IMPROVED EFFORTS TO COMBAT HEALTH CARE FRAUD

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

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IMPROVED EFFORTS TO COMBAT HEALTH CARE FRAUD

WEDNESDAY, MARCH 2, 2011

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON OVERSIGHT,
Washington, DC.

The Subcommittee met, pursuant to call, at 2:09 p.m., in Room 1100, Longworth House Office Building, Hon. Charles Boustany [Chairman of the Subcommittee] presiding.

[The advisory of the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

Wednesday, February 23, 2011

Boustany Announces Hearing on Improving Efforts to Combat Health Care Fraud

Congressman Charles W. Boustany, Jr., MD, (R–LA), Chairman of the Subcommittee on Oversight of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on improving efforts to combat health care fraud. **The hearing will take place on Wednesday, March 2, 2011, in Room 1100 of the Longworth House Office Building, immediately after a brief Subcommittee organizational meeting beginning at 2:00 p.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include experts on health care fraud from both the public and private sectors. Any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Health care fraud costs the American taxpayer tens of billions of dollars every year, significantly increasing Medicare spending. As a GAO-designated "high-risk" program since 1990, Medicare continues to attract those who defraud the government through kickbacks, identity theft, and billing for services and equipment beneficiaries never receive or do not need. The Medicare program covered 47 million beneficiaries who are senior citizens or have disabilities in 2010 with estimated outlays of $509 billion, according to GAO. With the Medicare Board of Trustees predicting that Medicare expenditures will reach nearly $1 trillion per year by 2019, a rapidly increasing amount of taxpayer dollars will be vulnerable to fraud unless greater steps are taken to stem the tide.

The Federal Bureau of Investigation estimates that between 3 and 10 percent of health care spending is fraudulent. With the Centers for Medicare and Medicaid Services estimating current health care spending to be over $2.5 trillion, anywhere from $75 to $250 billion is lost annually to fraud. As much as $80 billion of this fraud is in the federal health care programs, including up to $50 billion in Medicare alone. Though it is difficult to accurately quantify the total costs of health care fraud, experts at the National Health Care Anti-Fraud Association predict that with rising health care spending, total health care fraud, waste, and abuse could rise to as high as $330 billion per year by 2013.

In announcing the hearing, Chairman Boustany said, **"The Federal Government borrows 41 cents for every dollar it spends, and a growing portion of this is within the Medicare program. At a time when the Federal Government is hemorrhaging money, we have to make every effort to stop fraud within the health care system. It is important that Congress oversee what is happening to this money. This hearing will explore recent efforts to combat Medicare fraud and what the government can be doing better. It will also explore what the private sector is doing to stop fraud and how public and private actors might better work together in this effort."**

FOCUS OF THE HEARING:

The hearing will focus on current policies and programs designed to prevent and punish Medicare fraud, as well as new and innovative practices aimed at preventing health care fraud in the private sector. The hearing will also explore how the public sector and private sector can learn from each other about new tools to combat Medicare fraud, waste, and abuse.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov,* select "Hearings." Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Wednesday, March 16, 2011.** Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–3625 or (202) 225–2610.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone, and fax numbers of each witness.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://www.waysandmeans.house.gov/*.

Chairman BOUSTANY. Now we will turn to today's hearing on health care fraud.

I want to begin this hearing by welcoming our guests, who are here to join a very important discussion about health care fraud. And, gentlemen, I know you have been very busy today, and we appreciate you being here today.

For our first panel, we welcome Dr. Peter Budetti, who serves as deputy administrator of the Centers for Medicare and Medicaid Services and is director of its Center for Program Integrity. Welcome.

We also welcome Mr. Lewis Morris. Mr. Morris serves as the chief counsel to the Department of Health and Human Services' Office of Inspector General, an organization that is on the front lines of the fight against health care fraud. Welcome.

On our second panel, we will hear from Karen Ignagni from America's Health Insurance Plans, and Lou Saccoccio from the National Health Care Antifraud Association. Both of these witnesses will provide insight into how the public and private sectors work together to fight health care fraud and where we might be able to improve anti-fraud efforts, and I thank them for coming as well.

We also have a very rare chance to hear from Mr. Ike Odelugo. Through a variety of schemes involving durable medical equipment, Mr. Odelugo defrauded the Medicare program of an estimated $9 million. Since his days of committing health care fraud, he has assisted law enforcement efforts to track down those engaged in similar activities. Today, he will describe both how he went about defrauding the Medicare system and, in his experience, just how easy it was.

This promises to be an eye-opening hearing on a very critical topic. This is not simply about those committing fraud; it is about the patients and health care providers that are hurt by it. I come from a family line of physicians, and, as a cardiothoracic surgeon, I certainly understand that every dollar lost to health care fraud is a dollar not spent on patient care.

And we are not talking about small sums of money. Health care spending accounts for one-sixth of our Nation's economy, and within this spending is an incredible amount of money lost to fraudsters. Professor Malcolm Sparrow of the Harvard Kennedy School said before the Senate Judiciary Committee in 2009, "The units of measure for losses due to health care fraud and abuse in this country are hundreds of billions of dollars per year. We just don't know the first digit."

The FBI estimates that between 3 and 10 percent of all health care spending is fraudulent, as much as $250 billion each and every year. As much as $50 billion of this yearly fraud is in the Medicare program, and to put it another way, that is over $135 million per day in the Medicare system alone.

Medicare crooks are robbing the American taxpayer each and every year of the same amount it took Bernie Madoff decades to rob from his private investors. Medicare fraud has become such an attractive target for criminals that the FBI and OIG have seen an increasing number of foreign criminal groups coming to America to exploit the program because it is less risky and a lot more lucrative than other illegal ventures.

Without action, the problem is only going to get worse. The Medicare program had estimated outlays of $509 billion in the year 2010, and that number is expected to grow at a rapid pace as 7,000 baby boomers become eligible for Medicare every single day in the year 2011. CMS expects annual Medicare spending to approach $900 billion by 2019, and, as this spending goes up, so will the amount of taxpayer money potentially lost to fraud.

While the Affordable Care Act included some new anti-fraud provisions, it left a lot of suggestions by the Office of Inspector General, Government Accountability Office, and Members of Congress from both parties on the cutting-room floor.

At the same time, the law created a host of new health care spending programs. The Congressional Budget Office estimates these new programs will cost $940 billion over the next 10 years

and much more after that. CBO has estimated the act's anti-fraud provisions would save about $5.8 billion over the next 10 years. That is less than 1 percent of the expected fraud against Federal health care programs during the same period.

There is also good news on the subject. Just last month a joint effort by the Departments of Justice and Health and Human Services resulted in charges against 111 defendants for allegedly defrauding the Medicare program of over $225 million. This was the largest crackdown we have seen yet, and we look forward to hearing about these and other efforts from our witnesses.

There was also a lot to explore regarding potential private-public collaborations. As private health insurers develop new methods in technology to prevent fraud, it is important that the public and private sector work together in what should be a mutually beneficial collaboration.

With important reforms, new technology, better use of data, and increased cooperation between the public and private sector, it is my hope we can put a substantial dent in the problem of health care fraud. This hearing seeks to begin that process.

Before I yield to our ranking member, Mr. Lewis, I ask unanimous consent that all members' written statements be included in the record, and without objection, so ordered.

Chairman BOUSTANY. Mr. Lewis, we will now turn to you for your opening statement.

Mr. LEWIS. Thank you very much, Chairman Boustany, for holding this important hearing on ways to fight health care fraud. This is an important topic that touches the lives of millions of Americans. Our health care dollars are too precious, and we must ensure that those dollars are spent on health care.

Last year, this subcommittee held a hearing on fraud in the Medicare program. We learned about new tools and new approaches that were being used to protect Medicare patients and return billions of dollars to the program and the taxpayers. We also explored the new provisions of the Affordable Care Act that gave government agents new tools to fight fraud.

Today, I look forward to learning how these tools are being used to protect the Medicare program. I am interested in the new initiatives of the Department of Health and Human Services in this area. I am also interested in learning how people become involved in Medicare fraud and how health plans, government agencies, and organizations can work together to detect and stop this abuse.

In closing, Mr. Chairman, I would like to thank the witnesses for being here today. I thank you for your testimony and your willingness to share your experiences and ideas. I remain committed to protecting the Medicare program and finding new ways to work together with you and my colleagues to fight fraud in this important program. Together we can ensure that the Medicare program remains strong for the next generation of Americans.

With that, Mr. Chairman, I yield back my time.

Chairman BOUSTANY. Thank you, Mr. Lewis.

We have a vote called. I think what we will do is take the witnesses' testimony now and then probably recess at that point for three votes, and then we will return and resume the hearing.

So now we would like to turn to our first panel of witnesses. I want to welcome Dr. Peter Budetti, deputy administrator and director of the Center for Program Integrity with CMS. Mr. Budetti, you may proceed.

STATEMENT OF PETER BUDETTI, M.D., DEPUTY ADMINISTRATOR AND DIRECTOR, CENTER FOR PROGRAM INTEGRITY, CENTERS FOR MEDICARE AND MEDICAID SERVICES, WASHINGTON, D.C.

Dr. BUDETTI. Thank you very much, Chairman—Dr. Boustany and Ranking Member Lewis and Members of the Subcommittee for the invitation to discuss the Centers for Medicare & Medicaid Services' efforts to reduce fraud, waste, and abuse in the Medicare, Medicaid, and CHIP programs. I am also very pleased to be sharing the table with my distinguished colleague in fighting fraud, the chief counsel for the Office of the Inspector General, Lewis Morris.

Mr. Chairman, from the first day that I had the privilege of accepting this job about a year ago, I have been asked two questions over and over again: Why do you let crooks into the Medicare and Medicaid programs, and why do you pay their claims when they are fraudulent? And I am very pleased to be able to report to you today that we are making a great deal of progress on both fronts. We will be keeping the bad guys out of the programs, the people who don't belong there, while working to make sure that the good providers and suppliers who are our partners have, if anything, less difficulties with our processes, and we will be moving to deny claims and screen them out when they are fraudulent and should not be paid. And we actually will be doing that in collaboration with our colleagues at the Office of the Inspector General.

Under the leadership of Secretary Sebelius, CMS has taken several administrative steps to better meet the emerging needs and challenges in fighting fraud and abuse. The Secretary consolidated within CMS, program activities into four centers, one of which is the new Center for Program Integrity, and that is the one that I have the privilege of leading. This has served our purposes well. It has also helped foster our collaboration with our law enforcement partners.

The Affordable Care Act also enhances this organizational change by providing us with an opportunity to jointly develop Medicare and Medicaid policies together, because the new center combines the Medicaid Program Integrity Group and the Medicare Program Integrity Group under the same roof for the first time; and because the Affordable Care Act, for example, the screening provisions in the Affordable Care Act apply equally to Medicare and Medicaid, this gives us a new opportunity to consolidate and to coordinate the programs and activities and policies across both programs to assure better consistency in what we are about.

You might wonder whether administrative changes at an organization really mean anything. I can tell you that in our case, creating a Center for Program Integrity that is on a par with the other major components within the Centers for Medicare & Medicaid Services, elevates the issue substantially for both internally and also sends a message to the would-be fraudsters that we are taking this seriously.

To explain how we have been transforming our fraud detection and prevention work, I now draw your attention to our chart which I believe we have also given you some hard copies of—but this is a poster that depicts how we are moving from our historical state which was based on "pay and chase"—pay claims first and then try to find problems afterwards—to preventing fraud. That is our number one goal.

Number two, we are committed not to pursuing a monolithic approach but, rather, to use our resources to apply to bad actors and to identify those who pose the most serious risks to our programs.

Third, we are taking advantage of advances in technology and other innovations to modernize our approaches to doing this.

Four, consistent with this administration's commitment to being transparent and accountable, we are developing performance measures that will specify what our targets are for improvement.

Five, we are actively engaging our public and private partners from across the spectrum because there is much to learn from others who are engaged in fighting fraud, and we know that the private sector is oftentimes victim to the same schemes and to the same fraudsters as the public sector is.

Finally, we are committed to coordination and integration among all the CMS fraud fighting programs wherever possible.

I would like to particularly stress one point, Mr. Chairman, which is that as we crack down on those who would commit fraud, we are mindful of the necessity to be fair to health care providers and suppliers who are our partners in caring for beneficiaries, and to protect beneficiary access to necessary health services. This requires striking the right balance between preventing fraud and other improper payments without impeding the delivery of critical health care services to beneficiaries.

We will always respect the fact that the vast majority of health care providers and suppliers are honest people who provide critical health care services to millions of Americans every day, and we are committed to providing health care services to our beneficiaries while reducing the burden on legitimate providers, targeting fraudsters, and saving taxpayer dollars.

I appreciate the opportunity to meet with you today, and I will be happy to answer any of your questions later on. Thank you very much.

Chairman BOUSTANY. Thank you, Dr. Budetti, and I should say also that your full written statements will be made part of the record, as is customary.

[The prepared statement of Dr. Budetti follows:]

STATEMENT OF

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

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

ON

PUBLIC AND PRIVATE SECTOR EFFORTS TO DETECT FRAUD IN THE HEALTH CARE SYSTEM

BEFORE THE

UNITED STATES HOUSE COMMITTEE ON WAYS & MEANS,
SUBCOMMITTEE ON OVERSIGHT

MARCH 2, 2011

U.S. House Committee on Ways & Means, Subcommittee on Oversight
Hearing on Public and Private Sector Efforts to Detect Fraud in the Health Care System
March 2, 2011

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

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

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

Bringing Activities Together into the Center for Program Integrity

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

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

Strategic Principles for Program Integrity Operations

As we continue the process of implementing these authorities and strengthening the integrity of the Federal health care programs, we are mindful of the impact our new rules have on health care providers and suppliers, who are our partners in caring for beneficiaries and have the awareness needed to assist us in continuing to protect beneficiary access to necessary health care services, supplies or medication. CMS is committed to improving care for our beneficiaries and engaging States and law-abiding providers and suppliers to ensure our activities reflect their interests. As we seek to reduce fraud, waste, and abuse in Medicare, Medicaid, and CHIP, we are mindful of

striking the right balance between preventing fraud and other improper payments without impeding the delivery of critical health care services to beneficiaries. At their core, Federal health care programs are designed to provide affordable health care to families in need, people with disabilities, and aging Americans. Additionally, the vast majority of health care providers are honest people who abide by their legal and professional duties and provide critical health care services to millions of CMS beneficiaries every day. CMS is committed to providing health care services to beneficiaries, while reducing the burden on legitimate providers, targeting fraudsters and saving taxpayer dollars.

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

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

CMS' Efforts to Implement the Affordable Care Act

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

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

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

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

This new rule implements the statutory authority for CMS to impose a temporary enrollment moratorium if the Secretary determines such a moratorium is necessary to prevent or combat fraud, waste, or abuse. We will assess the impact of any proposed moratorium on beneficiary access and take this into consideration. We will publish a notice of the moratorium including a rationale for the moratorium in the *Federal Register*. Other preventive measures include new levels of coordination between

Medicare and State Medicaid agencies. For example, State Medicaid programs are now required to terminate a provider that has been terminated for cause by Medicare or another State Medicaid agency.

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

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

Other Implementation Steps – CMS-6010-IFC

CMS published an interim final rule with comment period (CMS-6010-IFC) in the *Federal Register* on May 5, 2010 that implemented some new anti-fraud authorities and provisions of the Affordable Care Act. This rule, which took effect July 6, 2010, requires all providers of medical or other items or services and suppliers that qualify for a National Provider Identifier (NPI) to include their NPI on all applications to enroll in Federal health care programs and to also include their NPI on all claims for payment submitted to Medicare and Medicaid. CMS-6010-IFC also requires that physicians and eligible professionals who order or refer home health services or most Medicare Part B-

covered items and services for Medicare fee-for-service beneficiaries be enrolled in Medicare. In addition, it adds requirements for providers, physicians, and suppliers participating in the Medicare program to provide access and maintain documentation on orders or requests for payments for items or services at high risk of fraud, waste, and abuse, such as DMEPOS, home health services, and certain other items or services as specified by the Secretary.

Other Affordable Care Act Authorities

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

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

Expanded Use of Recovery Audit Contractors

CMS is drawing from the lessons learned from the Medicare Fee-For-Service (FFS) Recovery Audit Contractor (RAC) Program to implement the new statutory authority given in the Affordable Care Act to expand the program to Medicare Parts C and D and Medicaid. In order to address the fundamental differences in payment structure between

FFS, Medicare Part C(managed care), Medicare Part D and State-run Medicaid programs, CMS has taken a multi-pronged approach to implementation of the new Affordable Care Act authorities. In January, CMS awarded a contract to identify incorrect payments and recoup overpayments in Medicare Part D. Additionally, we are seeking public comment through a solicitation issued on December 27, 2010 in the Federal Register on innovative strategies for review of additional Medicare Parts C and D data, including the effectiveness of sponsors' anti-fraud plans.

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

Increased Flexibility in Medicaid Recovery Rules

CMS issued a State Medicaid Director letter in July 2010, providing initial guidance on the recovery of Medicaid overpayments as required by the Affordable Care Act. States now have up to one year from the date of discovery of an overpayment in Medicaid to recover, or attempt to recover, such overpayment before being required to refund the Federal share of the overpayment. Prior to passage of the Affordable Care Act, States were allowed only up to 60 days from the date of discovery of an overpayment to recover such overpayment before making the adjustment to the Federal share. CMS appreciates this new flexibility for States. The additional time provided under the Affordable Care

Act will enable States to more thoroughly root out fraud and overpayments. However, for overpayments resulting from fraud, if an ongoing administrative or judicial process prevents a State from recovering an overpayment within one year of discovery, the State has an additional 30 days after a final judgment is made to recover the overpayment before making the adjustment to the Federal share.

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

In September 2010, CMS published the Voluntary Self-Referral Disclosure Protocol (SRDP) on its website to enable providers and suppliers to disclose actual or potential violations of the physician self-referral statute (Section 1877 of the Social Security Act). The SRDP contains instructions for providers and suppliers who make self-disclosures, and advises that the Affordable Care Act gives the Secretary the discretion to reduce the amount due and owing for a violation of the physician self-referral statute. The SRDP states the factors CMS may consider in reducing the amounts due and owing, including: (1) the nature and extent of the improper or illegal practice; (2) the timeliness of the self-disclosure; (3) the cooperation in providing additional information related to the disclosure; (4) the litigation risk associated with the matter disclosed; and (5) the financial position of the disclosing party.

Fraud Detection and Reporting

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

In order to take a more holistic approach to detecting and addressing fraud, CMS has worked to integrate the activities of the Program Safeguard Contractors (PSCs) into more comprehensive Zone Program Integrity Contractors (ZPICs). Before these reforms, each PSC focused on benefit integrity in limited parts of the Medicare program, making it possible for providers and suppliers to continue to submit fraudulent claims to one part of the Medicare program even after questionable claims had been identified in another part of the program. Instead, CMS is currently in the process of contracting with one ZPIC in

each of seven separate geographic zones, with an emphasis on designated high fraud areas. Unlike PSCs, ZPICs perform program integrity functions for all parts of Medicare. These contracting reforms have allowed CMS to break down silos in program integrity work and better identify potentially fraudulent behavior across all parts of the Medicare program.

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

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

Fiscal Year 2012 Budget Request

To continue the Administration's focus on fraud prevention and to build on the new authorities and resources provided by the Affordable Care Act, the President's Fiscal

Year 2012 Budget Request includes a package of program integrity legislative proposals across Medicare, Medicaid and CHIP that will save $32.3 billion over 10 years. These proposals, if enacted, would provide CMS with additional tools to reduce and prevent improper payments and ensure that those committing fraud are held responsible and cannot easily discharge their debts or reenter our programs to commit additional offenses.

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

HCFAC Program Successes

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

$1.9 more than the historical average. Additionally, the ROI for the Medicare Integrity Program's activities is 14 to 1.

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

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

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

Engaging Our Beneficiaries and Partners

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

In addition to working with AoA on expanding the SMPs, CMS is implementing a number of new mechanisms to better engage beneficiaries in identifying and preventing fraud. As part of that effort, CMS encourages its beneficiaries to check their Medicare claims summaries thoroughly. Medicare Summary Notices (MSNs) are sent to beneficiaries every 90 days; CMS is working with beneficiaries to redesign the MSNs to make them easier to understand so beneficiaries can spot potential fraud or overpayments on claims submitted for their care. Additionally, some 10 million beneficiaries are enrolled into www.mymedicare.gov, a secure website, and can now check their claims within 24 hours of the processing date. This information is also available through the 1-800-MEDICARE automated system. A fact sheet and informational card have been developed to educate and encourage beneficiaries or caregivers to check their claims frequently and to report any suspicious claims activity to Medicare. These materials are being used at the regional fraud prevention summits (described below) and have been shared with both State Health Insurance Plans (SHIPs) and SMPs.

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

Collaborating with Law Enforcement Partners

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

The Strike Force model has been very successful. Since its inception, Strike Force operations in nine cities have charged more than 990 individuals who collectively have falsely billed the Medicare program for more than $2.3 billion. This figure includes the Medicare Strike Force's latest successes, announced on February 17, 2011, charging 111 individuals with more than $225 million in false Medicare billing.

Sharing information and performance metrics broadly and engaging internal and external stakeholders requires establishing new partnerships with government and private sector groups. Because the public and private sectors have common challenges in fighting fraud and keeping fraudulent providers at bay, it makes sense that we should work together to

develop common solutions. In addition to the HEAT initiative, agencies including HHS, CMS, OIG, and DOJ have co-hosted a series of regional summits on health care fraud prevention.

Building on the momentum generated by the National Health Care Fraud Summit in January 2010, regional health care fraud prevention summits have been held across the country. These summits, held to date in Miami, Los Angeles, New York, and Boston with plans for additional cities, brought together Federal and State officials, law enforcement experts, private insurers, beneficiaries, caregivers, and health care providers to discuss innovative ways to eliminate fraud within the nation's health care system. These summits also featured educational panels that discussed best practices for providers, beneficiaries and law enforcement in preventing health care fraud. The panels included law enforcement officials, consumer experts, providers and representatives of key government agencies. CMS looks forward to continuing these summits in 2011 as well as more opportunities to bring these stakeholder communities together in other cities to continue this important dialogue and strengthen our cooperative efforts across the Federal government and with the private sector.

Data Analytics

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

strengthen CMS' program integrity work both within State Medicaid programs and across CMS. This robust State data set will be harmonized with Medicare claims data in the IDR to detect potential fraud, waste and abuse across multiple payers.

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

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

Further, the Small Business Jobs Act of 2010 provided $100 million, beginning in FY 2011 to phase-in the implementation of predictive analytics in Medicare FFS, Medicaid, and CHIP over four years. The new predictive modeling technology will incorporate lessons learned through pilot projects. For example, in one pilot, CMS partnered with the Federal Recovery Accountability and Transparency Board (RATB) to investigate a group of high-risk providers. By linking public data found on the Internet with other information, like fraud alerts from other payers and court records, we uncovered a potentially fraudulent scheme. The scheme involved opening multiple companies at the same location on the same day using provider numbers of physicians in other states. The data confirmed several suspect providers who were already under investigation and, through linkage analysis, identified affiliated providers who are now also under investigation.

Delivery System Reforms

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

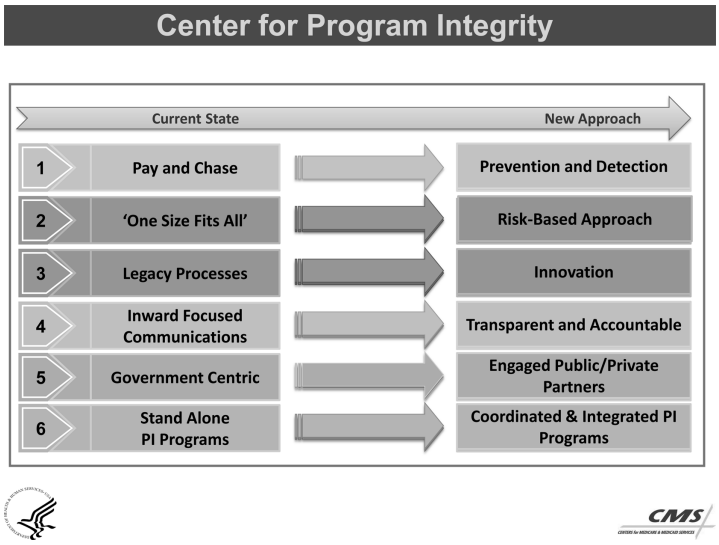
Medicare payments with market prices and thereby reduce the incentive for "bad-actors" to target Medicare.

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

Conclusion

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

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



Chairman BOUSTANY. Now, Mr. Morris, you may present your testimony.

STATEMENT OF LEWIS MORRIS, CHIEF COUNSEL, OFFICE OF INSPECTOR GENERAL, WASHINGTON, D.C.

Mr. MORRIS. Good afternoon, and thank you for the opportunity to testify about the efforts of the Office of Inspector General and our partners to combat health care waste, fraud, and abuse.

The OIG has been fighting the fight against health care waste, fraud, and abuse for over 30 years. Most of our health care integrity efforts are funded by the Health Care Fraud and Control program account, or HCFAC, and this anti-fraud program is a prudent investment of taxpayer dollars. Last fiscal year, HCFAC activities returned an unprecedented $4 billion in fraudulent and misspent funds. Over the last 3 years, for every dollar spent on the program integrity and enforcement efforts, the government has returned an average of $6.80. But despite our successes, there is much more to be done.

