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

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

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

WEDNESDAY, FEBRUARY 27, 2013

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

The subcommittee met, pursuant to call, at 10:15 a.m., in room 2123 of the Rayburn House Office Building, Hon. Joe Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Burgess, Hall, Shimkus, Murphy, Lance, Cassidy, Guthrie, Griffith, Bilirakis, Ellmers, McKinley, Pallone, Capps, Schakowsky, Matheson, Green, Butterfield, Barrow, Christensen, Castor, Sarbanes and Waxman (ex officio).

Staff present: Clay Alspach, Chief Counsel, Health; Matt Bravo, Professional Staff Member; Paul Edattel, Professional Staff Member, Health; Steve Ferrara, Health Fellow; Sydne Harwick, Staff Assistant; Robert Horne, Professional Staff Member, Health; Carly McWilliams, Legislative Clerk; John O'Shea, Professional Staff Member, Health; Monica Popp, Professional Staff Member, Health; Andrew Powaleny, Deputy Press Secretary; Chris Sarley, Policy Coordinator, Environment and Economy; Alli Corr, Democratic Policy Analyst; Amy Hall, Democratic Senior Professional Staff Member; Elizabeth Letter, Democratic Assistant Press Secretary; and Karen Nelson, Democratic Deputy Committee Staff Director for Health.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. The subcommittee will come to order. The Chair will recognize himself for an opening statement.

According to data from the Centers for Medicare and Medicaid Services, in 2011, Medicare spending accounted for 21 percent of total national health expenditures. Medicaid makes up another 15 percent of total NHE.

Medicare has been on the Government Accountability Office's high-risk list continuously since GAO began designating programs as high risk in 1990, and it remains there in GAO's February 2013 report entitled "High Risk Series: An Update."

In 2012, Medicare spent approximately $555 billion caring for more than 49 million beneficiaries. CMS estimates that out of that $555 billion, $44 billion—nearly 8 percent—were improper pay-

ments. The report noted that while Medicare has made progress toward addressing some of GAO's previous concerns and the program's known deficiencies, not enough had been done to warrant its removal from the list.

Medicaid entered the high-risk list in 2003 and has also remained there. With total expenditures of $436 billion in 2011 for its approximately 70 million low-income beneficiaries, the Department of Health and Human Services estimates that Medicaid's national improper payment rate is 7.1 percent. These improper payment figures represent only those payments that CMS knows were improper. Estimates of the real cost of waste, fraud and abuse in these programs are much higher.

In an April 2012 study, former CMS Administrator Donald Berwick and RAND Corporation analyst Andrew Hackbarth estimated that fraud and abuse added as much as $98 billion to Medicare and Medicaid spending in 2011. And, without any significant program integrity changes, the Affordable Care Act will add an additional 7 million people to the Medicaid rolls in 2014. By 2022, that number will grow to 11 million new enrollees.

The ACA also contains perverse incentives for private insurance companies to ignore waste and fraud, which drives up premiums and copayments for consumers. The ACA's Medical Loss Ratio provision requires health plans to spend 80 percent for plans in the individual and group market and 85 percent for large group plans of premium revenue on medical care. Supporters of the MLR claim it was designed to protect consumers from unscrupulous insurance companies. However, under the regulation, investments in fraud detection, and even quality improvement and care coordination, fall under administrative expenses, which can only make up 20 percent of a plan's spending. Plans struggling to make the 80 or 85 percent threshold for medical costs often can't risk these activities, which could save consumers money and provide them with a higher quality of care, for fear of being penalized and having to pay rebates. Even worse, if a plan does identify fraud, cutting those fraudulent payments and activities actually reduces their amount of spending on medical costs, making it even harder for them to reach the 80 or 85 percent threshold. We are actually exporting the inefficiencies of federal health programs into the private sector.

While some here today may champion MLR, it is apparent to me that MLR will not reduce the tens of billions of taxpayer dollars lost each year to improper payments, but rather add to it, and that is a problem. Simply eliminating waste, fraud, and abuse is not going to put Medicare and Medicaid on solid financial ground, but the threat it poses to sick Americans cannot be ignored any longer. We have an obligation to use taxpayer funds in the most responsible and efficient ways possible, an obligation we are not currently meeting.

I thank all of our witnesses for being here today. I look forward to hearing from our GAO witnesses what areas in the Medicare and Medicaid programs are most vulnerable to fraud and their recommendations to combat improper payments. I also look forward to hearing from our private sector witnesses about the tools and innovations they use to fight waste, fraud and abuse on a daily basis.

Thank you, and I yield back.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

According to data from the Centers for Medicare and Medicaid Services (CMS), in 2011, Medicare spending accounted for 21% of total national health expenditures (NHEs). Medicaid makes up another 15% of total NHE.

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Simply eliminating waste, fraud, and abuse is not going to put Medicare and Medicaid on solid financial ground, but ignoring the threat it poses to sick Americans cannot be ignored any longer.

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Thank you.

Mr. PITTS. The Chair now recognizes the ranking member of the Subcommittee on Health, Mr. Pallone, for 5 minutes for an opening statement.

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

Mr. PALLONE. Thank you, Chairman Pitts, and good morning to everyone.

Fighting fraud across all health care settings is critical. I think we can all agree on that. In fact, this committee has an important role in ensuring that the government is aggressive in addressing long-term solutions to an ongoing threat, and I am committed to working with my colleagues now and in the future to help support the constant work that must be done to cut waste, fraud and abuse.

But I am not entirely sure that another hearing on this topic, since one was held less than 3 months ago, is necessary so soon. Instead, I think we should be examining the impact of the looming sequestration, which is just 2 days away. Mr. Waxman and I along with other senior members of this committee requested that we look at how sequestration will affect the programs and agencies we oversee. For example, in New Jersey, nearly 4,000 fewer children will receive vaccines for disease such as measles, mumps, rubella, tetanus, whooping cough, influenza and hepatitis B due to reduced funding for vaccinations, and the New Jersey State Department of Public Health will lose about $752,000, resulting in around 18,800 fewer HIV tests. These spending cuts not only threaten our economy but also a range of vital services that I think our time today would be better spent examining.

Fraud schemes come in all shapes and sizes and affect all kinds of insurance, public and private alike. Whether it is a sham storefront posing as a legitimate provider or legitimate businesses billing for services that were never provided, it all has the same result: undermining the integrity of our public health system and driving up health care costs. So for every dollar put into the pockets of criminals or program abusers, a dollar is taken out of the system to provide much-needed care to millions of people including Medicare seniors.

I think we can all agree that a strong commitment to combat health care fraud and abuse was included within the Affordable Care Act. The law contains over 30 antifraud provisions to assist CMS, the OIG and the Justice Department in identifying abusive suppliers and fraudulent billing practices. The most important provisions change the way we fight fraud by heading off the bad actors before they strike and thwarting their enrollment into their federal programs in the first place. In this way, we aren't left chasing a payment once the money is already out the door. And we also made important improvements in the ACA to the False Claims Act, which is another useful tool that can help address fraud and abuse.

Today we will hear from CMS about the great work already being done. Over the past 4 years, enforcement efforts have recovered $14.9 billion, and I think that is considerable progress. In fact, return on investment for each dollar spent on health care-related fraud and abuse investigations in the last 3 years has been $7.90.

So we will also hear from the GAO about their high-risk report released this month. That report notes that while making positive steps, there is still a lot of areas or a number of areas that continue to need improvement.

So I know we are going to hear from the panel. I think we must continue to innovate. Bad actors are always going to find loopholes, and it is our job to keep one step ahead of them.

Thank you again, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the vice chairman of the subcommittee, Dr. Burgess, for 5 minutes for an opening statement.

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

Mr. BURGESS. Thank you, Mr. Chairman, and I will acknowledge that members on both sides of the dais have a fundamental sense of fairness about this and they want to preserve, protect and defend the program that is there to serve the most vulnerable seniors in our population.

I agree with the ranking member that it does seem like we have a lot of hearings about this. I will agree that it doesn't seem that there has been a lot of movement in the right direction. I would disagree that this hearing is not important and we should be focusing on something else because, after all, the sequester would not even be necessary if Congress was doing its job in oversight, if the Administration was doing its job and the agencies were doing their job and didn't allow these dollars to be delivered hand over fist to felons and organized crime in the first place.

I do feel that the Federal Government has not done enough to address this issue. Sure, we had a hearing right at the end of the last Congress, the Oversight and Investigations Subcommittee. In fact, we have some of the same witnesses here today. But I got to tell you, it bothers me that we keep having to have these hearings and we don't seem to ever move the needle.

I took the liberty of doing a little Google search last night, and Googled the name Janet Reno and Medicare fraud, and it turns out in February of 1998, 15 years ago this month, Janet Reno stood in front of the American Hospital Association and said fraud in the Medicare and Medicaid system is the number one priority for her Justice Department, and it was going to end with her. Well, here we are 15 years later and we are having the same discussion.

The analysts, the law enforcement officials estimate that 10 percent of total health care expenditures are lost to fraud on an annual basis, and guess what? That 10 percent is not equally distributed between the public and private parts of our health care system. No, the loss falls disproportionately on the part that is under the jurisdiction and control of the Federal Government. The Government Accountability Office, who we have here with us this morning, and others have said these characteristics are unsustainable. Eliminating waste, fraud and abuse that hemorrhages billions of dollars from our country's government-run health care program should be the foremost priority of this committee. And again, I will say it one more time: How can we protect the

most vulnerable in our society if we don't protect the integrity of the system that was intended to serve them?

If we are serious about bringing down the cost of health care, if we are serious about protecting the patient, if we are serious about avoiding another sequester, if we are serious about fixing the inequities in the payment system for physicians in Medicare, we ought to be all about eliminating this problem and eliminating it in this Congress, not waiting for another Congress, not waiting for another President. The time is now.

The private sector has developed ways to combat fraud that really doesn't burden providers or patients. They are able to catch far more incidents of fraudulent activity. The Centers for Medicare and Medicaid Services has attempted to develop new efforts to recover funds but the current system to prevent improper payments is just simply not working, and I know we have some of the same witnesses we had here in December. I will use the Visa example again. I gave my credit card to my staff to go out and by lunch for our staff at Chick-fil-A last December. I am calling on my cell phone on the House Floor, hey, somebody is trying to charge $100 worth of Chick-fil-A on your credit card, is that oK, and I affirmed that it was. Why do we not have the same system of safeguards when we spend so many billions of dollars in our health care system?

Now, in fairness, one of our witnesses, Dr. Budetti, thank you very much for being here this morning and thank you for coming in to brief my staff and myself earlier in the last Congress. I appreciate the efforts that you have underway. The Government Accountability Office has made recommendations, some dating back years and years, and they failed to be implemented. Well, it begs the question: Why is this acceptable?

So if we are going to be developing new and innovative approaches to fight fraud, and it is becoming increasingly important that we do so, I do look forward to hearing the testimony from the witnesses today but let us hear that testimony with in mind the fact that we are going to solve this problem.

Thank you, Mr. Chairman, for the indulgence and I will yield back the balance of my time.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the ranking member of the full committee, Mr. Waxman, for 5 minutes for an opening statement.

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

Mr. WAXMAN. Thank you, Mr. Chairman. I appreciate your holding this hearing today and for focusing on the important topic of health care waste, fraud and abuse. Improving our health care system, both private and public, requires pursuing dollars that are wasted or diverted, dollars that add to our costs, but don't improve health.

I have dedicated much of my career in Congress to improving the quality and efficiency of both the Medicare and Medicaid programs. Fighting fraud is critical to both of these and critical to being re-

sponsible stewards of taxpayers' dollars, an issue where we should be able to achieve bipartisan consensus.

I am very pleased by the recent reports that have highlighted our progress fighting fraud and abuse. According to the Administration's most recent report on the Health Care Fraud and Abuse Control Program, health care fraud prevention and enforcement efforts recovered a record $4.2 billion in fiscal year 2012. For each dollar spent on health care-related fraud and abuse investigations in the last three years, we recovered $7.90, the highest return on investment in the 16-year history of the program.

We are now seeing the impact of provisions in the Affordable Care Act that help us move away from the traditional "pay and chase" approach to a more proactive approach designed to prevent fraud before it occurs. Other Administration initiatives, such as implementing the Command Center, which brings together the Centers for Medicare and Medicaid Services, the Office of the Inspector General and the Federal Bureau of Investigation, and the Health Care Fraud Prevention and Enforcement Action Team, which is taking action against Medicare fraud in fraud hot spots across the country, are bringing more tools and resources in the fight against fraud.

We also need to ensure that the public and private sectors are collaborating, because we know that schemes that affect programs like Medicare and Medicaid often are also perpetrated against private payers as well. The Administration has initiated the Health Care Fraud Prevention Partnership that is bringing together federal and state officials with private insurers and health care antifraud groups to do just that. The value of these new prevention-oriented approaches is that they target fraud and abuse before it occurs and leverage partnerships across government and the private sector to support this important work.

Another tool in the health care fraud-fighting arsenal, which also is a form of public-private partnership, is the False Claims Act. This law incentivizes private parties to bring suit on behalf of the government to recover fraudulent payments and has been effective in helping get the federal and State governments reimbursed for a number of high-profile fraud schemes.

We cannot rest on our laurels and be satisfied with the current successes in fraud fighting. The data clearly shows that we are moving in the right direction. But just as the fraudsters are constantly looking for the next new scheme, we too must continue our work, and I look forward to hearing from our panels of experts about the opportunities and challenges moving forward, and I want to yield the balance of my time to Ms. Schakowsky.

Ms. SCHAKOWSKY. I thank the gentleman so much, and I appreciate his decades of work to make Medicare, Medicaid, the programs our citizens rely on, more efficient.

But I have to say, the passion that I heard from Dr. Burgess, it is as if we don't share that, and I want to set the record straight, that we want to and have been cutting the waste, fraud and abuse and we need to build on our successes, the $4.2 billion in fiscal year 2012. I think we can start with that and go further.

And I also want to say that it is as if the election didn't happen. As I recall, the $716 billion that Democrats were able to save

through Obamacare that reduced the cost of Medicare without cutting benefits was used as a sledgehammer accusing Democrats of cutting Medicare and in fact we did reduce the cost. Rather than being applauded for that at the time, it was used to say that we are the ones that are really taking away something from Medicare beneficiaries when of course we weren't.

So let us get on the same page here. We agree, we all agree that waste, fraud and abuse is a problem. We have begun and let us continue to do something serious about it.

Thank you. I yield back.

Mr. PITTS. The Chair thanks the gentlelady.

We have two panels for today's hearing. On our first panel, we have Dr. Peter Budetti, Deputy Administrator and Director at the Center for Program Integrity at CMS, and Ms. Kathleen King and Ms. Carolyn Yocom, who are both Directors of Health Care at the Government Accountability Office. Thank you for coming this morning. Your written testimony will be entered into the record. I will recognize each of you for 5 minutes to summarize your testimony.

Dr. Budetti, you are recognized for 5 minutes for your opening statement.

STATEMENTS OF PETER BUDETTI, DEPUTY ADMINISTRATOR AND DIRECTOR, CENTER FOR PROGRAM INTEGRITY, CENTERS FOR MEDICARE AND MEDICAID SERVICES; KATHLEEN M. KING, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE; AND CAROLYN L. YOCOM, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE

STATEMENT OF PETER BUDETTI

Dr. BUDETTI. Good morning, and thank you, Chairman Pitts and Ranking Member Pallone and members of the subcommittee for this invitation to appear before you today.

As the Deputy Administrator of the Centers for Medicare and Medicaid Services for Program Integrity and Director of the Center for Program Integrity, I am now into my third year of having the privilege of overseeing program integrity efforts for the Medicare and Medicaid programs, which is a top priority for this Administration and for CMS, and it is an area where I am very pleased to say that new tools and a collaborative approach are indeed helping us move beyond pay and chase to preventing fraud before it happens.

A key component of our fraud-fighting approach is what we call the Fraud Prevention System, or FPS. This system, this high-tech system, highly sophisticated system that we put into place in the middle of 2011, analyzes all Medicare fee-for-service claims using risk-based algorithms and generates alerts. CMS and our program integrity contractors can then stop, prevent and identify improper payments using a variety of administrative tools and actions including prepayment review, claims denials, payment suspensions, revocation of Medicare billing privileges, and referrals to law enforcement.

We have a poster for you here today that demonstrates the initial results from the first year of implementation of the Fraud Prevention System. Our numbers show that we did achieve a positive return on investment, saving an estimated $3 for every $1 we spent in the first year and that we have prevented or identified an estimated $115.4 million in improper payments. In addition, and very importantly, this system generated leads for over 500 new fraud investigations and provided new information for over 500 existing fraud investigations.

To further enhance our program integrity efforts, we have implemented a risk-based screening process for newly enrolling and revalidating Medicare providers and suppliers. This system is designed to both make it easier for the legitimate providers and suppliers, some 20,000 of whom applied to be able to bill in the Medicare program every month, to make it easier on the enrollment side for them to get into the program while making it much harder for the bad guys to get in and makes it easier for us to find the bad guys if they do get in and kick them out.

We have implemented the terms of the Affordable Care Act that required us to put into place risk-based screening so that people in the higher-risk categories are subject to greater scrutiny prior to their enrollment or revalidation in Medicare. Since March of 2011, our processes have validated or revalidated enrollment for nearly 410,000 Medicare providers, and because of this, we have deactivated some 136,000 enrollments and revoked over 12,000 enrollments that were not appropriate or not timely in the program.

We have also made major progress in engaging other federal partners to improve the collaboration in fighting fraud. Thanks to a variety of efforts, federal, State and local law enforcement health care fraud activities are being coordinated more and more and, as you have heard, and as I will talk about in a second, we are also engaging with our fraud-fighting partners in the private sector to improve the integrity of Medicare and Medicaid.

We are working with our State partners to improve and enhance our program integrity activities in the Medicaid program and we have taken steps to ensure that someone who is caught defrauding the program in one State cannot simply move to another State. We have implemented the Recovery Auditor program in Medicaid, and the States are already reporting some $95 million in recovered payments in the first phase of implementation of that program.

We have been working more closely with law enforcement, both through our new command center, which provides a collaborative environment so that we can work together and not just talk to each other one after the other, and we have had a string of successes in terms of building new models and engaging in new approaches to fighting fraud coming out of our collaboration in the command center.

Medicare and Medicaid and health care fraud anywhere affects every American by draining critical resources from our health care system. The Administration has made stopping fraud and improper payments a top priority, and today new tools and a collaborative approach are moving us beyond pay and chase to preventing fraud before it happens. I look forward to continuing to work with you to make Medicare and Medicaid stronger, more effective programs

by protecting their integrity and safeguarding taxpayer resources, and I thank you for this opportunity to appear before you, and I will be happy to answer questions later. Thank you, Mr. Chairman.

