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Contact:

**CMS ACTING ADMINISTRATOR KERRY WEEMS FRAUD AND
COMPLIANCE SPEECH**

CMS Acting Administrator Kerry Weems

Health Care Compliance Association/American Health Lawyers

Fraud and Compliance Forum

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Good morning everyone. Thank you for coming. I want to start out with some simple, stage-setting concepts. One of the things CMS gets asked a lot is: "What's your estimate for fraud, how many taxpayer dollars go to fraud?"

To answer that question, I'll need to point out to a room full of lawyers the obvious. Fraud is a crime. Crimes are prosecuted and discovered to be crimes by the criminal justice system, not by a civil administrative agency. CMS discovers what might be fraud and hands that over to the Inspector General to investigate and the Justice Department to prosecute, but does not determine fraud. We do have an estimate of improper payments, which are payments that CMS made in error, based on the claims presented. Some of that may be fraud, but that's for the Inspector General and the Justice Department to decide.

Now CMS does engage in efforts to protect the integrity of our programs from fraud. For our main suite of program integrity activities, we are allocated \$720 million annually. In a moment, I will discuss some changes in our program integrity strategies, but let's take a moment to remind ourselves that fraud and the necessary integrity activities on CMS' part, and the necessary compliance activities on the providers' part, are costly and burdensome.

Many, if not most, of you in the room represent the costs of compliance. You are the transaction costs of fraud. As CMS, the Inspector General, and the Justice Department intensify our anti-fraud efforts, the costs on honest, compliant providers go up—and they have to hire more of you.

Let me now give you an idea of how we are intensifying our efforts and changing our strategies.

First, today, we are announcing new Audit Contractors for the permanent Recovery Audit program. They are:

Diversified Collection Services, Inc. of Livermore, California, in Region A, initially working in Maine, New Hampshire, Vermont, Massachusetts, Rhode Island and New York.

- **CGI Technologies and Solutions, Inc. of Fairfax, Virginia**, in Region B, initially working in Michigan, Indiana and Minnesota.
- **Connolly Consulting Associates, Inc. of Wilton, Connecticut**, in Region C, initially working in South Carolina, Florida, Colorado and New Mexico.
- **HealthDataInsights, Inc. of Las Vegas, Nevada**, in Region D, initially working in Montana, Wyoming, North Dakota, South Dakota, Utah and Arizona.

I know that many providers, and those of you who work with industry, have been waiting for this announcement. We've taken some time, but we wanted to get this right.

Medicare oversees a variety of payment systems and a network of contractors that process over 1.2 billion claims each year from over 1 million health care providers, among them hospitals, physicians, skilled nursing facilities, labs, ambulance companies, and durable medical equipment suppliers.

The new RACs were selected in an open competition. Among the evaluation criteria: their technical approach on claims analysis; their track record with customer service; a review of possible conflicts of interest, and their contingency fee bids, among other criteria.

This permanent RAC program eventually will run nationwide. It's the successor to the three-year RAC Demonstration Program that ran in California, Florida, New York, Massachusetts, South Carolina, and Arizona.

The RAC program uses traditional Medicare auditing tools—data analysis, post-payment claim reviews, and recovery—but with a twist. It makes transparency a high priority, requires oversight of auditors, and pays contractors on a contingency basis.

The nationwide program builds on some important lessons learned from the demonstration. For example:

- We require RACs to have a medical director, coding experts on board, and credentials of reviewers must be presented on request.
- If an audit results in denial of a claim, the medical director must be available to discuss the denial if requested to do so. If the denial is overturned at any level of appeal, the RAC must pay back the contingency fee.

The cost to run the program was significantly less than the amount it recovered for Medicare—20 cents for every dollar collected. RACs identified \$1.03 billion in improper payments; \$37.8 million of which were underpayments.

The majority of providers gave the RAC demonstration program good marks.

We know this because we had Gallup conduct a telephone survey between May and July 2007. Seventy-four percent of respondents said our efforts to recoup overpayments were fair and reasonable. Seventy-one percent thought that RACs applied Medicare policies correctly.

We want to make sure the new contractors keep up the good work.

CMS has already begun to reach out to providers and suppliers at the local level, and it's essential that we do this before the RACs begin looking at records and make determinations about the appropriateness of payments. Beginning in November, CMS will conduct face-to-face meetings in every state. Until a provider has had one of these meetings with us, that provider will **not** receive correspondence from the RAC.

Right now, we're working with the AHA and AMA to educate providers on the RAC program, and we're scheduling two special Open Door Forums—also in November—as part of this outreach.

Concerns will be heard. No one likes to be audited, but when a provider is contacted by an auditor, we at CMS want to make sure we can minimize the burden.

There is new CMS oversight of RACs built into the permanent program. CMS will approve separately all medical necessity issues RACs want to review.

Firms that participated in the demonstration will likely be more ready than others to begin the audit process, but I would not expect to see much activity outside of CMS until after the first of the year.

