrity Contractors that would improve our relationships with providers while leveraging existing resources. The goal is to foster cooperation and communication between the different regional program integrity contractors to ensure a national approach to providers or trends that cut across regions; additionally, we believe it will be beneficial to have contractors focused on both Medicare and Medicaid fraud, waste and abuse.

CMS also continues to refine our Medicare Part D program integrity efforts and enhance our oversight of the Medicare Drug Integrity Contractor (MEDIC), which is charged with identifying and investigating potential fraud, and abuse, and developing cases for referral to law enforcement agencies. The MEDIC has implemented a new proactive data analysis effort to identify potential program vulnerabilities, which it shares with a variety of fraud fighting partners, including Part D Plan Sponsors.

Healthcare Fraud Prevention Partnership (HFPP)

CMS has established an ongoing partnership with the private sector to fight fraud, waste, and abuse across the health care system. Making data collections available in this way can assist payers in evaluating trends, recognizing patterns consistent with potential fraud, waste, and abuse, and potentially uncovering schemes or bad actors they could not otherwise identify using only their own information. Such collaboration is the purpose of the Healthcare Fraud Prevention Partnership (HFPP), which currently has 35 partner organizations from the public and private sectors, law enforcement, and other organizations combatting fraud, waste, and abuse.

The HFPP has successfully completed several proof-of-concept studies, and additional studies are underway. One of the proof-of-concept studies involved the sharing of payment codes which a partner determined to be commonly mis-billed or abused in some way, as well as fraud schemes their organization has encountered, including details about the scheme such as the geographic area where it manifested. Based on this study, partners have taken substantive actions including implementing payment edits regarding some of the abused codes, as well as conducting investigations into the fraud schemes shared by another partner where they had exposure as well. This resulted in putting providers on payment suspension through, in some cases, complete termination from their plan.

Command Center

Collaboration between program officials and law enforcement is a critical cornerstone in improving health care fraud, waste, and abuse detection and investigation. As a natural progression from early collaborative meetings, on July 31, 2012, CMS opened its Command Center, which provides the advanced technologies and collaborative environment for a multi-disciplinary team of experts and decision makers to more efficiently coordinate policies and case actions, reduce duplication of efforts, and streamline fraud investigations for more immediate administrative action. The Command Center has become a Center of Excellence and has quickly attracted visitors from across the Federal Government and other entities, including international groups that are interested in learning more about our efforts. Since its opening, the Command Center has supported 93 missions that included over 688 unique participants from CMS and our

partners, including HHS OIG and the Federal Bureau of Investigation. These collaborative activities will enable CMS to more quickly and efficiently take administrative actions such as revoking Medicare billing privileges and suspending payments. CMS is also working with other Federal agencies in the Command Center to pool resources to tackle cross-cutting issues surrounding fraud, waste, and abuse prevention.

Health Care Fraud Prevention & Enforcement Action Team

In addition to CMS's commitment to collaboration, the sustained success of Health Care Fraud Prevention & Enforcement Action Team (HEAT) demonstrates the effectiveness of the Cabinet-level commitment between HHS and DOJ to prevent and prosecute health care fraud. Since its creation in May 2009, HEAT has played a critical role in identifying new enforcement initiatives and expanding data sharing to a cross-government health care fraud, waste, and abuse data intelligence sharing workgroup. A key component of HEAT is the presence of Medicare Strike Force Teams, interagency teams of analysts, investigators, and prosecutors, who target emerging or migrating fraud schemes such as criminals masquerading as healthcare providers or suppliers.

In May 2013, a nationwide takedown by Medicare Fraud Strike Force operations in eight cities resulted in charges against 89 individuals, including doctors, nurses and other licensed medical professionals, for their alleged participation in Medicare fraud schemes involving approximately \$223 million in false billings. The defendants charged were accused of various health care fraud-related crimes, including conspiracy to commit health care fraud, violations of the anti-kickback statute, and money laundering. The charges were based on a variety of alleged fraud schemes involving various medical treatments and services, primarily home health care, but also including mental health services, psychotherapy, physical and occupational therapy, durable medical equipment (DME), and ambulance services. This coordinated takedown was the sixth national Medicare fraud takedown in Strike Force history.

In the six and a half years since its inception,¹¹ Strike Force prosecutors have filed more than 788 cases charging more than 1,727 defendants who collectively billed the Medicare program more than \$5.5 billion; 1,137 defendants pleaded guilty and 148 others were convicted in jury trials;

¹¹ Specifically, the period from May 7, 2007, through September 30, 2013.

1087 defendants were sentenced to imprisonment for an average term of about 47 months.

This collaborative effort is having a measurable impact on Medicare reimbursements for certain medical services that have been targeted by the Medicare Strike Force. For instance, Medicare payments for DME in Miami have been subject to both an overwhelming law enforcement response and an aggressive and multifaceted strategy by CMS to address the epidemic of fraud. Since 2006, when payments hit an all-time high, exceeding \$73 million in one quarter, these payments have decreased to \$15 million a quarter. Similarly, Strike Force and CMS activity targeting fraud in Community Mental Health Centers (CMHCs) began in 2008 and accelerated in 2010, ultimately leading to a payment decrease from the peak in 2008 of \$70 million a quarter to a decline to \$10 million per quarter.

Field Offices

CMS has designated program integrity field offices located in or near the HEAT cities of Miami, Los Angeles, and New York that provide a CMS presence in high risk fraud areas of the country. All three field offices have staff that are designated CMS Strike Force Liaisons, who coordinate with law enforcement, facilitate data analysis, and expedite suspension requests. The field offices also work with CMS central office and the ZPICs to conduct data analysis to proactively identify targets, and to coordinate efforts among various contractors and agencies to identify local issues and vulnerabilities with national or regional impact.

The field offices develop solutions to the most challenging program integrity issues in their region. In Miami, for example, the field office has boots on the ground working to root out fraud in home health by performing provider and beneficiary interviews. The Los Angeles staff is working with county Emergency Medical Service licensing authorities, CMS contractors, and local law enforcement to address emerging schemes among ambulance providers. The New York staff have collaborated with New York and New Jersey licensing boards to identify providers whose licensure actions were not being posted to public websites timely, resulting in identification of more than a dozen providers whose licenses to practice were revoked. New York field staff have also testified as Medicare expert witnesses in thirteen Medicare civil and criminal fraud trials and sentencing hearings in 6 states and Puerto Rico in the past two

years. These efforts have resulted in nearly 100 revocations of Medicare billing privileges in FY 2013.

Coordinated and Integrated Efforts to Detect, Prevent, and Deter Fraud, Waste, and Abuse

As we have implemented new efforts that make it harder for bad actors to enroll or bill in our systems, we are always evaluating how to make it easier for legitimate physicians and other providers to participate in Medicare and care for beneficiaries. Providers enrolling in Medicare for the first time now have a much easier experience enrolling than in years past. Everything can be submitted online, using the web-based “PECOS” (the Provider Enrollment, Chain and Ownership System – the official record of every provider in Medicare). CMS is also employing new technologies to communicate with physicians, including email, Facebook, and Twitter. We also recognize the risks and challenges that many physicians face in today’s healthcare landscape. We are dedicated to helping physicians stay on track with important updates in our Medicare and Medicaid operations. The Center for Program Integrity is making it easier for physicians to resolve issues of identity theft.¹² We’re providing information on how to protect physicians’ medical identity,¹³ numerous educational toolkits,¹⁴ and Continuing Medical Education¹⁵ on CMS program integrity activities.

Enrollment Special Study

The Enrollment Special Study is a project designed to stop fraudulent providers from obtaining new Medicare provider numbers, reduce the number of habitual “bad providers” from re-entering the Medicare system after they have been kicked out, and shift from the pay-and-chase approach that has existed in years past. In this project, site visits are conducted prior to enrollment, and providers are targeted for a closer review. The project is limited to CMHCs, Comprehensive Outpatient Rehabilitation Facilities, and Independent Diagnostic Testing Facilities in South Florida. Once the Medicare Administrative Contractor conducts a site visit, it assesses the provider’s individual risk, based on historical fraud risk factors developed by CMS. If the

¹² <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/ProviderVictimPOCs.pdf>

¹³ <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SafeMed-ID-Products.pdf>

¹⁴ <http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Provider-Education-Toolkits/provider-ed-tools.html>

¹⁵ <http://www.stopmedicarefraud.gov/forproviders/index.html>

provider appears to be suspect or pose an elevated risk of fraud, the provider is referred to the ZPIC for investigation and administrative action, as appropriate. This project began as a one year project in July 2009 and has been extended due to its success.

Educating Beneficiaries: A Key Tool in Preventing Fraud

Beneficiary involvement is a key component of all of CMS's anti-fraud efforts. Alert and vigilant beneficiaries, family members, and caregivers are some of our most valuable partners in stopping fraudulent activity. Information from beneficiaries and other parties helps us to quickly identify potentially fraudulent practices, stop payment to suspect providers and suppliers for inappropriate services or items, and prevent further abuses in the program. We also want to recognize this Committee for the creation of The United States Special Committee on Aging Fraud Hotline and commend your efforts in educating seniors and others about the dangers of fraud.

CMS is making it easier for seniors to help us fight fraud, waste, and abuse. In June 2013, CMS began sending redesigned Medicare Summary Notices (MSNs),¹⁶ the explanation of benefits for people with Medicare fee-for-service, to make it easier for beneficiaries to spot fraud or errors. The new MSNs include clearer language, descriptions and definitions, and have a dedicated section that tells beneficiaries how to spot potential fraud, waste, and abuse. Beneficiaries are encouraged to report fraud, waste, and abuse to 1-800-MEDICARE, and this is promoted in the re-designed MSN. CMS has an incentive reward program that currently offers a reward of 10 percent of the amount recovered up to \$1,000 paid to Medicare beneficiaries and other individuals whose tips about suspected fraud lead to the successful recovery of funds. Last year, CMS released a proposed rule that if finalized, would increase these rewards to 15 percent of the amount recovered up to \$10 million.¹⁷

Senior Medicare Patrols

CMS has also been partnering with the Administration for Community Living (ACL) to lend support to the Senior Medicare Patrol (SMP) program, a volunteer-based national program that

¹⁶ <http://blog.medicare.gov/2013/06/06/redesigned-with-you-in-mind-your-medicare-summary-notice/>

¹⁷ <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-04-24.html>

educates Medicare beneficiaries, their families, and caregivers to prevent, detect, and report Medicare fraud, waste and abuse. The SMP program empowers Medicare beneficiaries through increased awareness and understanding of health care programs and educates them on how to recognize and report fraud. During 2012, SMP program grantees' staff and more than 5000 volunteers reached nearly 1.5 million people with group education sessions and one-on-one counseling.¹⁸ SMP projects also work to resolve beneficiary complaints of potential fraud in partnership with State and national fraud control and consumer protection entities, including Medicare contractors, State Medicaid fraud control units, State attorneys general, HHS OIG, and the Federal Trade Commission.

