STATEMENT OF

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ON

"SAVING TAXPAYER DOLLARS BY CURBING WASTE AND FRAUD IN MEDICAID"

BEFORE THE
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Hearing on "Saving Taxpayer Dollars by Curbing Waste and Fraud in Medicaid"
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Chairman Carper, Ranking Member Brown, and Members of the Subcommittee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) program integrity efforts for the Medicaid 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 and implemented large-scale, innovative improvements to our program integrity strategy to shift beyond a "pay and chase" approach by focusing new attention on preventing fraud. Simultaneously, CMS is using the same innovative tools to further enhance our collaboration with our State and law enforcement partners in detecting and preventing fraud.

Preventing and Detecting Fraud in the Federal Health Care Programs

CMS directly administers Medicare through contracts with private companies that process claims for Medicare benefits. Medicaid is administered by the States within the bounds of Federal law and regulations, and CMS partners with each State Medicaid program to support program integrity efforts. In April 2010, Secretary Sebelius announced the alignment of Medicare and Medicaid program integrity functions with the creation of the Center for Program Integrity (CPI) in CMS. This newly-established Center brought together the oversight of Medicare Program Integrity and Medicaid Program Integrity to coordinate resources and best practices for overall program improvement. The Affordable Care Act (P.L. 111-148 and P.L. 111-152) and the Small Business Jobs Act of 2010 (P.L.111-240) provided additional opportunities to strategically combat fraud, waste, and abuse with a coordinated approach in Medicare and Medicaid.

The New "Twin Pillar" Strategy

CMS has implemented a twin pillar approach to fraud prevention in Medicare that builds upon program integrity efforts focused on detecting and prosecuting fraud. The first pillar is the new Fraud Prevention System (FPS), which applies predictive analytic technology on claims prior to payment to identify aberrant and suspicious billing patterns. The second pillar is the Automated Provider Screening (APS) system, which identifies ineligible providers or suppliers prior to their enrollment or revalidation. Together, these innovative new systems, the FPS and APS, are growing in their capacity to protect patients and taxpayers from those intent on defrauding our programs. These pillars represent a comprehensive 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 Medicaid Program

Medicaid is the primary source of medical assistance for 56 million low-income and disabled Americans. Although the Federal government establishes requirements for the program, States design, implement, administer, and oversee their own Medicaid programs. The Federal government and States share in the cost of the program. State governments have a great deal of programmatic flexibility within which to tailor their Medicaid programs to their unique political, budgetary, and economic environments. As a result, there is variation among the States in eligibility, services, reimbursement rates to providers and health plans, and approaches to program integrity. The Federal government reimburses a portion of State costs for medical services through a statutorily determined matching rate called the Federal Medical Assistance Percentage, or FMAP, which is based on each State's per capita income relative to the national average and normally ranges between 50 and 75 percent. The Federal government also reimburses the States a portion of their administrative costs through varying matching rates determined according to statute, ranging from 50 percent to 90 percent. The total net Federal Medicaid outlays in fiscal year (FY) 2011 are approximately $275 billion.

Preventing and Detecting Fraud in Medicaid

States have primary responsibility for policing fraud, waste, and abuse in their Medicaid programs, and they have significant financial interest in doing so as they pay, on average, 43 percent of the cost of the program. CMS plays a significant role through the provision of technical assistance,

guidance, and oversight in the State-based efforts. Section 1936 of the Social Security Act ("the Act") provides CMS with the authorities to fight fraud and abuse by Medicaid providers by requiring CMS to contract with private sector entities to review provider claims data, audit providers, identify overpayments, and educate providers and other individuals about payment integrity and quality of care. CMS works with partner agencies at the Federal and State levels to enhance these efforts, including preventing the enrollment of individuals and organizations that would abuse or defraud the Medicaid program and removing fraudulent or abusive providers when detected.

CMS is evaluating many of the tools used in Medicare for opportunities to transfer the knowledge and lessons learned to the Medicaid program. Specifically, CMS is evaluating the use of the twin pillars, FPS and APS, on State data. CMS is also actively pursuing ways to apply advanced data analytics technology, including predictive analytics, to the Medicaid program. CMS is required, under the Small Business Jobs Act of 2010, to complete an analysis of the cost-effectiveness and feasibility of expanding predictive analytics technology to Medicaid and the Children's Health Insurance Program (CHIP) after the third implementation year of the FPS. Based on this analysis, the law requires CMS to expand predictive analytics to Medicaid and CHIP by April 1, 2015.