Even the limited RAC demonstration was very successful.

We are firmly committed to moving forward with the RACs. Additional states will be added to each RAC region in 2009.

The RACs are but one approach in a continual effort to maintain the integrity of our programs—from accurate payment to fighting fraud.

When the words “Medicare Fraud” come up, those in the know think of two types of Medicare providers and two areas—Durable Medical Equipment suppliers, home health; South Florida and Los Angeles.

Until it was delayed, we had a competitive bidding program for DME. I made it my business to visit DME suppliers in the 10 cities this program was operating. Along the way I met many DME suppliers and found them to be honest, compassionate caring businessmen and women. The same is true of home health agencies. But the image of these honest businesspeople is stained with the criminal acts of others in their line of work

When those involved in criminal enterprises hear the words “Medicare program integrity,” they think of pocket-protected bureaucrats inspecting claims forms, medical records or electronic submissions. In many cases, they would be right. However, our tactics are changing.

Where we see unusual or high volume or high dollar claims, we will still examine the claims, but we will also visit the provider or supplier, we will visit and interview beneficiaries, and, in the case of home health, we will visit the ordering physician. Some of these visits will be CMS employees or contractors; some of these visits will be conducted by law enforcement personnel who will have badges and handcuffs, not pocket protectors.

We will be looking at the entire chain to ensure that high-volume prescribers are prescribing only what is medically necessary, to ensure that suppliers or other providers are in fact providing what was prescribed, and to ensure that the beneficiary has a true medical need and is not, willingly or otherwise, a part of a criminal enterprise.

Let me discuss how this will work in two settings, Home Health and DME.

Home health care fraud is a particularly contemptible example. People are eligible for nursing care at home only if they are so frail they cannot leave the house. The legitimate providers who take care of them provide an essential, even admirable, service.

But the number of illegitimate providers is multiplying. Between 1998 and 2007 there's been close to a 60 percent increase in dollars home health agencies received, even while the number of home health agencies and visits dropped 20 percent.

People who would stoop to bilk beneficiaries and taxpayers for fraudulent home health services are people like the ex-offender in Hialeah, Florida who billed Medicare \$7.4 million for home infusion medication to 12,290 fictitious patients with HIV.

In fact, a large part of the problem is in just that area of the country.

In Miami-Dade, we've noticed a curious trend—an explosive growth in outlier payments for home health. In 2007, outlier payments accounted for nearly 60 percent of total home health spending and over 200 of the approximately 300 Miami-Dade home health agencies received half or more of their Medicare revenue from outlier payments.

We were thinking of just calling them "liar payments."

On October 2 we suspended payment to the top ten Miami-Dade home health agencies with the highest percentage of outlier payments in 2007, and we're moving to recover any overpayments to these agencies between 2004 and 2008.

As a change in our strategy, we will not be relying just on paper and electrons to determine proper or improper claims; we are interviewing beneficiaries to determine whether services were ever rendered, and the ordering physician to see if the services were medically necessary.

All Miami-Dade home health agencies—not just these ten—will be required to apply for recertification and re-enroll in Medicare and to expect a site visit from Medicare—a burden imposed even on the innocent. Moving forward, CMS will place a five percent cap on Miami-Dade home health outlier payments in 2009. Exceeding the cap will trigger a CMS interview with the ordering physician. The home health agency may receive the higher payment, but it will be based on our findings after meeting with the doctor.

The foundation of this new program is the strong collaboration among the Medicare Fraud Law Enforcement Strike Force, state agency partners, as well as CMS's program integrity and survey and certification divisions. I expect there will be a number of criminal referrals to come from our efforts.

Home medical equipment—"DMEPOS"—is the industry that gets the most reports of fraud. In hot spots like South Florida and Los Angeles, where Medicare billing is disproportionately high, the number of DMEPOS suppliers increased nearly 20 percent between 2005 and 2007.

Fraud cases you've heard about typically involve DMEPOS. These are cases like the GAO "sting" that succeeded in getting two fake medical equipment companies enrolled in Medicare and paid for non-existent medical equipment. Or the "dead doctors" scam, in which durable medical equipment suppliers' claim forms listed a deceased doctor as ordering the equipment.

Until this summer, CMS had one important tool to fight DMEPOS fraud—the DMEPOS Competitive Bidding program. That program was delayed by the Medicare Improvements for Patients and Providers Act—MIPPA.

Under the competitive bidding program, CMS paid suppliers a price that reflected local market prices for medical equipment and required suppliers to meet stringent financial and quality standards. At the time the law took effect, competitive bidding was already saving beneficiaries an average of 26 percent on walkers, wheelchairs, hospital beds, oxygen equipment and other items. But suppliers who didn't make it into the program lobbied—successfully as it turned out—for delay.