Moving Forward

Medicare fraud, waste, and abuse affect every American by draining critical resources from our health care system. The Administration has made stopping fraud and improper payments a top priority. We have more tools than ever before to move beyond "pay and chase" and implement strategic changes in pursuing and detecting fraud, waste, and abuse. We are focused on preventing fraud before it happens by stopping fraudsters from enrolling or maintaining enrollment in Medicare or Medicaid, using sophisticated analytics to identify improper billing before claims are paid, and by rapid pursuit and implementation of administrative actions that are appropriate to the behavior. Our comprehensive program integrity strategy implements innovative data technologies and draws on expertise from across the country. As we integrate strategies and engage our Federal, State, and private sector partners, Medicare will become a stronger, more effective program. I look forward to working with this Committee and the Congress as we continue to make improvements in protecting the integrity of our health care programs and safeguarding taxpayer resources.

¹⁸ <http://oig.hhs.gov/oei/reports/oei-02-13-00170.pdf>

Questions for the Record

U.S. Senate Special Committee on Aging

**“Preventing Medicare Fraud: How Can We
Best Protect Seniors And Taxpayers?”**

March 26, 2014

**Questions for the Record
Brian Martens**

Senator Bill Nelson, Chairman

Question:

What will the fraud schemes of tomorrow look like in Florida?

Response:

While it is difficult to predict specific fraud schemes of the future, we suspect the actions of criminals will continue to meld and merge in reaction to enforcement crackdowns. If recent history is a predictor, prescription drug schemes will increase including the more profitable schemes involving non-controlled substances. We have recently seen increases in our investigations under the Medicare Part C program where schemes are more difficult to detect because our data access is severely limited.

Question:

CMS testified about its fraud prevention system today. Does OIG track how many leads you get from this system? If not, can you just tell us based on your experience in Florida whether you are getting a lot of leads from the fraud prevention system, and give some examples of those leads?

Response:

OIG receives referrals from the ZPIC and does not track if the lead originated from the fraud prevention system.

Question:

How does OIG coordinate investigations with State agencies and CMS contractors in Florida and elsewhere?

Response:

In Florida, the OIG Office of Investigations (OI) meets monthly with the CMS contractor (ZPIC) to discuss potential case referrals, recent issues and coordination of ZPIC support. OI co-chairs several Healthcare Fraud Working Groups with other Federal, State, and local law enforcement agencies throughout the State. In Miami, one investigative team is comprised of OI special agents, State agency law enforcement agents and a State prosecutor specially designated to prosecute joint cases in Federal court. OI meets regularly with State law enforcement to share information and work cooperatively to maximize effectiveness of human intelligence and resources. When working in various task force teams, law enforcement coordination of investigations are managed in a systematic approach depending on the task force. Strike Force teams include HHS OIG special agents, FBI special agents, and prosecutors from the US Attorney’s Office and/or the US Department of Justice. Other agencies may supplement the teams, but the core Strike Force team is comprised of those members. Otherwise, law enforcement coordination of each investigation is handled on an ad hoc basis depending on the case specifics and the jurisdictions involved.

Question:

You mentioned that OIG does not have the resources it needs to fight fraud. If you are fully funded this year, what will your office (meaning your office in Florida) use the money for?

Response:

OIG’s request includes funding to support the Health Care Fraud and Abuse Control (HCFAC) program and expand the Administration’s multiagency initiative to prevent health care fraud and enforce current antifraud laws through the Healthcare Fraud Prevention and Enforcement Action Team (HEAT) initiative. Medicare Fraud Strike Forces, a part of HEAT, have been central to our successes in combating Medicare Fraud, particularly in South Florida. In fiscal year 2013 alone nationwide Strike Force activity resulted in the filing of charges against 274 individuals or entities, 251 criminal actions, and \$333 million in investigative receivables. Of those results, although understaffed, the Miami Strike Force was responsible for the filing of charges against 128 individuals or entities, 174 criminal

actions and over \$247 million in investigative receivables. OIG's budget request will allow OIG to further implement Strike Forces by alleviating current Strike Force staffing challenges and using data analysis to target new efforts to combat current and emerging fraud schemes in new and existing locations. This approach ensures that our enforcement efforts target the areas and activities most vulnerable to health care fraud.

Due to reduced funding OIG is currently in a hiring freeze and has lost over 200 people over the past two years. During fiscal year 2013 OIG offered two rounds of buyouts. As a result OIG has fewer resources available to fight Medicare and Medicaid fraud—by the end of fiscal year 2014, we expect to reduce Medicare and Medicaid oversight by 20 percent due to lack of resources. The HCFAC program, which OIG is a key participant, has significant and demonstrated success. The 2013 HCFAC Annual Report notes that \$8.1 was returned for every \$1 expended. Since 1997 the program has returned over \$25.9 billion to the Medicare Trust Funds. Funding OIG's budget request will allow OIG to stop its hiring freeze and expand its efforts in these highly successful fraud enforcement and oversight activities.

Question:

Mr. Martens, I commend you for your work to crack down on Community Mental Health Centers. As you may know, in October of last year, CMS issued final—and much needed—guidance for Conditions of Participation for Community Mental Health Centers that are officially in effect this October. That guidance should help to reduce fraud. However, the final rule States that CMS will survey CMHCs only once every five years to ensure requirements are met. This does not seem very often.

Given resource constraints, how can CMS work with folks on the ground in hot-fraud areas like Miami, for instance, to ensure that we have more oversight than just once every five years?

Response:

We would encourage CMS to consider measures such as performing unannounced site visit spot checks, maximizing the use of technological resources and delivering via tracking service or courier a secured laptop with camera recording capabilities to facilities and performing virtual unannounced sight visit spot checks. If billing patterns are suspicious, we encourage CMS to communicate their concerns directly and promptly with OIG special agents. CMS could also consider annual re-enrollment license verification, and temporary projects to address CMHC fraud in fraud-prone areas.

Question:

Are there any strategies beyond full certification that CMS could have in place that would provide at least some additional oversight given that CMHCs have been such a problem for us in the past?

Response:

Strategies to consider could include:

- CMS inspection “jump” teams equipped with video cameras could help with oversight if they conduct unannounced site visits.
- Penalties and recoveries against those involved in fraud to the fullest extent possible, including complicit beneficiaries, to serve as a deterrent against future fraud.
- Public service announcements and educational campaigns.
- State licensure/certification.
- Accrediting authority for CMHCs.

Question:

Mr. Martens, as you may know, based on the IG's findings with CMHCs, this Committee requested a broader investigation into provider credentialing in the Medicare mental health benefit.

Can you provide examples of any other potentially concerning areas of mental health fraud that you've seen on the ground?

Response:

Medicare has been billed for full therapy sessions when only partial sessions took place or they never occurred. Staff have been instructed to alter patient charts and notes from therapy sessions in order to make it appear that the patients being treated qualified for partial hospitalization program (PHP) treatments, when, in fact, they did not. False patient charts were signed authorizing unnecessary treatment or continued treatment for patients who were not eligible for PHP treatment, without a physician examination of the patients or the charts. Diagnoses and medication types and levels have been falsified by clinic employees and doctors to make it appear that patients qualified for PHP treatments. Group therapy sessions are billed

as higher-reimbursing individual therapy sessions and often those group therapy sessions consist of patients watching a movie or eating lunch and playing games. We have also seen cases in which patients have not received expensive anti-psychotic drugs paid for by Medicare.

Question:

Do you think adequate compliance checks are in place to ensure that only Medicare-eligible mental health providers that meet both State and Federal certification requirements bill Medicare for services?

Response:

OIG has investigated many types of mental health providers who committed Medicare fraud. The providers conducted sham therapy sessions for patients ineligible for PHP treatment, altered records, paid kickbacks and billed Medicare for services not rendered. When individuals intend to steal from Medicare, we have found that they do so despite any number of certifications or advanced degrees they have achieved.

Question:

We believe this report will be completed by this summer. If you could communicate that back to the IG, that would be appreciated.

Response:

OIG is examining CMS's processes for ensuring that mental health care providers are appropriately credentialed (i.e., licensed/certified) to bill for Medicare services. We expect to have the work completed by August 2014 and to share our results with Hill staff at that time.

Question:

Mr. Martens, I was particularly interested to hear that within Medicare Part D, specifically, pharmacy fraud is an area where you are seeing huge growth—the caseload has quadrupled. I think it is very important to highlight that you said that OIG drug fraud cases are not limited to investigating schemes involving only controlled substances—but are increasingly involved in matters involving high-cost, brand-name prescription drugs. This Committee has been working on a report looking at the reasons behind certain discrepancies in use between popular brand-name and generic drugs, and pharmacy fraud and improper prescribing of high-cost brand-name drugs is one issue under exploration.

Can you describe the types of schemes that you see on the ground with respects to pharmacy fraud of high-cost, brand-name drugs, and the impact that such schemes may have more broadly on taxpayer dollars in the Part D program?

Response:

OIG has conducted a series of studies on questionable billing patterns in Medicare Part D. In our first study, we identified over 2,600 retail pharmacies with questionable billing. Many of these pharmacies billed extremely high dollar amounts per beneficiary or per prescriber. Others billed for extremely high percentages of Schedule II controlled substances or brand-name drugs. In a second study, we identified over 700 general-care physicians with questionable prescribing patterns. Many of these physicians prescribed extremely high percentages of Schedule II or III controlled substance; while others prescribed high numbers of prescriptions per beneficiary. A third report found that Part D inappropriately paid for drugs ordered by individuals who clearly did not have the authority to prescribe, such as message therapists and athletic trainers. The last report in the series is forthcoming. It focuses on questionable utilization patterns of Human Immunodeficiency Virus (HIV) drugs. The report will identify beneficiaries such as those who received HIV drugs from an extremely high number of pharmacies or prescribers. We expect this report to be released this summer.

Reports:

- *Retail Pharmacies With Questionable Part D Billing (OEI-02-09-00600)*
- *Prescribers With Questionable Patterns in Medicare Part D (OEI-02-09-00603)*
- *Medicare Inappropriately Paid for Drugs Ordered by Individuals Without Prescribing Authority (OEI-02-09-00608)*
- *Forthcoming: Part D Beneficiaries With Questionable Utilization Patterns for HIV Drugs*

Pharmacy fraud under Medicare Part D represents the largest increase in our investigative casework. Fraud schemes involved high-cost, brand-name non-controlled drugs, create a massive financial burden upon Federal healthcare programs—specifically to Medicare and Medicaid. An individual pharmacy can easily bill millions of dollars in these types of fraudulent pharmaceuticals.

