STATEMENT OF

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ON

HARNESSING TECHNOLOGY AND INNOVATION TO CUT WASTE AND CURB FRAUD IN FEDERAL HEALTH PROGRAMS

BEFORE THE

UNITED STATES SENATE COMMITTEE ON HOMELAND SECURITY & GOVERNMENTAL AFFAIRS,

SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT INFORMATION, FEDERAL SERVICES, AND INTERNATIONAL SECURITY

JULY 12, 2011

U.S. Senate Committee on Homeland Security & Governmental Affairs
Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security

Hearing on "Harnessing Technology and Innovation to Cut Waste and Curb Fraud in Federal Health Programs"
July 12, 2011

Chairman Carper, Ranking Member Brown, and Members of the Subcommittee, thank you for the invitation to discuss how the Centers for Medicare & Medicaid Services' (CMS) advanced technological initiatives will draw on private sector experience to reduce fraud, waste, and abuse in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

The Administration is committed to reducing fraud, waste, and improper payments. On June 13, 2011, President Obama launched the Campaign to Cut Waste, a campaign to find and eliminate misspent tax dollars in every agency and department across the Federal government.

Complementing that effort, on July 1, 2011, CMS implemented a new predictive modeling technology developed with private industry experts to fight Medicare fraud. Similar to the technology used by credit card companies, predictive modeling will help identify fraudulent Medicare claims prior to payment on a nationwide basis so we can begin to take action to stop fraudulent payments before they are made. This initiative builds on the new anti-fraud tools and resources provided by the Affordable Care Act. These tools include new screening and enrollment requirements, strengthened authority to suspend potentially fraudulent payments, and increased coordination of antifraud actions and policies between Medicare and Medicaid. Together, these tools are helping us move beyond "pay and chase" recovery operations to an approach that prevents fraud and abuse prior to providing payment.

Predictive Modeling

To combat health care fraud more effectively, CMS is developing new methods and technologies to get ahead of criminals and identify their patterns of behavior early. We have launched an ambitious national effort to stop criminals at every step of the claims process – by strengthening Medicare enrollment standards and processes, by making it harder for fraudsters to bill

Medicare, and now by seeking to uncover suspicious billing patterns that may indicate fraud. This is not easy, but it is a challenge this Administration is committed to meeting. Every workday, Medicare pays out more than $1 billion from 4.5 million claims, and is statutorily required to pay claims quickly, usually within 14 to 30 days. Preventing fraud in Medicare involves paying serious attention to an important balance: carrying out our core responsibility to protect beneficiary access to necessary health care services and to reduce the administrative burden on legitimate providers, while identifying and thoroughly investigating suspect claims and reducing fraud, waste, and abuse.

The new authorities given to us by Congress and the experience of private sector industries in combating fraud have greatly enhanced our capacity to carry out this task. We are now using predictive modeling technology to assign risk scores to Medicare claims, which can allow us to focus our investigative resources. Predictive modeling is an innovative technology that can detect potential fraud and abuse by simultaneously analyzing multiple data sources, such as provider billing patterns and the distance between service location and a beneficiary's address, for a very large number of claims. Many private industries use similar predictive models to protect against fraud. Our new system is able to identify suspect claims before we pay. Through this new technology, we now have an integrated view of fee-for-service Medicare claims nationwide, expanding our analysis beyond designated regions to reveal scams that may be operating across the country. This comprehensive view allows our investigators to see and analyze billing patterns as claims are submitted, instead of relying primarily on post-payment data.

Small Business Jobs Act Authorities

Nationwide Implementation of Predictive Modeling for Medicare Fee-for-Service

CMS is actively implementing the new tools and authorities given to us by Congress to reduce fraud, waste, and abuse. The Small Business Jobs Act of 2010 (P.L. 111-240) originally envisioned a phased-in approach for predictive modeling technology. I am pleased to report that we have implemented this provision aggressively and efficiently only nine months after the President signed the bill into law. In one important aspect, we are well ahead of the statutory schedule: instead of implementing predictive modeling in an initial ten States in the first

implementation year, as required by the statute, we applied the predictive modeling technology to Medicare fee-for-service claims nationwide on July 1, 2011. All claims across the country are now being screened before they are paid. The ones with the highest risk scores will receive immediate attention and additional review by our analysts through our new rapid response strategy. The rapid response strategy will permit us to examine the conduct that produced the high-risk score, and then to consider a wide variety of appropriate actions, including claim denial, payment suspension or revocation, as well as referral to law enforcement. We decided to implement the technology nationwide to maximize the benefit from predictive models as soon as possible. Nationwide implementation also helps CMS integrate the technology into the Medicare fee-for-service program efficiently across our Medicare Administrative Contractors and anti-fraud contractors. We will also evaluate the possibility of expanding predictive modeling to Medicaid and CHIP over the next few years.