CMS is currently working to identify specific FPS algorithms applicable to Medicaid and will be performing an analysis of one State's Medicaid claims data using the identified algorithms. Once the analysis is complete, we will share the results with the State. We anticipate the analysis being complete before the end of the year. As another example, CMS is engaged in an additional pilot to screen all of one State's Medicaid providers using the APS. Once the analysis is complete, we will provide the results to the State for their action as appropriate. The goal of this test project is to demonstrate the utility of using an automated screening application to screen Medicaid providers, and we expect results later this year. Once we test the effectiveness of these types of solutions in Medicaid, our goal is to expand these capabilities to more States. CMS is also supporting States' use of predictive analytics through technical assistance and education.

CMS is collaborating with our State partners to ensure that those caught defrauding Medicare will not be able to defraud Medicaid, and those identified as fraudsters in one State will not be able to replicate their scams in another State's Medicaid program. Specifically, the Affordable Care Act

and CMS' implementing regulations require States to terminate from the Medicaid program those Medicare providers or suppliers whose billing privileges have been revoked, or terminated for cause by another State's Medicaid or CHIP program. Similarly, under current authority, the Medicare program may also revoke the billing privileges of its providers or suppliers terminated by State Medicaid or CHIP agencies.

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

CMS Collaboration with States on Medicaid Program Integrity

To address Medicaid's structure as a Federal-State partnership, CMS has developed initiatives specifically designed to assist States in strengthening their own efforts to combat fraud, waste, and abuse. The Medicaid Integrity Institute (MII) is one of CMS' most significant achievements in Medicaid program integrity. The MII provides for the continuing education of State program integrity employees, including specific coursework focused on predictive analytics. At the MII, CMS has a unique opportunity to offer substantive training, technical assistance, and support to States in a structured learning environment. From its inception in 2008 through May 2012, CMS has continually offered MII courses and trained more than 3,000 State employees at no cost to the States. These State employees are able to learn and share information with program integrity staff from other States on topics such as emerging trends in Medicaid fraud, data collection, and fraud detection skills, along with other helpful topics. In 2012, CMS has already held several events at the MII and plans to host a Data Expert Symposium this summer to bring together State Medicaid data experts to exchange ideas about predictive analytics, including algorithm development and trend analysis.[1]

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

Additionally, to provide effective support and assistance to States to combat Medicaid fraud, waste, and abuse, and to gauge States' efforts in this regard, CMS conducts triennial comprehensive reviews of each State's program integrity activities. We use the State Program Integrity Reviews to identify and disseminate best practices. The review areas include provider enrollment, provider disclosures, program integrity, managed care operations, and the interaction between the State's Medicaid agency and its Medicaid Fraud Control Unit (MFCU). CMS also conducts follow-up reviews to evaluate the success of the State's corrective actions.

Through its reviews, CMS has identified 52 unduplicated program integrity "best practices" that we have publicized to all States through annual summaries of our efforts. The guidance includes specific examples of how States have created well-functioning and committed partnerships between the State Medicaid agency and its MFCU. CMS, working with State Medicaid agencies and MFCUs, issued guidance in September 2008 entitled "Performance Standard for Referrals of Suspected Fraud from a Single State Agency to a Medicaid Fraud Control Unit." CMS, State Medicaid agencies, and MFCUs developed this performance standard to provide State program integrity units with a clear understanding of how to comply with requirements for making referrals of fraud to MFCUs. In concert with the release of the performance standard, MIG issued a second guidance document, "Best Practices for Medicaid Program Integrity Units' Interactions with Medicaid Fraud Control Units." This document advises State program integrity units of the circumstances under which they should refer cases to their MFCUs, and provides guidance for interactions between State program integrity units and their MFCUs, with specific examples of actions taken by States that have created well-functioning and committed partnerships between the two entities.

CPI is taking steps to improve communication and coordination on cross-cutting issues, which will strengthen program integrity efforts in both Medicare and Medicaid while potentially saving both programs valuable resources. For example, many States require that Medicaid DME providers be enrolled in Medicare to participate in Medicaid. In these states, there are opportunities to leverage resources and share information regarding changes in enrollment status and the results of site visits and other investigations. We are partnering with three States to test strategies and develop processes for improved information sharing between programs regarding DME provider enrollment activities.

