ASSESSING MEDICARE AND MEDICAID PROGRAM INTEGRITY

HEARING

BEFORE THE

SUBCOMMITTEE ON GOVERNMENT ORGANIZATION, EFFICIENCY AND FINANCIAL MANAGEMENT

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

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ASSESSING MEDICARE AND MEDICAID PROGRAM INTEGRITY

Thursday, June 7, 2012

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON GOVERNMENT ORGANIZATION,
EFFICIENCY, AND FINANCIAL MANAGEMENT,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, D.C.

The subcommittee met, pursuant to call, at 9:40 a.m., in Room 2154, Rayburn House Office Building, Hon. Todd Platts [chairman of the subcommittee] presiding.

Present: Representatives Platts, Lankford, Farenthold, Towns, and Norton.

Also Present: Representative Bachmann.

Staff Present: Ali Ahmad, Communications Advisor; Alexia Ardolina, Assistant Clerk; Kurt Bardella, Senior Policy Advisor; Molly Boyl, Parliamentarian; Sharon Casey, Senior Assistant Clerk; Katelyn E. Christ, Professional Staff Member; John Cuaderes, Deputy Staff Director; Gwen D'Luzansky, Research Analyst; Adam P. Fromm, Director of Member Services and Committee Operations; Linda Good, Chief Clerk; Ryan M. Hambleton, Professional Staff Member; Mark D. Marin, Director of Oversight; Christine Martin, Counsel; Mary Pritchau, Professional Staff Member; Noelle Turbitt, Staff Assistant; Peter Warren, Legislative Policy Director; Jaron Bourke, Minority Director of Administration; Beverly Britton Fraser, Minority Counsel; Ashley Etienne, Minority Director of Communications; Devon Hill, Minority Staff Assistant; and Safiya Simmons, Minority Press Secretary.

Mr. PLATTS. Good morning. This hearing of the Subcommittee on Government Organization, Efficiency, and Financial Management will come to order. I first apologize to all of our guests and our witnesses and my colleagues for the short delay in getting started. Given that the delay is my responsibility, I am going to abbreviate my opening statement to get us back on track, but we are appreciative of everyone's participation here today, and especially our witnesses.

This hearing is focused on the fiscal integrity of Medicare and Medicaid and it is our subcommittee's third hearing on this issue of helping to ensure that we do right by the American people in how we handle their hard-earned dollars that they send to Washington. And an important focus of this subcommittee for many years, going back to when I first joined it, my first term in Congress in 2001 under the chairmanship of Steve Horn, is how to prevent the making of improper payments by the Federal Government.

And when we look at Medicaid and Medicare, more than half of the most recent years' identified improper payments were within these two programs, approximately $65 billion of the American people's money that was not properly handled on their behalf by the Federal Government.

Today's hearing is looking at how these programs can do better, and we certainly appreciate our witnesses' participation and your insights and knowledge that you will share with us. As in the past and working with the former chairman of the full committee and the chairman of this subcommittee, and now-ranking member Mr. Towns, our approach has always been a partnership with Federal departments and agencies and programs. We are not out to play "gotcha" but we are simply here to see how can we do better and how can we help those involved specifically in the operation of Medicare and Medicaid and those who work with us at GAO and the Inspector General's Office; how we can improve the effectiveness, efficiency of these programs, and ultimately serve the American people through these very important programs where the hundred million Americans receive health-care benefits but do so in a responsible manner where we are certainly getting a good return on the investment and properly handling their money.

So we will look forward to your testimony.

And with that, I am going to yield to the ranking member from New York, Mr. Towns, for the purposes of an opening statement.

Mr. TOWNS. Thank you very much, Mr. Chairman, and thank you for holding this hearing.

This subcommittee has held several hearings about fraud and waste in these critical health-care programs that we must continue to do so because we need to answer the question: Can we administer these programs more efficiently by reducing improper payments and fraud?

Last year, Medicare covered about 50 million beneficiaries and spent approximately $560 billion, which is about 15 percent of the total Federal spending. Medicaid likewise provides coverage for about 70 million people nationwide and cost the government approximately $260 billion last year, about 8 percent of the Federal spending. These numbers are expected to grow as our population gets older.

This country increases reliance over time on Medicaid and Medicare is unfortunately translating into a significant level of waste and fraud. Improper payments for Medicare was recently estimated to be $42 billion; and for Medicaid, $21.9 billion. That is a lot of money. That is the reason why both of these programs continue to be on the GAO's high-risk list.

The Affordable Care Act includes a number of provisions that will enhance our efforts to fight waste and fraud in Medicare and Medicaid. Eliminating avoidable mistakes and cracking down on criminals will be important elements in achieving this goal.

Today we will look at some of the innovative steps that the Center for Medicare and Medicaid Services is taking to reduce improper payments and fight fraud. We will also examine some of the shortcomings that prevent existing programs from reaching their full cost savings potential.

There is no single approach that will result in the reduction of waste and fraud in the health-care system. The solution requires a multi-tiered approach involving stakeholders in Congress, CMS, the private sector, and law enforcement all working together in order to achieve this goal.

I thank our witnesses for their testimony, and I look forward to hearing your recommendations and suggestions that we might make.

So on that note, Mr. Chairman, I yield back.

Mr. PLATTS. Thank you, Mr. Towns. I appreciate your testimony.

I would now ask unanimous consent that our distinguished colleague from Minnesota, the gentlelady, Representative Bachman, be allowed to participate in today's hearing for both the purpose of questions and an opening statement, and, without objection, so ordered.

I now yield to the gentlelady for her opening statement.

Mrs. BACHMANN. Chairman Platts and Ranking Member Towns, I thank you so much for your consideration and graciousness allowing me to be able to testify briefly before this committee today on this critical program, and I thank you also for the bipartisan way in which this committee is moving forward on this subject. As we are on the cusp of a major expansion in Medicaid in the United States, it is more important than ever, and I commend this committee for taking up this important issue about saving the expenditure of the people's money. And I thank you for that.

In April, I testified in a joint hearing of two oversight committees' subcommittees on the complete lack of reporting, collection, and verification of meaningful data in Medicaid. I underscore what I just said. That is a breathtaking statement. There is a complete lack of reporting, collection, and verification of meaningful data in Medicaid. The same is not true for Medicare. That is why this is a bipartisan issue and one that we hope will focus on helping the needs of the poorest among us in the United States who must have these program moneys in order to survive.

The staff report from that hearing stated, "Minnesota provides a stunning example of how States are failing to properly ensure the appropriate use of taxpayer dollars spent on Medicaid managed care. This is something we are not proud of. In order for States to ensure the appropriate use of taxpayer dollars, they must be able and willing to collect the data that shows how much is paid in a claim, for what, and to whom. That is only basic common decency.

Since the investigation into Minnesota's Medicaid fraud has unfolded, several implicated parties have begun to offer up excuses.

According to the trade organization for managed care organizations, the Department of Human Services actually has the data but not the ability to analyze it. They say the State's computer system is too antiquated. But in contradiction to this, a DHS assistant commissioner said the data is "literally analyzed by DHS on a daily basis and has been for years." So now, either the trade association representing the health plan is fudging or DHS is. We need to find out who. It is our job to immediately get to the bottom of this. And I thank the committee for what you are doing.

CMS is already tasked with identifying patterns or instances of fraud and abuse in Medicare and Medicaid. That much we know,

and that much is good. But despite that, they require no documented data. Now, the two don't go together. You can't do your job if you don't have documented data.

That is why this month I am introducing a bill that will hold CMS accountable to ensure stated audits are conducted properly. That is why this is totally bipartisan, a bipartisan bill. We just want to know where the people's money is going and is it going to help the poor people in this country who need these services.

But because this situation needs immediate attention, I am proud to announce that I am sending a letter today to CMS calling for an immediate third-party independent audit of Minnesota's books. We can't allow taxpayer dollars to flow without proper record keeping ever again.

Thank you again to the committee for your fine work, Ranking Member Towns, and also for your fine work, Chairman Platts. I am thrilled to be a partner with you in this important work that you are doing.

And I yield back.

Mr. PLATTS. I thank the gentlelady for her opening statement and her involvement and interest in the issue, as well as your focus on the efforts of Minnesota specifically in seeking to make sure we do right by all of our taxpayers in Minnesota and across this great Nation.

All members will have 7 days to submit opening statements and extraneous material for the record.

I will now proceed to our panel of witnesses. And we are delighted to have a group of distinguished public servants with us who bring a welcome knowledge to our hearing today.

First, we have Dr. Peter Budetti, who is director of the Center for Program Integrity at the Centers for Medicare and Medicaid Services; Ms. Ann Maxwell, regional inspector general for evaluation and inspections in the Office of the Inspector General for the Department of Health and Human Services; as well as Ms. Carolyn Yocum, who is director of health care for Medicaid at the United States Government Accountability Office; and Ms. Kathleen King, director of health care for Medicare at the United States Government Accountability Office.

We thank all of our witnesses for being here with us today. Pursuant to committee rules, if I could ask all four of you to stand and raise your right hand and allow us to swear you in before your testimony.

Raise your right hand. Do you solemnly swear or affirm that the testimony you are about to give this committee will be the truth, the whole truth, and nothing but the truth? Let the record reflect that all four witnesses answered in the affirmative.

We appreciate the extensive written testimony you provided us, what I call my homework in preparation for our committee hearings, and your doing so certainly allows both members and staff to be better prepared to have a good engagement here today.

With your oral testimony here today, if you can seek to limit yourself to roughly 5 minutes. You will see the light system in front of you. If you do need to go over a little bit, that is fine. But for the purpose of allowing members to get into exchange and Q&A with you, we will try to limit to 5 minutes.

Dr. Budetti, we will begin with you.

WITNESS STATEMENTS

STATEMENT OF PETER BUDETTI, M.D.

Dr. BUDETTI. Thank you, Mr. Chairman, and thank you Chairman Platts, Ranking Member Towns, and members of the subcommittee for this invitation to discuss the Centers for Medicare and Medicaid Services program integrity efforts for the Medicare and Medicaid programs.

As I describe in detail in my written statement, the administration made important strides in reducing fraud, waste, and improper payments. And I draw your attention to this chart, which I hope is in a font that at least some of us in the room can read, which illustrates the framework within which we have taken action over the last 2 years.

The first point is moving beyond a pay-and-chase approach by focusing new attention on preventing fraud. We are adopting what we call a twin pillar approach, building upon the traditional program integrity efforts that focus on detecting and prosecuting fraud.

We have implemented an approach that involves two pillars. One is what we are calling the fraud prevention system, which applies predictive analytic technology on claims prior to payment to identify aberrant and suspicious billing patterns. And the second pillar is the automated provider screening system which focuses on identifying ineligible providers or suppliers prior to their enrollment or revalidation.

These innovative new systems are designed to work together. They're growing in their capacity to protect patients and taxpayers from those intent on defrauding our programs. They represent an integrated approach to program integrity, preventing fraud before payments are made, keeping bad providers and suppliers out of Medicare in the first place, and quickly removing wrongdoers once they are detected. These complement the traditional program integrity activities which continue.

Second, we would like to emphasize that our work is on a risk-based approach. We are not approaching this on a one-size-fits-all model. For example, in addition to the detailed assessment of credentials and other requirements that all providers and suppliers undergo through the automated provider screening system, we've identified those in a moderate level of risk who are now required to also undergo site visits and those in the high level of risk who will be subject to fingerprint-based criminal background checks.

The fraud prevention system itself, the way it operates, represents another example of our risk-based approach. It targets our investigative resources to suspicious claims and providers, generates alerts in priority order, allowing our program integrity analysts to investigate the most egregious or suspect aberrant activity.

Third, innovation. For the first time in the history of the program, CMS is using a system to apply advanced analytics against Medicare fee-for-service claims on a streaming national basis. This has enabled us to identify schemes operating across Medicare Parts A and B claims and across the country.

The fraud prevention system aggregates A and B data claims in near realtime, and this has revolutionized our approach. For example, our investigators formerly had to check multiple systems to determine whether a beneficiary had ever visited a doctor who billed Medicare for services and supplies. We've now consolidated disbursed pieces of claims data, beneficiary visits with the doctor, or orders for durable medical equipment and hospital, and other providers and other services provided under Part A, enabling our investigators to automatically see the full picture.

Similarly, in the second pillar of our approach, the automated provider screening system, this is another significant advancement and innovation. We're using advanced technology in a way that we are committed to both rooting out and screening out the bad guys while making it easier for the legitimate providers to enter the Medicare program.

We expect that our enhancements to the Medicare enrollment system will speed up the time for legitimate providers to get in and our screening processes will keep out the bad ones.

The fourth point, transparency and accountability, which are high priorities for this administration. We've held a number of regional fraud prevention summits around the country with a wide range of stakeholders and the general public, and we have engaged in a number of efforts to make sure that the public is aware of what we are doing to combat fraud and how they can join with us in doing that.

We are engaging the public and private sector more extensively. For example, we conducted a month-long fraud prevention awareness month in concert with the California Medical Association and the State of California, and we've involved the private sector, especially the medical community, very closely in our remodeling of the enrollment system to address needs that they themselves have identified.

And finally, I'm coordinating and integrating the program integrity programs. When Secretary Sebelius created the Center for Program Integrity, she brought together the Medicare and the Medicaid program integrity activities for the first time. This has provided a strong basis now for communication between the programs and for aligning as much as possible the fraud policy—anti-fraud policies and procedures across Medicare and Medicaid, as required in many cases by the Affordable Care Act.

Mr. Chairman, Medicare and Medicaid fraud, we agree with you, they affect every American by draining critical resources and contributing to the rising cost of health care. We've made a firm commitment in this administration to rein in fraud, waste, and improper payments. We have more tools than ever to move beyond "pay and chase" and implement

strategic changes in pursuing and detecting fraud, waste, and abuse.

I look forward to continuing to work with you as we make improvements in protecting the integrity of the Federal Health Care programs, and I very much appreciate your interest in our doing so.

Thank you for this opportunity to speak with you.

Mr. PLATTS. Thank you, Dr. Budetti.

[Prepared statement of Dr. Budetti follows:]

U.S. House Committee on Oversight and Government Reform
Subcommittee on Government Organization, Efficiency, and Financial Management
Hearing on "Assessing Medicare and Medicaid Program Integrity"
June 7, 2012

Chairman Platts, Ranking Member Towns, and Members of the Subcommittee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) program integrity efforts for the Medicare and Medicaid programs.

The Administration has made important strides in reducing fraud, waste and improper payments across the government. Over the last two years, CMS has implemented powerful new anti-fraud tools provided by Congress, as well as designed and implemented large-scale, innovative improvements to our Medicare and Medicaid program integrity strategy to shift beyond a "pay and chase" approach by focusing new attention on preventing fraud. Simultaneously, CMS is using the same innovative tools to further enhance our collaboration with our law enforcement partners in detecting and preventing fraud.

Preventing and Detecting Fraud in Medicare

CMS directly administers Medicare through contracts with private companies that process claims for Medicare benefits. Every workday, Medicare pays out more than $1 billion from some 4.5 million claims, and is statutorily required to pay claims quickly, usually within 14 to 30 days. Preventing fraud in Medicare involves striking an important balance: protecting beneficiary access to necessary health care services and reducing the administrative burden on legitimate providers, while ensuring that taxpayer dollars are not lost to fraud, waste, and abuse.

CMS is using many of the new anti-fraud authorities provided in the Affordable Care Act (P.L. 111-148 and P.L. 111-152) and the Small Business Jobs Act of 2010 (P.L.111-240) to strategically combat fraud, waste, and abuse, and is integrating additional tools into our current program integrity efforts. These new tools and authorities support our comprehensive strategy to prevent and detect fraud and abuse. These tools and authorities also require CMS to work closely with States, our law enforcement partners, the private sector, and health care

providers. These efforts to date have resulted in record monetary recoveries of health care fraud and a more than 75 percent increase in defendants charged in criminal fraud cases, increasing from 797 individuals in 2008 to 1,430 last year. I am confident that the improvements we have put in place over the past two years will provide increasingly greater protections to Medicare and Medicaid for a long time to come.

The New "Twin Pillar" Strategy

Building upon our traditional program integrity efforts that focus on detecting and prosecuting fraud, CMS has implemented a twin pillar approach to fraud prevention in Medicare. The first pillar is the new Fraud Prevention System (FPS), which applies predictive analytic technology on claims prior to payment to identify aberrant and suspicious billing patterns. The second pillar is the Automated Provider Screening (APS) system, which identifies ineligible providers or suppliers prior to their enrollment or revalidation. Together these innovative new systems, the FPS and APS, are growing in their capacity to protect patients and taxpayers from those intent on defrauding our programs. These pillars represent an integrated approach to program integrity – preventing fraud before payments are made, keeping bad providers and suppliers out of Medicare in the first place, and quickly removing wrongdoers from the program once they are detected.

The First Pillar: The Fraud Prevention System

The FPS is the predictive analytic technology required under the Small Business Jobs Act. Since June 30, 2011, the FPS has been running predictive algorithms and other sophisticated analytics nationwide against all Medicare fee-for-service and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) claims prior to payment. CMS is well ahead of the statutory implementation schedule, which called for phasing in the technology in the 10 highest fraud States in the Medicare fee-for-service program by July 1, 2011. Nationwide implementation of the technology maximizes the benefits of the FPS and permitted CMS to efficiently integrate the technology into the Medicare fee-for-service program and train our anti-fraud contractors.

CMS uses the FPS to target investigative resources to suspect claims and providers, and swiftly impose administrative action when warranted. The system generates alerts in priority order, allowing program integrity analysts to further investigate the most egregious, suspect, or aberrant

activity. CMS and our program integrity contractors use the FPS to stop, prevent, and identify improper payments using a variety of administrative tools and actions, including claim denials, payment suspensions, revocation of Medicare billing privileges, and referrals to law enforcement. Under the direction of CMS' Center for Program Integrity (CPI), Zone Program Integrity Contractors (ZPICs):

- Develop investigative leads generated by the FPS and perform data analysis to identify cases of suspected fraud, waste, and abuse;
- Make recommendations to CMS for appropriate administrative actions to protect Medicare Trust Fund dollars;
- Make referrals to law enforcement for potential prosecution and provide support for ongoing investigations; and
- Identify improper payments to be recovered.

In the first ten months of implementation of the FPS, 1010 active ZPIC investigations have been supported by leads generated by the FPS. Specifically, the FPS directly resulted in 591 new investigations, while also supporting 419 pre-existing investigations. CMS is currently identifying the range of performance metrics that will fully capture the success of the FPS, and this fall, a report to Congress about the first implementation year of the FPS will describe these metrics.

Additionally, the FPS has led to 550 direct interviews with providers suspected of participating in fraudulent activity, and over 1,541 interviews with beneficiaries to confirm whether they received services for which the Medicare program had been billed. These numbers are increasing every day. The beneficiary interviews are similar to the inquiries credit card companies make to cardholders when a suspicious purchase is flagged. CMS uses the information learned from these beneficiary interviews along with historical claims data to identify the characteristics of potentially bad actors and then builds that information into the FPS's predictive algorithms and other sophisticated analytics. Additionally, CMS incorporates beneficiary complaints about potential fraudulent providers submitted via 1-800-MEDICARE directly into the FPS to further refine our analytics.

For the first time in the history of the program, CMS is using a system to apply advanced analytics against Medicare fee-for-service claims on a streaming, national basis. This has enabled CMS to identify schemes operating across Medicare Parts A and B claims and across the country. The FPS aggregates Parts A and B claims in near-real time, and this comprehensive view of claims is revolutionizing our program integrity work. For example, ZPIC investigators formerly had to check multiple systems to determine whether a beneficiary ever visited the doctor who billed Medicare for services and supplies. The FPS has consolidated the dispersed pieces of claims data – beneficiary visits with a doctor or orders for DMEPOS billed under Part B, and hospital and other provider services billed under Part A – enabling ZPICs to automatically see the full picture. Equally important, the FPS organizes the data to quickly show when two providers on opposite ends of the country are billing Medicare on behalf of the same beneficiary, rooting out potential compromised beneficiary numbers and other fraudulent activity.

The Second Pillar: Enhanced Provider Enrollment and Automated Provider Screening

The second pillar of CMS' program integrity strategy is enhanced enrollment and screening requirements for providers and suppliers seeking to enroll or revalidate their enrollment in Medicare. This innovative approach is designed to leverage the increased scrutiny applied to bad actors while simultaneously making it easier and more efficient for legitimate providers and suppliers to enroll or re-enroll in the Medicare program. CMS launched the APS technology on December 31, 2011. Medicare Administrative Contractors (MACs) and the National Supplier Clearinghouse (NSC) for DMEPOS enrollment are responsible for provider and supplier enrollment. Historically, the MACs and the NSC have processed paper applications and crosschecked information manually against various databases to verify provider and supplier enrollment requirements such as licensure status. Today, CMS is using the new APS technology to conduct routine and automated screening checks of providers and suppliers against thousands of private and public databases to more efficiently identify and remove ineligible providers and suppliers from Medicare. CMS anticipates that the new process will decrease the application processing time for providers and suppliers, while enabling CMS to continuously monitor the accuracy of its enrollment data and to assess applicants' risk to the program using standard analyses of provider and supplier data.

Provider enrollment is the gateway to the Medicare program, and CMS has made significant improvements that have begun to change the way providers and suppliers interact with CMS. The Provider Enrollment, Chain, and Ownership System (PECOS) maintains the official record of information for all providers, suppliers, and associated groups enrolled in Medicare. Provider enrollment data is used for claims payment, fraud prevention initiatives, and law enforcement activities. A key strategy for improving the process for honest providers, while clamping down on bad actors, is the creation of an all-digital process for web-based PECOS. CMS has already implemented the web-based payment of the application fee and now permits the use of electronic signatures on applications. The availability of the electronic signature option eliminates the requirement that providers and suppliers mail a paper signature at the end of the application process. As a result, CMS has seen a significant increase in the submission of web applications, especially for institutional providers, group practices, and DMEPOS suppliers.

The APS technology complements our approach to implementing the enhanced screening requirements enacted in the Affordable Care Act. This new screening strategy is tailored to both categorical and individual provider risk, rather than a one-size-fits-all approach. Categories of providers and suppliers in the "moderate" level of risk are now required to undergo an on-site visit prior to enrolling or upon revalidation of their Medicare billing privileges. This new requirement expanded on-site visits to many providers and suppliers that were previously not subject to such site visits as a requirement for enrolling in the Medicare program. In addition to announced and unannounced site visits, providers and suppliers who are designated in the "high" level of risk will be subject to fingerprint-based criminal background checks. As a result of the new Affordable Care Act screening requirements, CMS estimates that approximately 50,000 additional site visits will be conducted between March 2011 and March 2015 to ensure providers and suppliers are operational and meet certain enrollment requirements.

CMS completed the procurement of a national site visit contractor to increase efficiency and standardization of the site visits and the contractor recently started performing these site visits. The National Site Visit Contractor (NSVC) began performing site visits in late January 2012. As of April 30, 2012 the NSVC completed 6,871 site visits; of those completed, the NSVC

determined 223 sites to be nonoperational; those enrollments were either denied or revoked as deemed appropriate.

CMS has embarked on an ambitious project to revalidate the enrollments of all existing 1.5 million Medicare suppliers and providers by 2015 under the new Affordable Care Act screening requirements. Since March 25, 2011, CMS enrolled or revalidated enrollment information for approximately 275,439 Medicare providers and suppliers under the enhanced screening requirements of the Affordable Care Act. These efforts will ensure that only qualified and legitimate providers and suppliers can provide health care items and services to Medicare beneficiaries.

The FPS, APS, and other enrollment enhancements promote synergy in CMS program integrity activities. For example, based on FPS leads, CMS identified specific providers and suppliers as top priorities for revalidation. As a result of screening providers and suppliers that pose an elevated risk as identified by the FPS, CMS has moved to revoke and deactivate the billing privileges and enrollment records of providers and suppliers that do not meet current Medicare enrollment requirements. The first phase of revalidation led to 13,066 deactivations of provider practice locations for non-response to the revalidation request, as of March 1, 2012. The second phase of revalidation has resulted in the deactivation of 6,278 provider enrollments records for non-response and 4,319 revocations after it was determined the providers were not properly licensed in the state in which they were enrolled, as of May 1, 2012.[1] These initiatives complement the traditional program integrity work and additional provider enrollment enhancements that CMS continues to implement.

Preventing and Detecting Fraud in Medicaid

As a State-based program, Medicaid is administered very differently than Medicare. However many of the tools CMS is applying in Medicare are being evaluated for use in Medicaid. CMS is collaborating with our State partners to ensure that those caught defrauding Medicare will not be able to defraud Medicaid, and those identified as fraudsters in one State will not be able to

[1] We note that the first and second phase revalidation results are preliminary results as deactivated providers could reactivate over time with updated practice information or after showing evidence of proper licensing.

replicate their scams in another State's Medicaid program. Specifically, the Affordable Care Act and CMS' implementing regulations require States to terminate from Medicaid providers or suppliers who have been revoked by Medicare, or terminated for cause by another State's Medicaid program or the Children's Health Insurance Program (CHIP). Similarly, under current authority, Medicare may also revoke providers or suppliers that have been terminated by State Medicaid agencies or CHIP.

To support State efforts to share such information, CMS implemented a web-based application that allows States to share information regarding terminated providers and to view information on Medicare providers and suppliers that have had their billing privileges revoked for cause. We are confident that this interactive tool for States is the beginning of a smarter, more efficient Federal-State partnership, integrating technology solutions to routinely share relevant program information in a collaborative effort.

CMS is also actively pursuing ways to apply advanced data analytics technology, including predictive analytics, to the Medicaid program. CMS is required, under the Small Business Jobs Act of 2010, to complete an analysis of the cost-effectiveness and feasibility of expanding predictive analytics technology to Medicaid and CHIP after the third implementation year of the FPS. Based on this analysis, the law requires CMS to expand predictive analytics to Medicaid and CHIP by April 1, 2015. Although Medicaid is administered and organized in a distinctly different way than Medicare, we believe there are opportunities to transfer the knowledge and lessons learned through the FPS and APS in Medicare to States for use in Medicaid. For example, we are currently working to identify specific FPS algorithms that are relevant to Medicaid and will be performing an analysis of one State's Medicaid claims data using the identified algorithms. Once the analysis is complete, we will share the results back with the State. We anticipate the analysis being complete before the end of the year. As another example, we are partnering with the same State to screen all of the State's Medicaid providers using the APS. Once the analysis is complete, we will provide the results back to the State for their action as appropriate. The goal of this test project is to demonstrate the utility of using an automated screening application to screen Medicaid providers, and we expect results later this year. While both of the initiatives described above involve only a few States, once we test the

effectiveness of these types of solutions in Medicaid, our goal is to expand these capabilities to more States. CMS is also supporting States' use of predictive analytics through technical assistance and education, including specific coursework focused on predictive analytics at the Medicaid Integrity Institute.

CMS Collaboration with States on Medicaid Program Integrity

States have primary responsibility for policing fraud, waste, and abuse in their Medicaid programs, and they have significant financial interest in doing so as they pay, on average, 43 percent of the cost of the program. However, CMS also has a significant role to play, providing technical assistance, guidance, and oversight in the State-based efforts. Section 1936 of the Social Security Act provides CMS with the authorities to fight fraud and abuse by Medicaid providers by requiring CMS to contract with private sector entities to review provider claims data, audit providers, identify overpayments, and educate providers 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.