Most pharmacies maintain a small brand-name drug inventory. Audits of those pharmacies are ineffective because the PBMs (pharmacy benefit managers) only have claims information from their individual respective clients, which represent only a small portion of the pharmacy's inventory. Unless a comprehensive audit from all PBMs is completed at a pharmacy simultaneously, drug shortages will not be identified.

Categories of non-controlled fraud schemes include drugs such as the atypical anti-psychotics, pulmonary medications, some GI medications, and chemotherapy agents. The list of drugs of concern is in the hundreds.

This fraud scheme is perpetrated in various ways. First, pharmacies bill for the drugs but do not dispense them. This often involves a provider writing medically unnecessary prescriptions for beneficiaries who are co-conspirators in the fraud. A patient "recruiter" will then take the beneficiaries to a pharmacy participating in the scheme. The prescriptions are filled, but the recruiter then pays the beneficiary a cash kickback in exchange for the medication. The medication is then recycled back to the pharmacy to be put back into the pharmacy inventory. Federal health programs are billed for the medication and can eventually purchase the same medication multiple times.

Another common scheme is for medically unnecessary drugs to be dispensed to be used as "potentiators." When these drugs are combined with opiates or stimulants on the street, they cause a higher serum level of the opiate active ingredient, which enhance the euphoria from the opiate. An example of this is the HIV medication Ritonavir, which releases 3–4 times the active ingredient oxycodone, versus taking the oxycodone by itself. This creates a street demand for these non-controlled drugs and invites diversion.

Question:

What types of Medicare beneficiaries are targeted in these types of schemes?

Response:

In our case work we have seen a range of beneficiaries targeted in fraud schemes, including:

- Beneficiaries prone to drug abuse in need of pain relievers or seeking pain relievers.
- Beneficiaries receiving Medicare due to disability.
- Beneficiaries living in socio-economically depressed geographical areas or group residences such as retirement communities.
- Various ethnic groups are sometimes targets of coercion. They are threatened in various manners to comply and participate.
- Unwitting beneficiaries will be approached or cold-called by individuals misrepresenting themselves with sound alike names such as "Med-E-Care" or "Med Care." The beneficiary then falls prey to a "survey" or "verification" scam, thinking the individual is from Medicare. We have seen similar internet scams.

Question:

How does OIG hold fraudsters accountable for what they owe beneficiaries—for example, co-payments charged for medically unnecessary procedures? Do you typically require any type of community restitution in corporate integrity agreements?

Response:

The vast majority of civil health care fraud cases are resolved through the False Claims Act, which is administered by the Department of Justice (DOJ), which could provide additional insights. In many cases, the government is not aware of the identity of the patients involved in the underlying fraud because damages are based on a statistically valid sample of claims.

DOJ has required patient notification to occur in cases where there are allegations of patient harm. In standard settlement language, DOJ typically includes the following provision which protects beneficiaries from collection of payment by the settling entity for the settlement amount: "X agrees that it waives and shall not seek payment for any of the health care billings covered by this Agreement from any health care beneficiaries or their parents, sponsors, legally responsible individuals, or third party payors based upon the claims defined as Covered Conduct."

Corporate Integrity Agreements (CIA) are intended to improve compliance in an organization as it moves forward after a health care settlement. CIAs are forward-looking and do not include repayment provisions for the conduct that has already been resolved. CIAs require providers to notify the OIG if certain "reportable events" occur. Standard CIA language, in cases where quality of care issues are resolved, include required reporting to the OIG "a violation of the obligation to provide items or services of a quality that meets professionally recognized standards of health care where such violation has occurred in one or more instances and presents

an imminent danger to the health, safety, or well-being of a Federal health care program beneficiary or places the beneficiary unnecessarily in high-risk situations.”

When criminal matters are accepted for prosecution by the U.S. Department of Justice, the Department of Justice’s Victim-Witness Specialists coordinate victim notification of restitution eligibility, rights and procedures. Additional information can be found at <http://www.justice.gov/criminal/vns/>.

In an OIG case prosecuted by the U.S. Department of Justice, *United States v. Hoffman-Vaile*, the court rejected the defendant’s argument that losses in a Medicare fraud be reduced from the billed amount where the losses to Medicare were only 80 percent of the amount billed by the defendant. The court noted that private insurers and patients were also victims of the fraud and their losses, collectively, encompassed the other 20 percent. While not charged, those acts constituted relevant conduct for the purposes of loss calculation. Victims who submitted claims to the court for restitution of their co-payments were reimbursed. See page two of the 2010 US Sentencing Commission report: http://www.ussc.gov/Education_and_Training/Annual_National_Training_Seminar/2010/004b_Loss_Primer.pdf.

Senator Elizabeth Warren

Many Medicare and Medicaid fraud cases involving large health care corporations result in settlements. A significant portion of the government’s Medicare and Medicaid fraud cases are brought under the False Claims Act. The Department of Justice reported that \$2.6 billion was recovered from False Claims Act settlements of healthcare fraud cases in fiscal year 2012.¹ According to the IRS’s audit guidelines,² quote “experience has shown that almost every defendant deducts the entire amount of a False Claims Act settlement as a business expense.” Not all of these deductions hold up under IRS auditor scrutiny, but it is clear that companies try, and get away with, these deductions if they continue to file their taxes in this manner. Given the reliance on settlements to recoup funds and punish entities that defraud the government, the American people should be given the information necessary to understand the details. I introduced Truth in Settlements with Senator Coburn to require agencies to publicly disclose the details of settlements, like how they are calculated and whether they are tax deductible.

Question:

1. Do CMS and the HHS OIG agree that more clarity about exactly what these settlements mean can help taxpayers to understand the effectiveness of our government’s enforcement efforts?

2. The HHS OIG and CMS could commit to more transparency about settlement agreements without legislation. Will you commit to posting information about the details of Medicare and Medicaid fraud settlements on your joint, consumer-friendly Medicare fraud website,³ the HHS OIG website,⁴ and in your press releases, including how the settlements are calculated, and whether they are tax deductible? And if not, why not?

Response:

OIG agrees that transparency is an important goal. Consistent with this goal, OIG has for many years posted on our website summaries of the relevant facts of all civil monetary penalty settlements and judgments. We also recognize that transparency can have costs as well as benefits in the context of settlement negotiations, because the Department of Justice (DOJ) has primary responsibility for the litigation and resolution of health care fraud cases, OIG defers to DOJ regarding the appropriate level of detail about settlement calculations and negotiations that can be released without compromising ongoing and future settlement negotiations or jeopardizing other law enforcement activities. OIG does not determine the appropriate tax treatment of settlement amounts.

¹ <http://www.justice.gov/opa/pr/2013/December/13-civ-1352.html>.

² <http://www.irs.gov/Businesses/Attachment-1-to-Industry-Director-Directive-on-Government-Settlements-Directive-%231>.

³ <http://www.stopmedicarefraud.gov>.

⁴ <http://oig.hhs.gov/>.

Senator Jeff Flake*CMS Moratorium*

It is my understanding that the underlying premise of the Medicare home health benefit is that, if properly used, it can lower Medicare spending by moving patients sooner from higher cost settings to their own homes. However, recently released Medicare claims data reveal that nearly 90 percent of all excessive home health spending is occurring in about 25 counties in five States. It is my understanding that the Center for Medicare and Medicaid Services (CMS) has instituted a moratorium on new providers in certain areas but that this moratorium has not been implemented in every area that CMS has identified with issues related to excessive home health spending.

Question:

What steps have been taken to evaluate the effectiveness of the moratorium?

Response:

OIG would defer to CMS as the cognizant program agency for response.

Question:

How many new home health agencies applicants were submitted during the moratorium?

Response:

OIG does not process home health agency application and would defer to CMS for response.

Question:

What authority does the Secretary, CMS, or the Office of Inspector General have to review existing providers in these areas that are targeted for abusing the current system and what else is being done to address the problem of excessive home health spending?

Response:

OIG has many fraud enforcement tools that can be used to identify and stop fraud or excessive spending in the home health arena. These tools include investigating and bringing cases under the Civil Monetary Penalties Law and excluding individuals through OIG's exclusion authorities.

Utilization Issue

The Medicare Payment Advisory Commission (Medpac) data seems to recognize the higher rates of home health use in just five States. It is estimated that reducing utilization in just 25 counties to the 75th percentile could save Medicare over \$1 billion annually.

Question:

- What further steps to address this problem beyond the moratoria you have proposed?
- Has there been any consideration of placing a reasonable limit on homecare episodes?

Response:

OIG would defer to CMS as the programmatic agency for response.

Question:

In your opinion, would a limit on homecare episodes reduce fraud and save the Federal Government money?

Response:

We have found that criminals try to find ways to bill around any caps, limits, edits or barriers that are established in order to maximize their ability to steal from Medicare in as few attempts as possible. Therefore, it is important to explore additional safeguards to reduce and deter fraud.

While OIG has not specifically evaluated potential strategies to limit homecare episodes, factors to consider should include whether placing a limit on home health episodes could have implications on patient access to care and potentially result in patients seeking care in more expensive settings if they do not want to use up their home health benefit or have already exceeded the limit.

U.S. Senate Special Committee on Aging

**“Preventing Medicare Fraud: How Can We
Best Protect Seniors And Taxpayers?”**

March 26, 2014

**Questions for the Record
Lou Saccoccio**

Senator Bill Nelson, Chairman

Question: Mr. Saccoccio, what’s the single most important way we can strengthen the efforts of the Healthcare Fraud Prevention Partnership?

Response:

I would actually like to offer two ideas in response to the question above.

First, it is vital that the funding and resources necessary to realize the full potential of the Healthcare Fraud Prevention Partnership (HFPP) be provided. The HFPP is a groundbreaking effort aimed at aligning efforts of the public and private sectors against health care fraud. It is an entity with a thoughtful, well-defined structure that requires administrative and technical investment. In essence, the HFPP is an exercise in trust and collaboration that depends upon broad participation by interested parties. Therefore, it is important that we do what we can to ensure its success from the start by dedicating adequate funding and resources. Adequate funding will convey confidence in the program and attract participation. In contrast, a lack of support will convey uncertainty.