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

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

CMS Redesign of the National Medicaid Audit Program

CMS has learned important lessons during the initial years of the Medicaid Integrity Program. Beginning in early 2010, CMS determined through internal analysis, environmental assessments, parallel discussions with stakeholders, and reviews of contractor performance that the initial auditing model of the Medicaid Integrity Program required fundamental changes to effectively support States in their efforts to combat fraud, waste, and abuse in their Medicaid programs. In short, we recognized that audits based solely on a subset of post-payment data provided to the Federal government (the Medicaid Statistical Information System (MSIS)) [2] and carried out with little input from States had mixed results, at best. The Department of Health and Human Services' Office of Inspector General (HHS-OIG) and the Government Accountability Office (GAO) have

[2] MSIS data is the primary data source for Medicaid statistical data, and is a subset of Medicaid eligibility and claims data from all 50 States and the District of Columbia.

reported findings consistent with those identified by our internal assessments. CMS' 2010 Annual Report to Congress[3] on the Medicaid Integrity Program contained a section entitled "Redesign of the National Audit Program" that described how CMS was approaching improvements to Medicaid program integrity. Since February 2011, CMS stopped initiating audits by our contractors based on the results of algorithms developed solely using MSIS data. CMS instead has focused on developing collaborative auditing projects with the States.

The collaborative approach allows CMS to work alongside States in identifying areas that warrant further investigation and to develop the audit targets. Through this process CMS can more effectively support a State's program integrity efforts. In addition, the corresponding data for the collaborative audits is in many cases provided or supplemented by the States, making the data more complete and thus increasing the accuracy of any audit findings. The number of collaborative audits has progressively increased.

Since the earliest collaborative audits were assigned to Medicaid Integrity Contractors (MICs) in January 2010, CMS has worked with States to develop and assign 137 collaborative audits in 15 States that collectively represent approximately 53 percent of all Medicaid expenditures in FY 2011. CMS is committed to expanding collaborative audit projects to a broader number of States, and is in discussions with 15 additional States that make up approximately 26 percent of FY 2011 Medicaid expenditures.

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

[3] http://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/Downloads/fy10rtc.pdf; page 24.

As noted earlier, others came to many of the same conclusions for the need for changes to strengthen Medicaid program integrity that resulted from our own internal analysis. Recently, the HHS OIG,[4] the Medicaid and CHIP Payment and Access Commission (MACPAC),[5] the National Association of Medicaid Directors (NAMD),[6] and GAO[7] have identified many of these same factors and have made recommendations for changes to the Medicaid Integrity Program that parallel CMS' plans for restructuring the program. We appreciate the work of our oversight partners and have taken their recommendations into consideration as we make ongoing changes to improve the program integrity efforts in the Medicaid program.

Both the OIG and GAO reports primarily focused on early results of the National Medicaid Audit Program and noted CMS' efforts to improve its program and expand collaborative audits with States appear to enhance results. In CMS' review of the relevant reports, including those from MACPAC and NAMD, we note there were similar recommendations, and we are pleased to note the Medicaid Integrity Program improvements CMS has initiated address many recommendations in those reports. Beyond the expansion of collaborative audits, examples include improving alignment of State and Federal audit activities, expanding support and training of State program integrity staff in vulnerable areas such as program integrity oversight of managed care and evolving integrated care models, facilitating development of State capacity and access to cost effective analytics technology, and providing guidance for better quantifying the effectiveness of program integrity activities to demonstrate impact of cost avoidance from prevention.

CMS is implementing the program redesign in a phased approach which involves piloting new concepts and sharing best practices with States, as well as collaborating with States to use State data directly for the National Medicaid Audit Program. These improvements include expanding reviews to managed care entities, refining the identification of audit targets like high-risk providers serving

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

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

[6] NAMD, "Rethinking Medicaid Program Integrity: Eliminating Duplication and Investing in Effective, High-Value Tools." March 2012. http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/namd_medicaid_pi_position_paper_final_120319.pdf

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

both Medicare and Medicaid beneficiaries, examining areas where greater efficiency can be obtained, and enhancing support to States in their recovery of overpayments.

CMS is constructing an analytical approach that will assist States with their assessment of managed care rate setting. In addition, we intend to assess industry practices, share State best practices, and exchange ideas through the educational courses CMS sponsors at the Medicaid Integrity Institute.

Improving Data to Fight Fraud in Medicaid

CMS has made significant improvements to our databases and analytical systems in recent years. However, we acknowledge that more can be done. CMS is committed to enhancing the quality and availability of our data to States. CMS is keenly aware that States' appropriate access to Medicare data and analytic tools could strengthen the State agency's ability to prevent and mitigate improper Medicaid payments. CMS is working toward solutions to provide States with sufficient access to CMS data for program integrity purposes. There are privacy, contractual, operational and potential regulatory constraints that need to be resolved in order to implement an efficient and effective process for sharing Medicare data with States for program integrity. However, the agency does release Medicare data to states for research purposes, which could include some data analysis for program integrity; we are looking into what flexibilities may be within existing research protocols to allow States, for example, to use predictive analytic models to identify fraudulent activity worth scrutiny. We anticipate solutions will need to be implemented in stages based on current constraints and technology.