[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

"FOSTERING INNOVATION TO FIGHT
WASTE, FRAUD, AND ABUSE IN HEALTH CARE"

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

FEBRUARY 27, 2013

U.S. House of Representatives
Committee on Energy and Commerce, Subcommittee on Health
Hearing on "Fostering Innovation to Fight Waste, Fraud, and Abuse in Health Care"
February 27, 2013

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

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

Preventing Fraud in the Medicare and Medicaid Programs

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

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

Fraud Prevention System

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

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

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

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

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

Integrated Data Repository and One Program Integrity

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

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

Enhanced Provider Screening

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

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

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

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

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

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

CMS Collaboration with States on Medicaid Program Integrity

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

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

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

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

Medicaid RAC Programs

The Affordable Care Act expanded the Recovery Audit Contractors (RACs) to Medicaid. State Medicaid agencies are required to contract with RACs to identify and recover overpayments and identify underpayments made to Medicaid providers. As of February 15, 2013, 42 States and the District of Columbia have implemented Medicaid RAC programs. CMS developed the Medicaid RACs-At-A-Glance website[3] to facilitate transparency and monitoring. In 2012, CMS enhanced RACs-At-A-Glance by including State-reported information on each State's Medicaid RAC program, including contact information for the State Program Integrity Director; the name of each RAC vendor and Medical Director; contingency fee rates for the identification and recovery of overpayments; fee structure for the identification of underpayments; user-friendly charts and data; and State profile pages. The website will include performance metrics later this year. For FY 2012, the States have recovered a total Federal and State share combined amount of $95.64 million and returned a total of $57.57 million to the Department of Health and Human Services (HHS), through the State Medicaid RAC programs.

[3] http://w2.dehpg.net/RACSS/Map.aspx

The Medicare-Medicaid Data Match Program

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

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

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

Command Center

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

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

Health Care Fraud Prevention & Enforcement Action Team (HEAT)

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

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

Since its inception:

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

Healthcare Fraud Prevention Partnership

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

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

Moving Forward

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

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

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

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

Mr. PITTS. The Chair thanks the gentleman and now recognizes Ms. King for 5 minutes for opening statement.

STATEMENT OF KATHLEEN M. KING

Ms. KING. Chairman Pitts, Ranking Member Pallone and members of the subcommittee, I am pleased to be here today to discuss our recent high-risk report on Medicare and Medicaid. I am joined by my colleagues, Carolyn Yocom and James Cosgrove.

For many years, we have designated these programs as high risk because of their size, complexity and susceptibility to improper payments. Together, these two programs finance vital health care services for nearly 120 million Americans. Ensuring that they function effectively and efficiently should be a high priority.

CMS has taken a number of important steps in Medicare to improve payment systems in traditional fee-for-service and Medicare Advantage. For example, CMS has implemented a competitive bidding program for durable medical equipment that pays selected providers at competitively determined prices. To date, it has produced savings while beneficiary access and satisfaction appeared stable in early assessments.

However, we have also identified a number of opportunities for CMS to improve and refine payments to encourage appropriate use of services such as improving the accuracy of payments for Medicare Advantage.

With respect to program integrity, CMS has made reducing improper payments one of their key priorities and has made progress in error rate measurement. CMS has also implemented provisions of the Patient Protection and Affordable Care Act to enhance its ability to screen providers before allowing them to enroll in Medicare. This should have prevented providers intent on defrauding the program from gaining entry. It has also implemented a fraud prevention system which uses analytic methods to screen provider billing and beneficiary utilization data before claims are paid to identify those that are potentially fraudulent. While these are important steps, we have made recommendations to CMS to enhance program integrity such as identifying measurable performance metrics and goals for the Fraud Prevention System.

With respect to Medicaid, both Congress and the Administration have demonstrated commitment and leadership to making Medicaid fiscal and program integrity a priority. I would like to highlight two areas where there has been some progress but concerns remain. First, with regard to improper payments to providers, some positive steps toward improving transparency and reducing improper payments have been taken in recent years such as increased guidance to States regarding oversight of providers. However, key challenges remain including eliminating duplication between CMS and State program integrity efforts and refocusing national audits on cost-effective approaches. Also, our work has identified areas where CMS could streamline and improve its oversight of States' improper payments.

Second, supplemental payments, that is, payments above and beyond regular Medicaid payments for services, continue to be a large and growing problem. In fiscal year 2011, States reported spending at least $43 billion on supplemental payments up from $32 billion

in fiscal year 2010. While a variety of actions have helped curb supplemental payment arrangements, gaps in oversight remain. In 2010, CMS implemented new transparency and accountability requirements for certain Medicaid supplemental payments known as disproportionate share, or DSH payments. However, similar standards for calculating, reporting and auditing non-DSH supplemental payments have not been established. Although Medicaid payments are not always limited to the cost of providing Medicaid services, when payments greatly exceed Medicaid costs, it raises questions about their purpose, relation to Medicaid service and whether such payments contribute to beneficiaries' access to quality care.

Congress, HHS and CMS have taken steps to improve the fiscal integrity of Medicaid. However, more federal oversight is needed, particularly in the areas of addressing improper payments and oversight of supplemental payments. In both cases, CMS oversight has been hampered by data systems that do not provide complete and timely data.

Mr. Chairman, this concludes my prepared remarks. I would be happy to answer questions.

[The prepared statement of Ms. King follows:]

United States Government Accountability Office

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Testimony

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GAO'S 2013 HIGH-RISK UPDATE

Medicare and Medicaid

Statement of Kathleen M. King
Director, Health Care

Carolyn L. Yocom
Director, Health Care

GAO-13-433T

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United States Government Accountability Office
Washington, DC 20548

Chairman Pitts, Ranking Member Pallone, and Members of the Subcommittee:

Thank you for the opportunity to discuss our recent work on Medicare and Medicaid. Since 1990, GAO has regularly reported on programs as part of our high-risk series, which focuses on government operations that we have identified as high risk due to their greater vulnerability to fraud, waste, abuse, and mismanagement or their need to address economy, efficiency, or effectiveness challenges. Our high-risk series has brought much-needed focus to problems impeding effective government and costing billions of dollars each year. My remarks today on Medicare and Medicaid are drawn from GAO's 2013 high-risk update.[1] (See Relevant GAO Products for a list of reports that form the basis of this statement.)

Medicare Program

Background

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

Why Medicare is High Risk

GAO designated Medicare as a high-risk area in 1990 because of its complexity and susceptibility to improper payments, which, added to its size, have led to serious management challenges. Medicare spending must be held much more firmly in check to sustain the program over the

[1]GAO, *High-Risk Series: An Update*, GAO-13-283 (Washington, D.C.: February 2013).

long term, while continuing to ensure that beneficiaries have access to appropriate health care. To help do so, GAO has identified opportunities to make Medicare payment methods more efficient and cost-effective. In addition, the size of the program makes it important for CMS to manage program functions more effectively and better oversee the program's integrity and quality of patient care. The following areas delineate where GAO has identified opportunities for improvements.

- *Reforming and refining payments*. CMS has implemented broad-based reforms to payment systems in the traditional Medicare fee-for-service (FFS) program as well as Medicare Advantage (MA) plans, where about a quarter of Medicare beneficiaries receive their care. Many reforms introduce financial incentives into payment structures to explicitly reward quality and efficiency. Important initiatives include steps toward transitioning Medicare's FFS physician payment system from one that rewards volume of services to one in which value—as measured by quality and cost of care—is used to determine payment. As CMS progresses to full implementation of its value-based payment system, it will be important for the agency to use reliable quality and cost measures and methodological approaches that maximize the number of physicians for whom value can be determined.

  GAO's work identified opportunities for CMS to introduce additional payment method refinements and controls in Medicare FFS to encourage appropriate use of services. For example, self-referral, where a provider refers patients to entities in which the provider or the provider's family has a financial interest, continues to be a concern for advanced imaging services. GAO's analysis showed that providers' referrals of advanced imaging services substantially increased once they start to self-refer. GAO estimated that such additional referrals cost more than $100 million in 1 year. Further, although Medicare's payment system gives hospitals an incentive to seek the best price for implantable medical devices (IMD), GAO determined that hospitals may vary in their ability to do so. The lack of price transparency and variation in amounts hospitals pay for some IMDs—and may pass on to the Medicare program—raise questions about whether hospitals are achieving the best prices possible.

  For the MA program, CMS has made progress implementing required adjustments to plan payments to align them more closely with the cost of care in the traditional Medicare program. However, in a January 2012 report, GAO indicated that CMS could still improve the accuracy of payments to MA plans. The payment adjustment CMS makes to MA plans to account for differences in diagnostic coding between MA

plans and Medicare FFS was $2.7 billion in 2010 while GAO's estimate was that a more accurate adjustment would have been between $3.9 billion and $5.8 billion. In another report on MA plans, GAO reviewed a demonstration CMS established to test an alternative bonus payment structure. This demonstration is estimated to cost more than $8.3 billion over 10 years and offsets a significant portion of the MA payment reductions made by the Patient Protection and Affordable Care Act (PPACA), as amended, during its 3-year time frame. GAO identified significant shortcomings in the demonstration's design that preclude a credible evaluation of the effect of incentives on plans' quality improvement. For this reason, GAO recommended that the Secretary of Health and Human Services cancel the demonstration and implement the quality bonus payments provided for under the PPACA. HHS has continued the demonstration.

- *Improving program management.* CMS has overcome some challenges in managing Medicare as it implemented some recent program improvements. For example, GAO had previously reported that Medicare sometimes overpaid for durable medical equipment (DME) items relative to other payers. To achieve Medicare savings, in 2009 CMS began implementing a DME competitive bidding program. In this program, CMS contracts with select suppliers to provide DME to beneficiaries and pays them at competitively determined prices based on the bids. GAO found that beneficiary access and satisfaction appeared stable in early assessments, and the competitive bidding program has led to savings. Similarly, in the past, CMS was sometimes hampered in identifying situations when Medicare should be the secondary payer, and the Medicare, Medicaid, and State Children's Health Insurance Program Extension Act of 2007 mandated reporting of such situations. Since CMS's implementation of the mandatory reporting for non-group health plans, program savings increased by $124 million from 2008 through 2011.

  CMS has improved its overall guidance and oversight of contracts, an area where GAO found pervasive internal control weaknesses in 2009 that put billions of taxpayers' dollars at risk. Improvements include adding internal controls and testing the agency's review of contract payments, adding new checklists and policies to document compliance with federal acquisition requirements, and enhancing its policies and procedures for tracking, investigating, and resolving contract audit and evaluation findings.

- *Enhancing program integrity*. The Administration and CMS have made reducing improper payments one of their priority initiatives. CMS has made progress in error rate measurement and in 2011 was able to report the error rate for all Medicare components for the first time, including the prescription drug benefit (Part D). CMS's performance plan has set targets for percentages of improper payments, with the targets slightly lower in each year. However, as reported in 2012, the rate of improper payments in FFS and Part C exceeded CMS's target rates. Thus, additional efforts will be needed to further reduce improper payments in FFS and Part C.

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

  CMS also has implemented the Fraud Prevention System (FPS), which uses analytic methods to examine claims before payment to help identify and prioritize investigations of potential fraud. Specifically, FPS analyzes Medicare claims data using models of potentially fraudulent behavior, which results in automatic alerts on specific claims and providers. These alerts are then prioritized for program integrity analysts to review and investigate as appropriate. According to program integrity officials, FPS is intended to help facilitate the agency's shift from focusing on recovering fraudulent payments after they have been made, to taking actions more quickly when aberrant billing patterns are identified. However, the system is

not fully integrated with CMS's existing information-technology systems, and CMS has not defined and measured quantifiable benefits and performance goals for it. In addition, GAO reported in 2011 that CMS had not incorporated all the data into its Integrated Data Repository, as planned, which limited the repository's use for identifying potentially fraudulent claims.

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

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

What Remains to Be Done

CMS has not met GAO's criteria to have the Medicare program removed from the High-Risk List. For example, although CMS has made progress in measuring and reducing improper payment rates in different parts of the program, it has yet to demonstrate sustained progress in lowering the rates. Because the size of Medicare relative to other programs leads to aggregate improper payments that are extremely large, continuing to reduce improper payments in this program should remain a priority for CMS. Further, CMS should complete some actions required by PPACA that were designed to improve the integrity of the program, such as

determining which providers must post surety bonds to help in recovering payments for fraudulent billing, using fingerprint screening for high-risk providers, issuing a final regulation that requires providers to disclose additional information, and establishing core elements for provider compliance programs.

To refine Medicare payment methods to encourage efficient provision of services, CMS should

- ensure the implementation of an effective physician profiling system, to help support use of value-based modifiers;
- develop and implement approaches to identify self-referred claims, reduce payments to recognize efficiencies achieved when the same provider refers and provides the service, and take steps to ensure the appropriateness of service provision;
- cancel the current MA Quality Bonus Demonstration and implement the quality bonus payment provisions in PPACA, as amended; and
- improve the accuracy of the adjustment of payments to MA plans for diagnostic coding differences, such as by using more current data in determining the amount of the adjustment.

To enhance program integrity, CMS should

- improve the structure and processes related to use of prepayment controls and assess the feasibility of increasing contractors' incentives for their use; and
- develop or finalize schedules and plans for its information technology efforts related to improper payments and fraud, including the FPS; define quantifiable benefits, measurable performance targets, and goals for these efforts; and use the targets and goals to determine their effectiveness.

To improve oversight of patient care and safety, CMS should

- strengthen oversight of nursing home complaint investigations by improving the reliability of its complaints database and clarifying guidance for its state performance standards, and

- use strategic planning to guide and gauge the progress of its planned efforts to meet the goals of the Five-Star Quality Rating System for nursing homes.

Medicaid Program

Background

The Medicaid program is a federal and state program that covered acute health care, long-term care, and other services for about 70 million low-income people in fiscal year 2011; it is one of the largest sources of funding for medical and health-related services for America's most vulnerable populations. Medicaid consists of more than 50 distinct state-based programs. The federal government matches state expenditures for most Medicaid services using the Federal Medical Assistance Percentage, a statutory formula based in part on each state's per capita income. Medicaid is a significant expenditure for the federal government and the states, with total expenditures of $436 billion in 2011. CMS is responsible for overseeing the program at the federal level, while states administer their respective programs' day-to-day operations.

Why Medicaid is High Risk

GAO designated Medicaid as a high-risk program because of its size, growth, diversity of programs, and concerns about the adequacy of fiscal oversight, which is necessary to prevent inappropriate program spending. Both Congress and the administration have demonstrated commitment and leadership to making Medicaid fiscal and program integrity a priority. In 2012, committees in Congress held hearings on reducing Medicaid improper payments and on improving oversight of the program. HHS continues to review and report on the rate of Medicaid improper payments, and continues to train and provide technical assistance to states on approaches to prevent improper payments. Among other actions, CMS issued guidance to states on removing providers from their Medicaid programs who have been terminated for committing fraud in other states' Medicaid programs or in Medicare, and required improved reporting and independent audits of states' Medicaid supplemental payments made to certain providers known as disproportionate share hospitals. However, stronger federal oversight of Medicaid is warranted as the program continues to grow in size and spending. For example, potential Medicaid expansions under PPACA are estimated to result in the enrollment of about 7 million additional individuals in 2014, growing to 11 million in 2022. The federal government is responsible for paying more than 90 percent of the increased costs associated with this expansion.

CMS will need new tools and resources as the law is implemented, including more reliable data for assessing expenditures, measuring performance, and preventing improper payments. Areas where program oversight has been insufficient include the following:

- *Improper payments to Medicaid providers serving program beneficiaries.* Improper payments to providers who submit inappropriate claims can result in substantial financial losses to states and the federal government. In its 2012 financial report, HHS estimated—on the basis of individual state error rates from a sample of 17 states reviewed on an annual rotating basis—a national improper payment rate for Medicaid of 7.1 percent (with the federal share estimated at $19.2 billion).

  Positive steps toward improving transparency and reducing improper payments have been taken in recent years. In May 2011, CMS issued guidance to states on processes to remove providers from their program when the providers have been terminated from another state's Medicaid program or terminated from Medicare as required by PPACA. In addition, CMS has committed to (1) redesigning its national Medicaid audit program, which relied on data that were incomplete, unreliable, and untimely, and, as a result cost significantly more than the potential overpayments it identified; and (2) using its comprehensive reviews of state integrity program activities to better target audits toward states with significant weaknesses in their ability to detect overpayments. Separate from this initiative, CMS is also testing the cost-effectiveness and feasibility of establishing a fraud prevention system for Medicaid by April 1, 2015; however key challenges remain, including improving key data systems so that they provide reliable and complete data needed to implement effective programs to identify and prevent improper payments; eliminating duplication between CMS and state program integrity efforts; and refocusing national audit efforts on approaches that are cost-effective.

- *Financing methods that are inappropriate, and large supplemental payments that are not always transparent.* Some states have established varied financing arrangements involving Medicaid supplemental payments that inappropriately increase federal Medicaid matching payments. The total amount of supplemental payments has increased in recent years. In fiscal year 2011, states reported spending at least $43 billion, up from $32 billion in fiscal year 2010 and $23 billion in fiscal year 2006. GAO and others have reported concerns with states' Medicaid supplemental payments over the last decade, including the use of supplemental payment arrangements to

increase federal funding without a commensurate increase in state funding, and concerns that the payments were not used for Medicaid purposes. Large increases in reported supplemental payments have been identified as a major factor that contributed to increased Medicaid spending on hospital services in 2010.

A variety of federal legislative, regulatory, and CMS actions have helped curb inappropriate arrangements, but gaps remain. In 2003, CMS began an initiative to closely review state supplemental payments and required states to end those it found inappropriate; however, in 2008, GAO reported that CMS had not reviewed all supplemental payment arrangements to ensure payments were appropriate and were for Medicaid purposes. Starting in 2010, CMS implemented new transparency and accountability requirements for certain Medicaid supplemental payments, known as Disproportionate Share Hospital (DSH) payments, including new reporting and auditing requirements for these payments. In 2012, GAO found that the new requirements improve CMS's ability to oversee DSH payments by better assuring that states comply with federal requirements, including accurate calculation of payment amounts to ensure payments are not excessive. However, similar standards for calculating, reporting, and auditing of other types of Medicaid supplemental payments—referred to here as non-DSH supplemental payments—have not been established even though these payments have increased significantly in recent years and exceeded DSH supplemental payments in total amounts. Although Medicaid payments are not limited to the costs of delivering Medicaid services, Medicaid payments that greatly exceed Medicaid costs raise questions about the purpose of the payments, how payments relate to Medicaid services, whether payments are consistent with economy and efficiency, and whether payments contribute to beneficiaries' access to quality care.

