



**STATEMENT OF
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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

ON

HEALTH CARE FRAUD

BEFORE THE

**SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES,
EDUCATION, AND RELATED AGENCIES**

COMMITTEE ON APPROPRIATIONS

UNITED STATES HOUSE OF REPRESENTATIVES

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Chairman Obey, Ranking Member Tiahrt, and Members of the Subcommittee, thank you for the invitation to discuss the Administration's commitment to combat health care fraud.

Health care fraud is a national problem, prevalent in federal and state as well as private insurance programs. From our work in this area, it appears that fraud is on the rise and the criminals who perpetrate it have become more organized and sophisticated. Unfortunately, no one knows exactly how much health care fraud costs this country, but we estimate it to be in the billions of dollars each year. We are responding by coordinating anti-fraud efforts across the government, and we will establish new partnerships with the private sector as part of our approach to the problem.

Last May, the President established a joint task force between the Department of Health and Human Services (HHS) and the Department of Justice (DOJ) to strike against fraud hot spots in targeted cities across the country and develop new policies and approaches to combat health care fraud. Our joint operation, known as the Health Care Fraud Prevention and Enforcement Action Team or Project HEAT, has been enormously successful so far, and you will hear today of our plans to expand strike forces into additional cities.

Fraud can result in improper payments. But fraud is not the only cause of wasteful spending in federal health care programs. Payments for unnecessary medical services, for claims with insufficient documentation, for ineligible patients and to ineligible providers, are examples of improper expenditures that squander taxpayer dollars and drive up health care costs.

The Obama administration is focused on reducing all improper payments in federal programs, whether the result of criminal intent, greed or inefficiencies. So the Fiscal Year (FY) 2011 Budget Request to the Congress covers all types of fraud and abuse, as well as other categories of improper payments. With this funding request, we will be adding resources to law enforcement and program oversight, as well as to program integrity operations in the Centers for Medicare & Medicaid Services (CMS).

To demonstrate our commitment, the FY 2011 Budget includes a record \$1.7 billion to fight waste, fraud, and other improper payments. This includes \$561 million in discretionary funding, a \$250 million increase over FY 2010. Projecting this discretionary investment over 10 years, together with new program authorities and administrative actions proposed in the budget, will save nearly \$25 billion in Medicare and Medicaid expenditures over 10 years

Further, the President's health insurance reform proposal released on February 22nd envisions aggressive, new program integrity authorities. The President's proposal builds on the unprecedented array of new authorities to fight waste, fraud, and abuse outlined in both the House and Senate health insurance reform bills by incorporating a number of additional proposals. These proposals range from imposing tougher disclosure requirements to identifying high-risk providers who have defrauded the taxpayers.

National Summit on Health Care Fraud

Since last May, when the joint HHS-DOJ task force was established, we have dramatically increased our activity to improve our law enforcement and program integrity efforts. These efforts led to the National Summit on Health Care Fraud, held January 28, 2010. The Summit brought together federal and state officials, law enforcement experts, private insurers, computer technology professionals, health care providers and beneficiaries for an unprecedented meeting to identify the scope of fraud, identify weaknesses in current systems and propose new solutions.

The fraud Summit helped publicize our approach to enhance federal inter-agency cooperation to target fraud and identify methods to bolster these efforts, including better and faster ways of analyzing claims data to detect fraud, prosecute perpetrators, and utilize our civil and administrative remedies to recover and return money to the Medicare Trust Fund, Medicaid programs, and other victims. The Summit has also inspired a new framework of strategic principles to improve CMS program integrity operations.