Those intent on breaking the law are becoming more sophisticated, and the schemes more difficult to detect. Some fraud schemes are viral. They replicate easily and they migrate. As law enforcement cracks down on a particular scheme, the criminals may redesign it or relocate to another city. When their schemes are detected, some perpetrators have fled with stolen Medicare funds and become fugitives.

To fight health care fraud, our response must be swift, agile, and well-organized. My written testimony describes in more detail our collaborative efforts and fraud-fighting initiatives, and this afternoon I would like to highlight three of the government's ongoing initiatives.

First, our Medicare Strike Forces are cracking down on criminals in fraud hot spots across the country. Since their inception in 2007, Strike Force operations have charged almost 1,000 defendants whose fraud schemes have involved more than $2.3 billion in Medicare claims. Just last month, as you referenced, sir, Strike Forces engaged in the largest Federal health care fraud takedown in history. The teams charged more than 100 defendants in nine cities, including doctors, nurses, and health care company owners. The alleged fraud schemes involved more than $225 million in Medicare billings.

Second, the OIG is using its exclusion authorities to bar from the Federal health care program those individuals who lack integrity and pose a threat to our beneficiaries. In particular, we are holding responsible the corporate executives who are accountable for their company's criminal behavior. Health care is not limited to career criminals and sham providers. Unfortunately, major corporations also commit fraud, sometimes on a grand scale. We are concerned that some executives of these health care companies may believe that as long as the ill-gotten profits outweigh civil penalties and criminal fines, health care fraud is worth the risk. The long and short of it is that we aim to change that cross-benefit calculus by excluding the executives who are responsible for the fraud either directly or because of their position of responsibility in the company. We are mindful of our obligation to exercise this authority judiciously, but if an executive knew or should have known of the criminal misconduct of his organization, we will operate on the presumption in favor of excluding in order to protect our program and its beneficiaries.

Our third initiative enlists the public and the vast majority of honest health care providers to help prevent fraud. For example, we are conducting free compliance seminars in six cities. One of those is taking place in Tampa, Florida, today. These seminars educate providers on fraud risks and share compliance best practices. We also recently published a fraud and abuse booklet for new physicians. It provides guidance on how physicians can comply with the fraud and abuse laws in their relationship with papers, vendors, and fellow providers. We have had over 27,000 hits on our Web site for this booklet alone.

We are also reaching out to the public to play a very special role in helping us track down Medicare fraud fugitives. We have posted online on our Web site OIG's most wanted health care fraud fugitives, and I have included a snapshot of that Internet posting for your consideration. Our current most wanted list includes 10 individuals who allegedly defrauded taxpayers of more than $136 million.

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

Thank you for your support of our mission, and I would be pleased to answer any questions.

[The prepared statement of Mr. Morris follows:]

Testimony of:
Lewis Morris
Chief Counsel to the Inspector General
U.S. Department of Health & Human Services

Good afternoon Chairmen Camp and Boustany, Ranking Members Levin and Lewis, and other distinguished Members of the Subcommittee. I am Lewis Morris, Chief Counsel to the Inspector General for the U.S. Department of Health & Human Services (HHS or the Department). Thank you for the opportunity to testify about the progress the Office of Inspector General (OIG) and its partners are making to combat fraud, waste, and abuse in the Federal health care programs.

My testimony describes OIG's unique role in protecting the integrity of the Medicare and Medicaid programs; provides an overview of the nature and scope of health care fraud, waste, and abuse; and highlights three ongoing initiatives aimed at strengthening the integrity of these crucial programs. The three initiatives involve targeting fraud "hot spots" with Medicare Fraud Strike Force teams, strengthening our ability to protect the Federal health care programs from untrustworthy providers, and enhancing our collaboration with the private sector, including health care providers, insurers and the public.

Our program integrity efforts, which are funded primarily through the Health Care Fraud and Abuse Control (HCFAC) Program, represent a prudent investment of taxpayer dollars. Over the past three years, for every $1 spent on the HCFAC Program, average of $6.80 has been returned to the Government. That's an almost seven-to-one return on every dollar invested in HCFAC.

The Office of Inspector General is Committed to Protecting HHS Programs and Beneficiaries

OIG is an independent, nonpartisan agency within HHS. Our mission is to protect the integrity of more than 300 programs administered by the Department and the citizens served by those programs. Approximately 80 percent of OIG's resources are dedicated to promoting the efficiency and effectiveness of the Medicare and Medicaid programs and protecting these programs and their beneficiaries from fraud and abuse. OIG investigates suspected fraud and refers cases to the Department of Justice (DOJ) for criminal and civil actions. We impose administrative remedies, such as monetary penalties or exclusion from participation in Federal health care programs. We also evaluate and audit programs and providers and make life-saving and cost-saving recommendations to the Department on a wide variety of issues, including quality of care, recovery of improper payments, and reducing excessive payments for medical services, equipment, and prescription drugs.

Through this work, OIG helps to identify and recover billions of dollars in fraudulent, abusive, or wasteful payments and also raise awareness of these critical issues among policy makers, government agencies, and the health care community at large. We engage the health care community and promote compliance with program rules and requirements. OIG has a strong track record of building on our successes, employing all oversight and enforcement tools

available to us, and maximizing our impact in protecting the integrity of government health care programs and the health and welfare of people served by them.

Health Care Fraud, Waste, and Abuse Are Serious Problems Requiring Sustained Commitment to Fight Them

Fraud, waste, and abuse in the health care system cost taxpayers billions of dollars each year and put beneficiaries' health and welfare at risk. The impact of these losses and risks is magnified by the growing number of people served by these programs and the increased strain on Federal and State budgets.

Although there is no precise measure of health care fraud, we know that it is a serious problem that demands an aggressive response. OIG has been leading the fight against health care fraud, waste and abuse for more than 30 years. Since the inception of the HCFAC Program in 1997, audits and investigations under the Program have returned to the Federal Government $18 billion in fraudulent or misspent funds. Over the past fiscal year alone, OIG has opened more than 1,700 health care fraud investigations. Additionally, OIG's enforcement efforts have resulted in more than 900 criminal and civil actions and over $3 billion in expected investigative recoveries in FY 2010. The small number of providers who are intent on abusing the system can cost taxpayers billions of dollars.

In the fight against health care fraud, we work closely with DOJ, our Federal, State, and local law enforcement partners, and our colleagues at the Centers for Medicare & Medicaid Services (CMS) and the Food and Drug Administration (FDA). OIG conducts joint investigations with law enforcement agencies where there is concurrent jurisdiction and where sharing expertise or authority will lead to the best results possible. Additionally, commercial and private insurance entities and trade associations, such as the National Health Care Anti-Fraud Association (NHCAA), play pivotal roles in the identification and prevention of health care fraud.

Health care fraud schemes commonly include purposely billing for services that were not provided or were not medically necessary, billing for a higher level of service than what was provided, misreporting costs or other data to increase payments, paying kickbacks, illegally marketing products, and/or stealing providers' or beneficiaries' identities. The perpetrators of these schemes range from street criminals, who believe it is safer and more profitable to steal from Medicare than to traffic in illegal drugs, to Fortune 500 companies that pay kickbacks to physicians in return for referrals.

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

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

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

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

Despite OIG's successes, there is more to be done. Those intent on breaking the law are becoming more sophisticated and the schemes are becoming more difficult to detect. Some fraud schemes are viral, i.e., schemes are replicated rapidly within geographic and ethnic communities. Health care fraud also migrates—as law enforcement cracks down on a particular scheme, the criminals may shift the scheme (e.g., suppliers fraudulently billing for DME have shifted to fraudulent billing for home health services) or relocate to a new geographic area in response to our enforcement efforts. To combat this fraud, the Government's response must be swift, agile, and well organized.

Medicare Fraud Strike Forces Are a Proven Success in Fighting Fraud in "Hot Spots"

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

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

Strike Forces use data analysis and a collaborative approach to focus enforcement resources in geographic areas at high risk for fraud. Strike Force cases are data driven to pinpoint fraud "hot spots" through the identification of unusual billing patterns as they occur. To support this approach, OIG established a team of data experts comprised of OIG special agents, statisticians, programmers, and auditors. Together, the team brings a wealth of experience in utilizing data analysis tools combined with criminal intelligence gathered directly from special agents in the field to identify more quickly health care fraud schemes and trends. To expand the coalition of data experts focused on this effort, OIG has garnered the support and participation of our law enforcement partners at DOJ and FBI.

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

The Strike Force model has proven highly successful. The majority of subjects in Strike Force cases are engaging in 100 percent fraud, i.e., not providing any legitimate services to beneficiaries. Since their inception in 2007, Strike Force operations in nine cities have charged almost 1,000 individuals for fraud schemes involving more than $2.3 billion in claims.

Just last month, HEAT Strike Forces engaged in the largest Federal health care fraud takedown in history. Teams across the country charged over 100 defendants in nine cities, including doctors, nurses, health care company owners and executives for their alleged participation in Medicare fraud schemes involving more than $225 million in false billing. The defendants charged as a part of the operation are accused of various health care related crimes ranging from violating the anti-kickback statute to money laundering to aggravated identity theft. More than 300 OIG special agents participated in partnership with other Federal and State agencies, including fellow Offices of Inspector General.

The effectiveness of the Strike Force model is enhanced by our use of several important tools. We work closely with CMS to suspend payments to the perpetrators of these schemes and in other cases where we have credible allegations of fraud. For example, during a July 2010 Strike Force operation, OIG worked with CMS to initiate payment suspensions and pre-pay edits on 18 providers and suppliers targeted by the investigation. The prompt action taken by OIG and CMS stopped the potential loss of over $1.3 million in claims submitted by the defendants. During the February Strike Force operations discussed above, OIG and CMS worked to impose payment

suspensions that immediately prevented a loss of over a quarter million dollars in claims submitted by Strike Force targets.

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

Better access to, and use of, CMS claims data also is critical to the Strike Force model and for all health care fraud detection and enforcement activities. To be most effective, it is essential that law enforcement have access to robust, "real time" claims data—data that are available as soon as claims are submitted to Medicare. Timely data are also essential to our ability to respond with agility as criminals shift their schemes and locations to avoid detection. We have made important strides in obtaining data more quickly and efficiently. For example, we have obtained limited law enforcement access to real-time data, and OIG and DOJ are working with CMS to expand this access. Continued improvements in access to data, as well as creation of more robust data sets, are critical to OIG's ability to identify and investigate fraud.

Promoting Program Integrity by Removing Untrustworthy Individuals from the Health Care Programs

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

There are many grounds for exclusion. Some are mandatory and imposed for a minimum of 5 years. These include a conviction related to the Medicare or Medicaid program and a conviction related to patient abuse. Other exclusions are imposed at OIG's discretion. There are a significant number of grounds for permissive exclusion, including actions based on a sanction taken by a State licensing authority or conduct that could trigger False Claims Act liability.

No program payment may be made for any item or service that an excluded person or entity furnishes, orders, or prescribes. This payment prohibition applies regardless of whether the excluded person is paid directly by the programs (like a physician) or whether the payment is made from the program to another person (such as payments to a hospital for services by its employed nurses and other staff, or payments to a pharmacy for drugs manufactured by a pharmaceutical company). Those who employ the services of an excluded individual or entity for the provision of items or services reimbursable by Medicare or Medicaid may be subject to monetary penalties and program exclusion. Because of its scope and effect, the risk of exclusion creates a strong incentive to comply with the programs' rules and requirements.

In imposing discretionary exclusions, OIG must weigh the fraud and abuse risks to the programs and beneficiaries against the impact on patient access to care if the provider or entity is excluded from the Federal health care programs. Some hospital systems, pharmaceutical manufacturers,

and other providers play such a critical role in the care delivery system that they may believe that they are "too big to fire" and thus OIG would never exclude them and thereby risk compromising the welfare of our beneficiaries. We are concerned that the providers that engage in health care fraud may consider civil penalties and criminal fines a cost of doing business. As long as the profit from fraud outweighs those costs, abusive corporate behavior is likely to continue. For example, some major pharmaceutical corporations that have been convicted of crimes and paid hundreds of millions of dollars in False Claims Act settlements continue to participate in the Federal health care programs, in part because of the potential patient harm that could result from an exclusion.

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

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

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

We are mindful of our obligation to exercise this authority judiciously, and we do not propose to exclude all officers and managing employees of a company that is convicted of a health care-related offense. However, when there is evidence that an executive knew or should have known of the underlying criminal misconduct of the organization, OIG will operate with a presumption in favor of exclusion of that executive. We have published guidance on our Web site that sets out factors we will consider when evaluating whether a section (b)(15) exclusion should be imposed in a particular case.[1] This guidance alerts health care providers and executives to the standards of ethical conduct and responsibility to which they will be held accountable by OIG. Even if we decide exclusion of a major health care entity is not in the best interests of Federal

[1] Available online at http://oig.hhs.gov/fraud/exclusions/files/permissive_excl_under_1128b15_10192010.pdf.

health care programs and their beneficiaries, we may decide that executives in positions of responsibility at the time of the fraud should no longer hold such positions with entities that do business with the programs.

OIG is Strengthening Collaboration with the Private Sector, Health Care Providers, and the Public

We recognize that the Federal health care programs can learn a great deal from how the private sector, including private insurers and the finance industry, combats fraud. OIG has increased its efforts both to learn from the private sector and to share information with its private sector counterparts. Collaboration with private health care insurers can be mutually beneficial and we are increasing these efforts through our active participation in the NHCAA. Through NHCAA forums, we build relationships, share information, and learn about new fraud-fighting tools and techniques.

For example, we collaborate to identify fraud trends that target both Medicare and private insurers and share information on organized crime and medical identity theft. OIG agents have participated in joint investigations with private insurance companies and, subject to applicable legal restrictions, shared field intelligence. These joint investigative efforts can be very effective and in an effort to replicate their success, OIG has started a public/private "best practices" initiative. In coordination with DOJ, we are surveying the U.S. Attorneys' health care fraud working groups, Medicaid Fraud Control Units and health insurers' special investigative units to identify where public/private information sharing was most successful. The survey results will be translated into a series of "best practices" recommendations that promote a culture of information sharing between public and private partners working together to combat health care fraud.

We also recognize that the vast majority of health care providers are honest and well-intentioned. They are valuable partners in ensuring the integrity of Federal health care programs. OIG produces extensive resources to assist industry stakeholders in understanding the fraud and abuse laws and designing and implementing effective compliance programs. OIG also offers a way for providers that uncover fraudulent billings or other misconduct within their organizations to self-disclose the problem and to work with OIG to the resolve the issue, including return of the inappropriate payments.

Another example of OIG's commitment to promoting compliance is our HEAT Provider Compliance Training Initiative. The initiative brings together representatives from a variety of Government agencies to provide free compliance training to local provider, legal, and compliance communities. The speakers discuss fraud risk areas uncovered by OIG's work and share compliance best practices. This will enable providers to strengthen their own compliance efforts and more effectively identify and avoid illegal schemes that may be targeting their communities. The first seminar took place in Houston last month and we will be going to Tampa, Kansas City, Baton Rouge, Denver, and Washington, DC, during the spring of 2011. OIG also will provide a webcast of the seminar for individuals who are unable to attend an in-person training session.

In response to requests for more guidance for physicians just beginning the practice of medicine, OIG recently published *A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse*.[2] The *Roadmap* summarizes the main Federal fraud and abuse laws and provides guidance on how physicians should comply with these laws in their relationships with payers, vendors, and fellow providers.

We also use the power of the Internet to enlist the public in the fight against health care fraud. Our internet site, http://oig.hhs.gov, offers a wealth of information to health care providers and patients about ways to reduce the risk of fraud and abuse, including OIG voluntary compliance program guidance, fraud alerts, and advisory opinions on the fraud and abuse laws. OIG also offers a guide for patients to avoid becoming the victim of medical identity theft, a growing problem which can disrupt lives, damage credit ratings, and waste taxpayer dollars. We offer tips to Medicare beneficiaries and their caregivers on how to avoid medical identity theft and where to report misuse of personal information.[3]

We also have posted OIG's list of the most-wanted health care fraud fugitives, including photographs and details on the fugitives and their fraud schemes.[4] Our current most wanted list includes 10 individuals who have allegedly defrauded taxpayers approximately $136 million. We are asking the public to help us bring these fugitives to justice by reporting any information about their whereabouts to our Web site or fugitive hotline (1-888-476-4453).

Conclusion

Health care fraud, waste, and abuse cost taxpayers billions of dollars every year and require focused attention and commitment to solutions. Through the dedicated efforts of OIG professionals and our collaboration with other stakeholders, we have achieved substantial results in the form of recovered funds, enforcement actions, and recommendations to remedy program vulnerabilities.

I would be happy to answer any questions.

[2] Available online at http://oig.hhs.gov/fraud/PhysicianEducation/.
[3] Available online at http://oig.hhs.gov/fraud/IDTheft/.
[4] Available online at http://oig.hhs.gov/fugitives/.

Chairman BOUSTANY. Thank you, Mr. Morris and Dr. Budetti.

What we are going to do now, since we have this pending vote, we are going to recess and we will return promptly—we have three votes—and resume with questioning. And I appreciate your indulgence. The committee stands in recess.

[Recess.]

Chairman BOUSTANY. The committee will resume its proceedings, and we will start off with questions, now that you all have both given your testimony.

Mr. Morris, I think you were before our committee last year, and we spoke about fostering better cooperation between health care

providers and anti-fraud efforts, and both of you alluded to this in your oral testimony.

I am interested in further exploring the role of physicians in preventing health care fraud; identifying it, helping you on the front end to identify it. Certainly physicians, nurses, other medical professionals, are in a unique position to pick up on fraudulent activity on the ground, as sort of direct intelligence on the ground as to what is happening. And I know you and I spoke about the case in Lafayette, in my hometown, and how it involved a whistle-blower who was actually a partner of a physician who brought something to light that maybe for years had been ongoing and really—was really not detectable until that whistle-blower activity.

So what barriers are there now that you are seeing that would inhibit physicians and other providers from coming forward and helping you in your efforts to identify potentially fraudulent activity?

Mr. MORRIS. I think there are a number of opportunities. We have to do a better job of reaching out to physicians and other professionals. Part of it is through education. I made reference in my written testimony to the Road Map for new physicians, and the idea behind that actually came from medical residents who told us they didn't understand what the fraud and abuse laws were. OIG put together a booklet that will help them not only protect themselves but also be able to recognize when a practice is doing something that they might not want to get involved in. Education is part of our outreach.

Every time we go out and demonstrate our commitment to compliance, demonstrate that we recognize that this is a complex program and that there are lots of opportunities to make mistakes, and that it is incumbent on physicians to embrace compliance, that that is the way to go. We are not a hammer looking at everything as a nail. Building that trust goes a long way.

Next week we are meeting with the American Medical Association to get their ideas on how we can work together better and ways we can spot opportunities for collaboration. I think a big part of it is education. A large part of our efforts is also sending a message of compliance, that physicians and nurses and other professionals can be our partners in ensuring that waste, fraud, and abuse don't harm our program.

Chairman BOUSTANY. Thank you. Dr. Budetti.

Dr. BUDETTI. Yes. Thank you, Mr. Chairman.

We have had a series of regional fraud prevention summits, and at each one of the summits, the Attorney General and the Secretary have chaired them, and then we have had panels with law enforcement and providers and beneficiaries. And then I have put together breakout sessions with providers at each one of the regional fraud prevention summits, and I have to say, I am extremely encouraged by the response of physicians and providers that I have been meeting with in these groups; that they are now very interested in working with us on this, to the point where I have been so impressed that I actually have created a position within the Center for Program Integrity of a medical officer.

So I am hiring a full-time medical officer to work with the physicians and other health care providers around the country on pro-

gram integrity issues, both to get the message to them but also to listen and to figure out what it is that we can work on together and what we could do different inside of CMS that would be more responsive. Because the message we have gotten from the providers was very straightforward, but it went in two directions. It was, on the one hand, they really want to work on this. On the other hand, they want us to do what Mr. Morris just said, which is not treat everybody the same; recognize the big difference between fraudsters and honest physicians, and we are committed to doing that. So I think there is a real opportunity here to work very closely with the medical community and other providers because the enthusiasm seems very strong on their side.

Mr. MORRIS. If I could add one more thing, we share the view that physicians should be part of our team, and we also have a chief medical officer who provides valuable counsel to us as we do our work, planning and ensuring that we best understand what is going on from the physician's perspective.

Chairman BOUSTANY. I know in the private sector, the private insurers often go through credentialing processes. Can you talk a little bit about what you are doing now at CMS in that regard?

Dr. BUDETTI. One of the major provisions in the recent legislation that will take effect, our final regulation will take effect on March 25, speaks to screening of applicants to be able to bill Medicare and Medicaid. We all know that that has been kind of a soft spot in the programs, people getting in too easily. But under the new authorities, we are doing risk-based screenings so that categories of providers and suppliers are assigned to different levels of risk with different levels of screening. Then they also have to revalidate periodically, every 3 or 5 years depending upon the categories. So this is a new approach. It is going to mean a much greater degree of scrutiny for the high-risk providers, and about the same scrutiny, but maybe done more efficiently for other providers.

We get something on the average of 19,000 applications every month to become a provider in Medicare. So it is a large number of people that we have to screen through because most of them are going to be honest, of course, but with our new screening systems, we are very pleased to have that authority and we are putting it into place with a great deal of energy.

Chairman BOUSTANY. Thank you. Mr. Lewis, you may inquire.

Mr. LEWIS. Thank you very much, Mr. Chairman. Welcome.

Dr. Budetti, in your testimony, you talk about the new fraud fighting tools because of the Affordable Care Act. If the Affordable Care Act is repealed, what would that do to your ability to fight fraud in Federal health programs?

Dr. BUDETTI. Thank you, Mr. Lewis.

Yes, the Affordable Care Act did provide us with very powerful new tools, as well as resources. Both of those are extremely important to us. I mentioned the screening provisions. The Secretary also has authority to declare a moratorium on enrollment of new providers or suppliers, where necessary, to fight fraud. We have a different test for when we can suspend payments when there is a credible allegation of fraud. We have coordination of a number of activities such as termination of Medicare and Medicaid, linking

those two together. There is a variety of other provisions related to enhancing the requirements for durable medical equipment and home health that are areas of high risk. There are additional penalties for violation of the statutes that are involved. There is a wide range of very important authorities in the Affordable Care Act, and we are very pleased to have them and look forward to implementing all of them.

Mr. LEWIS. Could you explain to Members of the Committee why the Medicare Strike Forces have been so successful, and do you plan to expand them?

Dr. BUDETTI. Mr. Lewis, I am very pleased with the success of the Strike Forces. I think I will turn to my colleague, Mr. Morris, who is more directly involved in those.

Mr. MORRIS. The Medicare Fraud Strike Forces represent a collaborative effort that includes the Inspector General's Office, CMS, the Department of Justice, and U.S. Attorneys' Offices. Part of the reason they are successful is we are working better together. We are using data to spot fraud hot spots and get to the problem quicker. Instead of waiting 6 months or a year to identify an abusive provider, we know within weeks if someone is engaged in Medicare fraud.

By putting resources into these fraud spots and focusing prosecutors and dedicated investigative resources, we are able to more effectively deploy them in strategic fashion. We are getting remarkable results as a result of those efforts.

Mr. LEWIS. Thank you very much.

Mr. Morris, in your testimony you discuss the agency's ability to exclude providers from Medicare. On average, how many providers do you bar from Medicare each year, and how has your focus on corporate executives helped you fight fraud?

Mr. MORRIS. On average, we exclude around 3,300 individuals and entities each year from the Federal health care programs. The basis of those exclusions include convictions related to Medicare fraud and patient abuse, as well as a number of discretionary authorities; loss of licensure in a State, for example.

One of the things that we would like to close a loophole on is our ability to go after corporate executives who are responsible for corporate crime but evade our exclusion tool by simply quitting the company. The current statute only allows us to exclude if the person continues to be employed by that sanctioned entity. We think we need to close that loophole.

We also need the ability to focus on related entities. If we identify one nursing home that has committed criminal abuse of its residents, ofttimes that is because the corporate heads have denied needed resources to that facility. It has been very difficult for us to get up to the corporate heads and hold them responsible for the abuse of residents in an individual facility, and the amendment of our discretionary exclusion authority would give us the ability to do that and be able to say to that corporate executive, you are out of our program because you are not treating our residents the way we expect you to.

Mr. LEWIS. Again, I want to thank the two of you for being here and thank you for your service. I yield back, Mr. Chairman.

Chairman BOUSTANY. I thank the ranking member for his questions.

The chair now recognizes Ms. Black, if you are ready, or I can now move on.

Ms. BLACK. Is there someone else ready?

Chairman BOUSTANY. We will give you some time. Ms. Jenkins, you may inquire.

Ms. JENKINS. Thank you, Mr. Chairman. Thank you for joining us.

Mr. Budetti, one of the new tools put in place by the new health care law was the requirement for face-to-face meetings for certain Medicare services. In Section 6407 of the bill, it requires that a provider conduct face-to-face meetings before certifying that patient is eligible for their home health services. And while I understand the intent of this regulation to fight abuse of the system, I wonder if your agency has taken regional concerns into consideration.