- *Managed care rate setting and quality of data used to set such rates has not been consistently reviewed by CMS.* Requirements for Medicaid managed care rates to be actuarially sound are key safeguards in efforts to ensure that federal spending is appropriate. In 2010, GAO reported that CMS had been inconsistent in ensuring that states are complying with the actuarial soundness requirements. Further, GAO found that CMS efforts were not sufficient to ensure the quality of the data used by states to set managed care rates. With limited information on data quality, CMS cannot ensure that states' managed care rates are appropriate, which places billions of dollars at risk for misspending.

- *Demonstrations that inappropriately increase federal costs.* HHS has the authority to waive certain statutory provisions to allow states to implement demonstrations that test ideas for achieving program objectives. By policy, demonstrations should not increase federal costs. However, GAO reported in 2008 that HHS had approved two state demonstrations that could substantially increase the federal financial liability. At the time of GAO's work in 2007, HHS disagreed with GAO's recommendation to improve the demonstration review process through steps such as clarifying the criteria for reviewing and approving states' proposed spending limits, and ensuring that valid methods were used to demonstrate budget neutrality. Consequentially, GAO elevated this recommendation to Congress for consideration. HHS subsequently reported taking steps, such as monitoring the spending under ongoing approved demonstrations, to improve its oversight; however, as of December 2012, HHS had not planned on any changes in the criteria and methods used to determine budget neutrality of demonstrations prior to approving them.

What Remains to Be Done

Congress, HHS, and CMS have taken steps to improve the fiscal integrity of Medicaid, and CMS has implemented certain GAO recommendations, such as improving the information collected on certain supplemental payments and issuing guidance to states to better prevent payment of improper claims. However, more federal oversight of Medicaid's fiscal and program integrity is needed. For example, CMS oversight of program integrity has been challenged by data systems that do not provide reliable, complete, and timely data. States also have key roles in reducing improper payments to providers in developing, implementing, and evaluating the effectiveness of corrective plans to reduce improper payments.

CMS should also continue taking steps to improve oversight of Medicaid managed care payment rate-setting and Medicaid supplemental payments. In November 2012, GAO suggested that Congress require CMS to take certain steps to improve the transparency of and accountability for Medicaid non-DSH supplemental payments, including requiring improved reporting and independent audits of these payments. In addition, GAO's suggestion that Congress require HHS to improve the criteria and methods used to ensure the budget neutrality of Medicaid demonstrations remains valid.

Thank you, Chairman Pitts, Ranking Member Pallone, and Members of the Committee. This concludes our testimony. We would be pleased to answer any questions.

If you or your staff have any questions about this testimony, please contact Kathleen King at 202-512-7114 or kingk@gao.gov or Carolyn Yocom at 202-512-7114 or yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Martin T. Gahart, Assistant Director; Kristin Ekelund; and Krister Friday were key contributors to this statement.

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Mr. PITTS. The Chair thanks the gentlelady and now recognizes Ms. Yocom for 5 minutes for an opening statement.

Ms. YOCOM. Chairman Pitts and Ranking Member Pallone and members of the subcommittee, Ms. King and I combined our statements so I am available to answer any questions regarding Medicaid.

Mr. PITTS. Thank you. I will now begin questioning and recognize myself for 5 minutes for that purpose.

Dr. Budetti, it is often said that CMS uses a pay-and-chase model to fight fraud in our Nation's entitlement programs. That is, CMS will unknowingly process a fraudulent payment and then try to recover payment down the road. My understanding is that CMS still largely operates reactively. Are you aware of any single claim using the Fraud Prevention System that stopped a claim before it was paid?

Dr. BUDETTI. Mr. Pitts, the history certainly has been of a predominantly pay-and-chase approach, and that is what the Fraud Prevention System is changing, and I would like to point out something that is really quite different with the Fraud Prevention System than the way we have done things in the past because in the past, most of our screening was done on a single claim-by-claim basis, and what the Fraud Prevention System allows us to do, it is triggered by claims that into the system, but then what happens is, we are able to combine not just one claim but the pattern of claims that we are seeing and the pattern of beneficiaries being served and the pattern of services being billed as well as lots of other forms of information to produce, if you will, a picture of an entire book of business, and that book of business then is given a risk score, and based upon that risk score, we then are able to take action, and that is the basis of the $115 million in savings, which includes many ways of stopping the payments.

Mr. PITTS. So the answer is no?

Dr. BUDETTI. No, the answer is yes. We have definitely been implementing systems that are stopping payments from going out the door triggered by incoming claims but looking at a broader perspective. For example, one of the ways we like to stop payments is to kick somebody out of the program once we have identified the fact that they don't belong in the program.

Mr. PITTS. Thank you.

Ms. King, Dr. Budetti testified before the Health Oversight and Government Reform Committee on April 5, 2011, that most of the $60 billion in improper payments accounted for in 2010 were not "usually fraudulent nor necessarily payments for inappropriate claims" but rather, indications that errors were made by the Provider in filing a claim or inappropriately billing or a service. In that same year, his former boss, Donald Berwick, put the number at $98 billion. Frankly, I haven't seen one indication that CMS truly knows how much it loses each year much less whether a majority of these payments are not usually fraudulent. Do you agree with Dr. Budetti's assertion that most of the payments are not fraudulent but merely billing errors by providers?

Ms. KING. Mr. Chairman, I would like to distinguish between improper payments and potentially fraudulent payments. Improper payments are those payments that should not have been made for

any reason, and they include both overpayments and underpayments, and each year HHS measures the rate of improper payments. It is true that most of the problems related to improper payments are related to inadequate or missing documentation, so a large part of that is they have not supplied the proper documentation or the documentation is inadequate.

But i would like to point out the difference between improper payments and fraud. There is no measure of fraud in the Medicare program, in part because you can't determine everything that is fraudulent because a lot of fraud is committed and it doesn't hit the improper payment screens. For example, if I sell my beneficiary number to someone and they use it to obtain services, and if those services are billed correctly, they are not going to show up as an improper payment. And fraud is actually only determined by a court of law because it involves a deliberate attempt to deceive and to cheat.

Mr. PITTS. Thank you.

Ms. Yocom, in GAO's most recent report, you note that States have increasingly used supplemental payments through sophisticated financing arrangements such as provider taxes. Increased scrutiny of such payments has raised significant concerns from the States who believe they have limited resources to fund their already strained Medicaid programs. Given the drastic expansion of the Medicaid program in 2014, do you not see a further increase in the use of such State funding arrangements?

Ms. YOCOM. Mr. Chairman, our work has shown that there has been an increase in the use of supplemental payments rising from about $23 billion in 2006 up to about $43 billion in 2011. We do have some outstanding recommendations for CMS involving in particular the use of non-DSH supplemental payments, which currently there is not enough reporting and transparency regarding their oversight, approval and use.

Mr. PITTS. Thank you. My time has expired. The Chair recognizes the ranking member, Mr. Pallone, 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman.

Dr. Budetti, if Congress fails to act in the next couple days, sequestration will result in a 2 percent cut in the Medicare funding, and I know that funding for fraud and abuse work is not exempt from this cut. Can you tell me yes or no, though, is the funding for your program integrity work at CMS exempt from the sequester? Just yes or no.

Dr. BUDETTI. No, sir. My understanding is it is not exempt.

Mr. PALLONE. All right. Then can you tell me if your budget takes a 2 percent cut as required in the sequester, is it logical to assume that this cut will have a negative effect on the staff and activities that are currently being used to fight fraud?

Dr. BUDETTI. All of our activities, Mr. Pallone, to fight fraud and to reduce improper payments depend upon our resources, and anything that reduces our resources is going to mean that we will have lowered ability to carry out our mission.

Mr. PALLONE. According to your own HCFAC report, fraud and abuse activities have had an eight to one return on investment over the past 3 years. Is it true a cut to program integrity as a result

of the sequester could negatively affect the ability to return fraudulently obtained monies to the Medicare trust fund?

Dr. BUDETTI. That is a serious consideration because what we have learned over the years of the Health Care Fraud and Abuse Control program is that the more we do spend looking for fraud, the more we find, and so the return on investment has actually gone up the more we spend. So cutting back would be expected to have just the opposite effect.

Mr. PALLONE. Thank you. Now, I wanted to ask you, waste, fraud and abuse are not unique to public programs. It is fair to say that many, if not all, the fraudulent practices that we are addressing in public programs at the federal and State level are also issues for private health payers and sharing information and collaboration between the public and private sector are critical to these efforts. So could you tell us about the work CMS is doing to increase collaboration and coordination both internally between Medicare and Medicaid and externally with private payers?

Dr. BUDETTI. We have joined with the Attorney General and the Secretary joined together to establish the Public-Private Partnership for Health Care Fraud Prevention. We have a number of health plans and antifraud associations and other private sector partners that we are working together with as well as State agencies and other law enforcement agencies to work together on a problem. This is in recognition of the fact that actually health care fraud knows no boundaries and it attacks everybody, and we have already had the first serious interactions between the parties in the public-private partnerships, health care fraud prevention partnership, and we are building on that, and the intention is that we will be sharing best practices, data, analytic tools across the public and private sector. This is a very exciting and very important step forward for us to marshal resources throughout the health care system to fight fraud.

Mr. PALLONE. Thanks.

Let me go to Ms. Yocom and ask her about CMS. CMS through its Medicaid Integrity Institute and other programs is working to partner with States and help to build State-level antifraud capacity. Can you give us a sense of how they are doing and are their program oversight activities that CMS has taken that appear to be effective, in your opinion?

Ms. YOCOM. Sir, there has been some improvements in the improper payment rate in Medicaid. It has decreased by about a percent, and in terms of dollar value, from about 21.9 to about 19.2 billion.

There is more to be done. Our recommendations and our outstanding work is focusing on having CMS collaborate more with States to both augment their program activities and to support their program activities. Our work has found that those collaborative audits have actually been the most successful of the efforts that have happened to date.

Mr. PALLONE. Did you want to comment on what I mentioned before in terms of, you know, dealing with the private sector as well and what they are doing?

Ms. YOCOM. I don't think we have work that I can respond to you on that.

Mr. PALLONE. All right. Thanks so much. I yield back.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the vice chairman of the committee, Dr. Burgess, 5 minutes for questions.

Mr. BURGESS. Thank you, Mr. Chairman.

Ms. King, let me ask you a quick question that deals with third-party liability payment. Congress intended that Medicaid be the payer of last resort. My staff has been in contact with you about improving Medicaid third-party liability. To what extent do you feel that it is necessary to address this?

Ms. KING. Sir, Medicare or Medicaid?

Mr. BURGESS. Medicaid.

Ms. KING. GAO's work on third-party is pretty dated at this point. We have some studies——

Mr. BURGESS. So the answer would be, you think it would be worthwhile to look into this?

Ms. KING. Yes.

Mr. BURGESS. As I understand, the last report was in 2006.

Ms. KING. Correct.

Mr. BURGESS. It demonstrated a significant problem. Will you be willing to work with my staff to see if we can't move the needle on this one a little bit?

Ms. KING. We certainly would.

Mr. BURGESS. Thank you.

Dr. Budetti, at this committee's last hearing on fraud, we asked the Government Accountability Office to provide a list of recommendations to combat waste, fraud and abuse in Medicare and Medicaid that had yet to be implemented. So in a sense of fairness, maybe you can give us an update on some of these things. I am going to ask for really brief answers like yes or no answers to these questions. Have you implemented the GAO recommendation from February 2009 that CMS should expand the types of improper billing practices that are grounds for revoking a home health provider's billing privileges?

Dr. BUDETTI. Dr. Burgess, I don't have the specifics on the individual programs right in front of me. I can tell you that the vast majority of the GAO recommendations are in some kind of process of our responding to them, but I would be delighted to give you a specific answer——

Mr. BURGESS. I wish you would.

Dr. BUDETTI. —for the record afterwards.

Mr. BURGESS. It is a possible no but may be an incomplete. Yes or no, have you implemented the GAO recommendation from March of 2010 to require the agency to evaluate RAC audits to correct the vulnerabilities identified in the agency? Those are the recovery audits.

Dr. BUDETTI. Well, again, I can't speak to the individual one right offhand but we do have lists, we do track these and I will be delighted to get that to you.

Mr. BURGESS. I have a list myself, happily, and I am anxious to track this with you because it is important. The GAO makes recommendations. We are here fighting the same problem we fight year after year after year. It is important that we make some progress: I will tell you what. In the interest of time, we will leave

the GAO reports and maybe you can work with my office to get us answers.

Now, it is referenced several times under the President's Affordable Care Act under subtitle (e), Medicare and Medicaid, CHIP program integrity provisions, several provisions that were signed into law by the President. Maybe we can just briefly run through those and you can tell me if those have been implemented. The face-to-face encounter with the patient that is required before a physician may certify eligibility for durable medical equipment.

Dr. BUDETTI. I believe that one has been implemented.

Mr. BURGESS. So that is a yes? Ding, ding, ding. Good for you. Implement criminal background checks for fingerprinting for providers and suppliers considered at risk.

Dr. BUDETTI. We have not finished the implementation of that for a number of reasons, in part related to the FBI's own internal rewarding of its contracts, but we are in the process, very much in the process of putting that into place, sir.

Mr. BURGESS. It has been almost 3 years since this was signed into law. It is important stuff. I would get the FBI, the Justice Department engaged because it was felt to be important by the President. He signed it into law. Let us see that it is implemented. How about implementing limitations on how much high-risk providers and suppliers can bill the Medicare program within the first year?

Dr. BUDETTI. We are in the process of developing——

Mr. BURGESS. So that is an incomplete. How about implementing a temporary moratorium for new Medicare providers from enrolling and billing the Medicare program even though there are more than enough suppliers to furnish health care services in certain areas of the country?

Dr. BUDETTI. That is a very important tool. We have been looking very carefully at the places to implement it, and we have—we are in the process of moving forward with that where we think it is appropriate as an adjunct to all of the other tools.

Mr. BURGESS. Well, an important tool but it is——

Dr. BUDETTI. We have not implemented a moratorium yet.

Mr. BURGESS. It is languishing, and we are coming up on 3 years, establish a compliance program for fee-for-service providers and suppliers.

Dr. BUDETTI. We are still in the process of working on that, in part because the Inspector General has long since had very sound guidance for providers for voluntary compliance programs.

Mr. BURGESS. OK. I am running out of time. That is also an incomplete. Implement a surety bond on home health agencies and certain other providers of services and supplies?

Dr. BUDETTI. The surety bond program is in place for DME but we are still in the process of implementing it beyond that.

Mr. BURGESS. For home health specifically, that is a no, and what about implementing checks to make sure that a physician actually referred a Medicare beneficiary for medical service before paying the claim?

Dr. BUDETTI. We do have processes in place for doing that.

Mr. BURGESS. Incomplete, so one out of those seven things that were signed into law by the President that are always referenced as hey, these are important things that we want the Affordable

Care Act to do to combat fraud, we are still waiting to see if they in fact will be effective.

Thank you, Mr. Chairman. You have been generous. I will yield back.

Mr. PITTS. The chair thanks the gentleman and now recognize the gentleman from Texas, Mr. Green, 5 minutes for questions.

Mr. GREEN. Thank you, Mr. Chairman, for the time, and I appreciate our panel has taken the time to be here today.

The rising cost of health care threatens our Nation's economy and puts more and more families at financial risk, although I have to say that I just read an interesting article in Time magazine last week that said Medicare is the ultimate cost saver in health care, but that is not part of my questions. I believe the key part of saving money is keeping people healthier longer. To achieve this, people must have the health care coverage necessary that they can be seen when they first get sick and not have to wait until it is so bad they need urgent care.

My question is to GAO and CMS. Can the Government Accountability Office or CMS estimate the government or private sector costs from the administrative waste associated with the phenomenon in Medicaid known as "the churn" where people who are eligible for Medicaid are discharged from the rolls for bureaucratic or paperwork reasons or for some temporary changes in income that do not impact their long-term eligibility for Medicaid? Is there any studies that you all have been able to do on that?

Ms. YOCOM. We have not done any studies in that area. We have taken a brief look at express-lane eligibility and the extent to which that is a potential benefit. There are a few States that have reported some cost savings. From our perspective, those savings always have to be offset by ensuring that eligibility is correctly calculated.

Mr. GREEN. Well, and I agree, and I know a lot of States have a 6-month eligibility, and if you have a senior citizen who forgets to return the letter, you know, instead of being treated for diabetes they will end with an episode and end up even costing more. Again, to GAO and CMS: Can GAO and CMS describe the costs to the State and federal budget associated with the ongoing determinations of whether people are eligible for Medicaid? For example, my State requires people on Medicaid to be determined eligible every 6 months, and despite the fact that most people who are on Medicaid are eligible for the program for much longer period of time and it requires adult Texans on Medicaid to show up in person for their redetermination, and I know we can cut our Medicaid rolls by making that happen. The problem is that that increases our costs by making someone who may be so ill or a senior citizen drop off and then get back on. Is there any quantification of that?

Ms. YOCOM. We have not done any quantification of the costs and benefits associated with that.

Mr. GREEN. Because I know on a State level, oftentimes they can quantify that if they do this, this will cut our rolls X amount, but in the long run, those folks who are typically so ill, they will be back on and much more costly. I would sure appreciate it if there was an option on that.

My last question to the GAO. Where should we assign the government expenditures for the following hypothetical? A Medicaid beneficiary with diabetes eligible for and enrolled in Medicaid is removed from the rolls because he or she failed to respond to a letter sent by the State to confirm their residency at a particular address. Two months later, that person has a diabetic event because the diabetes went unmanaged and is reenrolled in Medicaid at the time and now the costs are more expensive of inpatient and emergency care is billed to Medicaid. If that person were just covered by Medicaid for those two months, it would be more likely we wouldn't have seen those episodic costs. In your opinion, should these added costs be categorized as waste, fraud and abuse, and if not, where should we categorize that excessive waste and avoid unnecessary spending?

Ms. YOCOM. Sir, certainly getting care earlier is always beneficial to the patient. Our work on preventive services and taking a look at trying to balance costs and benefits, it is difficult to come up with an exact measure of cost and/or savings, and I don't believe that GAO has done that.

Mr. GREEN. Well, I understand, and I have a couple of seconds left. The private sector in some of the studies we have seen, both from businesses who provide the health care can show that they can save money for that continuing care, for that continuing much more reasonable maintenance of an illness instead of waiting for that episode.

