STATEMENT OF

JOHN SPIEGEL

DIRECTOR, MEDICARE PROGRAM INTEGRITY GROUP
CENTER FOR PROGRAM INTEGRITY
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

"WASTE, FRAUD AND ABUSE: A CONTINUING THREAT TO MEDICARE AND MEDICAID"

BEFORE THE

UNITED STATES HOUSE COMMITTEE ON ENERGY & COMMERCE,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

MARCH 2, 2011

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

U.S. House Committee on Energy & Commerce,
Subcommittee on Oversight and Investigations
Hearing on "Waste, Fraud and Abuse: A Continuing Threat to Medicare and Medicaid"
March 2, 2011

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

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

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

Bringing Activities Together into the Center for Program Integrity

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

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

Strategic Principles for Program Integrity Operations

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

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

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

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

CMS' Efforts to Implement the Affordable Care Act

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

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

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

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

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

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

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

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

Other Implementation Steps – CMS-6010-IFC

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

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

Other Affordable Care Act Authorities

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

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

Expanded Use of Recovery Audit Contractors

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

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

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

Increased Flexibility in Medicaid Recovery Rules

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

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

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

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

Fraud Detection and Reporting

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

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

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

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

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

Fiscal Year 2012 Budget Request

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

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

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

HCFAC Program Successes

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

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

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

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

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

Engaging Our Beneficiaries and Partners

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

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

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

Collaborating with Law Enforcement Partners

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

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

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

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

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

Data Analytics

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

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

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

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

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

Delivery System Reforms

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

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

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

Conclusion

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

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

Center for Program Integrity

	Current State		New Approach
1	Pay and Chase	→	Prevention and Detection
2	'One Size Fits All'	→	Risk-Based Approach
3	Legacy Processes	→	Innovation
4	Inward Focused Communications	→	Transparent and Accountable
5	Government Centric	→	Engaged Public/Private Partners
6	Stand Alone PI Programs	→	Coordinated & Integrated PI Programs