

Statement of Timothy B. Hill, CFO
Centers for Medicare & Medicaid Services
On
Medicare Health Care Fraud & Abuse Efforts
Before the House Budget Committee
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Good morning Chairman Spratt, Ranking Member Ryan and distinguished Members of the Committee. I am pleased to be here today to discuss the Centers for Medicare & Medicaid Services' (CMS) efforts to combat fraud and abuse within Federal health care programs.

With increasing expenditures, expanding Federal benefits, and a growing beneficiary population, the importance and the challenges of safeguarding CMS programs are greater than ever. Fraud, waste, and abuse schemes have become increasingly complex, and are quick to adapt and stump even the latest oversight strategies of Congress, CMS, and our law enforcement partners. With CMS' expansive network of health care activities comes a tremendous responsibility to protect our programs' integrity, promote efficiency in their operation, and ensure safe and quality health care for all Americans.

Responsible and efficient stewardship of taxpayer dollars is a critical goal of this Administration, as evidenced by a government-wide effort to improve financial management by way of the President's Management Agenda (PMA). Under the PMA, Federal agencies are mobilizing people, resources, and technology to identify improper payments in high-risk programs, establishing aggressive improvement targets, and implementing corrective actions to meet those targets expeditiously. Consistent with these efforts, CMS is committed to identifying program weaknesses and vulnerabilities to help prevent fraud, waste, and abuse, and to improve quality of care in the Medicare program.

My testimony today will briefly describe the Agency's commitment to fiscal integrity and our evolving methods to prevent fraud and abuse within CMS programs. In addition, I will talk specifically about the Agency's numerous program integrity initiatives, the additional resources the CMS Health Care Fraud and Abuse Control (HCFAC) proposal brings to bear, and the potential return on investment offered by program integrity efforts.

Background on CMS Programs

CMS is the largest purchaser of health care in the United States, serving over 92 million Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) beneficiaries this year. Roughly two-thirds of CMS net outlays are devoted to Medicare, with Medicaid and SCHIP accounting for approximately one-third of CMS net outlays.

Medicare is a Federal health insurance program that provides comprehensive health insurance to more than 43 million people. Nearly 36 million individuals are entitled to Medicare because they are over the age of 65 and 7 million beneficiaries under age 65 are entitled because of disability; those under age 65 generally become eligible for Medicare after they have been entitled to Social Security disability cash benefits for 24 months. Gross Medicare outlays have grown from \$206 billion in Fiscal Year (FY) 1996 to nearly \$382 billion in FY 2006.

CMS processes claims and makes payments for fee-for-service (FFS) Medicare benefits through contracts with private companies: carriers, fiscal intermediaries (FIs), durable medical equipment (DME) Medicare Administrative Contractors (MACs), and A/B MACs. During 2007, CMS estimates that Medicare contractors will process well over one billion claims from providers, physicians, and suppliers for items and services that Medicare covers. Medicare contractors review claims submitted by providers to ensure payment is made only for Medicare-covered items and services that are reasonable and necessary and furnished to eligible individuals. In addition, CMS contracts with Program Safeguard Contractors (PSCs) to detect and deter Medicare fraud and abuse. Quality Improvement Organizations are contractors that ensure that payment is made only for medically necessary services and investigate beneficiary complaints about quality of care.

Improper Payments and Reduced Error Rates

Given the staggering size of Medicare program expenditures, even small payment errors can have a significant impact to the Federal Treasury and taxpayers. For this reason, CMS, as part of a sound financial management strategy, has a long history of using improper payment calculations as a tool to monitor the fiscal integrity of Medicare. CMS uses improper payment calculations to identify the amount of money that has been inappropriately paid, to identify and study the causes of the inappropriate payments, and to focus on strengthening internal controls to stop the improper payments from continuing.

In recent years, CMS has made great strides in significantly reducing the Medicare FFS error rate by educating providers about appropriate medical record documentation and methods to improve their accuracy and completeness. Paying claims right the first time ensures the proper expenditure of the Medicare trust funds and saves resources required to recover improper payments.

For example, in FY 2005, we strove for a Medicare FFS error rate of 7.9 percent and the actual error rate was 5.2 percent. For FY 2006, the goal was 5.1 percent and the actual error rate was 4.4 percent. The goal for FY 2007 is 4.3 percent and CMS in its 2007 Medicare FFS error rate mid-year report indicated that the error rate to date is 4.2 percent, making progress toward achieving the target error rate. The Agency has set a performance goal of further reducing the error rate to 4.2 percent by the end of FY 2008.