So Mr. Chairman, I would hope we would look at that not only from the private sector but also for Medicaid and Medicare, and I appreciate the time. I will yield back.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentleman from Louisiana, Dr. Cassidy, 5 minutes for questions.

Mr. CASSIDY. Thank you, sir.

Tagging off of what Mr. Pallone, now, in your testimony, you say that for every $1 spent, the program saves $7.90, and it begs the question, that if you have to take a 2 percent across-the-board cut, why are they going to cut the programs that would save you $7.90 per dollar spent? Is the management so inconsiderate of return on investment that they are going to cut something that saves $7.90 per dollar spent? That is the testimony you suggested.

Dr. BUDETTI. Dr. Cassidy, thank you for that question. As you know, the specific cuts related to the sequester have not occurred yet. There has been a lot of internal planning and preparation for the way to do any cuts if they should take effect.

Mr. CASSIDY. I have limited time. So if the taxpayer is listening and the taxpayer is wondering what kind of management would cut a program which has an ROI of $7.90 per dollar spent, and that is your testimony, what was management thinking that this would even be on the table?

Dr. BUDETTI. Well, what I would say, sir, is that the thinking is that our number one priority is making sure that beneficiaries get the medical care that they need, and if we have——

Mr. CASSIDY. But clearly, if Mr. Pallone is right, that the money you save goes back into the trust fund in order to support that medical care, I think the taxpayer has every right to wonder what

in the heck he is spending money for. If we are cutting something with an ROI of $7.90 per dollar spent, do you see my concern?

Dr. BUDETTI. I do see your concern. I also know that in the immediate short term, we have to worry about our principal mission, which is making sure that beneficiaries——

Mr. CASSIDY. So there is nothing else that can be cut between actually paying for medical services and something which gives you an ROI of $7.90 per dollar spent?

Dr. BUDETTI. There are very few things that have been exempted under the terms of the sequester.

Mr. CASSIDY. I will tell you, it calls into question the wisdom of your management.

Secondly, you create the impression that if we cut under the sequester all these valuable things, but then what Dr. Burgess just brought up, which I am sure is because of his staff's good homework, not his own, that only one out of seven of these things demanded by the Affordable Care Act, which passed in 2010, has been fully implemented. It doesn't seem like a sequester cut now is going to be that which is fatal to their implementation. It actually seems as if there is kind of a casual timeline anyway.

Dr. BUDETTI. Sir, I would point out that there are a few more pages of provisions that actually have been implemented that——

Mr. CASSIDY. But I am speaking specifically about waste, fraud and abuse.

Dr. BUDETTI. That is exactly what I am talking about. We have implemented many provisions in the Affordable Care Act that have greatly strengthened our ability to fight waste, fraud and abuse, and in doing so, we always have to establish our priorities and allocate our resources appropriately.

Mr. CASSIDY. Well, if we are going to establish priorities, then I would suggest that the taxpayer would like that you continue to spend money which gives you a $7.90 return on investment per dollar spent.

Now, let me move on, and I don't mean to grill but this is obviously a process. We are all familiar with the New Yorker article about McAllen, Texas, under Medicare, the hospital in McAllen spent 180 percent of a cohort, of the amount spent on a cohort in El Paso. There is a follow-up article on that in Health Affairs in which Blue Cross Blue Shield patients, Texas Blue Cross Blue Shield, 7 percent less was spent for the cohort in McAllen than in El Paso. Under CMS, it is 180 percent more. On Blue Cross Blue Shield, it is 7 percent less. It seems like the problem may not be the docs, the patients or the hospital but it may be CMS's systems, just looking at the contrast between the two payers and the results they get. What comment would you have on that?

Dr. BUDETTI. I would say that one of the advantages of our having established the strike forces under the joint Department of Justice and Health and Human Service aegis has been to look at the highest fraud areas very carefully.

Mr. CASSIDY. But why did Blue Cross Blue Shield figure this out prospectively and we are having to do strike forces to get it retrospectively?

Dr. BUDETTI. The populations that are being served, sir, are very different. The situations are very different.

Mr. CASSIDY. Sixty-four years old and 65 years old, these are the same patients in the same hospital with the same doctors. Again, this seems somewhat of an indictment upon the system because there is not that much difference—I am a doc—between something who is 64 and 65.

Dr. BUDETTI. I don't have a specific answer for you on that, in that area. I would be happy to look for, you know, anything more specific, but I will say that we are focusing on the high-fraud areas and we are making major progress in identifying discrepancies like that and working together with law enforcement and with the private sector to do something about it.

Mr. CASSIDY. Thank you for your testimony. I yield back.

Dr. BUDETTI. Thank you, sir.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentlelady from California, Ms. Capps, 5 minutes for questions.

Mrs. CAPPS. Thank you, Mr. Chairman. I again thank the panelists for being here today.

Dr. Budetti, Dr. Burgess asked about several projects CMS is implementing from the Affordable Care Act, and you didn't really have time to address them. Would you like to take a minute now to tell us what CMS has been implementing from the ACA?

Dr. BUDETTI. There are many provisions of the Affordable Care Act that we have implemented. Some of the biggest ones involve the risk-based screening of providers and suppliers, which is a new way of identifying the suppliers and providers that are in the limited-risk group and are subjected to very detailed background checks but not to the same level of scrutiny as others. That is a very extensive program. We have established a program to alert States when someone is suspended or is terminated by one Medicaid program or by Medicare for cause so that other States can keep them from entering their program. That is an important step forward. We have implemented a number of aspects of our collaboration with law enforcement that have really moved things forward on that front. There are many provisions of the Affordable Care Act that have strengthened our ability to fight fraud, waste and abuse and we have implemented a great number of them.

Mrs. CAPPS. Thank you. You know, the hearing is about fraud, waste and abuse. We know these are significant problems for both public and private health care payers. The scope and complexity of health care itself as well as the diverse payers and the systems we have to pay for it certainly adds to the challenge. Both CMS and GAO acknowledge that we don't really know the true scope and cost of waste, fraud and abuse to the Federal Government.

My question has to do with how we can begin to get our hands around measuring the scope and the extent of the problem. Unless we do, we won't really know how to tackle it or how much to spend doing that. In that context, how do we measure the effectiveness of the efforts being undertaken now, just some of the problems that you just described?

Dr. BUDETTI. Sure. We have taken steps towards developing the methodology for measuring probable fraud. We intend to implement that in one particular arena, which is home health, and to apply that methodology. It involves a very sophisticated approach because as Ms. King pointed out, people don't often volunteer that

they have committed fraud so we can't do a simple survey, but we have made substantial progress toward having a methodology in place to estimate probable fraud. We intend to do that first in home health, and then once we have learned how well that works to apply it to other areas. We have done a very thorough job in the government of measuring improper payments, and improper payments encompass a wide range of reasons why a certain payment should not have been made, and we would very much like to move forward with a reliable measure of probable fraud.

Mrs. CAPPS. One sort of parallel question that hasn't been brought up. Measuring the impact of prevention—that is my background, public health—this is really hard to measure in any way. Can you share some of the metrics and benchmarks that you are using or working on in the area of preventive health?

Dr. BUDETTI. Sure, and I appreciate the question very much. I think the best way to illustrate it is with an example. When we put into place one of our models in the Fraud Prevention System, we identified a pattern of behavior that raised very strong suspicions, and we ended up identifying a particular potential fraudster who fell into the same pattern that others had perpetrated, others had billed hundreds of thousands of dollars or even millions of dollars to the program, but this particular one, I believe, had only billed us for $4,000 but it was the same scam and it was clear that they were just starting up and getting going, and so we are faced with the question of how do we take credit for finding something that had only billed us for $4,000. Now, that is exactly where we want to be. I mean, I would rather it be at $2,000 but $4,000 is a lot better than $4 million, but yet if we just say that we stopped something that prevented that when somebody had already billed us for $4,000 doesn't sound very impressive. So we have to figure out the best way to put, as the statute requires us, to put a dollar value on prevention, and that is a challenge but we are taking it on.

Mrs. CAPPS. I appreciate that. Thank you very much, and I yield back.

Mr. PITTS. The Chair thanks the gentlelady and now recognizes the gentleman from Illinois, Mr. Shimkus, 5 minutes for questions.

Mr. SHIMKUS. Thank you, Mr. Chairman.

I am not sure if it was Ms. Yocom or Ms. King who made the statement of trying to define improper payments from fraudulent payments.

Ms. KING. That would be me.

Mr. SHIMKUS. And, you know, we are almost in like bizarro world a little bit because improper payments, fraudulent payments, theft, abuse—Dr. Budetti, when you mentioned this $4,000, following this scheme of abuse, that is what credit card companies do every day. Dr. Burgess is right.

Now, I know, sir, you have done a pilot program on the magnetic strip card, identification card, I think it was in Indiana. Not a lot of fraud there. One, I would ask if we could get a release of the findings of that pilot program. Also, you know, I have also been involved in the magnetic chip issue. There was a bill last year by Mr. Gerlach. I would encourage all my colleagues to look at that bill from last year, 2925. It will probably get reintroduced this year. If major financial institutions can call someone and ask about an im-

proper payment that is outside their area within 12 hours of the payment being made, for the life of me, I don't understand why that is not a good system to help us identify improper payments and fraudulent payments. The billing on both ends, a statement released. Well, that is why we have a bill because we don't think you have effectively looked at it and we are slow, we are bureaucratic, we are not private sector and we just can't seem to get it done, and that hurts the payments to other folks. So that is my statement, that there is another bill coming to try to get us to move to a current world technology of a payment system that will help identify improper and fraudulent payments.

A real crisis in Medicaid is the funding. That is why these hearings are important, but in Illinois, we have $1,922,000,000 in backlog of unpaid bills that are sitting in our comptroller's office. There is another $700 million worth of bills that are being held by the State government before they give them to the comptroller, when then you add those up, that is $2.6 billion in unpaid Medicaid reimbursements to our providers. The delay in payment is 3 to 8 months, and of course, when they do pay, they are paying 70 percent of what the private sector is paying for the health care delivery. We are a disaster in Medicaid reimbursement to our health care providers, some smaller ones going broke or just saying we can't provide Medicaid anymore. Having said that, I know that, Ms. Yocom, the biggest challenge to the Medicaid program, through federal initiatives is the lag in Medicaid data from the States, and you have reviewed the discrepancy in the data from States and reported that CMS will need more reliable data for assessing expenditures and measuring performance in the Medicaid program. I would encourage you to get current data on Illinois.

Can you please outline the GAO work on aligning the States' expenditure data which in your 2012 October report showed significant discrepancies and reported expenditures of more than $40 billion for fiscal year 2009? Even in Washington, $40 billion is a bad discrepancy of reporting on payments.

Ms. YOCOM. Yes, sir. We did take a look at two expenditure systems that CMS operates. The first is an expenditure system that is the basis with which States claim their federal match. The second is a statistical system that takes the activities performed in the Medicaid program and looks at them from the perspective of the beneficiary. So it is beneficiary-specific payments. These two systems are not measuring the same thing, so there is some acceptance that they should be different, but we could not quantify the source of all the differences or the reasons why those differences occurred. At the end of the day, we ended up with about a 90 percent national match but on the State-by-State basis, there were significant variation across the different—in terms of the two systems.

Mr. SHIMKUS. Thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentlelady from Illinois, Ms. Schakowsky, for 5 minutes for questions.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman.

There was an earlier discussion about McAllen, Texas, and CMS's antifraud activities to root out fraud and unnecessary spending. Dr. Budetti, you mentioned the HEAT task force as

catching fraud on the back end, but isn't it also true that many of the Affordable Care Act provisions you are implementing are catching fraud on the front end? For example, the Fraud Prevention System, the new provider screening requirements, the cross-checking between bad providers and Medicare and Medicaid. So is it not accurate to say that—so my sense is that it is not accurate to say that you are doing nothing in these high-fraud areas on the front end, and I wondered if you could talk about how the front-end prevention is paying off.

Dr. BUDETTI. Thank you, Ms. Schakowsky. One of the things that I am extremely pleased with is our growing collaboration with law enforcement. Our law enforcement colleagues are very fond of saying that they don't believe that they can prosecute their way out of the current fraud situation after the fact, and so they have been very active partnering with us on the prevention side and on the early detection side as well, and we have agents from both the Office of Inspector General and the FBI who are assigned to work directly with us and who have been very much involved in helping us build the Fraud Prevention System and the models in the Fraud Prevention System and how to follow up on it, and when we do that, we are taking an across-the-board approach which says we want to stop as much as we can before it ever happens, and that is what we are able to do with activities under the Fraud Prevention System. We want to catch it early and take administrative action because if somebody has only stolen, say, $4,000, that may very well not be a case of law enforcement could ever pursue because of resources. But then we also want to work together when in fact some people do squeeze through and we have to chase after them after the fact. So our approach is to shift to moving beyond pay and chase but we cannot pay and chase in that sense.

Ms. SCHAKOWSKY. I wanted to ask you also about the—I feel like sometimes we overlook the importance that beneficiaries can play in fighting fraud, and I am wondering if you could discuss how Medicare beneficiaries can help CMS identify fraud and what steps CMS may have taken to make it easier for beneficiaries to spot fraud or errors.

Dr. BUDETTI. So I don't know if any of the members of the subcommittee have looked at their explanation of benefits recently, but when I got to CMS and we were reviewing the Medicare summary notices, we decided that we could do a better job of communicating both what the content was and the ability to highlight where there might be problems, and so over a period of time working with focus groups with Medicare beneficiaries and redesigning the Medicare summary notice, we have now produced a new statement that is going out for the first time this year. It has been available for people who would get their summary notices online previously but it is now going into the mail, and this will be much easier to read and much easier for individuals to look to see whether or not there is a problem with the billing that is attributed to their having gotten services and be able to raise questions.

In responding to that, we have also vastly upgraded and made much more user friendly the 1-800-MEDICARE call system way of dealing with calls that come in that raise questions about possible fraud, and last year something like 50,000 of the calls that came

in led to some level of escalation of our investigation to look behind an incoming call. So on both the summary notices and on the changes to the 1-800-MEDICARE call system and, on top of that, to our outreach to Medicare beneficiaries to inform them about these changes, we are very much engaging because our feeling is that, you know, 45 million, 50 million beneficiaries out there fighting fraud with us is one of the——

Ms. SCHAKOWSKY. Let me just say, I would like to see an example or two of the savings from beneficiaries.

Dr. BUDETTI. I would be happy to.

Ms. SCHAKOWSKY. Thank you.

Mr. PITTS. The Chair thanks the gentlelady and now recognizes the gentleman from Kentucky, Mr. Guthrie, 5 minutes for questions.

Mr. GUTHRIE. Thank you, Mr. Chairman, and thank you for coming and I appreciate your having this hearing on waste, fraud and abuse within the Medicare system and hope we continue to explore this.

But before I begin my questions, I would just like to bring to the committee's attention a company in Kentucky that has a plan to bring savings to the Medicare program through the home health program integrity measures. The industry's 2010 proposal to limit outlier payments has been successful in saving the program roughly $900 million per year in the first 2 years alone. Almost Family's proposal will build on that, and that includes episode limits for a beneficiary to get at the bad actors who are billing for lengthy episodes of care in excess of three or four per beneficiary. Estimates predict this would save Medicare nearly $1 billion per year. We should look at this and other industry proposals for a way to save money within the system and get the bad actors that are fraudulently draining Medicare dollars. I found that a lot of industries with good actors who are trying to do service and do things correctly immediately want to point out the bad actors immediately want to point out the bad actors because that affects the whole Medicaid and Medicare program.

I do have a question for Ms. Yocom and Dr. Budetti. I am interested in reviewing how the States use the funds in the health care law related to Medicaid IT payments. As you know, States are eligible to receive a 90 percent match from the Federal Government for the design and development of new systems through 2015. Has GAO initiated any integrity review of these funds and how they are expended to date?

Ms. YOCOM. We have not instituted an integrity review of the 90/10 matching States. There has been interest in that, and I believe we are planning to respond to that interest.

Mr. GUTHRIE. What are you doing now with CMS to ensure—this is a significant funding stream—that funds are being used appropriately? How are you managing that? I know you don't have a GAO study or initiative but how are you managing that to make sure it is being spent appropriately?

Dr. BUDETTI. We are working very closely with the States and encouraging the States to implement their advances in data systems and technology because that is a major aspect of oversight of the Medicaid program. If you would like more details on that, I

would be happy to get you a substantial amount of information on just what our approach is. But yes we do believe that having adequate and sophisticated data systems at the State level that can both analyze data and supply data better to the Federal Government that we need for oversight is one of our top priorities.

Mr. GUTHRIE. Thank you for that answer, and I do have 2–1/2 minutes I can yield, or yield to Dr. Burgess.

Mr. PITTS. Dr. Burgess.

Mr. BURGESS. I appreciate the gentleman for yielding.

Director Budetti, let me just ask you a couple of questions along the lines that Ms. Schakowsky was just asking. First off, do you have an app for that?

Dr. BUDETTI. For——

Mr. BURGESS. When you talked about your new explanation of benefits and forms that you are providing people.

Dr. BUDETTI. Well, that is a very interesting question, Dr. Burgess, because we have been looking into that possibility.

Mr. BURGESS. Well, I did a little research sitting here at the dais, and I typed the word "Medicare" into the app store and you don't have one but other people do, and it just seems, you know, knowing the way the world works, most people who get to the age where they are signing up for Medicare are going to be asking their 12-year-old grandson to help them navigate the smartphone. It may be something that is worth looking into.

I thank the gentleman for yielding, and I will yield back.

Dr. BUDETTI. In my case, I will rely on my 17-year-old grandson and my 5-year-old and my 4-year-old.

Mr. BURGESS. Great.

Dr. BUDETTI. The Chair thanks the gentleman and recognizes the gentlelady, Dr. Christensen, 5 minutes for questions.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman, and welcome to the panelists this morning.

I want to follow up also on Congresswoman Schakowsky's question, and I am glad to know that the notices to beneficiaries have improved. I am sure they have improved a lot over the 16 years that I have been having to explain them. And you pretty much answered how beneficiaries can help detect fraud, and I know that many seniors are just as concerned as we are with program integrity and are glad to help in fighting fraud. My constituents participate in the Senior Medicare Patrol program, and they seem to be very active. How widespread is this program across the States and territories and has it shown itself to be helpful in ensuring or reporting and helping program integrity?

Dr. BUDETTI. Dr. Christensen, when I got to my job at CMS, I decided that one thing we should do was invent the Senior Medicare Patrol and then I found out it already existed, so we worked very closely to help expand the resources available to the Senior Medicare Patrol for the first couple of years that I was on the job. It does extend to all States. There are programs operating, and I believe through the territories as well. It does involve many Medicare beneficiaries, and they receive extensive training in how to help seniors protect their identities, how to identify problems with potential fraud or abuse, and what to do about it and how to report it. So we consider this a very strong adjunct program of ours and

we have taken a lot of initiative in helping to support that program.

