STATEMENT OF

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ON

MEDICAID FRAUD

BEFORE THE

U.S. HOUSE COMMITTEE ON OVERSIGHT & GOVERNMENT REFORM
SUBCOMMITTEE ON GOVERNMENT ORGANIZATION, EFFICIENCY, AND FINANCIAL MANAGEMENT AND
SUBCOMMITTEE ON HEALTH CARE, DISTRICT OF COLUMBIA, CENSUS, AND THE NATIONAL ARCHIVES

DECEMBER 7, 2011

U.S. House Committee on Oversight & Government Reform
Subcommittee on Government Organization, Efficiency, and Financial Management and
Subcommittee on Health Care, District of Columbia, Census, and the National Archives
December 7, 2011

Chairmen Platts and Gowdy, Ranking Members Towns and Davis, and Members of the Subcommittees, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) efforts to reduce fraud, waste, and abuse in the Medicaid program.

The Affordable Care Act gives new tools to CMS and law enforcement officials to protect Federal health care programs from fraud, waste, and abuse. With this support, we are ramping up our Medicaid anti-fraud efforts by enhancing the quality of data used to detect fraud, investing in data analytics, and providing more "boots on the ground" to fight health care fraud. These efforts will increase our ability to prevent fraud before it happens, and to detect fraud when it does, allowing swifter recovery and corrective action. The Administration is strongly committed to ensuring that public resources are protected against losses from fraud and other improper payments by maintaining the integrity of the Medicaid program.

Background

Medicaid is the primary source of medical assistance for 56 million low-income and disabled Americans. Although the Federal government establishes requirements for the program, States design, implement, administer, and oversee their own Medicaid programs. The Federal government and States share in the cost of the program. State governments have a great deal of programmatic flexibility within which to tailor their Medicaid programs to their unique political, budgetary, and economic environments. As a result, there is variation among the States in eligibility, services, reimbursement rates to providers and health plans, and approaches to program integrity. The Federal government reimburses a portion of State costs for medical services through a statutorily determined matching rate called the Federal Medical Assistance Percentage, or FMAP, which is based on each State's per capita income and normally ranges between 50 and 75 percent. The Federal government also reimburses the States a portion of their administrative costs through varying matching rates determined according to statute, ranging

from 50 percent to 90 percent. The total net Federal Medicaid outlays in fiscal year (FY) 2011 are approximately $275 billion.

Deficit Reduction Act Authorities to Prevent and Reduce Fraud, Waste, and Abuse

Similar to all public and private health care programs, Medicaid can be a target for those who would abuse or defraud a health care program for personal gain. Recognizing the need for a greater focus on health care fraud at the public and private level, Congress gave CMS new authority and funding in the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) which modified section 1936 of the Social Security Act to establish and operate the Medicaid Integrity Program. The Medicaid Integrity Program protects Medicaid by administering the national Medicaid audit program while enhancing Federal oversight of State Medicaid programs. The Medicaid Integrity Program accomplishes this by providing States with technical assistance and support that enhances the Federal-State Partnership. Prior to the enactment of the DRA, States performed the majority of program integrity oversight in the Medicaid program.

Section 1936 of the Social Security Act, as modified by the DRA, provides CMS with ongoing authorities to fight fraud by requiring CMS to contract with Medicaid Integrity Contractors (MICs) to review provider claims, audit providers, identify overpayments, and educate providers, managed care entities, beneficiaries, and other individuals about payment integrity and quality of care. CMS works with partner agencies at the Federal and State levels to enhance these efforts, including preventing the enrollment of individuals and organizations that would abuse or defraud the Medicaid program and removing fraudulent or abusive providers when detected.

Analyzing Data

As part of Section 1936 of the Social Security Act, CMS uses "Review of Provider MICs" (Review MICs) to analyze Medicaid claims data provided by States to identify high-risk areas, potential vulnerabilities, and targets for audits. In April 2008, CMS began developing an information technology infrastructure comprised of a central data repository and analytical tools. The system became operational in January 2009. It is primarily populated with Medicaid Statistical Information System (MSIS) data, which is a subset of Medicaid eligibility and claims data from all 50 States and the District of Columbia. This State-submitted data includes over 40

million eligibility records and over 2 billion claims records per year. CMS uses algorithms and modeling to identify potential fraudulent, wasteful, or abusive payments based on analysis of the MSIS data.