Because of Medicaid's structure as a Federal-State partnership, CMS has developed initiatives that are specifically designed to assist States in strengthening their own efforts to combat fraud, waste, and abuse. One of CMS' most significant achievements is the Medicaid Integrity Institute (MII), which provides for the continuing education of State program integrity employees. At the MII, CMS has a unique opportunity to offer substantive training, technical assistance, and support to States in a structured learning environment. From its inception in 2008 through May 2012, CMS has continually offered MII courses and trained more than 3,000 State employees at no cost to the States. These State employees are able to learn and share information with program integrity staff from other States on topics such as emerging trends in Medicaid Fraud, data collection, and fraud detection skills, along with other helpful topics. In 2012, CMS has already held several events at the MII and plans to host a Data Expert

Symposium this summer to bring together State Medicaid data experts to exchange ideas about predictive analytics, including algorithm development and trend analysis.[2]

Just recently, CMS announced another initiative to assist States in their program integrity efforts. On May 30th, we launched the "CMS Provider Screening Innovator Challenge." This Challenge addresses our goals of improving our abilities to streamline operations, screen providers, and reduce fraud and abuse. Specifically, the Challenge is an innovation competition to develop a multi-State, multi-program provider screening software application which would be capable of risk scoring, credentialing validation, identity authentication, and sanction checks, while lowering burden on providers and reducing administrative and infrastructure expenses for States and Federal programs. Further information about the Challenge is available at www.medicaid.gov.

CMS also provides States assistance with "boots on the ground" for targeted special investigative activities. Since October 2007, CMS has participated in 12 projects in three States, with the majority occurring in Florida. CMS assisted States in the review of 654 providers, 43 home health agencies and DMEPOS suppliers, 52 group homes, and 192 assisted living facilities. During those reviews, CMS and States interviewed 1,150 beneficiaries and States took more than 540 actions against non-compliant providers (including, but not limited to fines, suspensions, licensing referrals, and State Medicaid Fraud Control Unit (MFCU) referrals). States reported these reviews have resulted in $40 million in savings through cost avoidance.

CMS Redesign of the Medicaid National Audit Program

Since the Medicaid Integrity Program is a fairly new program, we have had the opportunity to learn important lessons during the initial program years. Beginning in early 2010, CMS determined through internal analysis, environmental assessments, parallel discussions with stakeholders, and reviews of contractor performance that the initial auditing model of the Medicaid Integrity Program required fundamental changes in how it conducts its work in order to effectively support States in their efforts to combat fraud, waste, and abuse in their Medicaid

[2] Medicaid Integrity Institute FY-12Training Calendar: http://www.justice.gov/usao/eousa/ole/mii/mii_courses_12.pdf

programs. The 2010 Annual Report to Congress[3] on the Medicaid Integrity Program contained a section entitled "Redesign of the National Audit Program" that described how CMS was approaching improvements to Medicaid program integrity. An integral change in that redesign was the new focus on collaborative auditing projects with the States, which moved away from traditional stand-alone Federal audits that relied on post-pay data intended largely for research purposes[4] and moved to using more timely claims data residing with each state's Medicaid Management Information System (MMIS).

As the Department of Health and Human Services' Office of Inspector General (HHS-OIG), Government Accountability Office (GAO), and our own internal assessments have identified, audits based solely on post-payment data with little input from States have had mixed results. As such, since February 2011, CMS has focused on developing collaborative audits, which allows CMS to work alongside the States in identifying areas that warrant further investigation and deserve auditing. Through this process CMS can come alongside to support a State's program integrity efforts, and in most cases, use or supplement data from a State's MMIS. The number of collaborative audits have progressively increased and since February 2011. CMS no longer assigns audits to contractors based on the results of algorithms that were developed solely using CMS Medicaid Statistical Information System (MSIS) data.

Since the earliest collaborative audits were assigned to Medicaid Integrity Contractors (MICs) in January 2010, CMS has worked with States to develop and assign 137 collaborative audits in 15 States that collectively represent approximately 53 percent of all Medicaid expenditures in FY 2011. To continue towards expanding collaborative audit projects to a broader number of States, CMS is in discussions with 15 additional States that make up approximately 26 percent of FY 2011 Medicaid expenditures. For these collaborative audits, CMS and its contractors are working with each State to develop the audit targets. In addition, the corresponding data for the collaborative audits is in many cases provided or supplemented by the States, making the data more complete and thus, increasing the accuracy of any audit findings.

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[3] http://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/Downloads/fy10rtc.pdf; page 24.
[4] MSIS data is the primary data source for Medicaid statistical data, and is a subset of Medicaid eligibility and claims data from all 50 States and the District of Columbia.

CMS has continued to identify additional opportunities for program changes and improvement. CMS' redesign plan for Medicaid program integrity recognizes the significant emergence of Medicaid managed care penetration, anticipated growth in enrollment in the Medicaid program, the influence of new State Medicaid recovery audit contractors, as well as the need to eliminate certain redundant, ineffective, and inefficient practices. We are working within CMS and with our State partners to develop and test best practice approaches to managed care program integrity oversight that considers both the growth in enrollment and alternative funding arrangements.

As noted earlier, in addition to our own internal analysis, others came to many of the same conclusions for the need for changes to strengthen Medicaid program integrity. Recently, the HHS OIG,[5] the Medicaid and CHIP Payment and Access Commission (MACPAC),[6] the National Association of Medicaid Directors (NAMD),[7] and GAO[8] have identified many of these same factors and have made recommendations for changes to the Medicaid Integrity Program that parallel CMS' internal assessments and plans for restructuring the program. We appreciate the work of our partners and have taken their recommendations into consideration as we make ongoing changes to improve the program integrity efforts in our programs.

CMS is implementing the program redesign as a phased approach that involves piloting new concepts and sharing best practices with States, as well as total or supplementary use of direct State data for Medicaid Integrity Program audits. Meanwhile, CMS is working vigorously to reconfigure how to best review and audit Medicaid providers through our contractors. This reconfiguration includes expanding that review to include improving oversight of managed care entities, improving identification of audit targets like high-risk providers serving both Medicare and Medicaid beneficiaries, overhauling CMS' contractor structure, and enhancing support to States in their recovery of overpayments.

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[5] HHS OIG, "Early Assessment of Audit Medicaid Integrity Contractors." March 2012. http://oig.hhs.gov/oei/reports/oei-05-10-00210.pdf

[6] MACPAC, "Report to the Congress on Medicaid and CHIP." March 2012. http://www.macpac.gov/reports/2012-03-15_MACPAC_Report.pdf?attredirects=0&d=1

[7] NAMD, "Rethinking Medicaid Program Integrity: Eliminating Duplication and Investing in Effective, High-Value Tools." March 2012. http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public_namd_medicaid_pi_position_paper_final_120319.pdf

[8] GAO. "Medicare and Medicaid Fraud, Waste, and Abuse: Effective Implementation of Recent Laws and Agency Actions Could Health Reduce Improper Payments." March 2011. http://www.gao.gov/assets/130/125646.pdf

We are poised to expand the focus of our program integrity and oversight efforts. Specifically, we are expanding our program integrity efforts to address the growth of managed care in the States and the anticipated enrollment increase that will occur in 2014. In addition, as payment and service delivery reform methods are designed and implemented, we will work closely with our State partners to incorporate program integrity from the beginning. We are also working with our State partners on strategies to share information across programs and States about predicative analytics findings, terminated providers, and best practices.

Improving Data to Fight Fraud in Medicare and Medicaid

CMS has made significant improvements to our databases and analytical systems in recent years. However, we acknowledge that more can be done. CMS is committed to enhancing the quality and availability of our data to States as the agency and law enforcement continue to coordinate efforts, identify criminals, and prevent fraud on a system-wide basis. These efforts are being conducted in accordance with Affordable Care Act requirements for the centralization of certain claims data from Medicare, Medicaid, CHIP, the Department of Veterans Affairs, the Department of Defense, the Social Security Administration, and the Indian Health Service.

CMS continues to build the Integrated Data Repository (IDR) to provide a comprehensive view of Medicare and Medicaid data including claims, beneficiary data, and drug information. The IDR provides broader and easier access to data and enhanced data integration while strengthening and supporting CMS' analytical capabilities. The IDR is currently populated with seven years of historical Medicare Parts A, B, and D paid claims, and CMS is actively working to integrate pre-payment claims data.

CMS is also working to incorporate State Medicaid data into the IDR, while also working with States to improve the quality and consistency of the MSIS data from each State. MSIS data is the primary data source for Medicaid statistical data, and is a subset of Medicaid eligibility and claims data from all 50 States and the District of Columbia. To improve the quality of the MSIS data, and Medicaid data in general, CMS established the Medicaid and CHIP Business Information Solution (MACBIS) Council. This Council provides leadership and guidance in

support of efforts to create a more robust and comprehensive information management strategy for Medicaid and CHIP. 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.

The Council has initiated several efforts including the Transformed MSIS (T-MSIS) pilot project in 11 States, which together represent 40 percent of the nation's Medicaid expenditures. The heart of this pilot is to create a consolidated format from a variety of State information sources to satisfy multiple Medicaid and CHIP Federal information reporting requirements. CMS will use the results and lessons learned from these 11 States as the basis for national implementation by 2014. The MACBIS projects will lead to the development and deployment of improvements in data quality and availability for Medicaid program administration, oversight, and program integrity.

Improved data will allow CMS to analyze information from throughout the claims process to identify previously undetected indicators of aberrant activity. Used with the IDR, CMS' One Program Integrity (One PI) web-based portal helps CMS share data with our integrity contractors and law enforcement. The portal provides a single access point to the data within the IDR, as well as analytic tools to review the data. CMS has been working closely with our law enforcement colleagues to provide One PI training and support. Since October of 2010, CMS has trained a total of 622 program integrity contractors and CMS staff, including 82 law enforcement personnel, on the portal and tools on One PI.

CMS continues to improve access to better quality Medicaid data by exploring opportunities to collaborate with States participating in the Medicare-Medicaid Data Match Expansion Project (Medi-Medi) as well as working directly with States to obtain Medicaid data for specific collaborative projects.

As these efforts mature, we expect to be able to more easily transfer the lessons learned from Medicare program integrity analytics and algorithms, including predictive analytics, to the Medicaid Integrity Program. Like in Medicare, CMS' ultimate goal is to utilize predictive modeling to enhance our analytic capabilities, as well as 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.

Looking Forward

Medicare and Medicaid fraud affect every American by draining critical resources from our health care system, and contributing to the rising cost of health care for all. The Administration has made a firm commitment to rein in fraud, waste and improper payments. Today, we have more tools than ever before to move beyond "pay and chase" and implement strategic changes in pursuing and detecting fraud, waste, and abuse. I look forward to continuing to work with you as we make improvements in protecting the integrity of Federal health care programs and safeguarding taxpayer resources.

Mr. PLATTS. Ms. Maxwell.

STATEMENT OF ANN MAXWELL

Ms. MAXWELL. Good morning, Chairman Platts, Ranking Member Towns, and other distinguished members of the subcommittee.

Thank you for the opportunity to testify about the Office of Inspector General's evaluations of two national program integrity efforts. The national Medicaid audit program and the Medicare-Medicaid data match program, typically referred to as Medi-Medi.

Our evaluations reveal that these national integrity efforts in many ways resemble a funnel. Significant Federal and State resources are being poured in, but only limited results are trickling out.

Both national efforts are required to identify improper Medicaid payments for recovery. The National Medicaid Audit program strives to do this within States and across States. Medi-Medi attempts to detect overpayments in Medicaid and Medicare by matching the data across programs to identify suspicious patterns. However, both programs had limited success in achieving the goal of identifying Medicaid overpayments. As a result, both programs had a negative return on investment.

In 2010, the national Medicaid auto program paid contractors approximately $32 million to identify Medicaid overpayments of just half that amount. In fact, we discovered that 81 percent of the audits assigned in the first half of that year did not or are unlikely to find overpayments.

Medi-Medi also had a negative return on investment. Medi-Medi was appropriated $60 million over a 2-year period during which time it saved $58 million. Of that amount, only one-quarter, $11 million, was recovered on behalf of the 10 States that are participating at the time. The benefits of the Medicaid program were so minimal for two States that they opted to withdraw from the program. One of the States that withdrew from the program stated that it saved $2,000 after investing $250,000 of State funds.

There are a variety of challenges that limit the potential of these programs to attack Medicaid overpayments, including issues of Medicaid data, poor program administration and the lack of contractor accountability. The most fundamental challenge is the data.

National Medicaid data are not current, they are not complete, and they are not accurate. In fact, the data is not going to capture all of the elements necessary for the detection of fraud, waste, and abuse. Due to these data problems, the National Medicaid Audit Program wasted resources, auditing potential overpayments that were not real. They were merely mirages created by the data.

Due to these data problems, Medi-Medi does not have Medicaid data suitable for automated matching with Medicare data. CMS has said this matching will not be possible for a number of years.

In addition to these data challenges, CMS' administration of these programs was flawed. The National Medicaid Audit Program States suffered from inefficient communication between contractors and States that resulted in duplication of effort. Medi-Medi suffered from a lack of focus on Medicaid program integrity at the Federal level. CMS also did not always hold contractors account-

able from performing each of their tasks outlined in their statement of work.

Our evaluations raise questions about the overall effectiveness of the National Medicaid Audit Program and Medi-Medi. We recognize that CMS has taken steps to improve these programs based on recommendations from the OIG, from GAO, and CMS' own internal assessment. We recommend that CMS continue to evaluate the goals, the structure, and the operation of these programs to determine what aspects should be part of a national strategy to protect the Medicaid program.

Further, we believe that more must be done to overcome the significant shortcomings in the Medicaid data. Without timely, complete, accurate, and standardized Medicaid data, it is impossible to effectively detect systemic vulnerabilities that span across States and into the Medicare program.

Thank you again for the opportunity to present this work and to be a part of this discussion. The OIG shares your ongoing interest in program integrity, and I'd be happy to answer any questions that you might have on this topic.

Thank you.

Mr. PLATTS. Thank you, Ms. Maxwell.

[Prepared statement of Ms. Maxwell follows:]

Testimony Before the United States House of Representatives
Committee on Oversight and Government Reform:
Subcommittee on Government Organization, Efficiency and Financial Management

Assessing Medicare and Medicaid Program Integrity

Testimony of:
Ann Maxwell
Regional Inspector General
Office of Evaluation and Inspections
Office of Inspector General
Department of Health and Human Services

June 7, 2012

9:30 a.m.

Location: 2154 Rayburn House Office Building

Testimony of:
Ann Maxwell
Regional Inspector General for Evaluation and Inspections
Office of Inspector General, U.S. Department of Health and Human Services

Introduction

Good morning, Chairman Platts, Ranking Member Towns, and other distinguished Members of the Subcommittee. I am Ann Maxwell, Regional Inspector General for Evaluation and Inspections of the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG). I appreciate the opportunity to appear before you to discuss OIG's recent work focused on Medicaid program integrity.

My testimony today is based on several evaluations recently issued by OIG that focused on two national Medicaid integrity programs intended to augment States' efforts to protect Medicaid from fraud, waste, and abuse.[1] This body of work offers insights into the effectiveness of the Centers for Medicare & Medicaid's (CMS) National Medicaid Audit Program and the Medicare-Medicaid Data Match program (Medi-Medi Program).

OIG's work reveals that these programs are not effectively accomplishing their missions. A primary objective for both programs is to identify improper payments for recovery. However, both programs had low findings of actual overpayments and, as a result, yielded negative returns on investment. These programs also delivered very few referrals of potential fraud to OIG and our law enforcement partners. In many ways, these programs resemble a funnel through which significant Federal and State resources are being poured in and limited results are trickling out.

In evaluating these programs, we found a variety of challenges that limited their potential to successfully identify Medicaid overpayments and potential fraud. Most fundamentally, there are significant shortcomings in the data available to conduct efficient, national Medicaid program integrity oversight through data analysis and data mining. In addition, variation in State Medicaid policies presented significant learning curves for integrity contractors, which had difficulty accurately applying the policies unique to each State. These problems led Medicaid Integrity Contractors (MIC) to misidentify potential overpayments and the Medi-Medi Program to identify fewer overpayments and fewer cases of potential fraud for Medicaid than it did for Medicare.

[1] OIG evaluations that serve as the basis for this testimony are: (1) *Early Assessment of Review Medicaid Integrity Contractors*, OEI-05-10-00200, February 2012; (2) *Early Assessment of Audit Medicaid Integrity Contractors*, OEI-05-10-00210, March 2012; (3) *Status of 244 Provider Audit Targets Identified Using Review Medicaid Integrity Contractor Analysis*, OEI-05-10-00201, April 2012; and *The Medicare-Medicaid (Medi-Medi) Data Match Program*, OEI-09-08-00370, April 2012

The potential of these programs to safeguard Medicaid may also have been diminished by the way that CMS administered them. While the National Medicaid Audit Program appeared to suffer from too much CMS involvement, the Medi-Medi Program experienced the opposite problem: a lack of involvement by all of the relevant staff at the Federal level. In addition, CMS did not always hold the contractors operating these programs accountable for performing their contracted tasks.

Federal Medicaid Integrity Programs Were Created To Augment States' Efforts

The task of ensuring Medicaid program integrity has historically fallen primarily on States; the Federal Government has provided support and oversight. States have their own program integrity or inspector general offices dedicated to Medicaid. In addition, OIG supports the Medicaid Fraud Control Units (MFCU), which handle the majority of Medicaid fraud cases.

Only recently, legislation has led to a greatly expanded role in Medicaid program integrity for CMS. The Deficit Reduction Act (DRA) of 2005 established the Medicaid Integrity Program to fight fraud, waste, and abuse. The DRA requires CMS to contract with entities to identify overpayments to Medicaid providers. CMS contracted with two types of MICs—Review MICs and Audit MICs—to identify such overpayments. Together, their efforts are known as the National Medicaid Audit Program.[2]

In general, Review MICs conduct data mining on Medicaid claims, and Audit MICs conduct audits of specific providers. More specifically, Review MICs use Medicaid claims data made nationally available through CMS's Medicaid Statistical Information System (MSIS) to identify providers that potentially received overpayments. Audit MICs then audit selected providers to determine whether they had received actual overpayments that should be recouped by the State. This is what we refer to as the "traditional process."

In addition, CMS established a "collaborative process," in which CMS assigned collaborative audits when States were willing to participate. Collaborative audit targets are selected with the involvement of Audit and Review MICs, States, and CMS. The States provide input on program areas that are vulnerable to overpayments and the State policies that apply to those program areas. MICs, CMS, and the States then jointly develop data mining models to identify potential overpayments. Instead of using MSIS, collaborative audits identify potential overpayments using data available in each State's Medicaid Management Information Systems (MMIS). All parties then determine which providers identified with potential overpayments should be audited.

[2] A third contractor type, Education MICs, was also created by the DRA, but they are not involved in the audit program.

The DRA also funded an expansion of the Medi-Medi Program. The Medi-Medi Program enables CMS and participating State and Federal agencies to collaboratively analyze billing trends across the Medicare and Medicaid programs to identify potential fraud, waste, and abuse. Participation by State Medicaid agencies and other Federal agencies is optional, and States must contribute their own resources to participate. The purpose of analyzing Medicare and Medicaid claims data collectively is to detect billing patterns that indicate possible overpayments or fraud that may not be evident when analyzing the data separately.

CMS requires Medicare integrity contractors, known as the Program Safeguard Contractors (PSC), to perform mandated Medi-Medi Program integrity tasks, which consist of:

- identifying program vulnerabilities by using computer algorithms to look for payment anomalies that may indicate improper payments or potential fraud;
- coordinating State and Federal actions to protect Medicare and Medicaid expenditures; and
- increasing the effectiveness and efficiency of Medicare and Medicaid prepayment denials and recovery of fraudulent, wasteful, or abusive expenditures.[3]

Federal Program Integrity Efforts Show Limited Results in Protecting Medicaid From Fraud and Abuse

As CMS took on a more active role in Medicaid program integrity at the Federal level, OIG assessed those efforts. Our evaluations assessed the results of the National Medicaid Audit Program, operated by CMS and the MICs, and the Medi-Medi Program, operated by the PSCs. These evaluations also sought to identify barriers that might be limiting the efficiency and effectiveness of these programs integrity efforts.[4]

Federal Program Integrity Efforts Were Limited in Their Ability To Identify Medicaid Overpayments

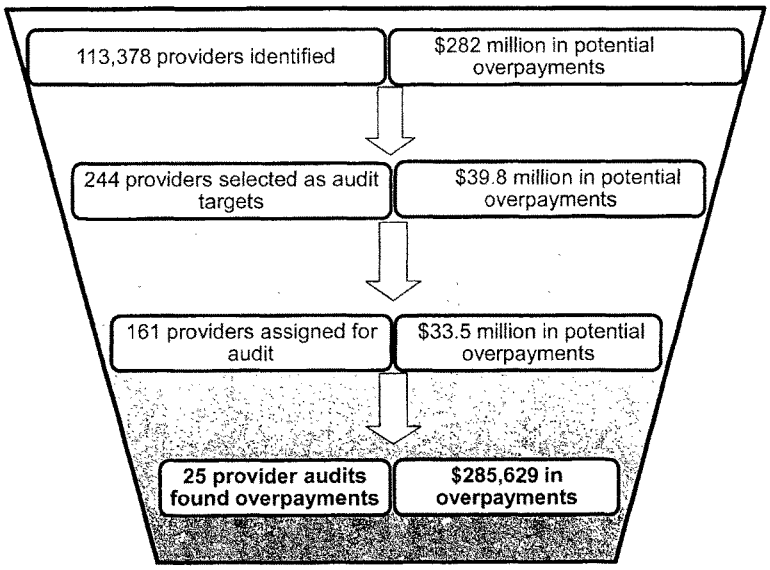
The National Medicaid Audit Program had limited results during the time of our review. Audits of providers selected using the traditional process had particularly limited results. As Chart 1 demonstrates, during our review period, Review MICs initially identified 113,378 providers with potential overpayments of $282 million, but after performing audits, the Audit MICs eventually found that only 25 of these providers had overpayments, which totaled $285,629. The remaining 102 completed audits found no overpayments.

[3] CMS is transitioning program integrity work from PSCs to Zone Program Integrity Contractors (ZPIC). The chief difference between PSCs and ZPICs is that ZPICs cover broader geographical areas and multiple parts of the Medicare program, whereas PSCs cover more limited areas and scopes.

[4] OIG's three evaluations of the National Medicaid Audit program are an early assessment of the program. These evaluations focused on program integrity activities conducted as the result of assignments CMS made to MICs between January 1 and June 30, 2010. CMS completed the process of awarding MIC task orders to cover all regions of the country in the fall of 2009. Our evaluation of the Medi-Medi Program focused on 2007 and 2008.

Chart 1 shows the process that resulted in the identification of $285,629 in actual overpayments.

Chart 1: Identification of Overpayments From Review MIC Analysis



A separate evaluation of audits assigned to Audit MICs also found few completed audits with findings of overpayments. OIG found that 81percent of these 370 audits either did not or are unlikely to identify overpayments. At the time of our review, only 11 percent of assigned audits were completed with findings, totaling $6.9 million in overpayments. The remaining audits had not progressed enough to draw conclusions about likely outcomes.

Most of the overpayment findings ($6.2 million) resulted from seven completed audits that used the collaborative approach. The remaining $700,000 in overpayments was identified by 35 audits that used the traditional approach.

The Medi-Medi Program also had limited results, recovering few funds for the Medicaid program. Between 2007 and 2008, the Medi-Medi Program recovered $11.3 million for Medicaid. During the same time period, Medi-Medi recovered more than three times that amount – $34.9 million – for Medicare. While the amount recovered for Medicaid increased

from $3.5 million in 2007 to $7.8 million in 2008, the total amount was still low compared to expenditures on the program.

Only 5 of the 10 participating States as of 2008 recovered Medicaid overpayments during our period of review.[5] Two of the participating States ultimately withdrew from the program, finding that it offered them minimal benefits. One of the two States that withdrew reported that it invested $250,000 of its own resources in the program, but recovered only $2,000 over a 5-year period (which included 2007 and 2008). However, during 2007 and 2008, that State also administered its own Medicaid integrity program, which recovered $28.9 million.

Identified Overpayments Yielded a Negative Return on Investment

The National Medicaid Audit Program did not identify overpayments commensurate with the investment CMS made in the program. In fiscal year (FY) 2010, CMS paid Review and Audit MICs approximately $32.1 million. Audit MICs identified $6.9 million in overpayments for assignments made in the first 6 months of calendar year 2010. Although we did not collect data for the other 6 months of the fiscal year, we have no information that would lead us to expect significantly different results. Projecting the 6-month results over a full year would yield less than $14 million, well below the annual expenditures. Further, these overpayment totals represent expected recoveries, not actual recoveries, and therefore may not all materialize as providers are given the chance to appeal the findings.

The Medi-Medi Program also had a poor return on investment. Although the Medi-Medi Program had better results for Medicare than for Medicaid, it was still not enough to achieve a positive return on investment during the time period we reviewed. In 2007 and 2008, Medicare and Medicaid expenditures recovered were $46.2 million and expenditures avoided were $11.6 million, bringing the program total to $57.8 million. However, CMS spent $60 million on the program during this same period.

Federal Program Integrity Contractors Made Few Medicaid Fraud Referrals

The National Medicaid Audit Program generated limited law enforcement referrals. During the time of our review, Review MICs did not identify any potential Medicaid fraud leads from their data mining efforts for CMS to review. CMS officials stated that they have now formalized the process for Review MICs to identify potential fraud leads. Audit MICs, however, have referred a limited number of fraud referrals to law enforcement over the course of the program.

The Medi-Medi Program also produced a small number of Medicaid law enforcement referrals. Over the 2 years we reviewed, the Medi-Medi Program produced 10 law enforcement referrals for Medicaid among the 10 participating States. Results for Medicare were better, although still

[5] After 2008, 7 additional States joined the Medi-Medi Program, resulting in a total of 15 participating States. As a result of the transition to ZPICs, the seven additional States joined the Medi-Medi Program as part of three geographic areas

limited, with 56 fraud referrals in this time period. Further, the vast majority of all referrals were in just 1 State, accounting for 41 percent (27 of 66) of the total referrals.

Poor Quality of Data Hindered National Medicaid Program Integrity Work

The poor quality of the Medicaid data on which these programs rely hindered their ability to efficiently detect suspicious trends in Medicaid claims for further auditing or investigation.

Review MICs use MSIS claims data to identify potential overpayments, the only national database of Medicaid claims and beneficiary eligibility information. However, OIG has found that the MSIS data are not current, available, complete, and accurate.[6] Further, MSIS does not capture all data elements that can assist in the detection of fraud, waste, and abuse.

Unlike the MICs, PSCs obtain Medicaid claims data directly from each participating State's MMIS to match them to Medicare data. This data are typically more complete and accurate. However, each State's MMIS data set is unique, rendering it difficult to match it to other States' MMIS data or to Medicare data.

The inaccuracies in and incompleteness of the MSIS data led Review MICs to misidentify providers with potential overpayments. One of the primary reasons audits resulted in no findings of overpayments was that the MSIS data used to pinpoint an audit target were inaccurate. In some instances, the reason that audits resulted in no findings of overpayments was that claims for outpatient services appeared as inpatient claims in MSIS, making the claims appear suspicious when they were, in fact, legitimate. In other cases, the State adjustments to claims were not reflected in MSIS, leading Review MICs to conclude that the State had overpaid a provider for a service when it had not.

The Medi-Medi Program faced different challenges attempting to use existing Medicaid data to fulfill its program integrity goals, mainly, efficiently matching State Medicaid data to Medicare data. The Integrated Data Repository was designed to automate the process of matching Medicaid to Medicare data. The repository contains data from Medicare Parts A, B, and D. However, as of the date of this testimony, Medicaid data are not yet included in the repository and are not projected to be included until at least 2015.

According to CMS, Medicaid data in their current form would not be appropriate to integrate into the Integrated Data Repository. MSIS data lack many of the standardized data elements needed for program integrity work and often lack consistency across States. Similarly, States' MMISs do not allow for efficient matching to Medicare data because the data are structured to meet State-specific needs, containing variables and data definitions unique to each.

[6] *OIG, MSIS Data Usefulness for Detecting Fraud, Waste, and Abuse,* OEI-04-07-00240, August 2009.

Medicaid Contractors Had Difficulty Accurately Applying State Medicaid Program Policies

Both the National Medicaid Audit Program and the Medi-Medi Program encountered problems when contractors incorrectly applied State Medicaid policies in their analyses of Medicaid data. Knowledge of State Medicaid policies is critical to correctly interpreting the data.

