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ON

"WASTE AND ABUSE IN GOVERNMENT HEALTH CARE"

BEFORE THE

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Chairman Gowdy, Ranking Member Davis, and Members of the Subcommittee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) efforts to reduce fraud, waste, and abuse in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

The Administration is committed to reducing waste and improper payments across the government. On November 20, 2009, President Obama issued Executive Order 13520 calling on all Federal agencies to reduce waste and improper payments across Federal programs and CMS is working hard to carry out the Order. In addition, the Administration announced last year that CMS will cut the Medicare FFS improper payment rate in half by 2012. CMS is making progress in meeting this goal, with a 1.9 percent point reduction in the error rate between FY 2009 and FY 2010.

In order to reduce improper payments and fight fraud within Federal health care programs, CMS is implementing a number of measures that will shift our enforcement and administrative efforts from a "pay and chase" mode to the prevention of fraudulent and other improper payments. This shift involves many different activities, which we are carrying out with ongoing corrective actions and the powerful new anti-fraud tools provided to CMS and our law enforcement partners under the Affordable Care Act.

Background on Improper Payments

Like other large and complex Federal programs, Medicare, Medicaid, and CHIP are susceptible to payment, billing and coding errors—called "improper payments." While these improper payments represent a fraction of total program spending, any level of

improper payment is unacceptable and CMS is aggressively working to reduce these claims processing, coding, and documentation errors.

When discussing improper payments, it is important to clarify what these billing anomalies are – and are not. Improper payments can result from a variety of assorted circumstances, including: 1) services with no documentation, 2) services with insufficient documentation, 3) incorrectly coded claims, or 4) services provided that were not determined "reasonable and necessary." Further, so-called improper payments do not always represent an unnecessary loss of Medicare, Medicaid, or CHIP funds. They are usually not fraudulent nor necessarily payments for inappropriate claims; rather, they tend to be an indication of errors made by the provider in filing a claim or inappropriately billing for a service. Most improper payments by providers and suppliers are classified as such because they relate to claims where the information in the medical record did not support the services billed. Examples of common payment errors made by Medicare providers include services that were performed in a medically unnecessary setting,[1] or were incorrectly coded.[2] Other payment errors result when providers or suppliers fail to submit documentation when requested, fail to submit adequate documentation to support the claim, or when Medicare pays a claim that should have been paid by a different group health plan or other liable party.

Medicare's claims payment systems have a series of automated edits to identify inappropriate claims, and the automated systems can detect and reject payment for medical services that are physically impossible, such as a hysterectomy billed for a male beneficiary. Additionally, CMS has developed "medically unlikely" payment systems edits, which catch services when the quantity billed exceeds acceptable clinical limits. Further, to help reduce medical necessity errors, which occur when documentation submitted by a provider or supplier does not sufficiently establish the beneficiary's

[1] Medically unnecessary setting: Medicare claims fall into this category when services are provided in a more intensive (and expensive) setting than is considered reasonable and necessary by Medicare. For example, if a minor surgery is done in an inpatient hospital setting on a healthy beneficiary, instead of in an outpatient setting, the entire claim is classified as an "improper payment."

[2] Incorrect coding: Claims are placed into this category when providers submit medical documentation that support a lower or higher code than the code submitted. (CMS Improper Medicare Fee-For-Service Payments Report, https://www.cms.gov/CERT/10_CERT_Reports_and_Data.asp#TopOfPage).

medical need for an item or service, CMS has developed Comparative Billing Reports, which compare a provider's billing pattern for various procedures or services to their peers on a State and national level.

Background on Program Integrity

In addition to reducing the improper payment rate, CMS recognizes the importance of having strong program integrity initiatives that will deter and end criminal activity that attempts to defraud Federal health care programs. We share Congress' commitment to protecting beneficiaries and ensuring taxpayer dollars are spent on legitimate items and services, both of which are at the forefront of our program integrity mission.

CMS is continuing to incorporate targeted screening and prevention activities into our claims and enrollment processes where appropriate. Our goal is to keep those individuals and companies that intend to defraud Medicare, Medicaid, and CHIP out of these programs in the first place, suspend payment on suspect claims before money goes out the door, and remove such individuals and companies from our programs if they do get in. The first step to preventing fraud in the Federal health care programs is to appropriately screen providers and suppliers who are enrolling or revalidating their enrollment to verify that only legitimate providers and suppliers who meet new stringent enrollment standards are providing care to program beneficiaries.