Additionally, CMS recently launched an initiative to transform the agency's approach to data and analytics. The Office of Information Products and Data Analysis (OIPDA) was established in May 2012 to make development, management, use, and dissemination of data and information resources a core function of CMS. [8] Over time, the initiative will modernize CMS' intricate data systems and policies, and help the agency to achieve the greatest improvements in health care delivery.

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8 http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4371&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&

Integrated Data Repository (IDR)

CMS has made great progress in building the Integrated Data Repository (IDR) to provide a comprehensive view of Medicare and Medicaid data including claims, beneficiary data, and drug information, and continues to address the remaining issues. The IDR provides broader and easier access to data and enhanced data integration while strengthening and supporting CMS' analytical capabilities. The IDR is currently populated with seven years of historical Medicare Parts A, B, and D paid claims, and CMS has recently integrated Part B and DME pre-payment claims. Part A pre-payment claims data will be integrated later this summer.

The IDR continues to be an integral part of CMS' data strategy. The IDR ensures a consistent, reliable, secure, enterprise-wide view of data supporting CMS and its partners in more effective delivery of quality health care at lower cost to CMS' beneficiaries through state-of-the-art health informatics.

CMS is also working to incorporate State Medicaid data into the IDR, while also working with States to improve the quality and consistency of the data reported to the Federal government from each State. MSIS data has been the primary data source for Medicaid statistical data. It is a subset of Medicaid eligibility and claims data from all 50 States and the District of Columbia. To improve the quality of the MSIS data, and Medicaid data in general, CMS established the Medicaid and CHIP Business Information Solution (MACBIS) Council. This Council provides leadership and guidance in support of efforts to create a more robust and comprehensive information management strategy for Medicaid and CHIP. The Council's strategy includes:

- Promoting consistent leadership on key challenges facing State health programs;
- Improving the efficiency and effectiveness of the Federal-State partnership;
- Making data on Medicaid, CHIP, and State health programs more widely available to stakeholders; and
- Reducing duplicative efforts within CMS and minimizing the burden on States.

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

MACBIS projects will lead to the development and deployment of improvements in data quality and availability for Medicaid program administration, oversight, and program integrity.

One Program Integrity (One PI)

Improved data and analytical tools will allow CMS and its partners to analyze information from throughout the claims process to identify previously undetected indicators of aberrant activity. Used with the IDR, CMS' One PI web-based portal, and analytic tools helps CMS share data with our integrity contractors and law enforcement and enhances their use of the data. CMS has been working closely with our law enforcement colleagues to provide One PI training and support. Since October of 2010, CMS has provided training at CMS's Baltimore Training Facility to a total of 622 program integrity contractors and CMS staff, including 82 law enforcement personnel, on the portal and tools on One PI.

The Medicare-Medicaid Data Match Program

The Medicare-Medicaid Data Match Program (Medi-Medi) is another CMS initiative to improve the use and availability of better quality Medicaid data. The Medi-Medi program began as a pilot project with the State of California in 2001; nine other states joined the Medi-Medi program between 2003 and 2005, followed by further expansions. The Medi-Medi program enables participating State and Federal Government agencies to collaboratively analyze billing trends across the Medicare and Medicaid programs to identify potential fraud, waste, and abuse. Currently, CMS is partnering with States that account for most of the expenditures in Medicaid; the 16 States that now participate in the Medi-Medi program account for more than half of total Medicaid expenditures. Participating States include: New York, New Jersey, Pennsylvania, North Carolina, Georgia, Florida, California, Texas, Colorado, Oklahoma, Utah, Iowa, Ohio, Mississippi, Missouri, and Arkansas.

CMS is working to identify ways the Medi-Medi program can be improved and made more beneficial to States. We are also exploring additional opportunities to collaborate with States as well as working directly with States to match Medicare and Medicaid data for specific collaborative projects. The APS and FPS pilots with State Medicaid data will also provide more collaboration between Medicare and Medicaid. In addition, we will be providing more opportunities for sharing

lessons learned from States that have made successful referrals and recouped Medicaid expenditures.

Looking Forward

As these efforts mature, we expect to be able to more easily transfer the lessons learned from Medicare program integrity analytics and algorithms, including predictive analytics, to the Medicaid Integrity Program. As in Medicare, CMS' ultimate goal is to use predictive modeling and other sophisticated analytics to enhance our capabilities, as well as increase information-sharing and collaboration among State Medicaid agencies to detect and deter aberrant billing and servicing patterns at the State level and on a regional or national scale.

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