ALLIANCE FOR HEALTH REFORM

Program Integrity: Preventing Health Care Fraud and Abuse

Alliance for Health Reform
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ED HOWARD: I'm Ed Howard. I want to welcome you to this briefing on behalf of Senator Rockefeller, our Board of Directors. It's a program that constitutes in some ways sort of a report from the front lines of the war against waste, fraud and abuse in America's healthcare system. Our system spends more than $2.5 trillion a year and wonder of wonders some of it is misspent. That misspending comes in a lot of flavors, including genuine disagreements over how to classify a given service or the need for a particular procedure or test, but a lot of it, a lot of the errant spending comes from intentional fraudulent activity. And that activity takes tens of billions of dollars away from its intended purpose.

This activity occurs in private programs and public programs everywhere that healthcare - everywhere that transactions occur. Now just in the last couple of weeks we've seen stories on the front pages about arrests and schemes that diverted hundreds of millions of dollars from legitimate purposes. Now these news stories usually focus on catching the crooks, but not on the efforts to prevent fraud from happening in the first place. And today we hope to look at both kinds of efforts as we look to get better value from our healthcare spending, which is something that we have to do for sure.

We're pleased to have as a partner in today's program, the Centene Corporation, which contracts to provide Medicaid coverage in a dozen states and it operates a number of related services like nurse call centers as well. Sharing moderating duties with me today is Glen Schuster, who is the Senior Vice President and the Chief Technology Officer for the company. Glen?

GLEN SCHUSTER: Thank you very much, Ed. On behalf of Centene Corporation, I'm delighted to join the Alliance for Health Reform and our panelists on today's briefing.

Thanks to the Alliance we are able to get together on these briefings to tackle tough health issues, such as waste, abuse and fraud, while increasing our understanding of how the federal government, states, and healthcare industry and others are responding to these different challenges. These briefings hopefully give us an opportunity to engage in a dialogue that can help improve the delivery and quality of healthcare.

At Centene, we are focused on coordinating health services for recipients of Medicaid, Medicare or other programs to help the uninsured. We are glad that this is an area of great industry to the Hill staff and the policy, advocacy and the research community as well. I'm looking forward to today's briefings and the opportunity to exchange views with my distinguished panelists.

ED HOWARD: Great. Thanks, Glen. A little housekeeping. In your packets you'll find lots of good information. You also should have had the chance to pick up a copy of this Center for American Progress paper by Marsha Simon, which we didn't get in time to put in your packets. There's biographical information, more extensive than we're going to be able to use orally to introduce our speakers. You'll find PowerPoint presentations in hardcopy as well. And a bunch of other background material that we didn't print is listed on the one page materials list in your kits. There's a webcast that'll be available probably sometime tomorrow on kff.org, which is a service of the Kaiser Family Foundation for which we're grateful. And a few days later, I hope later this week, you can also view a transcript of today's discussion on our website, allhealth.org.

A couple of things in your packets I want to call attention to if you've not been to these briefings before. There's a green question card that you can use to write a question down and submit it when we get to the Q&A part of the program. And there is a blue evaluation form that we fervently wish that you will fill out and give us your feedback. And let me just say one more word about the evaluations today. We, we learn a great deal out of your comments and we'd like more of you to fill them out. So once more something we did a few

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months ago, we're gonna try a pay for performance path, about a fourth of the folks usually fill these things out, if we get to 35-percent the alliance is gonna to donate $50 to Community of Hope. And if you don't know that group, among other things, it serves about 4,000 clients are its clinic in Adams Morgan. And if 50-percent of you complete the evaluation the donation will be $100. So you have motivation in addition to the altruistic means of improving the quality of programs of the Alliance. So let's get to that program. We have a terrific group of panelists today. They're gonna give some brief presentations and then we'll have a lot of time left to respond to your questions and to allow the panelists to interact.

And I'm very pleased to start our conversation with Peter Budetti, who is the Deputy Administrator CMS for Program Integrity. Many of you probably know Peter from his many years on the staff of the House Energy and Commerce Committee. He's a lawyer, he's a Pediatrician, he's the long time Chairman of the Board of Taxpayers against Fraud, which gives you some notion of the depth and expertise that he brings to this current duty at CMS. And we're very pleased to have him with us. Peter? Press that for red.

PETER BUDETTI: Thanks a lot, Ed. I'm really impressed with the turnout for this particular topic. It's great to see

so many people interested in fighting fraud. And I would think this has absolutely nothing to do with the free lunch.

I am delighted to talk to you today about a number of the new things that we're doing at CMS. And I want to - this is really the slide that counts. This is our guiding principal. We're being innovative in two directions. We are putting into place our national fraud prevention program to do two things simultaneously, making it easier on the good guys and making it harder on the bad guys, easier for honest providers to get into Medicare and have legitimate claims paid and more difficult for phony or fraudulent providers to enroll or to stay for that matter in the program or to receive payments.