Coordinating Program Oversight Activities

CMS follows four parallel strategies in carrying out our program oversight activities. They are prevention of incorrect payment, early detection, coordination, and enforcement.

- Prevention: CMS identifies problems before a claim is paid, through our payment systems, prepayment medical review activities, and education of providers and beneficiaries.

- Early detection: CMS finds problems quickly, using proactive data analysis, probe reviews of claims, audits and post payment claims reviews, data matches, and other sources to detect improper payments.
- Coordination: CMS works through public and private partnerships to identify and fight fraud and abuse. CMS recognizes the importance of working with contractors, beneficiaries, law enforcement partners, and other Federal and State agencies to improve the fiscal integrity of the Medicare trust funds.
- Enforcement: CMS ensures that action is taken when fraud and abuse is found. CMS will continue to work with our partners, including the Department of Health & Human Services (HHS)/Office of Inspector General (OIG), Department of Justice (DOJ), State agencies for survey and certification, Medicaid Fraud Control Units (MFCUs), and State Medicaid agencies to pursue appropriate corrective actions such as restitution, fines, penalties, damages, and program suspensions or exclusions.

Health Care Fraud and Abuse Control Program

For FY 2008, the Administration needs \$1.3 billion to support the HCFAC program. This spending supplements routine program oversight activities and is an investment in future savings from programs that account for a significant share of improper and wasteful payments within CMS.

The FY 2008 HCFAC funding request is a critical foundation of support for our Agency initiatives to uncover fraud and abuse in CMS programs. CMS appreciates the Committee's recognition of the prudence of investment in these activities, demonstrated by an adjustment to the discretionary budget cap for increased HCFAC funding. The return on investment and savings to the Medicare trust funds more than compensate for every dollar that we invest in fraud and abuse activities. With the growing pressures on the Medicare trust funds due to the aging of our population, each investment CMS makes in fighting fraud and recovering improper payments will have an exponential impact on Medicare's long-term sustainability.

As noted above, the Administration is requesting a total funding level of \$1.3 billion to carry out HCFAC functions, \$202 million over the FY 2007 level. Section 1128(c) of the Social Security Act authorized the HCFAC program and Section 1817(k) of the Act specified the levels of funding for the activities in this account. These funds are permanently appropriated and are made available through the apportionment process. Of the \$202 million, approximately \$20 million is the result of mandatory inflationary increases provided by the Tax Relief and Health Care Act of 2006 (P.L. 109-432) and the Deficit Reduction Act of 2005 (DRA) (P.L. 109-171). \$183 million comes from the FY 2008 Budget discretionary funding request for HCFAC, which is sufficient to supplement the mandatory dollars. The \$183 million in discretionary HCFAC funding will build upon programs with a proven record for maintaining the integrity of the Medicare trust funds and be used for prosecutions of Medicare Advantage and Part D health care matters, investigations, audits, inspections, evaluations, as well as for educating consumers and providers.

An investment in program integrity activities is needed to address new fraud concerns arising from the Part D drug benefit. As set forth in appropriations language, discretionary funds for HCFAC activities would be split among several government entities that collaborate to identify, prosecute, and fight fraud and abuse. In addition to \$138 million for Medicare Integrity Program (MIP) activities, the remaining \$45 million in HCFAC funding would be made available for work carried out by the HHS OIG, the Federal Bureau of Investigation (FBI), the DOJ, and other HHS agencies, including CMS.

Return on Investment in the Medicare Integrity Program

CMS tracks incorrect payments that were either avoided or recovered through initiatives funded by the MIP. The ratio of the amount spent on an activity compared to the measured savings is referred to as the return on investment (ROI). Activities have varying rates of return. For example, the ROI rate for all MIP activities is approximately 13 to 1; for the HCFAC account, the ROI is 4 to 1. From 1997 to 2005, HCFAC activities have returned approximately \$8.85 billion to the trust funds.

Medicare-Medicaid Data Matching Program

Another important program integrity initiative is the Medicare-Medicaid (Medi-Medi) data matching program. Data mining health care claims for fraudulent activity has been commonplace for several years. However, by jointly mining Medicare and Medicaid claims, new patterns are being detected that were not evident when viewed separately. The knowledge gleaned from our Medi-Medi activities helps each program identify and address internal vulnerabilities. CMS has 10 Medi-Medi projects in place in key States and, as mandated by the DRA, will expand the program nationwide. To date, more than 50 Medi-Medi cases have been referred to law enforcement, \$15 million in overpayments have been referred for collection, and \$25 million in improper payments have been caught before erroneous payments were made. This project is a key contributor to overall reductions in payment errors.