Strategic Principles for Program Integrity Operations

The first strategic principle is to tailor additional interventions towards the areas where fraud and abuse are greatest. This would involve providing CMS the administrative and statutory authority to redirect resources to significant areas of fraud, waste, and abuse. For example, we have already identified Durable Medical Equipment (DME) and Home Health Care as areas highly vulnerable to waste, fraud, and abuse. As a result, CMS has instituted stricter DME supplier and home health provider enrollment requirements in an effort to reduce the number of fraudulent providers participating in these programs. We need to make the Medicare and Medicaid programs flexible enough to shift resources to scrutinize claims and providers in high risk areas. Current authorities limit our ability to scrutinize claims. As a start, with the new funding request, we will redirect contracting resources to areas of greatest vulnerability.

The second strategic principle is to improve program integrity operations for Medicare and Medicaid. It calls for consolidation and coordination of program integrity policies at CMS and an overhaul of specific contractor functions relating to program integrity efforts for Medicare and Medicaid. They need to work in concert. These programs, combined, process 3.6 billion payments a year. Contractors who work under statutory deadlines requiring the prompt payment of claims process these claims and perform post-payment reviews. We need to coordinate these Medicare and Medicaid Program integrity policies and utilize state of the art technology at both the State and Federal levels to detect fraud and improper payments before the claims are paid. We need to take on the tough job of overhauling the claims processing system, and with the commitment of the President and the help of the Congress, we intend to do just that.

The third principle is to strengthen prevention of improper payments at the front end of our claims payment systems. Due to prompt pay requirements in Medicare, currently our systems are primarily focused on processing claims. Oftentimes, improper payments are

not discovered until after expenditures have been made. We are constantly in a pay and chase mode. We are steadily working to shift our emphasis to prevention. Part of this involves redesigning computer processing networks, but it also involves stricter provider enrollment criteria to conduct on-site visits of providers.

The fourth strategic principle is to establish new partnerships with the private sector to share information and methods to detect and prevent fraud. The public and private sectors have common problems, and we should seek common solutions.

Implementing these strategic principles will be an incremental process. This is a ship that cannot be turned around all at once and we must be mindful of the potential impact of these changes on providers and beneficiaries. We must keep in mind that these programs are designed to provide health care to needy, disabled, and aging Americans. We also need to remember that the vast majority of health care providers are honest people who do the right thing and are able to help millions of people everyday. So we strive to strike the right balance between providing health care and preventing improper payments.

Immediate Steps and Accomplishments

In the short term, thanks to this Committee's support of the President's budget request to combat health care fraud in FY 2009 and FY 2010, we have the resources to take some immediate steps such as strengthening CMS' provider enrollment efforts and initiating several projects to focus on areas of high programmatic vulnerability such as durable medical equipment, home health, and infusion therapy by doing more prepayment medical review and in person interviews to ensure that the services were actually provided. The Administration has taken steps to significantly improve oversight of the Medicare Part C and Part D programs. We have invested in critical data infrastructure, enhanced field operations at CMS, the Office of Inspector General (OIG), and DOJ, and initiated new efforts to reduce improper payments. These funds have made a difference and we expect to see even more results in the coming months.

Our FY 2011 Budget request and the continued commitment of the Administration and the Department will build on these successes. Our request would invest the new appropriations on the following priorities.

Health Care Fraud Prevention and Enforcement Action Team (HEAT)

As discussed above, Project HEAT is one of our key initiatives. The Project's goals include: exposing systemic vulnerabilities that have been exploited by fraudsters; identifying geographic locations most vulnerable to Medicare and Medicaid fraud; using information gleaned from data and law enforcement experience to enact fraud prevention programs; providing additional resources to our civil enforcement efforts under the False Claims Act and other legal tools to increase the money that is recovered on behalf of government health care programs; improving data sharing, including access to real-time data, to detect patterns of fraud; and strengthening partnerships between the public and private health care sectors and among Federal agencies.

Strike Force Teams

A central feature of the HEAT initiative is the use of Strike Force teams. Strike Forces are multi-agency units of Federal and State investigators, prosecutors, and analysts designed to identify, investigate, and prosecute Medicare fraud. Strike Forces combine sophisticated data analysis techniques and community policing approaches to identify fraud quickly and target enforcement resources effectively. Strike Force teams include DOJ prosecutors, HHS OIG and the Federal Bureau of Investigation (FBI) investigators, and often local law enforcement, and these teams are supported by a CMS data analysis team and CMS program experts.