CMS is aware of the limitations of the MSIS data because of our extensive use of the data, as well as from feedback from other groups such as the HHS Office of Inspector General (OIG) and State Medicaid Agencies. Limitations include deficiencies in the completeness, accuracy, and timeliness of the data, as well as lack of data standardizations among State programs. As a result, improving the data quality of the MSIS data is vital to program integrity efforts. CMS continues to improve access to better quality Medicaid data by leveraging the data available through the Medicare/Medicaid Data Match Expansion Project (Medi-Medi) and its participating States, as well as working directly with States to obtain Medicaid data for specific collaborative projects. While the MSIS data has limitations, CMS is able to use the MSIS data to identify trends and patterns that exist within individual States, as well as regionally and at the national level in an effort to detect and deter fraud, waste, and abuse in the Medicaid program.

In order to improve CMS and the States' data analysis efforts, the Medicaid and Children's Health Insurance Program (CHIP) Business Information and Solutions Council (MACBIS), an internal CMS governance body, provides leadership and guidance for a more robust and comprehensive information management strategy for Medicaid, CHIP, and State health programs. The council's strategy includes:

- Promoting consistent leadership on key challenges facing State health programs;
- Improving the efficiency and effectiveness of the Federal-State partnership;
- Making data on Medicaid, CHIP, and State health programs more widely available to stakeholders; and
- Reducing duplicative efforts within CMS and minimizing the burden on States.

CMS' Center for Medicaid and CHIP Services (CMCS) leads this effort. The MACBIS projects will lead to the development and deployment of enterprise-wide improvements in data quality and availability for Medicaid program administration, oversight, and integrity. As these efforts

mature, we will be able to better utilize our technical infrastructure and business intelligence tools for program integrity oversight by using analytics, algorithms, and queries.

In addition to efforts to improve the quality of the Medicaid data, CMS is actively pursuing ways to apply advanced data analytics technology, including predictive analytics, to the Medicaid Integrity Program. CMS' goal is to utilize predictive modeling to enhance its analytic capabilities and increase information sharing and collaboration among State Medicaid agencies to detect and deter aberrant billing and servicing patterns at the State level and on a regional or national scale.

Auditing Claims

Once claims have been analyzed through CMS' data system and shared with the State, the "Audit of Provider" MICs (Audit MICs) conduct post-payment audits of all types of Medicaid providers and advise States of potential overpayments made to these providers. Between the completion of the solicitation process for MICs in 2009 and November 1, 2011, Audit MICs have initiated 1,663 audits in 44 States. Those efforts have identified an estimated $15.2 million in overpayments, through both direct provider audits and automated reviews of State claims. In addition to Federal audits, States reported that they conducted an additional 122,631 audits in FY 2009. Those State efforts have identified an estimated $964 million in overpayments.

Educating Providers and Others on Medicaid Program Integrity Issues

The Medicaid Integrity Institute (MII) remains one of CMS' most significant achievements in fighting Medicaid fraud, in partnership with our colleagues at the U.S. Department of Justice (DOJ). In its four years of operations, the MII has offered numerous courses and trained more than 2,624 State employees at no cost to the States. Courses have included enhanced investigative and analytical skills, Medicaid program integrity fundamentals, and a symposium to exchange ideas, create best practice models, and identify emerging fraud trends.

States continue to report immediate value and benefit from the training offered at the MII. As a result of several MII courses, State staff from across the country have the opportunity to engage in productive dialogues about the challenges they face combating fraud, waste, and abuse issues

unique to their State Medicaid programs. This interaction permits participants to share their success stories, learn from others' best practices, give their Medicaid programs a wider range of perspectives on policy options, and help identify problem providers who attempt to migrate from one State Medicaid program to another. For example, one State recently reported it recovered $3.15 million through provider audits it conducted as the direct result of knowledge gained at the MII. We have also sponsored intensive Certified Professional Coder training[1] and auditing courses for 359 additional State employees.