Mrs. CHRISTENSEN. Thank you. I have a provider question as a person who has practiced medicine for more than 20 years before coming here, and having heard from my colleagues back then but also more so since I have been here about sometimes overzealous investigations and sometimes unwarranted investigations. But I am very interested, like my colleagues are, that efforts to fraud are effective, but also that they are fair to providers, especially those providing care to our Nation's most underserved communities who are sicker and where there are fewer resources, and I just want to say for the record, of course, and I am sure you will agree, that the vast majority of providers are honest actors who are not causing problems.

I would like to find out what CMS is doing to ensure that providers are your partners and not necessarily adversaries, and how effectively are you able to distinguish between who the bad actors and the good guys are, so that some of my colleagues or former colleagues are not feeling that they are being treated fairly in some of these investigations.

Dr. BUDETTI. First of all, this is a very high priority for us. I mentioned early on that we want to make the system easier and more efficient for the legitimate and vast majority of providers while making it much harder and more likely to spot the ones who don't belong in the program, and along those lines, I will give you one example, that in developing improvements in our enrollment processes, we worked very closely with the provider community. There is a long list of changes that we made to the enrollment system that came specifically out of group meetings that we had with providers, working side by side with them to have demonstrate to us online what the problems were that they were having with our system so that we could implement a fix to that problem. So that has been a big part of it. We have gotten a lot of positive feedback from the provider community in doing that.

And in terms of the audits and the potential for problems, one of the big advantages of moving the Medicare and Medicaid program integrity operations together into the Center for Program Integrity is, it is allowing us to pursue coordination and integration of a wide range of audits precisely for that reason, to make sure that we are doing the job but we are doing it as respectfully and appropriately as possible.

Mrs. CHRISTENSEN. Thank you. And on the enrollment, I understand you are transitioning away from a paper-based system of provider enrollment. Do you feel that you are able to capture the rural providers and some of those providers that are in the poor, urban communities as well?

Dr. BUDETTI. That is a very important consideration, and I will—I know that we have worked with large groups but I will be sure that we will check on what our outreach efforts have been.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman. I yield back.

Mr. PITTS. The Chair thanks the gentlelady and now recognizes the gentleman from Virginia, Mr. Griffith, 5 minutes for questions.

Mr. GRIFFITH. Thank you very much. I would like to pick up where Dr. Christensen left off because some of my providers don't

feel like there is much of a partnership going on, and I would direct your attention specifically to the RAC program where I am advised that the American Hospital Association based on self-reported data indicates that nationally, 74 percent of the appeals are being overturned in favor of the hospitals when this comes up, and apparently in my region, it is 78 percent. And it would seem to me, I mean, one of the problems that they are having is, they feel like these independent contractors are taking the money and saying wait a minute, we are not going to release this unless you go through the process, push it to the end, and then if you win in the end, you will get your money. And so this is a real concern for them because while we all want to get the bad guys, the hospitals by and large in my district are not the bad guys, they are the good guys, and I may not know of some exception to that rule but I think they are all pretty good providers and they are trying to do the best they can. And 78 percent being overturned on appeal indicates there is a problem in the system. Wouldn't you agree?

Dr. BUDETTI. So Mr. Griffith, I will say that we want to get it right, and we want to get it right for the good guys and we want it to be as efficient as possible. The very high—we have heard some very high appeal successes, but it is only a small fraction of total RAC determinations. So when appealed, the overturn rates seems to be growing, but still only a very small fraction of total RAC determinations are being appealed in the first place.

But having said that, we do want to get it right and so we have put into place a number of checks to look back at what the guidance is that is going to the recovery auditors, what the number of documents that they are able to request. There are a lot of things that we are doing to make sure that the system is working.

Mr. GRIFFITH. Well, I would encourage you to do that. I would say, I don't come from a medical background. I was a country lawyer, and most of the time when people lose, if it is close, they don't appeal, and I understand that. When they appeal, it means that they really think they have been treated wrongly. That being said, in my profession, if you had a 78 percent turnover rate, you would have a judge being removed, and that is what I am looking at is, that, you know, in this case, if we can't get it straightened out, we may have to look at a different system because that is not fair to the medical providers. And so I appreciate that.

Also, one of the other complaints they had that ought to be simple to fix is that when they are denied, they get a letter, but when they win or they get it overturned, they don't get a letter so all of a sudden a check comes in and then they have to track down, well, why did we get this check. It sure would be nice if there was a tracking number or a letter that came with that that said we have decided you were right and here is your check. Can you fix that?

Dr. BUDETTI. I will make every effort to look into that, sir. I have initiated a number of actions to, shall we say, improve our communications, and I will put this on the list.

Ms. KING. Sir, and if I might add?

Mr. GRIFFITH. Yes, ma'am.

Ms. KING. There has been a change in the design of the RAC program so that if the provider wins on appeal, the RAC doesn't get to keep the contingency payment, and that is a change from ear-

lier. And I would also add that we have been asked to look into—well, we have work underway now that looks at what is happening in postpayment review and the coordination of those contractors that are doing that and whether there is duplication, and also to look at the communications that they are issuing. So we will have something to say on that later this year.

Mr. GRIFFITH. Well, I really appreciate that, and I hope that you all will continue to work to make this an easier process for the providers that are just trying to do what they do, and that is to help heal people.

That being said, let me shift gears slightly and just ask if there isn't more you can do in the private sector. In our area, I represent southwest Virginia, which includes a big chunk of Appalachia, and we have had a problem with abusive drug usage, and some of the private companies are doing things that actually work to stop that such as they have one they call the lock-in program where if somebody is abusing, they don't stop giving them drugs if they need help but they don't let them go from doctor to doctor; they are locked in. Can we do things like that to try to look and see what the private sector is doing like the lock-in program? And there are others that I have here but my time is running out.

Dr. BUDETTI. We have been looking at what the options are because we agree that where there are problems such as the ones that you mentioned, we should look to do the most we can. I will say that the constraints that we have, certain rules that do or do not apply in the Medicare program, we may have different options in terms of what we can pursue. I don't know if you have looked at this or not.

Ms. KING. We have actually looked at it and we have made recommendations that CMS consider that, and I think their response back to us has been that they believe there are some legal restrictions.

Mr. GRIFFITH. Well, let us just say you are at the right place to get those legal restrictions changed, and if you need something that helps catch the bad guys but makes it easier on the health care providers, we would be glad to oblige.

Mr. PITTS. The Chair thanks the gentleman. The gentleman yields back. The Chair recognizes Ms. Ellmers, the gentlelady from North Carolina, 5 minutes for questions.

Mrs. ELLMERS. Thank you, Mr. Chairman, and thank you to the panel.

I have a couple of questions for you, and I am probably going to run out of time, so I would ask that I be able to submit some of my questions to you and that you would be able to give me a written response within a reasonable amount of time.

Dr. BUDETTI. Absolutely. We would be delighted to do that.

Mrs. ELLMERS. Wonderful. Well, let me start off with one question, and Ms. Yocom, I think this question is best suited to you, but feel free for anyone to answer.

Back in 2008, when Congress passed Section 1940 as amended to the Social Security Act, Section 1940 required that the Department of Health and Human Services, through CMS, to ensure that each of the 50 States implement an electronic verification system for their Medicaid programs to ensure current and future bene-

ficiaries meet the eligibility standards to qualify for assistance. My question for you is, since that time, being the 5 years that have passed now, how many States have fully implemented this program?

Ms. YOCOM. I may have to provide that for the record. We did do work looking at that for long-term care eligibility, and I believe it wasn't all States yet.

Mrs. ELLMERS. OK. Well, my understanding based on the information that I have, is that there is one State out of 50 that has put this in place, and that is the State of Florida. That is an incredible amount of time for this process to not have been put in place, and for me in North Carolina, this is significant. Why is it important to us? For every day that the electronig asset verification system is not in place in my home state of North Carolina, our state loses $275,000. At this point, 5 years in the process, this should have been put in place. So I guess I would ask, what is standing in the way? What possible reason could there be that only one State has fully implemented this process?

Ms. YOCOM. Again, we will provide additional for the record, but I do believe that a lot of it is around data systems and Medicaid and the need for them to be upgraded and improved.

Mrs. ELLMERS. OK. Well, my next question, I am going to shift gears a little bit here, and Dr. Budetti, this might be a question best suited for you. In the durable medical equipment competitive bidding process, the number of audits has increased dramatically. I have a number of 140 in 2010, up to 4,199 in 2012. That is a significant number of audits. Now, the audits themselves are basically giving that facility 45 days to report all information to basically show medical necessity, and obviously their payment or actually taking back the payment would be based on that information. Having been a nurse for over 20 years, I know working in a physician's office that you are dependent upon that particular physician's office to provide that information and then the facility or the company that has provided the durable medical equipment is incumbent to report the information to you. In the current state of health care with fewer physicians, and physicians having to decrease their overhead, that is a big problem. What are you doing today to help decrease this administrative cost to these durable medical equipment companies and to physicians who are also facing this burden?

Dr. BUDETTI. As you know, Congresswoman, durable medical equipment has been an area that has been subject to serious fraud in the past. It is one of the highest risk areas.

Mrs. ELLMERS. But sir, if I could interject——

Dr. BUDETTI. But I will say——

Mrs. ELLMERS. One of the issues that we were delineating here is between improper payments and fraud. A clerical error involving a signature, a date or, an order, is simply not fraud. So having identified that already, how could a company be required to send back reimbursement, or a physician's office be required to send back reimbursement, and then have to go into an appeal process that could take up to 14 to 24 months to recoup that payment? Isn't that a little excessive?

Dr. BUDETTI. So if there is a specific circumstance that you would like us to look into to get the details, I would be delighted to do

that. I can tell you that this is an area where we do need to be sure that the durable medical equipment has been appropriately ordered by someone who is qualified to order within the Medicare program and that there is documentation for that. That is the legal requirement. If there is an individual circumstance that appears to be somewhat of, you know, a problem, why don't you contact us and we will be delighted to get that information from you and——

Mrs. ELLMERS. We will definitely do that.

Dr. BUDETTI. —we will let you know where things stand.

Mrs. ELLMERS. I am over my time, so thank you very much.

Dr. BUDETTI. You are welcome.

Mrs. ELLMERS. I thank the chairman for indulging me.

Mr. PITTS. The Chair thanks the gentlelady and now recognizes the gentleman from Texas, Mr. Hall, 5 minutes for questions.

Mr. HALL. Thank you, sir.

Mr. Budetti, you mentioned the Recovery Audit Contractors, the RAC, how you are expanding that program into Medicaid, and I appreciate the fact that you and all the money you saved the government, all the fraud that they detect, and I see you as necessary with the abuse that is abound, and I have kind of a follow-up question to Dr. Christensen and Counsel McKinley.

I have a company in my district that has been accused of owing multiple millions of dollars back to the government because RACs claimed that some of the services they provided were unnecessary, just some of the services. They are now working with CMS on a payment plan that they can afford if they ever get in front of a judge, and lawyers—and I also note that RACs are paid on commission. Is that correct?

Dr. BUDETTI. The RACs are paid on a contingent-fee basis, yes, sir, so they only get to——

Mr. HALL. Well, you know, that is one of the things that kind of got lawyers in trouble and probably brought about the tort reform, that they would file cases with little merit but an insurance company would pay it to save money by paying it and not having to go to court. And it has brought a lot of criticism for lawyers. I am a lawyer but I remember a story, if I might tell it. You know, in Orlando, if you have gone there, you land in an airplane and then you get on a train and you go on it to where the tickets are made there, Orlando, and going there the doors will close on you if you are not careful, and just before they closed one time, a guy hollered, I want you to know that I am a lawyer and just got my degree last Monday night, and then the doors closed and they went on down the tracks. Somebody said, I hate lawyers, they are all geeks, and another guy in the crowd said, I resent that. He said well, I am sorry, I didn't mean to offend you. He said I am not a lawyer, I am a geek.

Something brought about bad things in the tort reform. Sometimes you know we do that. So I guess what I want to really ask you about, you acknowledge that part of your role is to strike an important balance to protect beneficiary access to necessary health care services and reduce the administrative burden on legitimate providers—I like that—while ensuring that the taxpayer dollars are not lost to fraud, waste and abuse, and I certainly support that. But what are some specific, concrete steps that CMS could take to

work with legitimate providers who may inadvertently find themselves ensnared by some of these antifraud initiatives? I think there is a huge distinction that should be made between a provider who is committing fraud, for example, billing for services that weren't rendered, and just plain making a mistake, and that is the situation I have in East Texas where they have been called upon to make payments that they are unable to make now, and if they are not able to get to the legal service that can't reach them for over a year, they have nothing to do but to shut their doors, and they provide very wonderful services to people and they might have made a mistake but they need a way to pay their out of it or prove that they didn't make a mistake. And since you all are paid on commission, you are going to be filing those. I don't say that you just file anything that comes in the door but if you don't file, you are on a commission basis, you don't make any money if you don't file. Do you think this is the best way to pay these contractors?

Dr. BUDETTI. Sir, the contingent-fee approach, of course, is a statutory requirement of the program.

Mr. HALL. I know you didn't devise it, we devised it, but what do you think about——

Dr. BUDETTI. But I will say that as I said before, about all of our programs, we want to get it right, and I think that one of the things that we are doing is greatly increasing our feedback to providers about exactly what the findings from the RAC program and what steps they can take to assure that they have the appropriate procedures in place in their billing and appropriate documentation and appropriate site of service so that we are giving them feedback. We are giving them comparative reports. We are giving them indications of what the RACs are finding and what the underlying data are behind what the RACs are allowed to look at by CMS. So we agree with you. We want the outreach to be even more successful in terms of educating the provider community, and we also want to be responsive to any specific problems like that and so again, sir, if there is something, a specific issue that you would like us to look into, we will be happy to do that, but we are building as much feedback as we can to try to make sure the program works as well as it can.

Mr. HALL. But the alternative is to go to the courthouse, and these people can't get to the courthouse for a long time because of the loads of a particular area, the courts. So maybe I would like to talk to you sometime about that.

My time is over. I thank the chairman.

Mr. PITTS. The Chair thanks the gentleman, and that concludes the first round of questioning. We will go to one follow-up per side. Dr. Burgess, you are recognized 5 minutes for questions.

Mr. BURGESS. Thank you, Mr. Chairman.

I think anyone who has watched this hearing this morning gets a sense of the enormous amount of time involved in all of these things, and what people have a hard time understanding is why it does take so much time. It takes the Government Accountability Office a little over a year to do a study and to deliver that back either to the legislative branch, where then it takes us time to come up with a legislative fix, or to the agency, and we see 3 years into the signing of the Affordable Care Act into law one out of

seven of the antifraud provisions have actually been enacted, not to say that you are not working on the others but 3 years does seem like a long time frame, and I don't know what can be done to accelerate the process. I know when GAO gets a request from us, they want to do a good job. It does take time but somehow we need to make this all work and work to the extent that we are not just delivering money to organized crime.

Let me just ask one last question, Dr. Budetti. To what extent are HHS and CMS using commercial public record database services such as those used by banks and retailers to verify the identity of providers and beneficiaries before claims are paid?

Dr. BUDETTI. So we have put into place and are building a system that will be even more extensive than it has been in the past in terms of getting access to a variety of databases such as the ones that you refer to in order to verify the provider and supplier information and to identify them. That is part of the Automated Provider Screening System capabilities that we are continuing to build out, and it will allow us to look not just at licensure and Social Security death files and other things but also at a wider range of databases that we will have access to and the system is being used in specific ways right now and it will be phased in as the core way of enrolling providers. So on the enrollment and on the revalidation side, we are very definitely moving in that direction and we have already made a great deal of progress.

Mr. BURGESS. I assume at some point in the future it is going to be linked to payments and billing as well.

Dr. BUDETTI. The Fraud Prevention System and the Automated Provider Screening System are specifically designed to be able to interact and talk to each other, if you will, so that the information we get from the one side can feed into the other side, and so yes, that is exactly the way that this is intended to operate.

Mr. BURGESS. Again, credit card companies figured this out 25 years ago, and it seems like we ought to be farther along than we are now.

Thank you, Mr. Chairman, for calling the witnesses. I will yield back my time.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the Ranking Member, Mr. Pallone, for a follow-up.

Mr. PALLONE. Thank you, Mr. Chairman.

I wanted to ask Ms. King, we have heard in the past recommendations that CMS pilot or adopt certain technologies like smart cards, and I think Mr. Shimkus actually mentioned this. Since much of GAO's work centers around making sure that the government is prudently spending taxpayer dollars, I would like to ask you from the GAO perspective, what questions should CMS be asking before embarking on any activity that would give tens of millions and even billions perhaps of dollars to a handful of companies in one industry to create this technology? What would you recommend?

Ms. KING. Mr. Pallone, we have actually been asked to look into smart cards, and we have a request in-house that we hope to start soon, and I think from that, we should be able to answer some of those questions like what are the costs and benefits, what are the risks, what are the downsides to this. Because, you know, right

now, as you know, Medicare has a paper card that displays the Social Security number, and we have recommended in the past that that be taken off of there, and CMS has estimated about $800 million to do that. We don't think that that estimate was credible and we asked them to do another one, but certainly any smart card effort would cost much more than replacing a paper card. So you are raising very legitimate questions, and we will be looking into it and advising both CMS and the Congress, we hope later this year.

Mr. PALLONE. Thank you.

Can I ask Dr. Budetti, is there anything else that the committee or Congress should do to help you in your ongoing efforts or activities, if you just wanted to comment in general?

Dr. BUDETTI. So Mr. Pallone, I appreciate the question and I have to say that we very much appreciate the support that the Congress has given us, and this is something that I think everybody agrees is important and so we will be delighted to continue to work with all the members on any ideas or any potential improvements that might come up. But we very much appreciate the support and the interest that is being shown in fighting fraud, waste and abuse because we all agree, this is a very important aspect of these programs, so thank you, Mr. Chairman, and thank you, Mr. Pallone.

Mr. PALLONE. I thank you and the whole panel, and I yield back, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman. The Chair thanks the panel for you testimony, for answering questions. It has been very informative. And at this time we will dismiss panel one and call panel two to the witness table, and I would like to thank the second panel for agreeing to testify before the subcommittee today, and I would like to quickly introduce our second panel as they come to the table.