Government funding dedicated to health care anti-fraud efforts has proven consistently to be a good investment. The Health Care Fraud and Abuse Control Program (HCFAC) was established under HIPAA and operates under the joint direction of the Attorney General and the Secretary of the Department of Health and Human Services (acting through the Inspector General). The program, now in its seventeenth year, is designed to coordinate Federal, State and local law enforcement activities with respect to health care fraud and abuse. The HCFAC annual report for fiscal year 2013 (published in February 2014) shows a return-on-investment (ROI) for the program over the last three years (2011–2013) to be \$8.1 returned for every \$1.00 expended. The average ROI for the life of the HCFAC program is \$5.4 returned for every \$1.00 expended. NHCAA conducts its own biennial survey of private insurers which reliably reveals similar ROI outcomes for anti-fraud investments made in the private sector.

Second, to help ensure that the HFPP is as effective as it can be as a facilitator of information exchange, Congress should consider enacting a Federal immunity statute that protects information sharing that takes place between HFPP participants. Many States provide immunity for fraud reporting (typically to law enforcement and regulatory agencies, although protections, as well as reporting requirements, vary by State). However, there exists no Federal protection for insurers that share information with one another or with the government about suspected health care fraud. NHCAA believes that we should remove unnecessary obstacles that inhibit fraud fighting efforts, and that providing protections for individuals and entities that share information and data concerning suspected health care fraud is a reasonable and prudent step to take.

Question:

Mr. Saccoccio, what do you count as the single greatest success of NHCAA in the fight against Medicare fraud?

Response:

I believe that NHCAA’s greatest success in the fight against Medicare fraud has been our ability for nearly 30 years to bring the private and public sectors together to work collaboratively on the issue of health care fraud. NHCAA has always been a private-public partnership with a straightforward mission: To protect and serve the public interest by increasing awareness and improving the detection, investigation, civil and criminal prosecution and prevention of health care fraud and abuse.

Our commitment to this mission is the same regardless of whether a patient has private health care coverage or is a beneficiary of Medicare, Medicaid, or other Federal or State program. Health care fraud is a complex crime that does not discriminate between types of medical coverage. NHCAA’s ability to bring private sector and government payers together in order to exchange health care fraud information is pivotal in connecting the dots to give a more complete picture of health care fraud.

In its role as a convener and facilitator of health care fraud information-sharing, NHCAA employs several tools. These include a secure, online data base of health

care fraud cases and schemes accessible by members and law enforcement; regular in-person investigative case discussion roundtable meetings; a request for investigative assistance program aimed at assisting law enforcement; a listserv tool where members can query their industry peers about unusual, pressing or particularly challenging issues; and regular communication vehicles (e-newsletters, fraud alerts, etc.) that disseminate relevant and timely health care fraud fighting insights and information.

It's worthy to note that government agencies such as HHS Office of Inspector General, the FBI and the Centers for Medicare & Medicaid Services (CMS) are all regular participants in NHCAA information sharing activities. These agencies often offer feedback that they view participation with NHCAA as an important aspect of fighting health care fraud in Medicare and other government health care programs. NHCAA has long been a champion of anti-fraud information exchange and this experience has taught us that it is very effective in combating health care fraud—whether it be in Medicare, Medicaid, or private health insurance.

U.S. Senate Special Committee on Aging

**“Preventing Medicare Fraud: How Can We
Best Protect Seniors And Taxpayers?”**

March 26, 2014

**Questions for the Record
Shantanu Agrawal**

Senator Bill Nelson, Chairman

In January of this year, you announced a temporary moratorium on Medicare enrollment of home health agencies in several cities including Fort Lauderdale, and extended the current moratorium on new home health agency enrollment in Miami for another six months. Many home health providers applauded this decision because they are doing the right thing and want to see the bad actors caught.

Question:

- This is a great example of CMS using one of the Affordable Care Act’s anti-fraud tools, and I applaud CMS for finally using this authority. From CMS’s standpoint, why are these moratoria so integral to fighting fraud?
- What has CMS has been doing while these moratoria are in place to prepare for when home health agencies will be able to enroll in Medicare again?

Response:

In the last year, CMS has imposed moratoria in seven geographic areas¹ for two service types as part of our comprehensive strategy to fight fraud, waste, and abuse while ensuring patient access to care is not interrupted. These moratoria are critical to our efforts because they allow CMS to pause provider and supplier entry into high risk markets while using other tools and authorities in collaboration with our law enforcement partners to remove bad actors from the program. In imposing these enrollment moratoria, CMS considered both qualitative and quantitative factors suggesting a high risk of fraud, waste, or abuse. CMS relied on law enforcement’s longstanding experience with ongoing and emerging fraud trends and activities through civil, criminal, and administrative investigations and prosecutions. CMS’ determination of high risk fraud in these provider and supplier types within these geographic locations was then confirmed by CMS’ data analysis, which relied on factors the agency identified as strong indicators of fraud risk.

For example, CMS determined that Miami-Dade County, Dallas County and Harris County (which contains the city of Houston) have the three highest ratios of home health providers to beneficiaries compared to similarly sized counties, and the Houston and Philadelphia metropolitan areas have some of the highest ratios of ambulance companies to beneficiaries—an important indicator of provider oversupply. CMS also considered the annual growth rate of the provider type, and found that in Chicago the number of home health agencies has grown at almost twice the national rate. In Detroit, CMS determined that, in addition to other factors, law enforcement activity is significant, and has resulted in 44 guilty pleas and six trial convictions since 2010, because fraud schemes are highly migratory and transitory in nature, the laws and regulations governing the moratoria authority provide CMS flexibility to use any and all relevant criteria to determine the need for a moratoria.

Imposing a moratorium can help reduce the risk of fraud, waste and abuse without compromising access to care. CMS carefully examined Medicare beneficiary access to services in all of these areas, and concluded that the moratoria will not affect access to care. The Agency also worked closely with each of the affected states to evaluate patient access to care, and these states reported that Medicaid and CHIP beneficiaries will continue to have access to services. During the moratoria period, CMS and the affected states are monitoring access to care to ensure that Medicare, Medicaid, and CHIP beneficiaries are receiving the services they need.

In each moratoria area, CMS is taking administrative actions such as payment suspensions and revocations of home health agencies and ambulance companies, as well as working with law enforcement to support investigations and prosecutions. For example, CMS has revoked or deactivated billing privileges of 21 Miami home

¹ The seven metropolitan areas where CMS has issued moratoria are: Miami, FL (Miami-Dade and Monroe Counties); Chicago, IL (Cook, DuPage, Kane, Lake, McHenry and Will Counties); Dallas, TX (Dallas, Collin, Denton, Ellis, Kaufman, Rockwall, and Tarrant counties); Houston, TX (Harris, Brazoria, Chambers, Fort Bend, Galveston, Liberty, Montgomery and Waller Counties); Detroit, MI (Wayne, Macomb, Monroe, Oakland, and Washtenaw Counties); Philadelphia, PA (Philadelphia, Bucks, Delaware, and Montgomery Counties in Pennsylvania and Burlington, Camden, and Gloucester Counties in New Jersey); and Fort Lauderdale, FL (Broward County).

health agencies in the first 60 days of the moratorium. Additionally, law enforcement made arrests in a \$48 million home health scheme, and secured guilty pleas against three home health recruiters in that scheme as well as guilty pleas from the owners of a clinic involved in an eight million dollar fraud scheme.

These activities are ensuring that only legitimate providers are enrolled in Miami, and CMS has other efforts that will strengthen the enrollment policies to better prevent bad actors from getting enrolled in the first place. For example, CMS issued a proposed rule² that would permit the denial of billing privileges of a provider, supplier, or individual if they were affiliated with an entity that has an existing bad debt. This proposal is targeted to providers that may be removed from the Medicare program with large outstanding debts, but then seek re-entry to the program as another entity. CMS is also in the process of awarding the contract for fingerprint-based background checks, which will be required for the entire category of providers in the geographic area where a moratorium was imposed. This screening process complements the database and other checks that CMS performs on all providers and suppliers seeking entry into the Medicare program. CMS anticipates that these enhanced enrollment safeguards will be in place by the end of calendar year 2014.

Question: In your testimony, you talk about how you have imposed additional screening for community mental health centers in Florida as part of an enrollment study. Have these intensive screening methods been applied nationwide, and if not, why not?

Response:

The joint Medicare Fraud Strike Force effort between the Departments of Justice and Health and Human Service began targeting Community Mental Health Center (CMHC) fraud in 2008, when total Medicare payments peaked at more than \$70 million per quarter. CMS and its law enforcement partners actively pursued the suspension, investigation, prosecution of fraudulent CMHC providers nationwide. The actions correspond to a national decline in CMHC billing to Medicare that has persisted to the present time. Now total Medicare payments are well under \$10 million per quarter, a savings to the Trust Fund exceeding \$60 million per quarter. As part of that effort, in 2009, CMS designed an enrollment special study targeting certain provider types, including CMHCs, for site visits and other administrative actions based on elevated risk factors in South Florida.

As a result of the Affordable Care Act, CMS has imposed additional scrutiny on CMHCs and other high risk providers. The law required CMS to implement categorical risk-based screening of providers and suppliers who want to participate in the Medicare and Medicaid programs, and CMS put these additional requirements in place for newly enrolling and revalidating Medicare and Medicaid providers and suppliers in March 2011. This enhanced screening requires certain categories of providers and suppliers that have historically posed a higher risk of fraud to receive greater scrutiny prior to their enrollment or revalidation in Medicare. States may rely on screening performed for Medicare. CMS has designated CMHCs to the moderate level of screening,³ which subjects them to the basic level of screening—including licensure and database checks—as well as announced or unannounced site visits prior to enrollment or re-enrollment. As part of the enhanced Medicare screening, 72 CMHCs have successfully revalidated, and since that time, six have been deactivated.

On October 29, 2013, CMS published a Final Rule establishing a formal set of conditions of participation for CMHCs, which are the health and safety regulations that Medicare providers must meet to participate in the Medicare program. The new Conditions of Participation will help raise standards for the 100 CMHCs that participate in Medicare and ensure high quality and safe care for the more than 13,000 Medicare beneficiaries they serve. To ensure that the mental health centers are meeting the new health and safety requirements, CMS will survey community mental health centers at least once every five years, although surveys may occur more frequently if a complaint is received by CMS or the state survey agency.

Senator Sheldon Whitehouse

Question:

The Small Business Jobs Act appropriated \$100 million to CMS to implement predictive analytics technologies. According to GAO, CMS spent \$26 million on the im-

² <http://www.gpo.gov/fdsys/pkg/FR-2013-04-29/html/2013-09991.htm>.

³ <http://www.gpo.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf>.

plementation of the Fraud Prevention System as of May 2012. How much has CMS spent on the system to date?

Response:

The Small Business Jobs Act required the HHS Office of Inspector General (OIG) to certify the actual and projected savings that result from the Fraud Prevention System (FPS). A critical component of that certification is the review of the methodology to calculate all costs associated with the FPS. In the first implementation year report, CMS reported an estimated cost of \$34.7 million. OIG recommended that CMS refine its methodology for the second year report, and CMS is in the process of doing so. We anticipate issuing the report soon.