CMS' Enhanced Efforts to Reduce Fraud, Waste, and Abuse

Recovery Audit Program

Recovery Audit Program in Medicare FFS: The Recovery Audit program is an important tool in CMS' efforts to detect improper payments and thereby reduce waste in Federal health care programs. The Recovery Audit program began as a limited State demonstration project required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.[3] Congress expanded the Recovery Audit program in the Tax Relief and Health Care Act of 2006, directing CMS to implement a permanent national

[3] CMS began this demonstration in Florida, California, and New York in 2005, and later expanded to Massachusetts, South Carolina, and Arizona.

Recovery Audit program in Medicare FFS by January 1, 2010. Recovery Auditors work to identify overpayments and underpayments in previously submitted and paid claims; per the statute, these contractors are paid on a contingency fee basis.

The demonstration project helped CMS identify improvements to the Recovery Audit program that were made before expanding to the permanent national program. During the demonstration, 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. Additionally, 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. 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 provide greater incentive for accurate identification of improper payments, CMS now requires Recovery Auditors to refund contingency fees for any decision overturned on appeal. Further, CMS has also ensured accuracy by hiring an independent Recovery Audit Validation Contractor. The Recovery Audit Validation Contractor provides external validation and helps ensure the accuracy of the Recovery Auditor claim determinations by conducting independent, third-party reviews of improper payments identified by the Recovery Auditors. The Recovery Audit Validation Contractor reviews potential automated audit areas and makes suggestions for the approval or rejection of proposed automated audits. This contractor also reviews the Recovery Auditors' processes including assessing demand letters for clarity, accuracy, and completeness.

Recovery Auditors have proven successful at identifying and correcting improper payments made by CMS. In the demonstration project, Recovery Auditors corrected $1.03 billion in improper payments, including approximately $990 million in

overpayments collected. The permanent Medicare FFS Recovery Audit program, as of March 1, 2011, has corrected a total of $261.5 million in improper payments, including $43.6 million in underpayments corrected and $217.9 million in overpayments collected.

More importantly, the Recovery Auditors also help CMS identify areas where policy changes, systems changes, and provider education and outreach can help prevent future improper payments. CMS employs a robust system to identify patterns in the vulnerabilities identified by Recovery Auditors and to undertake appropriate corrective actions. During the demonstration, Recovery Auditors identified a number of improper payments in claims related to inpatient rehabilitation facilities (IRF). CMS recognized that the Agency's policy was outdated and published a regulation (CMS 1538-F) to update the policy and also conducted extensive provider education to ensure that providers bill IRF claims correctly. In the national program, Recovery Auditors have identified several areas where edits can be helpful in preventing improper payments. CMS is implementing edits to stop the payment of claims for services provided after a beneficiary's date of death, to stop payments for durable medical equipment while the beneficiary is receiving care in an inpatient setting, and to stop the payment for individual services that should have been bundled into another payment. In addition, the claim processing contractors have been able to implement local system edits to stop improper payments relating to durable medical equipment bundling (wheelchair and accessories and knee prosthetics) and drugs paid exceeding recommended dosages.

However, some vulnerabilities cannot be fixed with automated edits and may require ongoing medical review and other more resource intensive activities. As such, the President's FY 2012 Budget Request includes a legislative proposal that would allow CMS to retain a dedicated portion of the funds recovered by Recovery Auditors to implement additional corrective actions to prevent future improper payments, such as targeted prepayment review and provider education. Funding these activities to prevent future improper payments is estimated to generate net savings of $230 million over 10 years.

Recovery Audit Program in Medicare Parts C and D: The Affordable Care Act expanded the Recovery Audit program to Medicare Parts C and D and the Medicaid program, and CMS is drawing from the lessons learned from the Medicare FFS Recovery Audit program as we implement this new statutory authority. In January 2011, CMS awarded a contract to identify incorrect payments and recoup overpayments in Medicare Part D. Additionally, we are seeking public comment through a solicitation issued on December 27, 2010 in the Federal Register on innovative strategies for review of additional Medicare Parts C and D data, including the effectiveness of sponsors' anti-fraud plans.