Predictive Modeling Contracts

Through the competitive solicitation and award process, we selected Northrop Grumman, a global provider of advanced information solutions, to implement our predictive modeling technology. Northrop Grumman has built an integrated team with Federal Network Systems, a Verizon company, and National Government Services, a longtime Medicare payment contractor, to develop, refine, and implement the new system, incorporating best practices from both public and private stakeholders into a system unique to CMS' needs.

Our contractor, using proven predictive models and other advanced analytics, has moved rapidly to implement the new technology. We have deployed algorithms and an analytical process that look at Medicare claims – by beneficiary, provider, service origin, and other variables – to identify potential problems and assign an ~~"a~~lert" and ~~"r~~isk scores" for those claims. The new system alerts us to a potential problem, including unusual billing patterns or other suspicious behavior , while simultaneously prioritizing claims so we can strategically target our resources for additional review and investigation, as necessary.

The Small Business Jobs Act requires two contracts, and CMS is in the final stages of awarding the second one. As described above, the first award to the integrated team of three companies

implemented all of the elements of the predictive modeling requirements on July 1, 2011. The additional contract will be awarded to develop additional predictive analytic models that will complement the existing models already in place. These models will run concurrently on the system implemented by Northrop Grumman and its team.

The new system will expand and grow in sophistication over time. We have started by using a set of well-established algorithms and will refine, develop, and identify additional algorithms over the coming months and years. We will base the new algorithms on a variety of sources, such as law enforcement investigations, private sector experience, and the results of our own data analyses and investigations.

Additional Fraud Detection Efforts

CMS is also implementing other exciting initiatives including streamlining the new health care provider enrollment requirements authorized by the Affordable Care Act. Last week, we posted a solicitation limited to eligible 8(a) contractors or businesses that meet the criteria for Small Disadvantaged Business qualification and are certified with the Small Business Administration for an automated provider enrollment screening solution following the successful completion of a pilot. The pilot leveraged an external private sector database to test the added value of augmenting our internal data on provider enrollment with publicly available information on a rolling basis. CMS verifies and validates various data elements on provider enrollment applications using a multitude of websites available to the general public. This process of verification is somewhat cumbersome, and resource intensive. Additionally, maintaining provider data is currently dependent on providers self-reporting changes in information that is relevant to Medicare enrollment. When changes are not reported at all or are reported in an untimely manner, providers who are not or are no longer eligible for enrollment continue to bill the program. We found that linking an automated screening tool to our Medicare enrollment database significantly reduced the application processing time by providing ~~"o~~ne-stop shopping" for enrollment relevant information. Continuous, automated monitoring of the enrollment database identified outdated provider records more quickly, and permitted the proactive confirmation of key information changes. This provides us with another opportunity to save

taxpayer money, particularly in the area of monitoring license expiration, by timely identifying ineligible providers and taking appropriate actions to ensure they are not improperly billing.

We anticipate that this new screening technology will automatically verify information provided on an enrollment application for all Medicare provider and supplier types in all 50 States, the District of Columbia, and the five Territories. The screening will compile CMS data and appropriate external data sources, such as the National Plan and Provider Enumeration Systems for the National Provider Identifier (NPI), the General Services Administration (GSA) Excluded Parties List, and the Office of the Inspector General (OIG) exclusion database. The screening will also actively monitor compliance with requirements such as license status or changes in physical location. We anticipate completing the competitive procurement process this fall, with full implementation by the end of the year.

Collaborating with the States

We have implemented the Medicaid and CHIP State Information Sharing (MCSIS) system that provides data directly to the States regarding terminated providers. For providers who have been terminated from one State Medicaid or CHIP program, this system will prevent enrollment in another State program, protecting scarce Medicaid and CHIP dollars. Further, CMS will be sharing information on providers that have been terminated from Medicare for cause with the State programs as well. If one program knows, all HHS (Medicare, Medicaid, CHIP) health programs should know. This tool is the beginning of a smarter, more efficient Federal-State partnership, integrating technology solutions to routinely share relevant program information in a collaborative effort.