Early results from the FPS show significant promise and CMS expects increased returns as the system matures over time. As reported in the FPS FY 2012 Report to Congress,⁴ in its first year of implementation, the FPS stopped, prevented or identified an estimated \$115.4 million in improper payments. The FPS achieved a positive return on investment, saving an estimated three dollars for every one dollar spent in the first year; CMS anticipates that the ability of FPS to identify bad actors and focus investigative resources on most egregious schemes will continue to expand.

Question:

In its 2012 report, GAO wrote that through July 2012 CMS had implemented a total of 25 predictive analytic models in that fell into three different model types. Can you please provide an update on the number and type of analytic models CMS has to date?

Response:

Since June 30, 2011, when CMS launched the FPS, CMS has been applying advanced analytics to Medicare fee-for-service (FFS) claims on a streaming, national basis. CMS designed the FPS to accommodate a variety of model types to address multiple kinds of fraud schemes. The most important indicator of success is that the models in the FPS have led to real world action—we have kicked bad actors out of the Medicare program, the surest way to protect Trust Fund dollars and beneficiaries into the future, and stopped identified overpayments and referred cases to law enforcement.

A key component of CMS's success using the FPS tool is the rigorous and structured governance process established that brings oversight, management, and control of selecting and developing new models. This structure allows CMS to examine innovative ideas from multiple stakeholders and move approved ideas into production to enhance the FPS. When OIG, GAO or other investigators identify vulnerabilities or schemes, the governance process converts ideas into functioning models that identify quality leads for CMS and its partners to investigate.

During the second implementation year, CMS added 39 new models to the FPS, of which eight were sophisticated predictive models focused on vulnerable service areas, which raises the total number of models to 74 models running simultaneously to monitor fraud, waste, and abuse. Predictive models are issue or service area focused; one predictive model includes many indicators that could each have been put into the technology as single models. A single predictive model is often as effective as multiple non-predictive models. The value of the FPS is the successful identification of leads based on a combination of models and model types. In addition, CMS refined 17 existing models based on the feedback received through the FPS and insights from field investigators, policy experts, clinicians, and data analysts.

Question:

The Small Business Jobs Act requires the Secretary, after considering an evaluation of ongoing efforts, to expand the use of the predictive analytics technologies to Medicaid and CHIP beginning April 1, 2015. That deadline is about year away. Does CMS expect to meet the April 2015 deadline for expanding the predictive analytics system? Has CMS developed benchmarks with its contractors on this expansion project?

Response:

Under the Small Business Jobs Act, CMS is required to evaluate the cost-effectiveness and feasibility of expanding predictive analytics technology to Medicaid and the Children's Health Insurance Program (CHIP) during the third implementation year of the FPS. Based on this analysis, the law requires CMS to determine whether to expand predictive analytics to Medicaid and CHIP by April 1, 2015. As required by the Small Business Jobs Act, the third-year implementation report will include

⁴<http://www.stopmedicarefraud.gov/fraud-rtc12142012.pdf>.

an analysis of the cost-effectiveness and feasibility of expanding predictive analytics technology to Medicaid and CHIP. As we conduct this analysis we are considering the challenges posed by the differences between Medicare and Medicaid/CHIP, including the differences in availability of prepayment data amongst the programs.

However, several State Medicaid programs are already in the process of implementing predictive analytics technology as part of their program integrity efforts. CMS may approve enhanced Federal Financial Participation for certain allowable activities and resources for predictive analytics technologies that are integrated with State Medicaid Management Information Systems. CMS approved enhanced funding for five states to implement predictive analytics. Currently, CMS is working to identify specific FPS algorithms relevant to Medicaid and planning to conduct an analysis of one state's Medicaid claims data using the identified algorithms. Once this analysis is complete, CMS will share the results with that state.

Question:

HHS concurred with GAO's recommendation that outcome-based performance targets and milestones should be established for the Fraud Prevention System, and noted that CMS intended to establish such targets and milestones based on the first performance year of the Fraud Prevention System. Can you please provide a few examples of the targets and milestones CMS has established for the system?

Response:

CMS developed the appropriate measures needed to estimate savings with respect to both improper payments recovered and improper payments avoided through the FPS in the first implementation year report. As part of cost savings, CMS identified cost avoidance associated with revoking provider billing privileges, amounts denied by prepayment edits, bill amounts denied by auto-denial edits, amounts held by payment suspension, the amount of overpayments referred for recovery, and the value of law enforcement referrals. CMS also established process measures, including the number of new or augmented leads generated by FPS. CMS developed schedules and plans to integrate the FPS with CMS's claims processing system, and committed to doubling the number of models in the second year of the FPS.⁵ Creating performance targets for program integrity work is challenging because it is necessary to balance incentives between developing merit-based efficiencies and achieving targeted savings outcomes. This is especially important in cases that are developed and referred to law enforcement by the Zone Program Integrity Contractors and Program Safeguard Contractors.

Senator Elizabeth Warren

Many Medicare and Medicaid fraud cases involving large health care corporations result in settlements. A significant portion of the government's Medicare and Medicaid fraud cases are brought under the False Claims Act. The Department of Justice reported that \$2.6 billion was recovered from False Claims Act settlements of healthcare fraud cases in fiscal year 2012. According to the IRS's audit guidelines, quote "experience has shown that almost every defendant deducts the entire amount of a False Claims Act settlement as a business expense." Not all of these deductions hold up under IRS auditor scrutiny, but it is clear that companies try, and get away with, these deductions if they continue to file their taxes in this manner. Given the reliance on settlements to recoup funds and punish entities that defraud the government, the American people should be given the information necessary to understand the details. I introduced Truth in Settlements with Senator Coburn to require agencies to publicly disclose the details of settlements, like how they are calculated and whether they are tax deductible.

Question:

1. Do CMS and the HHS OIG agree that more clarity about exactly what these settlements mean can help taxpayers to understand the effectiveness of our government's enforcement efforts?

2. The HHS OIG and CMS could commit to more transparency about settlement agreements without legislation. Will you commit to posting information about the details of Medicare and Medicaid fraud settlements on your joint, consumer-friendly Medicare fraud website, the HHS OIG website, and in your press releases, including how the settlements are calculated, and whether they are tax deductible? And if not, why not?

⁵ See page iv at <http://www.stopmedicarefraud.gov/fraud-rtc12142012.pdf>.

Response:

CMS has supported greater transparency in healthcare data through a number of initiatives but defers to the Department of Justice regarding the appropriate level of detail about settlement agreements that can be released without compromising ongoing settlement negotiations or jeopardizing other law enforcement activities.

Senator Jeff Flake*CMS Moratorium*

It is my understanding that the underlying premise of the Medicare home health benefit is that, if properly used, it can lower Medicare spending by moving patients sooner from higher cost settings to their own homes. However, recently released Medicare claims data reveal that nearly 90 percent of all excessive home health spending is occurring in about 25 counties in five states. It is my understanding that the Center for Medicare and Medicaid Services (CMS) has instituted a moratorium on new providers in certain areas but that this moratorium has not been implemented in every area that CMS has identified with issues related to excessive home health spending.

Question:

What steps have been taken to evaluate the effectiveness of the moratorium?

Response:

In the last year, CMS has imposed moratoria in seven geographic areas for two service types as part of our comprehensive strategy to fight fraud, waste, and abuse while ensuring patient access to care is not interrupted. These moratoria are critical to our efforts because they allow CMS to pause provider and supplier entry into high risk markets while using other tools and authorities in collaboration with our law enforcement partners to remove bad actors from the program. In imposing these enrollment moratoria, CMS considered both qualitative and quantitative factors suggesting a high risk of fraud, waste, or abuse. CMS relied on law enforcement's longstanding experience with ongoing and emerging fraud trends and activities through civil, criminal, and administrative investigations and prosecutions. CMS' determination of high risk fraud in these provider and supplier types within these geographic locations was then confirmed by CMS' data analysis, which relied on factors the agency identified as strong indicators of fraud risk.

For example, CMS determined that Miami-Dade County, Dallas County and Harris County (which contains the city of Houston) have the three highest ratios of home health providers to beneficiaries compared to similarly-sized counties, and Houston and Philadelphia have some of the highest ratios of ambulance companies to beneficiaries—an important indicator of provider oversupply. CMS also considered the annual growth rate of the provider type, and found that in Chicago the number of home health agencies has grown at almost twice the national rate. In Detroit, CMS determined that, in addition to other factors, law enforcement activity is significant, and has resulted in 44 guilty pleas and six trial convictions since 2010, because fraud schemes are highly migratory and transitory in nature, the laws and regulations governing the moratoria authority provide CMS flexibility to use any and all relevant information to determine the need for a moratoria.

Imposing a moratorium can help reduce the risk of fraud, waste and abuse without compromising access to care. CMS carefully examined Medicare beneficiary access to services in all of these areas, and concluded that the moratoria will not affect access to care. The Agency also worked closely with each of the affected states to evaluate patient access to care, and these states reported that Medicaid and CHIP beneficiaries will continue to have access to services. During the moratoria period, CMS and the affected states are monitoring access to care to ensure that Medicare, Medicaid, and CHIP beneficiaries are receiving the services they need.

Question:

How many new home health agencies applicants were submitted during the moratorium?

Response:

When a moratorium is imposed, existing providers and suppliers may continue to deliver and bill for services, but no new applications are approved for the designated provider or supplier-types in the designated areas, allowing CMS and its law enforcement partners use other tools and authorities to remove bad actors from the

program while pausing provider entry or re-entry into markets that CMS has determined have a significant potential for fraud, waste or abuse.

Between the implementation of the first set of moratoria on July 31, 2013, and March 21, 2014, CMS has denied 297 applications in the impacted areas. Some providers may not submit applications because they are aware that a moratorium is in place. Imposing a moratorium can help reduce the risk of fraud, waste and abuse without compromising access to care. CMS carefully examined Medicare beneficiary access to services in all of these areas, and concluded that the moratoria will not affect access to care.

Question:

What authority does the Secretary, CMS, or the Office of Inspector General have to review existing providers in these areas that are targeted for abusing the current system and what else is being done to address the problem of excessive home health spending?

Response:

In each moratoria area, CMS is using its existing authority to impose administrative actions such as payment suspensions and revocations of home health agencies and ambulance companies, as well as working with law enforcement to support investigations and prosecutions. For example, during the first six-month period of the moratorium on home health in Miami, law enforcement made arrests in a \$48 million home health scheme, and secured guilty pleas against three home health recruiters in that scheme as well as guilty pleas from the owners of a clinic involved in an eight million dollar fraud scheme. CMS also took action, and revoked or deactivated billing privileges of 21 home health agencies in the first 60 days of this moratorium.