In a rural State like Kansas, we already have a shortage of physicians, and this requirement is simply not feasible for direct supervision for outpatient therapeutic services for critical access in rural hospitals. If the regulations are followed as written, many of my hospitals would have to eliminate a lot of outpatient services, and that is creating access and cost issues for the beneficiaries.

So I was just wondering if you could speak to any discussions that you have had or any ideas for how to make this new requirement work in our rural communities.

Dr. BUDETTI. Well, thank you, Ms. Jenkins. I think that, of course, we are in the position of enforcing the statute as written, but we are also very much interested in not cutting off beneficiary access, and we are very sensitive to the kinds of issues that you are raising.

This area of home health and also the area of durable medical equipment have been high-risk areas for us, and so it is quite important for us to move forward with implementing some of the different approaches. But that is an area that we did listen to some of the comments that we received about the timetable, and we are responding to that, and we are very interested in working on this.

And I would be delighted to listen to any specific incident that you would like to relate from your home State of Kansas. I would be pleased to meet with you and listen to that and try to understand exactly what the kinds of issues are and how we might address those.

Ms. JENKINS. Okay. Thank you. We will look forward to taking you up on that offer.

On another note, CMS is expanding their use of recovery audit contractors, the RACs, and authority given to them by this new law. And I have some concerns that these contracts are for profit and aggressively going after claims with cash-strapped hospitals, especially in rural States like Kansas. While I agree that waste and fraud needs to be found and addressed, this seems to me to be a duplication of audit services. Search and probe audits were already occurring before this RAC process was authorized. The rate of denied claims by the RAC which are then being overturned is over 70 percent. During this time, if a hospital does not pay the recoupment requested and allows it to follow the automatic process,

interest is then charged on the claim amount to the hospital at over 13 percent; and even if the claims are reversed, they don't get their interest back.

So questions for you: What is the net cash to CMS on the RAC program, and can you speak to whether this is actually saving money in the health care system and increasing quality patient care, or is it simply shifting more of the cost to these small hospitals by requesting payment after the fact and adding to their administrative costs?

Dr. BUDETTI. The recovery audit contractor program is, as you mentioned, one that is based on contingency fees, and so they are paid for out of their recoveries, and so that is the structure of the RAC program, as you mentioned.

And the RAC program was implemented, first, in a small number of States, and it did experience a number of issues. And so the feedback that we got during the initial implementation phase has been taken into very strong consideration in shaping the way the program is being implemented going forward. We phased in the full national implementation for just that reason, and we are also taking that experience into account as we also follow the new provisions that require the expansion of RACs to Medicaid and to Part C and D of Medicare.

So the way that the RACs work is, as you mentioned, in terms of a portion of the recoveries is how they are funded, but we are working very, very hard to make sure that the kinds of things that the RACs learn both provide a basis for education to other providers so that they can deal with those kinds of issues and also so that we understand how to improve the RAC program.

I would have to get back to you on the exact recoveries. I do know that the rate of being overturned on appeal was much higher. I don't offhand remember the exact numbers but it was much higher during the initial phase, the pilot phase, and that many of the issues that came up in that setting are now being taken into consideration on implementation of the full program. But I will be happy to get you those numbers.

Ms. JENKINS. Okay. I would appreciate it. Thank you. I yield back.

[The information follows, The Honorable Ms. Jenkins:]

MS. JENKINS

So, questions for you: What is the net cash to CMS on the RAC program, and can you speak to whether this is actually saving money in the health care system and increasing quality patient care, or is it simply shifting more of the cost to these small hospitals by requesting payment after the fact and adding to their administrative costs?

DR. BUDETTI

Recovery Auditors have proven successful at identifying and correcting Medicare Fee-For-Service (FFS) improper payments. In the demonstration project, Recovery Auditors corrected $1.03 billion in improper payments, including approximately $990 million in overpayments collected. Since the inception of the permanent Medicare FFS Recovery Audit program in January 2010, as of March 1, 2011, the contractors have corrected a total of $261.5 million in improper payments, including $43.6 million in underpayments corrected and $217.9 million in overpayments collected.

CMS actively monitors the national Recovery Audit program and makes necessary adjustments to maintain a balance between provider burden (both financial and administrative) and increasing recoveries. CMS is committed to working with the Recovery Auditors, the provider community, and others to continuously improve the program and refine ongoing operations.

Regarding the appeals process, CMS has received successful feedback. During the Recovery Audit demonstration 8.2% of overpayment determinations were both challenged and overturned on appeal. Preliminary experience from the national program indicates the percentage of claims appealed may be less.

Chairman BOUSTANY. The gentlelady, Ms. Black, is recognized.

Ms. BLACK. Thank you, Mr. Chairman.

My question is for you, Mr. Morris, and I am going to borrow on my experiences at my State level. Tennessee was the pilot project for initiating universal care, and that program was called TennCare. It was unsuccessful. It failed and we had to disassemble it because of its high costs.

And one of the problems in that program that caused it to fail is the sheer amount of waste and fraud. And we do have an Office of Inspector General, and one of the things that we saw that was so effective is to have a hotline for people to actually call and report abuses, and it was very successful.

I didn't notice in your testimony—and of course, you have the most-wanted fugitives up here and the hotline for that—but do you have something in place that if just an individual knew of someone that was abusing the program, that they would be able to make a call so that you could investigate?

Mr. MORRIS. Yes, we do. The number is 1–800–HHSTIPS, T–I–P–S. We have operators standing by. They are trained to process complaints and concerns, many of which actually don't pertain to our program.

As an example, we get calls about Social Security checks. The operators are trained to send those over to Social Security. Operators also vet the continuing complaints and refer many of them to our Office of Investigations or our Office of Audit Services. We get thousands of hotline calls every month, and one of the jobs of these operators is to go through them, and those that have potential to start a criminal investigation or a civil investigation are sent to our investigative teams.

Ms. BLACK. And to follow up on that, can you give me some kind of an idea about how effective those calls are? Are you finding

that you are able to pick up fraud, waste, and abuse on those calls—or from those calls?

Mr. MORRIS. I would need to get back to you with the specific percentages within the universe of what actually turn into viable criminal investigations. As I mentioned, a number of the calls come from citizens who just need to talk to someone about a problem with the government. When we are not able to be directly responsive because it is an issue outside of our agency, we do make sure they get to the right place. But I will be glad to get back to you on the specifics of what percentage of those calls translate into a viable investigative lead.

Ms. BLACK. And how is it that you let the public know that this line is accessible and available to them?

Mr. MORRIS. Well, it is on our Web site, which gets thousands of hits every week. We make a point of bringing it to the attention of communities that we speak to.

I mentioned in my oral remarks that OIG staff are in Tampa, Florida, today, talking about compliance training to the provider communities down there, and the hotline is one of the features that we talk to them about. That way, if they see a problem, they know there are avenues to bring it to our attention.

Ms. BLACK. I would really like to get further feedback from you on how effective those calls are and whether you really are seeing some actual useful information.

Ms. BLACK. My second question along that same line is, you actually have in your written testimony how critical it is for the Office of Inspector General to obtain real-time data on Medicare claims from CMS. Are you able to get that data in a timely fashion?

Mr. MORRIS. We are make important strides, thanks to our partnership with Dr. Budetti and his team. The challenge right now, frankly, is one of technology. Dr. Budetti can speak better to this, but I believe that many of the claims processing systems that CMS has are somewhat antiquated, and there are about 20 different systems in play. CMS is making great efforts to move those systems into the 21st century so that we will be able to get data more quickly.

The other challenge, of course, we face is being able to do something with the data once it arrives at our door; and we are committing significant resources to be able to analyze the data so we can spot fraud trends and get to the site of a crime as quickly as possible.

Ms. BLACK. Well, thank you. And I do absolutely agree with you, because that is one thing we found in our State is that the data was there, and being able to mine that data was very, very helpful. So I certainly will encourage that we continue to do that. Thank you. I yield back my time.

Chairman BOUSTANY. Thank you. The chair now recognizes Mr. Becerra to inquire.

Mr. BECERRA. Thank you, Mr. Chairman, and again, thank you very much for having this be the very first hearing that the Oversight Subcommittee does.

Gentlemen, thank you very much actually for your patience, the interruption with votes. We appreciate you being here and the work you are doing.

Quick question. How much are you able to do with the health community in the private sector? We are talking about Medicare for the most part, Medicaid, but we know that there is a lot going on that overlaps between the private sector health care system and the public sector health care system. Any quick examples—and I want to get to some other questions—but any quick examples of how CMS is able to work with the private sector in health care to try to deal with fraud that hits both public and private sector health care?

Dr. BUDETTI. Sure. We are doing two things that I can speak to right off the top of my head. One is that we are now in the process of moving into, as Mr. Morris said, the 21st century, with the technology and the sophisticated analytics that are currently being applied in the private sector both in the health care industry and in other industries. So we are reaching out to get the best ideas and the best approaches from the private sector and use them in the public programs. That is one thing that we are doing.

We also have been engaged for some time in a dialogue with the private sector about building a public-private partnership to work together to fight fraud, and that is something that my colleague from the Inspector General could also speak to.

Mr. MORRIS. I did a quick check last night of the number of cases that our Office of Investigations is working with its private sector counterparts. We have 50 ongoing cases where we are sharing intelligence and resources, to tackle a problem which is both in the private and the public side. The NHCAA—you will be hearing from its representative in the next panel—I think will tell you that we are working very effectively together in finding new ways to improve. We are working on a best practices document, for example, so that we can find additional ways to multiply our efforts.

Mr. BECERRA. Excellent. I hope you continue to give us reports on how you are working together because we know that the costs of health care outside of Medicare and Medicaid are helping drive the costs of Medicare and Medicaid higher. And so to the degree that we help them tamp down costs on the private side, it helps us control them on the public side.

A question—and I had ask asked my staff what the acronym stood for, because last year my father ended up having a difficult time, and he survived an episode with a heart condition, but he got a CPAP machine, and it stands for continuous positive airway pressure. I just got to the point of calling it the CPAP, the air machine. It helps him breathe.

We know that there has been an issue with fraud in the area of DME, durable medical equipment, the CPAP machine, the oxygen equipment, the wheelchairs, the hospital beds that are often provided to beneficiaries under Medicare. And in the next panel, we are going to hear from an individual who was convicted of Medicare fraud involving durable medical equipment.

I wonder if you could tell me what was done in the historic health care reform of the Affordable Care Act which is going to

help us address what we know is pretty aggressive fraud in the area of durable medical equipment.

Dr. BUDETTI. The area of durable medical equipment, as you mentioned, also is in fact one of the high-priority areas. And I mentioned before that we had structured, as the act requires, our screening processes by categories, and the highest level of risk includes new durable medical equipment suppliers, and so they will be subject to the highest level of screening for new entrants.

There are also provisions in the Affordable Care Act that provide for increased surety bonds and other kinds of oversight of new DME providers and initial claims. We are also very much involved in a completely different approach which has to do with the implementation of competitive bidding for durable medical equipment, because when you have a limited number of bidders who undergo scrutiny to get into that program, we believe that will also be helpful in terms of having controls on it. And we have had a series of durable medical equipment specific initiatives in the past in south Florida and elsewhere.

So it is something that we are attacking from multiple points because that is an area that we have to do a better job of preventing fraud.

Mr. BECERRA. Mr. Morris, instead of answering to that question—I know I am going to run out of time—can I ask one last question? You are obviously using personnel. They are obviously having success in helping us detect and track down some of this fraud. What happens if you have to furlough or reduce your personnel because of budget constraints?

Mr. MORRIS. Because the significant part of our funding is off of the general appropriations—it is through the HCFAC account—we are going to be able to keep a law enforcement presence. It will be reduced, unfortunately.

I think the other challenge we will face will be just the general disruption when the government goes through a shutdown process. We will spend a lot of time on that instead of catching bad guys, but to the extent possible, with the funds available, we will continue to fight against fraud.

Mr. BECERRA. Thank you. Thank you, Mr. Chairman.

Chairman BOUSTANY. Mr. Gerlach, you may inquire.

Mr. GERLACH. Thank you, Mr. Chairman, and thank you, gentlemen.

Really quickly, want to give you a constituent matter that I just uncovered 2 months ago, and I would like to get your reaction to it based upon your testimony that you have presented to the subcommittee.

About 2 months ago, a constituent of mine, someone who is on Medicare, sought medical advice from his orthopedic surgeon regarding an MCL problem he was having with his knee. The orthopedic surgeon then prescribed a knee brace for him to help him with his recovery of that situation.

When Medicare was billed for that knee brace, it was billed for about $690. That really struck this gentleman as being very odd, based upon the knee brace that he got. So he went online to the manufacturer's Web site and saw online that the manufacturer is only retailing this knee brace for about $190, about 2½ to 3 times

more being reimbursed by Medicare for what the manufacturer is retailing this knee brace for.

So with that as a background, Mr. Budetti, for example, in your testimony you indicate that the Affordable Care Act has offered more opportunities and more provisions to combat fraud, as well as new tools for deterring wasteful and fiscally abusive practices to ensure the integrity of the program. So what would your specific recommendation be today to immediately halt this practice of Medicare paying 2½ to 3 times for this kind of medical product? And I am sure there are thousands of kinds of medical products that the system or the program reimburses for that are probably out of whack for what you could pick it up retail for. What are you doing specifically to halt that practice immediately?

Dr. BUDETTI. Thank you for that question, Mr. Gerlach.

What I mentioned just a minute ago, the competitive bidding for durable medical equipment projects a very substantial reduction in the prices that will be paid by Medicare. I believe it is on the order of 32 percent are based upon competitive bidding, and we believe that introducing this level of competition into the provision of durable medical equipment supplies is an important step towards combating exactly what you just mentioned.

I would also add in follow-up to Ms. Black's question from a minute ago——

Mr. GERLACH. May I interrupt just so I understand exactly what you are saying?

So you are going to have folks competitively bid to have the ability to be the entity that provides the product for that particular medical condition. Are you going to relate at all whatever those bids are to the real-world retail price for those products, or are you just going to allow bidding among certain entities but they still, even though you picked the lowest bid, may not be tied to what the reality is in terms of what that product retails for in the real world?

Dr. BUDETTI. You know, I would be very—I can't—I can't speak to the exact market dynamics that governed our initial implementation of the competitive bidding, Mr. Gerlach. I would be happy to look at exactly that issue for you and get back to you on how well the bids that we took compared to the market prices that we otherwise would have seen, because that is the core of what we are trying to do is to get to a point where we are paying either market price or whatever the market should be charging for things.

Mr. GERLACH. When was the last time, if you know, this competitive bidding process was used for a knee brace product in the program so that that would have been the basis to set this new brace price at $690?

Dr. BUDETTI. We are just implementing the competitive bidding this year, and it was in nine areas, but the projection is for it to be phased in across the country. I will be happy to get you all the details.

[The information follows, The Honorable Mr. Gerlach:]

MR. GERLACH

When was the last time, if you know, this competitive bidding process was used for a knee brace product in the program so that that would have been the basis to set this new brace price at $690?

DR. BUDETTI

We agree that Medicare pays above market cost for many items of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) due to the payment rules in effect and mandated by the statute since 1989. To correct these overpayments, the DMEPOS competitive bidding program is being phased in beginning with the highest cost, highest volume items. Off-the-shelf orthotics (or braces) are not currently covered under the competitive bidding program. However, other priority items, such as oxygen equipment and power wheelchairs that account for even more in annual allowed charges – over 6 billion are being phased in under the program. We are happy to report that contracts and savings are currently in effect for these items in 9 metropolitan areas and we are mandated to expandthe program to 91 additional areas this year.

Competitive bidding uses market forces to lower Medicare payments by requiring suppliers to bid against each other and win Medicare contracts based on their costs for furnishing items and services to Medicare beneficiaries. Contract suppliers must meet all of the current Medicare supplier eligibility requirements such as mandatory submission of claims, quality standards and accreditation, and surety bonds, in order to be eligible for a contract award under the program. At the end of the day, the program will use market forces to lower Medicare payment amounts for quality items and services that Medicare beneficiaries need.

Medicare allowed fee schedule payment amounts for DMEPOS items and services, including braces, are established in accordance with the exclusive payment rules mandated by the statute. Unless a change is made to the statute to require or authorize us to establish a different allowed amount for an item, this exclusive rule in the statute must be adhered to in accordance with Federal law. We agree that flexibilities such as competitive bidding should be available under the program to rein in overpayments such as the one you highlight.

Mr. GERLACH. Thank you, sir.

And real quickly, Mr. Morris, your office is obviously responsible for auditing, evaluating these programs. Have you at any time in the past looked at the overcharging, overpayment for products of this nature? And if so, what have your recommendations been, and how has CMS handled those recommendations; or has this been an issue you have not looked at before?

Mr. MORRIS. This is an issue we have looked at a great deal over the last 10 years or more. The OIG, of course, does not set prices. It merely does the audits. But we have looked at everything from wheelchairs to oxygen concentrators to orthotics and, in each

case, reported back to CMS that we believed that the program is paying way too much.

Mr. GERLACH. What has been the response by CMS to those recommendations?

Mr. MORRIS. It has varied a great deal on the particular product, but CMS has generally been receptive to our recommendations. In some instances, they put it out they felt they had legal barriers to actually reducing the prices. The competitive bidding process——

Mr. GERLACH. Have you had a systematic recommendation to cover all of the products that are utilized through the program, or have your recommendations been product specific, a wheelchair or a knee brace or an oxygen tank?

Mr. MORRIS. They have been product specific, but with broader programmatic recommendations that would go to the principle of we ought to pay at market rate and not above it.

Mr. GERLACH. It seems to me there ought to be some systematic recommendations, not individual equipment specific recommendations. There are probably problems across the entire spectrum of product reimbursement in the program. So, appreciate your additional thoughts on that.

Thank you, Mr. Chairman.

Chairman BOUSTANY. Mr. Kind, you may inquire.

Mr. KIND. Thank you, Mr. Chairman. Thank you for holding what I think is a very important hearing, and hopefully we will have an opportunity in the course of this session of Congress to get into this as well. I think it is very helpful.

Nothing drives people crazier than the thought of wasteful payments going out to fraudulent claims being made against the Medicare system. So I appreciate the work both of you gentlemen and your agencies are doing to combat this.

Mr. Morris, let me start with this. Have you had a chance to quantify the type of return we get on the dollar that we spend on anti-fraud measures, what type of return that we are recovering from that?

Mr. MORRIS. Yes, we have. We are very mindful of how valuable the taxpayers' dollars are, and we want to make sure we are a good investment. If you look at the money spent on our health care anti-fraud efforts in the last 3 years, we brought back to the government $6.80. That is a great ROI. So the short answer is yes, and it is a great number.

Mr. KIND. So, under the Affordable Care Act, if I got my numbers right, roughly $350 million was authorized over a 10-year period for the feet-on-the-street effort, and I think the President's 2012 effort was asking for about $270 million for HCFAC. You think that is going to be a wise use of the money as far as the potential for return?

Mr. MORRIS. I confess that I have a somewhat self-interested answer here. Yes, of course. More seriously, I can tell you that there are cases that we want to get to that our current resources do not allow us to. By way of example, we have put a lot of resources into the Medicare Strike Forces and realized a tremendous return both in taking bad guys off the street and saving Medicare money, but it has meant that some of our civil cases, civil cases in-

volving pharmaceutical fraud and others, have had to wait. The ability to bring more feet to the job and focus on those cases I think will return very positive benefits.

Mr. KIND. So you don't have to answer this, but it just seems intuitively, then, that this is an area where further budget cuts may end up costing us more in the long run if we are taking away that enforcement capability or investigative capability.

To follow up on what I think Ms. Black was referring to earlier, are we getting better at being able to distinguish innocent errors that are submitted versus outright fraudulent practices? Mr. Budetti.

Dr. BUDETTI. This is a very high priority for us to do exactly that, and that is why I mentioned the risk-based approach that we are taking. We are implementing a variety of different private sector approaches analyzing data and not just claims data, but moving into a much wider range of data. We have set a goal of having essentially zero false positives. We want to be very sure that we have reached the right conclusions in analyzing the data. So, yes, so I believe that we are making great progress in that direction.

Mr. KIND. Let me ask both of you if you have an opinion on this. But I think ultimately the key to whether health care reform is successful or not is our ability to change the way we pay for health care in this country, starting with Medicare and moving from the fee-for-service system we currently have under Medicare to a fee-for-value or a quality- or outcome-based reimbursement system. If we are successful in making that transition to a new reimbursement, rewarding value over volume, what impact is that going to have on fraudulent practices throughout the country?

Mr. MORRIS. I think it is going to have the potential of reducing conventional fraud, in for example the paying of a kickback to get a service ordered. The challenge we will face is that in any system of reimbursement, there are opportunities to exploit it. As we move into an integrated delivery system where we are rewarding quality, we are going to also need to make sure that some of the other reverse incentives don't result in skimping on care or steering of patients. We are mindful of those risks, but I think it is critical that we move to an integrated system and that we are going to have to give the system an opportunity to sort of try itself out. Every system has opportunities for exploitation and we are going to need to be vigilant.

Mr. KIND. Sure. Dr. Budetti.

Dr. BUDETTI. Yes. I think that, as you are well aware, we are moving towards implementing a number of new ways of organizing and paying for care with accountable care organizations and medical or health homes, value-based purchasing, a variety of different initiatives. In each case, we are raising exactly what Mr. Morris raised which is, if we are going to approach this from a new direction, let's look at what the vulnerabilities are. Let's do that prospectively so that we don't set ourselves up for a different kind of problem going forward.

So, yes, we might very well escape some of the past problems that we have had. We want to also be on the lookout for what kind of new situations we might encounter as we change the system.

Mr. KIND. All right. Thank you both. Thank you, Mr. Chairman.

Chairman BOUSTANY. Mr. Buchanan, you may inquire.

Mr. BUCHANAN. Thank you, Mr. Chairman for holding this important hearing. Gentlemen, I was curious because I hear so many numbers and I am a Member from Florida. But when you look at just the fraud or abuse or whatever for Medicare and Medicaid, what is the best number? What is the range that you use? Because there are so many numbers out there. I hear $100 billion, $60 billion. What is the estimate as it relates to basically Medicare and Medicaid?

Mr. MORRIS. We share your frustration that there is not one number and that there seem to be estimates all over the place—you hear everything from 3 to 10 percent, 3 percent being what the NHCAA estimates, 10 percent being what the GAO estimated about 10 years ago. To be honest with you, I don't think we know with precision how much fraud there is out there. That is in part because fraud is, by the nature of the crime, concealment. Good frauds go undetected.

Mr. BUCHANAN. But what is your best estimate? As someone who deals in this every day, what would you say is a range from a high to a low or whatever?

Mr. MORRIS. My best estimate, not based on any empirical proof but just everything we see, is that the fraud ranges anywhere from about $60 to $100 billion a year across all systems, public and private.

Mr. BUCHANAN. And how much is the public system, Medicare and Medicaid; just your estimate? And I am not holding you to it. I am just trying to get a sense of what that might be.

Mr. MORRIS. Well, if we assume that both public and private systems are preyed on by the same set of criminals, I think we can presume that we would share our proportion of the total health care expenditures. So it is going to be in the tens of billions of dollars. It is way too high.

Mr. BUCHANAN. Doctor, what is your thought on it?

Dr. BUDETTI. Yes, sir. I think that whatever it is, it is too high. I think that whether we have a number or not, that one thing that we do see is that the more we look for it, the more we find.

Mr. Morris mentioned the return on investment. The return on investment has been going up consistently over time as we have spent more money to fight fraud. I view that as both good news and bad news. It means that it is a wise investment of public funds. It also means that we are not on the flat of the curve, so to speak; that there is still quite a bit of fraud out there for us to find and to deal with. So I think that whatever the number is, it is very substantial, and it needs our attention.

Mr. BUCHANAN. Let me mention, you always hear—you brought it up here a few minutes ago about south Florida, Miami/Dade/Broward Counties. And being the only member on Ways and Means in Florida, I hear a lot of that even in my own district.

But let me state something that I read. It was reported by the University of Miami. There was a recent report out that said it is their understanding that six of the Nation's top most-wanted Medicare fraud fugitives have been given refuge in Cuba. Could this be the case? Is it ongoing? Is there any organized crime component

that you are aware of as it relates to fraud? And can it be any kind of a tie-in with the Cuban Government?

Mr. MORRIS. I am not aware of any tie-in to foreign governments as it relates to the health care fraud perpetrators that we either have listed here or elsewhere.

Mr. BUCHANAN. Have you heard about the six of the Nation's most-wanted Medicare fraud victims are in Florida—or, I mean, are in Cuba?

Mr. MORRIS. I have not. I have heard rumors that three of them are in Cuba in a Cuban jail.

Mr. BUCHANAN. Okay. Well, we hear different information. Doctor, do you have anything to add to that?

Dr. BUDETTI. No, I don't.

Mr. BUCHANAN. The other thought is, and you touched on this a little bit earlier, that you are working with the private sector together to combat fraud. In terms of the various agencies—you know, and I heard you touch on it a little bit—could you expand on that a little bit more, what you are doing? I know you can't be everywhere at all times. But in terms of working with the private sector to deal with fraud, what are you actually doing?

Mr. MORRIS. Well, let me give you a great example. The Investigation of the Year, awarded by the NHCAA last year, was for a collaborative effort in Kansas, focusing on a pill mill, two defendants who were pushing painkillers. They were associated with potentially 60 deaths from drug overdoses. The DEA, FBI, OIG teams and a number of private insurers came together, pooled their information on the prescription patterns and practices, identified the trends and were able to focus and build a case that would have otherwise taken far longer and taken far more resources.