MICs misidentified audit targets because they lacked the appropriate knowledge of each State's Medicaid program policies. Five of the seven State Medicaid oversight agencies interviewed stated that the audit targets were often inappropriate because of misinterpretation of State policy. For example, 44 audit targets were selected because of misidentified duplicate payments for services provided to dually eligible beneficiaries (i.e., beneficiaries enrolled in both Medicaid and Medicare). In these cases, Medicaid made two payments for each beneficiary's hospital stay, but in this instance, both payments were appropriate.[7, 8]

The Medi-Medi program also encountered these same issues with interpreting and analyzing Medicaid claims data. Four of the ten participating State Medicaid program integrity agencies said that the Medicare program integrity contractors administering the program do not understand Medicaid and that as a result they primarily analyze Medicare claims data.

Poor Program Administration Diminished the Potential of These Program Integrity Efforts

Our evaluations also reveal that poor administration of the National Medicaid Audit Program and the Medi-Medi Program appears to have limited their effectiveness. In addition, CMS did not always hold contractors accountable for the tasks outlined in their contracts. These are issues OIG has identified in the administration and oversight of Medicare integrity contractors for the past decade.

Basic Program Design Limited Efficiency and Effectiveness

Both the National Medicaid Audit Program and the Medi-Medi Program were constrained by elements of their program design. The National Medicaid Audit Program appears to have been constrained by the lack of communication among the contractors and States. At the time of our review, all communication, whether between Review and Audit MICs, between MICs and States, or between MICs and different divisions within CMS, went through a multistep process controlled by CMS. According to the MICs, this served to slow the flow of information and delayed work. Audit MICs stated that they felt compelled to duplicate Review MIC analyses

[7] One payment covered all inpatient services, and the second payment covered the coinsurance for ancillary services billed to Medicare during the hospital stay. The State Medicaid agency is required to pay for the Medicare coinsurance for dually eligible beneficiaries

[8] Social Security Act, §§ 1902(a)(10)(E) and 1905(p), 42 U.S.C. §§ 1396a(a)(10)(E) and 1396d(p). States may differ in the policies that determine how Medicare and Medicaid claims for dually eligible beneficiaries are submitted and recorded.

because they could not easily communicate with Review MICs or States. The inability to communicate freely also meant MICs could not take full advantage of States' knowledge of State Medicaid policies.

CMS stated in response to our report that it considered its involvement to be responsible oversight in establishing a new program. Now that the program has been in existence for several years, CMS is allowing freer communication among all the parties involved in the National Medicaid Audit Program.

While the National Medicaid Audit Program appeared to suffer from too much CMS involvement, the Medi-Medi Program experienced the opposite problem: a lack of involvement by all of the appropriate CMS staff. Federal Medicaid program integrity staff were not incorporated into the administration of the program. Rather, the Medi-Medi Program was administered entirely by the Medicare Program Integrity Group. Both States and Medi-Medi contractors indicated that this resulted in a deemphasis on Medicaid program integrity within the program, leaving the majority of Medi-Medi activities focused on Medicare claims analysis. In response to our evaluation, CMS stated that it is assessing ways to increase the involvement of Medicaid program integrity staff.

CMS Did Not Hold Contractors Fully Accountable

MICs were not held accountable for completing all of their contracted tasks. Review MICs' task orders with CMS state that Review MICs are to provide or recommend audit leads, among other tasks. However, during our review period, CMS stated that it expected Review MICs only to conduct data analysis and provide lists of providers ranked by the amount of their corresponding potential overpayments and did not expect them to recommend audit leads. As a result, Review MICs did not single out any individual providers on their lists as specific audit leads. Rather, Review MICs provided lists containing a total of more than 113,000 providers to CMS for its review. CMS selected only 244 of these providers as audit targets, suggesting that CMS did a significant amount of work to screen the provider lists. Thus, it appears that CMS staff completed much of the Review MICs' contracted tasks themselves.

Similarly, CMS did not hold PSCs fully accountable for their administration of the Medi-Medi Program. Although CMS conducts annual assessments of PSCs, CMS did not formally evaluate the PSCs on each of the contracted Medi-Medi tasks. OIG found CMS's documentation of PSC performance to be insufficient for drawing conclusions about their effectiveness in completing Medi-Medi tasks.

OIG Recommends Improvements to Medicaid Data and Program Administration

To improve the efficiency and effectiveness of these programs, we recommend that CMS:

- Devote the resources necessary to improve the quality of the Medicaid data available to conduct national Medicaid program integrity data analysis and mining;
- Improve the ability of contractors to properly analyze Medicaid data in light of State-specific policies;
- Evaluate the goals, design, and operations of both programs to determine what aspects of these programs should be part of a national Medicaid program integrity strategy. For the National Medicaid Audit Program, CMS should consider increasing the use of collaborative audits. Collaboration among Audit MICs, Review MICs, States, and CMS during audits appears to have improved the selection of audit targets and the efficiency of the audit process, leading to better results.
- Hold contractors accountable for all of the tasks outlined in their contracts by establishing clear expectations that align with the contracts and evaluating all tasks during the annual assessments.

In response, CMS stated that it has an initiative underway, called Transformed MSIS, to improve the quality of national Medicaid data. Additionally, CMS stated that it has redesigned its approach to audit assignments, instructing Audit MICs to focus on collaborative projects. In fact, CMS stated that it assigned more audits through the collaborative process than through the traditional process in 2011. CMS has also stated it has made significant strides in enhancing the effectiveness of the Medi-Medi Program. However, evidence of this has not been made available.

Conclusion: More Needs To Be Done To Protect the Integrity of Medicaid Payments

OIG's body of work raises questions about the overall effectiveness of the National Medicaid Audit Program and the Medi-Medi Program in protecting Medicaid from fraud, waste, and abuse. OIG's work reveals that neither program produced results commensurate with the investments made in them.

Given the size of current Federal and State outlays for Medicaid and the potential for increased outlays as the beneficiary population expands, a robust national approach to Medicaid program integrity is imperative.

While we are encouraged by the changes that CMS has made, more must be done to improve these programs and ensure the economical investment of Federal and State dollars. Critically, CMS needs to improve data available to each program to enable them to efficiently and effectively identify potential overpayments and possible fraud.

Thank you for your interest in this important issue and for the opportunity to be a part of this discussion about better protecting Medicaid funds from fraud, waste, and abuse. I would be happy to answer any questions.

Mr. PLATTS. Ms. Yocum.

STATEMENT OF CAROLYN YOCUM

Ms. YOCUM. Chairman Platts, Ranking Member Towns, and members of the subcommittee, we are pleased to be here today. I'm pleased to be here today with my colleague, Kathleen King, as you discuss program integrity in Medicaid and Medicare.

Our prior work has shown that CMS continues to face challenges with fiscal management of these programs which have some of the highest—largest estimated improper payments in the Federal Government. Both are on GAO's high-risk list in part because of concerns over improper payments.

Our remarks today are focused on CMS' progress and important steps that remain to be taken from the perspective of four key strategies and recommendations that have been identified in GAO's work:

First, strengthening provider enrollment standards and procedures to help reduce the risk of enrolling entities intent on defrauding the programs.

Second, improving prepayment controls to ensure that claims are paid correctly the first time.

Thirdly, improving postpayment review and recovery of improper payments.

And fourth, developing a robust process for tackling identified program vulnerabilities.

With regard to Medicaid, since 2007 CMS has monitored States' provider enrollment standards and procedures through comprehensive reviews of States. Within CMS' most recent comprehensive reviews, we found 230 instances of noncompliance with Federal laws or regulations related to States' provider enrollment standards and procedures.

CMS continues to develop better controls to detect improper claims before they are paid. In this area, the agency has identified—has initiated discussions with and provided guidance to States in anticipation of new analytic tools that can identify potential vulnerabilities before rather than after Medicaid claims are paid.

Regarding postpayment claims review, the importance of coordination with States has grown because of the increased number of entities conducting audits, including implementation of recovery audit contractors, or RACs. CMS' shift to collaborative audits with States should help avoid duplication of Federal and State audit efforts.

That said, CMS has not established a robust process for incorporating RAC identified vulnerabilities in State corrective action plans. CMS requires State Medicaid agencies to have a corrective action process as part of their activities to reduce their Medicaid error rates. And information from the Medicaid RAC program could be incorporated into these processes.

For Medicare, the Patient Protection and Affordable Care Act authorized CMS to implement several actions to strengthen provider enrollment. Some of these actions, such as developing a final rule on screening providers and suppliers, have been completed. But

other actions, such as implementing relevant statutory provisions and some of our prior recommendations, remain incomplete.

Our prior work found certain gaps in Medicare's prepayment controls, and we made recommendations for improvements, such as adding controls to identify unusually rapid increases in medical equipment billing. We are currently evaluating CMS' efforts in this area.

CMS has also taken steps to improve its postpayment reviews and recovery efforts. In March 2009, the agency began the National RAC Program for Medicare fee for service. As of May 2012, the agency reported that just under $2 billion was recouped due to these contractors' efforts. While CMS has implemented a RAC for its prescription drug program, it has not done so for its Medicare managed care plan.

Lastly, our March 2010 report on CMS' RAC demonstration program found that CMS had not established an adequate process to ensure prompt resolution of identified vulnerabilities. We've recommended that CMS do so, and we are currently evaluating the steps the agency has taken to develop such a process.

While CMS has made efforts to improve program integrity, further action is needed. We believe that many of the lessons learned from our work on Medicare could be applied to strengthen the Medicaid program as CMS and the States begin to use the additional tools provided through recent legislation.

Effectively implementing provisions of recent laws and our recommendations will be critical to reducing improper payments and ensuring that Federal funds are used for their intended purpose.

Mr. Chairman, this concludes our prepared remarks. We would be happy to answer any questions you or other members of the subcommittee may have.

Mr. PLATTS. Thank you, Ms. Yocum.

[Prepared statement of Ms. Yocum follows:]

United States Government Accountability Office

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PROGRAM INTEGRITY

Further Action Needed to Address Vulnerabilities in Medicaid and Medicare Programs

Statement of Carolyn L. Yocom
Director, Health Care

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Director, Health Care

GAO-12-803T

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Accountability * Integrity * Reliability

Highlights

Highlights of GAO-12-803T, a testimony before the Subcommittee on Government Organization, Efficiency, and Financial Management, Committee on Oversight and Government Reform, House of Representatives

June 7, 2012

PROGRAM INTEGRITY

Further Action Needed to Address Vulnerabilities in Medicaid and Medicare Programs

Why GAO Did This Study

In 2011, CMS estimated that Medicaid and Medicare had improper payments of $21.9 billion and almost $43 billion, respectively—among the largest for all federal programs. Both health care programs are on GAO's list of high-risk programs. Over the years, Congress has passed legislation designed to help address program integrity issues in the two programs but they remain vulnerable to fraud, waste, and abuse The program integrity challenges are different for Medicaid and Medicare. With 51 distinct state-based programs, Medicaid has complex challenges for finding the appropriate balance between state and federal efforts. Medicare uses contractors to help administer the program and CMS must oversee their efforts.

This statement examines the progress made and important steps still to be taken in these programs. GAO focused on four key strategies and recommendations that were designed to facilitate them that were identified in prior work and that could help reduce improper payments: (1) strengthening provider enrollment standards and procedures to ensure that only legitimate providers participate in the program; (2) improving prepayment controls; (3) improving postpayment claims review and recovery of improper payments; and (4) developing a robust process for addressing identified vulnerabilities. This statement is based on GAO products issued from April 2004 through May 2012 and interviews with agency officials and other stakeholders. In May 2012, GAO also received additional information from CMS on agency actions. GAO received technical comments from CMS officials and incorporated them into this statement.

View GAO-12-803T For more information, contact Carolyn L. Yocom at yocomc@gao gov or Kathleen M King at kingk@gao gov or contact us at (202) 512-7114.

What GAO Found

For the Medicaid program, the Centers for Medicare & Medicaid Services (CMS) and the states have taken some actions related to GAO's four key strategies but more needs to be done

- CMS's comprehensive state program integrity reviews identified provider enrollment as the most frequently cited area of concern but the agency has noted a positive trend in states' awareness of regulatory requirements
- CMS noted vulnerabilities in the prepayment reviews of claims in five states and effective practices in seven others In anticipation of new analytic tools to predict vulnerabilities before claims are paid, the agency has initiated discussions with and provided guidance to states
- CMS has begun collaborating with states to identify targets for federal postpayment audits, which should help to avoid duplication of federal and state audit efforts.
- CMS has not established a robust process for states to evaluate and address vulnerabilities identified by the states' new recovery audit contractors brought in to identify improper payments and recoup overpayments

For the Medicare program, CMS has acted to strengthen several of its strategies to better ensure program integrity, but other actions remain undone.

- Congress authorized CMS to implement several new or improved enrollment safeguards, including screening enrollment applications for categories of Medicare providers by risk level. CMS has issued a final rule to implement this and other changes, but has not completed other final rules and additional actions that could further strengthen enrollment procedures, such as rules to implement new surety bond provisions and provider and supplier disclosures
- GAO's prior work found certain gaps in Medicare's prepayment edits based on coverage and payment policies and made recommendations for improvement, such as adding edits to identify abnormally rapid increases in medical equipment billing. GAO is currently evaluating new CMS efforts in this area.
- CMS has begun using recovery auditing in its prescription drug program but not for its Medicare managed care plans.
- GAO recommended that CMS establish an adequate process to ensure prompt resolution of identified vulnerabilities in Medicare and is currently evaluating steps that CMS has taken recently

It is critical that CMS and the states continue working on reducing improper payments. While both have made efforts to reduce improper payments, further action is needed Although Medicaid presents different challenges, GAO believes that many of the lessons learned from its work on Medicare could be applied to strengthen Medicaid program integrity. These lessons can be applied as CMS and the states begin to use the additional tools provided through recent legislation. As the implementation process proceeds, GAO is continuing to monitor these issues. Effectively implementing provisions of recent laws and GAO's recommendations will be critical to reducing improper payments and ensuring that federal funds are used efficiently and for their intended purpose

Chairman Platts, Ranking Member Towns, and Members of the Subcommittee:

We are pleased to be here today to discuss our work regarding program integrity efforts in the Medicaid and Medicare programs. Medicaid and Medicare are two of the largest programs in the federal government, financing health care services for a combined total of approximately 119 million individuals at a cost of about $983 billion in 2011.[1] These two programs also have some of the largest reported estimates of improper payments—payments that either were made in an incorrect amount or should not have been made at all.[2] The Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that oversees Medicaid and Medicare, has estimated that improper payments in the Medicaid program were $21.9 billion in fiscal year 2011.[3] For the Medicare program, CMS estimated improper payments of almost $43 billion in fiscal year 2011.[4] In part because of

[1]Medicaid is the federal-state program that covers acute health care, long-term care, and other services for certain low-income people. It is also one of the largest components of state budgets. In 2011, Medicaid covered approximately 70 million people and estimated expenditures totaled about $427 billion, with a federal share of $271 billion and a state share of $157 billion (numbers do not add due to rounding). Medicare is the federally financed health insurance program for persons age 65 or over, certain individuals with disabilities, and individuals with end-stage renal disease. In 2011, Medicare covered almost 49 million people at an estimated cost of about $556 billion.

[2]An improper payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. This definition includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except where authorized by law), and any payment that does not account for credit for applicable discounts. Improper Payments Elimination and Recovery Act of 2010, Pub. L. No. 111-204, § 2(e), 124 Stat. 2224, 2227 (codified at 31 U.S.C. § 3321 note). Improper payments may be a result of fraud, waste, and abuse. Fraud represents intentional acts or representations to deceive with knowledge that the action or representation could result in an inappropriate gain. Waste includes inaccurate payments for services, such as unintentional duplicate payments. Abuse represents actions inconsistent with acceptable business or medical practices.

[3]In its *Fiscal Year 2011 Agency Financial Report*, HHS calculated and reported the 3-year (2009, 2010, and 2011) weighted average national payment error rate for Medicaid of 8.1 percent. See HHS, *Department of Health and Human Services FY 2011 Agency Financial Report* (Washington, D.C., Nov. 15, 2011).

[4]HHS, *Department of Health and Human Services FY 2011 Agency Financial Report*.

concerns over improper payments, we have identified both as high-risk programs.[5]

The program integrity challenges are different for Medicaid and Medicare. With 51 distinct state-based programs that are partially federally financed, Medicaid has complex challenges for finding the appropriate balance of state and federal efforts to ensure its integrity.[6] States are the first line of defense against Medicaid improper payments because they are responsible for ensuring the qualifications of providers who bill the program, detecting improper payments, recovering overpayments, and referring suspected cases of fraud and abuse to law enforcement authorities. However, CMS has a critical role ensuring that adequate controls are in place and states' actions to help reduce improper payments are effective—which involves balancing the agency's oversight and support roles. The Medicaid Integrity Group—an organization within CMS's Center for Program Integrity—is responsible for the Medicaid Integrity Program, which focuses on overseeing and supporting state program integrity activities.

Medicare's challenges are also significant. Since its inception, Medicare has been administered largely by contractors with federal oversight.[7] In Medicare Parts A and B, CMS contractors process and pay approximately 4.5 million claims per workday, manage the information technology payment systems, enroll providers, respond to beneficiary questions, and investigate potential Medicare fraud. In Medicare Advantage (Part C) and the Medicare prescription drug benefit (Part D), CMS contracts with private health plans and drug sponsors to administer the Medicare

[5]See GAO, *High-Risk Series An Update*, GAO-11-278 (Washington, D C February 2011)

[6]While American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the United States Virgin Islands, and Puerto Rico also receive federal funds for Medicaid, this statement focuses on the 50 states and the District of Columbia, which we refer to as 51 states

[7]The Medicare program consists of four parts A, B, C, and D Medicare Parts A and B are known as Medicare fee-for-service (FFS) Medicare Part A covers hospital and other inpatient stays Medicare Part B is optional, and covers hospital outpatient, physician, and other services. Medicare beneficiaries have the option of obtaining coverage for Medicare services from private health plans that participate in Medicare Advantage—Medicare's managed care program—also known as Part C All Medicare beneficiaries may purchase coverage for outpatient prescription drugs under Part D, either as a stand-alone benefit or as part of a Medicare Advantage plan

benefits. In that capacity, the plans and sponsors have a responsibility to help ensure Medicare program integrity, and CMS must oversee their efforts to help ensure proper payments The Medicare Integrity Group, also located within CMS's Center for Program Integrity, is responsible for the Medicare Integrity Program. However, other CMS components, such as the Office of Financial Management and the Center for Medicare, also share significant responsibilities for overseeing activities to ensure the integrity of the program.

Our testimony today focuses on the progress CMS has made and important steps still to be taken to better assure the integrity of the Medicaid and Medicare programs. We will focus on four key strategies and recommendations designed to facilitate them that were identified in our prior work and that can help reduce improper payments:

- Strengthening provider enrollment standards and procedures to help reduce the risk of enrolling entities intent on defrauding the program;
- Improving prepayment controls, to ensure that claims are paid correctly the first time;
- Improving postpayment claims review and recovery of improper payments to reduce the likelihood of and recoup overpayments; and
- Developing a robust process for tackling identified vulnerabilities in order to address risks that lead to improper payments.

This testimony is largely based on products that were issued from April 2004 through May 2012.[8] In addition, to assess CMS and state efforts to strengthen provider enrollment standards and procedures and improve prepayment and postpayment claims review for Medicaid, we analyzed CMS's comprehensive reviews of state program integrity activities and its audits of state Medicaid providers. This additional work was performed in May 2012. We also received updated information from CMS in May 2012 on its actions related to the laws, regulations, guidance, and open recommendations that we discuss in this statement. We shared the facts contained in this statement with CMS and have incorporated their comments as appropriate. Our work was conducted in accordance with

[8]The products listed at the end of this statement contain detailed information on the methodologies used in our work

generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Since 1996, Congress has taken important steps to increase program integrity funding and oversight, including the establishment of both the Medicaid and Medicare Integrity Programs. Table 1 summarizes several key congressional actions

Table 1: Key Congressional Actions to Increase Program Integrity Funding and Oversight in the Medicaid and Medicare Programs

Year	Congressional action	Statute
1996	Created the Medicare Integrity Program and established a dedicated fund for activities to address fraud, waste, and abuse in federal health care programs, including both Medicaid and Medicare[a]	Health Insurance Portability and Accountability Act of 1996[b]
2003	Directed CMS to conduct a 3-year demonstration project on the use of a new type of contractors—recovery audit contractors (RAC)—in identifying underpayments and overpayments, and recouping Medicare overpayments	Medicare Prescription Drug, Improvement, and Modernization Act of 2003[c]
2006	Established the Medicaid Integrity Program to support and oversee state Medicaid program integrity activities and included specific appropriations to reduce fraud, waste, and abuse	Deficit Reduction Act of 2005[d]
2010	Provided additional funding for program integrity activities and, among other things • Required states to establish Medicaid RACs and CMS to extend the Medicare RACs to Parts C and D of the Medicare program • Established new provider enrollment requirements for both programs • Required CMS to develop core elements for provider compliance programs • Authorized surety bond requirements for providers[e]	Patient Protection and Affordable Care Act[f]
2010	Required Medicare to begin using predictive analytics to identify and prevent fraud, with their use in Medicaid by 2015 to be based on the results of Medicare's experience[g]	Small Business Jobs Act of 2010[h]

Source: GAO analysis of selected federal laws

[a]The fund is known as the Health Care Fraud and Abuse Control account

[b]Pub. L. No. 104-191, §§ 201-202, 110 Stat. 1936, 1993, 1996 (codified at 42 U.S.C. §§ 1395i, 1395ddd)

[c]Pub. L. No. 108-173, § 306, 117 Stat. 2066, 2256-57. Subsequently, the Tax Relief and Health Care Act of 2006 required CMS to implement a national recovery audit contractor program by January 1, 2010. Pub. L. No. 109-432, div. B, title III, § 302, 120 Stat. 2922, 2991-92 (codified at 42 U.S.C. § 1395 ddd(h)).

[d]See Pub. L. No. 109-171, § 6034, 120 Stat. 4, 74-78 (2006) (codified at 42 U.S.C. § 1396u-6).

[e]A surety bond is a three-party agreement in which a company, known as a surety, agrees to compensate the bondholder if the bond purchaser fails to keep a specified promise.

[f]Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

[g]Predictive analytics include the use of algorithms and models to analyze claims before payment is made in order to identify unusual or suspicious patterns or abnormalities in provider networks, claims billing patterns, and beneficiary utilization.

[h]Pub. L. No. 111-240, § 4241, 124 Stat. 2504, 2599.

CMS and States Have Undertaken Efforts to Improve Medicaid Program Integrity, but More Needs to Be Done

CMS and the states are continuing to strengthen provider enrollment standards and procedures, as well as developing adequate controls to detect improper claims before they are paid. While CMS has made progress in collaborating more closely with states on federal postpayment claims reviews by shifting the focus to state-identified targets, it is too early to assess the potential for Medicaid recovery audit contractors (RAC) to avoid duplicating efforts of ongoing state and federal provider audits. Finally, the agency has not established a robust process for incorporating RAC-identified vulnerabilities in state corrective action plans.

Provider Enrollment Standards Remain a Concern, but CMS Has Reported Some Progress

CMS and the states continue efforts to strengthen the standards and procedures for enrolling Medicaid providers, which could help reduce the risk of enrolling providers intent on defrauding or abusing the program. Since 2007, CMS has monitored states' Medicaid provider enrollment standards and procedures—as well as other aspects of their programs—through comprehensive state program integrity reviews.[9] The Patient Protection and Affordable Care Act (PPACA) also included several provisions aimed at strengthening Medicaid provider enrollment standards and procedures.[10] For example, PPACA required states to conduct certain provider screening procedures, such as verifying provider

[9]CMS typically conducts triennial comprehensive state program integrity reviews of 16 to 17 states each year. These reviews assess the effectiveness of each state's Medicaid program integrity activities and compliance with federal statutes and regulations. The culmination of a review is a final report that details CMS's assessment of the state's program integrity effective and noteworthy practices, vulnerabilities, and compliance issues.

[10]For purposes of this report, we use the term provider to include both providers and suppliers.

licenses and terminating individuals or entities from Medicaid participation under certain circumstances.[11]

Our analysis of final reports from CMS's most recent comprehensive reviews for all 51 states found 230 instances of non-compliance with federal laws or federal regulatory requirements related to states' provider enrollment standards and procedures.[12] Most of the reviews we analyzed were conducted prior to CMS's final rule implementing PPACA provider enrollment provisions.[13] CMS cited at least 1 instance and as many as 8 instances of non-compliance for each state reviewed, with 31 states receiving 4 or 5 citations. About half of the citations were generally due to states' failures to verify provider licenses, or collect or disclose required ownership and related information.[14] In the introduction to its summary of 2011 comprehensive reviews, CMS noted that provider enrollment has been the most frequently cited area of non-compliance since it began these reviews in 2007. While these problems were identified in nearly every state, CMS also reported that it had noticed a positive trend in states' awareness of regulatory requirements and knowledge of how to implement the requirements.

[11]Circumstances that warrant termination include if the individual or entity owns, controls, or manages an entity that has unpaid overpayments or is affiliated with an individual or entity that has been suspended, excluded, or terminated from any state's Medicaid program. CMS and the HHS's Office of Inspector General (HHS-OIG) published a final rule regarding provider and supplier screening and enrollment on February 2, 2011, which became effective on March 25, 2011. *Medicare, Medicaid, and Children's Health Insurance Programs, Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers*, 76 *Fed. Reg.* 5862 (Feb. 2, 2011). CMS also issued additional guidance to states in December 2011.

[12]For our analysis, we included reports from the most recent comprehensive review for each of the 51 states that were available on CMS's website as of May 22, 2012—this included 5 states that were reviewed in 2011, 17 states that were reviewed in 2010, 18 states that were reviewed in 2009, and 11 states that were reviewed in 2008.

[13]CMS officials told us that none of the 16 states that were reviewed during fiscal year 2011 had fully implemented these PPACA provisions. Our analysis only included the fiscal year 2011 report for 5 states that were available on CMS's website as of May 22, 2012, for the other 11 states reviewed during that fiscal year but whose reports were not available online at the time of our analysis, we included the reports from their prior reviews.

[14]In these reviews, CMS also identified areas of vulnerability—areas where changes in states' provider enrollment standards and procedures could potentially reduce the risk of fraud, waste, and abuse.

In addition to identifying areas in which states needed to improve their provider enrollment standards and procedures, CMS's most recent comprehensive reviews of all 51 states identified a total of 53 instances of effective or noteworthy provider enrollment practices.[15] CMS credited 29 states with having at least one effective or noteworthy practice, and deemed 1 state to have five. For example, CMS found that this state had

- an innovative software package that automated the verification of licenses of potential Medicaid providers, which ensures that Medicaid does not allow payments to nonqualified health care providers;
- a team dedicated to conducting criminal background checks prior to approving a provider application; and
- a requirement that managed care providers be enrolled in Medicaid before they are eligible to become a member of a participating managed care plan's provider network, which ensures that such providers will have had a criminal background check conducted by the state.

In addition to the comprehensive reviews, CMS provided guidance periodically to states. In August 2010, CMS issued guidance to states on best practices related to provider enrollment. Among other things, this guidance recommended that states meet regularly and coordinate enrollment policy with provider enrollment personnel, ensure that provider enrollment forms request all required disclosures, and report to the HHS Office of Inspector General (OIG) any adverse actions taken on providers' Medicaid participation and providers' criminal convictions. In July 2011, the Medicaid Integrity Institute—CMS's national Medicaid training program for state program integrity officials—sponsored a symposium on PPACA's program integrity enhancements—including the provider enrollment provisions—and discussed strategies to achieve their timely implementation.

[15]Some of these noteworthy practices are now required under PPACA. For example, CMS noted that 4 of the states reviewed in 2010 were already screening providers prior to enrollment against some or all of the databases required by PPACA.