The moratoria complement CMS's outlier policy that limits the percentage of outlier payments that each home health agency can claim to address abuses of home health payments. This policy and the coordination with the Medicare Strike Force have contributed to a dramatic decline in payment for home health care in Miami and throughout Florida, and there has been a similar decline in Detroit.

Additionally, CMS has implemented the Affordable Care Act requirement that prior to certifying a patient's eligibility for an initial 60 day episode of home health care, the certifying physician must document that a face-to-face encounter has occurred with the patient. The face-to-face requirement ensures that the orders and certification for the home health services are based on a physician's current knowledge of the patient's clinical condition and provides additional accountability for the utilization of the home health benefit. At the end of the 60 day episode, a decision must be made whether or not to recertify the patient for a subsequent 60-day episode. CMS will continue to work with health care providers, specifically physicians, non-physician practitioners and home health agencies, to help them comply with the face-to-face requirements.

Utilization Issue

The Medicare Payment Advisory Commission (Medpac) data seems to recognize the higher rates of home health use in just five states. It is estimated that reducing utilization in just 25 counties to the 75th percentile could save Medicare over \$1 billion annually.

Question:

What further steps to address this problem beyond the moratoria you have proposed?

Response:

CMS has proposed other safeguards that will strengthen the enrollment policies to better prevent bad actors from getting enrolled in the first place. For example, CMS issued a proposed rule⁶ that would permit the denial of billing privileges of a provider, supplier, or individual if they were affiliated with an entity that has an existing bad debt. This proposal is targeted to providers and suppliers that may be removed from the Medicare program with large outstanding debts, then seek re-entry to the program as another entity. CMS is also in the process of awarding the contract for fingerprint-based background checks, which will be required for the entire category of providers in the geographic area where a moratorium was imposed once it has been lifted and these providers seek Medicare billing privileges. This screening process complements the database and other checks that CMS performs on all providers and suppliers seeking entry into the Medicare program. CMS antici-

⁶CMS-6045-P.

pates that these enhanced enrollment safeguards will be in place by the end of calendar year 2014.

CMS is also looking across service areas to expand tools that are impacting cost on a significant scale. CMS has also implemented private-sector strategies that are reducing Medicare expenditures, such as the use of prior authorization for certain services or benefits. CMS implemented a prior authorization process for scooters and power wheelchairs in seven states with high populations of fraud- and error-prone providers in 2012. As of August 2013, Medicare expenditures for these devices have decreased by \$117 million since the demonstration began, with decreases in both demonstration states and non-demonstration states. In the President's Budget, CMS proposed to expand its authority to use prior authorization to all Medicare fee-for-service items, particularly those service items that are at the highest risk for improper payment.

Question:

Has there been any consideration of placing a reasonable limit on homecare episodes?

Response:

It is important to remember that in most cases home health agencies are providing an important service to beneficiaries. When utilized appropriately, this benefit can help provide beneficiaries with much needed care, while maintaining independence and reducing the need for inpatient care. CMS must carefully balance the health needs of beneficiaries while when considering new approaches to fighting waste, fraud and abuse.

Question:

In your opinion, would a limit on homecare episodes reduce fraud and save the federal government money?

Response:

Any decision to place limits on any type of services beneficiaries receive needs to be balanced with the health needs of beneficiaries. Placing an arbitrary limit on the number of home visits a beneficiary would be eligible to receive could lead to some beneficiaries with complex or multiple health care needs to seek inpatient care, at which could result in higher costs to both the beneficiary and Medicare.

Statements for the Record

**Opening Statement for the Record of
Senator Susan M. Collins, Ranking Member**

Thank you, Mr. Chairman, for calling this hearing to highlight both the human and financial costs associated with fraud in the Medicare program and to examine ways that Medicare can work with private insurers and other stakeholders to improve fraud prevention.

The GAO has identified Medicare as being at high risk for improper payments and fraud for decades, since 1990. In 2012, Medicare reported that it had lost more than \$44 billion in improper payments due to waste, fraud, abuse, and mismanagement, and that estimate may well be too low.

This is simply unacceptable. The loss of these funds not only compromises the financial integrity of the Medicare program, but it also undermines our ability to provide needed health care services to the more than 54 million older and disabled Americans who depend on this vital program.

In far too many cases, Medicare fraud schemes have directly affected the quality of care and put some of our most vulnerable patients at risk. Many patients are harmed as a result of unnecessary procedures or medical services provided as part of schemes to defraud Medicare. We will hear this afternoon about one Michigan physician who allegedly gave seniors cancer treatments they did not need simply so he could bill Medicare for his services.

In the late 1990's, when I was Chairman of the Permanent Subcommittee on Investigations, we held a series of hearings to examine fraud in the Medicare program. We identified the dangerous trend of an increasing number of bogus providers entering the system with the sole and explicit purpose of robbing it. One of our witnesses told us that he went into Medicare fraud because it was easier than dealing drugs. He could make a lot more money at far less risk.

In other cases investigated by the Subcommittee, more than \$6 million in Medicare funds were sent to durable medical equipment companies that provided no goods or services whatsoever. One of these companies even listed an absurd fictitious address that, had it existed, would have been in the middle of the runway of the Miami International Airport.

We have made some progress in the battle against Medicare fraud since I chaired those hearings but the con artists have become increasingly clever in their schemes to rip off Medicare. We are devoting increased funding to Medicare program integrity activities to prevent improper payments and to detect fraud and prosecute offenders. Since it is estimated that we recover more than \$8 for every dollar spent on anti-fraud activities, these are wise investments of Federal funds.

In addition, Medicare contractors are now conducting onsite visits of durable medical equipment suppliers and other providers to make sure that they are legitimate businesses and meet required standards before they enroll in Medicare, and, we are doing a better job of screening Medicare providers by using licensing and background checks to stop fraudsters from entering the program in the first place.

I do want to emphasize one important point. The vast majority of medical professionals are caring, dedicated providers whose top priority is the welfare of their patients. They, too, are appalled at the unscrupulous bandits who take advantage of weaknesses in Medicare to bleed billions of dollars from the program.

Unfortunately, there is no line item in the budget titled "Waste, Fraud, and Abuse" that we can simply strike to eliminate this problem. The task of ferreting out wasteful and fraudulent spending is made all the more difficult by the ingenuity of the scam artists, but it is clear that we must do more to shift from a "pay and chase" strategy to combat Medicare fraud to one that prevents the harm from ever occurring in the first place.

Again, Mr. Chairman, thank you for calling this hearing.

**Statement for the Record of Senator
Robert P. Casey, Jr., Committee Member**

Chairman Nelson and Ranking Member Collins, thank you for holding today's hearing on Medicare fraud and methods of prevention. With over 50 million Medicare beneficiaries nationally, and over two million in Pennsylvania, Medicare benefits payments totaled over \$530 billion in 2012. Unfortunately, an estimated \$60–90 billion is lost annually in overpayments from the Medicare program. I was dismayed to learn about the extent to which health care providers and facilities in Pennsylvania have engaged in Medicare fraud.

Steps are being taken to improve the way that Medicare fraud is prevented and detected. In 2011, the Fraud Prevention System was launched, and a December 2012 report from CMS indicated that the Fraud Prevention System had identified approximately \$115.4 million in potential improper payments in the first year. A GAO report offered many recommendations to improve upon the integration with other systems and the measurement of performance milestones for the Fraud Prevention System, but no follow-up report from CMS has yet been made available. Addressing inefficiencies in our systems will limit fraud and abuse as we also improve service delivery.

In 1997, the first funding for the Senior Medicare Patrol (SMP) program was made available through the Administration on Aging, and Pennsylvania has had an SMP program since the program was introduced. The SMP program educates and trains older adults on identifying and reporting health care fraud. In Pennsylvania, the Center for Advocacy for the Rights and Interests of the Elderly (CARIE) administers the PA–SMP. Recently, over 10,000 community outreach events occurred nationally and reached an estimated 996,000 people. The PA–SMP had nearly 1,400 beneficiary inquiries in 2013. In addition, the PA–SMP was involved with 360 onsite outreach activities (e.g., senior centers, health and wellness fairs) which reached an estimated 14,400 people. To assure the ongoing and important work of the SMP program, I worked with Senator Sanders and my colleagues on the Health, Education, Labor and Pensions Committee to ensure continued support through the Older Americans Act reauthorization.

With 8,000 Baby Boomers turning 65 every day, we are at a critical point. Each of these new Baby Boomers is eligible for Medicare. An increase in the number of Medicare beneficiaries, will lead to an increase in Medicare spending which can also lead to increases in Medicare fraud. A hearing such as this one reinforces the importance of protecting our seniors, as well as the funds which are so needed to provide older adults the care they need.

I again would like to thank the Chairman and Ranking Member for calling this hearing. I look forward to hearing the testimony and working with my colleagues to continue the fight to stop waste and fraud and to improve the effectiveness of government services and agencies.

February 2013

HIGH-RISK SERIES

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Medicare Program

Why Area Is High Risk

In 2012, the Medicare program covered more than 49 million elderly and disabled beneficiaries at an estimated cost of \$555 billion, and reported improper payments estimated to be more than \$44 billion. The Centers for Medicare & Medicaid Services (CMS), which administers Medicare for the Department of Health and Human Services (HHS), is responsible for implementing payment methods that encourage efficient service delivery, managing Medicare to provide efficient and cost-effective services to beneficiaries, safeguarding the program from loss, and overseeing patient safety and care. Like health care spending in general, Medicare spending has grown faster than growth in the economy for many years. In the coming years, continued growth in the number of Medicare beneficiaries and program spending will create increasing challenges for the federal government.

What GAO Found

GAO designated Medicare as a high-risk area in 1990 because its complexity and susceptibility to improper payments, added to its size, have led to serious management challenges. Medicare spending must be held much more firmly in check to sustain the program over the long term, while continuing to ensure that beneficiaries have access to appropriate health care. To help do so, GAO has identified opportunities to make Medicare payment methods more efficient and cost-effective. In addition, the size of the program makes it important for CMS to manage program functions more effectively and better oversee the program's integrity and quality of patient care. The following areas delineate where GAO has identified opportunities for improvements.

