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ON

**MEDICARE CONTRACTORS' EFFORTS TO FIGHT FRAUD:
MOVING BEYOND "PAY AND CHASE"**

BEFORE THE

**U.S. HOUSE COMMITTEE ON ENERGY & COMMERCE,
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS**

JUNE 8, 2012

U.S. House Committee on Energy & Commerce
Subcommittee on Oversight & Investigations
Medicare Contractors' Efforts to Fight Fraud: Moving Beyond "Pay and Chase"

June 8, 2012

Chairman Stearns, Ranking Member DeGette, and Members of the Subcommittee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) program integrity efforts and its management of its contractors for the Medicare program. 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 program integrity strategy to shift beyond a "pay and chase" approach to preventing fraud. CMS' antifraud contractors are integral to our efforts to fight fraud and reduce improper payments.

CMS Fee-for-Service Antifraud Contractors

CMS' mission is to ensure health care security for all Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries. A major component in achieving this mission is the successful administration of Original Medicare, commonly known as fee-for-service (FFS) Medicare. The Medicare FFS program represents the majority of Medicare spending, with hospital and other institutional services representing the largest spending outlays.

CMS uses a variety of different contractors to administer and oversee the Medicare fee-for-service program. Each of these contractors has different roles and responsibilities. Some contractors specifically assist CMS in combating fraud and identifying improper payments, while others assist CMS' fraud fighting efforts as part of their broader responsibilities as fee-for-service contractors who process claims and recover overpayments. The antifraud contractors do not perform any inherently governmental functions. Their actions are performed consistent with detailed standards and guidance provided by the agency to perform an administrative function in support of the agency's mission.

The CMS' Office of Acquisition and Grants Management (OAGM) procures these contracts and the contracts are subject to Federal contracting laws and regulations. Once any procurement is finalized, contractor management is handled by the CMS component with primary responsibility based on the contractor's core functions. CMS' program integrity strategy is moving away from pay and chase toward a more effective strategy that identifies fraud before payments are made, keeps bad providers and suppliers out of Medicare in the first place, quickly removes wrongdoers from the program once they are detected, and recovers improper payments as early and swiftly as possible. This approach builds upon CMS' use of Medicare Administrative Contractors, Zone Program Integrity Contractors, and Recovery Audit Contractors. A description of each of these contractors is below:

Medicare Administrative Contractors (MACs)

MACs are the central point of contact for providers within the national fee-for-service program. CMS' Center for Medicare directly oversees MACs. MACs are the entities responsible for provider and supplier screening and enrollment, and they process approximately 19,000 provider and supplier enrollment applications per month to determine whether these entities meet the requirements to receive billing privileges. MACs also audit the hospital cost reports upon which CMS bases Medicare reimbursements to hospitals. CMS directs the MACs to revoke provider and supplier billing privileges when CMS, the ZPICs, or MAC data shows it as appropriate. In CY 2011, as CMS took steps to reduce vulnerabilities in the Medicare program, CMS revoked the billing privileges of 4,850 providers and suppliers, and deactivated 56,733 billing numbers.

The MACs process, approve, and deny enrollment applications according to the enrollment standards established by CMS. MACs process 4.5 million claims each day, totaling approximately 1.2 billion claims in fiscal year (FY) 2011, and handle the first level of a provider's claim appeal. They implement all Medicare payment system changes, and conduct regular training and outreach to providers to educate them on proper claims coding and new Medicare payment policies. While MACs focus on claims processing and enrollment activities generally, they also play important roles in CMS' anti-fraud efforts. For instance, MACs put automated edits in place to identify and address claim coding errors, mutually exclusive claims, or medically unlikely claims. MACs regularly analyze claims data received to identify providers

and suppliers with patterns of errors or unusually high volumes of particular claims types, and to develop additional prepayment edits. MACs coordinate the timing and implementation of these edits with other contractors. When MACs do identify potential fraud, they send the leads to the antifraud contractors to investigate further.

Zone Program Integrity Contractors (ZPICs)

CMS has nearly completed the process of transitioning from Program Safeguard Contractors (PSCs) to Zone Program Integrity Contractors (ZPICs). CMS created seven program integrity zones to align with the MAC jurisdictions. The ZPICs focus exclusively on a wide range of program integrity issues and projects. Six of the seven ZPICs have been awarded. The ZPICs and remaining PSC perform program integrity functions in these zones. The Center for Program Integrity within CMS directly manages the ZPICs. The ZPICs' main responsibilities are to:

- Develop investigative leads generated by the new Fraud Prevention System (FPS) and a variety of other sources;
- 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;
- Provide support for ongoing investigations;
- Provide feedback and support to CMS to improve the FPS; and
- Identify improper payments to be recovered.