CMS Continues to Monitor States' Implementation and Use of Prepayment Claims Review

While states are responsible for paying claims and conducting prepayment reviews of claims, CMS is responsible for ensuring that states have adequate controls to detect improper claims before they are paid. Two ways CMS provides this oversight are through (1) an examination of states' prepayment review processes, which occurs during CMS's comprehensive state program integrity reviews, and (2) the provision of guidance to states on their use of predictive analytics, which use algorithms and models to simultaneously analyze large numbers of claims from multiple data sources before payment is made in order to identify unusual or suspicious patterns or abnormalities in provider networks, claims billing patterns, and beneficiary utilization.

Although not all of CMS's comprehensive reviews included information on states' prepayment review processes, our analysis of the most recent comprehensive reviews for all 51 states noted vulnerabilities in the processes of 5 states and regulatory compliance issues in 1 state. For example, CMS found that 1 state did not conduct prepayment reviews or suspend or withhold payments to providers suspected of fraud and abuse. Rather, the state only withheld provider payments after determining that it had overpaid a provider. For another state, a very limited prepayment review process was seen as one of many issues contributing to what CMS characterized as the state's ineffective program integrity oversight and operations.

These comprehensive reviews also noted effective and noteworthy prepayment review processes in 7 states. For example, CMS highlighted one state's prepayment edit process that included an automated edit system to deny claims that failed to meet certain standards.[16] For another state, CMS recognized the state's efforts to effectively communicate program integrity concerns throughout its Medicaid agency; these communications included the establishment of an agencywide committee—with representation from the program integrity division—that regularly discussed current and proposed edits for inclusion in prepayment reviews.

[16]CMS's comprehensive reviews focus on states' prepayment review processes, not on the actual edits that states have in place

According to CMS officials, they have had discussions with and provided guidance and technical assistance to states regarding the use of predictive analytics to identify and prevent improper payments both informally and during three recent Medicaid Integrity Institute symposiums. CMS officials also told us that states are in varying stages of implementing predictive analytics; based on Medicare's experience, the Small Business Jobs Act of 2010 requires the use of predictive analytics in Medicaid beginning in 2015.[17]

Federal Postpayment Claims Reviews Are Becoming More Collaborative; Introduction of Recovery Audit Contractors Will Need to Avoid Duplication with Other Audit Efforts

Our prior work found that postpayment reviews are critical to identifying and recouping overpayments, but the importance of collaboration and coordination to avoid duplication has grown because of the increase in the number of entities other than states now conducting such reviews.[18,19] In 2011, we reported that collaborative audits were a promising approach to avoiding duplication of federal and state audit efforts.[20]

As directed by the Deficit Reduction Act of 2005, CMS established a federal program to audit state Medicaid claims. Since implementing federal audits in 2008, CMS's contractors have conducted a total of 1,662 postpayment audits, 1,550 of which were federal audits where CMS identified the audit targets and 112 of which were collaborative audits where CMS relied on state Medicaid integrity programs to identify audit targets.[21] Our analysis shows that since shifting to a more collaborative approach in 2010, the focus of audits has changed from an emphasis on hospitals to an emphasis on long-term care and pharmacy (see table 2).

[17]Pub L No 111-240, § 4241(c)(3), 124 Stat 2504, 2600

[18]See GAO, *Medicare Fraud, Waste, and Abuse Challenges and Strategies for Preventing Improper Payments*, GAO-10-844T (Washington, D C June 15, 2010)

[19]The Deficit Reduction Act of 2005 required CMS to conduct postpayment audits of state Medicaid claims payments and in 2010 PPACA required states to use audit contractors to recover overpayments and identify underpayments

[20]GAO, *Medicaid Program Integrity Expanded Federal Role Presents Challenges to and Opportunities for Assisting States*, GAO-12-288T (Washington, D C Dec 7, 2011)

[21]We are currently examining the effectiveness of CMS's audits of Medicaid claims—both the federal audits and CMS's redesign of those audits, which CMS refers to as collaborative audits Specifically, we are examining (1) the effectiveness of CMS's implementation of the national federal audit program, under which it conducted federal audits and (2) its efforts to redesign the national federal audit program, primarily through implementation of collaborative audits. We plan to issue this report in June 2012

Table 2: Number and Percentage of Provider Types Targeted by Federal and Collaborative Audits.

Provider type	Number of federal audits	Percentage of all federal audits[a]	Number of collaborative audits	Percentage of collaborative audits[a]
Hospital	584	38	11	10
Long-term care	284	18	33	29
Physician	227	15	8	7
Pharmacy	225	15	35	31
Home health	9	1	6	5
Durable medical equipment	45	3	1	1
Other	176	11	18	16
Total	**1,550**	**100**	**112**	**100**

Source: GAO analysis of CMS data.

Note: Data presented from 2008 through February 29, 2012. "Other" includes clinic, behavioral health, dental, personal care, managed care, hospice, ambulatory health care facilities, direct service providers, disability care services, home office, provider agency, transportation, therapeutic residential child care facility, and cases that CMS labeled "other."

[a]Column does not add up to 100 due to rounding.

PPACA requires state Medicaid programs to establish contracts with RACs, consistent with state law and similar to the contracts established for the Medicare program, subject to exceptions or requirements provided by CMS.[22] One or more of these RACs are to identify and recoup overpayments and identify underpayments made for services provided by state Medicaid programs. The National Association of Medicaid Directors (NAMD) in March 2012 noted concern about the potential for overlap between federal and state program integrity activities, particularly with respect to provider audits, and observed that the deployment of Medicaid RACs increased the potential for duplication.[23] CMS's shift to collaborative federal audits should help resolve the potential for duplication of state audit efforts because states identify the collaborative audit targets. However, a few states that we discussed the Medicaid RAC program with voiced concerns about the potential for duplication with their own audits. In its September 2011 final rule implementing the Medicaid RAC program, CMS disagreed with similar public comments that the

[22]Pub. L. No. 111-148, §6411(a)(1), 124 Stat. 119,773 (codified at 42 U.S.C. § 1396a(a)(42)(B)).

[23]NAMD, *Rethinking Medicaid Program Integrity: Eliminating Duplication and Investing in Effective, High-value Tools* (Washington, D.C., March 2012).

Medicaid RAC program would duplicate efforts of the federal national audit program because federal audit targets are vetted with states.[24] In this final rule, CMS acknowledged the potential for the duplication of efforts among different auditing entities and required states to coordinate their RAC efforts with other auditing entities. According to CMS, RACs are an efficient way to identify payment errors, while federal audits may be more effective in identifying or preventing fraudulent practices.

CMS defined implementation of state RAC programs to mean that states must have a signed contract in place with their selected contractors by January 1, 2012. According to agency officials, 32 states had signed contracts with RAC vendors as of May 31, 2012, but few states' Medicaid RAC programs were operational. In addition, officials told us that 17 states had requested exceptions due to implementation delays. The few states with operational RAC programs had not yet reported on whether RACs had increased state collections of improper payments. As a result, it is too early to assess the initial results and the potential for duplication, including the steps CMS and the states will take to avoid duplication.

CMS Has Not Established a Robust Process for Incorporating Identified Vulnerabilities in State Corrective Action Plans

Our prior work has demonstrated that CMS had not developed a robust process to specifically address identified vulnerabilities that lead to improper payments in Medicaid. Previously we reported that CMS, in its proposed rule for the Medicaid RAC program, did not include steps for states to collect information on RAC-identified vulnerabilities and to develop a corrective action plan to address them.[25] CMS requires state Medicaid agencies to have a corrective action process as part of their activities to reduce their Medicaid error rates. Information from the Medicaid RAC program could be incorporated into these processes. In response to a comment on the proposed rule noting this weakness, CMS acknowledged the importance of having RAC-identified vulnerabilities incorporated in state program integrity activities, observing, "if Medicaid

[24]Medicaid Program Recovery Audit Contractors, 76 Fed Reg 57,808 (Sept 16, 2011)

[25]See GAO, *Medicare and Medicaid Fraud, Waste, and Abuse Effective Implementation of Recent Laws and Agency Actions Could Help Reduce Improper Payments*, GAO-11-409T (Washington, D C Mar 9, 2011) We noted that having Medicaid RACs report to state Medicaid agencies and CMS on the vulnerabilities they identify and having a corrective action process to address those vulnerabilities would be important to reduce Medicaid improper payments

RACs identify program vulnerabilities as a result of their findings, we encourage RACs to share this information with States so that they can implement corrective action, such as pre-payment edits or other similar system fixes."[26] However, CMS did not incorporate a process for states to evaluate and address RAC-identified vulnerabilities into its final rule.

CMS Has Made Progress in Strengthening Its Medicare Program Integrity Efforts, but Further Actions Are Needed

CMS has made progress strengthening several of the strategies to better ensure the integrity of the Medicare program, such as implementing changes to provider enrollment. However, CMS has not completed other actions that could be helpful in addressing improper payments and reducing fraud, waste and abuse in the Medicare program, including implementation of some relevant PPACA provisions and some of our prior recommendations.

CMS Has Taken Action on Certain PPACA Provider Enrollment Provisions, but Not Completed Others

To address past weaknesses that allowed entities intent on committing fraud from enrolling in Medicare, PPACA authorized CMS to implement several actions to strengthen provider enrollment, some of which have been completed. Specifically, CMS has added screenings of categories of provider enrollment applications by risk level and new national enrollment screening and site visit contractors.

Screening Provider Enrollment Applications by Risk Level: CMS and the HHS-OIG issued a final rule with comment period in February 2011 to implement many of the new screening procedures required by PPACA.[27] CMS designated three levels of risk—high, moderate, and limited—with different screening procedures for categories of Medicare providers at each level. Providers in the high-risk level are subject to the most rigorous

[26] 76 Fed Reg 57808, 57,819

[27] 76 Fed Reg 5862 (Feb 2, 2011) In discussing the final rule, CMS noted that Medicare had already employed a number of the screening practices described in PPACA to determine if a provider is in compliance with federal and state requirements to enroll or to maintain enrollment in the Medicare program

screening.[28] Based in part on our work and that of the HHS-OIG, CMS designated newly enrolling home health agencies and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers as high risk and designated other providers at lower levels. Providers at all risk levels are screened to verify that they meet specific requirements established by Medicare, such as having current licenses or accreditation and valid Social Security numbers.[29] High- and moderate-risk providers are additionally subject to unannounced site visits. Further, depending on the risks presented, PPACA authorizes CMS to require fingerprint-based criminal history checks, and the posting of surety bonds for certain providers.[30]

CMS indicated in the discussion of the final rule that the agency will continue to review the criteria for its screening levels on an ongoing basis and would publish changes if the agency decided to update the assignment of screening levels for categories of Medicare providers. Doing so could become important because the Department of Justice (DOJ) and HHS reported multiple convictions or other legal actions against types of providers not currently at the high-risk level, including medical clinics and physical therapy practices.[31] CMS's implementation of accreditation for DMEPOS suppliers, and of a competitive bidding program, including in areas thought to have high fraud rates, may be

[28]PPACA specified that the enhanced screening procedures will apply to new providers and suppliers beginning 1 year after the date of enactment and to currently enrolled providers and suppliers 2 years after that date

[29]Screening may include verification of the following Social Security number, National Provider Identifier (NPI), National Practitioner Databank licensure, whether the provider has been excluded from federal health care programs by the HHS-OIG, taxpayer identification number, and death of an individual practitioner, owner, authorized official, delegated official, or supervising physician

[30]A surety bond is a three-party agreement in which a company, known as a surety, agrees to compensate the bondholder if the bond purchaser fails to keep a specified promise

[31]*The Department of Health and Human Services and the Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2011* (Washington, D C February 2012)

helping to reduce risk of DMEPOS fraud.[32] As a result, while continued vigilance on DMEPOS suppliers is warranted, other types of providers may become more problematic in the future. We are currently examining the types of providers involved in fraud cases investigated by the HHS-OIG and DOJ, which may help illuminate risk to the Medicare program from different types of providers.

New National Enrollment Screening and Site Visit Contractors: CMS contracted with two new types of entities at the end of 2011 to assume centralized responsibility for two functions that had been the responsibility of multiple contractors. One of the new contractors will be conducting automated screening to check that providers and suppliers have valid licensure, accreditation, a valid National Provider Identifier (NPI), and no presence on the HHS-OIG list of providers and suppliers excluded from participating in federal health care programs. The second contractor has begun conducting site visits of providers to determine if sites are legitimate and the providers meet certain Medicare standards.[33] CMS officials told us that the agency expects that these new contractors will provide more efficiency and consistency in their reviews.

However, our prior work found that CMS had not implemented other enrollment screening actions authorized by PPACA. These actions could help further reduce the enrollment of providers and suppliers intent on defrauding the Medicare program. They include issuing a rule to implement surety bonds for providers, completing contract awards to begin fingerprint-based criminal background checks, issuing a rule on provider and supplier disclosure requirements, and establishing the core elements for provider and supplier compliance programs.

[32]Competitive bidding is a process in which suppliers of medical equipment and supplies compete for the right to provide their products on the basis of established criteria, such as quality and price. See GAO, *Medicare: Review of the First Year of CMS's Durable Medical Equipment Competitive Bidding Program's Round 1 Rebid*, GAO-12-693 (Washington, D.C.: May 9, 2012).

[33]Site visits for DMEPOS suppliers will continue to be conducted by the contractor responsible for their enrollment. In addition, CMS at times exercises its authority to conduct a site visit or request its contractors to conduct a site visit for any Medicare provider or supplier.

Surety Bond: PPACA authorizes CMS to require a surety bond for certain types of at-risk providers. Surety bonds may serve as a source for recoupment of erroneous payments. CMS has not developed a proposed rule to require surety bonds as conditions of enrollment to implement this requirement. Extending the use of surety bonds to these new entities would augment a previous statutory requirement for DMEPOS suppliers to post a surety bond at the time of enrollment.[34] While CMS had required surety bonds from DMEPOS suppliers since 2009, CMS did not issue instructions for recovering overpayments through surety bonds, until January 2012, to take effect in February 2012. As of May 2012, CMS had not collected any funds from surety bond companies.

Fingerprint-based Criminal Background Checks: CMS officials told us that they are working with the Federal Bureau of Investigation to arrange a contract that will enable the agency to access information to help conduct fingerprint-based criminal background checks of high-risk providers and suppliers, which is a tool authorized by PPACA. The agency expects to have the necessary contract in place by early 2013.

Providers and Suppliers Disclosure: CMS had not completed development of regulations for increased disclosures of prior actions taken against providers and suppliers enrolling or revalidating enrollment in Medicare, such as whether the provider or supplier has been subject to a payment suspension from a federal health care program.[35] Agency officials indicated that developing the additional disclosure requirements was complicated by provider and supplier concerns about what types of information will be collected, what CMS will do with it, and how the privacy and security of this information will be maintained.

[34]42 U S C § 1395m (a)(16)(B) As of October 2009, DMEPOS suppliers were required to obtain and submit a surety bond in the amount of at least $50,000 A DMEPOS surety bond is a bond issued by an entity guaranteeing that a DMEPOS supplier will fulfill its obligation to Medicare If the obligation is not met, the surety bond is paid to Medicare *Medicare Program, Surety Bond Requirement for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS),* 74 Fed Reg 166 (Jan 2, 2009)

[35]At the time of initial enrollment or revalidation of enrollment, PPACA requires providers and suppliers to disclose any current or previous affiliation with another provider or supplier that has uncollected debt, has been or is subject to a payment suspension under a federal health care program, has been excluded from participation under Medicare, Medicaid, or State Children's Health Insurance Program, or has had its billing privileges denied or revoked

Compliance Program: CMS had not established the core elements of compliance programs for providers and suppliers, as required by PPACA. Agency officials indicated that they had sought public comments on the core elements, which they were considering, and were also studying criteria found in HHS-OIG model plans for possible inclusion.[36]

Additional Improvements to Prepayment Claims Review May Better Identify Improper Payments

Increased efforts to review claims on a prepayment basis can better prevent payments that should not be made. As claims go through Medicare's electronic claims payment systems, they are subjected to prepayment edits, most of which are fully automated; if a claim does not meet the criteria of the edit, it is automatically denied. Other prepayment edits are manual; they flag a claim for individual review by trained staff who determine if it should be paid. Due to the volume of claims, CMS has reported that less than 1 percent of Medicare claims are subject to manual medical record review by trained personnel.

Having effective prepayment edits that deny claims for ineligible providers and suppliers depends on having timely and accurate information about them, such as whether the providers are currently enrolled and have the appropriate license or accreditation to provide specific services. We have previously identified flaws in the timeliness and accuracy of data in the Provider Enrollment Chain and Ownership System (PECOS)—the database that maintains Medicare provider and supplier enrollment information, which may result in CMS making improper payments to ineligible providers and suppliers.[37] These weaknesses are related to the frequency with which CMS's contractors update enrollment information and the timeliness and accuracy of information obtained from outside

[36]A compliance program is an internal set of policies, processes, and procedures that a provider organization implements to help it act ethically and lawfully. In this context, a compliance program is intended to help provider and supplier organizations prevent and detect violations of Medicare laws and regulations. The HHS-OIG has developed a series of voluntary compliance program guidance documents directed at various segments of the health care industry, such as hospitals, nursing homes, third-party billers, and durable medical equipment suppliers, to encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements.

[37]See *Medicare Program Integrity: CMS Continues Efforts to Strengthen the Screening of Providers and Suppliers*, GAO-12-351 (Washington, D.C., Apr. 10, 2012).

entities, such as state licensing boards,[38] the HHS-OIG, and the Social Security Administration's Death Master File, which contains information on deceased individuals that can be used to identify deceased providers in order to deactivate their NPI. CMS has indicated that its new national screening contractor should improve the timeliness and accuracy of the provider and supplier information in PECOS by centralizing the process, increasing automation of the process, checking databases more frequently, and incorporating new sources of data, such as financial, business, tax, and geospatial data. We are planning to review the accuracy of PECOS information.

Having effective edits to implement coverage and payment policies before payment is made can also prevent improper payments. The Medicare program has defined categories of items and services eligible for coverage and excludes from coverage items or services that are determined not to be "reasonable and necessary for the diagnosis and treatment of an illness or injury or to improve functioning of a malformed body part."[39] CMS and its contractors set policies regarding when and how items and services will be covered by Medicare, as well as coding and billing requirements for payment, which can be implemented in the payment systems through edits. Our prior work found certain gaps in Medicare's prepayment edits based on coverage and payment policies and made recommendations for improvement, which have not all been implemented. For example, CMS has not developed edits to identify abnormally rapid increases in billing by DMEPOS suppliers, which is associated with fraudulent billing.[40] We are currently assessing CMS's implementation of edits on coverage and payment policies.

We are also currently evaluating a new CMS effort, the Fraud Prevention System (FPS), which uses predictive analytic technologies to analyze Medicare fee-for-service (FFS) claims as required by the Small Business

[38]Licensure is a mandatory process by which a state government grants permission to an individual practitioner or health care organization to engage in an occupation or profession

[39]42 U S C § 1395y(a)(1)(A)

[40]GAO, *Medicare Improvements Needed to Address Improper Payments for Medical Equipment and Supplies*, GAO-07-59 (Washington, D C Jan 31, 2007), *Follow-up on 2011 Report Status of Actions Taken to Reduce Duplication, Overlap, and Fragmentation, Save Tax Dollars, and Enhance Revenue*, GAO-12-453SP (Washington, D C Feb 28, 2012)

Jobs Act of 2010. According to CMS, FPS may enhance CMS's ability to identify potential fraud because it simultaneously analyzes large numbers of claims from multiple data sources nationwide before payment is made, thus allowing CMS to examine billing patterns across geographic regions for those that may indicate fraud. The results of FPS could lead to the initiation of payment suspensions, implementation of automatic claim denials, and identification of additional prepayment edits, investigations, or the revocation of Medicare billing privileges. CMS began using FPS to screen all FFS claims nationwide prior to payment as of June 30, 2011. Because FPS is relatively new, and we have not completed our work, it is too soon to determine whether FPS will improve CMS's ability to address fraud.

Adding New Contractors and Taking Additional Actions Could Improve Medicare Postpayment Claims Reviews

Adding new RACs into the Medicare program may help in identifying under or overpayments, and in recouping overpayments.[41] Prior to PPACA, CMS began a national RAC program in March 2009 for FFS Medicare.[42] As of May 2012, CMS reported that $1.86 billion was recouped due to these contractors' efforts from October 2009 through March 2012.

PPACA required the expansion of Medicare RACs to Parts C and D. CMS has implemented a RAC for Part D, but not for Part C.

- The agency awarded a Part D RAC task order[43] for a 1-year base period that began in January 2011, and 4 option years. The Part D RAC is modeled after the Medicare FFS RACs and conducts postpayment review of Part D claims for prescription drugs based on specific criteria determined by CMS. CMS has approved the Part D

[41]Recovery auditing has been used in various industries, including health care, to identify and collect overpayments for about 40 years

[42]The Medicare Prescription Drug, Improvement and Modernization Act of 2003 directed CMS to conduct a demonstration of the use of RACs in identifying underpayments and overpayments, and recouping overpayments in Medicare Pub L No 108-173, § 306, 117 Stat 2066, 2256-57 Subsequently, in December 2006 the Tax Relief and Health Care Act of 2006 required CMS to implement a national RAC program by January 1, 2010 Pub L No 109-432, div B, title III, § 302, 120 Stat 2924, 2991 (codified at 42 U S C § 1395ddd(h))

[43]A task order is a supplementary document that outlines specific expected services, supplies, or tasks to be provided under an established contract.

RAC to conduct postpayment review of claims to identify several issues leading to improper payments, such as payments to excluded providers and duplicate payments.[44] To ensure that the Part D RAC is making correct determinations of any improper payments, CMS has included a validation contractor to review Part D RAC determinations. CMS officials stated that the Part D RAC has started its review of 2007 claims data for prescription drug events and has identified potential overpayments to recoup.

- CMS has not yet awarded a Part C RAC task order or contract. Agency officials indicated that they are still considering different options for implementing a Part C RAC program to address improper Medicare Advantage plan payments. Plans are paid a monthly capitated per-person payment for enrolled beneficiaries, based on an approved bid amount and risk adjusted based on individual beneficiaries' health status. Most of the Part C payment errors are driven by errors in the risk adjustment data (clinical diagnosis data) submitted by the plans, due to diagnoses not supported by the medical records. CMS is currently auditing Part C plans' reporting of risk adjustment data. CMS officials indicated concern that adding additional contractors to identify Medicare Advantage plan payment errors would duplicate current efforts.

Further actions are also needed to improve use of two CMS information technology systems that could help analysts identify fraud after claims have been paid.[45]

- The Integrated Data Repository (IDR) became operational in September 2006 as a central data store of Medicare and other data needed to help CMS program integrity staff and contractors detect improper payments of claims. However, we found IDR did not include all the data that were planned to be incorporated by fiscal year 2010, because of technical obstacles and delays in funding. Further, as of December 2011, the agency had not finalized plans or developed

[44]The Part D RAC can propose other issues to audit, but any issue requires prior CMS approval before implementation. CMS limits the number of new audit issues the Part D RAC can propose to a maximum of five a year.

[45]GAO, *Fraud Detection Systems: Centers for Medicare and Medicaid Services Needs to Ensure More Widespread Use*, GAO-11-475 (Washington, D.C.: June 30, 2011).

reliable schedules for efforts to incorporate these data, which could lead to additional delays.

- One Program Integrity (One PI) is a web-based portal intended to provide CMS staff and contractors with a single source of access to data contained in IDR, as well as tools for analyzing those data. Although One PI is operational, as of May 2011, CMS had trained few program integrity analysts and the system was not being widely used.

GAO recommended that CMS take steps to finalize plans and reliable schedules for fully implementing and expanding the use of both IDR and One PI and to define measurable benefits. The agency has initiated activities to incorporate additional data into IDR and expand the use of One PI through additional user training. For example, CMS officials indicated that they began incorporating additional Medicare claims data into IDR in September 2011 and as of November 2011, had trained over 200 analysts who were using One PI. CMS officials reported having provided additional training in 2012. However, as of April 2012, CMS had not fully addressed our recommendations—for example, the agency had not finalized plans for adding Medicaid data into IDR.

Robust Process to Address Identified Vulnerabilities Could Help Reduce Improper Payments

Having mechanisms in place to resolve vulnerabilities that lead to improper payments is critical to effective program management, but our work has shown weaknesses in CMS's processes to address such vulnerabilities.[46] Our March 2010 report on the RAC demonstration program found that CMS had not established an adequate process during the demonstration or in planning for the national program to ensure prompt resolution of identified vulnerabilities in Medicare. Further, most

[46]We have reported that an agency should have policies and procedures to ensure that (1) the findings of all audits and reviews are promptly evaluated, (2) decisions are made about the appropriate response to these findings, and (3) actions are taken to correct or resolve the issues promptly. These are all aspects of internal control, which is the component of an organization's management that provides reasonable assurance that the organization achieves effective and efficient operations, reliable financial reporting, and compliance with applicable laws and regulations. Internal control standards provide a framework for identifying and addressing major performance challenges and areas at greatest risk for mismanagement. GAO, *Internal Control Standards: Internal Control Management and Evaluation Tool*, GAO-01-1008G (Washington, D.C.: August 2001).

vulnerabilities identified during the demonstration were not addressed.[47] We therefore recommended that CMS develop and implement a corrective action process that includes policies and procedures to ensure the agency promptly (1) evaluates findings of RAC audits, (2) decides on the appropriate response and a time frame for taking action based on established criteria, and (3) acts to correct the vulnerabilities identified.[48] In December 2011, the HHS-OIG found that CMS had not resolved or taken significant action to resolve 48 of 62 vulnerabilities reported in 2009 by CMS contractors specifically charged with addressing fraud.[49] The HHS-OIG made several recommendations, including that CMS have written procedures and time frames to assure that vulnerabilities were resolved. CMS has indicated that it is now tracking vulnerabilities identified from several types of contractors through a single vulnerability tracking process, and the agency has developed some written guidance on the process. We are currently examining aspects of CMS's vulnerability tracking process and will be reporting on it soon.

Concluding Observations

CMS and the states must continue and improve their efforts to reduce improper payments. Identifying the nature, extent, and underlying causes of improper payments, and developing adequate corrective action processes to address vulnerabilities, is an essential prerequisite to reducing them. Although Medicaid presents different challenges, we believe that many of the lessons learned from our Medicare work could be applied to strengthen Medicaid program integrity. These lessons can be applied as CMS and the states begin to use the additional tools to identify and recoup Medicaid improper payments provided through recent legislation. As CMS and the states implement these PPACA and Small Business Jobs Act provisions, additional evaluation and oversight will help determine whether the provisions are implemented as intended and have the desired effect on better ensuring proper payments. Moreover, we are continuing to monitor CMS and state efforts as the implementation process proceeds. Notably, we have work under way assessing CMS's

[47]GAO, *Medicare Recovery Audit Contracting: Weaknesses Remain in Addressing Vulnerabilities to Improper Payments, Although Improvements Made to Contractor Oversight*, GAO-10-143 (Washington, D.C.: Mar. 31, 2010)

[48]GAO-10-43

[49]HHS-OIG, *Addressing Vulnerabilities Reported by Medicare Benefit Integrity Contractors*, OEI-03-10-00500 (December 2011)

efforts to support and strengthen Medicaid program integrity through its Medicaid Integrity Program. We are also examining the effectiveness of different types of prepayment edits in Medicare, including CMS's oversight of its contractors in implementing those edits, and CMS's implementation of predictive analytics through FPS. The level of importance placed on effectively implementing our recommendations and the provisions of recent laws will be critical to reducing improper payments in the Medicaid and Medicare programs, and ensuring that federal funds are used efficiently and for their intended purposes.

Chairman Platts, Ranking Member Towns, and Members of the Subcommittee, this completes our prepared statement. We would be pleased to respond to any questions that you may have at this time.