- Reforming and refining payments.* CMS has implemented broad-based reforms to payment systems in the traditional Medicare fee-for-service (FFS) program as well as Medicare Advantage (MA) plans, where about a quarter of Medicare beneficiaries receive their care. Many reforms introduce financial incentives into payment structures to explicitly reward quality and efficiency. Important initiatives include steps toward transitioning Medicare's FFS physician payment system from one that rewards volume of services to one in which value—as measured by quality and cost of care—is used to determine payment. For example, CMS has begun to provide feedback to physicians about their resource use—an important step in encouraging efficiency—and this information, along with indicators of the quality of care delivered, will be used as part of calculating the value-based payment. GAO's work on the Physician Feedback Program found that CMS was experiencing both methodological and implementation challenges. As CMS progresses to full implementation of its value-based payment system, it will be important for the agency to use reliable quality and cost measures and

methodological approaches that maximize the number of physicians for whom value can be determined.

GAO's work identified opportunities for CMS to introduce additional payment method refinements and controls in Medicare FFS to encourage appropriate use of services. For example, self-referral, where a provider refers patients to entities in which the provider or the provider's family has a financial interest, continues to be a problem for advanced imaging services. GAO's analysis showed that providers' referrals of advanced imaging services substantially increased once they start to self-refer. GAO estimated that such additional referrals cost more than \$100 million in 1 year. However, CMS does not obtain information to identify which advanced imaging services are self-referred and monitor their use. Further, Medicare pays the same amount for self-referred services, even though certain efficiencies may be gained when the same provider orders, performs, and interprets an advanced imaging service. In addition, Medicare prices for certain services may be too high. For example, Medicare added drugs used to treat complications of end-stage renal disease (ESRD) to its bundled payment for ESRD care services starting on January 1, 2011, but based the payment on 2007 care patterns. However, utilization of these drugs to treat ESRD patients has declined since 2007. GAO estimates that Medicare expenditures would have been \$650 million to \$880 million lower in 2011 if the bundled payment rate was rebased to reflect 2011 utilization of ESRD drugs. Similarly, although Medicare's payment system gives hospitals an incentive to seek the best price for implantable medical devices (IMD), GAO determined that hospitals may vary in their ability to do so. The lack of price transparency and variation in amounts hospitals pay for some IMDs—and may pass on to the Medicare program—raise questions about whether hospitals are achieving the best prices possible.

For the Medicare Advantage (MA) program, CMS has made progress implementing required adjustments to plan payments to align them more closely with the cost of care in the traditional Medicare program. However, in a January 2012 report, GAO indicated that CMS could still improve the accuracy of payments to MA plans. The report found that an adjustment CMS makes to MA plan payments to improve accuracy to account for differences in beneficiary diagnostic coding between MA plans and Medicare FFS is inadequate, resulting in excess payments to MA plans estimated to be at least \$3 billion from 2010 to 2012. While federal law requires an increase in the minimum adjustment CMS must make, CMS will still need to modify its methodology to ensure the accuracy of adjustments in future years. In another report, GAO found that instead of implementing the MA quality bonus payment provisions in

the Patient Protection and Affordable Care Act (PPACA), as amended, CMS established a demonstration to test an alternative bonus payment structure. This demonstration is estimated to cost more than \$8.3 billion over 10 years and offsets a significant portion of the act's MA payment reductions during its 3-year time frame. GAO identified significant shortcomings in the demonstration's design that preclude a credible evaluation of the effect of incentives on plans' quality improvement. For this reason, GAO recommended that the Secretary of HHS cancel the demonstration and implement the quality bonus payments provided for under PPACA. GAO also raised concerns about whether the demonstration meets the requirements of the statute under which it is being conducted and therefore, falls within CMS's authority.

- *Improving program management.* CMS has overcome some challenges in managing Medicare as it implemented some recent program improvements. For example, GAO had previously reported that Medicare sometimes overpaid for durable medical equipment (DME) items relative to other payers. To achieve Medicare savings, in 2009 CMS began implementing a DME competitive bidding program. In this program, CMS contracts with select suppliers to provide DME to beneficiaries and pays them at competitively determined prices based on the bids. GAO found that beneficiary access and satisfaction appeared stable in early assessments, and the competitive bidding program has led to savings. Similarly, in the past, CMS was sometimes hampered in identifying situations when Medicare should be the secondary payer, and the Medicare, Medicaid, and State Children's Health Insurance Program Extension Act of 2007 mandated reporting of such situations. Since CMS's implementation of the mandatory reporting for nongroup health plans, program savings increased by \$124 million from 2008 through 2011. However, GAO found that the increase in contractors' workload to comply with increased mandatory reporting led to problems processing the cases promptly and that CMS's guidance and communications with non-group health plans could be improved. GAO also reported that Medicare is implementing two new programs to provide incentive payments to eligible providers that adopt and use health information technology, but the programs have some inconsistent requirements and have separate reporting requirements, which could increase the burden on providers trying to access the incentives. CMS has improved its overall guidance and oversight of contracts, an area where GAO found pervasive internal control weaknesses in 2009 that put billions of taxpayers' dollars at risk. Improvements include adding internal controls and testing the agency's review of contract payments, adding new checklists and policies to document compliance with federal

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acquisition requirements, and enhancing its policies and procedures for tracking, investigating, and resolving contract audit and evaluation findings.

- *Enhancing program integrity.* The administration and CMS have made reducing improper payments one of their priority initiatives. CMS has made progress in error rate measurement and in 2011 was able to report the error rate for all Medicare components for the first time, including the prescription drug benefit (Part D). CMS's performance plan has set targets for percentages of improper payments, with the targets slightly lower in each year. As reported in 2012, the rate of improper payments in Part D (3.1 percent) was lower than the target CMS set (3.2 percent)—however, the rate of improper payments in FFS and Part C—at 8.5 percent and 11.4 percent respectively—exceeded CMS's target rates of 5.4 percent and 10.4 percent. Thus, additional efforts will be needed to further reduce improper payments in FFS and Part C. If CMS reaches its targets for improper payments, it will take several more years to assess whether CMS can sustain progress in reducing improper payments. The estimation methodology for Parts C and D are relatively new, with few assessments made to develop a trend. Further, refinements to the methodology used to determine the final 2009 and 2010 FFS improper payment rates make them not comparable to estimates for earlier years.

CMS has also taken steps to try to strengthen Medicare program integrity and reduce vulnerabilities to improper payment, but some problems have yet to be fully addressed. For example, GAO's previous work found persistent weaknesses in Medicare's enrollment standards and procedures that increased the risk of providing billing privileges to entities intent on defrauding the program. CMS has implemented provisions in PPACA designed to strengthen provider enrollment procedures in several ways, such as designating risk levels for categories of providers and applying different screening procedures for providers at each level. In addition, CMS contracted with two new entities at the end of 2011 to assume centralized responsibility for automated screening of provider and supplier enrollment and for conducting site visits of providers. However, CMS has not completed other actions required by this legislation, including (1) determining which providers will be required to post surety bonds to help ensure the recovery of payments made for fraudulent billing, (2) contracting for fingerprint screening services for high-risk providers, (3) issuing a final regulation to require providers to disclose additional information, and (4) establishing core elements for provider compliance programs.

Sound and sufficient prepayment controls and post-payment analytic

capability to examine the appropriateness of paid claims are critical for proper payment. CMS has incorporated prepayment controls designed to automatically deny claims that do not meet Medicare's requirements, but GAO found that not all of these controls were working as intended. Further, the processes to identify the need for the controls and implement them had weaknesses that can lead to overpayments. For example, CMS has improved its corrective action process, including developing written guidance on its operation. However, the guidance still lacks procedures to specify time frames for taking corrective actions, methods for assessing the effects of corrective actions, and procedures to ensure that CMS considers instituting prepayment controls whenever possible to prevent making improper payments.

CMS also has implemented the Fraud Prevention System (FPS), which uses analytic methods to examine claims before payment to help identify and prioritize investigations of potential fraud. Specifically, FPS analyzes Medicare claims data using models of potentially fraudulent behavior, which results in automatic alerts on specific claims and providers, which are then prioritized for program integrity analysts to review and investigate as appropriate. According to program integrity officials, FPS is intended to help facilitate the agency's shift from focusing on recovering fraudulent payments after they have been made, to taking actions more quickly when aberrant billing patterns are identified. However, the system is not fully integrated with CMS's existing information technology systems, and CMS has not defined and measured quantifiable benefits and performance goals for it. For CMS's existing information technology for detecting improper or fraudulent claims after payment has been made, GAO reported in 2011 that CMS had not incorporated all the data into its Integrated Data Repository, as planned, which limited the repository's use for identifying potentially fraudulent claims. In 2011 CMS also had not taken all steps needed to ensure wide usage of its One Program Integrity information technology portal, a tool to help identify patterns of fraud, waste, or abuse. Nor was CMS in a position to identify, measure, and track benefits from these two information technology efforts. Since 2011, CMS has added data to its Integrated Data Repository and increased training to encourage the use of One Program Integrity.

- *Overseeing patient care and safety.* Although preventive care may reduce expenditures and improve health outcomes, GAO found in January 2012 that the use of preventive services by Medicare beneficiaries—those in FFS Medicare as well as those in MA plans—does not always align with the U.S. Preventive Services Task Force's clinical recommendations. Better alignment of preventive service use with Task Force recommendations depends on appropriate Medicare coverage and cost

sharing policies to encourage greater use of high-valued preventive services recommended by the Task Force and discourage use of low-value services for which clinical evidence suggests that the risks generally outweigh the benefits.

For some of the most vulnerable beneficiaries—those in nursing homes—weaknesses remain in oversight of the quality of care, although CMS has taken steps to improve it. For example, CMS contracts with state survey agencies to investigate complaints about nursing homes and helps ensure the adequacy of complaint processes by issuing guidance, monitoring data that state survey agencies enter into CMS's database, and annually assessing state agencies' performance against specific standards, but the agency found that states had difficulties meeting some of its standards for their complaint processes. CMS has taken steps to address GAO's recommendations to improve nursing home oversight, such as strengthening enforcement against nursing homes that have provided poor quality care, by increasing the number of facilities that will be subject to more intensive oversight and sanctions for failure to show improved care quality.

To provide information to consumers and improve provider quality, in 2008, CMS implemented the Five-Star Quality Rating System, which assigns each nursing home an overall rating and three component ratings—health inspections, staffing, and quality measures—based on the extent to which the nursing home meets CMS's quality standards and other measures. CMS has several efforts planned to improve the usability of the Five-Star System and provide additional information and quality measures. However, the agency lacks GAO-identified leading strategic planning practices—the use of milestones and timelines to guide and gauge progress toward desired results and the alignment of activities, resources, and goals—that could help it more efficiently and effectively improve the Five-Star System.