Since May 2009, this Administration has expanded Strike Force cities from two to seven locations. In addition to Miami and Los Angeles, Strike Force teams were launched in Houston and Detroit in May 2009 and then Brooklyn, Baton Rouge, and Tampa in December 2009.

In a short time, Strike Forces have proven their value. Since the first Strike Force team was launched in Miami in March 2007, Strike Force prosecutions have resulted in more than 270 convictions, indictments of more than 500 defendants, and more than \$240 million in court-ordered restitutions, fines, and penalties.

The Strike Force model also has accelerated the time frame for indicting criminals compared to the traditional criminal health care fraud case. Through a more efficient and coordinated process between our two Departments, the average length of time to secure a conviction has been nearly cut in half.

More Effective Partnership Between DOJ and HHS

The unprecedented and new partnership that HEAT has created between HHS and DOJ is breaking down bureaucratic silos to create a more efficient and coordinated effort against health care fraud.

The most critical area where this enriched partnership is already paying dividends is improved data sharing. DOJ, HHS OIG, and CMS are developing new tools and techniques to identify fraudulent activity by analyzing suspicious patterns in emerging claims data. In addition, we are improving the historical collection of Medicare claims data. Where it used to be scattered among several databases belonging to different contractors, we are combining all Medicare paid claims into a single, searchable database.

While we have come a long way in sharing this data with our partners and getting this information into the hands of law enforcement quickly, we need to do even better. We are working with our law enforcement partners to provide real-time data access, which will help stop fraudulent schemes and practices before they take root. With access to real time data and the comprehensive single searchable database, investigators will be able to use cutting edge technology and data mining techniques to identify potential fraud with unprecedented speed and efficiency.

This accomplishment means that we no longer have to wait for tips to come in. Instead, we are using tools that can show when claims for one kind of treatment may be many times higher in one county as compared to the county next door, with no reasonable explanation. For example, we were recently able to see that Miami Dade County, home to two percent of Medicare home health patients, had ninety percent of all home health patients receiving more than \$100,000 in care each year. By comparison, the average annual cost per Medicare beneficiary nationally is \$5,400. While there are legitimate situations where a home health agency should receive an increased payment for a patient with unusually high costs, what was happening in Miami Dade County appeared to be an abuse of Medicare's payment rules. To respond to this vulnerability, CMS instituted a cap on home health payments for high cost patients (called outliers) effective January 1, 2010. Through prompt actions such as this, CMS will reduce inappropriate home health payments.

Reducing Improper Payments

As I have said, reducing fraud is part of the Administration's overall goal of stopping all improper payments. Toward this end, on November 20, 2009, the President issued an Executive Order to reduce improper payments and eliminate waste in Federal programs. This Executive Order not only applied to Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), but to programs across the Federal government. While improper payment rates are not necessarily an indicator of fraud in Medicare or any other Federal program, they are an indicator of errors that need to be fixed. Improper payments include overpayments, underpayments, payments without proper documentation, and payments to ineligible participants.

HHS is working diligently to implement the requirements of the Executive Order. We have recently imposed a stricter methodology for calculating the Medicare fee-for-service (FFS) error rate. While this new, stricter methodology resulted in an increase in the FY 2009 error rate compared to previous error rates, we believe this more honest assessment of payment errors in Medicare FFS provides CMS with more complete information that can be used to focus corrective actions. Pursuant to the Executive Order, we will continue to refine our methodology to reflect the most relevant and accurate Medicare FFS error rates.

To reduce improper payments in Medicare FFS, we are taking action to ensure that providers are submitting all required documents to support a claim, that providers' signatures are legible, and that beneficiary claim histories are no longer being used to fill in missing treatment documentation. CMS will also be spending more time working with providers through increased training, education, and outreach to eliminate errors.