In addition, "Education MICs" assist in the education of providers and beneficiaries on program integrity efforts by developing materials and conducting training. For example, Education MICs help CMS enlist beneficiaries in our fight against fraud, including efforts such as the Protect Yourself, Protect Medicaid Campaign. CMS strongly believes that alert and vigilant Medicaid beneficiaries are one of the most valuable tools we have to stop fraudulent activity. Our Education MICs create public service announcements, distribute e-letters, and regularly update social networking sites to provide beneficiaries quick facts and tips about how to prevent, spot, and report Medicaid fraud. Education MICs encourage Medicaid beneficiaries to report fraud, waste, and abuse or criminal activities to their State's Medicaid Fraud Control Unit (MFCU) which is the State-administered law enforcement agency, Medicaid agency, the HHS fraud tips hotline, and the HHS OIG.

Due to the enactment of the DRA and Affordable Care Act, the creation of the Medicaid Integrity Program, and the establishment of our MICs, we have made great strides in combating Medicaid fraud. Today, thanks to increased funding and resources, we are able to investigate allegations of fraud quickly and competently, and report cases to law enforcement, as appropriate.

Supporting State Efforts to Combat Fraud, Waste, and Abuse

Because of Medicaid's unique Federal-State partnership, all of the strategies described above protect and enhance State Medicaid programs at a foundational level. We have also developed

[1] The MII's Certified Coder Boot Camp teaches the fundamentals of Current Procedural Terminology (CPT), ICD-9, and Healthcare Common Procedure Coding System (HCPCS) Level II coding.

initiatives that specifically work to assist States in strengthening their own efforts to combat fraud, waste, and abuse.

To provide and gauge effective support and assistance to States to combat Medicaid fraud, waste, and abuse, CMS conducts triennial comprehensive reviews of each State's program integrity activities. We use the State Program Integrity Reviews to identify and disseminate best practices. The review areas include provider enrollment, provider disclosures, program integrity, managed care operations, and the interaction between the State's Medicaid agency and its MFCU. We also conduct follow-up reviews to evaluate the success of the State's corrective actions.

Through its reviews, CMS has identified 52 unduplicated program integrity "best practices" that we have publicized to all States through annual summaries of our efforts. The guidance includes specific examples of how States have created well-functioning and committed partnerships between the State Medicaid agency and its MFCU. CMS, working with State Medicaid agencies and MFCUs, issued guidance in September 2008 entitled "Performance Standard for Referrals of Suspected Fraud from a Single State Agency to a Medicaid Fraud Control Unit." CMS, State Medicaid agencies, and MFCUs developed this performance standard to provide State program integrity units with a clear understanding of how to comply with requirements for making referrals of fraud to MFCUs. In concert with the release of the performance standard, MIG issued a second guidance document, "Best Practices for Medicaid Program Integrity Units' Interactions with Medicaid Fraud Control Units." This document advises State program integrity units of the circumstances under which they should refer cases to their MFCUs, and provides guidance for interactions between State program integrity units and their MFCUs, with specific examples of actions taken by States that have created well-functioning and committed partnerships between the two entities.

The MFCU, as a State-administered law enforcement agency independent of the State Medicaid Agency, investigates and prosecutes Medicaid fraud as well as patient abuse and neglect in health care facilities. The Federal government funds MFCUs on a 75 percent matching basis. The HHS OIG certifies, and annually recertifies, each MFCU.

CMS also developed the State Program Integrity Assessment (SPIA). Through the SPIA, CMS annually collects standardized, national data on State Medicaid program integrity activities for program evaluation and technical assistance support. The States and CMS use the SPIA to gauge their collective progress in improving the overall integrity of the Medicaid program. In FY 2009, States reported recovering $2.3 billion through program integrity efforts funded at $393.5 million, for a $5.58 to $1 return on investment.