What Remains to Be Done

As discussed, CMS has demonstrated high-level management commitment to measuring its payment error rate, as demonstrated by its development of a payment error rate for each part of the program. It has taken steps to reduce improper payments, such as by implementing some of the new provider enrollment requirements in PPACA and implementing certain payment controls. Further, CMS has introduced other initiatives to address its management challenges, such as implementing a competitive bidding program for DME and making serious efforts to better oversee nursing quality care and management of contracts. However, CMS has not met GAO's criteria to have the Medicare program removed from the

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High Risk List—for example, although CMS has made progress in measuring and reducing improper payment rates in different parts of the program, it has yet to demonstrate sustained progress in lowering the rates. Because the size of Medicare relative to other programs leads to aggregate improper payments that are extremely large, continuing to reduce improper payments in this program should remain a priority for CMS. Further, CMS should complete some actions required by PPACA that were designed to improve the integrity of the program, such as determining which providers must post surety bonds to help in recovering payments for fraudulent billing, using fingerprint screening for high-risk providers, issuing a final regulation that requires providers to disclose additional information, and establishing core elements for provider compliance programs.

CMS has implemented certain GAO recommendations—for example, for nursing home and contract oversight—but further action is needed on other recommendations. To refine Medicare payment methods to encourage efficient provision of services, CMS should

- ensure the implementation of an effective physician profiling system, to help support use of value-based modifiers;
 - develop and implement approaches to identify self-referred claims, reduce payments to recognize efficiencies achieved when the same provider refers and provides the service, and take steps to ensure the appropriateness of service provision;
 - cancel the current MA Quality Bonus Demonstration and implement the quality bonus payment provisions in PPACA, as amended; and
 - improve the accuracy of the adjustment of payments to MA plans for diagnostic coding differences, such as by using more current data in determining the amount of the adjustment.
- To improve program management, CMS should
- improve the cost-effectiveness of recovery of payments made improperly because Medicare was the secondary payer in situations involving non-group health plans, and decrease the reporting burden for non-group health plans while improving communication with plans' stakeholders.
- To enhance program integrity, CMS should

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- improve the structure and processes related to use of prepayment controls and assess the feasibility of increasing contractors' incentives for their use, and
- develop or finalize schedules and plans for its information technology efforts related to improper payments and fraud; define quantifiable benefits, measurable performance targets, and goals for these efforts; and use the targets and goals to determine their effectiveness.
To improve oversight of patient care and safety, CMS should
- provide coverage for preventive services recommended by the Preventive Services Task Force, as appropriate, considering cost-effectiveness and other criteria;
- strengthen oversight of nursing home complaint investigations by improving the reliability of its complaints database and clarifying guidance for its state performance standards; and
- use strategic planning to guide and gauge the progress of its planned efforts to meet the goals of the Five-Star Quality Rating System for nursing homes.

In addition, Congress should consider requiring the Secretary of HHS to rebase the ESRD bundled payment rate as soon as possible and on a periodic basis thereafter, using the most current available data, and requiring beneficiaries to share the cost of those preventive services that the Preventive Services Task Force has recommended against.

GAO Contact

For additional information about this high-risk area, contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov, or Kathleen King at (202) 512-7114 or kingk@gao.gov.

Related GAO Products

End-Stage Renal Disease: Reduction in Drug Utilization Suggests Bundled Payment Is Too High. GAO-13-190R. Washington, D.C.: December 7, 2012.

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The Senior Citizens League
Statement for the Record
on
Preventing Medicare Fraud: Protecting Seniors and Taxpayers
Submitted to the
Senate Special Committee on Aging

March 26, 2014
Washington, D.C.

On behalf of our approximately 1.2 million members and supporters, The Senior Citizens League (TSCL) would like to thank Senate Special Committee on Aging Chairman Bill Nelson and Ranking Member Susan Collins for convening this important hearing and for allowing us the opportunity to submit a statement regarding the prevention of Medicare fraud.

TSCL consists of active and informed members, and they tend to be older, less affluent seniors. Reducing fraud, waste, and abuse within Medicare is an incredibly important topic for them – we hear concerns from our members on a daily basis. They fully comprehend that the government’s ongoing failure to manage and root out fraud results in higher taxes for all and higher premiums for them. In our recent annual survey, more than 95 percent of our members said they strongly favor ramping up Medicare anti-fraud efforts.

Since 1990, the Government Accountability Office (GAO) has declared Medicare a high-risk program, due to its complexity and its susceptibility to improper payments. The administration recently estimated that in fiscal year 2012, the program spent at least \$44 billion on improper payments. These improper payments put a strain on Medicare’s finances and could, in the long run, threaten beneficiaries’ access to care.

Thousands of seniors fall victim to fraudulent activities each year. Typically, Medicare fraud involves dishonest providers or others who purchase or illicitly obtain Medicare identification numbers, and then submit claims to Medicare for goods and services that were never provided. For example, last fall, one Michigan cancer doctor was charged with deliberately misdiagnosing patients with cancer in order to justify submitting \$35 million in false claims to Medicare for intensive treatments like chemotherapy. In this particularly egregious example, employees of the physician reported that elderly patients were even being intentionally harmed in order to increase profits.

Perpetrators of Medicare fraud are rarely caught, and the media has frequently reported that organized crime groups have begun targeting Medicare because it is such a lucrative market. Many seniors are rightfully alarmed when they open their Medicare statements and discover that fraudulent or suspicious claims were made by someone who has stolen their Medicare number.

According to the Department of Justice (DOJ) and the Department Health and Human Services (HHS), efforts to fight Medicare fraud are cost-effective. HHS Secretary Kathleen Sebelius and Attorney General Eric Holder recently announced that for every dollar that is spent fighting fraud in federal health care programs, \$8.10 is recovered. Federal efforts to prevent fraud recovered a record-breaking \$4.3 billion in taxpayer dollars in fiscal year 2013, and in the past five years, \$19.2 billion has been returned to the Medicare Trust Funds, up from \$9.4 billion over the previous five-year period.

TSCL is pleased that joint efforts between DOJ and HHS have evidently been successful thus far. However, more work remains to be done before beneficiaries can rest assured that they will no longer be the targets of criminal activity by simply enrolling in Medicare.

To protect seniors and taxpayers from Medicare fraud, TSCL believes that Congress should pass the Preventing and Reducing Improper Medicare and Medicaid Expenditures (PRIME) Act of 2013 (S. 1123 and H.R. 2305). The PRIME Act, which was introduced in June by Senators Tom Carper and Tom Coburn, along with Representatives John Carney and Peter Roskam, represents a bipartisan, common-sense solution to fraud prevention. Thus far, it has garnered twenty-five cosponsors in the Senate and sixty in the House of Representatives. We are hopeful that both chambers will adopt it before the end of this year.

The PRIME Act is a comprehensive bill that we believe would go a long way in ensuring that scarce program dollars are appropriately spent. It has nine key components that build upon legislative efforts that have already been adopted, including measures within the Affordable Care Act and the Small Business Jobs Act. TSCL feels that four components in particular have the potential to significantly protect seniors and taxpayers from Medicare fraud.

First, the bill would provide incentives for Medicare Administrative Contractors (MACs) to reduce their improper payment error rates. In 2012, Medicare reported an error rate of 8.5 percent for its claims reimbursement process, which totaled \$29.6 billion in improper payments. Other federal health systems like TRICARE have successfully minimized their error rates by using incentive payment models for contractors. Under TRICARE, all contractors are responsible for payment errors that fall above a 2 percent threshold. MACs within the Medicare

program are capable of limiting their payment error rates, but until incentives are put in place, they are unlikely to do so. Nearly \$30 billion is lost each year to errors in the claims reimbursement process. By passing the PRIME Act and setting acceptable error rate benchmarks for MACs, this issue could be minimized.

Second, the PRIME Act would improve data sharing between Medicare and Medicaid so that payment errors for approximately 7 million dually eligible beneficiaries can be prevented. Dual eligibles typically have significant health care needs, so payment errors for them come at a higher cost to Medicare. Only a few state Medicaid offices currently coordinate with Medicare on payment errors related to dual eligibles. Most states use completely separate coding systems for processing bills and claims, which result in both programs paying for the same service. The PRIME Act would address this problem, which costs millions of dollars each year, by requiring greater coordination and data sharing between Medicare and Medicaid.

Third, the PRIME Act would strengthen penalties for those who illegally distribute Medicare beneficiary identification numbers. Currently, the legal ramifications for defrauding Medicare are not great enough, and in order to prevent wholesale fraud by organized crime groups, penalties must be increased. The PRIME Act would do just that by increasing fines and prison sentences for those who purchase, sell, or distribute beneficiary identification numbers with the intent to defraud the program.

Finally, the PRIME Act would encourage greater participation from seniors and other beneficiaries by enhancing the rewards program that currently exists and by improving education campaigns. Under current law, the Senior Medicare Patrol (SMP) – which consists of retired volunteers and staff educators – helps beneficiaries identify potential fraud by teaching them to review their quarterly Medicare statements for possible billing or coding mistakes. To date, more than 23 million seniors have been reached by SMP educational events, and nearly \$110 million has been returned to the Trust Fund due to SMP efforts. TSCL believes that seniors are capable of contributing a great deal to fraud prevention efforts, and we believe that increasing the work of SMPs will result in higher detection rates.

These four components of the PRIME Act, among others, have the potential to greatly reduce instances of Medicare fraud. In addition to passing the PRIME Act, we believe that Congress should take steps to ensure that Medicare benefits are not improperly received by those not legally entitled to them. According to a report released by the Office of the Inspector General in 2013, nearly 30,000 undocumented immigrants received Medicare benefits between 2009 and 2011, and a review of their claims revealed that Medicare had paid more than \$91.6 million on behalf of just 2,575 of the unlawfully present individuals.

TSCL believes that those who are not legally entitled to benefits should be removed from the Medicare rolls in order to reduce the strain on the program's finances. President Obama included this proposal in his budget blueprint for fiscal year 2015, and the Centers for Medicare and Medicaid Services (CMS) have vowed to have undocumented immigrants involuntarily un-enrolled from Medicare Advantage and Part D plans. We are hopeful that measures to address this issue will be implemented by CMS. However, Congressional action may be necessary in order to fully protect taxpayers from this type of Medicare fraud.

The problem of fraud, waste, and abuse within Medicare cannot be overstated, and while recent joint efforts between HHS and DOJ have been successful, TSCL believes that much more work remains. By adopting the comprehensive, bipartisan PRIME Act, and by removing ineligible beneficiaries from the Medicare rolls, we believe that a significant reduction in Medicare fraud can occur.

Again, we applaud the committee for its work on this important issue, and we thank Chairman Nelson and Ranking Member Collins for the opportunity to submit a statement for the record. In the coming months, we look forward to working with Congress, the Administration, and other stakeholders in any way necessary to protect seniors and taxpayers from Medicare fraud.