For the continuing education of State program integrity employees, the Medicaid Integrity Institute (MII) stands out as one of CMS's most significant achievements. The MII provides a unique opportunity for CMS to offer substantive training, technical assistance, and support to States in a structured learning environment. In its three years of existence, the MII has offered numerous courses and trained over 1,600 State employees at no cost to the States. Over time, the MII intends to create a credentialing process to elevate the professional qualifications of State Medicaid program integrity employees. As a result of the MII courses, State staff from across

the country have the opportunity to engage in productive dialogue about the challenges they face combating fraud, waste, and abuse issues unique to their State Medicaid programs. This interaction permits participants to share their success stories, to learn from other's successes, to give their Medicaid programs a wider range of perspectives on available policy options, and to help identify problem providers who attempt to migrate from one State Medicaid program to another.

Collaborating with the Private Sector

Building on the momentum generated by the National Health Care Fraud Summit in January 2010, CMS, in partnership with the Health and Human Services' OIG, the Department of Justice (DOJ), and the Administration on Aging, has convened regional health care fraud prevention summits across the country. These summits, held to date in Miami, Los Angeles, New York, Boston, Detroit, and Philadelphia, 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 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 continues to explore 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 is also developing a process to share data on payment suspensions of providers and suppliers who provide services to Medicare patients with supplemental coverage from private plans. We are continuing to evaluate the possibility of sharing this data with all private plans.

Affordable Care Act Fraud-Fighting Tools

The Affordable Care Act is the most comprehensive legislative step forward to fight health care fraud in over a decade. The Act gives CMS and law enforcement officials tools they have never had before to protect Federal health care programs from fraud, waste, and abuse. It also provided $350 million in new program integrity resources, plus an inflation adjustment. With

this support, we are ramping up our anti-fraud efforts by increasing scrutiny of claims before we pay them, investing in sophisticated data analytics, and providing more "boots on the ground" to fight health care fraud. Below I explain some of the tools that improve and enhance our efforts to prevent and detect fraud, and crack down on individuals who attempt health care fraud.

Enhanced Screening and Other Enrollment Requirements

On January 24, 2011, we announced a new rule (CMS-6028-FC) implementing a number of the Affordable Care Act's powerful new fraud prevention legislative tools. Under the rule, which took effect on March 25, 2011, CMS will conduct enhanced screening of categories of providers and suppliers that have historically posed a higher risk of fraud or abuse before they enroll in Medicare, Medicaid, or CHIP. The highest-risk categories of providers and suppliers, who will undergo the most extensive scrutiny, are newly enrolling suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) and home health agencies. The rule also establishes certain triggers that would move an individual provider or supplier into higher screening levels.

The enhanced screening established under the Affordable Care Act will generate a substantial number of unannounced site visits to providers and suppliers in the moderate and high-risk categories. Additionally, providers and suppliers who have been flagged through either predictive modeling or the automated enrollment screening will also undergo site visits to verify legitimacy. We anticipate that on-site inspections to validate or obtain information of record about different types of Medicare providers and suppliers will enhance our ability to follow up on suspect and high-risk providers. It will also help us efficiently meet the new site visit requirements for an expanded set of providers while reducing the time spent on site visits. To carry out a large number of site visits within very short timeframes, we have issued a request for information on our plan to consolidate site visit activities into one single national contract.

The rule also enforces the Secretary's new authority to impose a temporary moratorium on enrolling new providers or suppliers of a particular type in certain geographic areas, if that action is necessary to prevent or combat fraud, waste, and abuse. We plan to assess the impact of any proposed moratorium on beneficiary access, and we will publish a notice, including the rationale

for the moratorium, in the *Federal Register*. Importantly, the new rule implements the additional authority in the Affordable Care Act under which CMS, in consultation with the OIG, will suspend Medicare payments to providers or suppliers pending an investigation or final action on a credible allegation of fraud. The law has a parallel provision in the Medicaid program that requires States to withhold payments to Medicaid providers where there is a credible allegation of fraud. These tools will move Medicare and Medicaid beyond a "pay and chase" mode of having to track down fraudulent payments after the fact to one that prevents fraud before it occurs.

Increased Coordination of Fraud Prevention Efforts

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

Collaborating with Law Enforcement Partners

CMS is committed to working with our law enforcement partners, who take a lead role in investigating and prosecuting alleged fraud. CMS provides support and resources to the Strike Forces, which investigate and track down individuals and entities defrauding Medicare and other government health care programs. Strike Force prosecutions are "data driven" and target individuals and groups actively involved in ongoing fraud schemes. These efforts started in Miami in 2007and expanded to Los Angeles in 2008. In 2009 and 2010 under the HEAT initiative, we continued expanding the Strike Force to Detroit, Houston, Brooklyn, Tampa and Baton Rouge, and in 2011, the Strike Forces were expanded to Dallas and Chicago.