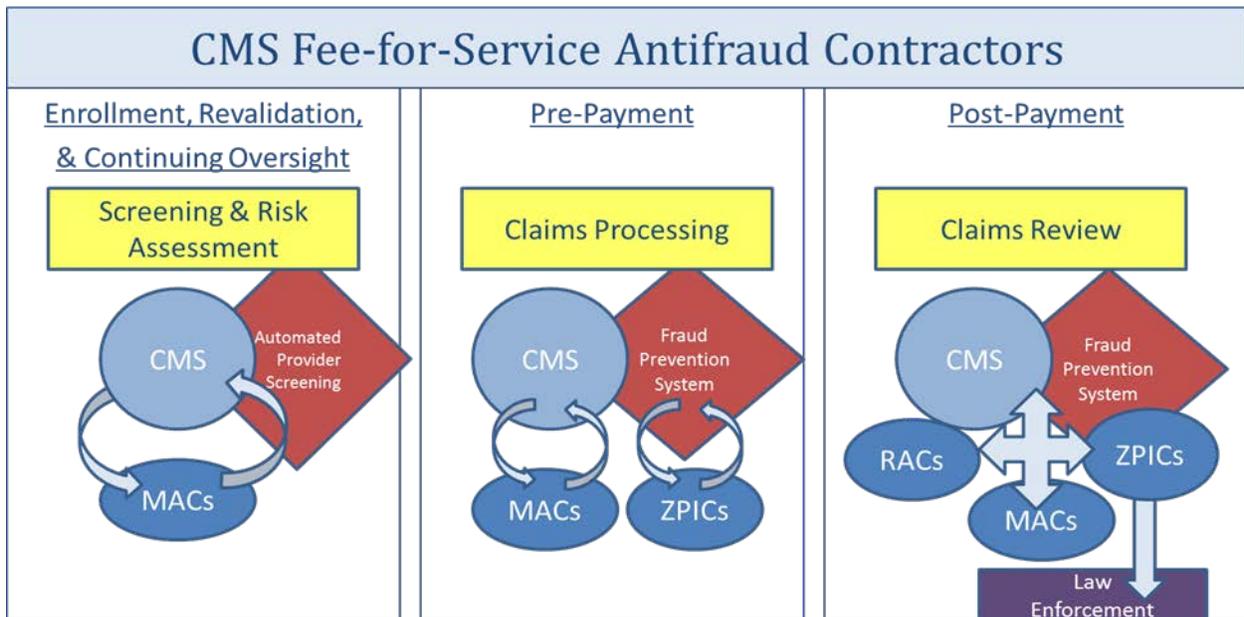
Unlike the MACs, the ZPICs' activities are dedicated exclusively to the prevention, detection, and recovery of potential fraud, waste, or abuse. The ZPICs coordinate with the MACs to implement administrative actions, including claim edits, payment suspensions, and revocations. ZPICs also refer overpayments to the MACs for collection. During 2011, CMS saved \$208 million by denying claims through pre-payment edits that ZPICs recommended to automatically stop improper claims before they are paid. ZPIC-recommended payment suspensions led to over \$27 million in recoveries against providers with overpayment demands.

Recovery Audit Contractors (RACs)

RACs’ primary responsibilities are to identify a wide range of improper payments – including, but not limited to fraud – and to make recommendations to CMS about how to reduce improper payments in the Medicare program. In the fee-for-service Medicare program, RACs have identified several vulnerabilities where CMS has implemented corrective actions to prevent future improper payments. For example, CMS’ contractors have implemented edits to stop the payment of claims provided after a beneficiary’s date of death, stop the payment of durable medical equipment claims while the beneficiary is receiving care in an inpatient setting, and stop the payment for individual services that should have been bundled into another payment. If RACs identify or uncover potential fraud, they are required to report it directly to CMS, and to refrain from reviewing claims that are subject to an ongoing fraud investigation. In FY 2011, Medicare fee-for-service RACs collected nearly \$797 million in overpayments, and already in the first half of FY 2012, Medicare fee-for-service RACs collected nearly \$1 billion in overpayments.