CMS also provides States assistance with "boots on the ground" for special investigative audits. Since October 2007, CMS has participated in 10 projects in three States, with the majority of activity occurring in Florida. States reported these reviews have resulted in $33.2 million in savings through cost avoidance. CMS helped States review 654 providers, 43 home health agencies and DME suppliers, and 52 group homes. During those reviews, CMS and States interviewed 1,150 beneficiaries and took more than 400 actions against non-compliant providers (including, but not limited to fines, suspensions, licensing referrals, and MFCU referrals). Besides identifying inappropriate provider activities, these reviews also result in an ongoing sentinel effect in these vulnerable areas of the Medicaid program.

Since 1998, the Medicaid Fraud & Abuse Technical Advisory Group (TAG) and its State subject matter experts have provided guidance to CMS on a variety of program integrity issues. The TAG is comprised of a chair and 10 regional representatives, all of whom are senior State program integrity officials. CMS meets with the TAG as well as other State program integrity officials in a monthly national teleconference and in annual face-to-face meetings. The Medicaid Fraud & Abuse TAG provides our State partners a critical voice in CMS' program integrity efforts.

To further build on this support, the Office of Management and Budget recently approved $2.9 million to fund a pilot project that tests an automated tool that screens providers for risk of fraud through the Partnership Fund for Program Integrity Innovation. Currently, HHS and the States lack standardized Medicaid provider data, which hampers the detection of potential fraud. This tool, which is being developed and tested in conjunction with four State partners,

could help prevent improper payments by weeding out fraudulent providers and focusing limited State resources on areas where fraud is most likely to occur. By reconfiguring how HHS and the States identify fraud trends, this new pilot aims to improve fraud detection capabilities and drive significant savings. Pilot results are expected in November 2012.

The Affordable Care Act and new Fraud-Fighting Tools at CMS

In addition to State and Federal efforts already underway, in March 2010, the President signed into law the Affordable Care Act, which included additional program integrity provisions that strengthened Medicaid integrity efforts. Several of these provisions were based on proposals from CMS, State Medicaid agencies, and law enforcement agencies. The Affordable Care Act also incorporated many provisions supporting the goal of the President's Executive Order 13520, *Reducing Improper Payments*, signed in November 2009.

Further, in April 2010, the Secretary of HHS created the Center for Program Integrity (CPI) to coordinate fraud, waste, and abuse prevention, detection, and enforcement efforts across CMS' Medicare, Medicaid, and CHIP programs. CPI's four major approaches to key anti-fraud activities are:

- **Prevention:** CPI will prevent fraud, waste, and abuse by expanding the breadth of the program integrity strategy beyond post-payment recoveries to preventing improper payments and resolving problems as they occur.
- **Detection**: CPI will focus on risk and reward compliance by targeting initiatives that identify bad actors while reducing the burden on legitimate providers and suppliers.
- **Increasing transparency and accountability**: CPI will be transparent and accountable to its stakeholders by sharing performance metrics on key program integrity activities.
- **Recovery:** CPI will focus on key strategies that increase recoveries to the Medicare Trust Funds and the Treasury.

Enhanced Screening and Other Enrollment Requirements

On January 24, 2011, CMS announced a final rule (CMS-6028-FC) implementing a number of the Affordable Care Act's powerful new fraud prevention legislative tools. The final rule:

- **Creates a rigorous screening process** for providers and suppliers enrolling in Medicare, Medicaid, and CHIP to keep fraudulent providers out of those programs. Categories of providers and suppliers that pose a moderate or high risk of fraud, for example durable medical equipment suppliers and home health agencies, are subject to additional screening requirements. States must follow the same screening procedure for Medicaid-only providers that CMS requires for Medicare providers. States may rely on CMS' screening results for providers enrolled in both Medicare and Medicaid. States may also rely on the results of the screenings provided by another State for the same provider. In addition, a provider must be terminated from any State Medicaid or CHIP program if the provider has been terminated from Medicare or another State's Medicaid or CHIP program for cause.
- **Permits temporary enrollment moratoria of new providers and suppliers.** Medicare and State Medicaid programs can temporarily stop enrollment of a category of providers or of providers within a geographic area that has been identified as high risk, as long as that will not impact access to care for patients.
- **Permits the suspension of payments** to providers and suppliers suspected of fraud. The Secretary of HHS or the State Medicaid Agency can suspend payments pending the investigation of a credible allegation of fraud, stopping the flow of money to potentially fraudulent providers.