The development and implementation of Electronic Health Records (EHR) should also have a positive impact on reducing the error rate for Medicare FFS. After EHRs are fully implemented there will be fewer errors for illegible or missing signatures. Further, documentation errors are the most frequent reason for claim denials. The expectation is

that the EHR will contain all the documentation to support the claim. In addition, EHRs should be easier to retrieve and submit when requested because the process will be electronic, as compared to manual photocopying which can lead to omissions, causing errors because of missing documentation.

The Health Care Fraud and Abuse Control (HCFAC) Program

The FY 2011 President's Budget includes \$1.7 billion for the HCFAC program, including mandatory and discretionary sources. Of this total, the discretionary HCFAC request is \$561 million, a \$250 million increase over FY 2010. This proposal is the largest one-year increase in HCFAC since its inception in 1997 and reflects the strong commitment the Administration is making to program integrity. Further, the \$561 million request is part of a multi-year strategy to implement our strategic principles and goals, and the Budget assumes this funding level will grow over each of the next 10 years.

Not only is this increase necessary to succeed in the fight against health care fraud, but we are confident this investment will more than pay for itself. Since its inception and through FY 2008, HCFAC has resulted in the return of \$13.1 billion to the Medicare trust funds and CMS. The return-on-investment from various HCFAC activities ranges from 6 to 1 for audit, investigative, and prosecutorial work performed by OIG and DOJ to 14 to 1 for the Medicare Integrity Program's prepayment edits and claims audits. The CMS actuaries conservatively estimate that the discretionary investment included in the Budget will yield about \$10 billion in Medicare and Medicaid program savings over the next 10 years.

The discretionary HCFAC request in our budget is part of a larger, government-wide effort to invest in program integrity activities that reduce improper payments and return funds to the Federal treasury. The Administration proposes to protect dollars requested for HCFAC and other program integrity activities in the budget process through allocation adjustments, a mechanism used by past administrations and Congresses. This budget mechanism ensures that this funding will not supplant other Federal spending on these activities or be diverted to other purposes.

Building on the momentum initiated last May, the entire \$250 million increase in our Budget advances the goals of the HEAT initiative. Specifically, the increase will support:

- 1) Strike Forces: Our request will support 13 new Strike Force cities, bringing the total number of Strike Force cities to 20.
- 2) Increased Prevention and Detection: CMS will make additional investments to its One Program Integrity database, which will facilitate efforts to share data with law enforcement in real-time and continue to break down bureaucratic silos. Further, CMS will hire new analysts to mine data, monitor billing patterns, and identify potential cases of fraud.

3) Expanded Law Enforcement Strategies: This investment will expand existing criminal and civil health care fraud investigations and prosecutions, particularly related to emerging fraud schemes in areas such as pharmaceutical services, medical devices, and durable medical equipment. 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.

4) New Authorities: The increase covers the costs of implementing new authorities included in the Budget that eliminate statutory and regulatory impediments to effective health care fraud prevention and enforcement. These proposals are described in greater detail in the next section.

New Program Integrity Authorities

The President's Budget includes seven legislative and administrative proposals that will strengthen efforts to fight Medicare and Medicaid fraud and abuse. This package of proposals will save nearly \$15 billion over 10 years. The legislative proposals in the President's Budget, and additional program integrity proposals, were included in the President's health reform proposal released on February 22.

Legislative Proposals Included in the Budget

Extrapolate Medicare Advantage Plan Sample Error Rate to Entire Plan Payment in Risk Adjustment Audits: Historically, CMS has only recovered overpayments from risk adjustment errors found in the audited sample. This proposal would require that CMS recover risk adjustment overpayments by extrapolating sample error rates to all audited plans through risk adjustment validation (RADV) audits. The plan payment will only be adjusted based on a statistically valid sample of beneficiaries. This proposal saves \$7.6 billion over ten years.