Sharing Data to Fight Fraud

The Affordable Care Act requires the centralization of certain claims data from Medicare, Medicaid and CHIP, the Department of Veterans Affairs, the Department of Defense, the Old-

Age, Survivors, and Disability Insurance program, and the Indian Health Service. Sharing data makes it easier for agency and law enforcement officials to coordinate and identify criminals and prevent fraud on a system-wide basis. Since 2006, CMS has been building the Integrated Data Repository (IDR), a data warehouse to integrate Medicare and Medicaid data so CMS and our partners can access data from a single source. The IDR will provide a comprehensive view of Medicare and Medicaid data including claims, beneficiary, and drug information. The IDR provides greater information sharing, broader and easier access to data, enhanced data integration, and increased security and privacy of data, while strengthening our analytical capabilities. The IDR makes fraud prevention and detection efforts more effective by eliminating duplicative efforts. It also provides a more rigorous source of data to help eliminate improper payments.

The IDR is currently populated with five years of historical Medicare Parts A, B, and D paid claims, and CMS is actively working to include pre-payment claims data. This additional data will allow us to analyze previously undetected indicators of aberrant activity throughout the claims process. We are also working to include the expanded set of data elements from States' Medicaid Management Information Systems that the Affordable Care Act requires States to report. This more robust State data set will be used alongside Medicare claims data in the IDR to detect potential fraud, waste, and abuse across multiple payers. Along with the IDR, the One Program Integrity (PI) web-based portal helps share data with our 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 law enforcement to provide training and support in the use of One PI for their needs. These data initiatives will strengthen our program integrity work within State Medicaid programs and across CMS.

New Tools to Target High Risk Entities

As noted above, the Affordable Care Act strengthens the government's authority to require certain providers and suppliers program—based on the risk of fraud, waste, or abuse they pose—to undergo a higher level of scrutiny before enrolling in the Medicare program. Also, CMS issued rules on May 5, 2010 (CMS-6010-IFC) implementing Affordable Care Act provisions that require providers and suppliers who order and refer certain items or services for Medicare and

Medicaid beneficiaries to enroll in Medicare and Medicaid and maintain documentation on those orders and referrals. Finally, the Secretary may now require certain provider and suppliers to post a surety bond that is commensurate with the provider or supplier's volume of billing.

New Focus on Compliance and Prevention

Under the new law, providers and suppliers must establish compliance programs to ensure that they are aware of anti-fraud requirements and good governance practices and have incorporated those practices into their operations. Nursing homes are subject to new compliance and ethics plan requirements. Other preventive measures focus on certain categories of providers and suppliers that have a history of abuse, including Home Health agencies, DMEPOS suppliers, and Community Mental Health Centers (CMHCs). For example, on November 17, 2010, CMS finalized a rule (CMS-1510-F) implementing the Affordable Care Act requirement for patients to receive a "face-to-face" visit with an appropriate health care professional when receiving Medicare home health and hospice services. Additionally, last week on July 5, 2011, CMS issued a proposed rule (CMS-2348-P) that aligns the Medicaid face-to-face requirements with the requirements in the Medicare programs. Another proposed rule implementing provisions in the Affordable Care Act was issued last week (CMS-1525-P). It requires CMHCs to provide at least 40 percent of their items and services to non-Medicare beneficiaries in order to prevent the creation of CMHCs solely for fraudulently billing Medicare.

Looking Forward

Medicare, Medicaid, and CHIP fraud affects every American by draining critical resources from our health care system, and contributes to the rising cost of health care for all. Taxpayer dollars lost to fraud, waste, and abuse harm multiple parties, particularly some of our most vulnerable citizens, not just the Federal government.

The Administration has made a firm commitment to rein in fraud and waste. With the new predictive modeling technology and Affordable Care Act provisions discussed today, we have more tools than ever before to move beyond "pay and chase" and implement important strategic changes in pursuing fraud, waste, and abuse. Through partnerships between public and private

stakeholders, we have learned, from each other, how to better protect our health care system. I am confident that the harder we work today, the stronger our system will be for years to come.

I look forward to working with you in the future as we continue to make improvements in protecting the integrity of Federal health care programs and safeguarding taxpayer resources.