CMS also issued rules on May 5, 2010 (CMS-6010-IFC) implementing Affordable Care Act provisions that require providers and suppliers who order and refer certain items or services for Medicare and Medicaid beneficiaries to enroll in Medicare and Medicaid, maintain documentation on those orders and referrals, and include the National Provider Identifier on all fee-for-service (FFS) enrollment applications and claims.

Established State Medicaid Recovery Audit Contractor (RAC) Program

On September 14, 2011, CMS released the final rule for the Medicaid Recovery Audit Contractor (RAC) program, a key part of the Affordable Care Act's initiatives to curb fraud, waste, and abuse. The Medicaid RAC program will help States identify and recover improper Medicaid payments, and States are required to have their RAC programs in place, absent an

exception, by January 1, 2012. Similar to the Medicare FFS Recovery Audit Program, States will pay the RACs a contingency fee out of any overpayments recovered. RACs review claims after payment, using both simple and detailed reviews that include medical records. RACs are required to employ trained medical professionals, certified coders, and a physician, unless CMS grants an exception. Further, CMS' Medicaid Recovery Audit Contractor At-A-Glance web page on the CMS website[2] provides basic information to the public and interested stakeholders about each State's Recovery Audit program.

The Affordable Care Act expanded RACs to Medicaid because of RACs' success within original Medicare – between October 1, 2010 and September 30, 2011, the Medicare FFS Recovery Audit Program has corrected a total of $939 million in improper payments. Over the next five years, we project that the Medicaid RAC effort will save the Medicaid program $2.1 billion, of which $910 million will be returned to the States. This effort complements the other efforts described above that target fraud, waste, and abuse in the health care system.

Partnering with Stakeholders to Improve Medicaid Program Integrity

Many of the Affordable Care Act provisions increase coordination between States, CMS, and our law enforcement partners at the HHS OIG and the DOJ. CMS is committed to working with our law enforcement partners, who take a lead role in investigating, determining, and prosecuting alleged fraud. By sharing information and requiring all States to terminate any provider or supplier that Medicare or another State terminated for cause, the Affordable Care Act ensures that fraudulent providers and suppliers cannot easily move from State to State or between Medicare and Medicaid. We are also providing training in the use of data analytic systems to the HHS OIG and DOJ, enabling investigators and law enforcement agents to more quickly detect and prosecute fraud schemes.

We also appreciate the efforts of the Government Accountability Office (GAO) and their recommendations on how to improve Medicaid program integrity. We continue to work to address the concerns raised by the GAO and to reduce improper payments and potential vulnerabilities in the Medicaid program. As a reminder, improper payments include both

[2] https://www.cms.gov/medicaidracs/home.aspx

overpayments and underpayments, and are not necessarily fraudulent in nature. CMS' commitment to reducing improper payments is demonstrated by the review and audit activities described above, as well as our collaborative efforts with the States, and the establishment of the RAC program and other Affordable Care Act initiatives. For FY 2011, Medicaid's national improper payment rate is 8.1 percent -- a drop from 9.4 percent in FY 2010. Despite this decrease, we remain focused on improving program integrity in Medicaid, and are confident that the actions outlined in this testimony, as well as the continued efforts of our Federal, State, and public partners, will continue to reduce improper payments.

Conclusion

CMS is committed to the integrity of the Medicaid program, and ensuring that we continue to advance in fraud prevention and detection. This Administration has made an unprecedented effort to reduce improper payments in Federal health care programs, invest in program integrity strategies, and rein in fraud, waste, and abuse. With the Affordable Care Act provisions, anti-fraud strategies, and partnerships discussed today, we have more resources than ever before to implement important strategic changes in pursuing fraud, waste, and abuse. Through partnerships between stakeholders, we have learned from each other how to protect our health care system. I am confident that the smarter we work today, with our partners, technology, and through training and education, the stronger our system will be for years to come. I look forward to working with you in the future as we continue to make improvements in protecting the integrity of Medicaid and safeguarding taxpayer resources.