GAO Contacts and Staff Acknowledgments

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Appendix I: Abbreviations

CMS	Centers for Medicare & Medicaid Services
DOJ	Department of Justice
DMEPOS	durable medical equipment, prosthetics, orthotics and supplies
FFS	fee-for-service
FPS	Fraud Prevention System
HHS	Department of Health and Human Services
IDR	Integrated Data Repository
NAMD	National Association of Medicaid Directors
NPI	National Provider Identifier
OIG	Office of Inspector General
PECOS	Provider Enrollment Chain and Ownership System
PPACA	Patient Protection and Affordable Care Act
RAC	recovery audit contractor

Related GAO Products

Medicare: Review of the First Year of CMS's Durable Medical Equipment Competitive Bidding Program's Round 1 Rebid GAO-12-693. Washington, D C.: May 9, 2012

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Mr. PLATTS. And Ms. King, I understand that Ms. Yocum was speaking for both of you.

Ms. KING. She is.

Mr. PLATTS. Okay. Thank you.

I will now yield myself 5 minutes for the purpose of questions.

Again, thank each of you for your testimony and your insights and look forward to not just today with this hearing, but in going forward to continue working with each of you and your respective offices as we collectively try to do right by the American people and how their dollars are used.

Dr. Budetti, I would like to start with you. In your written testimony here today, you talk about kind of the traditional approach and then as you highlighted, a new approach, and your written testimony certainly focused extensively on new efforts, the fraud prevention services, the automated provider screening process.

And the way I looked at your written testimony's kind of view, you have mentioned the more traditional and National Medicaid Audit Program, the Medi-Medi program, but you really didn't go into a lot of detail on that.

Should I take from that that there is some maybe acknowledgment or understanding that the findings of the Inspector General of GAO of the previous programs or the older programs focused on program integrity have not been as effective as we would like and that you are devoting more focus and resources on a new approach to the FPS and the APS?

Dr. BUDETTI. The short answer is yes, at least to the acknowledgment of the problems. You may not be surprised to know that I find very little to disagree with in much of what—what you've heard by way of testimony by the GAO and the Office of Inspector General.

The current leadership, I'll just focus on the Medicaid integrity programs, National Audit Program for a second, because I think that is where some of the most difficult problems have been identified.

The current leadership of that program took over in late 2009 and the program came into the Center for Program Integrity in early 2010. It was during that year that we identified internally that we were getting the wrong kinds of results—very limited, very limited results from the way that we were going about doing the national audits, and we both embarked on a way—a program to develop a new approach and also to cut off the old approach.

So the life history of the audits that were initiated under—being based on the inadequate data that you've heard described, they started in September of 2008 before we took over the program; and the last one, my information is, went out in February of 2011. During that time—so we have not sent one out since then, that's my understanding. And since then, we have been building a new approach which involves working more directly and more collaboratively with the States because the States do have—although they have it in very different systems in some cases and it's not completely easy to get access to—the States do have, of course, much more complete information than we've been getting at the Federal level.

So we've engaged with them in thus far, I understand, 137 collaborative audits. Those are taking place in States that represent about 53 percent of all Medicaid expenditures, and we are looking to expand that substantially over the coming year.

So we do acknowledge that there have been problems with the National Audit Program, and we initiated corrective action early on, and we are very much dedicated to improving that program.

Mr. PLATTS. Specifically on the approach, on the traditional approach and acknowledgment of the problems there, one that came out in the Inspector General's testimony and the written testimony, was the example between the— disparity between the review integrity contractors and the audit integrity contractors. And one example highlighted in that testimony was that the review contractors identified 113,000 providers with potential overpayments of $282 million, and then when the audit contractors went in and got into that information, there was only 25 of these 113,000 were determined to have been given overpayments, and only $285,000 actually found to have been inappropriate versus the $282 million. That is quite a disparity and shows a significant problem with that approach.

Dr. BUDETTI. That's exactly right. Those are the kinds of numbers that caused us to stop that approach and that has caused us to look to a new way of doing business.

One of the things that kept that going was that when the review contractors looked at the inadequate data, they made projections that looked very promising, and it wasn't until we found out that they in fact did not return any results when we went out and conducted the actual audits, that we decided that this was so problematic that we would stop that and we would have a new approach.

In the meantime, the Federal Government, as you've heard, does not have yet all of the data that are necessary for us to do the audits ourselves, and so we believe that for now the best way to go about this is to build up the collaborative audits, working closely with the States who do have the proper data.

Mr. PLATTS. A quick follow-up before I yield to the ranking member.

On that, so today are we still paying any review audit contractors going forward, or the audit integrity contractors under the old system?

Dr. BUDETTI. So we have existing contracts. We have some audits that are out there that have yet to be completed, and we are at this very moment, we are looking at the restructuring of our entire audit program so that we can use those resources in a much more effective way, and that also will tie in, if I have time later, I can talk about how that—we're exploring how that will tie into the use of our Medi-Medi resources as well.

Mr. PLATTS. That is a concern of those existing contracts and what we are paying out still, when clearly the results versus a collaborative approach and the new systems is night and day.

Dr. BUDETTI. We're directing them to new tasks that are still within the scope of their existing contracts, and we're exploring the way of—and we're exploring how to completely restructure our approach.

Mr. PLATTS. Okay. Thank you.

I now yield to gentleman from New York for the purpose of questions.

Mr. TOWNS. Thank you very much, Mr. Chairman.

Let me just begin by saying I am impressed that there is collaboration with CMS with the Inspector General's Office and the Department of Justice in law enforcement in recent years, which I understand has resulted in more than 600 criminals being successfully prosecuted for fraud against Medicaid and Medicare, and more than 500 of whom were serving prison sentences of over 42 months.

How many would that—I am trying to get the conviction rate. Would anybody know in terms of that number how many actual indictments?

Ms. KING. Sir, that is work that we are currently conducting, and we'll have the answer to that later this year.

Mr. TOWNS. Okay. Well, we would like to get the information.

Ms. KING. Both on the civil and the criminal front.

Mr. TOWNS. The reason I raise that is because the Inspector General indicated that there was a situation where you spent $250,000 to collect $2,000. You know, I just think we need to look at every area to make certain that there is not waste, fraud, and abuse.

Let me ask, do you think the fact that these systems do not talk to each other? I mean, what is the problem? And as the chairman had mentioned earlier on, this is not one of those committees where we "got you." We want to help. We recognize how important it is today more than ever that we save money and make certain that it is being used and used properly. So we want to be helpful.

But is it the fact that you do not have the money to put the system in place to be able to get the information that is necessary to be able to adjust? And let me say why I raise this question.

I was in bed one night, and at 1:30 in the morning I get a call from American Express; said to me that somebody was making a big purchase in the bar on my credit card, you know, and they said they hated to bother me so, but the point was that this was so unusual, I guess because my bar bill is like $5 I guess, I don't know. But I am not sure as to why it was so unusual. But anyway, the point was that they reached out to me to make certain that there was no fraud. I mean, they wanted to make certain that they took care of it right away. I mean, why can't we look and find a technique, a method to be able to do the same thing?

Dr. Budetti?

Dr. BUDETTI. Mr. Towns, I'm happy to report that under our new fraud prevention system, since as of the end of April, our investigators have conducted 1,541 interviews with beneficiaries that really are parallel to the call that you got, unfortunately, in the middle of the night from American Express, where we check to see whether or not beneficiaries can confirm that they have received the services that they may or may not have received. So that's very much built into part of what we're doing now.

Mr. TOWNS. How long has that been in place?

Dr. BUDETTI. This system went into place the end of June of last year. And so as of April of this year, we have counted 1,541 such interviews.

Mr. TOWNS. Okay.

Dr. BUDETTI. On the broader question of resources, we're very grateful to the Congress for the resources that have been provided. As you may know, the President has also asked for some additional resources in this area. I think that at the Federal level, we have had very good access to the kinds of data that we need and it is a question of putting the systems in place to deal with the information that we generate properly. I think a lot of States would tell you that they do face some resource constraints, notwithstanding that a lot of their expenditures would be covered by the Federal Government. So there are some ongoing discussions with States about that as well.

Mr. TOWNS. I really, I think my question is, is it the fact that you do not have the kind of resources that would make it possible for you to put a plan in place that will help you to be able to evaluate and to see in terms of what is really going on? You know, I sort of get the feel that the technology in the system is not in place to do that. And I know it takes some money to do that, and sometimes I think that instead of putting the money in, you know, we just sort of try and make do and then we end up spending more by trying to make do.

Dr. BUDETTI. We're very pleased that under the Small Business Jobs Act of 2010 and also under the additional funding that was provided in the Affordable Care Act, that we have very substantial resources. The Small Business Jobs Act is what specifically called on us to go ahead with what we were intending to do, which is to put into place the advanced technologies that I was talking about, the fraud prevention system, and that is in place and it has been up and running now since the end of June of last year.

So we believe on the Medicare side, we have the technology, we have the systems in place. They're going to grow and continue to grow and become more and more sophisticated over time. So I think that on that side, I think—I think we're in good shape. I do think we face the challenge that we're facing up to of translating that advancement on the Medicaid side.

Mr. TOWNS. I see my time has expired.

Mr. PLATTS. I thank the gentleman.

I now yield to the gentleman from Oklahoma, Mr. Lankford.

Mr. LANKFORD. Thank you, Mr. Chairman. And I would say to the ranking member, I am very pleased to hear that the pastor—it is rare for him to be in a bar late in the evening, so much so that American Express calls him and says it is a rare event. So glad to be able to hear that.

Let me bounce a couple of questions off of you as well, and I have some real concerns on the RAC audit process. If there is any one thing that I hear from hospitals, providers, and folks the most, it is the full-body cavity search that has become the RAC audit process.

I have several concerns. One begins just with the process of it. As a Federal Government, we are designed to serve the people, rather than them serve us. And the RAC audit process seems to have put the whole process on its head, that they exist there to serve us, and we are going to stay long enough until we find some fraud.

The contingency fee process part of it, my fear is it's turning this into a bounty hunter process, that we have outside contractors that are coming in and they're going to stay until they get paid, until they find something there.

That moves the system significantly towards we are going to find more fraud, but it also moves the system significantly towards a hostile, not helpful, environment in that.

Saying all of that, that is where we are, I feel. I don't know if anyone disagrees with me on that. I have yet to find anyone that disagrees with that. And I have had multiple conversations with that sense, if you have got a disagreement, I would like to hear about it.

But I also would like to hear how are we preparing people for these RAC audits and what process is occurring currently so when people arrive, it is an environment where we evaluate, as we should, we should hold people to account. But this should not be a hostile event.

Ms. KING. Representative Lankford, as you may know, the RAC program started with a demonstration.

Mr. LANKFORD. Right.

Ms. KING. And we evaluated that demonstration, and we did find a number of areas for concern. And there were some missteps on the part of CMS in terms of the issues that were explored there and, you know, perhaps overaggressiveness.

And I think that CMS, in implementing the national program, took a lot of those concerns into account, and they devised a system at CMS where all of their central players in the operation would get together and agree on what kinds of situations the RACs could look into, rather than having them just go out on their own. So in the national program, I think that part has been smoother.

Mr. LANKFORD. Still paying people a contingency based on what they find?

Ms. KING. That's the way the program was set up.

Mr. LANKFORD. The way it is set up.

Ms. KING. To pay on—to pay on contingency.

But, you know, one more thing I might add about that is the RAC program is designed to identify overpayments and underpayments, and it is not specifically designed to look for fraud. It's really looking at cases in which the agency has paid too much or too little.

Mr. LANKFORD. Right. But a lot of the underpayment, I mean, what do we have, a 4 percent national rate for underpayment?

Ms. KING. The vast majority are overpaid.

Mr. LANKFORD. Yeah. They are really going in looking for overpayments, obviously, on that. And it becomes an issue of what is an overpayment and how complex this is.

My assumption is it is typically we overpaid you because we shouldn't have paid you at all for this, because we disagree. You shouldn't have had them in the hospital 2 nights, or we disagree this shouldn't have been an overnight stay at all, or this procedure or this coding.

So agree or disagree on that?

Ms. KING. I agree, but they are following Medicare policy when they're doing the audits.

Mr. LANKFORD. When the hospital responds back to it, when there has been a denial, my understanding is there is about a 75 percent rate of turning that over. Am I correct or incorrect?

Ms. KING. When we did our work, we didn't have the information about what the overturn rate is.

Mr. LANKFORD. The appeal rate seems to be extremely high when we are looking for fraud, and we are fighting back and forth on whether this should have been through the process or not, whether it should have been a 1-night or 2-night or overnight at all, or whatever it may be. And then they appeal it and have a 75 percent appeal success rate. That tells me there is still an issue. There is still a problem hovering out there somewhere that we have got to be able to resolve, because we are creating a hostile environment with providers.

This is someone we should be serving. We should hold people to account, but we should also be serving them rather than creating an environment where they are spending tens of thousands to hundreds of thousands of dollars defending something that was valid.

Ms. KING. You know, we haven't looked at the implementation of the national program, so I really don't know there whether the appeal rate has gone down. And we did not have access to the appeal data during the course of our work. So you're raising valid concerns, but I don't know the answer.

Mr. LANKFORD. Mr. Budetti, you were going to say something.

Dr. BUDETTI. Yes, I would. I would just add a couple of things to that. One, I would echo what Ms. King said, but I would also add that CMS is listening to those kinds of concerns that you've identified. We've certainly heard them as well. We have put into place a demonstration project in order to work with hospitals when there is a question as to whether or not the patient should have been an in-patient or an out-patient, instead of a demonstration where hospitals can rebuild, if that is the determination, so that they don't lose the entire payment, as they have under standard operating procedures that have been in place.

We are also very much looking at all of those concerns, and they're a matter of a great deal of internal discussion in the agency at this time.

Mr. LANKFORD. I would encourage you to keep it as a matter of a great deal of internal discussion so we can try to evaluate it, because this obviously is an issue. I know this is a project you are trying to launch on it, but we have got to be able to resolve this.

With that, I yield back. Thank you.

Mr. PLATTS. I thank the gentleman. I now yield to gentlelady from Minnesota, Mrs. Bachmann.

Mrs. BACHMANN. Thank you again, Mr. Chair, and also Ranking Member Towns.

One area to look for fraud is with the Medicaid providers and others with the Medicaid—or the managed-care organizations.

And this would be a question for Dr. Budetti, if you will. And just briefly based on the concerns that the managed-care organizations are using Medicaid premium dollars to cross-subsidize other non-Medicaid State health plans, could you tell the committee what data you are gathering to combat these allegations, if any?

Dr. BUDETTI. Congresswoman, I think that you're aware that in your State, Minnesota, that after discussions with CMS that have been ongoing recently, that Minnesota has recently agreed to repay to CMS the appropriate Federal share of the amount of money that was contested. And we're currently reviewing the State's submission on that matter and have every intention of collecting the appropriate Federal share.

We are also——

Mrs. BACHMANN. But if I could ask, Dr. Budetti, how are they coming to the conclusion of what number? Because my question is about what data are you gathering so that we can be confident that States aren't taking Medicaid dollars and then using them for a cross-purpose to subsidize a non-Medicaid, non-Federal Medicaid State health plan. What specific data are you asking the States for, so we can be assured this isn't going on?

Dr. BUDETTI. I think that that question is very well taken. I think that we need to continue to build our capacity to collect the appropriate data on managed-care operations.

Mrs. BACHMANN. So we aren't collecting any data to that effect today?

Dr. BUDETTI. The emphasis has been on the fee-for-service side, I agree with you on that.

Mrs. BACHMANN. So we need to do better, it sounds like.

Dr. BUDETTI. We do need to do a better job in terms of getting that degree of oversight, and we are engaging in doing that.

Mrs. BACHMANN. Thank you. I agree. I think that shows a big hole that we have, because we are not even asking the right questions. I think that goes to Ranking Member Towns. The right question was asked of him at 1:30 in the morning. That is what we need to be doing, asking the right question. And clearly we are not.

Let me ask you also, Dr. Budetti, since 2006, CMS has now spent over a hundred million dollars developing the one program integrity system to merge Medicare and Medicaid data, and the Medicare data has been collected, but to date the Medicaid data has not been included. Now, this is significant. It has been 6 years.

Why is that, that the Medicaid data is not included, and what role should the States play in—or are they, perhaps, in delaying the collection of this data and are States withholding information from CMS?

Dr. BUDETTI. We certainly recognize that the data that we have been getting from the States are not adequate, and that's been at the core of our restructuring of the National Audit Program. We've been working very diligently over the last couple of years to improve that situation and to get the right kind of data.

There's a demonstration project going on with 10 States that's designed to look at the data that we're currently collecting, to identify the data that we do need to do proper oversight, and as well as a number of other program operation requirements at the Federal level, and then to get those data from those 10 States and to use that as a model for improving the flow of data from the States.

Mrs. BACHMANN. I would agree, but that doesn't answer my question why for 6 years we have Medicaid—Medicare data, but we don't have Medicaid.

Dr. BUDETTI. Yes.

Mrs. BACHMANN. There is just an absence. So the question is, is the State holding out on us? Are they not getting the data? Are we not holding them accountable?

So if you could get back to the committee and answer that question. I just have one question——

Dr. BUDETTI. Sure.

Mrs. BACHMANN. —for Ms. Yocum, if you could answer that also in the brief time I have.

The GAO lists Medicaid as a high-risk program, and GAO has previously issued reports that addresses CMS' lack of oversight into Medicaid managed-care rates. So given that we have three-fourths of Medicaid beneficiaries enrolled in some form of managed care, could you speak to the data that is used by GAO and CMS to address this aspect of Medicaid?

Ms. YOCUM. Certainly. Right now, one of the big issues across the Medicaid program are the different data systems and the extent to which they actually talk to each other. There are two different ways that managed-care data may be collected. One is through its expenditure system. The second is through a separate accounting system that looks at the managed-care reporting itself.

Our work that we looked at on an actuarial soundness in Medicaid managed care, we ended up going back to State plans and to States' contracts with managed-care plans in order to understand CMS' review and oversight in that area.

Mrs. BACHMANN. Mr. Chairman, I thank you for indulging me to be with the committee. It seems to me that there is a real problem in that we aren't asking the right questions. And I think we would be a lot farther down the road if we asked the right questions. That is the purpose of my legislation that I will be introducing shortly. But I thank the committee so much for graciously allowing me to be here today, and I thank Dr. Budetti for getting the answers to the committee to the question that I asked.

Mr. PLATTS. I thank the gentlelady.

And Dr. Budetti, if you would follow up in writing to the committee for the record in response to Representative Bachmann's questions.

And I think the focus that you have touched on here, and the ranking member and I were speaking about, it is so important that unless we have that data, we really won't be able to get to the root causes. And, you know, when I talk about internal controls, ultimately our goal is to get to the root causes of the improper payments, the fraud, the misuse of funds, but without the data, it is hard to know exactly where that is. So that focus, especially on the Medicaid side, is going to be so important to ultimately reducing the improper payment numbers for both Medicaid and Medicare.

I thank the gentlelady for participating.

I now yield to gentleman from Virginia, Mr. Connolly, for 5 minutes.

Mr. CONNOLLY. I thank the chair.

And I might ask my colleague who has joined us, and welcome her to the subcommittee—she indicated that we are not asking the right questions. Because I'm late, if you would indulge me, what pray tell is the right question?

Mrs. BACHMANN. I think the question is we want to have an independent third-party audit of where the payments are going. We today——

Mr. CONNOLLY. You mean the improper payments?

Mrs. BACHMANN. Thank you. That is a better way to phrase it, and I thank you for that correction for the gentleman.

We have not conducted for decades independent third-party audits of the States. We aren't asking the meaningful data. In our State of Minnesota, for instance, a bill has been presented from managed-care organizations to our State of Minnesota. The State pays it. It is almost like if you went to the grocery store and you had maybe what you thought was $35 worth of groceries in your grocery cart, and then the cashier said, Please give me $300. And you said, Well, let me see the grocery tape so I know what I'm paying for. And the cashier says, No, I'm not going to give you the grocery tape. Give me $300.

We at the Federal Government aren't demanding the itemized statement of what the managed-care organizations are charging the States, and then the States are passing that bill on to the Federal Government——

Mr. CONNOLLY. I thank my colleague.

Mrs. BACHMANN.—and we are just paying it. So thank you.

Mr. CONNOLLY. Thank you very much. I appreciate it.

Dr. Budetti, maybe start with you. What is your response to our colleague's concern certainly with her home State of Minnesota, and I am sure other States as well, this idea that I am paying $300, and I can't get the itemized bill to justify why I am paying $300, for example, at the grocery store. Is that applicable?

Dr. BUDETTI. We have acknowledged that the existing data that are reported by the States in this area to the Federal Government have proved to be inadequate for conducting Federal audits. I would point out that there's two ways to think about this. One is the Federal Government gets the data and does the audits or has people do the audits. The other is the Federal Government works with the States to make sure that the right data are available and works collaboratively with the States to do the audits.

The first model we're not—has not proved to be workable with the data sets that the Federal Government has been getting. We're working to improve those data sets. We're not abandoning that approach. We're working very hard to improve them.

But in the meantime, we know the States do have the data, and so we are embarking on a new approach with collaborative audits so that we will use our resources, with the States, to audit the data that are in the States. So we're approaching it from both sides. We don't want to wait until some future date when the Federal Government has perfect data from the States. We need to keep an eye on things right now, and that's what we're doing with the States.

Mr. CONNOLLY. Could I ask, given Medicare—we are talking about Medicare?

Dr. BUDETTI. So for Medicare, of course——

Mr. CONNOLLY. No, no. Wait.

Dr. BUDETTI. For Medicaid we don't have the data. The States do.

Mr. CONNOLLY. But Medicaid is not a new program.

Dr. BUDETTI. No, sir.

Mr. CONNOLLY. And obviously the problem did not occur only on this administration's watch. Why is it taking us so long to sort of figure this out and try to figure out systems to put in place to correct this defect?

Dr. BUDETTI. My understanding is that the current data set that's collected was designed for the use of the program. It was being used in other ways, and it has not proved to be adequate for the way that we need to use it now. I'm not an expert on the history of Medicaid's statistical information system, however. But I'd be happy to get you some background.

Mr. CONNOLLY. I think the subcommittee would appreciate it on both sides of the aisle.

Let me ask you this. I am under the impression that U.S. attorneys offices are focusing increasingly on Medicare fraud and recovering sizable amounts of money from fraud from vendors, medical practitioners, and the like. Is that a fair characterization of sort of this administration's decision to crack down on that fraud and trying to recover as much as possible?

Ms. Maxwell, did you want to comment on that? It looked like you were getting ready to comment.

All right. Dr. Budetti.

Dr. BUDETTI. I would be happy to yield to Ms. Maxwell. Sir, there are fraudsters who stay in business after we catch them, and they have assets that we can go after and recover. And in that case, as you know, there have been substantial recoveries in recent years. The most recent year was over $4 billion that was returned from a variety of different approaches.

Then there are fraudsters who, of course, disappear as soon as we identify what they are doing. They have no assets for us to go after. We still want to catch them. We still want to throw them in jail if we can. But that is why we need to build—that is why we are building our system that is designed to prevent fraud from occurring in the first place, because many of those fraudsters we will never recover anything from.

Mr. CONNOLLY. Right. Mr. Chairman, I know my time is up. And all of us on the subcommittee have been very focused on improper payments under your leadership. But fraud is an important subset, obviously, and making sure we have the focus of the Federal Government and the resources. And I must say I am impressed that the Obama administration has taken it very seriously. And I think the 99 U.S. attorneys offices are important allies in this particular component. So the more information I think we could get on that would be appreciated. I thank the chair.

Mr. PLATTS. I thank the gentleman. We will proceed with a second round of questions, and I yield myself 5 minutes for that purpose.

Dr. Budetti, you talk a lot in testimony, written and oral here today, about the automated provider screening process. And in your written testimony you give a number of examples of how it is helping to, you know, screen out either new applicants, new provider applicants that are illegitimate, inappropriate, as well as going back, and with a goal by 2015, to review all existing 1.5 million Medicare suppliers and providers. When I look at the numbers, and

I have tried to on page 6 of your testimony combine them, you talk about an initial review that kind of knocked out 13,000 deactivations of providers. And then you talk about an additional round, a second round that knocked out approximately another 10,000, 11,000. If I total those up, I come up to about 23,000, 24,000 providers in the review of existing—that 1.5 million. And, again, from your testimony apparently there has been about 275,000 existing providers, suppliers, who have been rescreened.

And so if my numbers add up correctly, we are talking 8 to 10 percent of existing providers and suppliers, that when we went back and looked at them, we knocked out for some reason as not appropriate and were eligible for taxpayer funds. If that number, 8 to 10 percent, is accurate, we are talking 120,000, 130,000 or more providers, if you translate that over 1.5 million. I mean that is obviously very disconcerting. Am I looking at that accurately, that that is perhaps the scale of the problem we are facing?

Dr. BUDETTI. So even one would be disconcerting as far as I am concerned, Mr. Platts. So I would share your concern. I will tell you that we started out with identifying the highest-risk providers. So our initial efforts were focused on people that we considered to be the highest risk. And those included people that we had reason to believe were not licensed to practice in the States in which they were eligible for Medicare, or they were not in the national database, they were only in the local systems. There were a number of criteria that we used to identify them.

So we started out by running all 800,000 physicians who were in the national database through the automated provider screening system to identify the ones who did not appear to be licensed in the place in which they were allowed—in which they had Medicare billing privileges. And so we examined those. And those represented a fair number of the ones——

Mr. PLATTS. Of that 800,000, about how many of the 800,000 came back as not being licensed?

Dr. BUDETTI. It was a fairly significant—I don't have it in front of me, but I would be happy to get it to you.

We then proceeded to run all 1.5 million providers and suppliers through the automated provider screening system to establish a baseline for future analysis, because we are doing several things. Not only are we in the process of revalidating all 1.5 million providers and suppliers, but we are also in the automated provider screening system putting into place an alert system. And the alert system will tell us between times, not just at enrollment, not just at revalidation, but if somebody dies, if somebody is convicted of a felony that is relevant for our concerns, if somebody loses their license, we will get pop-up alerts to that effect so that we can take action without waiting for the revalidation period. This is all new.

Most of what was done in the past was being done manually, and was substantially less efficient, I would say. So now at the same time that we are enrolling our new applicants, because we do get approximately 20,000 new applicants per month to be providers and suppliers of Medicare and Medicaid—in Medicare, we are also engaged in the revalidation process that has gone on, as you said. So the numbers may be a little different when we have finished with everybody because we started with the highest-risk weight.

Mr. PLATTS. So that 8 to 10 percent probably is high because you were specifically targeting the high risk.

Dr. BUDETTI. Yes.

Mr. PLATTS. But as you say, even if it is 1 percent, 15,000, it is still a huge——

Dr. BUDETTI. We should do something about it. Know about it and do something about it.

Mr. PLATTS. Yeah. That use of technology in the screening and the rescreening and those flags that go up that if there is a delicensing I think is critical to ultimately getting to where we want to be.

Ms. Maxwell, in your testimony you talk about States that have participated with CMS on Medicaid not very effectively, and you reference two States that have withdrawn, and one in particular that in participating in the partnership had only recovered a minimal amount, a couple thousand dollars, but when they withdrew they recovered about $28 million. Are you able to identify which State that was that withdrew and what did they do different, to the best of your knowledge, that was so much more effective?

Ms. MAXWELL. I am able to identify that State. It is the State of Washington. And it is my understanding that the $28.9 million that they recovered was part of their ongoing State Medicaid program integrity efforts.

Mr. PLATTS. Are you aware of what their efforts were that were so different that they succeeded significantly better than in the partnership with CMS?

Ms. MAXWELL. No, I am not aware of what they were doing that was different.

Mr. PLATTS. Why I ask that is that seems like that is an example of a State that has a good State-based program in place that, perhaps with the Medicare Integrity Institute at CMS, that we would want to look at to try to share that approach with other States—maybe will match up, maybe not, depending upon the comparison of States—but that we learn from those best practices out there and get that information shared.

So Dr. Budetti, are you familiar with what the Washington State had done and whether that has been looked at to replicate elsewhere?

Dr. BUDETTI. I can't speak exact precisely to that, but I can tell you that we have put into place a system of identifying best practices and sharing that among all of the States. We have an active process for doing that, as well as bringing people together. We have now passed the 3,000 State employees who have been trained down at the Medicaid Integrity Institute. And one of the activities that goes on certainly is networking and sharing of best practices. If you would like a little more information on the Washington program, I would be happy to get it for you. But I do know that we do certainly work our program integrity. Our Medicaid program integrity activities certainly have been very supportive for all the States, including Washington.

