



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

**ON**

**CUTTING WASTE, FRAUD, AND ABUSE IN MEDICARE AND MEDICAID**

**BEFORE THE**  
**U.S. HOUSE COMMITTEE ON ENERGY & COMMERCE**  
**SUBCOMMITTEE ON HEALTH**

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**House Committee on Energy & Commerce**  
**Subcommittee on Health**  
**Hearing on “Cutting Waste, Fraud, & Abuse in Medicare and Medicaid”**  
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Chairman Pallone, Ranking Member Shimkus, and Members of the Subcommittee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services’ (CMS) efforts to reduce waste, fraud, and abuse in the Medicare and Medicaid programs and the new tools and authorities given to the Secretary of the Department of Health & Human Services (HHS) and CMS in the Affordable Care Act of 2010.

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

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

As CMS works to implement the new authorities in the Affordable Care Act, we have a significant opportunity to build on existing efforts to combat waste, fraud, and abuse in Federal health care programs. These new authorities offer more front-end protections to keep those who are intent on committing fraud out of the programs and new tools for deterring wasteful and fiscally abusive practices, identifying and addressing fraudulent payment issues promptly, and ensuring the integrity of the Medicare and Medicaid

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

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

CMS recognizes the importance of having strong program integrity initiatives that will deter criminal activity and attempts to defraud Medicare or Medicaid. I share your commitment to ensuring taxpayer dollars are being spent on legitimate items and services. As we continue the process of implementing these authorities and improving our program integrity, we must make sure to do this in a way that is fair and transparent to plans and providers, who are our partners in caring for beneficiaries, and also work to ensure that beneficiary access to necessary health care services or medicines is not impeded. CMS' first priority is to our beneficiaries, and working with States and law-abiding providers and suppliers to protect their interests is an important goal in our program integrity work.

### **Strategic Principles for Program Integrity Operations**

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

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

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

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

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

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

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

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

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

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

The Affordable Care Act also provides for data sharing between Federal entities to monitor and assess high risk program areas and better identify potential sources of fraud. CMS will soon expand its Integrated Data Repository (IDR) to include claims and payment data, and intends to enter into data sharing and matching agreements with the Department of Veterans Affairs, the Department of Defense, the Social Security Administration, and the Indian Health Service to identify potential waste, fraud, and abuse throughout Federal health programs. Also, the Affordable Care Act requires States to report an expanded set of data elements to the Medicaid Management Information System (MMIS) that will strengthen CMS' program integrity work within State Medicaid programs.

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

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

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

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

Building on the momentum generated by the National Summit, HHS, along with its Federal partners, held two Regional Health Care Fraud Prevention Summits across the country this summer. These summits, held in Miami and Los Angeles, provided more opportunities to bring together a wide-array of Federal, State and local partners, beneficiaries, providers, insurers, and other interested parties to discuss innovative ways to eliminate fraud within the nation's health care system. These summits also featured educational panels that discussed best practices for both providers and law enforcement in preventing health care fraud. The panels included law enforcement officials, consumer experts, providers and representatives of key government agencies. CMS looks forward to additional opportunities to bring these stakeholder communities together in other cities to continue this important dialogue and strengthen our cooperative efforts across the Federal government and with the private sector.

CMS recognizes that our efforts to implement these strategic principles will be an incremental process. As we seek to reduce waste, fraud, and abuse in Medicare and Medicaid, we are mindful of striking the right balance between preventing fraud and other improper payments without impeding the delivery of critical health care services to

beneficiaries in need. At their core, Federal health care programs are designed to provide affordable health care to families in need, people with disabilities, and aging Americans. We do not want to prevent beneficiary access to important health care services or needed medications. Furthermore, the vast majority of health care providers are honest people who seek to do the right thing and provide critical health care services to millions of CMS beneficiaries every day.