First, Mr. Darrell Langlois, Vice President of Compliance, Privacy and Fraud at Blue Cross and Blue Shield of Louisiana, and Mr. Thomas Green, Managing Partner of Greene LLP. Again, thank you all for coming. We have your prepared statements and they will be made a part of the record.

Mr. Langlois, we will begin with you. You are recognized for 5 minutes to summarize your testimony.

STATEMENTS OF DARRELL LANGLOIS, VICE PRESIDENT, COMPLIANCE, PRIVACY AND FRAUD, BLUE CROSS AND BLUE SHIELD OF LOUISIANA; AND THOMAS M. GREENE, MANAGING PARTNER, GREENE LLP

STATEMENT OF DARRELL LANGLOIS

Mr. LANGLOIS. Thank you, Mr. Chair, Ranking Member Pallone and subcommittee members. I am Darrell Langlois, Vice President of Compliance and Privacy and Antifraud Activities with Blue Cross and Blue Shield of Louisiana. It is my pleasure to be here today to talk about a very important issue, and as I listened to the testimony and the conversation leading to this point, I want to tell you that health care fraud has far more reaching implications than simply the money and the dollars that are taken out of our system, and I would like to emphasize my testimony today on the fact that

many times and at an alarming rate, we find that the health care fraud that takes place is beyond the dollar and it is impacting the patients, you know, your family, my family in ways that are unmentionable, and that I through the quality of care that is received that ultimately results in patient harm.

In my 20-plus years of being in this field, working both nationally and locally, I can tell you I have been increasingly alarmed at what I have personally seen in my own State in cases that I have worked personally. These are not anecdotes. These are not stories read in the Wall Street Journal. These are stories and cases that I have worked personally, and it alarms me and concerns me, and I hope we talk a little bit about that today.

My testimony is going to touch two broad topics: first, what my organization has done in this regard, and second, how the Affordable Care Act's MLR provisions are serving to limit and hold back some of the investment that has taken place in the past in respect to health care fraud.

First, as far as my organization, we have structured a three-point strategy. It has evolved in the 20 years that I have been responsible for health care fraud at my organization, and is currently in this format. First, we believe that data is at the foremost and the forefront of what we must do. The implications, the indications and the analysis that must be done through data is apparent and foremost. The technology that is needed to ensure that we are successful in almost every turn in this regard is growing and evolving and some of it is there and available for us but we do need to see improvement in that area and we need to spend money in that area and we need to increase resources in that area to do some of the things that I think Representative Burgess and others have talked about in relation to other industries, how they have been more timely in that respect.

The second is public and private partnerships. I have been fortunate to work very closely with the law enforcement entities in my State. I could name names and go on and on. But we have been one of two plans around this country that has been successful and be included in the government's HEAT cases there in the State of Louisiana, and that is a direct result of our willingness to work hand and hand with our public partners in this health care fraud fight, and we think that needs to continue.

Finally, prepay is an avenue in which we must continue to follow. The pay-and-chase model has long been gone, long deemed unsuccessful, and I am proud and appreciative of the comments I have been hearing today, that that is something that no one is considering to be a success and no one is considering to be a strategy on a go-forward basis. We must keep the dollars out of the hands of those who are willing to defraud our system, and the best way to do that is to never pay the dollar in the first place on a prepay basis.

The second part of my testimony is to address the MLR provisions of the Affordable Care Act. Today, as we understand it, only the recovery portions of what a private payer is able to recover are provided to us as a benefit in that calculation. As we have just said, prepay is where the strategy needs to be and where the focus needs to be. So to have a calculation that focuses on an antiquated

or towards a strategy that no one wants to employ anymore seems to be something that we ought to consider changing. In that regard, we would offer that we broaden the perspective of what is allowed in this fight against health care fraud to something that is more than recoveries.

Also, again, as I started my testimony, I mentioned to you that my alarming concern that I have seen in my 20-plus years of this has been around the quality-of-care issue. I can tell you about cases where patients have died. I can tell you about cases where I have spoken to family members who have had their family members irreparably harmed physically as a result of what physicians or other professionals have chosen to do in the name of seeking money. That is something that comes about through investigations and not solely in the quality improvement area, and I would encourage strongly that the committee and Congress consider that those are the things that improve our system and should be accounted for in our Medical Loss Ratio.

That concludes my comments, and I will be prepared for any questions you may have.

[The prepared statement of Mr. Langlois follows:]

Fostering Innovation to Fight Waste, Fraud and Abuse in Health Care

by

Darrell Langlois
Vice President of Compliance, Privacy, and Fraud
Blue Cross and Blue Shield of Louisiana

for the
House Energy and Commerce Committee
Subcommittee on Health

February 27, 2013

I. Introduction

Chairman Pitts, Ranking Member Pallone, and members of the subcommittee, I am Darrell Langlois, Vice President of Compliance, Privacy, and Fraud for Blue Cross and Blue Shield of Louisiana. I have over 20 years of experience in fighting health care fraud, both locally and nationally. I sit on the board of directors of the National Health Care Anti-fraud Association and the Blue Cross and Blue Shield Association National Anti-fraud Advisory Board. Additionally, I am a member of the Health Care Fraud Prevention Partnership that was created by Health and Human Services Secretary Kathleen Sebelius and Attorney General Eric Holder. Blue Cross and Blue Shield of Louisiana has long been a leader in the fight against health care fraud as evidenced by their support of the investigations office and investment in technology to identify such fraud. Further, we have worked closely with the State legislature to craft legislation that places Louisiana in the forefront of this fight.

I appreciate this opportunity to testify on the strategies Blue Cross and Blue Shield of Louisiana has developed and implemented to prevent and detect health care fraud. Recognizing that fraud has far-reaching implications both for health care costs and quality, we are continually developing new and innovative strategies to identify fraud and halt practices that lead to substandard care – including the delivery of inappropriate or unnecessary services that may harm patients. These fraud prevention and detection programs are part of our broad-based strategy for improving health outcomes and achieving the optimal use of health care dollars on behalf of the enrollees we serve.

Our testimony focuses on two broad topics:

- The specific initiatives we have developed and implemented to fight health care fraud to improve quality and to prevent health care dollars from being wasted.

- The importance of recognizing, under the regulations for the new medical loss ratio (MLR) requirements, that fraud prevention programs play a key role in advancing quality improvement.

II. Our Programs to Prevent and Detect Health Care Fraud

Blue Cross and Blue Shield of Louisiana recognized the need to fight health care fraud in 1990 and dedicated an office for this purpose at that time. Since, we have continuously worked to improve our strategies based on national and local trends and data. Our number one strategy is the use of data to filter out those who defraud and abuse the system. We have utilized a peer comparison fraud management system by IBM since 1995 and have built numerous cases with evidence from this system. Claims are run through this system and can be measured against any number of over 3000 algorithms that are built specifically to identify possible fraud and abuse. Our second strategy is to partner with federal and local law enforcement as we believe strongly that a collaborative effort is far more productive than an isolated approach. We have been one of only two health care plans in the country to be included in the government's HEAT (Health Care Fraud Prevention Enforcement and Action Team) cases. We believe that those who defraud the system should be held accountable and not simply slapped on the wrist. This is why we work so closely with law enforcement. Finally, we hold to a strategy that we identify as many fraudulent claims as possible before they are paid. Recovering funds lost to fraud on a post-payment basis is largely unsuccessful. This approach requires sophisticated technological approaches that have not been widely used to date.

With these successful strategies, we have consistently outperformed national averages and gained national respect among our peers and government counterparts. However, the greatest achievement is when these strategies serve to identify and stop patient harm cases. We have identified, built and assisted in the successful prosecution of numerous cases that have stopped those who were physically harming patients in the name of money.

Many of the most egregious professionals who are willing to harm patients in the pursuit of more money are not halted in the traditional quality improvement programs. There are many reasons for this and often those who run such quality improvement programs reach out to the investigations office for assistance when they identify issues not already identified by fraud data research. Quality programs view claim data as largely accurate and truthful, thus patient harm is not easily identified with these assumptions. Anti-fraud techniques first work with the assumption that not all data is accurate and truthful and should be challenged for veracity and appropriateness. This is often where patient harm cases come to light as the investigations office has the ability to look deeper into the reality of what the data tells us. Quality improvement programs are not designed to challenge and further investigate what otherwise appears to be accurate and appropriate.

Our office has recently helped identify and stop patient harm cases involving cardiologists, internal medicine practices, and neurosurgeons. In these cases, patient harm ranged from death to irreparable harm to critical physiologic functions. Two of these cases resulted in professionals serving significant criminal sentences and a third resulted in the suspension of his license to perform surgery pending a review of his peers.

III. Recognizing the Role of Fraud Prevention in Quality Improvement

Under the Affordable Care Act (ACA), health plans are required to meet annual medical loss ratio (MLR) requirements of 80 percent in the individual and small group markets and 85 percent in the large group market. This means that health plans must spend a specified percentage of premium revenue on either reimbursement for clinical services provided to enrollees or "activities that improve health care quality." Health plans are required to pay rebates to enrollees if they fail to meet the MLR requirements. In addition to having broad concerns about the unintended consequences of these MLR requirements, we have specific concerns about the fact that the regulations for implementing this ACA provision do not properly recognize the important role that fraud prevention programs play in advancing quality improvement.

At Blue Cross and Blue Shield of Louisiana, our anti-fraud initiatives are strongly focused on preventing fraud before it takes place, rather than "paying and chasing" after the fact. This approach serves as a powerful deterrent in preventing not only inappropriate billings, but more importantly, preventing inappropriate delivery of unnecessary or inappropriate services from occurring in the first place. The success of these fraud prevention initiatives is evidenced by the fact that government programs now are incorporating these innovative private sector practices.

Given the role that health plan fraud prevention and detection programs have played in establishing effective models for public programs, improved data for law enforcement, and successful prevention efforts, we believe policymakers should reevaluate the treatment of such programs by the regulation for implementing the MLR requirements. Our specific concern is that the MLR regulation only provides 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 protect consumers, purchasers, and patients. As a result, the regulation

penalizes 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 regulation's treatment of fraud prevention expenses works at cross purposes with efforts by the federal government to emulate successful private sector programs. Instead of encouraging fraud prevention, the regulation threatens to stifle the next generation of private sector innovations that will be helpful to the federal government in the future. This approach also 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.

We urge Congress and the Administration to reconsider the treatment of fraud prevention programs under the current MLR regulations. Excluding these expenses, which help to improve quality, is contrary to the health reform goals of developing a system that delivers consistently high quality care, optimizes the use of health care resources, and enhances anti-fraud cooperation between private and public entities.

IV. Conclusion

Thank you again for the opportunity to testify on these important issues. We appreciate the committee's interest in strengthening efforts to prevent and detect health care fraud, and we stand ready to provide further information to assist in this effort.

Mr. PITTS. The chair thanks the gentleman, and Mr. Greene, you are recognized 5 minutes for opening statement.

STATEMENT OF THOMAS M. GREENE

Mr. GREENE. Thank you, Chairman Pitts, Ranking Member Pallone and members of this committee for inviting me to testify on innovations to fight fraud, waste and abuse. My name is Tom Greene, and my testimony today relates to my experience representing whistleblowers under the False Claims Act for more than 20 years. The vast majority of my False Claims Act cases have been in the health care industry. With respect to pharmaceutical marketing fraud litigation, I have also represented private payers including health insurance plans, Taft-Hartley funds and self-insured employers.

I am pleased to be here today to speak about the False Claims Act, which is an excellent model of how the United States can foster innovation in fighting health care fraud, waste and abuse.

The False Claims Act is a dynamic fraud-fighting machine which encourages the participation of insiders with knowledge of fraud and the management. That is really good for everyone. And because whistleblowers can pursue cases, even when the United States does not intervene, the False Claims Act can foster new ways of fighting health care fraud.

When I first filed what was the first off-label promotion False Claims Act case in 1996, the government attorneys were not convinced of the viability of that theory and declined to intervene. But once that case was settled in 2004, it set a precedent that kicked off $14 billion in other recoveries. All told, since 1986, more than $24 billion has been recovered by the government for health care fraud cases under the False Claims Act, thanks largely to courageous whistleblowers who often risk their own financial security.

Today I make three recommendations to improve the effectiveness of the False Claims Act. One is to clarify the pleading standard for such cases because many courts have applied the standard for common-law fraud. A second would be to do more to encourage States to enact false claims acts. And there is one more thing that Congress could do by addressing one impediment to investigation and pursuit of False Claims Act cases that attorneys in my position find particularly troubling. Although we are working on behalf of the United States when we pursue these cases, it is often very difficult to gain access to data from CMS. Such data can be critical to proving a False Claims Act case because many whistleblowers are in marketing, sales or servicing, and it is unusual for them to already have the data in hand when they come to the attorney. Some of these cases fail not because the fraud is uncertain but because we can't get CMS data. Frankly, it is ridiculous not to facilitate our access to CMS data when billions of taxpayer dollars hang in the balance.

Marketing fraud by pharmaceutical companies accounts for more than half of the health care money recovered under the False Claims Act, especially through off-label promotion of drugs. False or fraudulent off-label promotion is a serious problem which costs taxpayers billions of dollars through the payment of increased health insurance premiums, and this serious problem needs to be

addressed by Congress, in part because private payers don't have a fraud-fighting tool as potent as the False Claims Act.

Now, I believe that fraudulent pharmaceutical marketing can be stopped before it starts in five ways. First, fraudulent pharmaceutical marketing could be deterred by giving private payers a right of action because currently they are left to use ill-fitting options like RICO or patchworks of State laws. Second, marketing fraud can be deterred by giving teeth to the FDA Amendments Act clinical trial registration requirement. Third, it could be deterred by threatening the forfeiture of Hatch-Waxman Act patent extensions for particular drugs. As you know, these extensions are granted in part for cooperation with the FDA approval process. When drug companies do end runs around the FDA through off-label promotion, drug companies should forfeit these extensions. Fourth, pharmaceutical marketing fraud could also be deterred by making sure that pharmaceutical executives have some skin in the game personally. And lastly, I would like to recommend that Congress eliminate the incentives for medical device manufacturers to play games with the 510(k) approval process, which could be done by amending the Social Security Act to forbid reimbursement of off-label medical devices except in certain circumstances.

I would be happy to expand on any of these issues that I have commented on this morning, and there is additional detail in my written testimony.

I would like to thank you, Chairman Pitts and Ranking Member Pallone, for this opportunity to testify, and I am glad to respond to any questions that you might have.

[The prepared statement of Mr. Greene follows:]

Amendment to the Testimony of Thomas M. Greene, Managing Partner, Greene LLP
Before the House Energy & Commerce Subcommittee on Health
Hearing on Fostering Innovation to Fight Waste, Fraud, and Abuse in Health Care
February 27, 2013

Before the submission of this amendment, my testimony did not directly address the 2007 FDA Amendments Act, which strengthened and clarified the language in the 1997 FDAMA which created a national clinical trials registry. However, FDAAA only requires some, but not all, clinical trials to be registered, certain designs are not included, and the legislation focuses on *approved* drugs, biologics and devices. Of course, if properly enforced, this legislation would address some of the concerns I have discussed (Part II Recommendation 1, pages 27-30). It is clear, however, that the spirit as well as the letter of the registry provisions in FDAAA have been subverted, and stronger measures are necessary to accomplish the goals of that legislation.[1]

The reporting of results for registered clinical trials lags far behind the target 100% compliance rate, subjecting the medical literature to "selective outcome bias" and other reporting biases. A 2012 study in the British Medical Journal concluded that only 22% of clinical trials registered on clinicaltrials.gov report the results of the clinical trial within one year, despite the FDAAA requirement to do so.[2] With regard to Phase IV post-marketing studies, which are the studies most relevant for health care fraud with

[1] Many of the issues I discuss in this amendment are also addressed in an editorial published in the Journal of the American Medical Association by Kay Dickersin and Drummond Rennie. *JAMA*. 2012;307(17): 1861–64.

[2] Prayle, AP, Hurley MN, Smyth AR. Compliance with mandatory reporting of clinical trial results on ClinicalTrials.gov: cross sectional study. *BMJ*. 2012;344: d7373.

regard to FDA approved drugs, only 31% of registered studies reported results.[3] Only last week, the former president of Pfizer Global Research and Development admitted these statistics are accurate.[4]

FDAAA includes a $10,000 a day fine for failure to report results to the clinicaltrials.gov registry,[5] but it is clear that few fines, if any, have actually been levied. The fines themselves may not be a sufficient incentive to comply with the letter of FDAAA, considering that the fine is a pittance compared to the possible profits a company might enjoy by flouting the regulations.[6] If the law specified that failure to make a timely filing of negative results would be deemed to constitute scienter in any subsequent fraud litigation by a private party, it is likely that pharmaceutical companies and their researchers would comply with FDAAA much more frequently.

Moreover, many clinical trials are still not registered with clinicaltrials.gov at all. In many cases, this is because the registry requirement only requires filing of results of clinical trials with at least one site in the United States. But most of the major pharmaceutical companies are multi-national and even those that have no overseas

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[3] Id.

[4] Last week, on Forbes Magazine's website, John LaMattina, the former president of Pfizer Global Research and Development, admitted that BMJ's statistics were correct and that the reporting of results of clinical trials "is lagging." http://www.forbes.com/sites/johnlamattina/2013/02/14/bad-pharma-maybe-but-goldacres-selective-use-of-data-is-wrong/ (page 2 of comments, last accessed February 26, 2013).

[5] 21 U.S.C. § 333(f)(3)(B).

[6] "[T]he fine for noncompliance is $10,000 a day, which sounds spectacular, until you realise that it's only $3.5 million a year, which is chickenfeed for a drug bringing in $4 billion a year. And what's more, no such fine has ever been levied, through the entire history of the legislation." Goldacre, Ben. (2013). *Bad Pharma*. New York, NY: Faber and Faber, Inc. pp. 53–54

presence still license and sponsor drugs developed in foreign countries. If a drug is to be marketed in the United States, then all clinical trials studying its safety and efficacy, not just those conducted in the United States, should be registered and results reported. Pharmaceutical research performed overseas is, in most cases, just as relevant to safety and efficacy issues as tests conducted in this country.

In addition, there is a significant difference between the simple registration of a trial, with or without the posting of summary results, and making the underlying patient-level data available so that the results can be verified and practitioners, decision-makers and researchers can draw their own conclusions from the full data set. I have dealt with this issue first hand; in the Neurontin litigation, we received full data sets from Pfizer's clinical trials through discovery. Because of this, we were able to get to the truth about Neurontin's efficacy for off-label indications. As an example, we were able to show that a clinical trial highly touted by Pfizer was irremediably compromised by the unblinding of patients. Without access to the underlying data, this sort of analysis would not have been possible. It should not require litigation for physicians to be able to analyze a study's purported results. Underlying data from clinical trials is also helpful to meta-analyses run by organizations like the Cochrane Collaboration, and withholding some data while releasing others can affect their conclusions immeasurably. Again, I saw this in Neurontin, where Pfizer's withholding of data from the Cochrane Collaboration obfuscated several of their reviews. As a result, the medical community and the patients they treat suffered.