Figure 1 below shows how CMS and its contractors communicate with each other during three key points within the Medicare fee-for-service process.

Figure 1



Moving Beyond Pay and Chase: The Twin Pillar Strategy

CMS has recently implemented a twin pillar approach for advancing our fraud prevention strategy in Medicare. The first pillar is the new Fraud Prevention System (FPS) that 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 that is identifying ineligible providers and suppliers prior to enrollment or revalidation. Together, these two innovative, comprehensive 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 twin pillar approach builds on CMS’ use of the MACs, ZPICs, and RACs, and over time will leverage these contractor resources to more efficiently and effectively combat fraud, waste, and abuse and reduce improper payments.

The First Pillar: The Fraud Prevention System

CMS is committed to the goal of detecting potential fraud before suspect claims are paid. 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 and identifying automated claims edits that the MACs have then implemented. 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 permits CMS to efficiently integrate the technology into the Medicare fee-for-service program and train our anti-fraud contractors.

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 system 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 potentially-related 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 CMS and the ZPICs to automatically see the full picture. Equally important, the FPS organizes the data to quickly show when two providers or suppliers 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.

Importantly, the FPS is a resource management tool; the system automatically sets priorities for our program integrity contractors' workload to target investigative resources to suspect claims and providers, and swiftly impose administrative action when warranted. The system generates alerts in order of priority, allowing program integrity analysts to further investigate the most egregious, suspect, or aberrant activity. CMS and our antifraud 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. The FPS is also strengthening CMS' ability to manage the ZPICs, for instance by permitting CMS to better observe and understand differences in how various ZPICs are managing similar issues.

In the first ten months of implementation of the FPS, the new preventive system resulted in:

- Leads for 591 new investigations
- Supporting information for 419 pre-existing investigations
- Leads for 550 direct interviews with providers and suppliers suspected of participating in fraudulent activity
- Leads for over 1,541 interviews with beneficiaries to confirm whether they received services for which the Medicare program had been billed.

The FPS may be compared to similar, more well-known predictive modeling technologies, such as the algorithms employed in the credit card industry to generate interviews of cardholders

when suspect items are charged. Indeed the FPS metrics related to provider, supplier, and beneficiary interviews are particularly encouraging and exciting because they show that CMS has turned Congress' vision of bringing this proactive strategy to bear on a large scale in the Medicare arena into reality.

The Second Pillar: Enhanced Provider Enrollment and Automated Provider Screening

CMS must go beyond pay and chase to stop criminals whose intent is to enroll in Medicare, quickly submit a high dollar value of claims, and then close up shop once they have been paid. To prevent this from occurring, CMS has been working to strengthen upfront protections to keep bad actors out, as provider enrollment is the gateway to the Medicare program. This approach is more effective than one based solely on recovering overpayments because it is extremely difficult to recover overpayments from fraudulent providers and suppliers, whose goal is not to provide quality care to our beneficiaries, but rather to defraud taxpayers and CMS. Strengthened provider enrollment standards also protect beneficiaries from fraudulent providers who may provide inappropriate or low-quality care.

In September 2011, CMS began an ambitious project to revalidate the enrollment of all existing 1.5 million Medicare suppliers and providers by 2015 under the new Affordable Care Act screening requirements. The new requirements directed the Secretary to establish different levels of screening for categories of providers and suppliers based on risk. The three risk levels that have been established – limited, moderate, and high – correspond to increasing levels of scrutiny. Providers and suppliers in the moderate and high screening levels are subject to announced or unannounced site visits prior to either initial enrollment or revalidation. CMS has estimated 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. Providers and suppliers in the high level of screening will be subject to new fingerprint-based criminal history checks after CMS awards a contract with an FBI-approved company in early 2013.

To complement the new screening requirements, CMS launched the Automated Provider Screening (APS) system on December 31, 2011. The MACs have historically relied on paper

applications and crosschecking information manually against various databases to verify enrollment requirements such as licensure status. The APS conducts 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 changes that may affect the accuracy of its enrollment data even after providers and suppliers are enrolled or revalidated, and to assess applicants' risk to the program using standard analyses of provider and supplier data.