The result is we got the convictions and we were able to close down a pill mill that was threatening citizens' lives. That is a great example of how we can work with the private sector to pool our resources and our intel to get to a just result.

Mr. BUCHANAN. We have 1,300 pill mills. We are dealing with that right now. I will yield back.

Chairman BOUSTANY. Yes. Gentlemen, thank you for your testimony and your answers to these questions. Please be advised that members may have written questions they would like to submit, and I would ask you to oblige. Thank you for the work you are doing, and we look forward to hearing from you again on this ongoing problem that we are having to deal with on Medicare health care fraud.

Mr. MORRIS. Thank you very much, Mr. Chairman. Members.

Chairman BOUSTANY. I would now ask the second panel to take their seats.

I want to thank and welcome Karen Ignagni, President and CEO of America's Health Insurance Plans; Mr. Louis Saccoccio, Executive Director of the National Health Care Anti-Fraud Association; and Mr. Ike Odelugo who has pled guilty to State and Federal charges related to Medicare fraud. And I want to thank all of you for being here as we try to delve into this important subject and try to understand what more might need to be done.

You will each have 5 minutes to present your oral testimony. Your full written statements will be made a part of the record. And Ms. Ignagni, we will begin with you. Thank you.

STATEMENT OF KAREN IGNAGNI, PRESIDENT AND CEO, AMERICA'S HEALTH INSURANCE PLANS, WASHINGTON, D.C.

Ms. IGNAGNI. Thank you, Mr. Chairman, Dr. Boustany, Ranking Member Lewis, and Members of the Subcommittee. We are pleased to have the opportunity today to discuss how health plans are playing a leadership role in fighting and preventing health care fraud; how we are working with the Department of Health and Human Services—a number of you inquired about that; how we are working with law enforcement and where there are opportunities to do even more.

Our members have developed cutting-edge techniques, as you have heard this afternoon, to identify fraud and halt practices that lead to substandard care. We are involved in flagging the delivery of inappropriate or unnecessary services that may harm patients, inappropriate charges or charges for phantom services; detecting unlicensed or unqualified personnel, and identifying substance abuse and increasingly identity theft. Our members' anti-fraud initiatives have prioritized preventing fraud before it takes place rather than paying and chasing after the fact.

We are proud that these initiatives were models for the important new efforts being made in the public sector and believe now even more progress can be made. Health plans fight fraud by operating special investigations units that are staffed with personnel with clinical, statistical, and law enforcement expertise. They do four things: They perform intensive license and qualification review. That is the credentialing function. They work to identify potential fraud before a claim is paid by employing sophisticated software techniques to detect anomalies in billing. They investigate the clinical basis for the claim that has been flagged and tagged by relying on physicians, pharmacists, and other trained personnel. Quite a number of these matters, as you heard this afternoon, involve medical equipment, infusion, and narcotics prescribing. We take action by suspending payments when fraud is detected, jettisoning providers from networks, and providing information to law enforcement.

Increasingly, efforts are focused on preventing identity theft. When a patient borrows a friend's identity to obtain insurance coverage, harm can result to the real beneficiary of that insurance policy who may be inappropriately or incorrectly tagged with the wrong blood type or identified inappropriately as having a condition they do not have. We detect substance abuse as a very, very high-priority activity, a current fraud and abuse initiative that literally has life-and-death significance.

Looking ahead we have offered the committee this afternoon four recommendations:

First, we are urging a reconsideration of how fraud prevention and credentialing programs are treated under the interim final regulation for the new medical loss ratio requirement. The Department of Health and Human Services' interim final rule adopts the recommendations that were made by the National Association of

Insurance Commissioners which, in those recommendations, only allowed fraud recoveries to be considered as quality improvement, not the cost of programs that have been the focus of discussion this afternoon, the prevention and early intervention. This is at odds with the promising efforts now being incorporated into the public sector programs which are based on the very programs that our members have pioneered. Similarly, the MLR interim final regulation excludes provider credentialing from the definition of activities that improve health care quality which is now recognized as a critical function, and we applaud the Department for doing that in the efforts that are underway. We urge the committee to ask for reconsideration of how these programs are handled.

Second, we have recommended that existing partnerships between the private and public sectors be strengthened. We have made a recommendation about how that can happen. We think a simple aspect of more clarity about the ability of law enforcement to share information is important in this endeavor.

Third, we recommend that the health plans should be included in restitution agreements when the Department of Justice or other enforcement agencies enter into agreements and obtain restitution from people who commit health care fraud. This is done sometimes, not always; and we think there are opportunities here.

Fourth, we recommend creating a safe harbor for health plans that supply information concerning suspected health care fraud to any public or private entity.

Mr. Chairman, there has been a great deal of progress made in certain States. We are encouraged by that. We think there should be a more uniform approach, and we hope that the committee might consider that more attention could be paid to that matter. This concludes our testimony. We appreciate the opportunity to be here.

And, Mr. Chairman, we are very happy to have the opportunity to sit next to Mr. Saccoccio who has done a fantastic job operating his group that has brought many in the public and private sectors together to share this kind of information. Thank you very much.

Chairman BOUSTANY. I thank you.

[The prepared statement of Ms. Ignagni follows:]

Testimony

for

House Ways and Means Committee
Subcommittee on Oversight

Health Plan Programs to Combat Fraud, Waste, and Abuse

by
Karen Ignagni
President and CEO
America's Health Insurance Plans

March 2, 2011

I. Introduction

Chairman Boustany, Ranking Member Lewis, and members of the subcommittee, I am Karen Ignagni, CEO of America's Health Insurance Plans (AHIP), which is the national association representing health insurance plans that provide coverage to more than 200 million Americans. Our members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs.

We appreciate this opportunity to testify on the important role private health insurance plans play in preventing and detecting fraud, waste and abuse. As increasingly sophisticated schemes targeting scarce health care dollars are devised, an effective fraud-fighting strategy is a critical issue for health plans and the enrollees they serve. Recognizing that fraud has far-reaching implications both for health care costs and quality, our members have demonstrated strong leadership in continually developing new and innovative strategies to combat fraud, while also serving as valuable partners for federal and state law enforcement officials.

Our testimony addresses two issues:

- How health plans' fraud detection units are using cutting-edge techniques to identify practices leading to substandard care – including overuse, underuse, or misuse of medical treatment; and

- Our suggestions for improving fraud detection and prevention in both public and private programs.

II. How Health Plans Use Cutting-Edge Techniques in Detecting and Preventing Fraud

Health care fraud is not a victimless crime; it has an enormous adverse impact on quality while also imposing higher costs on consumers, employers, and taxpayers. Health plans have developed effective fraud prevention and detection programs as part of a broad-based strategy for improving health outcomes and achieving the optimal use of health care dollars. Moreover, the success of health plans' fraud prevention initiatives is evidenced by the fact that government programs now are incorporating these innovative private sector practices.

Health plans fight fraud by operating special investigations units (SIUs) that are staffed with qualified personnel, including many with statistical, medical, and law enforcement experience. These SIUs perform sophisticated tasks that include investigating claims, coordinating with law enforcement personnel, training in-house personnel to identify and report possible fraud, developing and using sophisticated software to identify possible fraudulent claims, initiating civil actions seeking recovery of improper claims payments, and preparing "evidence packages" of suspected fraudulent providers for the benefit of law enforcement entities. Health plans also are vigilant about the credentialing of providers to be included in their networks, and continue to monitor the maintenance of those credentials to assure quality.

Health plans use sophisticated fraud detection software to identify individuals who provide care using false credentials, deliver medically unnecessary services, or make treatment decisions based on illegal referral relationships. Health plans place a high priority on identifying providers who perform or order medically unnecessary procedures or whose practice patterns lead to the delivery of inappropriate or unnecessary care that can threaten the health and safety of patients.

The intensity of health plan fraud prevention programs is highlighted in a recent AHIP Research Brief,[1] entitled "Insurers' Efforts to Prevent Health Care Fraud." Based on data collected in a survey of health plans serving 95 million enrollees, the report details how health plan programs prevent and detect fraud, including how they marshal resources to identify and prevent potential fraud, *rather* than "paying and chasing" after the fact. Indeed, the report emphasizes that deterrence may generate the greatest impact from insurers' anti-fraud programs. The knowledge that health plans have robust anti-fraud measures and controls likely prevents many inappropriate billings or claims from occurring in the first place.

Four Steps in Preventing Inappropriate, Unnecessary Billing or Falsification of Medical Records

The specific tools that health plans use to assure integrity and detect the delivery of inappropriate or unnecessary care vary by company, but usually include the following four categories of activities:

[1] AHIP Center for Policy and Research, Insurers' Efforts to Prevent Health Care Fraud, January 2011.

- **Identifying potential fraud:** The first step is for the anti-fraud units to develop and use procedures to identify and detect suspect claims. The goal is to have this occur up-front, and to identify patterns of performing, ordering, or delivering medically unnecessary procedures before the claim is paid. Identification of such claims can come from the health plan's own systems, where software detects aberrant billing patterns, using data analysis and other analytics techniques. Information on suspected cases of fraud also is obtained from law enforcement agencies, as well as from the National Health Care Anti-Fraud Association (NHCAA). Members of the public also play an important role, as our members' fraud "hotlines" encourage patients as well as providers to report information that helps identify fraud in real-time, before payments are made.

- **"Tagging" suspected cases of fraud:** The second step is for such suspicious claims to be "tagged" for further review before payment. Health plans have been steadily expanding their use of technology to increase their capabilities for detecting fraud, such as through the implementation of electronic "smart flags" or "tags" that quickly identify potentially false or misleading diagnoses, as well as "mining" of claims databases to find suspected cases. A particularly important strategy is the widespread use of predictive modeling to identify suspected cases of fraud by particular providers, often for a more intensive review before claims are paid. For example, a Texas pain clinic case raised red flags based on the enormous quantity of painkillers prescribed, as well as the continual, regular submission of bills every two weeks – bills for services that turned out to be illusory, since patients were required to sign blank medical notes to "prove" they were at the clinic and received the injections. Claims are "scored" to identify those that have a high probability of fraud, and compared to historical claims data to catch statistical "outliers." An example would be clearly excessive claims, such as one physician submitting claims for 20 hours or more of work every day of the year. Such predictive modeling is an important tool when state prompt pay laws often require payments to providers to be made quickly, before a full investigation can be undertaken.

- **Investigating and auditing suspected fraudulent claims:** The next step includes extensive investigation and auditing of suspected claims, comprising medical record review, clinical investigations, and coordination with clinical services departments (including in-house doctors and nurses) to develop appropriate medical opinion of the legitimacy of the claim. Companies are hiring and training personnel to become more knowledgeable about health care fraud and prevention, and involving their auditors in working across multiple

disciplines. Those consulted in this review might include not only clinical and pharmacy personnel, but also state and federal law enforcement officials.

- **Taking action on suspected fraud:** While claims found to be appropriate and accurate would then be paid, claims that are suspected to be fraudulent would be handled on a case-by-case basis. In certain cases, facts that may constitute violations of law would be escalated by referral to a federal or state law enforcement agency (including the FBI and State Attorneys General) through development of what our special investigations units call an "evidence package" detailing the possible fraud. Health plans' data, including extensive computer runs, are valuable evidence for prosecutors in subsequent trials.

Health Plan Techniques as Models

Health plans' cutting-edge techniques have been recognized as effective and have served as a model for government programs. For example, the Medicare fee-for-service system historically has taken a "pay and chase" approach – meaning that often millions of dollars are paid *before* fraud is identified, thus making it difficult to recover funds that already have been lost to fraud. Now, however, significant efforts are underway to incorporate some of the best ideas of the private sector, including up-front detection and prevention, authority to suspend payments to a suspected provider, and enhanced data-sharing.

- **Protecting Patients From Unlicensed or Unqualified Providers**

Health plan credentialing programs are designed to ensure that a particular provider is licensed, has appropriate credentials, does not have a criminal record, and has not been disciplined or otherwise sanctioned. Consistent with the need for up-front detection and prevention, government programs are adopting the intensive credentialing of providers that health plans perform before they are allowed to be included in networks. To counter the historical ability of unscrupulous providers to participate in public programs simply by supplying a tax ID number and a "license," the Affordable Care Act (ACA) beefs up CMS's program integrity activities to mirror credentialing efforts employed by the private sector. Under the ACA, the Secretary of HHS is given the authority to impose enhanced oversight and screening measures, including licensure checks, background checks and site visits, on providers enrolled in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). Indeed, for those providers deemed even a "limited" risk of fraud, waste and abuse, beginning on March 23, 2011, newly enrolling providers would be subject not only to verification, but also to database checks on a

pre- and post-enrollment basis to ensure that they continue to meet the enrollment criteria for their type of provider.

- **Suspending Payments When Fraud is Detected**

Health plans typically have included in their contracts with providers the ability to suspend payments for fraud if improper billing practices are suspected – an ability critical to maintaining quality standards and ensuring that enrollees receive appropriate health care services and treatments. In addition, health plans' contracts typically allow them to recover funds from providers who engage in improper and/or inappropriate billing practices, and even close the provider's panel or terminate the provider (in addition to recovering overpayments) if the provider intentionally engages in improper billing practices. The new anti-fraud provisions incorporate these practices into government programs and now allow the suspension of payments to providers in the case of "credible evidence of fraud" for more than 180-days.

- **Data Sharing**

In addition to thorough credentialing and oversight of providers, plus suspension of payments in cases of suspected fraud, another important technique in health plans' arsenal against fraud is *data-sharing both internally and externally*. Often, fraud investigations combine the expertise of a number of experts, including clinical investigators, auditors, and physicians and, as necessary, outside experts to prevent and detect fraud through a coordinated approach. For example, fraud prevention programs that focus on the diversion, misuse and inappropriate prescribing of narcotic drugs (e.g., OxyContin) typically include close collaboration between the fraud unit's investigators and a plan's clinical services department to address the intersection between abusive conduct and quality of care.

In terms of sharing data outside of the plan, the NHCAA, founded in 1985 by a coalition of private health insurers and government officials, has been instrumental in assisting our members to pool information and identify the latest fraud and abuse trends and schemes. So too, in the public sector, the HHS Office of Inspector General (OIG) now has new authority to access data for oversight and law enforcement activities; for example, the OIG now can enter into data-sharing agreements with the Social Security Administration, as well as expand its data-bank to include claims and payment data from other programs, such as the Veterans Administration and the Department of Defense. As we highlight in our recommendations below, we believe that these initiatives are crucial but that more work needs to be done to facilitate information sharing with the private sector.

- **Preventing Identity Theft**

When a patient borrows a friend's identity to obtain insurance coverage, harm can result to the real beneficiary of that insurance policy, who may be tagged with the wrong blood type or be identified as having those medical conditions for which the friend received treatment. There also have been instances where patients have stolen a doctor's billing identity, as one health plan discovered when its computer software revealed that a psychiatrist's identity was being used to allegedly bill for seeing an impossible 63 patients in a single day.[2] The private sector is exploring technologies to combat these examples of medical identity theft, perhaps by methods such as biometrics incorporated in a patient's insurance card to assure that the patient is present.[3] Indeed, a bill introduced in 2010, H.R. 5044, the "Medicare Fraud Enforcement and Prevention Act," mirrored that idea, providing for a pilot program that implements biometric technology to ensure that individuals entitled to Medicare benefits are "physically present at the time and place of receipt of certain items and services."

- **Detecting Substance Abuse**

A current fraud and abuse initiative that literally has "life and death" significance for patients is the growing problem of substance abuse – both identifying members who are battling a substance abuse problem, or abusing their pharmacy benefit, as well as investigating those prescribers who exploit member addiction for financial gain. Our members are seeing an increase in the prescribing of pharmaceuticals, especially controlled substances such as painkillers, for a non-legitimate medical purpose in violation of the law. Health plans employ data analysis to flag those who may be prescribing inappropriately or members who may be battling a substance abuse problem. In the latter case, the plan's medical personnel will organize substance abuse treatment.

III. Recommendations for Improving Fraud Prevention and Detection in Both Public and Private Programs

Looking ahead, additional measures are needed to improve the prevention and detection of fraud. To meet this goal, we offer the following four recommendations for the Committee's consideration.

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[2] Appleby, J., "Medical claims 'mined' to find fraud: Use of detection software spreads," USA Today, November 7, 2006.

[3] Harnish, A., "Analytics Improving Insurers' Claims Fraud Detection Efforts," Insurance and Technology, August 16, 2010.

Recognize the Role of Fraud Prevention and Credentialing Activities in Quality Improvement

Given the role that health plan fraud prevention and detection programs and credentialing have played in establishing effective models for public programs, improved data for law enforcement, and successful prevention efforts, how these programs are categorized under the implementation of the medical loss ratio (MLR) provision of the ACA should be reevaluated.

The specific issue relating to fraud prevention is that the MLR Interim Final Rule (IFR) states that it adopts the recommendations made by the National Association of Insurance Commissioners (NAIC). In turn, the NAIC's recommendations only provide a credit for fraud "recoveries" – i.e., funds that were paid out to providers and then recovered under "pay and chase" initiatives. It does not include the cost of developing and administering anti-fraud programs that detect fraud before claims are paid and in the process help to protect consumers, purchasers, and patients. As a result, the IFR would penalize health plans for committing resources to innovative programs that prevent and detect fraudulent conduct or prevent the delivery of unnecessary services or care.

By taking this approach, the MLR IFR's treatment of fraud prevention expenses works at cross purposes with new government efforts to emulate successful private sector programs, such as those described here, and it is at odds with the broad recognition by leaders in the private and public sectors that there is a direct link between fraud prevention activities and improved health care quality and outcomes.

Similarly, the MLR IFR categorically excludes provider credentialing from the definition of activities that improve health care quality. As now recognized in government programs, provider credentialing is a critical function that helps ensure, among other things, that the providers from whom an individual or family seeks care are properly licensed and qualified – thereby contributing directly to patient safety.

We would urge a reconsideration of potential options for the treatment of fraud prevention and credentialing programs. Excluding these expenses is contrary to the health reform goals of developing a system to deliver consistently high quality care, optimizing the use of health care resources, and enhancing anti-fraud cooperation between private and public entities.

Enhance Information Available to the Private Sector Through Increased Data-Sharing With the Public Sector

Partnerships that promote information sharing between the private and public sectors are crucial to the success of fraud prevention efforts. Indeed, such partnerships were envisioned under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which resulted in federal guidelines that encouraged the sharing of information among federal, state and local law enforcement entities, and recognized the large stake that health plans have as well in anti-fraud initiatives. Unfortunately, the HIPAA vision has not been fulfilled with respect to information sharing from public to private programs, likely hampered in part by the misperception by some federal and state agents that they lack the authority to share health care fraud information with their private counterparts.

Regardless of the specific reasons, there is much more to do in this area to make information sharing a two-way street between public and private programs, especially given that health plans are often administrative partners in public programs such as Medicare. Health plans are valuable partners for prosecutors for several reasons. They have advanced information technology infrastructures that can give law enforcement agencies a 360 degree view of a particular provider's behavior. Plans also can track clinical information across multiple providers, whether individual or institutional, and often in multiple geographic locations. That information can highlight the "outliers," whether in the form of overbilling, billing for treatments not rendered, or falsifying a diagnosis. In addition, plans often have access to drug utilization review systems that can determine when an individual is committing fraud by filling multiple prescriptions for a controlled substance, or when a prescriber is prescribing doses of such substances that far exceed normally expected amounts.

One of HHS' strategic principles[4] for fighting health care fraud is to establish new partnerships with the private sector to share information and strategies for detecting and preventing fraud. We strongly support that direction, including further efforts by federal and state agencies to clarify the permissibility, as well as the beneficial nature, of sharing health care fraud-related information with private insurers engaged in fighting fraud.

[4] HHS Testimony before House Appropriations Committee, March 4, 2010.

Ensure the Inclusion of Private Sector Government Program Components In Federal Cases

Our health plans commend the comprehensive federal Health Care Fraud and Abuse Control Program, begun in 2009 under the direction of the Attorney General and the Secretary of HHS, for its anti-fraud activities that have returned over $15.6 billion to the federal government through audit and investigative recoveries.[5] As active partners with the government in contributing information and data to health care fraud prosecutions, health plans are concerned that it is a missed opportunity for their policyholders and employer purchasers when in some instances they are not included in settlements when the Department of Justice or other enforcement agencies enter into agreements and obtain restitution from providers. This is a missed opportunity for federal and state prosecutors as well. Including the amounts lost by private plans, as well as public programs, in their prosecutions is likely to allow federal and state prosecutors to seek and obtain even larger penalties against those who commit fraud. Recognizing that Medical Supplement insurers, Medicaid health plans, Medicare Advantage plans, and commercial insurers often are adversely affected by health care providers who defraud public programs, health plans should be included in restitution agreements.

Protection for Governmental and Private Plans Working Together

Another issue that deserves scrutiny is whether private health plans may be subject to lawsuits as a result of supplying information on cases of suspected fraud to law enforcement agencies. HIPAA contains only a limited immunity provision[6] that appears to confer "qualified immunity" for providing information regarding fraud and abuse, but solely to the Secretary or Attorney General. Thus the possibility exists that a health plan might be found civilly or criminally liable for providing what it believes to be accurate information on cases of suspected fraud and abuse to a government agency, even at the government agency's request. There have been situations where unscrupulous providers have chosen to sue health plans for libel or other charges when under investigation for suspected fraud. A number of states have recognized the chilling effect such lawsuits or threatened actions have on robust private sector initiatives and have enacted limited immunity statutes for health care fraud; all states, as well as the federal government, should do so.

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[5] Testimony of Lewis Morris, Chief Counsel OIG, House Committee on Ways and Means, June 15, 2010.
[6] 42 U.S.C. § 1320a-7c, 42 U.S.C. § 1320c-6.

To expand and clarify the HIPAA language, we recommend that stronger protections be created by setting up a "safe harbor" for health plans supplying information concerning suspected health care fraud to not just the Secretary or Attorney General, but to any other private or public entity. This should include protection for health plans, should they report suspected health care fraud on any NAIC Uniform Fraud Reporting Form specifically developed for health insurance fraud reporting. Such a safe harbor should apply unless the information is false and the person providing it knew, or had reason to believe, that the information was false.

IV. Conclusion

Thank you for considering our perspectives on the important national goal of preventing and detecting health care fraud and, in so doing, improving health care quality and patient outcomes for the American people. We stand ready to work with the Committee to address opportunities for strengthening fraud prevention in both the private sector and public programs.

Chairman BOUSTANY. Mr. Saccoccio, you may proceed.

STATEMENT OF LOUIS SACCOCCIO, EXECUTIVE DIRECTOR, NATIONAL HEALTH CARE ANTI-FRAUD ASSOCIATION, WASHINGTON, D.C.

Mr. SACCOCCIO. Thank you. Good afternoon, Chairman Boustany, Ranking Member Lewis, and other distinguished Members of the Committee. I am Louis Saccoccio, Executive Director of the National Health Care Anti-Fraud Association, NHCAA.

NHCAA was established in 1985 and it is the leading national organization focused exclusively on combating health care fraud.

We are uncommon amongst associations in that we are a private-public partnership. Our members comprise more than 85 of the Nation's most prominent private health insurers, along with more than 80 Federal, State, and local government law enforcement and regulatory agencies that have jurisdiction over health care fraud who participate in NHCAA's law enforcement liaisons.

NHCAA's mission is simple: to protect and serve the public interests by increasing awareness and improving the detection, investigation, civil and criminal prosecution, and prevention of health care fraud. The magnitude of this mission remains the same regardless of whether the patient has health care coverage as an individual or through an employer or through Medicare, Medicaid, TRICARE, or other Federal or State program.

Health care fraud is a serious and costly problem that affects every patient and every taxpayer in America. Just as importantly, health care fraud is a crime that directly affects the quality of health care. Patients are physically and emotionally harmed by health care fraud. As a result, fighting health care fraud is not only a financial necessity, it is a patient safety imperative. Also, health care fraud does not discriminate between types of medical coverage. The same schemes used to defraud Medicare migrate over to private insurers, and schemes perpetrated against private insurers make their way into government programs.

Additionally, many private insurers are Medicare Part C and D contractors or provide Medicaid coverage in the States, making clear the intrinsic connection between private and public interests.

As a result, the main part I want to emphasize is the importance of anti-fraud information-sharing between private and public payers. NHCAA has stood as an example of the power of a private-public partnership against health care fraud since its founding, and we believe that health care fraud should be addressed with private-public solutions.

One salient example that illustrates the power of cooperative efforts against health care fraud can be found in south Florida. In response to the challenge of health care fraud schemes in south Florida, including fraud schemes involving infusion therapy in home health care, NHCAA formed the South Florida Work Group. In meetings held in 2009 and 2010, this NHCAA work group brought together representatives of private insurers, FBI headquarters, and field divisions, CMS, HHS, OIG, DOJ, the Miami U.S. Attorney's Office, and other Federal and State law enforcement agencies, to address the health care fraud schemes emanating in south Florida. The details of the emerging schemes, investigatory tactics and the results of recent prosecutions were discussed with the dual goals of preventing additional losses in south Florida and preventing the schemes from spreading and taking hold in other parts of the country.