Track Drug Utilizers and Prescribers to Reduce Over-utilization under Medicaid: While some States currently track high utilizers of prescription drugs in the Medicaid program, they are currently not required to do so by law. This proposal will improve Medicaid integrity and beneficiary quality of care by requiring States to monitor high-risk billing activity to identify prescribing and utilization patterns that may indicate fraud, abuse or excessive utilization of certain prescription drugs and remediate any preventable episodes of care. This proposal saves \$4.2 billion over ten years.

Establish a CMS-IRS Data Match to Identify Fraudulent Providers: A recent pilot program showed a correlation between individuals not paying taxes and defrauding the Medicare program. This proposal would authorize CMS to work collaboratively with IRS to determine which individuals and entities have not filed Federal tax returns, without disclosing protected tax information. By requiring IRS to disclose to CMS the entities that have evaded filing taxes and matching the data against provider billing data, this proposal will enable CMS to better detect potentially fraudulent providers in the Medicare program. It will also ensure that only providers who pay their taxes and comply

with the law are able to be Medicare providers. This proposal saves \$1.2 billion over ten years.

Modify Medical Review Limitations: Contractors are currently hindered in their efforts to lower improper payments by statutory limits placed on prepayment medical review. This proposal would lift medical review limitations to allow greater flexibility in identifying fraudulent providers. It will also allow a provider to remain on prepayment review for longer than one year if there is not significant improvement to that provider's error rate. This proposal saves \$73 million over ten years.

Administrative Proposals Included in the Budget

Consolidate Medical Review: This proposal will continue CMS efforts to streamline contracting and build on existing contracting reforms. It will consolidate medical review into specialized Medicare Administrative Contractors (MACs) to improve consistency and efficiency by reducing duplication of effort. This proposal saves \$1.5 billion over 10 years.

Consolidate Medicare Provider Enrollment Activities: Consolidating provider enrollment into a smaller number of specialized MACs will have many benefits: significantly reduced administrative costs, more consistent application of CMS policy, improved program oversight, and, in the end, only the best equipped contractors handling provider enrollment due to increased competition. This saves \$140 million over 10 years.

Expand Medicare Revocations for Abuse of Billing Privileges: This proposal will expand CMS authority to revoke billing privileges for providers who commit certain types of fraud, waste, and abuse. Under this expanded authority, CMS could verify whether providers' claims are valid through the review of beneficiary statements and provider attestations to determine if services or equipment were actually delivered. While this proposal does not produce significant savings, it is expected to lead to more revocations of abusive providers' billing privileges in the Medicare program.

Other Program Integrity Proposals in the President's Health Reform Proposal

The President's health insurance reform proposal, released on February 22, builds on the aggressive program integrity proposals included in the House and Senate health insurance reform bills by adding legislative proposals from the FY 2011 Budget and other Congressional health insurance reform plans. These proposals: establish a comprehensive Medicare and Medicaid sanctions database to allow law enforcement to access information related to past sanctions on providers and suppliers; prevent fraudulent health care providers from discharging overpayment amounts owed the Secretary through bankruptcy; strengthen the Secretary's ability to exclude individuals who knowingly submit false or fraudulent claims from participating in Medicare; and add strong sanctions, including jail time, for individuals who purchase, sell, or distribute Medicare beneficiary identification numbers or billing privileges under Medicare or Medicaid – if done knowingly, intentionally, and with intent to defraud. The proposals will also help States reduce health care errors, enhance patient safety, encourage efficient resolution of disputes, and improve access to liability insurance through tort reform.

Conclusion

As a Nation, we have allowed health care fraud and improper payments to begin to undermine the integrity of our public and private health care insurance programs. As a result, taxpayer dollars have been stolen, fraud has driven up health care costs, and in a few cases, patients have been endangered. Reversing the problem will require a long-term, sustainable approach. We believe we have the right approach to succeed in overturning fraud and abuse. We want to work with you as we move forward, and we ask for your guidance and support.