Preventing Fraud and Abuse with Program Safeguard Contractors

As previously mentioned, CMS' actions to safeguard Federal funds are not merely limited to the error rate programs described in this testimony. Program and fiscal integrity oversight is an integral part of CMS' financial management strategy, and a high priority is placed on detecting and preventing fraud and abuse. To that end, CMS has made significant changes to its program integrity activities in recent years.

The PSCs are CMS' fraud, waste and abuse detection contractors. As of 2006, PSCs were established nationwide across all provider and supplier types in the Medicare FFS program. The PSCs perform data analysis to identify potential problem areas, investigate potential fraud, develop fraud cases for referral to law enforcement and coordinate Medicare fraud, waste and abuse efforts with CMS' internal and external partners (e.g., law enforcement, affiliated contractors (i.e., intermediaries, carriers), and MACs).

To further supplement the PSCs' fraud identification efforts, CMS is making improvements to our own internal data analysis efforts. We are collecting vulnerability data from many of our partners, including Medicare contractors, and using a variety of data analysis tools to review Medicare claims data. Much of our work will focus on

addressing vulnerabilities early in their lifecycle, and those that have high estimated dollar impact to the Medicare program. Our program integrity efforts will focus on the top 10 vulnerabilities identified through our data analysis and developing corrective actions to address these identified vulnerabilities.

Program Integrity Efforts with Recovery Audit Contractors

Section 306 of the MMA gave CMS additional authority to pilot a new contracting authority designed to detect improper payments. This MMA provision directs the Secretary to demonstrate the use of Recovery Audit Contractors (RACs) in identifying Medicare underpayments and overpayments, and collecting Medicare overpayments. CMS implemented RACs in three States – Florida, New York and California – and in FY 2006, the RACs collected \$68.6 million in overpayments and identified more than \$300 million in improper payments.

The RAC program is consistent with the President's Management Agenda objective to prevent improper payments in Federal programs. CMS designed the demonstration to accomplish two specific goals – to demonstrate whether RACs can identify past improper payments in the Medicare FFS program and to determine whether the RACs can provide information to CMS that could help prevent future improper payments. In response to encouraging results under this demonstration effort to date, Congress mandated the expansion of the RAC effort nationally in the Tax Relief and Health Care Act of 2006, and the Agency is now in the process of developing its expansion and implementation plans.

Program Integrity Enforcement via Satellite Offices

CMS has taken several specific actions to ensure that Federal dollars are being properly spent and fraudulent billings are stopped when they are detected. In particular, we have recently opened a new satellite office in New York City. This office, in conjunction with the existing Los Angeles satellite office, and an enhanced Miami office, will help curtail fraudulent spending in these high-risk regions of the country. CMS' three satellite offices will provide additional on-the-ground efforts to deter, detect, and report fraud, waste, and

abuse in these high-vulnerability areas. The satellite offices enable CMS to be proactive in identifying potential fraud and abuse and promptly taking the appropriate corrective actions. Having an additional presence in these cities will allow CMS to better collaborate with our partners to design, develop, manage, and participate in special anti-fraud and abuse projects/programs.

Through the combined efforts of the Los Angeles satellite office, the PSC and the claims processing contractors operating in California, CMS has identified over \$2.1 billion in improper payments in calendar years 2005 through 2006. This includes the prepayment denial of claims based upon fraud indicators and the post payment identification of overpayments for claims identified as potentially fraudulent or highly suspect. The Los Angeles office has also conducted a special project that addressed improper billing and potentially fraudulent claims submitted by Independent Diagnostic Testing Facilities (IDTFs) operating in California. This special project resulted in approximately \$163 million in denied charges and the termination of Medicare billing privileges for 83 IDTF providers.

Provider Enrollment

CMS has seen a marked increase in fraud and abuse activities during the past few years that can be directly tied to provider enrollment issues. These activities are primarily focused in high vulnerability areas of the country such as Los Angeles, Miami, and Houston where a large number of beneficiaries and providers/suppliers are located. To fight fraud, CMS has sought to tighten the provider enrollment process, provide more rigorous oversight and monitoring once a provider/supplier enrolls in the program, and strengthen the provider revocation process.