Mr. PLATTS. If there is any information that you have available regarding Washington State and perhaps what they did different that seemed to be much more effective than what had been done in that partnership, that would be great.

I see my time has well expired. So I yield to the ranking member for questions.

Mr. TOWNS. Thank you very much, Mr. Chairman. Let me begin with you, Ms. Maxwell. Does OIG use any cutting-edge technology tools of its own to help fight fraud?

Ms. MAXWELL. Yes. The Office of Inspector General has increasingly used a data-driven approach. We have developed our own data warehouse that allows for the collection of data across the Medicare programs, and we mine that. In particular, we have used that approach in our strike force efforts. Since 2009, HHS and DOJ have created rapid response investigative teams in nine cities around the country, and those cities are targeted through the use of data.

Mr. TOWNS. Could you comment on the effective tools that CMS is using in terms of tools they have in place and they are using, and the new ones that have been implemented? Could you comment on that?

Ms. MAXWELL. The study that I am prepared to speak on focused primarily on Medicaid program integrity. And the tools I believe you are referencing are on the Medicare side, so I don't have any comment on those.

Mr. TOWNS. All right. Let me ask you, Ms. Yocom or Mrs. King, is it necessary to have so many categories of contractors? Can't we consolidate some of the roles and still reach our objective?

Ms. KING. I think on the Medicare side, since its inception Medicare has largely been run by contractors. There has been some significant consolidation on the Medicare side. It used to be that there were organizations called carriers and intermediaries that processed Medicare fee-for-service claims. They have been consolidated into the Medicare administrative contractors. And now there are many fewer of them. And also the program safeguard contractors have been consolidated up to the same level as the Medicare administrative contractors.

That said, there are still different types of contractors that have specific functions. But you know, I don't know that that is—it is not something that we have looked at, but I don't know on its face that that would be inappropriate.

Ms. YOCOM. Sir, on the Medicaid side, GAO does have some ongoing work that is looking at some of the contractors that are participating in the Medicaid integrity group. And that will be out this summer.

Mr. TOWNS. All right. Let me ask this. When you make recommendations, do they follow it?

Ms. KING. Largely. That is something that we keep track of. And we go back once a year and we look at that. And I think that our track record is many more recommendations are adopted than not, of those that the agency agrees with.

Ms. YOCOM. Overall, it is about 80 percent of our recommendations get acted on by the agencies that we review.

Mr. TOWNS. Are the ones that they do not adopt, are they saying that it is a lack of resources?

Ms. YOCOM. I think it would be hard to describe at a global level what the reasons are. Sometimes it may be resources, sometimes

it may also just be that they disagree and they don't believe it is a high enough priority.

Ms. KING. Sometimes I think it is conflicting priorities. The agency has a lot of work to do, and we make recommendations, and they are in agreement with them, but they have higher priorities that bump them.

Mr. TOWNS. Right. Let me conclude, Ms. Maxwell, with you. How widespread is the problem of lack of oversight of contractors? And what is the ultimate effect on program integrity?

Ms. MAXWELL. Speaking with respect to the Medicaid program that our reports touch upon, we did find instances of lack of contract oversight by CMS, as I had mentioned. The contractor was not held accountable to all the tasks in its statement of work. On the Medi-Medi side, the annual assessment of the Medicaid—the Medicare program integrity contractor that runs that program did not actually assess all of the variables in that task order.

Mr. TOWNS. I see, Mr. Chairman, my time has expired, so I yield back.

Mr. PLATTS. Okay. I thank the gentleman. Just a quick follow-up before I go to the gentleman from Oklahoma. On that failure to fulfill all the task orders, all the requirements, was there any consequences for not doing that that you are aware of?

Ms. MAXWELL. No. What we were told is that at the time—which was early in the program—CMS did not expect for the contractors to fulfill these particular aspects of their statement of work. It is my understanding that they have changed, and they are now holding the contractors more accountable to all the tasks in their contract.

Mr. PLATTS. Thank you. Yield to the gentleman from Oklahoma.

Mr. LANKFORD. Thank you. Let me do a quick follow up statement, finish out talking about the RAC audits. I do have a statement from the AMA about the RAC audits I would like to be added into the record.

Mr. PLATTS. Without objection, so ordered.

Mr. LANKFORD. Questions and issues that they had as well. Is there a system in place—still with coding and billing, some of those things are automated. Obviously, when they go through an audit they can get a chance to look at those, and those will bounce up. When I do my taxes, I go through a program, at the end of it, it comes back and does a red flag for me on everything and says, okay, double-check and make sure this is contract.

For providers, do they have any system like that so that before someone comes in and does a RAC audit, someone is checked and rechecked locally, this might come up as a question? This is not consistent with typical billing. Is there anything like that that is in place for the providers?

Dr. BUDETTI. I do know that there are a number of reasons why claims are not accepted the first time around and providers get information back on the claims. But I really can't speak to that, exactly that point in detail.

Mr. LANKFORD. This is submitted online. It is submitted through a program, right?

Dr. BUDETTI. Most of those are now, yes.

Mr. LANKFORD. Right. That is what I assume. So what I am asking, is there a way to be able to set that up so it is built so it checks it locally before they ever submit it, that there is a quick verification of that to say double-check this line was left out, this code seems to be inconsistent with this one?

Ms. KING. That is not something that we have ever looked at. But my understanding is that the providers do use software billing programs that would enable them to check for those kinds of things.

Mr. LANKFORD. Okay. But you are saying that is not something that——

Ms. KING. That we have looked at.

Mr. LANKFORD. They purchase a separate one that actually attaches to a third-party software somewhere that does that?

Ms. KING. Yes, sir.

Mr. LANKFORD. Because obviously the goal of this is that it is right the first time, not that we are paying chasing, and not that we are trying to do a RAC audit to be able to come down on someone on that.

Ms. YOCOM. Our statement does talk about CMS's efforts on the Medicaid side in this area looking for prepayment edits. CMS has to date looked primarily just at the process for doing this, not necessarily at the content of the individual edits. They have identified some notable practices, some of which sort of stop the claim and identify what information is necessary.

Ms. KING. And on the Medicare side, we are doing a significant amount of work on Medicare prepayment edits so that Medicare would not pay claims that are not in conformance with its policies or for providers who are not eligible. But I think that you were asking questions that, you know, on the provider side, what do they do so that by the time they submit a claim it is clean.

Mr. LANKFORD. That is correct. The goal is that when it is submitted it is clean, it has been checked and rechecked, and then they have some confidence that this is going through on it.

Ms. Maxwell, I am very concerned on the data matching, the Medi-Medi program, in your testimony that in previous years we spent $60 million on a program that recouped $57.8 million. That doesn't seem like a real great investment in the process. The question is, is this a program that can be improved? Is this a program that needs to be terminated? Are there ideas that have been submitted to what to do with it at this point?

Ms. MAXWELL. The core issue that I bring up in the testimony today is the fact that the program is supposed to be matching Medicare and Medicaid data, and yet it doesn't have the Medicaid data to match. So it is perhaps not surprising that they are not finding as much as they would expect. And certainly they are finding very, very little on the Medicaid side for that reason as well. So to improve that program, as well as the MIC program that we talk about, really it goes back to the Medicaid data. We absolutely need national standardized Medicaid data to make these programs worthwhile.

Mr. LANKFORD. Is there a reason that the Medicaid data can't be standardized to the Medicare data as far as how it is drawn in

from a provider—obviously, most providers do both anyway—that those systems can't be consistent?

Dr. BUDETTI. Just to engage this a little bit, Mr. Lankford, the Medi-Medi program operates on a State-by-State basis, so that the contractors who are actually the Medicare investigative contractors work with the State. And as I said before when I was talking about expanding our collaborative audits, we believe that this is a framework that we can use for enhancing our ability to work with the individual States. We have some 15 States now, representing well over half of all Medicaid expenditures, that are in the Medi-Medi program. A couple of those State's, or one in particular we believe, has recently shown that with appropriate use of the Medi-Medi approach, it can have very substantial returns. And so we believe that this is a way for us to build out part of our collaborative approach with the States because of being onsite with the States, working directly with them, and engaging them with both the Medicare and Medicaid data.

Mr. LANKFORD. So what is an appropriate return? Obviously, you know, spending as much as you get back in is not an appropriate return.

Dr. BUDETTI. No. The return that we are seeing in more recent times is much higher than that. I don't have the numbers in front of me, but I would be delighted to share them with the committee, because we believe they are very positive. But we don't—we think there is more to do. There is definitely still more to do.

Mr. LANKFORD. Thank you. With that, I yield back.

Mr. PLATTS. Thank the gentleman. I have just a couple final questions I want to try to get into the record, and then I apologize, I have got a markup going on down the hall in Ed & Workforce, and have amendments I need to get there to offer. But a quick follow-up on the Medi-Medi issue and the States' compliance or provision of data.

Ms. Maxwell, in your testimony you reference that while there is Medicare Part A, B, and D information in, when it comes to Medicaid, the projected time frame is another 3 years, 2015.

And Dr. Budetti, would you agree with that projection? And if so, why another 3 years before—you know, that is 3 more years of lack of information to act on to prevent fraud and improper payments.

Dr. BUDETTI. Our current target is 2014, not 2015, I believe, for the full—for getting the Medicaid data into the integrated data repository, which then is accessed through the One PI system. But I agree with you that we can't just sit and wait for those data to be available. That is why we have our pilots underway, to identify the best way to do this, and to get States actively pursuing doing this, and why we are also engaging the States in a hands-on collaborative way so that we are not just dependent on the data that flow to us.

Mr. PLATTS. Right. Is there a point where—and maybe you are already thinking of this or looking at this—where you look at the Medi-Medi system and IDR versus your FPS and your APS systems that you have now put in place and say Listen, we have just got to cut our losses and move onto what apparently appears to be more effective, as opposed to trying to fix what has been going on for years in these older systems?

Dr. BUDETTI. Thank you for raising that question, because that is actually a very important aspect of the fraud prevention system is that it involves streaming data, live data. It is as if you were, I don't know, looking at all of the publications that were coming out every day and screening through them for certain problems. Whereas the IDR is more like the Library of Congress that has all of the reserve data in it, which is extremely important for a number of purposes, not just program integrity purposes, but a number of different activities in CMS depend upon and use the IDR. But the IDR is also the warehouse, the data warehouse upon which our models for the fraud prevention system are based. Because if you have 5 or 6 years' worth of data, we can build very sophisticated models, and then we put them into place to catch the streaming data on the fraud prevention side.

So the two go hand in hand. One is not replacing the other. In fact, they are very much a combined approach. And both are extremely relevant. And the IDR for many aspects is an extremely valuable tool that gets more important all the time.

Mr. PLATTS. So if you get that State data in there on the Medicaid side, the IDR, all the more effective the traditional approach is going to be to allow that One PI system to better work. But also your new approach——

Dr. BUDETTI. Yes.

Mr. PLATTS. —and developing those analytics to really say, you know, what is the pattern of fraud that we then try to put in those flags in going forward.

Dr. BUDETTI. That is exactly right. They are intimately related. The one is kind of the cornerstone of the other. It also allows us to test the models ahead of time, before putting them into place, by looking at historical data.

Mr. PLATTS. Great. I won't be in this chair a year from now or 2 years from now, where hopefully all of this is more fulfilled. Whether that is a colleague on my side of the aisle—I am biased that we stay in the majority—or Mr. Towns returns to the chair, as he and I have switched positions here a number of times—remains to be seen. But I am certain whether it is under the leadership of Chairman Issa and the full committee, or Mr. Towns on the Democratic side, the importance of these issues are going to continue to be looked at by this subcommittee, whoever is in this chair. And we certainly want to have success in going forward.

A final question, and I have got probably 12 more I would like to ask but not the time to do so. And I am going to conclude with I am going to say two quick ones, and I will say quick.

But first is Dr. Budetti, with getting that State data in, I mean the way I read it is there are regs and requirements in place that the States have not adequately complied with as far as providing the data that they are supposed to. Is that a fair statement? And if so, what, if any, consequences have been threatened to the States to help ensure compliance? Because we are giving them one heck of a lot of money. And if they don't want to comply with what we think is necessary oversight and protection against fraud and misuse, you know, they need to understand that they can't just continue on.

Dr. BUDETTI. So the States have been cooperating with the existing requests which constitutes the Medicaid Statistical Information System data. What we need to do now is to flesh out exactly what data elements and what formats and what periodicity, and so all the details of reporting data from the States that we need to put into the new data that we are going to be collecting from the States. And that is a work that is taking some time. The States have different data systems. They have different ways of handling the data. And so we need to build that out extensively. But we do anticipate that we will learn from the transformed Medicaid Statistical Information System project, and we will then be able to do that.

Yes, Mr. Platts, under the Affordable Care Act we can hold the States accountable for doing that. We want to make sure that we are doing it in a way that is supportive for them and for us, and to get it done in a way that is not disruptive.

Mr. PLATTS. Certainly the carrot versus the stick approach hopefully is effective. But the States, are they being made aware that yes, you will comply with this? We want to work hand in hand with you, but ultimately if you don't, there is a stick available as well to ensure compliance in some form?

Dr. BUDETTI. The Affordable Care Act spells that out quite nicely, yes.

Mr. PLATTS. Final question to Ms. Yocom and Ms. King. You know, GAO over the years has made a lot of recommendations, some of which have been embraced, others that haven't. If you had to highlight one or two of your recommendations that you would see as most important to ensuring program integrity and what you would estimate the effectiveness of those recommendations would be in reducing that $65 billion improper payments number, what would that one or two recommendations be?

Ms. YOCOM. Well, on the Medicaid side some of our recommendations are yet to come, and will be forthcoming soon. I think the big areas where CMS needs to focus are on continuing to work with the States on the data, continuing to collaborate with States on program integrity issues. And the collaborative audits are a very promising approach. We do think that their refocused view is a good one.

Mr. PLATTS. And certainly in the testimony, the collaborative approach has had much greater success than the prior efforts kind of going——

Ms. YOCOM. That is correct. Yeah.

Mr. PLATTS. Yeah. Ms. King?

Ms. KING. And on the Medicare side, I think that we believe that CMS has taken some very important steps in the last couple of years. Certainly the new provider enrollment screening measures, the implementation of the fraud prevention system, which we are currently evaluating. And we are also looking at prepayment edits. So we will have more to say about that later. But certainly we see a positive direction.

Mr. PLATTS. Okay. Thank you. Mr. Towns?

Mr. TOWNS. Let me begin by thanking you, Mr. Chairman, for saying that I might be in the chair. But I need to let you know I am retiring after 30 years.

Mr. PLATTS. Actually, Mr. Towns, I apologize. We are both going to be gone. So somebody will be in both of these chairs.

Mr. TOWNS. I just want to make that clear. Thank you so much. But let me also ask, Mr. Chairman, that we hold the record open to get the information that we requested in reference to the indictment and conviction numbers. I would like to get that to see in terms of what the rate, you know, of conviction is versus indictment.

And of course I wanted to say again, Mr. Chairman, that I really feel that we still have a lot of work to do. And I think that my question at this point in time would be what can we do on this side that might be helpful to you? You know, sometimes as legislators, we just point our finger and point our finger and point our finger. But we want to really, really come up with a solution. So if there is something that we need to do, let us know. I mean you can say it now or you can put it to us in writing. Because we would like to just correct it. Because there is still some serious problems. And the fact that—I think that information in is important. And if you are not getting the proper information in, then it is not going to help you in the end. So if you have suggestions to us as to what we might be able to do, I entertain that in my next few seconds.

Ms. KING. Mr. Towns, if I just might clarify, we are working to identify the rates of investigations and convictions in both the criminal and civil fraud matters. And we have taken 2005 as a base year, and we are comparing it to 2010. That work is not quite done yet, but will be done later this year.

Mr. TOWNS. Okay. Fine. So we should not hold the record open, you are saying, to get the information. I mean, what are you saying?

Ms. KING. No, don't hold the record open because it is not done yet. But we are close to finishing it.

Mr. TOWNS. But you will give us the information before I retire?

Ms. KING. Yes, sir.

Mr. TOWNS. Thank you. Thank you, Mr. Chairman.

Mr. PLATTS. Thank the gentleman. We will keep the record open for 2 weeks for that follow-on information that has been requested. Certainly appreciate that.

Also, I would ask unanimous consent, I have a statement for the record from the National Association of Medicaid Directors that focuses on their concern about the duplication of efforts at the Federal and State level, and the importance of a seamless coordination so we are not spending money on replicating what either we are already doing at the Federal level or at the State level or vice versa. So without objection, so ordered.

I want to thank all of our witnesses again. And you know, I think that as I read through the testimony in preparation for the hearing, and the staff's leg work in preparing and what we heard today, is there are a lot of concerns about what has transpired in the past and the ineffectiveness of program integrity efforts. And as Mr. Lankford identified, one example where $60 million spent to recoup less than that, obviously that is not a good cost-benefit to the American taxpayers. But I also think that what comes through is that CMS, in conjunction with the Inspector General's Office and GAO, is working forward in a way that is learning from

the mistakes of the past and learning what worked in the past, such as collaborative efforts versus other approaches, and seeking to put in place a truly effective program integrity system that will bring down that improper payments number hopefully dramatically in the years ahead. Because in doing so, we help us address both the debt that we have as a Nation, but also those dollars are truly benefiting those in need of these health-care services, whether it be Medicaid or Medicare, as opposed to lining the pockets of criminals and wrongdoers. So I am encouraged that we are headed in the right direction, as we need to.

The ranking member and I do have about 7 months left, so that gives us 7 more months to work with, not torment you in this partnership approach. And we look forward to that continued dialogue as we go forward. So this hearing stands adjourned.

[Whereupon, at 11:14 a.m., the subcommittee was adjourned.]

Rep. Platts Opening Statement
"Assessing Medicare and Medicaid Program Integrity"
June 7, 2012

The purpose of today's hearing is to assess the fiscal integrity of the Medicare and Medicaid programs.

This is the third in a series of hearings the Government Organization Subcommittee has held this Congress focusing on issues within Medicare and Medicaid. Last July, the Subcommittee held a hearing on improper payments made through the Medicare program.

In December, we heard testimony from Richard West, a disabled Vietnam War veteran who had to file a whistleblower lawsuit before the government would investigate his Medicaid provider. When the government finally did investigate, it resulted in a $150 million settlement, the largest recovery ever in home health care fraud.

We have learned from these hearings that there are significant problems concerning Medicare and Medicaid program integrity.

Medicare and Medicaid are both extremely susceptible to waste, fraud, and abuse. Due to their vulnerability to fraud and improper payments, both programs appear regularly on the "high-risk list" compiled by the Government Accountability Office (GAO).

In Fiscal Year 2011, the Department of Health and Human Services (HHS) identified $64.8 billion in improper payments for both these programs. This amounts to over 56 percent of *all* improper payments identified by the government for that year.

Due to the size and complexity of Medicare and Medicaid, strong oversight and accountability is imperative.

Congress has given funding to the Centers for Medicare and Medicaid Services (CMS) since 1996 to implement several program integrity initiatives for Medicare and Medicaid. Additionally, CMS works in outside partnerships with private contractors and several federal and state entities to identify and prosecute Medicare and Medicaid related fraud. However, CMS has still had difficulty improving the fiscal integrity of these programs.

One significant area of concern is data quality. Reliable, accurate data is essential to prevent fraud, waste, and abuse in Medicare and Medicaid. Unfortunately, reports have consistently shown that CMS's many data systems are uncoordinated, ineffective and underutilized.

In 2006, CMS initiated two additional data systems to improve data quality and access. However, GAO issued a report finding that both systems were inadequate and that only seven percent of program officials actually used the programs to analyze data.[1] GAO also could not find any evidence of financial benefits in implementing the new systems, despite the fact that CMS has been using them for over five years.

There are also problems with state-reported data. Many states are not reporting all required data, and there are often lag times of up to a year between when states report data and when CMS receives and verifies it. The Office of the Inspector General for HHS (HHS OIG) also found that much of the information that was reported in these systems is not useful for fraud, waste, and abuse detection.[2]

In April 2012, the HHS OIG uncovered even more problems with CMS' program integrity initiatives when it released its report on the Medicare-Medicaid Data Match Program. This program is supposed to allow State

[1] GAO, *Fraud Detection Systems: Centers for Medicare and Medicaid Services Needs to Ensure More Widespread Use*, June 2011, p. 2, http://www.gao.gov/new.items/d11475.pdf.
[2] HHS OIG, *MSIS Data Usefulness for Detecting Fraud, Waste, and Abuse*, August 26, 2009, http://oig.hhs.gov/oei/reports/oei-04-07-00240.pdf.

and Federal Government agencies to analyze Medicare and Medicaid data jointly to identify potential fraud, but the HHS OIG found that the program costs more to run than it saves. CMS claims to have made significant strides in enhancing the effectiveness of the program, but has not produced any evidence of these changes.[3]

GAO and HHS OIG have both made numerous recommendations to CMS to improve program integrity for Medicare and Medicaid, but many of these recommendations have not been implemented. Our hearing today will review these recommendations and examine why CMS has not followed them.

The American people deserve a government that safeguards their tax dollars and spends them wisely. Unfortunately, CMS has not effectively overseen Medicare and Medicaid, which has led to billions of dollars of waste each year. We must do more to strengthen the integrity of these programs and increase the accountability of government spending.

I look forward to hearing the testimony of our witnesses today about how best this task can be accomplished.

[3] HHS OIG, *The Medicare-Medicaid (Medi-Medi) Data Match Program*, April 2012, http://oig.hhs.gov/oei/reports/oei-09-08-00370.pdf

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STATEMENT
OF
CONGRESSWOMAN MICHELE BACHMANN
BEFORE THE
OVERSIGHT AND GOVERNMENT REFORM
SUBCOMMITTEE ON GOVERNMENT ORGANIZATION, EFFICIENCY
AND FINANCIAL MANAGEMENT HEARING

"ASSESSING MEDICARE AND MEDICAID PROGRAM INTEGRITY"

Chairman Platts, Ranking Member Towns, and Committee Members, thank you for your attention to the critical condition of Medicaid's program integrity.

In April, I testified in a joint hearing of two Oversight Committee subcommittees on the complete lack of reporting, collection, and verification of meaningful data in Medicaid. The staff report from that hearing stated, "Minnesota provides a stunning example of how states are failing to properly ensure the appropriate use of taxpayer dollars spent on Medicaid managed care."

In order for states to ensure the appropriate use of taxpayer dollars, they must be able and willing to collect the data that shows how much is paid in a claim, for what, and to whom. Since the investigation into Minnesota Medicaid fraud has unfolded, several implicated parties have begun to offer up excuses. According to the trade organization for the managed care organizations (MCOs), the Department of Human Services (DHS) actually has the data but not the ability to analyze it. They say the state's computer system is too antiquated.

But in contradiction to this, a DHS Assistant Commissioner said that the data "is literally analyzed by DHS on a daily basis, and has been for years."

Now either the trade association representing the health plans is fudging, or DHS is.

It's our job to immediately get to the bottom of this. CMS is already tasked with identifying patterns or instances of fraud and abuse in Medicare and Medicaid, but despite that, they are requiring no documented data.

This month I am introducing a bill that will hold CMS accountable to ensure stated audits are conducted properly.

But because this situation needs immediate attention, I am proud to announce that I am sending a letter today to CMS, calling for an immediate third-party, independent audit of Minnesota's books.

We cannot allow taxpayer dollars to flow without proper record keeping ever again.

Thank you again to the committee and I yield back.

Statement of Congressman Gerald E. Connolly (VA-11)
Subcommittee on Government Organization, Efficiency and Financial Management
Assessing Medicare and Medicaid Program Integrity
June 7, 2012

Thank you, Chairman Platts, for holding this important hearing to examine the Centers for Medicare and Medicaid Services' (CMS) efforts to root out waste, fraud, and abuse. I also want to commend the Chairman for his longstanding commitment to holding CMS accountable for reducing improper payments to enhance the integrity of the Medicare and Medicaid programs.

As my colleagues know, it is imperative that we remain committed to eliminating the unacceptable improper payments that threaten the solvency of Medicare and Medicaid. These vital programs provide health care coverage to over 100 million people across the Nation, many of whom comprise the most vulnerable segments of our society, impoverished children and seniors.

It also is worth noting that the pervasive problem of improper payments in Medicare and Medicaid is a decades-old, structural issue resulting from each program's daunting size, scope, and complexity, which are commensurate with their level of importance to the well-being of millions of Americans. Indeed, Medicare has been on the Government Accountability Office's (GAO) "high risk" list since 1990, and Medicaid has been featured on the list since 2003. Clearly the challenge of improving CMS's efficiency and effectiveness to eliminate improper payments transcends administrations, politics, and may in fact represent one of the few opportunities for pragmatic Members of Congress to roll up our sleeves and work together in a bipartisan fashion to both reduce the deficit, and improve the lives of millions of Americans.

I am particularly interested in focusing today on how CMS is leveraging the authorities provided by the Affordable Care Act to bolster the agency's information technology tools to detect and prevent fraudulent and improper payments. Unfortunately, as both GAO and the CMS Office of Inspector General will discuss at today's hearing, the initial results of these IT tools have yet to yield the desired results in terms of concrete cost-savings and enhanced enforcement. I look forward to examining the lessons CMS has learned from these early efforts, and working with the Chairman to ensure CMS fully implements the GAO and OIG recommendations addressing the need to enhance contracting performance standards, strategic planning, and performance reporting.

Finally, I must mention that additional hearings and legislation, if necessary, may be beneficial in spurring CMS to step up its program integrity efforts. However, we should all recognize that our ultimate success in targeting and eliminating improper Medicare and Medicaid payments will depend on the dedicated work of our highly-skilled Federal employees. Indiscriminate cuts to the Federal workforce, which we have tasked with implementing program integrity initiatives, will sabotage these efforts. We are sitting on a potential gold mine of savings for American taxpayers, and now is not the time to be pound wise and penny foolish.

Chairman Platts, thank you again for your leadership on this issue. I look forward to our continued collaboration in maintaining oversight of improper payments, and to the testimony of our witnesses.

Statement for the Record Submitted on Behalf of the Council For Quality Respiratory Care

United States House Oversight and Government Reform Committee
Subcommittee on Government Organization, Efficiency, and Financial Management

Hearing on "Assessing Medicare and Medicaid Program Integrity"

June 7, 2012

The Council for Quality Respiratory Care (CQRC) appreciates the opportunity to submit this written statement for the record of the June 7, 2012, U.S. House Committee on Oversight and Government Reform Subcommittee on Government Organization, Efficiency, and Financial Management hearing entitled "Assessing Medicare and Medicaid Program Integrity." CQRC applauds the Subcommittee's Leadership and Members for holding this hearing to help ensure the integrity of the Medicare program. CQRC strongly supports efforts to eliminate fraud and abuse in the Medicare program and has worked with Congress and the Centers for Medicare and Medicaid Services (CMS) on this important initiative. Unfortunately, recent overzealous auditing activity by Medicare contractors threatens beneficiary access and supplier viability—without advancing the goal of eliminating fraud in the Medicare program. These misguided activities result in an enormous waste of resources that detract funds away from stopping actual fraud. We call on Congress to oversee the activities of its contractors to ensure they are balanced and fair.

CQRC Supports Eliminating Fraud and Abuse in the Medicare Program

As you recall, the CQRC is a coalition of the nation's six leading home oxygen therapy providers and two manufacturers of high quality respiratory and other home medical equipment. Together, we provide in-home patient services and respiratory equipment to more than 600,000 (the majority) of the more than one million Medicare beneficiaries who rely upon home oxygen therapy to maintain their independence and enhance their quality of life. Our members also employ approximately 35,000 people in the United States.

The CQRC strongly supports eliminating fraud and abuse in the Medicare program. These efforts must be rational, balanced, and targeted to ensure that scarce Medicare funds are directed at activities that appropriately need to be curtailed. CMS should ensure adherence to program requirements without unnecessary burdening legitimate suppliers, physicians, and beneficiaries.