### **Engaging Our Beneficiaries and Partners**

Meanwhile, HHS and CMS continue to work with and rely on our beneficiaries and collaborate with our partners to reduce waste, fraud, and abuse in Medicare and Medicaid. The Senior Medicare Patrols (SMP) program, led by the HHS Administration on Aging (AoA), empowers seniors to identify and fight fraud through increased awareness and understanding of Federal healthcare programs. This knowledge helps seniors protect themselves from the economic and health-related consequences of Medicare and Medicaid waste, fraud, and abuse. In partnership with State and national fraud control/consumer protection entities, including Medicare contractors, State Medicaid fraud control units, State attorneys general, the HHS OIG, and CMS, SMP projects also work to resolve beneficiary complaints of potential fraud. Over the last decade, nearly 2.6 million beneficiaries have been educated through approximately 67,500 group education sessions led by SMP staff or SMP projects. On a one-time basis, HHS plans to expand the size of the SMP program in the coming year and put more people in the community to assist in the fight against fraud.

In addition to working with AoA on expanding the SMPs, CMS is implementing a number of new mechanisms to better engage beneficiaries in identifying and preventing fraud. As part of that effort, CMS encourages its beneficiaries to check their Medicare claims summaries thoroughly. Medicare Summaries Notices (MSNs) are sent to beneficiaries every 90 days. Additionally, beneficiaries can now check their claims within days of the processing date by using either the “MyMedicare” secure website or the 1-800-MEDICARE automated system. A fact sheet and informational card has been developed to educate and encourage beneficiaries or caregivers to check their claims

frequently and to report any suspicious claims activity to Medicare. These materials are being used at the regional fraud summits and have been shared with both State Health Insurance Plans (SHIPs) and SMPs.

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

CMS is in the process of developing a “fraud heat map.” As calls come into 1-800-MEDICARE, data will be geographically displayed, which will allow CMS to quickly see shifts in fraud calls over time and to drill down by various parameters such as claim type, geographic location, and fraud type, and to listen to the actual call if necessary. CMS is also exploring new options for streamlining the process and timeframe for investigating fraud complaints, while seeking to preserve the efficiencies and cost-effectiveness of a single call center like 1-800-MEDICARE. These updated processes will help CMS to more quickly and efficiently examine and address waste, fraud, and abuse issues.

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

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

In Medicaid, we are actively working to give our State partners the tools to implement important provisions of the Affordable Care Act. On July 13, 2010, CMS issued a letter to State Medicaid Directors on State recovery of Medicaid overpayments. This letter provides initial guidance on how States can move forward in implementing Section 6506 of the Affordable Care Act, which became effective March 23, 2010. Under Section 6506, States now have up to one year from the date of discovery of an overpayment for Medicaid services to recover, or to attempt to recover, such overpayment before being required to refund the Federal share of the overpayment. Prior to passage of the Affordable Care Act, States were allowed up to 60 days from the date of discovery of an overpayment to recover such overpayment before making the adjustment to the Federal share. CMS appreciates this new flexibility for States. The additional time provided under the Affordable Care Act may help encourage States to be more aggressive in rooting out fraud and overpayments. CMS continues to provide technical assistance to States' to support their Medicaid program integrity efforts.

### **CMS' Efforts to Implement the Affordable Care Act**

#### **Initial Steps – CMS-6010-IFC**

CMS published an interim final rule with comment (CMS-6010-IFC) in the Federal Register on May 5, 2010 that began the process of implementing the new authorities and provisions of the Affordable Care Act. This rule had an effective date of July 6, 2010. This rule requires all providers of medical or other items or services and suppliers that

qualify for a National Provider Identifier (NPI) to include their NPI on all applications to enroll in and on all claims for payment submitted under Medicare and Medicaid. This rule also requires physicians and eligible professionals who order and refer covered items and services for Medicare beneficiaries to be enrolled in Medicare. In addition, it adds requirements for providers, physicians, and other suppliers participating in the Medicare program to provide documentation on referrals to programs at high risk of waste and abuse – specifically, DMEPOS, home health services, and other items or services as specified by the Secretary.

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

### **New Actions – CMS-6028-P**

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

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

### ***Enrollment Screening and Controls***

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

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

### ***Suspension of Providers or Suppliers***

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

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

### ***Compliance Programs***

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

### **Other Program Integrity Tools**

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

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

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

### **Conclusion**

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

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