CMS is also implementing new strategies to remove fraudulent providers from the Medicare program. Our Los Angeles satellite office has recently identified situations in which some physicians are submitting claims for services that have not been furnished to a specific individual on the date of service. These instances include but are not limited to situations where the beneficiary is deceased, the directing physician or beneficiary was

not in the State or country when the services were furnished, or the equipment necessary for testing is not present where the testing is said to have occurred. We proposed through regulation that CMS have the authority to remove these fraudulent providers from the Medicare program.

Durable Medical Equipment Fraud

As the Secretary noted in his earlier testimony, within the last 18 months, CMS and the OIG have identified and documented a significant amount of fraud being committed by DME suppliers in Miami and the Los Angeles metropolitan area. While both regions of the country have high numbers of Medicare beneficiaries, there has been a tremendous spike in the number of providers and utilization; the number of DME providers has almost doubled and billing from the providers remains disproportionately high.

During FY 2006, the National Supplier Clearinghouse (NSC), the national enrollment contractor for DME suppliers, conducted 1,472 inspections of Miami DME suppliers. As of October 2006, the billing numbers of 634 DME suppliers had been revoked, including 143 suppliers that had been enrolled within the previous 12 months. This effort, which is still ongoing, resulted in a projected savings to the Medicare program of \$317 million. The NSC spent approximately \$3 million on all enrollment efforts in Miami, resulting in a ROI of greater than 100:1 (\$100 in savings for each dollar spent to conduct the project). A similar initiative was conducted in the Los Angeles area last year.

The types of fraud committed by the DME suppliers in Miami and the Los Angeles metropolitan areas included: (1) billing for services not rendered, which involved claims for power wheelchairs, scooters, nutritional products (e.g., Ensure), orthotics, prosthetics, hospital beds, etc., and (2) billing for services not medically necessary. CMS and its contractors have identified thousands of Medicare beneficiaries living in California and Florida who are receiving DME items that they did not require based upon their medical history and/or are receiving Medicare Explanation of Benefits (EOBs) for items that are not only unnecessary, but never ordered by their physician and never received by the beneficiary. CMS staff in Los Angeles and Miami have interviewed multiple physicians

who have provided attestations that they never saw the patients for which DME was ordered and correspondingly never ordered by the suspect DME.

New Approaches to Fight Fraud

Under the initiative announced by Secretary Leavitt on July 2, 2007, CMS will implement a demonstration project requiring DME suppliers in Miami and Los Angeles to reapply for participation in Medicare in order to maintain their billing privileges. Letters will be sent out to suppliers in the demonstration locales asking that they resubmit an application to be a qualified Medicare DME supplier. Those who fail to reapply within 30 days of receiving a letter from CMS; fail to report a change in ownership or address; or fail to report having owners, partners, directors or managing employees who have committed a felony within the past 10 years will have their billing privileges revoked. DME suppliers who do not have their Medicare billing privileges revoked based on the information contained in their application will be subject to enhanced review and potential site visits.

As Secretary Leavitt relayed earlier today, CMS is launching an aggressive campaign to detect and prevent fraud and abuse activities, using a multi-prong approach. While the DME demonstration program is a first step, we also are carefully watching potential fraud trends in other industries, including home health and infusion therapies.

Medicaid Program Integrity

The HCFAC program, which is funded through Medicare's Hospital Insurance Trust Fund, has the Medicare program as its primary focus. In the Medicaid program, program integrity efforts have been funded through grants to the State MFCUs and, to a limited extent, from non-MIP activities in the HCFAC program.

The DRA was a major step in providing new resources for program integrity efforts in Medicaid. The DRA provided a dedicated and permanent funding stream for the Medi-Medi Data Match Program, which had received some start-up funds from the HCFAC account. It also established and provided permanent funding for the Medicaid Integrity

Program (\$50 million this year) that will reach a total of \$75 million annually by FY 2009 and each year thereafter.

Conclusion

When unscrupulous providers defraud Medicare, they are cheating us all – particularly more than 43 million people who rely on Medicare for their health care needs.

Beneficiaries with stolen identities may lose eligibility for equipment in later years if a sham provider has already billed Medicare on their behalf. When suppliers provide empty promises to beneficiaries, they may simply be left without the equipment necessary to support their chronic conditions. And finally, illegal billing diverts funding from all beneficiaries in order to pay those engaged in fraudulent activity. For these and many other reasons, we take program integrity and other anti-fraud efforts very seriously at CMS.

Thank you for having me here to testify today. CMS appreciates your support of our efforts, and I would be happy to answer any questions.