This type of anti-fraud information-sharing is critical to the success of anti-fraud efforts. HHS, OIG, CMS, and DOJ have demonstrated a strong commitment to information-sharing with private insurers and are working with NHCAA to identify the barriers, both actual and perceived, to effective anti-fraud information-sharing with the goal of increasing the effectiveness of this critical tool in the fight against health care fraud.

It would greatly enhance the fight against health care fraud if Federal and State agencies clearly communicate to their agents the guidelines for sharing information with private insurers, emphasizing that information-sharing for the purposes of preventing, detecting, and investigating health care fraud is authorized and encouraged, consistent with applicable legal principles.

In addition to information-sharing, the other effective way to detect emerging fraud patterns and schemes in a timely manner is to apply cutting-edge technology to the data to detect risk and emerging fraud trends. The pay-and-chase model of combating health care fraud, while necessary in certain cases, is no longer tenable as the primary method of fighting this crime. In recognition of this fact, many private sector health insurers now devote additional resources to predictive modeling technology and real-time analytics, applying the fraud prevention methods on the front end, prior to medical claims being made.

The Federal Government has also recognized the value of real-time data analysis as a key aspect of its interagency HEAT initiative. The Medicare Strike Force model, as you have heard, employed by the HEAT program combines Medicare paid claims into a single searchable database, identifying potential fraud more quickly and effectively. Additionally, CMS is working to implement risk-scoring technology to apply effective predictive models to Medicare.

NHCAA is encouraged by the renewed Federal emphasis given to fighting health care fraud, and NHCAA knows continued investment and innovation are critical. And as greater attention is given to eradicated fraud from government health care programs, we urge decisionmakers to also recognize and encourage the important role that private insurers play in keeping our health care system healthy and free from fraud.

Thank you for allowing me to testify today. I would be happy to answer any questions. Thank you.

Chairman BOUSTANY. Thank you Mr. Saccoccio.

[The prepared statement of Mr. Saccoccio follows:]

Statement of Louis Saccoccio

Executive Director

National Health Care Anti-Fraud Association

on

Improving Efforts to Combat Health Care Fraud

Before the

U.S. House Committee on Ways and Means

Subcommittee on Oversight

March 2, 2011

Testimony of:
Louis Saccoccio
Executive Director
National Health Care Anti-Fraud Association

Good afternoon, Chairman Boustany, Ranking Member Lewis, and other distinguished Members of the Subcommittee. I am Louis Saccoccio, Executive Director of the National Health Care Anti-Fraud Association (NHCAA).

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NHCAA's mission is simple: 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. The magnitude of this mission remains the same regardless of whether a patient has health coverage as an individual or through an employer, Medicare, Medicaid, TRICARE or other federal or state program.

I am grateful for the opportunity to discuss the problem of health care fraud with you. In my testimony today, I draw upon our organization's 25-plus years of experience focusing on this single issue. Health care fraud is a serious and costly problem that affects every patient and every taxpayer in America. The financial losses due to health care fraud are estimated to range from $75 billion to a staggering $250 billion a year. These financial losses are compounded by numerous instances of patient harm—unfortunate and insidious side effects of health care fraud.

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. For example, Medicare alone pays 4.4 million claims per day to 1.5 million providers nationwide. Add to that the fact that fraud can conceivably be committed by anyone in the system, and that those committing fraud have the full range of medical conditions, treatments and patients on which to base false claims. Plus, detecting health care fraud often requires the knowledge and application of clinical best practices, as well as knowledge of medical terminology and specialized coding systems, including CPT and CDT codes, DRGs, ICD-9 codes, and the forthcoming ICD-10 codes. Clearly, health care fraud can be a challenging crime to prevent and detect. The perpetrators of this crime have proven themselves to be creative, nimble and aggressive. As a result, employing the most effective fraud prevention and detection techniques is critical to achieving success.

Just as importantly, health care fraud is a crime that directly affects the quality of health care delivery. Patients are physically and emotionally harmed by health care fraud. As a result, fighting health care fraud is not only a financial necessity; it is a patient safety imperative. For example, anti-fraud efforts identify and prevent unnecessary and potentially harmful medical care and procedures. Shockingly, the perpetrators of some types of health care fraud schemes deliberately and callously place trusting patients at significant risk of injury or even death. While distressing to imagine, there are cases where patients have been subjected to unnecessary or dangerous medical procedures simply because of greed. Patients may also unknowingly receive unapproved or experimental procedures or devices.

Additionally, anti-fraud efforts identify dangerous prescription drug abuse by patients and overprescribing by some physicians. Prescription drug abuse is a growing problem. Addicts will go "doctor shopping" in order to get multiple prescriptions from several physicians and will then fill them at different pharmacies. Often, it's the insurer that is best able to connect the dots and identify potentially fatal overprescribing by physicians and the resulting prescription drug abuse by patients.

Anti-fraud efforts also identify and prevent medical identity theft. Using a person's name or other identifying information without that person's knowledge or consent to obtain medical services, or to submit false insurance claims for payment, constitutes medical identity theft. It can result in erroneous information being added to a person's medical record or the creation of a fictitious medical record in the victim's name. Victims of medical identity theft could receive the wrong (and potentially harmful) medical treatment, find that their health insurance benefits have been exhausted, become uninsurable for life insurance coverage, and have their ability to obtain employment impacted. Untangling the web of deceit spun by perpetrators of medical identity theft can be a grueling and stressful endeavor and the effects of this crime can plague a victim's medical and financial status for years to come.

My testimony today will focus on three issues which NHCAA believes are critical to successfully combating health care fraud. The first is the importance of anti-fraud information sharing among all payers of health care, including the sharing of information between private insurers and public programs. The second is the critical role of data consolidation and data analytics in being able to prevent precious health care dollars from being lost to fraud. Finally, I will address the importance of the new tools provided by the Patient Protection and Affordable Care Act, and the need for both private and public investment in anti-fraud activities.

I. The sharing of anti-fraud information among all payers – government programs and private insurers alike — is crucial to successfully fighting health care fraud and should be encouraged and enhanced.

Health care fraud does not discriminate between types of medical coverage. The same schemes used to defraud Medicare migrate over to private insurers, and schemes perpetrated against private insurers make their way into government programs. Additionally, many private insurers are Medicare Parts C and D contractors or provide Medicaid coverage in the states, making clear the intrinsic connection between private and public interests.

NHCAA has stood as an example of the power of a private-public partnership against health care fraud since its founding, and we believe that health care fraud should be addressed with private-public solutions. We believe that government entities, tasked with fighting fraud and safeguarding our health system, and private insurers, responsible for protecting their beneficiaries and customers, can and should work cooperatively on this critical issue of mutual interest. Our experience has taught us that investigative information sharing works in combating health care fraud, and NHCAA dedicates itself to providing venues in which the sharing of relevant information can take place.

For example, NHCAA hosts several anti-fraud information sharing meetings each year in which private health plans and representatives of the FBI, the Investigations Division of HHS-OIG, Medicaid Fraud Control Units, TRICARE, and other federal and state agencies come together to share information about developing fraud schemes and trends. Additionally, NHCAA'S Request for Investigative Assistance (RIA) process allows government agents to easily query private health insurers regarding their exposure in active health care fraud cases. For the past decade, NHCAA has conducted a biennial survey of its private sector members that aims to assess the structure, staffing, funding, operations and results of health insurer investigative units. In the most recent survey report (with data collected in 2009), 100% of respondents reported that they responded to NHCAA Requests for Investigation Assistance from law enforcement.

In addition to the NHCAA-sponsored information-sharing meetings, many U.S. Attorney Offices sponsor health care fraud task forces which hold routine meetings. In the same survey mentioned above, 89 percent of NHCAA private insurer members stated that they have shared case information at law enforcement-sponsored health care fraud task force meetings.[1] It is clear that private insurers regularly share information with law enforcement, which in turn aids ongoing investigations.

[1] NHCAA Anti-Fraud Management Survey for Calendar Year 2009, National Health Care Anti-Fraud Association, June 2010.

The Department of Justice has developed guidelines for the operation of the Health Care Fraud & Abuse Control Program (HCFAC) established by HIPAA that 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" recognizes the importance of a coordinated program, bringing together both the public and private sectors in the organized fight against health care fraud.[2] Likewise, CMS has recognized the value of greater information sharing. During a September 22, 2010, Congressional subcommittee hearing, Peter Budetti, M.D., J.D., Deputy Administrator and Director of the Center for Program Integrity, stated: "Sharing information and performance metrics broadly and engaging internal and external stakeholders involves establishing new partnerships with government and private sector groups. Because the public and private sectors have common challenges in fighting fraud and keeping fraudulent providers at bay, it makes sense that we should join together in seeking common solutions."

One salient example which illustrates the power of cooperative efforts against health care fraud can be found in South Florida, viewed by many as the epicenter for emerging fraud schemes. Here, "phantom" health care providers, which do not exist except on paper, yet manage to defraud public and private programs of millions of dollars, became an acute problem over the last several years. One effort by HHS-OIG in 2007 to validate durable medical equipment, prosthetics, orthotics, and supply (DMEPOS) providers under Medicare revealed that nearly one third – 491 – of the 1,581 DME providers in three South Florida counties simply did not exist.[3] These phantom providers across South Florida collected hundreds of millions of dollars from Medicare, Medicaid and other public programs.

During this time, the Department of Justice (DOJ) organized its first Health Care Fraud Strike Force in Miami-Dade.[4] While the government-led Strike Force was investigating, much of the information about these phantom providers was also being developed by private health insurers, much of it driven by information provided by beneficiaries – individuals who received

[2] See http://www.usdoj.gov/ag/readingroom/hcarefraud2.htm.
[3] See http://oig.hhs.gov/publications/docs/press/2007/PRSouthFlorida.pdf.
[4] See http://www.stopmedicarefraud.gov/heatsuccess/heat_taskforce_miami.pdf.

Explanation of Benefit forms from their public or private insurer for services they had not received.

Once information began to be shared between the public and private sectors, NHCAA member company investigators and others were able to review beneficiary information to determine that the same social security numbers were being used repeatedly by these phantom providers. A search of claim histories showed short, intense billing cycles by these providers, billing numerous services within a week or two, and many checks returned as non-deliverable or stale dated. When these alleged providers were contacted by telephone, the phone calls typically reflected disconnected numbers or full voicemail boxes. Messages that were left by investigators were never returned. In the few instances when a live person answered the phone, they did not speak English (or pretended not to speak English), could not provide any information, or simply hung up.

In response to the challenge of phantom providers and other health care fraud schemes in South Florida, including fraud schemes involving infusion therapy and home health care, NHCAA formed a South Florida Work Group. In meetings held in 2009 and 2010, this NHCAA work group brought together representatives of private insurers, FBI headquarters and 10 FBI field divisions, the Centers for Medicare and Medicaid Services (CMS), the Department of Health and Human Services Office of Inspector General (HHS-OIG), the Justice Department, the Miami U.S. Attorney's Office, the Office of Personnel Management Office of Inspector General (OPM-OIG), the Department of Defense (DOD) TRICARE, and local law enforcement to address the health care fraud schemes emerging from South Florida. The details of the emerging schemes, investigatory tactics, and the results of recent prosecutions were discussed with the dual goals of preventing additional losses in South Florida and preventing the schemes from spreading and taking hold in other parts of the nation.

Despite the success of information sharing which has progressed between the private and public payers of health care, on occasion some federal and state agents have been under the misapprehension that they do not have the authority to share information about health care fraud

with private insurers, creating an unnecessary yet significant obstacle in coordinated fraud fighting efforts. It would greatly enhance the fight against health care fraud if federal and state agencies clearly communicate with their agents the guidelines for sharing information with private insurers, emphasizing that information sharing for the purposes of preventing, detecting and investigating health care fraud is authorized and encouraged consistent with applicable legal principles. NHCAA is working closely with the HHS-OIG, CMS, and DOJ to identify the barriers, both actual and perceived, to effective anti-fraud information sharing with the goal of increasing the effectiveness of this critical tool in the fight against health care fraud.

II. Data analysis and aggregation are essential tools in the health care fraud detection and prevention efforts of today and tomorrow.

The numbers are staggering. The U.S. health care system spends $2.5 trillion dollars and generates billions of claims a year from hundreds of thousands of health care service and product providers. The vast majority of these providers of 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 claims for potential fraud, each payer is limited to the claims it receives and adjudicates. There is no single repository of health care claims similar to what exists for property and casualty insurance claims.[5] The complexity and size of the health care system, along with understandable concerns for patient privacy, probably make such a data base impracticable. This fact further emphasizes the importance of anti-fraud information sharing among all payers of health care.

Nevertheless, data consolidation is possible at some level. NHCAA is encouraged by the expanded data matching provisions provided for in Section 6402(a) of the Patient Protection &

[5] See https://claimsearch.iso.com

Affordable Care Act. This section mandates an expanded "Integrated Data Repository" at CMS that will incorporate data from all federal health care programs:

- Medicare Parts A, B, C & D;
- Medicaid;
- CHIP;
- Health-related programs administered by the Secretary of Veterans Affairs;
- Health-related programs administered by the Secretary of Defense;
- Federal old-age, survivors, and disability insurance benefits established under Title II; and
- The Indian Health Service and the Contract Health Service program.

The law stipulates that inclusion of Medicare data into the Integrated Data Repository "shall be a priority," and data from the other Federal programs shall be included "as appropriate." As a result, this provision establishes the *ability* to create an "all claims" database, albeit limited to government programs, with the purpose of conducting law enforcement and oversight activities. This is a major step in the right direction for analyzing claims data in a way which will allow potential losses to be stemmed and emerging schemes to be identified at the earliest possible time.

Given the diversity of providers and payers and the complexity of the health care system—as well as the sheer volume of activity—the challenge of preventing fraud is enormous. Clearly, the only way to detect emerging fraud patterns and schemes in a timely manner is to aggregate claims data as much as practicable and then to apply cutting-edge technology to the data to detect risks and emerging fraud trends. The "pay and chase" model of combating health care fraud, while necessary in certain cases, is no longer tenable as the primary method of fighting this crime.

In recognition of this fact, many private sector health insurers now devote additional resources to predictive modeling technology and real-time analytics, applying them to fraud prevention efforts on the front end, prior to medical claims being paid. This is similar to the technology that

credit card companies and financial institutions use to detect and prevent fraud. It works by searching vast amounts of data then building models based on patterns that emerge from that data.

The federal government has also recognized the value of real-time data analysis as a key aspect of its inter-agency HEAT initiative. The Health Care Fraud Prevention and Enforcement Action Team (HEAT) counts among its goals improved data sharing—including access to real-time data—to detect fraud patterns, and strengthened partnerships between the public and private health sectors and among federal agencies. The Medicare Strike Force model employed by the HEAT program combines all Medicare paid claims into a single, searchable database, identifying potential fraud more quickly and effectively. There are currently Strike Force teams operating in nine metro centers across the country—this includes an expansion to two additional cities announced just last month. The Strike Forces' use of improved real time data access and analysis has resulted in more than 520 successful prosecutions and 465 indictments involving charges filed against 829 defendants over the last three and a half years.[6]

Congress has demonstrated further commitment to combating fraud by applying predictive modeling techniques to health care anti-fraud efforts through the Small Business Jobs and Credit Act of 2010, signed into law last September. The Act includes language that establishes predictive analytics technologies requirements for the Medicare fee-for-service program, directing the HHS Secretary to use predictive modeling and other analytics technologies to identify improper claims for reimbursement and prevent their payment.

The law describes a four-year implementation process and stipulates that the use of predictive analytics in fraud detection shall commence by July 1, 2011, in 10 states identified by the Secretary as having the highest risk of waste, fraud, or abuse in the Medicare fee-for service program. Importantly, CMS has indicated that it plans to accelerate the program, estimating that real-time analysis of national Medicare claims data "should be possible by 2012."[7] This

[6] These statistics are for the period of May 7, 2007 through September 30, 2010 as reported in the HCFAC Report for Fiscal Year 2010, http://oig.hhs.gov/publications/docs/hcfac/hcfacreport2010.pdf.
[7] http://www.nextgov.com/nextgov/ng_20110209_7724.php#

ambitious push to implement predictive modeling signals the determination of CMS to root out fraud and safeguard our finite health care dollars.

NHCAA supports efforts among its members, both public and private, to shift greater attention and resources to predictive modeling, real-time analytics and other data intensive tools that will help detect fraud sooner and prevent it before it occurs.

III. Investment in innovative health care fraud prevention, detection and investigation tools and programs is vital and should be encouraged.

There is no doubt that good work has been done in the fight against health care fraud. When it was established under HIPAA, the National Health Care Fraud & Abuse Control Program (HCFAC) was intended to be "a far-reaching program to combat fraud and abuse in health care, including both public and private health plans." Now, 14 years later, the documented success of HCFAC affirms the wisdom of making that investment. Published this past January, the HCFAC report for Fiscal Year 2010 shows a return on investment (ROI) of $4.90 returned for every $1 spent since the program began. The three-year average ROI for Fiscal Years 2008-2010 is considerable at $6.80 to $1. According to the report, the HCFAC account has returned more than $18 billion to the Medicare Trust Fund since the program's inception. Similar to the HCFAC program findings, NHCAA's private-sector members consistently yield solid returns for their anti-fraud investments. However, given the wide range in terms of size and scope of business of NHCAA's private insurer members, the ROI for anti-fraud activities varies from company to company.

More recent programmatic anti-fraud initiatives—including the HEAT program, the Medicare Strike Forces, as well as National and Regional Health Care Fraud Prevention Summits co-hosted by Secretary Sebelius and Attorney General Holder—have also demonstrated success and promise, employing collaborative approaches to prevent and identify health care fraud, and

educating providers and beneficiaries about the problem of fraud. Moreover, the numerous anti-fraud tools enabled by the Patient Protection and Affordable Care Act (ACA) are very good news for patients and taxpayers alike. For instance, the new screening requirements for providers participating in Medicare, Medicaid and the Children's Health Insurance Program (CHIP) are a big step in the direction of preventing fraud before it occurs by helping to deny access to these programs by potential fraudsters. Designed based on the potential risk of fraud by a certain category of provider, the three levels of provider screening spelled out in the final rule will serve to protect our nation's health care investment.

The ACA also authorizes the Secretary to impose a temporary moratorium (6 months) on the enrollment of new providers of services and suppliers under Medicare, Medicaid and CHIP when necessary to prevent or combat fraud, waste or abuse. Notably, the final rule allows for moratoria in cases where CMS identifies a particular provider or supplier type and/or a particular geographic area as having a significant potential for fraud, waste or abuse. This is particularly important because health care fraud often manifests much like a fad would—it surfaces in one place or among one group, takes hold and proliferates. It's important to be able to suppress it when and where it appears in order to limit its reach.

The ACA also creates the ability of the Secretary to suspend payments to a particular provider "pending an investigation of a credible allegation of fraud . . unless the Secretary determines there is good cause not to suspend such payments." Several changes were also made to the Medicaid Integrity Program including new provisions regarding exclusions from the Medicaid program. For instance, a provider's participation will be terminated under Medicaid if it has been terminated under Medicare or other state plan.

Among the many new anti-fraud provisions included as part of the health care reform package, additional funding for anti-fraud efforts was also a noteworthy inclusion. The law allows for an additional $350 million to be appropriated to the fraud fighting cause between 2011 and 2020. NHCAA is confident that Congress and the public will be pleased with the results of this investment, as there is proven value in making anti-fraud investments.

The President's proposed budget for Fiscal Year 2012 is further acknowledgment that anti-fraud resources are a sound investment. The budget proposes a $270 million increase for discretionary funding for Health Care Fraud & Abuse Control, and we applaud this commitment. The proposed increase is needed to fund the expansion of the strike forces and to advance the goal of shifting from the "pay and chase" fraud fighting concept to one that employs technology to prevent and detect fraud prior to claims being paid. The return on investment for anti-fraud initiatives is significant, and therefore the increase in funding for these initiatives would be consistent with Congress' focus on reducing government spending.

These recent federal anti-fraud programs and initiatives, along with the substantial increase of funding and new anti-fraud tools enabled by the ACA, are very positive steps, particularly for government health programs. However, the recent regulatory decision to categorize anti-fraud activities undertaken by private insurers as simple "cost containment" in the recently published medical loss ratio (MLR) interim final rules runs counter to the direction taken by the ACA. Consistent with the necessary priority given to anti-fraud efforts in the federal health care programs, private health plans should be given every incentive to invest in the technology and resources necessary to fight fraud and protect patients—particularly when the need to shift away from the "pay and chase" model is now. NHCAA is concerned that accounting for anti-fraud investments as "administrative" without acknowledging the quality-affirming aspects of this work will serve as a disincentive to fraud prevention investments by private insurers. And we know that the nature of health care fraud demands constant reevaluation of methods and means and continual investment to stay ahead of the curve.

Conclusion

Health care fraud costs taxpayers billions of dollars every year, and fighting it requires focused attention and a commitment to innovative solutions. NHCAA believes that a comprehensive approach to fighting fraud must include all payers, public and private. If there is such a thing as a

silver bullet for solving the health care fraud conundrum, enabling genuine information sharing among stakeholders is our best bet.

The schemes devised by perpetrators of health care fraud take many forms, and the perpetrators of fraud are opportunistic. As a result, we must stay vigilant and work to anticipate and identify the risks, and to develop strategies to meet these risks. Right now, harnessing the enormous quantities of data produced by our health care system in order to identify and predict fraud holds great promise. We encourage continued investment in both time and resources to exploring and implementing data consolidation and data mining techniques.

NHCAA is encouraged by the renewed federal emphasis given to fighting health care fraud. This hearing is an excellent example of this emphasis, as are the statutes, regulations and policies from the past several years that have enabled greater fraud fighting success. NHCAA knows continued investment and innovation are critical, and as greater attention is given to eradicating fraud from our government health care programs, we urge decision makers to also recognize and encourage the important role that private insurers play in keeping our health care system healthy and free from fraud.

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

Chairman BOUSTANY. And, Mr. Odelugo, thank you for being here. You may proceed, sir.

STATEMENT OF AGHAEGBUNA "IKE" ODELUGO, PLED GUILTY TO STATE AND FEDERAL CHARGES RELATED TO MEDICARE FRAUD; HAS BEEN ASSISTING LAW ENFORCEMENT WHILE AWAITING SENTENCING IN MAY; HOUSTON, TEXAS

Mr. ODELUGO. Thank you, Mr. Chairman and Members of the Committee. It is with profound humility and deep gratitude for this opportunity that I come before the Members of the Committee today to provide testimony on the pressing issue of Medicare fraud

in the durable medical equipment (DME) sector of the health care services industry.

My name is Aghaegbuna "Ike" Odelugo. I am from Nigeria and came to the United States in 1998 with the sincerest of intentions to eventually acquire my master's degree. Instead, beginning in 2005 and extending to 2008, I engaged in a business that presents unique opportunities for fraud and abuse. I am speaking of the DME sector of the health care services industry. I engaged in fraud and abuse in this industry. I participated with others in 14 different companies, reaching 11 different States.

DME fraud is incredibly easy to commit. The primary skill required to do it successfully is knowledge of basic data entry on a computer. Additionally required is the presence of so-called "marketers" who recruit patients and often falsify patient data and prescription data. With these two essential ingredients, one possesses a recipe for fraud and abuse. The oven in which this recipe is prepared is the Medicare system. This system has a number of weaknesses which are easily exploitable. This is a nonviolent crime and is often committed by very educated people, including business people, hospitals, doctors and administrators. It reaches across all ethnic and racial lines. It relies on an often unsuspecting victim base of Medicare recipients, elderly citizens who long for attention and care, who simply want someone to talk to. It also at times involves patients who willingly participate in the fraud.

DME providers who engage in this type of fraud either do their own billing or outsource the billing to persons such as myself. In my own experience, I dealt with 14 DME companies and did their billing. I often dealt directly with marketers who provided patient referrals, most of them fraudulent. I also dealt with physicians who knowingly participated in this fraud by knowingly writing prescriptions when they knew they were not medically necessary, or at times writing prescriptions for patients they never saw.

I am not here today to appear proud of what I have done, yet I want the Members of the Committee to understand that I have done everything humanly possible to correct my past wrongs. The opportunity to testify today before this subcommittee is something I am very grateful to be able to do.

Mr. Chairman and Members of the Committee, I want to thank you for allowing me the opportunity to address the Subcommittee on Oversight. I sincerely regret my actions over the past years and today's testimony, I hope, will be understood as part of a continuing effort on my part to help in any way I can to correct my wrongs and prevent future wrongs.

I also wish to take this opportunity to publicly thank Assistant United States Attorney Al Balboni and Special Agent Joseph Martin of Health and Human Services for the confidence they have placed in me during the course of my continued cooperation.

Finally, I wish to publicly apologize to this body and, most of all, to the American taxpayers. I am now prepared to answer any questions the Members of the Committee may have. Thank you.

Chairman BOUSTANY. Thank you, Mr. Odelugo. We appreciate your testimony.

[The prepared statement of Mr. Odelugo follows:]

PREPARED TESTIMONY OF AGHAEGBUNA ODELUGO
BEFORE THE HOUSE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON OVERSIGHT

Mr. Chairman and Members of the Committee:

It is with profound humility, and deep gratitude for this opportunity, that I come before the Members of the Committee today to provide testimony on the pressing issue of Medicare fraud in the durable medical equipment (DME) sector of the healthcare services industry. My name is Aghaegbuna "Ike" Odelugo. I am from Nigeria and came to the United States in 1998 with the sincerest of intentions to eventually acquire my master's degree. Instead, beginning in 2005 and extending to 2008, I engaged in a business that presents unique opportunities for fraud and abuse. I am speaking of the DME sector of the healthcare services industry. I engaged in fraud and abuse in this industry. I participated with others in fourteen different companies reaching eleven different states.