Current Contractor Auditing Activity Does Not Reflect a Balanced Approach

Despite the ongoing cooperation and support CQRC members provide in fighting fraud and abuse, the volume of recent auditing efforts has increased ten-fold. In many of these cases, the resulting denials received do not relate to actual fraudulent activity, but rather involve auditors retroactively applying new rules, ignoring documents submitted, and misinterpreting or overzealously searching for technical errors in Medicare requirements.

It is not clear whether the contractor behavior is due to a lack of training, a desire to be overly aggressive, mis-aligned incentives in the administration of the audit programs, or other reasons. If left unchecked, however, such overregulation will cripple the private market and place the home respiratory therapy benefit (particularly for oxygen and sleep therapy) at risk.

What is clear is that millions of dollars are wasted through the appeals process only to have these denials overturned by Administrative Law Judges. Thus, any savings amounts based upon initial denial statistics are substantially overstated. Given the egregious nature of some of the audit results, we anticipate that approximately 90 percent of the denials will be overturned through the lengthy review process.

Current Auditing Activity Is Likely to Cause Access Problems for Beneficiaries
The burdensome auditing activities are likely to result in serious access problems for beneficiaries as suppliers find it more difficult, if not impossible, to provide services without being paid for them in a timely manner because of pre-payment review status. For example, if a supplier is not paid for services and equipment for what could be three or more years during the audit process, it is unlikely the supplier will assume the risk of not being paid for that period of time. It will not be in a position to continue serving the beneficiaries, unless the beneficiaries agree to pay out of pocket. If a supplier were to take such risk and won on appeal, beneficiaries would then be forced to pay multiple years of co-payments. It is unfair to beneficiaries not to require audit contractors to get it right during the initial review. The current auditing practices will result in a de facto elimination of the Medicare home respiratory benefit.

Audits Lack Transparency and Provide Insufficient Information
Additionally, the audits lack transparency and clarity so it is often impossible to understand the reason behind the denial. Auditors often use boilerplate language that does not explain the reason for a denial, making it almost impossible for a supplier to understand why the documentation submitted was insufficient. These audits result in repetitive denials of payment for services provided to beneficiaries who unquestionably qualify for coverage.

Contractors Have Created Inefficiencies with Inconsistent Auditing Requirements
Contractors are going above and beyond CMS requirements by instituting burdensome, and in many cases nonsensical, requirements. The implementation of the audits has been highly inefficient, costly, inconsistent, and burdensome for both providers and the federal government. Examples of the problematic audits include:

- ***Denials that apply new documentation requirements to periods prior to the carrier's communication of new requirements.*** Often the documents requested do not exist because physicians who create the records did not previously generate these documents since there was no requirement to do so at the time. In other instances, the rules themselves have not changed, but in applying them carriers have changed the extent of the documentation that they deem to be acceptable. Suppliers are expected to play "catch up" by obtaining medical records that are 5 or 10 years old, were never requested in past audits, and have little or no bearing on the beneficiary's current medical need for oxygen. A recent pilot project in which the contractors focus only on initial claims we believe will demonstrate a substantial decrease

in the error rate; however the project only became effective in late March/early April, so it is too early to make any conclusions. We strongly urge CMS to continue this project for at least one year and to share the data results (distinguishing among the different reasons for denials) with the industry on an ongoing basis.

- ***Denials even though the supplier submits the required documents.*** For example, a denial may be noted as an illegible physician signature even though the physician signs and types or prints his/her name or the record is clearly part of an authentic hospital record, with entries from multiple parties, only some of which have not provided signature attestations.

- ***Denials because a specified document was not provided even though the auditor did not request the document in its detailed document request letter.*** In some cases when an auditor supplements its request for records and the supplier complies, the carrier fails to correlate the new information with the previous file and denies the claims. Although the auditor has authority to reopen the claim and resolve the matter quickly, it routinely subjects the supplier to another level of appeal, additional payment delay, and additional administrative costs.

- ***Denials when the same patient is being audited for multiple service dates.*** Even if the supplier sends a single set of documents that are accepted for one of the service dates as sufficient, the auditor deems the documents not adequate to support medical need for the other dates of service for the same patient.

- ***Denials because an auditor misinterprets Medicare requirements.*** For example, the audit contractor refuses to allow suppliers to be paid for supplies shipped based upon a corrected physician's prescription when the CMS manual clearly recognizes that such corrections or clarifications to physician orders will be effective as of the original or initial date of service

- ***Denials of claims submitted by a supplier who has taken over patients from another supplier that went out of business because the prior supplier did not adequately respond to an audit for the patient.***

- ***Denials of supplies without notice to the supplier because patient owns the equipment used to administer the drug.*** In some cases, carriers have denied payment for important home respiratory therapy medicines because Medicare has no record of paying for the patient's nebulizer. The carrier did not seek clarification as to why there might not be such a record (for example, the patient owns the nebulizer already or it was paid for by a different health plan)

Congress Should Oversee the Audit Process to Ensure that it is Balanced and Fair

CQRC is committed to fighting fraud and abuse and working with Congress to identify appropriate solutions that protect the Medicare program. Contactor audits must be implemented in a manner that balances both the goal of combating fraud and abuse with the practical realities that suppliers and beneficiaries face. Without Congressional oversight, precious audit resources will continue to be misspent on activities that do not effectively reduce fraud and abuse.

CQRC looks forward to working with Congress to ensure a rational, fair, and effective solution to the severe problems caused by current auditing activities. Should you have any further questions, please do not hesitate to contact Kathy Lester at (202) 457-6000.

CRQC Members

Aerocare Holdings, Inc.
American HomePatient, Inc.
Apria Healthcare
Lincare Holdings
Pacific Pulmonary Services
Rotech Healthcare, Inc.
Philips Home Healthcare Solutions
ResMed Inc.

Statement of the

American Medical Association

before the

House Committee on Oversight & Government Reform
Government Organization, Efficiency, and Financial Management Subcommittee

RE: Assessing Medicare and Medicaid Program Integrity

June 7, 2012

The American Medical Association (AMA) is pleased to provide the Government Organization, Efficiency, and Financial Management Subcommittee of the Committee on Oversight & Government Reform with information regarding Medicare and Medicaid program integrity initiatives.

Physicians are firmly committed to eradicating fraud and abuse from the federal health care programs. Monies that inappropriately flow from the federal health care programs divert vital resources that should be devoted to patient care. The AMA has long believed that the most efficient way to combat fraud is to employ targeted, streamlined methods of fraud identification and enforcement, rather than overly burdensome requirements for all physicians, the majority of whom strive to comply with the rules and regulations governing participation in the Medicare program.

Physicians are also concerned about efforts to recoup improper payments, which often occur in the absence of fraud. Many physicians are unaware when they are incorrectly documenting or billing. Others are confused about frequent changes to Medicare payment policy and are overwhelmed by divergent billing requirements and guidance. The AMA believes that burdensome audits and payment reviews are not the most efficient way to reduce the health care programs improper payment rate. Rather, education regarding payment and documentation policies, with an eye toward statistical outlier billing patterns, is the most efficient way to effectively reduce the improper payment rate.

Combating Fraud

Predictive modeling and data analytics, if employed properly, can result in more efficient health care fraud identification. Seamless fraud detection methods that move from "pay and chase" to identify aberrant billing patterns and activity can be the way forward from onerous post-payment activities, which can be expensive for the federal government and physicians. However, because claims coding and documentation implicates complicated clinical issues, such efforts must be coupled with physician input and ongoing review.

Coordination among law enforcement agencies is also an effective tool to prevent fraud. The AMA has recently engaged in regional health care fraud summits convened by the Department of Health and Human Services (HHS) Office of Inspector General, the Department of Justice (DOJ), CMS, and local law enforcement to collaborate on new methods for fighting fraud. Integral to this inter-agency effort is the use of Health Care Fraud Prevention and Fraud Enforcement

(HEAT) Teams, which have contributed to record recoveries in the past several years. These efforts are consistent with AMA objectives to employ focused fraud investigations that are less likely to waste taxpayer or physician resources.

Physician identity theft also poses a threat to the federal health care programs. Earlier this week a member of a crime ring that stole physicians' identities to perpetrate a $18.9 million Medicare fraud scheme was found guilty. (*United States v Shagoyan*, C.D. Cal., No. CR 08-01084, *verdict* 6/1/12). Physician identities are vulnerable because physician identifiers are publically available, and something as simple as a prescription pad may be enough to engage in fraudulent activity. Physician victims of identity theft can face devastating financial liabilities, among other problems. In recognition of this issue, CMS recently launched a new program to aid physician victims of identity theft in resolving erroneous financial liabilities, an effort that the AMA supports.

Reducing Improper Payments

Greater physician education and outreach is the first step in reducing the improper payment rate. Overall, improper payments are not the result of fraud or willful abuse. Instead, misunderstanding regarding payment policy or documentation requirements is often at the root of improper payments, as these guidelines are ever-changing. While the AMA often serves as an educator of the physician community, the partnership of federal regulators is required. To effectively reduce the improper payment rate, increased physician education and outreach from CMS concerning correct coding and billing requirements is a necessity.

Part of this education is the employment of physician Contractor Medical Directors (CMDs) to facilitate clinical-based discussions and serve as a bridge between physicians and federal programs on coverage and coding matters. Physician CMDs are a valuable resource for physicians to obtain education about Medicare's payment and coverage policies, and a venue for physician-to-physician discussion of Medicare policies that impact patient care. However, the interaction between physicians and CMDs has been inhibited by the overall reduction of CMDs. Since the transition from carriers and fiscal intermediaries to the MACs, and the subsequent reduction of the number of MACs nationwide, the number of CMDs at the MAC-level has also decreased, leading to confusion in the medical community. Unless a state medical society decides that a regional, multi-state CMD is appropriate, there should be a minimum of one physician CMD per state who is devoted to Medicare Part B issues.

The sheer number of audit contractors is also a serious concern for physicians. Currently, CMS contracts with Zone Program Integrity Contractors (ZPICs), Comprehensive Error Rate Testing (CERT) contractors, Medicare Recovery Auditors (Medicare RACs), Medicaid Recovery Audit Contractors (Medicaid RACs), Program Safeguard Contractors (PSCs), Payment Error Measurement Rate (PERM) Contractors, Medicaid Integrity Contractors (MICs), Medicare Administrative Contractors (MACs), Medicare Advantage (MA) audits, and others.[1] While some of these programs do have unique functions, there is considerable overlap and duplication among them. These auditors largely employ divergent operational guidelines and standards; demand letters, appeals processes, documentation limits, and look back periods are inconsistent.

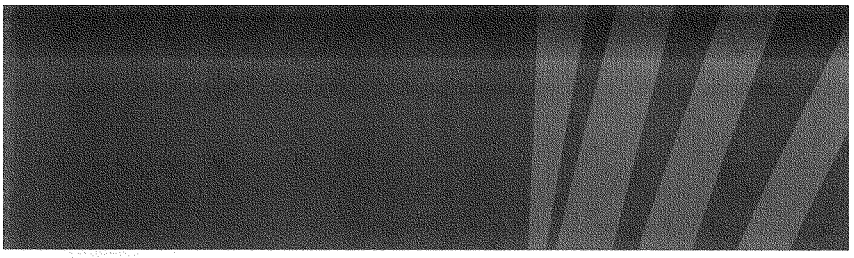
[1] CMS, *Contractor Entities At A Glance Who May Contact You About Specific Centers for Medicare & Medicaid Services (CMS) Activities*, at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ContractorEntityGuide_ICN906983.pdf.

Physicians spend a great deal of time determining which contractor is auditing them, under what authority, and what the guidelines are for response. This confusion and misspent time unduly burdens physicians and contravenes the swift recoupment of improper payments to the federal government. In recognition of this inefficiency, CMS has committed to undertake an "Audit of Audits" to review the myriad federal audit contractors and identify areas of duplication. The AMA strongly supports this effort, and believes that the ultimate goal of this effort should be a reduction in conflicting and overlapping audits and audit policies.

Lastly, the AMA continues to have serious concerns with the Medicare & Medicaid RAC programs. The programs' contingency fee structure inappropriately incentivizes the RACs to conduct "fishing expeditions" that are exceedingly burdensome for physician practices. The RACs are also often inaccurate: CMS' FY2010 Recovery Auditor Report to Congress reported that 46.2 percent of the claims appealed were decided in the provider's favor. This number is far too high; these errors result in needless expense for Medicare appeals tribunals and physicians. To promote efficiency and the best use of federal funds to identify improper payments, greater oversight of RAC contractors and safeguards for physicians are needed.

Conclusion

Thank you for the opportunity to provide a statement for today's hearing. We look forward to a continued dialogue with the Government Organization, Efficiency, and Financial Management Subcommittee on these important issues.



NAMD
National Association of
Medicaid Directors

Rethinking Medicaid Program Integrity:

Eliminating Duplication and Investing in Effective, High-value Tools

March 2012

444 North Capitol Street, Suite 309 • Washington, DC 20001 • Phone: 202.403.8620 • www.namd-us.org

A Message from the Director

Nationally, over $366 billion spent (federal and state) on 59.5 million Medicaid recipients. The magnitude of such program that serves many of the most vulnerable individuals demands an equivalent and appropriate level of accountability – from federal and state governments, providers, enrollees and other stakeholders that touch the program.

Medicaid Directors are sensitive to their role as stewards of the public's trust. States are strongly committed to ensuring accurate payments and prevention of fraud, waste and abuse. They are working to ensure all dedicated resources produce a positive return on investment. To do so they increasingly are using more sophisticated tools for data mining and deployment of technology.

However, in recent years, Medicaid Directors have become concerned by the disjointed and ineffective approach to Medicaid program integrity. States are struggling to balance the maintenance of existing efforts and meeting new requirements, including coordination with a multitude of federal efforts. The challenges and concerns for every state are magnified during this period of historic change for the Medicaid program – and for the health care system broadly – as well as the ongoing budget constraints experienced by the vast majority of Medicaid agencies.

The confluence of these factors is precisely why Medicaid Directors believe now is the time to reexamine the current approach to Medicaid program integrity. States want to ensure that program integrity is about creating a health care culture where there are the incentives to provide better health outcomes and common sense ways to avoid over- or underutilization of services.

The following position paper describes the landscape of federal Medicaid program integrity activities. However it is more than a description of programs. NAMD offers a window into the duplication and inefficiencies that currently exist. We present Directors' perspectives on what is truly needed and recommendations for rethinking the approach to achieve these. Through their Association, Medicaid Directors are committed to working to achieve this vision.

Matt Salo
Executive Director
National Association of Medicaid Directors

Introduction

Medicaid program integrity is among the highest priorities of the nation's Medicaid Directors and is a key component of every initiative and program states conduct. Throughout the nation's Medicaid agencies, Directors seek to promote economy, efficiency, accountability, and integrity in the management and delivery of services in order to ensure that they are effective stewards of the Medicaid program's limited resources.

States use multi-pronged strategies aimed first at prevention—the most critical ingredient to successful program integrity (PI). Auditors, analysts, and a host of other employees and consultants work to prevent the loss of public dollars to fraud and abuse. Recovery efforts supplement prevention, and include prosecuting fraud cases in court, and pursuing overpayments to providers when they cannot be prevented.

Program Integrity Defined

Program integrity is about creating a culture where there are consistent incentives to provide better health outcomes within a context that avoids over- or underutilization of services. It also requires effective program management and ongoing program monitoring at the federal and state levels. These efforts affect the ability of states and the federal government to ensure taxpayer dollars are spent appropriately. Effective program integrity will ensure:

- Accurate eligibility determination;
- Prospective and current providers meet state and federal participation requirements;
- Services provided to beneficiaries are medically necessary and appropriate;
- Medicaid remains the payer of last resort when other insurers or programs are responsible for an enrollee's care; and
- Provider payments are made in the correct amount and only for covered services.

Despite federal and state investments and a strong commitment to this vision of program integrity, these are the overarching challenges impeding effective implementation:

- Federal programs are typically not tailored to meet unique, state-identified fraud, waste, and abuse priorities and related program integrity activities, nor are they responsive to other inherent state variations such as state policies, program characteristics, and organizational structures.
- Federal requirements – those long-standing as well as recently added mandates – often force states to divert resources from highly effective activities.
- State and federal roles in the operation and oversight of program integrity efforts have blurred over time, creating overlap, inefficiencies, and confusion.
- Access to and utilization of federal data sources is challenging. Existing federal and state databases and data warehouses are not coordinated, difficult to navigate, and present limitations to the accessing of valuable investigative information.

NAMD proposes to work across states and with our federal partners to remedy these barriers to effective PI.

The program integrity landscape

Medicaid fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or some other person and includes any act that constitutes fraud under applicable federal or state law. Waste is not currently defined in federal Medicaid regulations, however it is generally understood to encompass the over-utilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act. Abuse includes provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care and health care coding. It also includes non-fraudulent recipient practices that result in unnecessary cost to the Medicaid program.

While all Medicaid programs have ultimate responsibility for combating fraud, waste and abuse, the scope and execution of program integrity activities varies by state. The authorities and delegation of these responsibilities can also differ based on the organizational structure and departmental roles. For example, in one state the Medicaid agency may carry out most if not all program integrity-related activities, while in other states these roles are spread across agencies. Finally, the scope of states' portfolio or definitions of program integrity can vary. For example, some but not all Medicaid agencies define coordination of benefits and third party liability activities as a core component of their program integrity efforts.

Despite the high priority Medicaid leaders at all level of government give to program integrity, truly effective programs are not possible in the current environment. Challenges to optimal program integrity include a lack of coordination across federal agencies, insufficient collaboration and ineffective communication with states by the various federal entities executing program integrity activities, and a *solution du jour* approach which simply layers untested approaches – each with their own bureaucracy and program requirements– on top of one another without ever pausing to look at what has worked and what has not. Resources dedicated to complying with unproven programs are simply a distraction for states and divert attention and resources from high-value program integrity activities.

While fighting fraud and abuse is important, there is no doubt the proliferation of agencies tasked with some role in Medicaid program integrity is responsible for considerable duplication. Medicaid program integrity involves various agencies at the federal level, including the following:

- Centers for Medicare and Medicaid Services' (CMS) Center for Program Integrity including its Medicaid Integrity Group (MIG),
- CMS' Office of Financial Management, and
- CMS' Center for Medicaid and CHIP Operations;
- HHS Office of the Inspector General (OIG);
- U.S. Department of Justice, including the Drug Enforcement Administration (DEA); and
- Federal Bureau of Investigations (FBI).

At the state level program integrity efforts are undertaken taken by the following:

- State Medicaid agencies;
- Medicaid Fraud Control Units (MFCUs);
- Separately elect State Auditors (where applicable);
- State Medicaid Inspector Generals (where applicable);
- State Attorneys General; and
- Others depending on the specific state.

A lack of information or faulty communication between these different levels of government and across all agencies, such as information sharing between the Medicare program and state Medicaid agencies, can dramatically reduce the effectiveness of both prevention and recovery efforts by both programs.

The following is a brief description of some of the primary federal programs.

Medicaid Eligibility Quality Control (MEQC). Federal regulations require states to conduct annual Medicaid eligibility quality control projects. States can choose whether to sample from the entire Medicaid population, or conduct special studies that focus on a specific group of recipients. Some states have received waivers to meet the MEQC requirements.

Medicaid Fraud Control Units (MFCUs). A Medicaid Fraud Control Unit is a single entity of state government, generally housed in the Attorney General's office, that conducts a statewide program for the investigation and prosecution of health care providers that defraud the Medicaid program. In addition, a MFCU reviews complaints of abuse or neglect of nursing home residents. The Unit is also charged with investigating fraud in the administration of the program and for providing for the collection or referral for collection to the single state agency and overpayments it identifies in carrying out its activities. With the approval of the Inspector General of the relevant federal agency, MFCUs may investigate fraud in any federally funded health care program, such as Medicare, primarily related to Medicaid. MFCUs receive an annual federal grant from HHS, and the federal grant must be matched with 25 percent state funds.

Medicaid Integrity Contractors (MIC). The Deficit Reduction Act (DRA) of 2005 established the CMS Medicaid Integrity Program at CMS as part of a five-year program to combat fraud, waste and abuse. The MIC was one of the initiatives spawned by the additional funding provided to CMS. The MIC is a CMS selected and funded contractor that operate in three distinct components (data, audit, and education) in each of the CMS regions. The data contractor searches state MSIS data housed in the CMS data center for aberrant providers, which are then audited by the audit contractor. The state must recover the CMS identified overpayment and return the federal share of the overpayment.

Medicaid Integrity Group (MIG) reviews. The Medicaid Integrity Group is an outgrowth of the additional funding CMS received in the Deficit Reduction Act (DRA). The intent of the MIG review is to determine that the states are complying with the program integrity requirements in Title 42 CFR, including that the Medicaid agency has a plan for the identification, full investigation, reporting, and referral of suspected fraud and abuse cases to appropriate agencies.

Medicare-Medicaid Data Match Program (Medi-Medi). The Medicare-Medicaid Data Match Program, or "Medi-Medi," initially began in California to detect and prevent Medicaid fraud and abuse. The program expanded to other states, and with the passage of the Deficient Reduction Act of 2005, funding increased to roll out the program nationwide. Medi-Medi is accomplished by using computer algorithms to combine Medicaid and Medicare data to identify improper billing and utilization patterns. Medi-Medi includes state, regional, and national efforts and requires collaboration among state Medicaid agencies, CMS, and state and federal law enforcement officials. CMS selects Zone Program Integrity Contractors (ZPICs) that consolidate Medicare Parts A, B, C, D, and Medi-Medi Benefit Integrity Activities.

Payment Error Rate Measurement (PERM). The PERM process was developed by CMS as a response to the Improper Payments Information Act of 2002 (IPIA). Under PERM, reviews are conducted in three areas: (1) fee-for-service (FFS), (2) managed care, and (3) program eligibility for both the Medicaid and CHIP programs. The results of these reviews are used to produce national program error rates, as required under the IPIA, as well as state-specific program error rates. CMS has developed a national contracting strategy for measuring the first two areas, FFS and managed care. States are responsible for measuring the third area, program eligibility, for both programs. Because states administer Medicaid and CHIP according to each state's unique program, the states necessarily need to be participants in the measurement process.

Recovery Audit Contractors (RAC). The RAC is a contingency fee based contractor program mandated by the Affordable Care Act. While CMS has provided states flexibility in the contracting and operation of their individual RAC programs, the RAC program audits the same state claims from state data for overpayments and for mandated identification of underpayments as MICs. Further, the RAC is reimbursed at a contracted percentage of the identified improper payments identified, which cannot exceed the highest rate for a Medicare RAC, currently 12.5 percent. Complicating the contracting with RACs is the fact that the contracted percentage can change every year based on how the CMS contracts for Medicare and that the percentage can be higher for DME.

Recommendations for strengthening the approach to Medicaid program integrity

States are fully committed to working with federal policymakers and agencies to improve the integrity of the Medicaid program. However, the nation's Medicaid directors seek to ensure that resources go only to effective, high-value initiatives. Realizing this goal will require more deliberate communication between federal and state leaders. Specifically, federal and state policymakers should meet face-to-face to coordinate and clarify our respective roles, to define our visions and expectations for a high-performing Medicaid program, and to create pathways for collaboration and sharing tools across all levels of government. Meaningful dialogue between states and federal leaders could lay the foundation for ongoing, two-way learning on these critical aspects of program integrity.

Below are specific recommendations to federal and state leaders for strengthening the integrity of the Medicaid program.

Clarify the roles of the state and federal governments

One of the first steps for federal and state leaders is to define their respective roles. Prior to enactment of the Deficit Reduction Act of 2005 (DRA), states and the federal government had more distinct roles in fraud, waste, and abuse efforts, with states operating the programs and CMS serving as the overseer of state activities. The DRA's relatively significant investment in federal Medicaid PI corresponds with the increase in layering of federal programs and requirements as well as an imbalance in the resources available to addresses federal requirements.

Medicaid PI efforts are undermined where federal and state roles have blurred. The ambiguity has led to significant duplication and inefficiency as well as confusion about information sharing and which entity is carrying out any particular activity. Overlapping and duplicative activities also can make it difficult to meet intended deadlines.

One example where this occurs is with the Medicaid Integrity Contractors (MICs). States are supportive of the work underway by the MIC education contractors to create educational material intended for providers and also believe the MICs could do more to look at multi-state eligibility issues and multi-state provider activities. However, other components of the MIC initiative present significant problems. Specifically, duplication and confusion occurs with the activities of the MIC audit contractors and the additional work they create for Medicaid PI units. Most recently, implantation of the RAC requirements appears to be exacerbating this phenomenon through apparent duplication of responsibilities and efforts of the MIC's and the RAC's. Other problems plaguing the Audit MIC program include insufficient coordination with states when MICs contact providers and mine state data and the use of the Medicaid Statistical Information System (MSIS) data for the audits. As described in the HHS OIG's February 2012 report, "Early Assessment of Review Medicaid Integrity Contractors," the MSIS data used by the Review MICS lacks information important for conducting program integrity activities.

Without a doubt, states are the front line for preventing, identifying, and remediating fraud, waste, and abuse in their respective Medicaid programs. However, Medicaid program integrity

requires a collaborative model between and among all governmental entities. Further, the collaborative model is multi-pronged. That is, federal agencies, particularly within CMS, must improve their internal coordination and, in turn, federal agencies must collaborate with ongoing activities with the states. In addition, states and federal policymakers must focus on improving responsiveness to problems as identified and rapid course-correction to ineffective approaches and programs.

Improve collaboration and communication between Medicare and Medicaid

Medicaid Directors also call on federal policymakers to convene a task force dedicated to addressing the obfuscated relationship between Medicaid and Medicare program integrity activities. One logical convener for this effort is CMS' Medicare-Medicaid Coordination Office, which has demonstrated unprecedented ability to bridge challenging issues between the two programs.

Despite common interests in program integrity and overlap in enrolled beneficiaries and providers, the current fragmented relationship between the two programs creates overlap and undermines federal and state efforts. For example, site verification for nursing homes and other facility-based providers and provider screening are required for both Medicare and Medicaid. However, there is no pathway for the two programs to build on or leverage their respective efforts.

This task force, with participation by all relevant agencies at HHS as well as the states, should be charged with defining the respective roles and developing policy recommendations aimed at the following:

- Breaking down the long-standing barriers to communication and improving collaboration between the two programs;
- Eliminating duplication of effort on activities that touch the same providers, beneficiaries or other stakeholders;
- Transitioning federal resources to initiatives that address the needs of the states;
- Creating a vehicle for rapid course-correction to ineffective initiatives; and
- Creating a pathway for states to leverage Medicare's powerful data analytics, predictive modeling and other information and resources.

While working to harmonize efforts, Medicaid Directors also ask federal policymakers to carefully consider any future federal legislation that seeks to apply Medicare-specific requirements and programs to Medicaid. These programs serve populations with different needs and work with a wider range of providers. These fundamental differences combined with variations in state Medicaid programs, policies, and organizational structures create conflict when a program originally designed for Medicare is simply mandated to apply to the Medicaid program.

Instead, when legislating or implementing new programs, these differences must be recognized and incorporated and proposed with feasible implementation timelines. Further, the federal government should define its success measures up front as new initiatives start in order to make more informed decisions about the appropriateness of applying Medicare initiatives to Medicaid.

Invest in resources tailored to unique state Medicaid programs

States are the front line for protecting the integrity of the Medicaid program, including identifying and preventing fraud, waste and abuse and remediating those situations where it does occur. They are best situated to identify and target resources to program vulnerabilities. Medicaid Directors also believe program integrity must include a focus on reorienting the Medicaid payment and delivery structures to pay for high-value services. However, increasingly the federally-driven approach to fighting fraud, waste and abuse require Medicaid programs to redeploy staff from state-level programs that may be yielding good results.

The federal government should support states in sustaining successful programs or further refining their efforts to meet unique state needs and conditions. The following overarching principles are aimed at reprioritizing and guiding the federal and state focus on prudent investments that support implementation of only the most effective PI practices.