Since March 25, 2011, CMS has enrolled or revalidated enrollment information for approximately 275,439 Medicare providers and suppliers under the enhanced screening requirements of the Affordable Care Act. The first phase of revalidation led to 13,066 deactivations of provider and supplier 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 and supplier enrollment records for non-response and 4,319 revocations after it was determined the providers and suppliers were not properly licensed in the State in which they were enrolled, as of May 1, 2012.¹

Provider enrollment safeguards, recently improved by the new APS, are CMS's first line of defense against paying fraudulent or improper claims. These improvements are vitally important because they enable legitimate providers and suppliers to enroll easily and quickly in the Medicare program, while clamping down on bad actors to keep them out of the program.

Post-Payment Review and Recovery of Improper Payments

CMS has an additional opportunity to administratively recover improper payments after payment is made, through analysis and investigation conducted by Medicare contractors.

After payment is made, CMS and its contractors continue to analyze FPS results and historical claims data to identify suspected overpayments and potential fraud. ZPICs may make fraud

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.

referrals to law enforcement for further investigation, or identify and send potential fraudulent or improper payments to MACs to collect, or in some situations, do both.

In cases of fraud, CMS vigorously pursues post-payment remedies, including overpayment recoveries, in close collaboration with our law enforcement colleagues. In conjunction with CMS' antifraud efforts, our law enforcement partners have recovered \$4.1 billion in FY 2011, including \$2.5 billion to the Medicare Trust Fund. Our recovery efforts have been strengthened by collaboration between Department of Health and Human Services (HHS) and the Department of Justice (DOJ) on the joint Health Care Fraud Prevention & Enforcement Team (HEAT) which combines the agencies' analytic, investigative, and prosecutorial resources in fraud hot spots to form Strike Forces. Since 2008, the number of defendants charged with criminal health care fraud has increased by more than 75 percent, from 797 in 2008 to 1,430 in 2011.

For potential overpayment referrals to a MAC, the MAC makes a final determination as to the dollar amount to demand for recovery and sends the demand letter to the provider.

MACs validate ZPIC-recommended potential overpayments against a variety of sources, including contractual and regulatory requirements, as well as their review of the claims information. The MAC reviews the claims history to determine if there have been other adjustments or recovery actions, which could affect the demanded amount, and if the amounts identified were for claims paid within the past four years, the period that is open for collection of overpayment unless there is "fraud or similar fault." If there have been other adjustments or recovery actions on a claim, then the overpayment amount could be affected because portions of the ZPIC-identified overpayment may have already been recovered by the other Medicare contractors. While providers and suppliers may repay the overpaid amounts directly to a MAC, it is more typical for MACs to collect overpayments by adjusting future claims payments, making it operationally simple and effective to recoup payment from providers and suppliers that are still actively billing. If a provider or supplier appeals the determination, collection must be stayed until completion of the administrative appeals process. The provider or supplier has 120 days to appeal the overpayment determination. If providers or suppliers are delinquent on the repayment of determined overpayments after 6 months, the debt is referred to the Department of Treasury for collection.

While post-payment reviews may suffice to recover overpayments from legitimate, established providers and suppliers, there are significant challenges to recovering overpayments from those that are attempting to defraud the Medicare program. ZPICs target their analysis and investigative resources exclusively towards identifying possible illegitimate providers and fraud. However, MACs sometimes have difficulty recovering the ZPIC-identified overpayments since such illegitimate providers tend to close their businesses, liquidate their assets, or leave the country as soon as Medicare payments stop or when they receive an overpayment demand letter from the MACs. In these situations, the MACs' typical way of collecting overpayments by adjusting future claims may not be as effective, since there will be no future claims. Because of the nature of fraud and the fact that bad actors often are not operating legitimate, ongoing healthcare businesses, CMS' fraud prevention strategy is the key to protecting the Trust Funds from would-be bad actors. New tools available to CMS, like our twin pillar strategy, prevent payment to fraudsters in the first place and provide new ways to keep them from re-enrolling in some other guise, while working in conjunction with the aggressive pursuit of overpayment recoveries and support of our law enforcement partners in criminal investigations and prosecutions.

RACs conduct post-payment reviews and make recommendations to CMS by identifying opportunities for reducing improper payments. Overpayments identified by the Medicare FFS RACs are also sent to the MACs for collection. In the past, RAC reviews in Medicare have focused on incorrect coding, erroneous billing practices, and billing for the wrong setting of care. Unlike other Medicare program integrity contractors, RACs' reviews are more likely to identify overpayments from providers who are still enrolled and billing in Medicare.