DME fraud is incredibly easy to commit. The primary skill required to do it successfully is knowledge of basic data entry on a computer. Additionally required is the presence of so-called "marketers" who recruit patients and often falsify patient data and prescription data. With these two essential ingredients, one possesses a recipe for fraud and abuse. The oven in which this recipe is prepared is the Medicare system. This system has a number of weaknesses which are easily exploitable and of which I shall speak more. This is a non-violent crime and is often committed by very educated people, including business people, hospitals, doctors and administrators. It reaches across all ethnic and racial lines. It relies on an often unsuspecting victim base of Medicare recipients, elderly citizens who long for attention and care, who simply want someone to talk to. It also, at times, involves patients who willingly participate in the fraud.

DME providers who engage in this type of fraud either do their own billing or outsource the billing to persons such as myself. In my own experience, I dealt with fourteen DME companies and did their billing. I often dealt directly with marketers who provided patient referrals, most of them fraudulent. I also dealt with physicians who knowingly participated in this fraud by knowingly writing prescriptions when they knew they were not medically necessary or, at times, writing prescriptions for patients they never saw. I have cooperated for over two years with federal law enforcement authorities and my cooperation has resulted in the arrest and prosecution of numerous individuals in many states as well as ongoing investigations in other states. I am not here today to appear proud of what I have done, yet I want the Members of the Committee to understand that I have done everything humanly possible to correct my past

wrongs. The opportunity to testify today before this Subcommittee is something I am very grateful to be able to do.

DME providers often maintain an appearance of legitimacy by billing for a percentage of legitimate claims. These legitimate billings, in my own experience, constituted approximately 40% of all billings. The appearance of legitimacy, however, is maintained to allow the furtherance of the fraudulent activity. This further complicates the ability of law enforcement to uncover this type of fraud. It also permits the offender to rationalize his or her fraudulent activities.

I humbly submit that Congress can, and should, implement certain changes to the Medicare reimbursement system that will, in my opinion, eliminate up to 70% of certain types of DME fraud. I shall now elaborate on what I perceive to be some of the more easily exploitable areas of the Medicare reimbursement process.

FORGED PRESCRIPTIONS

Much DME fraud is perpetrated by marketers and providers who submit claims for reimbursement based on forged prescriptions by doctors. A person engaging in this fraud will typically purchase a forged prescription from a marketer for a price determined by the amount the person anticipates earning. Usually this would be an amount of 15% to 20% of the anticipated profit. The claim is submitted to Medicare electronically. Medicare then reimburses the claim and the illegitimate profit is earned. What is missing, however, is a bill from the "physician" who rendered the medical services which resulted in the writing of the prescription. Medicare should implement a system that cross-references electronically each claim for equipment reimbursement with the parallel claim from the physician for reimbursement for the medical services provided. In this manner, forged prescriptions will be more readily detected. Doctors bill for their services. This is how they get paid. It will be rare for a doctor to not bill for his or her services. Once the bill from the doctor is received, it can be electronically cross-referenced with the claim submitted by the DME provider. If Medicare does not receive a bill from the physician for the service, then the claim from the DME provider should be denied.

MULTIPLE BILLING CODES

Medicare maintains a system of multiple billing codes for essentially the same piece of medical equipment. As an example, a wheelchair may have four or five different codes with only minor differences underlying each code. A fraudulent DME biller may submit a claim for a particular wheelchair and that claim will be denied because Medicare already has a flag on the particular code due to excessive usage in a geographic region. The biller can then simply resubmit the claim using another code that in reality reflects only a minor difference in the equipment, for example a safety strap rather than a seat belt. Medicare should move toward a more standardized billing code system that would eliminate the ability to do multiple billings for

the same item. Alternatively, Medicare should put into place a method of detecting multiple billings for rejected claims.

Both the example of forged prescriptions and multiple billing codes are exploitable defects in the system that can be corrected with software programming. Because the system is interfaced by the biller electronically, a change in the program at Medicare to automatically cross-reference physician and DME provider billing, as well as cross-referencing multiple code entries for the same equipment should be implemented.

PHYSICIAN UPIN

Physicians are given a "unique physician identifier number" (UPIN) to prove that the physician is who he/she claims to be. These numbers are readily available to the public online. The UPIN can be a useful tool for a fraudulent DME provider to exploit. The UPIN is necessary to facilitate the electronic transmission of the claim to Medicare. Astonishingly, UPIN's are accessible to anyone who knows where to look for them on the internet. These critical identifiers should be kept secure by Medicare. As this statement is being written, I have looked up the UPIN's of several doctors simply to illustrate to the Members of the Committee how easily accessible this critical information is. Again, this information should be secure by law. Doing so would frustrate the efforts of many healthcare providers who engage in fraud.

MEDICARE PROVIDER NUMBERS

One of the easier things to acquire in the DME fraud arena is a Medicare provider number. There are a number of persons engaged in DME fraud that have criminal backgrounds or who are under indictment yet they still get Medicare provider numbers. I have personally witnessed persons with criminal backgrounds receive approval for a Medicare provider number. This entire process should be more strictly enforced and background investigations should be conducted on all applicants.

BONDED DME

There should a probationary period for any DME provider for one to two years during which they would be required to be bonded by an independent bonding company. Such bond requirements are not unusual in the context of government contracting. In the DME business, because of the high volume of Medicare claims, the DME provider is, in essence, a modified government contractor. Imposing the requirement of a bond would weed out those who wished to enter the market for a "quick hit" and then close shop after a year or so. It would also share some of the burden currently on the shoulders of Medicare to investigate DME start-ups. Finally, it would provide a safety net to Medicare and the American taxpayer in the event fraud was detected in the early stages of the operation of the business. The legitimate DME provider should have little difficulty in complying with Medicare's regulations and, following a reasonable period of time, would become "certified" and no longer need to be bonded.

QUARTERLY SUBMISSIONS

A practical tool which Congress could implement in the Medicare system and which would both discourage fraud and lead to its early detection is a requirement that DME providers submit, on a quarterly basis, their paperwork for review. These documents could be scanned and submitted electronically and then randomly audited. This, of course, would be a substantial expense. However, given the magnitude of healthcare fraud in the United States, this cost of such random auditing would be minimal in relation to the overall savings to the American taxpayer. No DME provider engaging in fraud believes that he or she will ever have to have the actual paperwork they maintain reviewed by the government. They all believe that a physical inspection of their business will never happen to them. Requiring the submission of paperwork, even with the knowledge that it may not be randomly selected, is a powerful disincentive to engage in fraud. At this time, there is no requirement that paperwork be submitted.

RATES OF REIMBURESEMENT

I would like to finally talk about what I perceive to be the most significant flaw in Medicare: the rates of reimbursement. I do not know who decides, or how the decision is made, but the rate of reimbursement for certain pieces of durable medical equipment is beyond exorbitant. An example is the case of the knee braces. These items are available on the market to a DME provider for less than $100.00. Medicare, however, reimburse, if I remember correctly, approximately 1,000% of this cost. Back braces that cost approximately $100.00 are reimbursed at a rate of almost 900%. Wheelchairs that cost less than $1,000.00 are reimbursed at almost 500% of cost. For anyone engaging in fraud, these numbers are too good to be true. It defies logic to believe that a system like Medicare can reimburse at these rates and not attract a great deal of fraud.

I have not mentioned the issue of corrupt physicians, of whom there are many. I have personally worked with physicians who have taken kickbacks in the form of payment for prescriptions. I know that some of these physicians have been arrested and prosecuted and others have not. It is difficult for me to make recommendations regarding physicians because, frankly, if a doctor is going to be corrupt, there is, in my opinion, little that can be done to stop them. However, if the doctors are checked for their billings and spikes in certain types of equipment are found to exist, this should raise a flag for investigators. Additionally, I have encountered doctors who have written fifty prescriptions on the back of a car in a parking lot simply to make some quick cash. When confronted, they have stated that their signature was forged. Implementing the recommendation above regarding cross-referencing of physician billing to DME billing would contribute to eliminating this practice.

Mr. Chairman and Members of the Committee, I want to again thank you for allowing me the opportunity to address the Subcommittee on Oversight. I sincerely regret my actions over the past years and today's testimony, I hope, will be understood as part of a continuing effort on my part to help in any way I can to correct my wrongs and prevent future wrongs. I also wish to take this opportunity to publicly thank Assistant United States Attorney Al Balboni and Special Agent Joseph Martin of Health and Human Services for the confidence they have placed in me during the course of my continuing cooperation. Finally, I wish to publicly apologize to this body and, most of all, to the American taxpayers.

Thank you.

Chairman BOUSTANY. Ms. Ignagni, in your testimony you mentioned the possible negative impact of the medical loss ratio rules

on a private insurer's anti-fraud efforts. Could you elaborate more on that? What will happen if this rule is fully implemented, and what the impact will be on your efforts or your private insurer companies, their efforts to conduct anti-fraud activities?

Ms. IGNAGNI. Thank you, Mr. Chairman. We appreciate the opportunity to speak more about this. Essentially what the MLR requirements involve in a very direct way is that it allows plans to categorize expenditures for health care quality activities. What is not included in the quality activities are two buckets, basically. Number one, credentialing of providers. Dr. Budetti talked, I think very effectively, about the importance of that being added to government programs. We agree with that. We have pioneered those techniques. We are not allowed to account for those under quality in the present recommendation that was submitted by the NAIC to the Department of Health and Human Services, number one.

Number two, also the preventive aspects that I talked about and Mr. Saccoccio talked about; the data mining, the predictive modeling, the early detection prevention that now the Department is working very hard also to incorporate into their public programs, again, important activities underway at HHS. We have had those activities underway for very, very many years and have been very successfully undergoing and engaging in programs and efforts. So we flagged that both for the NAIC, we flagged it for the Department, and we wanted to flag it today as the committee is focusing on the progress that is being made now in public programs, particularly incorporating these very techniques. It is penny-wise and pound-foolish, essentially.

Chairman BOUSTANY. So in addition to that, both you and the panel before you talked about the importance of public-private partnerships.

Ms. IGNAGNI. Yes, sir.

Chairman BOUSTANY. And if this rule goes forward, it really hurts your ability to conduct anti-fraud activity at a time when we are trying to enhance and move forward on these collaborations between the private sector and the public sector. Is that correct?

Ms. IGNAGNI. The incentives are, as you have correctly stated, now under the recommendations that were made originally by the NAIC, and there was considerable discussion about that here. It is only for the pay-and-chase situation. And that is precisely what everyone wants to get away from and what our plans have worked very, very hard to actually not only think about executing programs but actually operating programs very effectively and very successfully.

And as you heard from Mr. Morris who spoke very effectively about this as well, we are now turned to by law enforcement agencies for help in their activities, and are very effectively doing that.

Chairman BOUSTANY. Mr. Saccoccio, do you want to comment on that as well?

Mr. SACCOCCIO. Yes. You know, we feel that if you look at the Federal side, a lot of resources have been put into anti-fraud efforts. And the President's budget I know asks for an increase of discretionary funding for the health care fraud and abuse control program. There are additional fundings in the Affordable Care Act. It doesn't make sense to put all those investments on the Federal

side and then create a rule that is really a disincentive for private plans to invest in the type of preventive-type techniques that you want to use to go after fraud.

Chairman BOUSTANY. It runs counter to the whole effort, it seems.

Mr. SACCOCCIO. That is correct.

Chairman BOUSTANY. Okay. Thank you.

With regard to the interaction between private sector and public, when a private insurance company highly suspects fraud or actually detects fraud, you do contact CMS to notify them, right? Most of the time or all the time?

Ms. IGNAGNI. The first place that normally this contact is made is law enforcement. Oftentimes there are criminal cases that our plans suggest and expect based on what they are seeing in their data. So oftentimes that is the first place.

Increasingly, Mr. Chairman, there will be this exchange of information now with the new activities that are being built in the public sector. We have similar kinds of activities. So it is easier to go back and forth. And there has been a great deal of communication both in Mr. Saccoccio's association as well as with law enforcement directly. We think there is an opportunity—more opportunity for information-sharing from law enforcement to the private sector, when there is a case that has been opened, to more routinely share information. And we think that there needs to be some clarification in that regard to make sure that agents are aware that that is permissible and that they can do that.

Chairman BOUSTANY. So you still are encountering some barriers there whereby a Federal agent may not feel comfortable cooperating or collaborating with——

Ms. IGNAGNI. In some cases. We think there is just an opportunity for clarity here and there could be more consistency and more uniformity of practice.

Chairman BOUSTANY. And if you have further suggestions specifically on how we might do that, you might bring it forward to the committee.

Ms. IGNAGNI. Thank you, sir.

Chairman BOUSTANY. Thank you. Mr. Kind, you may inquire.

Mr. KIND. Thank you, Mr. Chairman. And I thank the panelists for their testimony here today. Karen, let me continue with you for a second. You said first referral goes to local law enforcement for follow-up and possible prosecution. Have you found that they have the level of competency or expertise in order to pursue these investigations?

Ms. IGNAGNI. It is a very good question that you are posing. And it really depends on the issue at hand. This is a very important question. In some cases they are very active—we had a case recently where one of our special fraud investigative units found that they were being billed for phantom procedures by infusion clinics that weren't providing services to anyone. They were just being billed. And they noticed that in the data because they noticed an uptick from what was going on usually in the community. So it caused them to ask questions and so on.

That is fairly straightforward in terms of how that compares statistically with norms. If you have certain overutilization of proce-

dures which are very clinical, very high tech, we have found now that there is a great deal of activity going on in law enforcement to make sure that they are getting the kind of medical expertise that Mr. Morris talked about, frankly, with the medical director being involved in the OIG activities. There is quite a lot of that going on.

And I know Mr. Saccoccio has far more experience than I do. So I am happy to yield to him, Mr. Kind, for more explanation about this.

But generally we are finding that in our units, we have staffed them with people who know about law enforcement, people who are clinicians, people who know about pharmacy, and people who are statisticians. And that served our plans very, very well, to have a full panel of techniques they can deploy.

Mr. KIND. Mr. Saccoccio, do you have anything to add?

Mr. SACCOCCIO. Mr. Kind, one of our goals and one of our missions at NHCAA is to educate investigators about fraud. So we probably educate between 150 to 200 FBI agents every year, about 50 to 70 IG agents every year. So that that is an important part of what we do, too, and that was the concept behind this public-private partnership. And when this education takes place, it is both private and public investigators coming together, sharing their experiences, sharing what they know, their best practices. And that is really critical.

So I think we are seeing that. For example, the FBI and the IG does have that expertise. As they bring in new agents, we take them into our programs, educate them about what they need to know, because you are dealing with coding and medical jargon and those kinds of things that you know, say, maybe a new FBI agent isn't aware of. But I know the agency is very good about getting their agents trained, and we do a lot of that with them.

Mr. KIND. Karen, if we eventually move from fee-for-service to fee-for-value reimbursement, is that going to have any impact on anti-fraud measures?

Ms. IGNAGNI. This is also a thoughtful question. I heard you pose it to the last panel. I think, Yes, but. Let me just tell you the "but" I was thinking when I was sitting back there listening. What we are seeing in some of our fraud units also is when you go to bundling of payments and you have more integration, there are new skills that are required to make sure that we are not seeing up coding in that situation. So, yes. But I want to provisionally say that there are new skills and tools that we are already deploying to make sure that we can spotlight problems.

Also moving from the ICD–9 to ICD–10 coding system, you are going to be creating thousands of new codes. We are very concerned about upcoding there as well. So we will be deploying new skills to make sure we are spotlighting that early.

Mr. KIND. And what about the build-on on the HIT systems and the integration of those systems? Is that going to enhance data collection?

Ms. IGNAGNI. It has in our case. What we have seen is just the investment that we have made in infrastructure in HIT, has really allowed the statistical tools to be deployed. They are very sophisticated and you need the right kinds of personnel to operate them,

obviously. But this investment in IT allows that to move much faster.

In the old days we used to be looking at clinical charts. Now we are looking at data and we can look at reports and we look at statistical profiles, frankly, of areas and different practitioners.

Mr. KIND. Thank you. I have to go run and vote.

Mr. GERLACH. [Presiding.] Let me follow up on some of the points you made in your testimony. And you see members moving off of the dais here because we had a vote series called about 15 minutes ago, so that is why they are running over to the floor and voting and then some of them are coming back as well, given the space that we have between a couple of the votes. So we would like to try to conclude the hearing today, and hopefully we can do that with your continued testimony here over the next few minutes.

Mr. Odelugo, if I may go to you, sir. Thank you for testifying today. And thank you for your insights. We heard from the other two presenters on the panel with you, some of their more systematic views of what is happening with health care fraud, their experiences out there in the system from a systematic standpoint.

You were very much involved in fraudulent activity through your individual activity and those of those you partnered with. You said in your testimony that it was incredibly easy to commit fraud, and as a result you billed the system for over $1 million, if our information is correct. Is that accurate?

How long did it take you to put in place the plan of action that you engaged in, getting other folks to participate with you to the point where you were able to make claims and ultimately collect over $1 million in Medicare reimbursement payments?

Mr. ODELUGO. It didn't take me that long. It was just a matter of understanding the system.

Mr. GERLACH. I am sorry. Say that again?

Mr. ODELUGO. I said it didn't take that long. It was a matter of understanding the system and setting up the structures. Not more than a month.

Mr. GERLACH. Okay. The people you worked with in this process, in this scheme, how did you approach them? And how willing were they to participate? Because, obviously, they were going to make money out of this scheme that they shouldn't have been making. Was it pure greed? Or what was it that got you to entice them to participate in this fraudulent activity?

Mr. ODELUGO. Basically I didn't approach them. I found—well, like I found a loop in the system where I could bill for some things on a patient—maybe out of a patient bill up to $4,000, $5,000. And I kind of set up a billing system. Where most of them were interested in billing for wheelchairs, I was concentrating on billing for these ortho-kits. And they couldn't figure it out on how to do it. So most of them had to come to me to bill for their provider services.

Mr. GERLACH. Was there somebody that gave you this idea initially to participate in this activity? Or did somehow you decide, you have accessed physician identifier numbers on the computer and figured out how to move forward?

Mr. ODELUGO. No. Just like I heard your last question you were asking about the knee brace. My understanding, the cost of the back brace which was about $960, against $80. And then, you

know, from there, I started getting into more of it. Then I got to know about the hinged knee braces. All of this is right in the computer. You go online, you can see them and how much they pay for it. And you just get the correct code and bill it. That is all it takes.

Mr. GERLACH. Okay. Ms. Ignagni and Mr. Saccoccio, have you had an opportunity to read the Affordable Care Act's anti-fraud provisions that were enacted in this law? And if so, what is your overall sense of how effective they might be? Or what other recommendations would you have that are not included in those provisions that we ought to be looking at making into law to try to really address the fraud and waste and abuse problems that we have?

Mr. SACCOCCIO. The anti-fraud provisions in the Affordable Care Act I think are going to be effective, with respect to the screening, as Dr. Budetti and Mr. Morris spoke about earlier. Screening, the moratorium, bringing in certain classes of providers, given the circumstances, the Secretary's ability to suspend payments when there is a credible allegation or credible evidence of fraud. All those things I think are good things.

The additional resources as far as money that is there, I think also obviously is a good thing, especially given the return on investment that you get. It is unlike maybe some other Federal spending. This is money that you put in, that you get back a nice return on investment.

As far as other things, I think there is—as CMS goes forward and develops their analytical tools, their data analytics, to the extent that they are able to share that information with private insurers, I think that would be very helpful. In other words, as they, say, get into the 21st century with respect to looking at Medicare data, as they begin to find trends and schemes, to be sure to share that with the private side. I mean, we do a lot of that now. But I think it is going to be important as they—because they have probably the largest group of data than any—the other private insurers obviously are divided up, you know, by company. Here with Medicare, to be able to get that information that they develop based on those analytics, I think would be very helpful and critical once they are able to do that.

Mr. GERLACH. Ms. Ignagni, do you agree?

Ms. IGNAGNI. I agree with Mr. Saccoccio. And I think further that one could provide more clarity about the sharing of information so that particularly law enforcement agents know that that is permissible.

Second, I do believe that there should be more thought to this issue of having safe harbors for health plans that actually provide information to State insurance commissioners, provide information to law enforcement, to the agency, to make sure that it is very clear that that is permissible and there will not be countersuits from providers who are at the other end of that information.

And then I do believe that in the area of restitution, it should be more routine that the private sector is included in those restitution agreements and efforts. And then finally the MLR, sir.

Mr. GERLACH. I will yield back to the chairman. Thank you.

Chairman BOUSTANY. [Presiding.] The chair recognizes the ranking member of the subcommittee, Mr. Lewis.

Mr. LEWIS. Thank you very much, Mr. Chairman. And welcome. Thank you for your testimony. I have had an opportunity to read over it.

Mr. Odelugo, we understand that you have been cooperating with law enforcement for over 2 years. Why did you initially get involved with Medicare fraud? And why have you chosen to come forward? What moves you? What suggested to you to cooperate, to come forward?

Mr. ODELUGO. Before I came forward, I really stopped doing it. I stopped doing that in December of 2007 when I knew there was an ongoing investigation on me. So I approached my attorney right here, and he advised me that the best thing for me to do was to come forward and get them to know me and talk to me. And that is how I got to turn myself in. And from then on, I started cooperating with them, based on their suggestion.

Mr. LEWIS. Do you have any regrets? Would you tell others that may have the desire, the urge to participate in defrauding Medicare or some other Federal health program, suggest to them that this is not the way to go?

Mr. ODELUGO. I have been doing that already.

Mr. LEWIS. All right. I appreciate that.

Mr. Saccoccio, on your Web site, you warn consumers about a new scam involving health care. What are the types of scams you have seen to date? What tips do you give consumers?

Mr. SACCOCCIO. I think probably if I had to pick the one top scam, it would be identity theft. And that is not just identity theft where person A steals person B's identity in order to get health care, but large-scale identity theft that occurs in Medicare and Medicaid, regrettably on a regular basis, where folks on the inside that is somebody, say, working at a clinical laboratory or a hospital, decides that they are going to take this information and sell it on the outside. So folks could still make false claims. Sometimes the information is obtained through misrepresentations, phone calls where seniors are fooled into giving their information over the phone.

So I think the biggest one right now is medical identity theft. And the biggest recommendation we give to consumers is to protect your health insurance information, whether it be Medicare, private insurance, whatever it happens to be. Make sure you protect that just like you would a credit card, your Social Security number. Just do not give that information out to anyone on the phone unless you particularly know who you are speaking to. So I think identity theft is really the biggest one.

And the other hot areas that we have seen I think are similar to Medicare. It has been DME. It has been home health care. It has been infusion therapy. And the other one, community mental health centers, are now I think becoming a challenge as well. But you know, from a patient and a consumer perspective, I think identity theft is the number one thing they need to look out for.

Mr. LEWIS. Thank you. Ms. Ignagni, I understand your members have experience in analyzing claims and they are using this to predict fraud. Based on their experience, what recommendation or best practice will you share with us and CMS?

Ms. IGNAGNI. I think, sir, that CMS now is in the process of adopting exactly the kinds of tools and techniques that we use. It is called in statistical terms "predictive modeling," software packages that actually detect anomalies in data. In other words, in a particular area, there are patterns of practice. When you see in the data that a particular physician, a particular pharmacy, a particular area, is up significantly or we have seen situations where physicians are billing over 50-some patients in a day, that would be an anomaly that this software would flag.

We have been very pleased that CMS now, and the Department, is adopting the same kind of tools and techniques, and they work very, very well to really give you that early intervention and that kind of emphasis on prevention so you want to detect fraud before any claim is paid.

It is much harder when you are paying and chasing, and it is much better when you can do this earlier on. And that is where we have really focused a great deal of our activities. And, frankly, that was the model on which there was a lot of discussion last year, and now the Department is actually operating those same skills.

Mr. LEWIS. I just want to thank you for being here and for your testimony. Mr. Chairman, thank you for holding this hearing.

Chairman BOUSTANY. Thank you. Ms. Jenkins, you may inquire.

Ms. JENKINS. Thank you, Mr. Chairman. And I, too, want to thank you for this hearing and thank you all for your testimony.

Ms. Ignagni, as you are aware, the Medicaid program was designated as high risk by the Government Accountability Office in 2003 and Medicare has been designated that way since 1990. In the last update on these high-risk programs back in February of this year, GAO states that CMS has not met their criteria for having the Medicare program removed from this list. And while they have implemented certain recommendations for Medicaid, more Federal oversight of the fiscal and program integrity is needed. The new health reform law expands eligibility to both of these programs.

So, could you just please address how this will affect your Association's ability to reduce fraud over an even larger population and pool of taxpayer dollars?

Ms. IGNAGNI. What our plans have done is actually pioneer a number of different practices which are very, very important. First, credentialing. We have put a lot of resources into making sure that physicians have the qualification that patients expect, that they are licensed, that they don't have malpractice efforts, that they have not been convicted of fraud, et cetera. They just go down the line. Those are very robust activities that we have worked very, very hard to make sure as we are putting together panels of practitioners, clinicians, that we can guarantee to our beneficiaries that we have executed those processes, number one.