Collaborate with states to develop targeted efforts to support high-performing Medicaid programs. Policymakers must rethink the current approach to fighting fraud, waste, and abuse in the Medicaid program. Through our Association, Medicaid Directors propose to work with federal policymakers to develop a broader, shared understanding of high-performing Medicaid programs. Based on fact-based research a checklist defining a high-performing Medicaid system could inform a common understanding of the effectiveness and efficiency of each state's Medicaid program.

Benchmarks, vehicles for sharing best practices, and processes for directing resources to high-value activities should flow from this vision. Specifically, Medicaid Directors ask that CMS redirect the focus and resources of the Medicaid Integrity Group (MIG) away from conducting reviews of Medicaid integrity programs. States are the front line for identifying and prioritizing the threats to program integrity in each of their programs. Therefore, the MIG should increasingly dedicate its resources to the formation and deployment of consulting teams to work with individual states to identify their challenges and to assist them in implementing efficiencies in their PI programs, which may include a single source contract to perform pre- and post-payment results.

For example, federal assistance could support various activities, including the following:

- Support state initiatives to increase training, education, and implementation of tools to improve the sophistication of their program integrity activities;
- Focus resources where states believe there are vulnerabilities, including in the areas of newly evolving integrated care models, for various aspects of PI for managed care programs, and home and community based services;
- Assist states with inter-state or inter-county initiatives; and
- Assist states with drug rebate recoveries.

Ultimately these and other state-focused and state-driven initiatives should lead to a more rational approach to promote the proper expenditure of Medicaid program funds, improve program integrity performance nationally, and ensure the operational and administrative excellence of the Medicaid integrity program.

Medicaid Directors also support the inclusion of an evaluation component for all existing and any federal fraud, waste, and abuse program going forward. A comprehensive assessment of program performance and outcomes will put fraud, waste and abuse programs on par with other efforts to measure the effectiveness and efficiency of other aspects of the Medicaid program.

Leverage federal investments in technology and data analytics tools. Medicaid Directors call on federal policymakers to make more strategic investments to expand the use of technology and data analytics tools for the Medicaid program. While some states have recently invested in more advanced data analytics tools that have helped them move further from "pay-and-chase" models of detecting fraud, additional federal support could speed implementation and maximize the use of these critical tools. In particular, CMS is able to negotiate the purchase of analytical tools at a price far lower than what any one state could negotiate on its own. States would like the ability to license federal technology or collaborate on other technical assistance resources, such as access to the expertise and tools for predictive analytics and data mining techniques that Medicare has developed in recent years.

Prioritize support for the Medicaid Integrity Institute. States strongly support ongoing and augmented investment in the Medicaid Integrity Institute (MII). The MII is the first national Medicaid program integrity training center for states. Since 2007, the MII has focused on developing a comprehensive program of study addressing aspects of Medicaid program integrity including fraud investigation, data mining and analysis, and case development.

MII helps ensure that program integrity staff stay informed of current trends and receive formal training. By doing so, it enables staff to more successfully identify fraud, waste and abuse, which in turn makes more efficient use of federal and state Medicaid funds. The training needs of the employees from state Medicaid program integrity units are the primary focus; however, employees from other Medicaid divisions also participate depending on the course objectives. Medicaid Directors support the MII's effort to grow the impact of this program through increased support, and the development of certifications and accreditation for MII program participants. Additional participation by CMS and other federal agency staff could help improve understanding and collaboration with states.

Include state Medicaid perspectives in federal audits on Medicaid fraud, waste, and abuse programs. In addition to evaluations, Medicaid Directors request that federal audits and reports about Medicaid program integrity include a state review requirement and an opportunity for formal state response to the report, similar to the process used by the Government Accountability Office when it evaluates federal agency activities and programs. Through our Association, Medicaid Directors are committed to working with federal partners to ensure a comprehensive, balanced analysis is provided to Congress and other stakeholders so that policymakers may act on the feedback as to how improve federal initiatives.

Evaluate the return on investment and utility of existing program integrity initiatives

Currently the federal oversight culture is focused on bureaucratic, and, at times, counterproductive processes to the detriment of better care for enrollees and value for the program. Within this context, states must dedicate limited staff resources to programs with negative, minimal, or no proven value to either states or the federal government. For example,

day-to-day functions are where many of the erroneous payments occur. However, states increasingly must divert limited IT resources to CMS-mandated projects rather than investing them in necessary, day-to-day operations of effective PI efforts.

At a minimum revamping federal fraud, waste and abuse requires the following:

- Forthright evaluation and corrective action that will eliminate existing programs that are misguided, duplicative, or ineffective.
- Accurate assessment of the financial support necessary for either CMS or states or both to develop and implement new activities and programs.
- A commitment and administrative actions to align incentives, particularly with regard to requirements for states to recoup funds.

As a first step, federal and state policymakers should collaborate in evaluation and streamlining of the following programs.

MICs and RACs. Medicaid Directors request federal policymakers eliminate the glaring overlap between the Medicaid Integrity Contractor (MIC) and the Recovery Audit Contractor (RAC) programs. Both federal initiatives will be auditing providers in addition to the state program integrity efforts in fee-for-service states. For states that rely heavily on managed care organizations the issue becomes even more complicated as the managed care contractors have internal program integrity efforts and many have their own contracted RACs. The duplicative efforts are forcing states to maintain complex databases simply to track various audit trails. That is, depending on which particular auditing entity identifies a problem (i.e. the state agency, MICs, RACs, etc), recovery must follow that audit, and when multiple audits identify the same problem, it becomes incredibly complex to determine the payment trails.

To the extent Congress continues to require and CMS operates these two programs, a rational, immediate, and relatively easy way to reduce the resource consumption by duplicative and lowest return on investment (ROI) audit functions would be to exempt states from certain audits, specifically MICS and/or RACS, for one or more audit cycles based on previous findings of a low rate of error.

Audit MICs. As previously noted, Medicaid Directors have concerns with state resources invested in and the utility of Audit MICs. States note that the Audit MICs have used outdated MSIS data – including one state that reported the auditors used six-year old MSIS data as a starting point for claims. Additionally, Audit MICs may be duplicating some of the algorithms used by states and not follow all state-level criteria, such as record retention requirements.

Medicaid Directors request that Congress and CMS undertake a thorough evaluation of the ROI of the Audit MIC program, including the protocols for conducting the audits and coordination with the Review MICs, the validity of the data reviewed, and the process for consultation with states. Given the differential impact depending on the size of state Medicaid programs, this review must look at the return for states on an individual basis, and not simply a national ROI. Directors recommend eliminating the Audit MIC program – and other programs -- that do not demonstrate a reasonable ROI for federal and state partners.

MIG reviews. Federal policymakers should undertake a cost effectiveness evaluation of the Medicaid Integrity Group (MIG) review, including an assessment of MIG review overlap with the

State Program Integrity Assessment (SPIA). The purpose of the MIG review is to determine that the states are complying with the program integrity requirements in Title 42 CFR, as well as, to identify best practices that can be shared with other states. States report that initial reviews were a fairly productive venture that provided an independent review of operations and some helpful recommendations.

However, in subsequent MIG cycles, the reviews have lost focus and become unwieldy. The time and effort states expend to complete the extensive review guides and the production lost from a week-long review produce, at best, a questionable return on investment for states. The review guides themselves have expanded exponentially. The onsite review with CMS staff occupy key state program integrity staff for several days and require extensive time and staff contributions from senior managers for various divisions, such as provider services, the General Counsel, fiscal services, and network operations. Additionally these reviews may require a significant level of participation from all managed care plans, the pharmacy benefit manager, and the dental benefit manager.

In addition, MIG efforts to share best practices have generally been limited in nature. At a minimum, MIG staff should be directed to disseminate findings among state Medicaid officials. In addition, the MIG should intensify its focus on efforts to develop a standard cost avoidance methodology that could be used by states to demonstrate greater savings beyond what is actually recouped. Such a tool would provide an opportunity to more accurately assess the value of federal and state activities.

Medi-Medi. Medi-Medi continues to fall short of full, effective implementation despite significant investments of federal funding to build a data repository and expand the program. As mentioned early, states seek the opportunity to have a thorough dialogue on this issue through a task force. In the meantime, states have identified the following concerns with this program:

1) States review inappropriate payments to identify if there are opportunities to implement edits in their payment systems. However, the broader state approach to program integrity does not fit well with the federal Medi-Medi Project and its contractors, which are solely focused on generating law enforcement referrals.

2) Database development and data access continue to experience operational hurdles. Some participating states report that assumptions about the relationship of Medicaid data fields/definitions to Medicare data fields/definitions were frequently incorrect, requiring revisions. Thus, some participating states have found that the resulting database is neither intuitive nor simple to access and use for data mining. Further, as states implement new MMIS, this will likely require re-mapping and extracting of data.

3) States believe the CMS contractor concentrates on Medicare payments with a secondary focus on Medicaid payments. Further, Medicare and Medicaid billing and payment policies differ greatly. In some states, significant state resources have been utilized to explain why Medicaid data, wrongly analyzed using Medicare policy by CMS contractors, did not present any evidence of violation of Medicaid rules/procedures.

PERM and MEQC. There are also multiple federal programs that audit Medicaid eligibility processes, specifically the Medicaid Eligibility Quality Control (MEQC) program and the Payment Error Rate Measurement (PERM) program. While states have ongoing concerns with certain

aspects of the PERM program, generally they believe it appears to be complete review for both eligibility and claims. Despite efforts to integrate the MEQC process with PERM, Medicaid Directors believe MEQC has long outlived its useful life.

PERM. There are three fundamental problems with PERM– as well as other audit programs – that impede its well-intentioned goals:

1) The required PERM audits duplicate other federal and state audit activities and create confusion and additional burden for the providers involved.

2) PERM is frequently mischaracterized or misunderstood as a measure of fraud in Medicaid programs. There is a clear need for federal agencies to reinforce that PERM is a snapshot in time of the percentage of claims that are identified as *potential* errors. PERM errors do *not* equate to a percentage of dollars in error or potential savings to a Medicaid program.

3) There is a lack of common understanding of what qualifies as an error in PERM. In other words there are too many instances where federal regulations, as well as the federal contractors carrying out the audits, fail to accurately interpret and apply state policies for the PERM project or where federal timelines conflict with state timelines for processing claims. In turn, the PERM rates are not an accurate reflection of program integrity in most states.

Focus on streamlining and improving access to data

Better data systems and expanded access to existing systems are essential for improving efforts to prevent, identify, and where appropriate, take action in response to Medicaid fraud, waste, and abuse. While states are making progress, many still have inadequate technological infrastructures and a basic inability to interrogate databases efficiently to ferret out improper claims. A number of states indicate that they need better, more targeted data, to pinpoint areas most likely to foster problems, as well as guidance and technical assistance on acquiring new data systems and other fraud and abuse detection tools.

Leverage Medicare data. Working through our Association, Medicaid Directors are committed to partnering with federal policymakers to develop reasonable policies and functional data exchange systems between Medicare and Medicaid. Despite investments in projects like the Medicare-Medicaid Data Match Program, commonly referred to as "Medi-Medi", coordination between Medicare and Medicaid remains insufficient and ineffective in many states.

Reconciling differences in data formats between Medicare and Medicaid requires tremendous time and state resources, and can sometimes impede state efforts to use this information in a timely, effective manner, even when it is made available to them. Medicare and Medicaid billing and payment policies differ greatly. In order to be successful in efforts to protect the integrity of Medicare and Medicaid, state and federal governments must work together on the appropriate scope and format of data that is shared as well as the relationship with CMS contractors. In addition, sharing Medicare Part D data (including price information) and data matches with the Drug Enforcement Agency (DEA) would significantly enhance state program integrity efforts by helping to reduce fraud, waste and abuse.

Coordinate the "build" of any Medicaid data warehouses. There are significant federal efforts under way to build data sources that house Medicaid data. While such data warehouses have the stated purpose of strengthening federal and state program integrity initiatives, the current approach is lacking in at least two major ways.

First, the federal efforts currently underway appear fragmented, with multiple overlapping "pilots" led by multiple CMS contractors. These contractors are typically unable to articulate to states how the efforts relate to the overall vision and goals for Medicaid program integrity initiatives. Further, states report that few of these contractors bring any knowledge or understanding of Medicaid data. Medicaid Directors urge CMS to ensure that when states invest valuable state resources in the development of an analytic database, the utility to states is clearly documented, particularly when assessing this investment against competing state priorities.

Improve collaboration between Medicaid and the HHS OIG. Medicaid Directors most frequently interact with the HHS OIG as part of federal audits. However, states believe increased communication and collaboration and review of OIG methodologies could prove more effective for all levels of government.

Medicaid Directors particularly seek to work more closely with the OIG to identify priority targets for investigations on an individual and/or state specific basis. Medicaid Directors wish to collaborate with the OIG to review current investigative methodologies, specifically the sampling methodology. We believe this review is necessary in order to address current concerns with methodologies that lead to overstated overpayments.

States also wish to work with the OIG to address inefficiencies with various databases. For example, CMS requires monthly searches of overlapping federal databases to identify any excluded providers and contractors. These monthly data matches must identify excluded individuals who have been convicted of health care fraud. The (OIG) maintains the List of Excluded Individual/Entities (LEIE) database, but the LEIE is not user friendly and only allows a small number of names and social security numbers (SSN) to be searched at any time. This places a significant burden on states, managed care organizations, providers, etc. In addition, the LEIE does not a maintain history of exclusions and does not include dates when exclusions started. In an attempt to improve inefficiency, CMS created a MED database that is downloadable with names and SSNs, but will only allow *states* to download the database. It cannot be shared with managed care entities or providers. Federal agencies should streamline and improve access to key information to minimize these burdensome processes.

CMS also requires states, managed care plans, providers, etc. to search the Excluded Parties List System (EPLS) maintained by the General Services Administration (GSA) for parties excluded from contracting with the Federal government. This is onerous for states because it only allows a limited number of parties to be searched at one time and has no capability for any of the previously mentioned groups to download the database to match against current providers, employees, etc. Medicaid Directors urge federal policymakers to consider creating a single database that would combine the LEIE, EPLS, data on terminated providers, HHS' Healthcare Integrity & Protection Database, which collects data on healthcare-related civil judgments and criminal convictions, injunctions, federal and state licensing actions, exclusions, and any other adjudicated actions defined in HIPDB regulations, as well as other databases states are supposed to be checking, such as the Social Security Administration's Death Master File. This approach has

the potential to allow states to fully automate the match while not generating lists of "suspect matches" for manual follow up.

Conclusion

State Medicaid Directors face more than programmatic hurdles in their race to bend, shape and re-tool their programs. We look forward to working with Congress, the Administration, and other stakeholders to address not only the potential barriers to improved program integrity in Medicaid, but the need to encourage, support and inform innovation on a scale equal to Medicaid's critical role as the nation's health care safety net.

The National Association for Medicaid Directors (NAMD) is a bipartisan, professional, nonprofit organization of representatives of state Medicaid agencies (including the District of Columbia and the territories). NAMD provides a focused, coordinated voice for the Medicaid program in national policy discussion and to effectively meet the needs of its member states now and in the future.

Questions for Dr. Peter Budetti
Director of Center for Program Integrity
Centers for Medicare and Medicaid Services

Rep. Todd Platts
Subcommittee on Government Organization, Efficiency and Financial Management

Hearing on "Assessing Medicare and Medicaid Program Integrity"

1. **Medicaid data sets currently reported by states to the Centers for Medicare and Medicaid Services ("CMS") are inadequate for the purpose of conducting federal audits. What updates and adjustments is CMS making to state Medicaid data sets to correct for this deficiency?**

Answer: CMS is working to incorporate State Medicaid data into the Integrated Data Repository (IDR), while also working with States to improve the quality and consistency of the Medicaid Statistical Information System (MSIS) data from each State. MSIS data is the primary data source for Medicaid statistical data, and is a subset of Medicaid eligibility and claims data from all 50 States and the District of Columbia. To improve the quality of the MSIS data, and Medicaid data in general, CMS established the Medicaid and CHIP Business Information Solution (MACBIS) Council. This Council provides leadership and guidance in support of efforts to create a more robust and comprehensive information management strategy for Medicaid and CHIP. 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.

The Council has initiated several efforts including the Transformed MSIS (T-MSIS) pilot project in 11 States, which together represents 40 percent of the nation's Medicaid expenditures. The heart of this pilot is to create a consolidated format from a variety of State information sources to satisfy multiple Medicaid and CHIP Federal information reporting requirements. CMS will use the results and lessons learned from these 11 States as the basis for national implementation by 2014. The MACBIS projects will lead to the development and deployment of improvements in data quality and availability for Medicaid program administration, oversight, and program integrity.

Improved data will allow CMS to analyze information from throughout the claims process to identify previously undetected indicators of aberrant activity.

CMS continues to improve access to better quality Medicaid data by exploring opportunities to collaborate with States participating in the Medicare-Medicaid Data Match Expansion Project (Medi-Medi) as well as working directly with States to obtain Medicaid data for specific collaborative projects.

2. Please explain how data from the "demonstration project" currently underway in ten states will be used, as you stated in your oral remarks, "as a model for improving the flow of data from the states." How does CMS verify that the rates being assessed through the "demonstration projects" using managed care organizations are legitimate, when they have no Medicaid encounter data?

Answer: We are evaluating what elements can be implemented at this time nationwide. Our evaluation of the pilot, and forthcoming guidance, will not only consult the pilot States but also garner input from all State Medicaid and CHIP programs. We should know more once the evaluation is complete in the coming months.

The pilot includes Medicaid encounter data. A number of States already report encounter data to CMS, but the reporting is not as consistent, uniform, and complete as needed. We have included specific encounter reporting requirements as part of terms and conditions in our State-wide waivers, and are working now with all States to evaluate their encounter data reporting. The ACA also included authority for CMS to apply penalties when States fail to report encounter data to us.

States set MCO rates which are certified by a licensed and qualified actuary as actuarially sound. The data which support such rate-setting can include historic fee for service claims, encounter data, and MCO financial data, depending on the structure and history of the State managed care program. CMS gives financial support to States for collection and maintenance of encounter data, and for validation of the data.

3. Why has Medicaid data still not been integrated into the One Program Integrity ("One PI") system? Are states withholding this information from CMS and, if so, which states?

Answer: Since we are working on transforming the data set States report to us for all of Medicaid and CHIP, not just PI, we will implement this provision once the current T-MSIS pilot and its evaluation are complete. That way, we are requiring data elements that we know the States are capable of reporting at this time.

4. What has CMS done to ensure states provide Medicaid data to One PI by the "current target" date of 2014 and, if they fail to comply by this time, what are the consequences?

Answer: Incorporating State Medicaid data into the IDR is a priority and we are working diligently to incorporate Medicaid data for all 50 states into the IDR. We are aware that States have new and competing priorities in a tightened fiscal environment and we are working closely with them to help streamline data requests under the agency's Medicaid and CHIP Business Information and Solutions (MACBIS) data initiative. This initiative is intended to result in the development of a national system to address the needs of Federal and State Medicaid partners. CMS intends to incorporate Medicaid data for all 50 States into IDR by the end of fiscal year 2014.

5. Washington State withdrew from the Medicare-Medicaid Data Match ("Medi-Medi") program after recovering only $2,000 over a five-year period; however, the State recovered $28.9 million through its own Medicaid PI efforts from 2007-2008. Please

explain why Washington State was so successful in its Medicaid PI efforts and describe best practices from Washington's experience that can be replicated by other states.

Answer: In its most recent CMS program integrity review published in January 2011, Washington State was cited for noteworthy practices for incorporating an analytical approach to its PI work and for fostering an agency-wide commitment to PI. It also ranked in the upper third of all States for recoveries (2007-2009). However, as with all States, each performs well in certain areas but also has opportunities for improvement in others. In general, Washington's overall PI practices and activities are as noteworthy as a number of other States that are larger or smaller than Washington.

With regard to its analytical approach to PI, Washington implemented a Fraud Abuse Detection System in October of 2010 which is used to analyze post payment data to detect aberrancies Washington then uses this information to develop edits in their claims systems, conduct probe audits, or evaluate potential policy changes. Washington staff participate as faculty at the Medicaid Integrity Institute (MII). Washington State is engaged with CMS in several collaborative audits and is also partnering with CMS on the T-MSIS pilot to enhance and strengthen the Medicaid national data set.

6. **Please provide the return on investment information for the Medi-Medi program that you referenced during your oral testimony as being "much higher" than currently reported.**

Answer: CMS anticipates that we will have more information as updated data becomes available.

7. **Older PI systems such as the Integrated Data Repository (IDR) and the Medi-Medi program seem to be less effective than newer programs like the Fraud Prevention System (FPS) and the Automated Provider Screening system (APS). Do you think it is time to cut our losses with these older systems and transition to only using these newer approaches?**

Answer: While the Fraud Prevention System (FPS) and Automated Provider Screening System (APS) are important new tools that will enhance our efforts to fight fraud, they will not replace the IDR. The FPS is a tool the Center for Program Integrity (CPI) is using on the existing claims processing system to look at claims in "near real time" – that is, as claims are being submitted to us for payment. This allows us the ability to flag suspect claims using predictive analytics, through risk algorithms, and conduct prepayment review. Thus, we are working towards stopping potentially fraudulent claims before they are paid.

In contrast, the IDR is a data warehouse integrating Medicare data into a single source for users across the agency. It provides a multi-centric view of the data encompassing more than just claims data, but also beneficiary, plan and clinical perspectives (e.g., quality data). CMS continues to build the IDR to provide a comprehensive view of Medicare and Medicaid data including claims, beneficiary data, and drug information.

8. How many of the 800,000 physicians in the National Provider Database that were run through the APS system did CMS find were actually unlicensed to practice in the state in which they had Medicare billing privileges (what CMS calls "high risk" providers)?

Answer: As of June 7, 2012, CMS removed 14,858 physicians from the program because they were not licensed in the State where they told Medicare they would provide care.

9. How many health care providers that have participated in the Recovery Audit Contractor ("RAC") program to date have appealed allegations that they made improper Medicare Fee for Service ("FFS") payments? What proportion of these appeal cases has been successful?

Answer: CMS monitors appeal information as part of our oversight of the Medicare Recovery Audit program. Under the terms of the contract, Recovery Auditors who have any claim overturned, at any level of appeal, are required to return any contingency fee paid. Therefore, the Recovery Auditors have no financial incentive to deny claims inappropriately.

In FY 2011, the percentage of claims with overpayment determinations that were appealed in the provider's favor in the Medicare Fee-for-Service (FFS) Recovery Audit program was 2.7%. There were 903,372 claims with overpayment determinations and 56,620 were appealed. Of the claims appealed, 24,548 claims were decided in the provider's favor. This includes determinations made in FY 2011 at any level of appeal.

10. Please explain how the RAC "demonstration project" has informed CMS on how it can better work with providers to resolve concerns about the RAC audit process.

Answer: CMS learned a variety of valuable administrative and programmatic lessons from the Recovery Auditor demonstration project that have informed current program efforts. CMS acknowledged that several of the concerns raised by providers in the demonstration were valid, and addressing them prior to national rollout has resulted in positive changes that will enable the national Recovery Audit program to maximize transparency, ensure accuracy, and minimize provider burden.

Every Recovery Auditor is now required to hire a physician medical director, which gives providers additional assurance that the reviews of their medical decisions are accurate and handled appropriately. Providers expressed concerns that filling multiple requests for medical records for review created a burden. As a result, CMS created sliding scale limits, based on provider size, for the number of medical records that can be requested by Recovery Auditors from a provider. In order to ensure accurate determinations of payments made in error, Recovery Auditors must now also secure pre-approval from CMS of issues they wish to pursue for review, meaning that before a Recovery Auditor can proceed with large numbers of reviews, CMS staff, and if necessary, a third party independent reviewer, must examine and approve the proposed provider type, error type, policy violated, and potential improper payment amount per claim to ensure that the review is appropriate. In addition, to address the concern that Recovery Auditors might have an incentive to over-identify improper payments, CMS now requires them to refund contingency fees for any decision overturned on appeal.

Questions for Dr. Peter Budetti
Director of Center for Program Integrity
Centers for Medicare and Medicaid Services

Rep. James Lankford
Subcommittee on Government Organization, Efficiency and Financial Management

Hearing on "Assessing Medicare and Medicaid Program Integrity"

1. For the record:
Mr. Lankford: I thank the Chairman for the opportunity to examine the cost of fraud, waste and abuse in our healthcare system. Each year, approximately $70 billion is lost to Medicare and Medicaid fraud and abuse, amounting to nearly $1 trillion over ten years. Reducing health care costs will demand that we improve our efforts to identify this fraud and eliminate it.

These efforts should be targeted in order to strengthen cost effective benefits and services. For example, nearly half a million skilled caregivers are helping to address the high cost of healthcare by providing skilled services to patients in their homes. Many of the medical treatments that were once offered only in a hospital or a physician's office are now being safely, effectively, and much more cost-efficiently provided in patients' homes. This benefit is particularly important in rural areas where seniors are faced with driving long distances to secure care.

I understand that in the home health program, CMS has been successful in using data to pinpoint where fraud is occurring. By targeting fraudulent activity, CMS can prevent it from occurring, and protect both seniors and taxpayers. I would like to learn more about CMS efforts to target fraud in this manner, and would appreciate your response to the following questions:

a) What has CMS learned from the examination of outlier abuse in home health?

Answer: CMS has taken aggressive action to address abuses of outlier payments to home health agencies. Outlier payments are designed to cover the extra costs in providing care to the costliest beneficiaries. To address abuses of these payments, CMS set a limit on the percentage of outlier payments that each home health agency can claim. Claims data indicate that these program integrity efforts have had a significant impact. In Miami, Medicare's total home health payments dropped by more than a third and its home health outlier payments dropped by more than 90 percent from 2009 to 2011.

Importantly, CMS is using new advanced analytic tools to detect fraud that may not be visible during an outlier analysis. The Fraud Prevention System (FPS) is the predictive analytic technology required under the "Small Business Jobs Act of 2010," (P.L.111-240). Since June 30, 2011, the FPS has been running predictive algorithms and other sophisticated analytics nationwide against all Medicare fee-for-service claims prior to payment. CMS uses the FPS to target investigative resources to suspect claims and providers, and swiftly impose administrative action when warranted. For the first time in the history of the program, CMS is using a system to apply advanced analytics against Medicare fee-for-service claims on a streaming, national

basis. This has enabled CMS to identify schemes operating across Medicare Parts A and B claims and across the country. The FPS aggregates Parts A and B claims in near-real time, and this comprehensive view of claims is revolutionizing our program integrity work. For example, zone program integrity contractor (ZPIC) investigators formerly had to check multiple systems to determine whether a beneficiary ever visited the doctor who billed Medicare for services and supplies. The FPS has consolidated the dispersed pieces of claims data – beneficiary visits with a doctor or orders for durable medical equipment, prosthetics, and orthotics billed under Part B, and hospital and other provider services billed under Part A – enabling ZPICs to automatically see the full picture. Equally important, the FPS organizes the data to quickly show when two providers on opposite sides of the country are billing Medicare on behalf of the same beneficiary, rooting out potential compromised beneficiary numbers and other fraudulent activity.

b) Have you examined measures to eliminate waste, fraud and abuse? What integrity reforms could be implemented to reduce the cost of the program instead of instituting a tax on seniors?

Answer: CMS is taking additional steps to address potential vulnerabilities in the enrollment and claims payment process for home health agencies (HHA). Under new screening provisions, all newly enrolling HHAs are considered a high risk provider/supplier and are therefore subject to unannounced site visits. As part of CMS' efforts to revalidate enrollment for currently enrolled HHAs, they were sent revalidation notices prior to December 31, 2011 and are currently being processed. All HHAs are subject to an unannounced physical site visit as part of the revalidation process.

The Affordable Care Act also enhanced CMS' authority to suspend payments for credible allegations of fraud. In February, CMS announced the suspension of payments or other appropriate administrative actions to78 home health agencies involved in an alleged fraud scheme in Dallas that was part of the February 28, 2012 Health Care Prevention Action Team (HEAT) Strike Force takedown.

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