Recovery Audit Program in Medicaid: To implement the expansion of the Recovery Audit program to Medicaid included in the Affordable Care Act, CMS issued a State Medicaid Director letter in October 2010 that offered initial guidance on the implementation of the Medicaid Recovery Audit requirements and also published a Notice of Proposed Rulemaking on November 10, 2010. To date, CMS has provided significant technical assistance to States through all-State calls and webinars and has begun the coordination with States that have Recovery Audit contracts in place, as required by the statute. Further, on February 17, 2011, CMS launched a Medicaid Recovery Audit Contractor At-A-Glance web page on the CMS website.[4] The page provides basic information to the public and interested stakeholders about each State's Recovery Audit program.

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

On January 24, 2011, HHS and CMS announced a rule that implements new Affordable Care Act tools to fight fraud, strengthen the integrity of Medicare, Medicaid, and CHIP, and protect taxpayer dollars. This rule became effective March 25, 2011, and puts in place important prevention safeguards that will help CMS move beyond the "pay and chase" approach to fighting fraud.

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

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

In addition, CMS-6028-FC implements the Affordable Care Act provision that authorizes CMS to require that providers who order and refer certain items or services for Medicaid beneficiaries be enrolled in the State's Medicaid program; this is similar to the new Medicare requirement included in CMS-6010-IFC published last spring, which also requires all providers of medical or other items or services and suppliers that qualify for a National Provider Identifier (NPI) to include their NPI on all applications to enroll in Federal health care programs and to also include their NPI on all claims for payment submitted to Medicare and Medicaid.

CMS-6028-FC also implements the statutory authority for CMS to impose a temporary enrollment moratorium if the Secretary determines such a moratorium is necessary to prevent or combat fraud, waste, or abuse. We plan to assess the impact of any proposed moratorium on beneficiary access, and publish a notice including the rationale for the moratorium in the *Federal Register*. Other preventive measures include new levels of coordination between Medicare and State Medicaid agencies. For example, State Medicaid programs are now required to terminate a provider that has been terminated by Medicare or another State Medicaid agency.

Stopping Payment of Suspect Claims: CMS-6028-FC allows Medicare payments to be suspended from providers or suppliers if there is a credible allegation of fraud pending an

investigation or final action. The law also requires States to suspend payments to Medicaid providers where there is a credible allegation of fraud. This enhanced authority will help prevent taxpayer dollars from being used to pay fraudulent providers and suppliers.

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

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

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

Fiscal Year 2012 Budget Request

To continue the Administration's focus on fraud and improper payment prevention and to build on the new authorities and resources provided by the Affordable Care Act, the President's Fiscal Year 2012 Budget Request includes a package of program integrity legislative proposals across Medicare, Medicaid, and CHIP that will save $32.3 billion over 10 years. These proposals, if enacted, would provide CMS with additional tools to reduce and prevent improper payments and ensure that those committing fraud are held responsible and cannot easily discharge their debts or reenter our programs to commit additional offenses.

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

HCFAC Program Successes

HCFAC has been steadily growing since it began in 1997 and, as shown in the recently released FY 2010 HCFAC report, this investment in fraud fighting resources is paying dividends. The HCFAC report demonstrates the value of this program; in FY 2010 alone, the program resulted in a record $4 billion in recoveries. The HCFAC return-on-

investment (ROI) is currently the highest it has ever been; the 3 year rolling ROI (FY 2008- FY 2010) averaging all HCFAC activities is $6.8 to $1; this is $1.9 more than the historical average. Additionally, the ROI for the Medicare Integrity Program's activities is 14 to 1.

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

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

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

Engaging Our Beneficiaries and Partners to Reduce Fraud, Waste, and Abuse

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

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

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

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

Collaborating with Law Enforcement Partners and the Private Sector

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

FBI, HHS/OIG and CMS. The HEAT task force is working to identify new enforcement initiatives and areas for increased oversight and prevention, including how to increase efficiency in pharmaceutical and medical device investigations.

The Strike Force model has been very successful. Since its inception, Strike Force operations in nine cities have charged more than 1000 individuals who collectively have falsely billed the Medicare program for more than $2.3 billion. This figure includes the Medicare Strike Force's latest successes, announced on February 17, 2011, charging 114 individuals with more than $225 million in false Medicare billing.

Sharing information and performance metrics broadly and engaging internal and external stakeholders requires establishing new partnerships with government and private sector groups. Because the public and private sectors have common challenges in fighting fraud and keeping fraudulent providers at bay, it makes sense that we should work together to develop common solutions. In addition to the HEAT initiative, agencies including HHS, CMS, OIG, and DOJ have co-hosted a series of regional summits on health care fraud prevention.