In 2007, Medicare paid more than \$12 billion for services claimed by more than 104,000 durable medical equipment suppliers across the U.S., with an average of nearly 20,000 services and items billed by each supplier. We can't afford to roll back our efforts to fight durable medical equipment fraud.

That's why CMS is launching a stop-gap program today, focusing on the worst offenders in high-risk areas of the country, to fill the gap created by the law.

The new anti-fraud program zeroes in on Medicare fraud in seven high-risk areas across the country, where CMS will increase our oversight of the highest paid DMEPOS suppliers and the highest billed DMEPOS equipment and supplies.

It increases pre-payment reviews of medical equipment suppliers.

It singles out the highest-billed claims—continuous positive airway pressure “C-Pap” devices, oxygen equipment, glucose monitors and test strips, and power wheelchairs—the most lucrative items for suppliers, with the greatest risk of fraud.

It toughens background checks on new suppliers.

It increases scrutiny of the highest ordering physicians and the highest utilizing beneficiaries.

The stop-gap plan goes beyond the current durable medical equipment Provider Enrollment Demonstrations in Los Angeles and Miami, which—by the way—have already revoked over 1,000 billing numbers and raised the tally of phony suppliers kicked out of Medicare by 50 percent, in these two cities alone.

The plan also targets the highest utilizing beneficiaries who are participating in the fraud in exchange for kickbacks, and focuses on the equipment and supplies most likely to be abused.

This is important. An elaborate Los Angeles scam involving shell companies, kickbacks, sham contracts, and hospital cover-ups paid homeless people to get themselves admitted to hospitals. Medicare paid for these bogus admissions.

As important as these new measures are, it’s worth saying right now that all of these activities—and the additional expense to the Medicare program—would be completely unnecessary if the competitive bidding program had been allowed to go forward.

Meanwhile, we’re taking measures to step up anti-fraud activities nationwide.

Soon, we will issue a new rule to require certain suppliers of durable medical equipment to obtain a surety bond, in order to deter illegitimate suppliers from signing up with Medicare and reimburse Medicare for overpayments. This is an important step to kick fraudulent suppliers out of the program and keep them out.

We’re targeting physicians who order large quantities of medications or medical equipment, and interviewing beneficiaries to ensure they receive

what had been ordered. Efforts like these are saving taxpayers nearly \$120 million.

We recently took the opportunity to consolidate the myriad anti-fraud programs we administer under one umbrella. The new program, Zone Program Integrity Contractors, or ZPICs, serve the same jurisdictions as the Medicare Administrative Contractors which replaced the old fiscal intermediaries and carriers.

The ZPICs have a broad portfolio, ranging from conducting investigations and providing support to law enforcement, to conducting audits of Medicare Advantage plans.

Five of these ZPICs will concentrate on fraud “hot spots.”

One last, related program I want to mention this morning. CMS has been working with the Internal Revenue Service and the Financial Management Service at the Treasury Department and, beginning today, will participate in the Federal Payment Levy Program.

CMS has posted a MLN Matters article on our website explaining how the program works. Briefly, CMS provides Medicare payment data to the IRS so Treasury can collect unpaid taxes by garnishing Medicare payments. CMS will send notices to delinquent taxpayers who participate in the Medicare program, letting them know the amount taken out of their payments, as well as a Treasury Department contact number they can call for more information or to discuss next steps.

Health care is big business so it stands to reason that health care fraud is big business, too. Depression-era outlaw Willie Sutton, when asked why he robbed banks, said “That’s where the money is.” The same holds true for CMS.

CMS’s job is to provide health insurance for more than 90 million Americans. We manage a lot of money—this year around \$675 billion. If your objective is stealing, our health care programs—Medicare, Medicaid and the State Children’s Health Insurance Program—are big targets. Combined, they give CMS the 17th largest GDP in the world.

Fraud imposes costs on the entire system. They include the administrative burdens of tracking down fraudsters. They include the cost of allocating resources to sham enterprises when they should have supported vulnerable people with legitimate needs. They include greater scrutiny, higher costs,

and the greater burden of running a business imposed on the vast majority of honest providers.

You can talk about this in economic terms, but what we're really addressing here is theft. Theft is a crime.

Fighting fraud requires commitment, as well as the resources to sustain that commitment. Over the past four years, the Administration has requested \$579 million for the Health Care Fraud and Abuse Control Fund. Congress has not provided any of these resources.

In his 2009 budget, President Bush requested an additional \$198 million for HHS to expand Medicare's fraud-fighting ability. It's unlikely that Congress will consider any funding before next year.

Congress should hold CMS accountable for stopping fraud, but it also needs to provide resources and support.

Over the years, we've been able to save beneficiaries and taxpayers billions of dollars. However, we need to do more. Even one dollar paid to fraud is too much. CMS is working overtime to make sure that fraudsters will not find an easy mark in Medicare.

Rest assured, any Administration that follows ours will have the same high level of commitment. Yet they will need the tools to accomplish the mission, or they will never be able to achieve the goal.