The Medicare FFS RAC program has had increasing success since its national implementation in October 2009, which has resulted in the recovery of over \$1.86 billion in overpayments. Already in the first half of FY 2012, the RACs have collected more overpayments than during all of FY 2011.

CMS MA and Part D Contractors

The Medicare Advantage (MA) managed care benefit (Part C) and the prescription drug benefit (Part D) differ significantly from Medicare fee-for-service and, as a result, require different approaches and internal controls to measure and address improper payments. Unlike Medicare fee-for-service, CMS prospectively pays Medicare Part C and Part D plans a monthly capitated payment. Each per-person payment is based on a bid amount, approved by CMS, that reflects the plan's estimate of average costs to provide benefit coverage to enrollees. CMS adjusts these payments to take into account the cost associated with treating individual beneficiaries based on health status. This process is called “risk adjustment.” CMS is using the Risk Adjustment Data Validation (RADV) program to reduce the payment error rate in the MA program and save taxpayer money. In addition, Part D payments are also reconciled against expected costs, and risk-sharing rules authorized in law are applied to further mitigate plan risk. All MA and Part C plans are required to have a compliance program in place, which includes a program to prevent, detect, and refer fraud, waste, and abuse. As part of these compliance program efforts, MA and Part D plans are also required to apply these policies and procedures to their downstream entities, such as their Pharmacy Benefit Manager, network pharmacies, and contracted providers.

CMS contracts with two private organizations, called Medicare Drug Integrity Contractors (MEDICs) for all MA and Part D program integrity work. The national benefit integrity MEDIC has the following responsibilities:

- Managing all incoming complaints about Part C and Part D fraud, waste, and abuse;
- Using new and innovative techniques to monitor and analyze information to help identify potential fraud;
- Working with law enforcement, MA and prescription drug plans, consumer groups, and other key partners to protect consumers and enforce Medicare’s rules; and Identifying program vulnerabilities.

The outreach and education MEDIC has the following responsibilities:

- Facilitating a quarterly workgroup with key partners; and
- Providing basic tips for consumers on how to protect themselves from potential scams.

The national benefit integrity MEDIC also conducts proactive analyses that result in case referrals to law enforcement. For example, the national benefit integrity MEDIC conducts a proactive analysis called Miles Too Great. Miles Too Great identifies instances when it is unlikely that a beneficiary could fill a prescription in two or more locations that are too far apart. This relatively simple calculation may identify drug-seeking beneficiaries, over-prescribers, or services not rendered. Another method is to look at pharmacy change of ownership and determine if there is a sudden change in billing behavior after the change of ownership. From April 2010 to May 2012, the national benefit integrity MEDIC referred cases associated with \$169 million in Part D payments to law enforcement because of proactive data analysis.

In FY 2011, the national benefit integrity MEDIC received approximately 342 actionable complaints (within the MEDIC's scope) per month, processed 34 requests for information from law enforcement per month, and referred an average of 36 cases per month. The national benefit integrity MEDIC was responsible for assisting the HHS Office of Inspector General and DOJ (through data analysis and investigative case development) in achieving 4 guilty pleas, 7 arrests, and 8 indictments. One case produced a 34-count indictment and included a group of 25 individuals and 26 pharmacies owned by one individual in the Detroit area involving approximately \$38 million in Medicare funds.

The outreach and education MEDIC hosts quarterly Part C and Part D fraud workgroup meetings where attendees share information and data on identified or suspected fraudulent schemes. CMS, pharmacy benefit managers, sponsoring organizations, MA plans, as well as local, State, and Federal law enforcement officials attended the workgroups. The Part D workgroup recently provided a useful forum for discussion of inventory shortages involving Part D claims (for example, drugs billed, but not dispensed).

Looking Forward

Medicare provides essential health benefits to millions of Americans who depend on the program to receive the health care they need. Protecting these benefits relies on coordination and communication between CMS and the contractors described today, as well as Medicare providers, beneficiaries, and law enforcement. CMS has demonstrated success in the collection

of overpayments using the RACs, and I believe the new innovative, preventive antifraud tools will likewise provide increasingly greater program integrity protections to Medicare for a long time to come. CMS continues to implement a wide range of improvements aimed at preventing payments to bad actors that may not continue in business once their fraudulent activities are uncovered. Today, I am happy to say, CMS and our contractors have more tools than ever to 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.