Number two, the whole area that the chairman was inquiring about a few minutes ago in terms of how do you step back and prevent fraud, getting the statistical packages operating with—they are called SIUs, special investigative units, with clinicians, with statisticians, with pharmacy experts, with law enforcement experts, so that you can look at what we are seeing in the data; where are

their hot spots, if you will; where is there trouble? What needs to be done? We flag claims and then we do further investigations. So that is on the front end.

Also, when payments are made, there are similar processes that are executed to make sure you are following those; if we have missed anything, to make sure that we are catching it also on the back end. Similarly for pharmacy, in the area of pharmacy, we have found clinics that are prescribing pain medications. There have been a number of efforts to shut those clinics down, detect them, et cetera. There has been a great deal of work between our health plans and law enforcement and public officials to do exactly that. And you will see that expanding.

Infusion, as Mr. Saccoccio said, we have seen a very, very significant uptick in problems related to infusion; clinics springing up, billing, and no patients behind those bills. So we have worked very hard to put in place practices that will detect that.

Unnecessary procedures that can be life-threatening for patients. We have seen situations where physicians have operated on patients who didn't need those operations. Or in some cases people weren't qualified to actually practice the services they were providing. So unnecessary services, a very, very big area. I must say, of course, that the majority of physicians, of course, are upstanding, ethical individuals. But there are some bad apples. So our tools and techniques are designed to detect those.

We worked very closely with Mr. Saccoccio's Association that has brought together health plans, law enforcement, and public officials to share this kind of information. Mr. Saccoccio does a great deal of training, as he indicated, which is very, very important to make sure that all sides have access to the best practices that work and that work effectively.

And now that the public agencies have adopted the practices of private sector plans, then I think there is reason to be very, very hopeful about the ability to do even more to share information under the auspices of Mr. Saccoccio's Association and the activities that are underway at the Department that we heard about earlier.

Ms. JENKINS. Okay. Thank you.

Ms. IGNAGNI. Sure.

Ms. JENKINS. Ten years ago, back in Kansas City, we had one of the most horrendous cases of health care fraud that I ever heard of. A local pharmacist was convicted of diluting nearly 100,000 prescriptions for 4,000 patients. His profits came from diluting expensive chemotherapy medications. A local pharmaceutical sales rep was the first one to suspect foul play. He discovered that pharmacist was selling more of a specific drug than he was purchasing from him. He worked with a doctor who used this pharmacy and the local authorities to bring charges against the pharmacist.

Mr. Ignagni and Mr. Saccoccio, you both mentioned the need for more public-private cooperation to help combat health care fraud. The case I just mentioned was greatly assisted by private companies. Can either one of you elaborate on what else those of us in Congress can do to allow and encourage private companies to work with CMS and our law enforcement to reduce fraud in the system?

Mr. SACCOCCIO. Well, I think, as I mentioned, data analysis is going to become critical going forward. CMS is in the process of

looking for and putting in place the right type of system as far as predictive modeling for Medicare. I think it is going to be critically important as they develop these systems on the set of data that they have, which is an enormous set of data, that that data be shared, that what comes out of that data be shared with the private side.

It is critically important not just for the commercial side, but remember again the private insurers have Medicare Part C, Part D. They are doing Medicaid in the State. So there is a lot of tie-in both on the private side and public side in the public program. So I think that sharing of data is going to be critically important.

And then I think the other thing is, there is a commitment I believe on the part of the IG and HHS, CMS, and DOJ to share information with the private side. I think a lot of that information has to filter down to the agents in the field; that they need very specific guidance about what they can and can't do. And we have been working with Mr. Morris, with Dr. Budetti, and others to try to address that particular issue. And hopefully in the near future we are going to see some progress along those lines, too. Where agents are in the field though, okay, this is not only okay for me to do, it is something that I should be doing.

Ms. JENKINS. Thank you. We will look forward to working with you. I yield back.

Chairman BOUSTANY. One final question for you. Mr. Odelugo, how easy is it to get physician provider numbers in your experience and to file additional claims? You know, if you get denied, getting a different number and filing additional claims. Could you talk a little bit more about your experience with that?

Mr. ODELUGO. Thank you, Mr. Chairman. Basically to get a physician's UPIN number, you just have to go online and pick it out. It is public information.

Chairman BOUSTANY. So just go online and you can find these numbers?

Mr. ODELUGO. Yes. You just get it from there. You can even get the one that has the closest ZIP Code to wherever the patient lives, and you can input it on the system and transmit.

Chairman BOUSTANY. Is there a method to what provider numbers you would pinpoint? Do you look for those who perhaps may be licensed in multiple States versus just in a single location?

Mr. ODELUGO. Well most providers will want to get licensed in every four regions of Medicare. That way they can bill for any patient, depending on where they are. That is why if you look at my statement or my recommendations, I was trying to suggest that any claim that doesn't cross-reference with the doctor's billing for the services should not be paid. That way, providers cannot just turn in a claim without the doctor billing for the services of, you know, doing the prescription.

So try to implement it that way because most of businesses are done by the billers. Most billers know whatever is going on between the doctors and the providers. But they transmit the claims. If they can have it where they can get the billers to be held responsible for a little bit of whatever that is going on, that can help assist them.

Chairman BOUSTANY. Thank you. Mr. Lewis, do you have any further questions?

Mr. LEWIS. Mr. Chairman, I don't have any further questions.

Chairman BOUSTANY. Thank you. Well, that will conclude our questioning of the witnesses. I want to thank all of you for being here today and providing your testimony and answering questions of the members. I want to remind you that members may have some written questions they would like to submit later to you, and I would ask you if you would oblige and make those answers a part of the record.

One final thing, Mr. Ranking Member, Mr. Roskam, a member of the full committee, has a statement that he would like to submit for the record.

Mr. LEWIS. Without objection.

Chairman BOUSTANY. Without objection, so ordered.

[The information follows, The Honorable Mr. Roskam:]

Statement for the Record
Ways and Means Oversight Subcommittee Hearing on Improving Efforts to Combat Healthcare Fraud
Congressman Peter Roskam
03/02/2011

Chairman Boustany, Ranking Member Lewis, and Members of the Ways and Means Oversight Subcommittee, thank you for holding this important hearing on improving efforts to combat healthcare fraud. Last Congress, I was given the opportunity to testify before Ways and Means and Energy and Commerce Subcommittees on similar topics and I am thankful for the opportunity to submit a statement today. What differentiates this opportunity from similar hearings on this topic in the past is that the subcommittee is bringing together the private and public sectors to share strategies and ideas on fraud mitigation.

Fraud permeates both private and public healthcare programs, but Medicare and Medicaid are especially susceptible to fraud due to their size and centralized administrative pricing structure. Fraudsters often jump between public and private programs and move from region to region to evade detection. A collaborative effort is necessary to gain a holistic view of the problem in its entirety. Private insurers have incentives and innovative strategies to prevent fraud and the Centers for Medicare and Medicaid Services (CMS) has the largest, most comprehensive claims database in the country. These services and resources are integral towards improving efforts to combat healthcare fraud and communication between parties is essential to any prevention and detection strategy. There is near unanimity from the witnesses that mitigation efforts need to move towards a more effective pre-payment strategy and I have been an advocate for by pushing predictive modeling and other innovative technology.

President Obama said at the State of the Union Address, "Let me be the first to say that anything can be improved. If you have ideas about how to improve this law by making care better or more affordable, I am eager to work with you." The House will take a major step towards improving the regulatory environment for businesses by repealing the onerous 1099 tax form reporting requirements of the healthcare law tomorrow. I propose improving efforts to combat healthcare fraud in a bipartisan manner and hearings such as this are an important first investigatory step towards that goal.

I welcome efforts by CMS to better measure Medicare fraud. The Health and Human Services/Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2010 said, "The purpose of the first research project is to begin the implementation of the determination of a baseline estimate of Medicare fraud. This involves developing and prototyping a methodology to estimate the total amount of fraudulent payments." Currently, the Administration has the Comprehensive Error Rate Testing (CERT) percentage but it is not a measurement of over- and under-payments, not fraud specifically. It is difficult to prescribe a solution to a systemic problem if one cannot fully comprehend the scope of that problem. This is a logical starting point.

Witnesses today will discuss the virtues of predictive modeling technology to better detect fraud before payments are made. On the first panel, CMS and HHS-OIG are realizing the potential benefits. In his testimony before the Ways and Means Full Committee earlier this month, CMS Administrator Berwick said, "CMS is currently integrating predictive modeling as part of an end-to-end solution that is transparent, measurable, and triggers effective, timely administrative actions. Innovative risk scoring technology applies a combination of behavioral analyses, network analyses, and predictive analyses that are proven to effectively identify complex patterns of fraud and improper payment schemes… CMS is very excited about the potential of new data analysis and prediction tools to improve the Agency's ability to prevent payment of fraudulent claims." Last fall, the HHS-OIG office testified, "We are committed to enhancing existing data analysis and mining capabilities and employing advanced techniques such as predictive analytics and social network analysis, to counter new and existing fraud schemes." However, this technology will first be applied post-payment. I do not want the technology to be implemented poorly or have high incidences of false positives, but I would like to see the technology applied pre-payment sooner rather than later in order to prevent reimbursement from leaving the Medicare Trust Fund. Post-payment review may help focus scarce enforcement resources, but pre-payment review will prevent the payments from going out the door in the first place. This is a much wiser solution. I will use my Congressional oversight responsibilities to ensure effective implementation, but want to serve as a resource to CMS as a partner in fraud prevention.

It works and needs to be effectively implemented. Predictive modeling is a process used in analytics to create a statistical model of future behavior that is used in industries such as financial services, utility companies, and retail for multiple applications including probability scoring assessments. Predictive modeling was utilized by the financial services industry in the early 1990s to model consumer behavior. Initially, there was a cultural resistance to implement predictive modeling throughout the industry. However, within five years, 80 percent of financial services institutions had implemented the solution. Fraudsters were flocking to institutions that had not adapted a predictive modeling strategy. The industry, which handles $11 trillion in transactions yearly, suffers only .047 percent in fraud thanks to a predictive modeling system that stops fraud and abuse at the point of sale. Fraud in Medicare accounts to closer 10 percent of payments. The technology works but needs to be moved quickly and seamlessly to the front-end of the claims process, before payment is made.

Before CMS embraced the technology, representatives from the second panel were utilizing analytics and advocating for wide adoption. The National Health Care Anti-Fraud Association (NHCAA) wrote me last year supporting my legislative efforts, "For the last several years NHCAA has been examining the value of prepayment medical claims review and we are convinced that this approach holds great promise… Many NHCAA members are beginning to devote additional resources to predictive modeling technology and real-time analytics and applying them to fraud prevention efforts on the frontend, prior to medical claims being paid. Put simply, stopping a fraudulent dollar before it goes out the door is inherently more efficient than trying to recoup that dollar after it has been paid." America's Health Insurance Plans (AHIP) recently surveyed

members and found they foresee more "modeling with analytics to identify aberrant claims earlier... eliminate pay and chase scenarios." The industry must work with CMS to integrate this technology into the Medicare claims database. Communication and collaboration are vital and it is necessary for the private sector to work with the federal government.

One problem inhibiting private sector adoption and development of predictive modeling and other fraud prevention efforts is the arbitrary medical loss ratio (MLR) requirements of the new healthcare law. These requirements limit investment and options for saving beneficiaries' premium dollars from fraud. In fact, the Congressional Budget Office (CBO) said that if the MLR levels were only five percentage points higher, "this further expansion of the federal government's role in the health insurance market would make such insurance an essentially governmental program." Even federal officials have repeatedly pushed for more funding to prevent fraud, insisting they would detect and prevent more of it from occurring, returning taxpayer dollars to the Medicare Trust Fund. Private insurers should not be limited in fraud prevention efforts.

Again, thank you for this opportunity to submit my comments. This is an important first step in what I hope to be a bipartisan healthcare fraud prevention effort. The American people are looking for Members of Congress to cut unnecessary spending with a projected budget deficit of $1.5 trillion. Preventing fraudulent payments before they go out the door is vital to the sustainability of public healthcare programs. Let's turn "pay and chase" to "pay quickly, but only if legitimate."

Chairman BOUSTANY. With that, we will conclude this hearing, and the hearing is adjourned.

[Whereupon, at 4:22 p.m., the subcommittee was adjourned.]

[Submissions for the Record follow:]

Academy of Managed Care Pharmacy, Letter

March 15, 2011

Academy of Managed Care Pharmacy
100 N. Pitt Street, Suite 400
Alexandria, VA 22314

The Honorable Charles Boustany
Chairman
Subcommittee on Oversight
Committee on Ways & Means
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Chairman Boustany:

Thank you for the opportunity to provide written comments related to the March 2, 2011, hearing entitled "Improving Efforts to Combat Health Care Fraud." The Academy of Managed Care Pharmacy (AMCP) is pleased to have the opportunity to suggest additional approaches to stemming the growth of Medicare fraud.

The Academy is a national professional association of pharmacists and other health care practitioners who serve society by the application of sound medication management principles and strategies to improve health care for all. The Academy's 6,000 members develop and provide a diversified range of clinical, educational and business management services and strategies on behalf of the more than 200 million Americans covered by a managed care pharmacy benefit. Various of the Academy's members work within managed care organizations to prevent Medicare fraud in the Medicare Part D drug benefit.

Federal and private-sector estimates of Medicare fraud range from three percent to 10 percent of total expenditures, amounting to between $68 billion and $226 billion annually. HHS Secretary Sebelius said "When criminals steal from Medicare, they are stealing from all of us."[1] The substantial size of the dollars lost annually in fraud, waste and abuse in Medicare Parts A, B, C and D have prompted Medicare fraud to be one of the federal government's top priorities. Fraudulent activity within pharmacy benefits can take many forms, including patients acquiring prescriptions under false pretenses, providers writing illegitimate prescriptions and the trafficking of counterfeit drugs.

First, the Academy strongly supports the premise of stopping the cycle of "paying and chasing" fraudulent activity. The Academy appreciates the inclusion of Section 6402 in the Patient Protection and Affordable Care Act, P.L. 111-148, (the Affordable Care Act) that permits the Secretary to suspend payments to a provider of services or supplier under Medicare Parts A and B, pending an investigation of a credible allegation of fraud against the provider of services or supplier, unless there is good cause not to suspend the payment. Pursuant to this provision, the Secretary is required to consult with the

[1] Gebhart, F., *"CMS Launches Anti-fraud Program," Drug Topics*. December 2009.

Inspector General of the Department of Health and Human Services in determining whether there is a credible allegation of fraud.

The Academy strongly recommends that the Committee consider legislation that would extend the authority in the Affordable Care Act to suspend payment of claims wherein there is a credible allegation of fraud in Medicare Part D. Such legislation should provide for an expansion of time in which managed care organizations pay claims believed to be fraudulent. Further, AMCP recommends that Medicare Part D be included in the law by extending to the Secretary and/or Office of Inspector General the authority to suspend payments through the existing managed care organizations in instances of fraud.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) adopted a reduced period in which prescription drug plans (PDP) are required to pay pharmacies. As a result, Part D plans are limited to a retrospective analysis of pharmacy claims and provider payment trends which are primarily directed at administration errors, e.g., coding errors, etc.

Generally, a seven to 10-day payment cycle is required to meet MIPPA's 14 day "prompt payment" standard. For instance, a two-day time period between the end of a payment cycle (run on day 11) and the production of payment (run on day 13) obviates any significant prospective opportunity to conduct analysis of claims and reimbursement data prior to payment being sent to the pharmacy provider. As a result, Part D plans must rely on a "pay and chase" approach to recovering suspected fraud once proven. One plan's experience is that since 2006, approximately 9% to 12% of retrospectively reviewed claims have been deemed outliers and warranted additional scrutiny and investigation. Some of the metrics used by managed care organizations in a retrospective analysis include the following:

- Pharmacy provider reimbursement spikes relative to peers per payment cycle
- Increased brand drug dispensing, relative to generic drug dispensing (compared to peers)
- Increased dispensing/reimbursement of targeted high cost therapeutic classes or therapeutic classes with street value on the black market, i.e.:
  - Controlled substances
  - HIV drugs
  - Injectible specialty drugs
- Geographic prescription claim volume per capita, as compared to peers

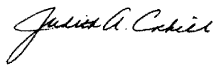
Second, the Academy appreciates the expanded data matching provisions provided for in Section 6402(a) of the Affordable Care Act. Section 6402(a) expands the "Integrated Data Repository" (IDR) at CMS that will incorporate data from all federal health care programs, including Medicare Parts A, B, C and D; Medicaid; CHIP; health-related programs administered by the Secretary of Veterans Affairs; health-related programs administered by the Department of Defense; Federal old-age survivors, and disability insurance benefits established under Title II of the Social Security Act; and the Indian Health Service and the Contract Health Service program. This provision establishes the ability to create a comprehensive database that reflects all claims involving federal government programs.

The Academy submits that it may be useful to link the claims data compiled in the IDR with the data compiled by the Medicare Drug Integrity Contractor (MEDIC) reporting infrastructure. The MEDIC database contains reports of fraud from private sector managed care organizations. To end the cycle of "paying and chasing" fraudulent activity, it will be important to ensure that there is a two-way communication of information between the public and private sectors with regard to fraudulent activity.

Fraud, waste and abuse are unacceptable within any health care program, especially within health care programs that are financed through taxpayer dollars. In a time of diminishing financial resources, it is more important than ever that Medicare providers, including Part D plan sponsors, are effectively able to combat suspected fraud. AMCP recognizes the seriousness of this problem and is supportive of efforts that would reduce the instance of fraudulent activity.

The Academy would be pleased to work with you to develop legislative language that addresses fraudulent activity in the Medicare Part D drug benefit. Thank you again for the opportunity to provide these written comments. Please do not hesitate to contact Lauren L. Fuller, Director of Legislative Affairs, at 703-683-8416 or lfuller@amcp.org if we may be of further assistance.

Sincerely,



Judy A. Cahill
Executive Director

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cc: The Honorable John Lewis
Ranking Member

Prepared Statement of Apria Healthcare

APRIA HEALTHCARE®

House Ways and Means Committee
Oversight Subcommittee Hearing on
"Improving Efforts to Combat Health Care Fraud"
March 2, 2011

Statement for the Record

Prepared by
Apria Healthcare
26220 Enterprise Court
Lake Forest, CA 92630

Introduction

We are writing to provide formal comments related to the House Ways and Means Committee Oversight Subcommittee hearing scheduled on Wednesday, March 2, entitled, "Improving Efforts to Combat Health Care Fraud." Apria Healthcare is a national provider of home respiratory, specialty infusion therapy and medical equipment services with a long history of serving both Medicare/Medicaid and commercially insured patients across the United States. With over 11,500 employees and 500 locations, Apria serves over two million patients' homecare needs annually throughout all 50 states. Accredited for all service lines for over 20 years, Apria Healthcare was the first provider of durable medical equipment and respiratory services to voluntarily seek and obtain accreditation.

With a comprehensive corporate compliance program in place for over a decade, which incorporates the Health and Human Services Office of Inspector General's (HHS/OIG) Guidelines for Healthcare Organizations, Apria has been a leader in strengthening the industry's overall compliance and anti-fraud and abuse efforts. For example, Apria has used its longstanding experience to offer specific recommendations to both Congress and the Centers for Medicare and Medicaid Services (CMS) and to lead the development of new, comprehensive Codes of Ethics for the two primary trade associations dedicated to the DMEPOS and home infusion segments of homecare.

Anti-Fraud and Abuse Efforts Play Key Role But Current Investments Are Misdirected

Apria strongly agrees with the need to reduce the amount of fraud, waste and abuse in the healthcare system and to prevent such fraud from occurring in the first place. We also recognize that audits and fraud investigations are integral components of the government's efforts to ensure that claims are properly paid. Apria has therefore been extremely troubled by the recent auditing trend, which has unduly targeted legitimate providers, has been highly inefficient, inconsistent and administratively burdensome for both providers and the government, has impermissibly applied new auditing standards retroactively and has completely lacked transparency.

We refer specifically to auditing efforts through what is known as Medicare Zone Program Integrity Contractors (ZPICs). Over the last eight months, Apria has received over 5000 individual line-item audit requests, which represents triple the volume compared to the eight months prior. In the case of two of Apria's Florida facilities, the ZPIC in question sent out individual requests (an envelope containing three pages) for each of 1,500 dates of service – totaling over 4,500 pages or nine reams of paper just for two moderately sized branch locations. While multiple dates of service in question were for the same patient, the ZPIC did not request one set of paperwork pertaining to all dates of service for that particular patient. Instead, the ZPIC required Apria to submit individual responses for each date of service, resulting in our having to repeatedly submit all of the paperwork necessary to substantiate the claim for each date of service.

Incorrect Data Calculations and Error Rates Submitted to Congress

Especially troubling are the incorrect conclusions and error rates being calculated by the ZPIC, which are ultimately reported to the CMS Durable Medical Equipment Medicare Administrative Contractor (DMEMAC), CMS and Congress, and the questionable data requests being made by ZPIC auditors. Regarding the first point, the ZPIC reported to one of our branches that it had a 100 percent error rate, based on only six dates of service out of hundreds that had been requested and to which we responded on a timely basis, five of which the ZPIC incorrectly alleged that the paperwork hadn't been submitted. Examples of the questionable data requests made to one of our Florida branches include on-site inspectors requesting photographs of all of the Medicare patients we serve and a list of our current and ex-employees' Social Security numbers. No auditor in the history of Medicare audits has ever requested photographs of patients and no regulation requiring providers to obtain photographs of home-based patients exists, not to mention the fact that such a practice would potentially violate the government's own federal regulations concerning patient privacy (Health Insurance Portability and Accountability Act (HIPAA)). The on-site auditor commented verbally that it was clear that we operated a legitimate location which was properly licensed by the State of Florida, included a real warehouse, company-owned vehicles, obvious inventory and busy staff, making the request for current and ex-employees' Social Security numbers more curious indeed.

It is also important to note that during the five months in which the ZPIC conducted a medical necessity review, Medicare held payment on the audited product lines – a practice which has already had severe consequences for smaller providers who cannot withstand the adverse impact on their cash flow. Finally, when Apria brought this matter to CMS' attention, CMS did not participate in a substantive review and discussion of the claims at issue with Apria and the ZPIC but instead advised Apria to appeal the ZPIC's determinations on more than 1,000 dates of service, at significant cost to the government as well as to Apria.

A very high percentage of these appeals will likely be overturned by higher level administrative law judges (ALJs), thus supporting our point that certain aspects of the new audits represent a misapplication of anti-fraud and abuse funds that could otherwise be put to better use either in the area of real-time monitoring of brand new or rapidly-growing Medicare providers or in pursuing truly criminal or potentially criminal providers. Also, by the time the ALJs rule on the appeals, an incorrect error rate will have already been reported to various government officials, thus resulting in potentially misleading and incorrect conclusions, which are rarely, if ever, corrected.

Retroactive Application of Brand-New Auditing Standards is Contrary to Administrative Law Principles

In addition to the burdensome requirements being imposed by the ZPICs and erroneous audit results, Apria is disturbed that CMS' auditors are *retroactively* applying these new auditing standards, contrary to well-established principles of administrative law. The retroactive application includes claims for patients referred to service as long ago as a decade. By its very nature, a rule applies to *future* occurrences. CMS has clearly engaged in retroactive rulemaking with respect to many of its new medical necessity documentation policies and has imposed new documentation policies on claims upon pre- and post-payment review of which DMEPOS suppliers had no prior notice. This is exactly the type of retroactive rulemaking prohibited under *Bowen v. Georgetown University Hospital*, 488 U.S. 204, 208-209 (1988), and its progeny.

It also became clear during a series of conference calls we held with various CMS officials based in Florida and Baltimore that they were unaware of at least some of the ZPICs' practices, thus calling into question whether CMS is appropriately carrying out its oversight responsibilities with regard to its subcontractors' operating policies and procedures. This also leads to inconsistent practices among the various auditing bodies. CMS officials were surprised by some of the data requests being made by the ZPIC subcontractors and asked for more detail to be provided by us so that they could address the behaviors. Yet, most of these processes are not documented in writing anywhere in the Program Integrity Manual, Medicare Learning Matters, Medicare DMEPOS Quality Standards, Medicare DMEPOS Supplier Standards or any other guidance document.

Summary

We conclude by reiterating Apria's absolute support for proper use of Medicare resources to effectively combat fraud, waste and abuse. It is critical, however, that these efforts be rational, balanced and targeted on a "rifle shot vs. shotgun" basis so that legitimate suppliers with a long history of serving the Medicare program are not unduly burdened. As Dr. Peter Budetti said in an interview with Richard Shackelford, President of the American Health Lawyers Association, "Certainly one of our {CMS' Center for Program Integrity} biggest challenges is preventing fraud while not adversely affecting beneficiary access or our partnership with legitimate providers and suppliers" (p. 4, January 2011 issue of *AHLA Connections*). Moreover, in public testimony, the HHS OIG has stated on the record that "[inadvertent] errors do not equal fraud."

We urge Congress and the Centers for Medicare and Medicaid Services to provide needed oversight to the ZPIC process to ensure that real fraud, waste and abuse is targeted and ultimately eliminated.