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

CMS has hosted well-attended Provider Interaction Sessions at these regional health care fraud prevention summits, as well as multiple Open Door Forums and other professional outreach activities to discuss the impact of new Affordable Care Act requirements with physicians and other medical professionals. This communication has demonstrated physicians' and other practitioners' strong interest in working with CMS and HHS in eliminating fraud, waste and abuse in the federal health care programs. CMS has demonstrated its commitment to continuing and improving these conversations; a Medical Officer was recently hired to be a liaison for providers on program integrity issues and activities.

Improving CMS' Data Analytic Capabilities

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

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

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

Further, the Small Business Jobs Act of 2010 provided $100 million, beginning in FY 2011 to phase-in the implementation of predictive analytics in Medicare FFS, Medicaid, and CHIP over four years. The new predictive modeling technology will incorporate

lessons learned through pilot projects. For example, in one pilot, CMS partnered with the Federal Recovery Accountability and Transparency Board (RATB) to investigate a group of high-risk providers. By linking public data found on the Internet with other information, like fraud alerts from other payers and court records, we uncovered a potentially fraudulent scheme. The scheme involved opening multiple companies at the same location on the same day using provider numbers of physicians in other states. The data confirmed several suspect providers who were already under investigation and, through linkage analysis, identified affiliated providers who are now also under investigation.

Delivery System Reforms

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

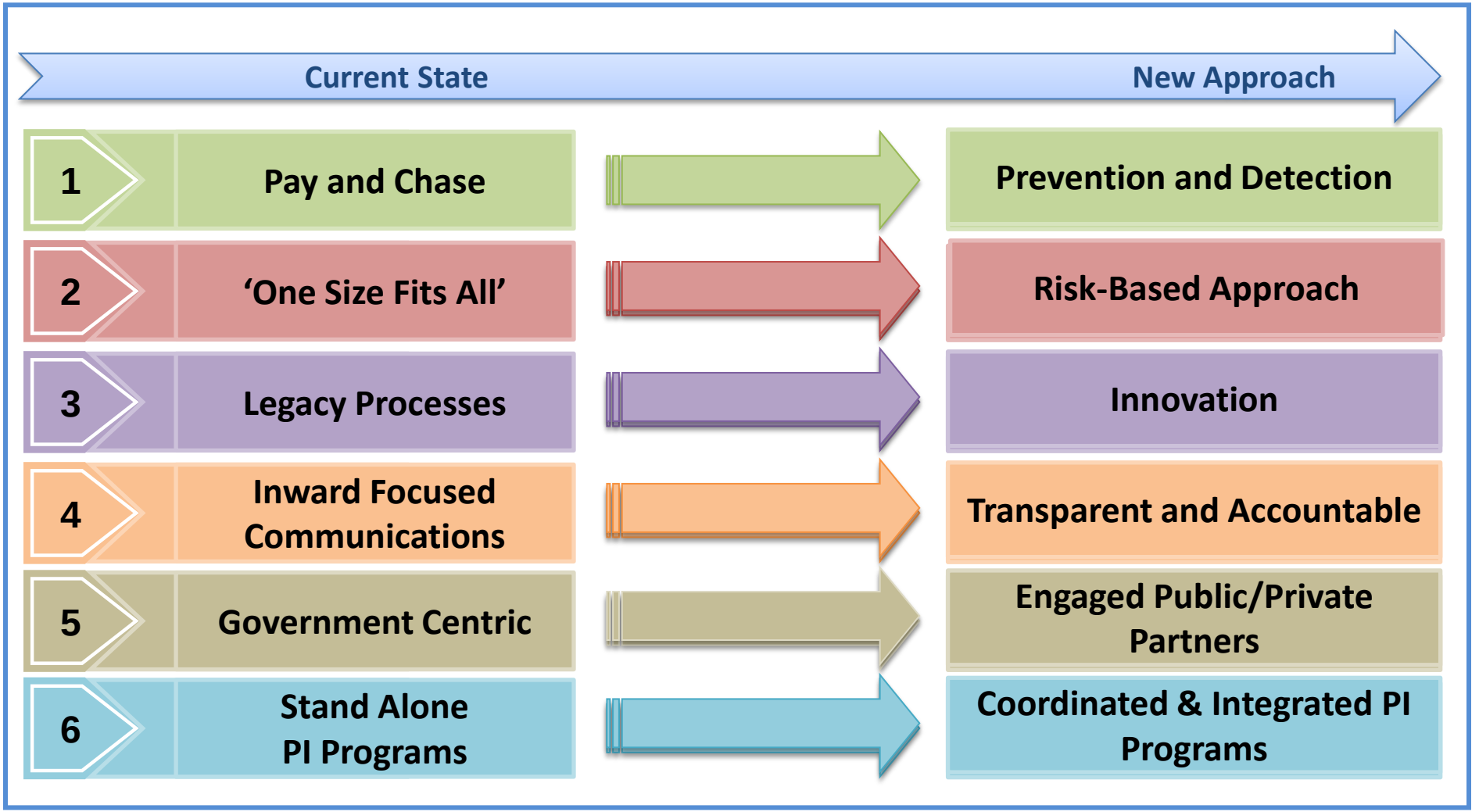
All of these new authorities and analytical tools will help move CMS beyond its historical "pay and chase" mode to a prevention-oriented approach with strong fraud deterrents and increased enrollment screenings, new disclosure and transparency guidelines, and early identification of high-risk providers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