For all of these reasons, I renew my recommendation that a stronger push be made to require the registration of all clinical trials at their early stages, so that the "selective outcome reporting" variety of publication bias no longer plagues the medical literature. Greater transparency is needed, so that physicians and medical researchers can accurately gauge the accuracy of the conclusions drawn by studies' authors. A bill proposed in the 112th Congress, the TEST Act proposed by Congressman Markey, would require that any trial that could be used to support an application for FDA approval be registered in Clinicaltrials.gov and that the results be reported in a timely fashion.[7] I urge this subcommittee to reconsider the proposals within that bill, and to otherwise revisit the issues raised by the inconsistent registration and reporting of clinical trials.

[7] Drazen, Jeffrey M. Transparency for Clinical Trials – the TEST ACT. N Engl J Med 2012; 367:863–64. "The TEST Act expands reporting requirements under existing federal law by broadening the scope to include all interventional studies of drugs or devices, regardless of phase (i.e., including phase 1) design (i.e., including single-group trials), or approval status (i.e., making no distinction between trials of approved vs. unapproved products); requiring all foreign trials that are used to support marketing in the United states to be registered; mandating results reporting for all trials within 2 years after study completion (including trials of unapproved drugs or devices); and extending results reporting to include the deposition of consent and protocol documents approved by institutional review boards."

Mr. PITTS. The chair thanks the gentleman. I will now begin questioning and recognize myself 5 minutes for that purpose.

Mr. Langlois, your testimony describes many of the important investment plans to prevent fraudulent payments and improve quality so you can attract customers. I would like to ask you to expound on this some more. If a plan expands its provider network based on their customers' desire to receive care from a particular doctor or physician practice, does the MLR classify the associated cost as an administrative expense and doesn't this penalize a plan for expanding consumer choice in doctors and providers?

Mr. LANGLOIS. It is my understanding that that is an administrative expense, and as such would have to factor into the overall cost of our products and the overall cost of health care, which would serve as the—as the costs go higher would serve to limit choices for our customers and those who participate in the program.

Mr. PITTS. Now, plans often work to ensure that health care practitioners are properly credentialed to provide care. Are these quality-enhancing activities punished by the MLR rule?

Mr. LANGLOIS. Again, it is my understanding that those are considered administrative costs, which do not benefit that calculation and would serve to discourage to the extent it doesn't make reasonable sense to the organization, would discourage them from participating in that activity at some reasonable level.

Mr. PITTS. So it would penalize a plan for ensuring credential providers are serving their customers?

Mr. LANGLOIS. Yes, sir.

Mr. PITTS. Now, these are necessary and non-negotiable costs that we all want to encourage health plans to incur, and clearly are not the kinds of costs that Congress wants to curtail. Network expansion and credentialing providers are critically important and beneficial to customers, to consumers, and clearly enhances value for their premium dollars. I am not sure, by why is HHS classifying these expenses as administrative when they are expended specifically to improve the quality of a network that a patient can access?

Mr. LANGLOIS. I am afraid I don't have the answer to that question as I did not participate in the process.

Mr. PITTS. Now, in your testimony, you write that "The MLR regulations' treatment of fraud prevention expenses works at cross purposes with efforts by the Federal Government to emulate successful private sector programs." Could you expound on these comments?

Mr. LANGLOIS. Sure. As an organization under the current MLR calculation chooses to spend money or no spend money as it works today, if they choose to spend money and invest in this critical function, every dollar they spend works against them in the calculation of the MLR. Therefore, a choice has to be made according to many factors by those who have the opportunity to spend that money and they have to make it in spite of the fact that it is going to work against them in the MLR calculation knowing that it could be better for the organization and its members to go ahead in the money. My recommendation, of course, would be to take away that cross-purpose and make it a dual win-win. Let us not only spend the money in a manner that is beneficial to the system and for our

customers but let us also let it work for us during the MLR calculation, which serves to better our system overall.

Mr. PITTS. Now, there remains significant interest in Congress about antifraud efforts in Medicare and Medicaid. We just heard from the Administration that fighting fraud in Medicare was a key goal of the Administration. Yet the MLR regulation excludes health plan investments and initiatives to prevent fraud from those activities that improve health care quality. Does this create a perverse incentive in the commercial insurance market to tackle fraud on the pay-and-chase side rather than the prevention side just at a time when CMS is stepping away from the pay-and-chase model?

Mr. LANGLOIS. It certainly seems that way. Again, as I testified a few minutes ago, recovery processes are the old way of doing things, and for the calculation of the MLR to only afford a benefit in that regard does seem to be outdated and something that should be seriously considered to be changed. That is by far a method and an approach that my peers and this industry are going away from as quickly as possible for many reasons, but certainly I think that should change in our calculation.

Mr. PITTS. Finally, members from both sides of the aisle have stated that Congress should promote policies that encourage young people to purchase health coverage. However, doesn't the MRI penalize enrolling young and healthy individuals in health plans since doing so makes complying with the MLR standard more difficult?

Mr. LANGLOIS. If you consider from the perspective that if the MLR calculation continues as it is and that continued investment in fraud or the lack thereof allowing fraud to further be perpetrated into larger extent, that will serve only to increase the overall cost of health care fraud, and we know that that is the primary factor for the young in which to engage and participate in the health system. So for those reasons, as you mentioned, I would say the answer is yes.

Mr. PITTS. Thank you. My time is expired. The Chair recognizes the ranking member, Mr. Pallone, 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman.

A question for Mr. Langlois. You spoke in your testimony about concerns about the way antifraud activity is counted as part of the Affordable Care Act provisions for calculation of the MLR. But didn't NAIC, the National Association of Insurance—well let me ask you this. The Administration felt like it was taking a balanced approach in this, giving credit for dollars recovered but not for fraud prevention activity, and based on information on the Blue Cross and Blue Shield of Louisiana Web site, it looks like your return on investment for fraud-related activity is on the order of 10 to one. So the National Association of Insurance Commissioners, didn't they support this compromise regarding fraud and abuse work at the MLR?

Mr. LANGLOIS. I am not sure I understand.

Mr. PALLONE. The NAIC, which is the National Association of Insurance Commissioners, they supported this compromise, the idea that—I mean, I am asking you if they did—my understanding is that they did—that, you know, we take this balanced approach where you give credit for dollars recovered but not for fraud pre-

vention activity, and my understanding is that they supported that balanced approach. Is that true, and is that a factor in the fact that you have this high return on investment for fraud-related activity?

Mr. LANGLOIS. I think I have two responses to the question. First of all, I have worked somewhat with the NAIC on an unofficial basis. We happen to be at the same location, and a gentleman was speaking on this very issue, and I made the same comments that I am making here today to him and asked if there could be reconsideration. I am not aware and did not participate in any request for it to be a balanced approach and that this was the result of that, but I will say that in my speaking directly to the NAIC on this matter, I have echoed the same comments I made today. They seemed receptive but of course indicated that there would be have to be further evaluation before any changes could be made.

As to the dollars that you reference on our Web site about our activities, those dollars are largely not on a recovery basis. Those dollars are largely saved on a prepay basis and depends from year to year times and cases and situations will adjust to be flexible from year to year but the recoveries are not solely represented by the number you read. Those are a function, an aggregation of all savings that our office works towards.

Mr. PALLONE. Well, let me ask you this. Has Blue Cross and Blue Shield of Louisiana had to cut back on any of its antifraud activities as a result of the MLR requirements? Have you had to make any cutbacks?

Mr. LANGLOIS. Could I ask you to ask the question one more time? I missed the first part.

Mr. PALLONE. In other words, has Blue Cross and Blue Shield of Louisiana had to cut back on any of its, you know, basically reduce any of its antifraud activities as a result of the MLR requirements?

Mr. LANGLOIS. You know, the word "cutback" would seem to——

Mr. PALLONE. Or to reduce.

Mr. LANGLOIS. To reduce, and I would say that where we are, we have held steady. The organization has recognized since 1990 that health care fraud is a problem and as such its investment has held steady, but as I mentioned earlier——

Mr. PALLONE. But then you haven't had to cut back or reduce as a result of that requirement?

Mr. LANGLOIS. We have not been allowed to go forward. We have not cut back but we have not been allowed to move forward with investments that are necessary as the technology increases, and we have been looking at technology that is something that we believe is needed but has been unable t move forward at this point.

Mr. PALLONE. I mean, I am just trying to point out that the NAIC, which represents the Nation's insurance commissioners, agrees with the current MLR calculation with respect to fraud.

Let me ask you one more thing. You know, I was excited to learn about your participation in the Health Care Fraud Prevention Partnership being led by the Secretary and the Attorney General, and are there any activities being undertaken by CMS that you think have been particularly helpful or supportive of your efforts? Let me ask you that.

Mr. LANGLOIS. Actually, there was one initiative that I was a participant in with a small number of people that I looked up very

fondly and was very hopeful that the process would carry out. As you might imagine, there are times when CMS recognizes that a provider is engaged in an activity that is worthy of their attention and so they will place a stop-payment or a hold on that provider until they can better determine what is taking place. There is a ton of Medicare supplemental private products that are on the market which my organization also sells. When CMS previously was stopping these payments, we were not made aware so a payment claim filed by a provider may not have made its way through CMS but was being passed on to us as the private supplemental payer and we were unaware of the activity that was taking place. There was an initiative that was begun to where that information could be shared, and as a result that provider would not see payments that could potentially have been fraudulent either from CMS or us, and I was very appreciative and fond of that process. Unfortunately, I think at this point the process hasn't made its way to fruition but we are hopeful that it will, and that was one that I very much looked forward to.

Mr. PALLONE. Thank you. Thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the vice chair, Dr. Burgess, 5 minutes for questions.

Mr. BURGESS. Thank you, Mr. Chairman, and Mr. Langlois and Mr. Greene, thank you both for being here today. I appreciate your time spent with the committee.

Let me ask you as a representative of a private insurance company. You have heard the discussion and the size, the number of dollars that are involved at CMS in fraudulent or inappropriate transfers of funds. Do you have anything approaching that in the Blue Cross Blue Shield world?

Mr. LANGLOIS. As to an evaluation of what those numbers are? Unfortunately, the best measure we have at this point is, we work very closely with the other antifraud activities around the country, both on the private side, and we also recognize the CMS side, and we measure our success according to what we are seeing other payers execute in the antifraud world. I get asked the question a lot, and I know it is maybe not the greatest of answers but I will tell you, do we know at any particular time how many people are speeding down the interstate, and the answer is, we don't, but we know it is happening and it is impossible to gauge that. So I don't have that but I can tell you that the returns on investments that we have been turning in the last 20 years has not slowed down, has increased, and again, I would just emphasize the stories and the cases we are seeing around quality have really brought an alarming sense to us.

Mr. BURGESS. Give us a sense of what you are talking about there. Can you give us an example?

Mr. LANGLOIS. In the quality?

Mr. BURGESS. Yes.

Mr. LANGLOIS. Real quickly, there are three cases that recently resulted in the State of Louisiana. The first was a cardiologist who in the name of money was placing stents in patients who had no business undergoing a knife or any surgeries at all. We testified. This was a great public-private collaboration. We as victims were brought in this case. The government was brought as a victim in

this case. We both testified, and the cardiologist recently was ordered to head to prison just before Christmas 2012. There were millions of dollars involved, and as I spoke at a meeting in that area, I had a family member step up and said I just wanted to let you know that my brother was one who was unnecessarily operated on and was now irreparably harmed.

This was not identified in a quality improvement program. This was not identified by a group of nurses who sit in the back of a particular area and work on a diabetic approach with someone. This was identified through hard-nosed investigative efforts both at the public side and the private side, and we brought it to bear. In another example, we had——

Mr. BURGESS. Let me stop you there for just a second, and I do want to hear your second example, but in the private insurance world, somebody is going to call a 1–800 number somewhere and get preauthorization for that procedure, are they not?

Mr. LANGLOIS. Yes, and in this instance, the cardiologist was willing to provide the information that would make that appropriate yes answer on the pre authorization. He was capable of giving the information that made that appropriate when in fact the information was not accurate. He owned not only the cardiology clinic but he owned the lab in which those diagnostic-type studies were done to justify the surgery in the first place, and he forged that information necessary to make the surgery.

Mr. BURGESS. Well, do you feel that that is something—I mean, was this just a one-off where one person is performing this or do you feel that there is a larger problem there?

Mr. LANGLOIS. No, you will find if you read the literature among the government health care fraud and you talk to others, I believe previous testimony was heard by Alanna Lavelle at WellPoint. She spoke about cardiology and stent procedures in her world, and she does not do business in Louisiana, so clearly this is not a perception or a one-off situation.

Mr. BURGESS. And what have you done as an industry to more carefully define and refine that so that you not only prevent the inappropriate transfer of funds but you also prevent the inapt delivery of care? I mean, basically that is up-selling someone who came in with a problem that was not of cardiac origin who then got a cardiac procedure. Am I correct?

Mr. LANGLOIS. Correct. The use of data analysis, again, the three points I talked about earlier, use of data analysis, the direct collaboration with the Federal Government and reviewing things on a more prepayment basis in refining those. We talked about—I was asked the question, have we cut back. We haven't cut back but of course we haven't extended forward the way we want to. If I were still doing the things 20 years ago today as I was doing then, I wouldn't be successful. We have had to evolve and move forward, and not being able to do that is some ways hurtful.

Mr. BURGESS. Give us quickly your other example.

Mr. LANGLOIS. Of course, this is throughout the country and probably throughout the world, but we had an internal-medicine practitioner who was willing to dole out OxyContin and various other controlled substances to patients despite in his own practice he had newspaper articles that articulated that his patients were

distributing the same drugs he was prescribing on the street yet he continued to prescribe those drugs. There were at least eight deaths associated with overdosages and other things to the point that one of his patients actually sold the drug to another individual, who died as a result. So it wasn't even a patient of that doctor, yet death followed his prescription onto another unsuspecting individual. That individual has currently lost his license and is serving 16 years in federal prison, again, another collaborative effort between public and private, not identified in a quality improvement arena, rather identified in an investigation angle, but certainly taking a bad doctor out of the system that we all had to pay for.

Mr. BURGESS. Thank you, Mr. Chairman. I will yield back.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentlelady, Dr. Christensen, 5 minutes for questions.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman.

Mr. Greene, I wanted to ask some questions around your testimony. Since 1986, over $35 billion, I understand, has been recovered through the False Claims Act for the government, and the majority of those recoveries come, as you have stated, as a result of whistleblower-initiated cases, health care-related recoveries from pharmaceutical companies, hospitals and clinical laboratories. Can you give us a few brief examples of what some of the kind of fraud involved were involved in those cases, and what other kind of cases other than the pharmaceutical, which you said represented the vast majority of dollars, what other kinds of cases have successfully returned money to the States or Federal Government?

Mr. GREENE. I can, and I touch on this in more detail in my written testimony but I can summarize here. First, I would like to say that the majority of health care recoveries under the False Claims Act come from whistleblower-initiated qui tam cases rather than cases initiated by the government. Qui tam cases outnumber the ones initiated by the government by five to one. Health care cases under the False Claims Act come in many different forms. You might have a hospital or nursing home that up-codes claims to get higher reimbursements or for billing services that were not actually performed, testing labs cause billing for unnecessary lab tests or again for tests not performed. There are cases that are based on violation of the Anti-Kickback statute or the Stark law where physicians are getting illicit payments or benefits for lucrative self-referrals. Durable-equipment companies bill for equipment that was never delivered, and you can have medical supply companies that can be the basis for actionable fraud. One of my cases was just recently unsealed. It involves unnecessary delivery of oxygen supplies. So really, there are many different types of cases. Somebody usually sees this fraud occur and sometimes someone will step forward and blow the whistle.

Mrs. CHRISTENSEN. You know, and while the False Claims Act specifically deals with getting money back to the government, it seems to me that private payers, insurance companies, employer benefit plans can be equally victimized by these fraudulent practices, and I think we have heard some of that already in the testimony. Can you please elaborate on how private parties are affected and what recourse they have at this time?

Mr. GREENE. Well, I will start off by saying private payers don't have the potent tool, the False Claims Act, that the Federal Government has, but yet they can be the victim of frauds, they can be the victim of medical tests or products that are ordered as a result of kickbacks. Really, what they are faced with, the only thing they can rely on really are patchwork of State laws or RICO claims, and those are imperfect. If Congress would consider pass a private right of action, that might give private payers like Blue Cross sitting here at the table an opportunity to recover the costs that they spent as a result of fraud. Like I say, it has been difficult to try to put together a large group of health insurance plans across the country to bring these cases in the form of class actions. Courts are not always receptive to that, again, because of the patchwork of State laws that these claims are brought under or RICO. I think if we had a private right of action for third-party payers that perhaps offered double damages and an attorney fee-shifting provision, that would begin to give private payers the tools that they would need to recover some of the monies they have lost as a result of fraud.

Mrs. CHRISTENSEN. Mr. Langlois, I think you have answered most of my questions around MLR and the public-private partnership, so I don't know if you want to comment on the last question around False Claims Act not, you know, being an avenue where companies such as yours might be able to recover.

Mr. LANGLOIS. It is a great question, and I appreciate you bringing it up, and I respect Mr. Greene for his attempt to benefit us. We identified 2 years ago in my State, particularly myself and a State senator of Louisiana, the need for this, and we in the last legislative session actually passed a false claim trouble damage act provision at the State law level that allows whenever I am a victim of a health care fraud to bring about damages and penalties to those who do such similar to the federal level.

Now, the way it works—and I won't belabor this point—but the way it works is, I retain the monies that I was a victim of and lost. The second and third level of payment from the trouble damage calculation returns to the State in its effort to fight and better fund health care fraud efforts. So I very much appreciate the point he made and I do think that there are opportunities there.

Mr. PITTS. The Chair thanks the gentlelady and now recognizes the gentleman from Virginia, Mr. Griffith, 5 minutes for questions.

Mr. GRIFFITH. I guess my concern relates to the lawsuit type, and Mr. Greene, I am going to ask you, I know you are trying to ferret out people who are doing things that are just fraudulent outright but don't you think it might have a chilling effect on those folks who are using an off-label use in cases with patients who might have severe illnesses such as AIDS, rare diseases, cancer, etc.? Don't you think that if you take that too far that you can actually hurt some of the patients who may need an off-label use?