Respectfully Submitted,

/s/
Lisa M. Getson
Executive Vice President
Government Relations and Corporate Compliance

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Prepared Statement of Dream Software

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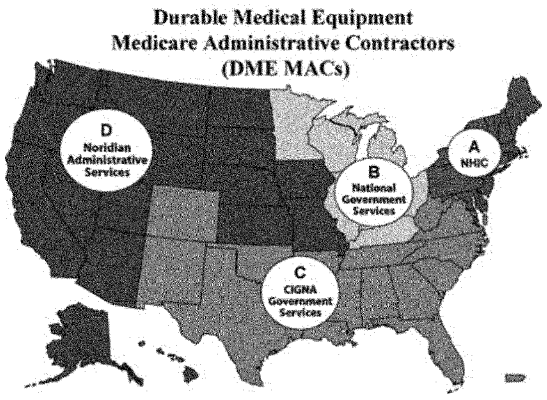
Table of Contents

Background

In 2010, Medicare providers or Home Medical Equipment Dealers (sometimes referred to as HME'S or DME'S, Durable Medical Equipment Dealers) processed over 75,000,000 Medicare part B claims for Home Medical Equipment through the Medicare System. Medicare is split into 4 regions and is administered based on 5 year contracts by private insurance companies. These regions are A, B, C, and D. Each region has a geographic coverage area that is split up by adjoining states. Below is a map indicating the current coverage areas.



Medicare Part B items can be among the most difficult of all items to prescribe by physicians. Unlike prescribing prescription medications, Medical equipment often cannot be simply prescribed by the treating physician and then reimbursed. In many cases the patient may be required to "qualify" through some sort of testing or evaluation and documentation process in order to meet the requirements for Medicare payment for equipment. Due to this stringent process on many types of equipment as well as all of the required coverage criteria and supporting documentation that must be completed, prescribing home medical equipment can be a very tedious process for both physicians and home medical equipment providers. Under today's system, it can take an HME between 9 and 27 days to complete all of the required paperwork, testing, qualifying, documentation and other requirements to ensure reimbursement by Medicare. As more complicated treatments are developed, this process continues to get worse and more cumbersome for HME providers.

In 2010 Medicare reimbursed approximately $10.5 Billion dollars for claims submitted to the Medicare system for home medical equipment. It is important to understand that Medicare's reimbursement is still based on the Honor system. What this means is that during the billing process, HME providers bill Medicare using a HCPCS coding that identifies products and services rendered to Medicare Beneficiaries. If a product that has been prescribed by a Physician requires a "qualification" and or additional documentation to support the medical necessity, then two letters alphabetic "Modifiers" are placed onto the end of the HCPCS codes. These alpha characters represent to Medicare that the HME provider has, in fact, completed the required "qualification" and/or has the supporting documentation required by Medicare in their possession. It is important to note that at no time is this required information submitted to Medicare. The Modifier is an indicator to Medicare that, should Medicare decide to review these required documents, the provider has them and can provide Medicare with these documents.

In 2010, Medicare processed over 75,000,000 total Medicare Claims for home medical equipment. Based on the Office Inspector General (OIG) report for 2010, the OIG believes that 50.9% of those claims did not meet the coverage requirements or possess the required documentation. This means that Medicare improperly paid over $5 billion in claims for Home Medical Equipment. To fully understand this, it is important to understand exactly what may have been deemed as Fraud. Fraud can take multiple forms in Medicare. Fraud can be that an HME provider never supplied an item, yet they billed Medicare for this item. Fraud can be that an item was delivered to a patient yet all of the required documentation or qualification was not present. Fraud can also be that the item was delivered and documentation or qualification was present but the criteria required for that item was not met by the patient.

There are several reasons that improper payments account for over 50% of the Medicare Part B home medical equipment expenditures. The first and primary reason is that since Medicare uses the Honor system mentioned above, the only way to catch Fraud is through physical audits of providers. This is obviously a very long and tedious process and impossible to catch the majority of fraudulent claims. In 2010 over 100,000 Medicare Part B providers in the U.S billed Medicare for home medical equipment. It is unknown exactly how many Medicare auditors there are in the U.S., but it is very safe to assume that there is no way that they can cover this huge number of providers. When fraud is found, Medicare seeks to recoup damages based on the type of fraud created and can be, in some cases, triple the amount actually paid to the provider by Medicare. In most cases, the HME providers do not have the money to pay the fines so much of the overpayments due to fraud are never collected. For all fraud detected, investigated, and prosecuted, Medicare still only recoups less than 50% of the money paid out on average. The second reason that Fraud accounts for such a high proportion of

Medicare spending is the complicated process of billing and documenting the patent requirements that are mandated by Medicare. It has been reported that Medicare changes the rules once every 15 minutes for some item reimbursed by Medicare. Providers receive mounds of complicated to read paperwork from Medicare and the regional DME MACS, (The Private Insurance company administering Medicare benefits in the area that the patient resides) each month. In most cases, providers do their best to interpret these requirements but spend a tremendous amount of money on consultants and attorneys to ensure that their processes and procedures for patient processing and billing are accurate. In many cases, even when the DME MAC is contacted directly and asked specific questions, they may be unable to provide a correct answer. It is also well documented that if an HME provider were to call two different customer service representatives for any of the DME MAC insurance providers, they are likely to get two different and possibly conflicting responses to their questions.

Approximately 15.5% of all claims submitted to Medicare are denied. There can be multiple reasons for why a claim can be denied, but in most cases, the reason for denial is that the claim filed was not completed correctly. Denied claims cost the regional insurance companies approximately 15-25% more to process. Adding the denied claims to the reported fraud claims equals 65% of all claims possess some type of problem.

During January of 2009, President Obama launched and initiative that all healthcare records are to be electronic within the next 5 years. Unfortunately, most physicians and HME providers answer to that initiative has been to scan documents to files on computers and thus replace the paper files with electronic files. While this is successful in creating more office space, it is not providing a solution to the ongoing problem of fraud and provides no ability to report or analyze the data that is contained in those records.

Dream Software

Dream Software was founded in April 2009 with the concept that the future of Home Medical Equipment providers and Medicare would heavily depend on the use of Healthcare IT that would allow HME providers the ability to increase their sales and revenue without increasing their overhead. As Reimbursement for various Medical Equipment products continue to decrease and operating costs increase, it is imperative that HME providers fully embrace technology as a way to reduce overhead and increase efficiencies. It is well documented that each claim costs the average HME provider in excess of $15.80 to only process the paperwork associated with the claim. This figure does not include the cost to deliver setup and maintain this patient nor does it include any allowance for customer service to answer questions for Physicians and Patients.

Dream Software Products

Dream Referral – Dream Referral is an e-prescribing, web based software package that walks physician through the process of prescribing medical equipment. Dream Referral indicates to the prescribing physician when any part of the required documentation is not completed or completed incorrectly, ensuring that the patients prescription and associated documentation is completed correctly the first time, thus reducing physicians and HME providers time to finish the documentation. Dream Referral allows complete electronic signature and transmission to the HME provider that will either ship or deliver the required medical equipment. The entire process takes only a few minutes and ensures that the patient receives the necessary equipment much faster than what is currently experienced today. Dream Referral allows for delivery confirmation by the HME provider to ensure that the physician's files are updated with real time information.

Dream Referral goes way beyond the current electronic health records requirements. Dream Referral allows for complete automation, real time reporting, and Fraud Prevention. Dream Referral has the ability to communicate directly with Medicare and Private Insurance systems allowing the required documentation to be delivered to Medicare or the insurance provider well in advance of payment by Medicare or Private Insurance companies. This process could allow Medicare the ability to provide real time

claims adjudication and stop payments to any provider where fraud is believed. In 2010, the OIG estimated that 50.1% of the claims filed for Home Medical Equipment were improperly paid due to the fact that they did not have the required documentation. Dream Referral, when fully integrated could eliminate that entirely. As the system becomes more complex and more data analyzed, it is believed that this system could closely predict Medicare expenditures in the coming years as well as providing real time data analysis rather than years old data analysis. The real time reporting capabilities allow for real time tracking of any events, spikes, irregularities, and any other occurrences in the system.

Dream Referral, once implemented could save providers over $1.5 billion annually in processing costs related to Medicare Claims. Dream Referral could also dramatically reduce the 15.5% of denied claims by ensuring that orders were completed correctly and accurately and that only those beneficiaries that meet the required criteria would receive reimbursement for the needed equipment.

Summary

In a world where everyone is seeking answers for Healthcare issues, Dream Referral stands ready to solve the largest problem in the industry. Dream Referral is ready to be implemented immediately saving the American Tax payers as much as $5 billion annually. There is a solution to “Pay and Chase”. It is ready today. We just ask your help in ensuring that the problems that have faced the Medicare system for so long do not continue when there is a solution ready to solve the problem.

There has never been a solution that is a win-win for everyone involved

Physicians – Save 65% of employee time spent completing Medicare Paperwork.

Home Medical Equipment Providers – Save over $1.5 billion annually in processing costs.

Medicare – Elimination of Medicare Fraud.

Prepared Statement of Pharmaceutical Care Management Association

PCMA
PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION

Statement for the Record of the

Pharmaceutical Care Management Association

Submitted to the

UNITED STATES HOUSE OF REPRESENTATIVES

COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON OVERSIGHT

"Hearing on Improving Efforts to Combat Health Care Fraud"

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The Pharmaceutical Care Management Association (PCMA) is the national association representing America's pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 210 million Americans with health coverage provided through Fortune 500 employers, health insurers, labor unions, Medicare, Medicaid, and the Federal Employees Health Benefits Program (FEHBP). PCMA appreciates the opportunity to submit a statement for the record to the Subcommittee on Oversight of the Committee on Ways and Means related to health care fraud, waste and abuse (FWA).

PBMs typically reduce drug benefit costs by 30 percent for public and private payers by encouraging the use of generic drug alternatives, negotiating discounts from manufacturers and drug stores, saving money with home delivery, and using health information technology like e-prescribing to reduce waste and improve patient safety. Prior to the advent of these tools, there was no system wide approach to fully address the real dangers and costs of misuse, overuse, or under-use of prescription drugs. In the Medicare Part D program, research cited by the Centers for Medicare & Medicaid Services (CMS) notes that strong Part D plan negotiations have been a key driver in the benefit, which is now expected to cost taxpayers $373 billion over ten years, a 41 percent drop from the initial cost estimate of $634 billion for 2004-2013.

Most estimates of Medicare fraud are at three to ten percent of all claims. With increasing spending along with the complexity of our health care system, the amount of total dollars lost due to fraud will only increase, barring systematic and successful detection and prevention. Although not a significant area for fraudulent activity, prescription drugs are not immune to this threat. Whether it is through doctor and pharmacy shopping to obtain prescription drugs illegally, or simply a pharmacy billing for more prescriptions than it actually dispenses—law enforcement, Part D plans, and pharmacy benefit managers (PBMs) must remain vigilant.

PBMs are dedicated to providing access to affordable prescription drugs while protecting tax payer resources from FWA. Pharmacy claims, unlike medical claims, are typically adjudicated in real-time as the patient stands at the pharmacy counter or upon dispensing the drug by a mail-service pharmacy. Most of these claims are adjudicated electronically, which not only provides a seamless process for the beneficiaries, but also provides the ability to stop the more obvious FWA from occurring. In addition, PBMs monitor overall claims and detect patterns of potential abuse or fraud. For example, an individual who fills multiple prescriptions at multiple pharmacies is a likely fraud candidate, as is a pharmacy whose claims sharply increase in a given period of time.

With nearly 5 billion prescription drug claims processed per year, detecting and preventing FWA before a claim is paid is far superior to paying a claim and then chasing down the fraudster to pay it back, known as "pay and chase." Unfortunately, one statutory provision in Part D makes it especially difficult for Part D plans to avoid "pay and chase" scenarios: a requirement that a Part D plan pay a pharmacy within fourteen days regardless of suspicion of fraud. Even if a PBM has evidence that a fraud is occurring, as long as the claims that have been submitted are "clean," it must pay them. This is not the case in any other part of Medicare.

As with any business, PBMs rely on auditing their contracted pharmacies periodically to ensure that they are not engaged in less detectable forms of fraud—small dollar transactions or others that may seem legitimate until studied more closely. In a business that transacts nearly 5 billion claims annually, there must be unfettered ability to audit randomly and with little notice, to provide greater opportunity to detect pharmacy fraud.

PCMA believes that the National Health Care Anti-Fraud Association's (NHCAA) analysis entitled "Seven Guiding Principles for Policymakers" in fighting health care fraud underscores the efforts PBMs are making to detect and prevent fraud. At the same time, the NHCAA's analysis raises questions about legislative efforts in the 111th, and potentially 112th, Congress to reduce accountability and oversight especially of independent pharmacies.

Some policy proposals meant to help independent pharmacies inadvertently open the door to fraud, abuse, and wasteful spending. The NHCAA's white paper suggests that the following types of policies, many of them contained in recent legislative proposals, would be problematic:

Policies that require payers to partner with pharmacies that are banned from federal programs ("Any Willing Pharmacy" policies). Legislation that would force plans to include in their networks even pharmacies that have been banned from federal programs "runs counter" to preventing fraud, according to NHCAA. This low bar would allow admission for pharmacists "even if they have records of harmful prescription errors or a high number of consumer complaints."

Policies that undermine payers' ability to audit independent pharmacies suspected of fraud ("Audit Reform" policies). CMS is required by law to audit Medicare Part D plans every three years. Similarly, many pharmacy benefit managers periodically audit pharmacies that are part of their networks. In addition to random audits, PBMs typically request audits upon suspicion of fraud. NHCAA supports measures that would "protect the integrity of health care audits by giving auditors more discretion and flexibility to perform their duties." Unfortunately, legislative proposals championed by the independent drugstore lobby would instead grant pharmacies (even those with wasteful or abusive practices) substantial advance notice before they were subject to audits. PCMA supports continuing to permit PBMs and health plans to audit as needed both randomly and upon suspicion of fraud, without notice.

Policies that reduce payers' time to verify pharmacy claims before payment ("Prompt Pay" policies). PCMA believes strongly that insufficient time to investigate potential fraud before paying a claim leads to so-called "pay and chase." It is much more difficult to recover payments after the fact than to spend adequate time identifying potentially fraudulent claims and avoiding paying them. In its report, NHCAA notes that "if claims are not rushed through the payment process, auditors and investigators will have more opportunities to detect attempts at fraud before they come to fruition." So-called "prompt pay" laws in Medicare Part D that mandate rapid payment reduce the time available to detect pharmacy fraud, waste, and abuse and should be repealed. At the very least, Part D plans should be able to suspend payments when they suspect fraud, reflecting the same authority already provided in Medicare Parts A and B. What is good for one part of the program should be good for the other part.

On behalf of PCMA and our members, we look forward to working with the Committee to develop ways in which to rid the system of fraud, waste and abuse to safeguard federal government resources, while ensuring that patients maintain high access to needed medications.

MATERIAL SUBMITTED FOR THE RECORD

Questions from the Honorable Chairman Boustany

House Committee on Ways and Means, Subcommittee on Oversight
Question for the Record and Response from
Dr. Peter Budetti, Director, Center for Program Integrity
Center for Medicare & Medicaid Services

Chairman Boustany, Jr.

The Inspector General has reported that when 1,500 durable medical equipment suppliers were subject to unannounced site visits in 2007, nearly a third were found to fail basic Medicare standards and were kicked out of the program. A lot of these providers appealed their revocations, and 91 percent were reinstated and allowed to bill Medicare again. Of these suppliers, as many as two-thirds have had their billing privileges revoked again, and many have been indicted for health care fraud. It is unclear by what standards good suppliers are allowed to stay *in* the system and bad ones are kept *out*. The Office of Inspector General has suggested that CMS develop better criteria on the types of evidence necessary to reinstate billing privileges so that there is more consistency in the system.

Question: What has your agency done, if anything, to remedy this problem? If no progress has taken place, why not? Please provide copies of the current evidentiary criteria used in these cases.

Answer: With respect to the 1,500 revocations in question, a substantial number of these were overturned because it was later determined by ALJ hearing officers that the initial evidence of the supplier's non-operational status would be insufficient to withstand an appeal at the Administrative Law Judge (ALJ) level. However, CMS has taken multiple steps to address the concerns identified by the OIG in 2008. In 2009, CMS began to require accreditation for DMEPOS suppliers; additionally CMS implemented a final rule in 2008 to address the high rates of revocations overturned on appeal by implementing a process that permits reconsideration and requires DMEPOS suppliers to submit evidence much earlier in the process. This led to a decrease from 118,000 DMEPOS suppliers in 2007 to 95,000 in early 2009. Largely as a result of these new requirements, 16,000 suppliers did not enroll in Medicare, an additional 7,000 did not comply with the accreditation standards.

If a DMEPOS supplier's Medicare billing privileges are revoked, the supplier may submit a Corrective Action Plan (CAP) and/or a request for reconsideration. Both are submitted to the National Supplier Clearinghouse (NSC), the Medicare enrollment contractor for DMEPOS suppliers. The former must be submitted within 30 calendar days of the date of the revocation notice; the latter, within 60 calendar days of the date of said notice.

The CAP process gives suppliers the opportunity to correct the deficiencies that resulted in the denial or revocation of billing privileges. A CAP must contain verifiable evidence that the supplier is now in compliance with all enrollment requirements. If this can be shown, the supplier's billing privileges may be reinstated. With respect to reconsiderations, the NSC's review is limited to its initial reason for imposing a revocation at the time it issued the action and whether the Medicare contractor made the correct decision to revoke. In

other words, the review is limited to the question of whether the supplier was in compliance at the time the contractor made its decision, as opposed to whether the supplier is in compliance now. This latter standard was recently promulgated so as to prevent a supplier from being able to re-enter Medicare months after the revocation by arguing that it is now in compliance.

Your agency published a Final Rule regarding the enhanced screening requirements for providers, based on levels of risk to program integrity. The rule requires that CMS screen 20 percent of current providers and suppliers each year, so that all will have been screened by the end of 2015.

Question: Does CMS anticipate that enrollment fees will fully cover the cost of this additional screening? If the deadline will not be met, when does the agency plan to complete the screening?

Answer: The Affordable Care Act requires that the application fee be used for program integrity activities, including covering the costs of the new screening requirements. Although we do not know for certain whether the fees will be adequate to cover all costs of screening, we will monitor implementation costs closely and will assess the adequacy of the fees at a later time after we have had some experience with the new requirements. Additionally, the Affordable Care Act requires that all providers and suppliers enrolling or revalidating enrollment in Medicare be screened under the new requirements by March 23, 2013. In order to enable us to meet this deadline, we have clarified for the provider and supplier communities that CMS has the authority to require off-cycle revalidations of enrollment records that will trigger the new screening measures. State Medicaid agencies have until 2015 to ensure that Medicaid and CHIP providers and suppliers have been screened according to the new requirements.

The CMS FY 2012 budget justification includes an increase in your Center's number of full-time employees from 53 to 57 employees.

Question: Can you please provide a breakdown of the titles of all of your current employees, and the city where they are based. Also, provide an explanation of the need for four additional employees and a description of those positions.

Answer: For 2010, CPI had 51 Program Management full-time employees (FTE). Our 2011 estimated FTE level of 53 and our projected need of 57 FTE slots in our FY 2012 Budget Request are to support our ongoing work and the need for more analysts for the increased data workload, with new Congressional mandates to implement the Affordable Care Act and with existing program and systems workloads. These requested FTE levels will provide CPI with the level of staff needed to support the increased workload resulting from our work on the new authorities provided by the Affordable Care Act and other expanded Program Integrity initiatives, including the HEAT Task Force and increased HCFAC efforts.

In your written testimony, you wrote about your "strategic principles" for program integrity. The Subcommittee understands your office has hired a private contractor to develop the Center for Program Integrity's "strategic plan."

Question: Can you please provide more information on this, such as the status of the plan, the cost of the contract, and how long the plan has been in development? Is it correct the contractor is also performing other duties for your office, such as responding to comments related to Federal regulations?

Answer: The Center used an existing organizational development contract with Deloitte through the CMS Office of Human Resources and the Office of Personnel Management to help with the establishment of the new Center, including both the organizational structure and the change management required. The scope of the work for the Center under this contract consisted of three phases: Assessment, Design and Implementation. This contract was not utilized to aid CPI in any way in developing responses to comments related to Federal regulations.

The Assessment phase focused initially on interviews with internal and external stakeholders, gathering information on the existing business process, and developing internal strategic planning documents, the purpose of which was to guide organizational design efforts such as reorganizations of staff within the Center, refocusing Center activities, helping staff with culture change, and identifying key strengths and weaknesses. One of the outputs of the internal planning documents was the development of a budget spreadsheet cross walking budget activities to the Center's strategic principles and ensuring alignment of the budget and staff resources on the key strategic goals.

The Design phase analyzed existing organizational structure and business process flows and supported CPI in the redesign of our organization and business processes. The current Implementation phase includes supporting CPI in implementing the various processes and plans that have been developed thus far, including developing and utilizing project management processes and tools to ensure CPI operates efficiently.

With CPI being operational almost a year, less support is needed of Deloitte and as a result the Implementation phase is also winding down, with the contract ending in July 2011. In total, the contract cost $2.875 million.

House Committee on Ways and Means, Subcommittee on Oversight
Question for the Record and Response from
Lewis Morris, Chief Counsel, Office of Inspector General

Chairman Boustany, Jr.

Question: In your written testimony, you emphasized how critical it is for the Office of Inspector General to obtain "real-time" data on Medicare claims from CMS. Please explain what level of access is currently available. Please also elaborate on how this data could help law enforcement efforts, and what obstacles currently prevent the IG from obtaining this data.

Answer: Access to "real time" data could help law enforcement efforts by allowing agents and analysts to increase their response time once they have identified potential fraudulent billing patterns. This is especially useful when criminals shift their schemes to try to avoid detection.

Currently, the OIG has limited law enforcement access to "real time" Medicare claims data through a system called Next Generation Desktop (NGD). NGD is maintained by CMS in support of the 1-800-MEDICARE hotline. OIG is working closely with CMS to expand our access to "real time" claims data and to enhance the NGD platform to better support law enforcement purposes. The reason that our access is limited thus far is a technology issue. The infrastructure does not yet exist for OIG to get the comprehensive data access that we would like, but OIG is working closely with CMS to address this need.

In addition, OIG has access to historical claims through the national Medicare claims database, Services Tracking Analysis and Reporting System (STARS). The claims data in STARS is updated on a monthly basis. CMS has expanded its systems capacity to support broad OIG access and has trained OIG agents how to use the database.

Questions from Mr. Gerlach

MR. GERLACH

When was the last time, if you know, this competitive bidding process was used for a knee brace product in the program so that that would have been the basis to set this new brace price at $690?

DR. BUDETTI

We agree that Medicare pays above market cost for many items of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) due to the payment rules in effect and mandated by the statute since 1989. To correct these overpayments, the DMEPOS competitive bidding program is being phased in beginning with the highest cost, highest volume items. Off-the-shelf orthotics (or braces) are not currently covered under the competitive bidding program. However, other priority items, such as oxygen equipment and power wheelchairs that account for even more in annual allowed charges – over 6 billion are being phased in under the program. We are happy to report that contracts and savings are currently in effect for these items in 9 metropolitan areas and we are mandated to expandthe program to 91 additional areas this year.

Competitive bidding uses market forces to lower Medicare payments by requiring suppliers to bid against each other and win Medicare contracts based on their costs for furnishing items and services to Medicare beneficiaries. Contract suppliers must meet all of the current Medicare supplier eligibility requirements such as mandatory submission of claims, quality standards and accreditation, and surety bonds, in order to be eligible for a contract award under the program. At the end of the day, the program will use market forces to lower Medicare payment amounts for quality items and services that Medicare beneficiaries need.

Medicare allowed fee schedule payment amounts for DMEPOS items and services, including braces, are established in accordance with the exclusive payment rules mandated by the statute. Unless a change is made to the statute to require or authorize us to establish a different allowed amount for an item, this exclusive rule in the statute must be adhered to in accordance with Federal law. We agree that flexibilities such as competitive bidding should be available under the program to rein in overpayments such as the one you highlight.

Questions from Ms. Jenkins

MS. JENKINS

So, questions for you: What is the net cash to CMS on the RAC program, and can you speak to whether this is actually saving money in the health care system and increasing quality patient care, or is it simply shifting more of the cost to these small hospitals by requesting payment after the fact and adding to their administrative costs?

DR. BUDETTI

Recovery Auditors have proven successful at identifying and correcting Medicare Fee-For-Service (FFS) improper payments. In the demonstration project, Recovery Auditors corrected $1.03 billion in improper payments, including approximately $990 million in overpayments collected. Since the inception of the permanent Medicare FFS Recovery Audit program in January 2010, as of March 1, 2011, the contractors have corrected a total of $261.5 million in improper payments, including $43.6 million in underpayments corrected and $217.9 million in overpayments collected.

CMS actively monitors the national Recovery Audit program and makes necessary adjustments to maintain a balance between provider burden (both financial and administrative) and increasing recoveries. CMS is committed to working with the Recovery Auditors, the provider community, and others to continuously improve the program and refine ongoing operations.

Regarding the appeals process, CMS has received successful feedback. During the Recovery Audit demonstration 8.2% of overpayment determinations were both challenged and overturned on appeal. Preliminary experience from the national program indicates the percentage of claims appealed may be less.