Conclusion

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

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

Center for Program Integrity



Peter P. Budetti, M.D., J.D.

Dr. Peter Budetti is Deputy Administrator for Program Integrity at the Centers for Medicare & Medicaid Services (CMS), and the Director of the CMS Center for Program Integrity. He has principal responsibility for program integrity policies and operations in the Medicare and Medicaid Programs. Before joining CMS, Dr. Budetti worked in a number of health care positions in government and the private sector.

Dr. Budetti's previous government service includes six years as Counsel, Subcommittee on Health and Environment, U.S. House of Representatives, under the Chairmanship of Congressman Henry A. Waxman. He was also a member of the professional staff, Senate Finance Committee, under the Chairmanship of Senator Daniel Patrick Moynihan and was a core legislative drafter for President Bill Clinton's Health Security Act. In his academic life, he founded and directed health policy research centers and held tenured professorships at Northwestern University and The George Washington University, and was a member of the faculty of the Philip R. Lee Institute for Health Policy Studies, University of California, San Francisco. Immediately before his appointment at CMS in February of 2010, Dr. Budetti had been the Edward E. and Helen T. Bartlett Foundation Professor of Public Health, Department of Health Administration and Policy, College of Public Health, University of Oklahoma, for over six years. During the 2009-2010 academic year he was on sabbatical, working with the National Association of Insurance Commissioners in Washington, D.C., on antifraud initiatives. Dr. Budetti was a member and long-time Chairman of the Board of Directors of Taxpayers Against Fraud (TAF), a nonprofit, public interest organization dedicated to combating fraud against the Federal Government.

Dr. Budetti's medical degree is from Columbia University College of Physicians and Surgeons; law degree from Boalt Hall, University of California, Berkeley; and undergraduate degree from the University of Notre Dame. A board-certified pediatrician and member of the California Bar (inactive), he was elected to the National Academy of Social Insurance in 1996.

Deborah A. Taylor

Deborah Taylor is the Centers for Medicare & Medicaid Services' (CMS') Chief Financial Officer (CFO) and the Director of the Office of Financial Management (OFM). As CMS' senior financial management executive, she is accountable and responsible for planning, directing, analyzing and coordinating the agency's comprehensive financial management functions, including the release of CMS' Annual Financial Report.

Ms. Taylor served as the Deputy Director of OFM for 5 years. Prior to becoming the Deputy Director, Deborah served as the Deputy CFO/ Director of the Accounting Management Group. In that position she was responsible for the financial management activities for the Medicare program including CMS' accounting processes, policies and all related financial reporting; debt referral; debt compromise and settlement activities; oversight of Medicare contractors financial management activities; and monitoring of the internal control environment.

Before joining CMS, Ms. Taylor served as the Assistant Director for Health and Human Services Audits for the General Accountability Office for 12 years. She has a vast array of accounting and auditing background having performed financial statement audits and reviews at such agencies as the IRS, Customs Service, D.C. Government, and CMS. She also worked closely with the FASAB and OMB in the development of several accounting standards and financial management requirements. She is an active member of the D.C. Chapter for the Association of Government Accountants (AGA), the Association for Independent CPAs (AICPA), and is a Certified Government Financial Manager.

Ms. Taylor has a Bachelor of Science degree in accounting from George Mason University and received her CPA from the state of Virginia in 1996.