Mr. GREENE. Well, I think what you are pointing out, and I recognize and of course courts recognize that physicians have and will always have the right based on the exercise of their independent medical judgment to prescribe a drug for an off-label use. There is nothing wrong with that.

Mr. GRIFFITH. But here comes the question, based on your written testimony. The question then becomes, though, that as I understand your testimony, your written forms says that if a company, though, has a study that says you can use this for a rare form of cancer and that some doctors have found it successful, that they may then open themselves up if the pharmaceutical—because if I am treating somebody in Abington, Virginia, I may not know that somebody in California or New York was successfully using-another physician was using an off-label drug to successfully treat this particular condition or disease that may be very severe. How am I supposed to find that out if the pharmaceutical company is barred from sending out the information?

Mr. GREENE. Well, they are not barred from sending out the information, Doctor.

Mr. GRIFFITH. I am not a doctor; I am a lawyer.

Mr. GREENE. Sorry. There are guidances and guidelines that allow the dissemination of scientific articles. What I am talking about is fraudulent promotion of off-label uses. What I am talking about is when a drug company comes up with a marketing strategy that is signed off by the president of the company, as was the marketing for Neurontin, that they are going to do an end run around the FDA approval process and they are only going to publish positive results, not negative. So we are talking about fraud. We are not talking about interfering with a physician's right to prescribe off-label. We are not talking about a drug company's right to disseminate truly scientific articles that talk about off-label uses provided they comply with safe harbors.

Mr. GRIFFITH. And I appreciate that and understand the distinction. Now, as I was reading this and listening to it, one of the things that I noticed was, you talked about how much money was recovered on the Neurontin. Is that how you say it?

Mr. GREENE. Yes, sir.

Mr. GRIFFITH. I am just curious how many folks were negatively impacted. Were there deaths? Because I am not familiar with that.

Mr. GREENE. I don't have the——

Mr. GRIFFITH. Were there deaths?

Mr. GREENE. —answer to that question.

Mr. GRIFFITH. Do you know if there were deaths?

Mr. GREENE. There were.

Mr. GRIFFITH. There were?

Mr. GREENE. There were. Keep in mind, with regard to Neurontin, the FDA, it was approved for adjunctive therapy for epilepsy in December of 1993, and the FDA told the company back in 1992 when they looked at the clinical trial data that it showed that the subjects were suffering from depression, suicidal ideation, and it can lead to suicide, and the FDA told the drug company that this drug will have a limited widespread usefulness. But they approved it as adjunctive therapy for epilepsy. What did the company do? It turned around and it marketed it to bipolar patients. That was off-label, and they never disclosed what the FDA had pointed out to them.

Mr. GRIFFITH. So as you send out the positive and the negative? You are not against pharmaceutical companies sending out articles

that highlight that this might also be helpful in some other disease area but that, you know, here is what we have got thus far?

Mr. GREENE. Provided they comply with the safe harbor guidelines. They can do that. They can disseminate truly scientific articles that describe accurately the results of their clinical research. The FDA has given them a safe harbor to do that. That is not fraudulent promotion.

Mr. GRIFFITH. All right. I thank you. I have 30 seconds if anybody wants it. I yield back.

Mr. PITTS. The Chair thanks the gentleman. The Chair thanks the second panel for your testimony, and I remind members that they have 10 business days to submit questions for the record, and I ask the witnesses to respond to the questions promptly. Members should submit their questions by the close of business on Wednesday, March 6.

Without objection, the subcommittee is adjourned.

[Whereupon, at 12:40 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Peter Budetti's Hearing
"Fostering Innovation to Fight Fraud, Waste and Abuse in Health Care"
Energy & Commerce Health Subcommittee

February 27, 2013

Additional Questions for the Record

The Honorable Renee Ellmers

1. **In 2008, Congress passed Section 1940 as an amendment to the Social Security Act. Section 1940 requires the Dept. of Health and Human Services, through CMS, to ensure that each of the 50 states implement an electronic asset verification system for their Medicaid programs to ensure current and future beneficiaries meet the eligibility standards to qualify for assistance. To date, only one state, Florida, has fully implemented the program. For every day that the electronic asset verification system is not in place in my home state of North Carolina, our state loses $275,000. Over 5 years, the cost is over $500 million to my state. As of today, 75% of states should have an electronic asset verification system in place. I'm deeply discouraged by the fact that this legislation continues to not be implemented, costing the state and federal government millions every day. I'd like your office to report back to this subcommittee what steps your agency can take to ensure full compliance with Section 1940 by the original deadline date of Sep. 30, 2013.**

Answer: Through FY 2012, 37 states were scheduled to implement asset verification system (AVS) programs. We are working with states to facilitate their compliance with the AVS requirement. Since all states are in the process of either replacing or modernizing their eligibility systems, and because CMS believes AVS would be a core component of a new eligibility system, we believe states can come into compliance with the AVS requirement by integrating the development of their AVS programs in their eligibility system upgrades. During this process, states will have to demonstrate their efforts to implement their systems. Specifically, states would need to show that the AVS is accounted for in the state's concept of operations and architectural diagrams for a modernized eligibility system; provide a justification for why implementing the AVS based on the modernized platform would be more efficient and economical for the Medicaid program; and provide interface control documents and business requirements reflecting the AVS system or, at a minimum, a schedule for producing them. CMS has offered states technical assistance and is working with states to proactively incorporate AVS into their planning for the current and upcoming fiscal year.

While the statute does not permit CMS to waive or otherwise delay the statutory requirement that all states implement an AVS program, the statute does provide flexibility with respect to the process for determining whether states are in fact in compliance with the AVS requirement. If a state were to take concrete steps to include the elements of an AVS in its advance planning documents for establishing a new eligibility determination system in preparation for 2014, CMS could consider such work to be a good faith effort toward compliance.

2. **Medicaid provides billions of dollars in payments to tax cheats who owe millions in unpaid taxes. According to a GAO investigation, almost 7,000 Medicaid providers in just three states owed $791 million in unpaid federal taxes, but received $6.6 billion in Medicaid reimbursements in just one year. For example, one nursing business owes over $3 million in unpaid taxes and has collected $200,000 from the Medicaid program. The business's owners – a married couple – "purchased a new home while their business was accumulating debt. The Internal Revenue Service (IRS) had to refer the case to the Department of Justice. What is CMS doing to stop this fraud and abuse?**

Answer: We are working with the Department of the Treasury and the IRS to explore appropriate ways to enhance collection of unpaid Federal taxes from Medicaid providers in ways that are administratively feasible, cost effective, and will not inappropriately impact the structural relationship states have with Medicaid providers.

Federal funds are provided to states at a specific Federal medical assistance percentage (FMAP) rate through a grant award process, which provides authority for states to draw down Federal matching funds to match states' Medicaid expenditures. Under this process, the Federal Government does not have a direct relationship with providers nor does it pay providers directly. Each state establishes and maintains the direct relationship with the Medicaid providers that participate in the state's Medicaid program, and make the payments to providers participating in the state's Medicaid program. As such, CMS cannot preclude a state from allowing a provider to participate in the state's Medicaid program. However, CMS is committed to supporting our state partners in their Medicaid program integrity efforts and working collaboratively with states to identify issues and providers for audit.

3. **We understand that we need to focus more efforts on true fraud, waste and abuse, but we also hear that many providers are being harassed by more aggressive audits and auditors. CMS itself admits in its 2014 call letter that PBMs are auditing for routine clerical and administrative errors and not true fraud. How does CMS distinguish between true fraud and abuse and administrative errors?**

Answer: We released the proposed 2014 call letter on February 15, 2013. We will accept comments on the proposed call letter until March 1, 2013, and will release the final call letter on April 1, 2013.

We understand your concern that aggressive audits could be overly burdensome for providers and suppliers, and try to maintain a balance between ensuring that our payments go to the appropriate person, for the appropriate service, at the appropriate time, while also ensuring that we do not distract providers and suppliers from their important responsibility – providing quality care to Medicare beneficiaries. We are working with the provider and supplier community to explore ways to streamline the process and minimize the impact of multiple audits. CMS does have certain limitations to protect providers from overly burdensome audits. For example, Recovery Auditors may only request a certain number of records from a particular provider in a time period, depending upon the size of the provider. Moreover, ZPICs and RACs coordinate their audit target areas in an effort to minimize burden and duplication.

4. **When coding a healing shoe or walking boot, instead of only coding for the healing shoe or walking boot, suppliers and providers are instructed to code for liners within the boot or shoe, as well as buckles and or straps / fasteners on the boot. This coding practice was also used in the fabrication of shoe orthotics. Instead of coding only the shoe orthotic as one product, suppliers and providers are instructed to code the various layered materials that were used to fabricate the orthotic. This is just one example of Medicare abuse within the health care system, but this example compounded throughout the country certainly contributes to the massive waste within the system. What is CMS doing to prevent this?**

Answer: The durable medical equipment, prosthetic, orthotic, and supply (DMEPOS) payment policy is discussed in local coverage determinations (LCDs) and Pricing Data Analysis and Coding (PDAC) articles. It is sometimes necessary for providers and suppliers to bill separately for certain DMEPOS products because the items may have both covered and non-covered uses, as defined by the Medicare benefit category for orthoses, and must be coded based on the beneficiary's condition. There are system edits in place to prevent payment for certain component items that should not be paid separately from the base orthosis, even if additional codes for those items appear on a claim. Also, billing of replacement components is not payable at initial issue of a base orthosis, or when provided on a routine basis, without regard to whether the original item is worn out.

5. **I heard recently from a constituent who had a patient at his clinic that had not filled a prescription that had been prescribed chronically to her for months. He thought she was being non-compliant and asked her she had not filled it. She said that she has several months stock of this prescription at home already, and said that she had told her mail order (closed door) pharmacy that she did not need this prescription, since she had temporarily stopped using the injection. But the mail order (closed door) pharmacy kept sending the prescription three months supply at a time. The cost of this prescription per month to Medicare is approximately $3400. Is CMS aware of such waste? What is CMS doing to prevent this waste?**

Answer: CMS has received complaints that beneficiaries have had medications delivered via mail order pharmacy services after the medications had been previously discontinued or were otherwise unwanted and unnecessary at the time of delivery. Once the prescription is delivered, pharmacies are unable to return the medication to stock and generally do not reverse the claim if the patient does not want the prescription. Consequently, automatic delivery practices are potentially generating significant waste and unnecessary additional costs for beneficiaries and the Part D program overall.

Consistent with regulatory requirements on Part D sponsors to control fraud, waste and abuse and in order to ensure that Medicare beneficiaries receive only new prescriptions and refills that are requested, CMS proposed in the draft Call Letter published February 15 that Part D sponsors should require their network retail and mail pharmacies to obtain patient consent to deliver a prescription, new or refill, prior to each delivery. CMS believes unintended waste and costs could be avoided if pharmacies confirmed with the patient that a refill, or new prescription

received directly from the physician, should be delivered. Such confirmation would be unnecessary if the beneficiary personally initiates the refill or new prescription request. This recommendation would not affect retail refill reminder programs that require the patient to pick-up the prescription.

While CMS is proposing this policy in the draft Call Letter for coverage for 2014, CMS is strongly encouraging sponsors to make this a requirement of their network pharmacies that offer such automatic refill programs for 2013. CMS believes shipment of unwanted medications is not only wasteful, but also a source of significant beneficiary aggravation and a financial imposition that can negatively affect enrollee satisfaction with the plan.

6. **I hear from a constituent recently about diabetic testing supplies. He hears the complaint regularly that his patients have too many diabetic testing supplies and the mail order diabetic supplier keep sending them even when they've asked them to stop. Is CMS aware of this waste? What step are you taking to prevent this?**

Answer: CMS continues working to identify suppliers who are improperly billing Medicare for diabetic testing supplies. CMS encourages beneficiaries to call the Fraud Hotline of the HHS Office of Inspector General at 1-800-HHS-TIPS (1-800-447-8477) if they receive diabetic supplies that they have not ordered. In addition, CMS encourages beneficiaries to refuse the delivery and/or return the supplies to the sender and keep a record of the sender's name and the date the items were returned.

Beginning July 1, 2013, Medicare will be contracting with a limited number of National Mail Order suppliers to furnish diabetes testing supplies to beneficiaries as part of the competitive bidding program. In addition to saving the Medicare program and beneficiaries money, the program will apply higher standards to suppliers and result in increased oversight and monitoring of this area of the program.

7. **There has been a great deal of concern over the use of the Social Security Number for identifying Medicare beneficiaries. Additionally, many technical experts indicate that the use of a single identifier like a Social Security Number is technologically insufficient to protect patients' personal information and identity. What specifically is CMS doing and what is the timeframe for implementation to implement a more sophisticated patient data machining strategy?**

Answer: CMS shares your concern regarding the risk and potential harm of identity theft for Medicare beneficiaries and works to educate beneficiaries about steps they can take to protect themselves and to minimize the unnecessary use of the Social Security number in our communications with beneficiaries. CMS is in the process of conducting a rigorous cost estimate for options to remove the Social Security number from the Medicare beneficiary card, including for the extensive systems changes that would be required for any transition to a new, non-SSN based identifier. CMS has begun exploring the potential for new technologies for beneficiary identification, including smart cards that use multiple authentication factors, such as an additional personal identification number or biometric identification, such as fingerprints. However, there are costs associated with such technologies, and use of biometrics has additional

operational and cost implications, including for other agencies such as SSA. There are also concerns about operationalizing under the current beneficiary enrollment processes and how requiring multi-factor authentication would impact beneficiaries' access to medical care. CMS is always interested in the potential for new technologies to improve our ability to detect and prevent fraud, including ideas regarding implementation of a more sophisticated patient data matching strategy.

8. How will the nationwide adoption of electronic health records and health information exchange capability have on the ability to help minimize Waste, Fraud, and Abuse in Medicare and Medicaid?

Answer: Electronic Health Records (EHRs) allow health care providers to record patients' health care or treatment information electronically, instead of using paper records. If providers use EHRs, they can join a network to securely share your records with each other. EHRs can help lower the chances of medical errors, eliminate duplicate tests, and may improve overall quality of care. EHRs can help providers have the same up-to-date information about a patient's conditions, treatments, tests, and prescriptions. Through better electronic tracking and health care coordination, EHRs can minimize waste within Medicare and Medicaid.

9. Recently there has been speculation in the media that Electronic Health Records (EHRs) have contributed to inappropriate over-coding and over-billing, especially in the area of Evaluation and Management Services. (1) Will not the nationwide adoption of the International Classification of Diseases ICD-10 coding system contribute substantially to Waste, Fraud, and Abuse prevention and detection? (2) What is the Administration doing to help providers, especially small providers move toward the new ICD-10 environment to which the nation is committed?

(1) Will not the nationwide adoption of the International Classification of Diseases ICD-10 coding system contribute substantially to Waste, Fraud, and Abuse prevention and detection?

Answer: A successful transition to ICD-10 is an important step in improving our Nation's health care system. On October 1, 2014, the ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets. The transition is occurring because ICD-9 codes have limited data about patients' medical conditions and hospital inpatient procedures. ICD-9 is 30 years old, it has outdated and obsolete terms, and is inconsistent with current medical practices. Also, the structure of ICD-9 limits the number of new codes that can be created, and many ICD-9 categories are full.

An important benefit of the transition to ICD-10 is that the coding system could help provide better data to prevent and detect health care fraud and abuse. ICD-10 provides much more specific reporting on diagnoses and procedures. Sectors of the body are catalogued meticulously, making it more difficult to submit duplicate claims, and making it easier to spot deceptive activity.

(2) What is the Administration doing to help providers, especially small providers move toward the new ICD-10 environment to which the nation is committed?

Answer: CMS has been actively working with all segments of the industry, including small providers, to raise awareness of the transition to ICD-10. Many industry leaders such as health plans and hospital networks are already well into various phases of implementation. As with any transition, there will be a learning curve. CMS is continuing its outreach and education efforts and has developed a comprehensive implementation strategy to include training and technical assistance; forums for best practices; and research to assess ICD-10 readiness. CMS has also developed implementation handbooks tailored to small provider groups and hosted ongoing technical assistance trainings. Many resources are available to help small providers on CMS' ICD-10 website for providers:
http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html

The Honorable Jim Matheson

1. **Can you discuss how this Fraud Prevention System is generating savings, as well as if it is reducing administrative burdens on legitimate providers who are doing the right thing?**

Answer: The Fraud Prevention System (FPS) is a key element in our comprehensive approach to combating fraud, waste, and abuse. For the first time in Medicare's history, all Medicare fee-for-service claims are being streamed through a single fraud prevention screening system, the FPS, before they are paid. Since June 30, 2011, every claim, more than one billion, has been screened and the FPS has achieved early results that prove the value of this innovative approach to fraud prevention. As the fraud detection computer models within the FPS grow in sophistication, the results will continue to improve.

In its first year, the FPS generated leads for 536 new fraud investigations, provided new information for 511 pre-existing investigations, and triggered thousands of provider and beneficiary interviews to verify that legitimate items and services were provided to Medicare beneficiaries. Within the first year of implementing the FPS, CMS stopped, prevented, or identified an estimated $115.4 million in payments. Based on investigations triggered by FPS leads CMS stopped payments worth an estimated $16.2 million using auto-denial and prepayment edits in the first FPS implementation year. For more information on our first year of FPS implementation please see our Report to Congress available at:
http://www.stopmedicarefraud.gov/fraud-rtc12142012.pdf

We try to maintain a balance between ensuring that our payments go to the appropriate person, for the appropriate service, at the appropriate time, while also ensuring that we do not distract providers and suppliers from their important responsibility – providing quality care to beneficiaries. We are working with the provider and supplier community to explore ways to streamline the process and minimize the impact of multiple audits.

2. Is this similar to what you are doing with the Fraud Prevention System? Are there other health sectors where similar proposals are being employed or would it be beneficial if they were employed?

Answer: The Fraud Prevention System (FPS) is a key element in our comprehensive approach to combating fraud, waste, and abuse. For the first time in Medicare's history, all Medicare fee-for-service claims are being streamed through a single fraud prevention screening system, the FPS, before they are paid. We are engaging the private sector through our Healthcare Fraud Prevention Partnership. The goal of the partnership is to improve fraud detection and prevent payment of fraudulent health care billings by finding and stopping schemes that cut across public and private payers. The partnership will enable those on the front lines of industry anti-fraud efforts to share information more easily with investigators, prosecutors, policymakers and other stakeholders. It will help law enforcement officials to more effectively identify and prevent suspicious activities and use the full range of tools and authorities provided by the Affordable Care Act and other essential statutes to combat and prosecute illegal actions.

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