I'm gonna go through the two - the twin pillars as we call it of our approach to accomplishing this. But I want to start off by giving you a quick overview that many of you may have been exposed to. But this is the list of our guiding approaches to accomplishing these tasks. To move from - beyond I should say, cause we'll always have to do some pay and chase, to move beyond pay and chase to actually preventing problems in the first place, to do things in a way that is risk based and applies our resources to the actual problems that we're encountering, rather than using a one size fits all approach, to fostering innovation to deal with the fact that we've had a

lot of legacy policies, legacy processes, legacy lots of stuff that's been around since the beginning of Medicare that maybe haven't been as efficient as they might otherwise be, to have much more by way of outward transparency and accountability, but not of course telling the bad guys what we're up to. But this administration is very strong on that and that's a very important component of what we're doing. To work increasingly with the private sector, as well as with our public sector partners. And to coordinate and integrate, both Medicare and Medicaid fraud - anti fraud activities at the same time that we are coordinating and integrating the activities that we're undertaking, the audits and the contract work and so forth. So that's a very big part of what we're doing. So this is an important overview of the center for program integrity.

We're moving to a new generation of activity where we are of course continuing to partner with law enforcement and to go after the bad guys and get rid of them when they actually get away with something. But also to take administrative actions that will interrupt the ability of people to steal from the programs, kicking them out of the program, cutting off their payments, doing all the things that are absolutely necessary in order to accomplish that goal. So these are the two halves of our twin pillars of approach. One is a system, an innovative analytic system that is largely claims based,

although as I'll tell you in a minute it actually incorporates a wide range of information.

And the second is the advanced analytics that we're bringing to provider screening and enrollment and doing those in a way that is far more efficient and also accomplishes the goal a lot quicker from the legitimate providers perspective.

Start off with the predicative analytics, our fraud prevention system. This was started on - up and running on June 30th of last year. We'd been running all Medicare Part A and B, and DME claims through the system before they are paid since that time. And using a complicated and sophisticated set of algorithms to highlight the problem areas and to generate what we call alerts that then allow us to direct our resources to those alerts and to take the appropriate actions, whether it's an investigation, whether it's a referral to law enforcement, whether it's an administrative action. All of those are part of our new screening system for claims.

This is a diagram of how it works. On the left hand side in the yellow box you can see that the system handles many different kinds of information, not just claims, but also things like the calls to 1-800-Medicare that raise questions about fraud possibilities, the results of investigations by our own investigators and by law enforcement, the compromised numbers database that we've developed with Medicare

beneficiaries and providers whose medical identities have been compromised in one way or another and used for fraudulent activities. So all of that information feeds into our system which then grows overtime. It's a learning system; it's a system that expands over time.

We have a lot of work going on to continue to add models and algorithms to the system, and to incorporate additional kinds of inputs. It's a - it's a system that will progress from simple rules through looking at identifying anomalies, to predicting where we're going to see problems to doing social networking, all of these are components of it that are being phased in over time.

I know many of us have had the view that the Medicare payment system is relatively simple. The claim goes into the Medicare administrative contractor, Medicare administrative contractor takes a quick look at it or a longer look at it and then pays the bill, well that isn't the way it works. It does go into the Medicare administrative contractors, but then it goes into our internal systems before it ever gets back to the max, either to be paid or not. And our fraud prevention system is being integrated into that in a way that will not slow up legitimate claims, but will be in a position to interrupt claims that shouldn't get paid.

On the providers screening side the gateway to Medicare is getting enrolled in Medicare from the provider and supplier side. Our system known as PECOS is the face of the enrollment side. That's the file with all of the people who have been able to enroll in Medicare. And we've done a lot to improve that system over the past year. We're very open about saying that legitimate providers and suppliers have had problems with our Medicare enrollment system, taking as long as 90 days, sometimes even longer to get in, which very - can be very cumbersome and also very costly to people who can't get into the system when they need to be in it.

We've had a number of complaints that we are responsive to. My favorite on this is the bottom one. We call any MAC at least three times if we have a question then we take the average answer. By the way there's a second half of that sentence which says we call three different shifts, so that we're sure to get three different response operators, so that we get three different opinions.

Legitimate providers and suppliers are seeing a vast improvement in our enrollment system and we're very responsive to their needs. We anticipate reducing by two-thirds the amount of time it takes to process claims and to do this online in a user friendly environment. We are genuinely focused on customer usability by making things, as I said, much more

interactive with the provider and supplier community, increasing communication with them. A lot of the changes that we have and this is a list of them, a lot of the changes that we have made or that are coming are the direct result of our interaction with the provider and supplier community, telling us what their problems were, bringing them into CMS to work with us, to demonstrate to us what their problems were. And to help us work through the ways to address those problems. So this is a very interactive process and it's been going along quite well. Nothing's ever perfect, but we've made a lot of progress along those lines and we're getting kudos. We're getting positive feedback.

But the other half of making - so that's the part that makes it easier on the legitimate providers, but we're also very conservative, of course about the fact that fraudulent providers and suppliers have been able to register with stolen medical identities and phony addresses to get back in after we've kicked them out. And to stay in the local MAC systems without ever being in our national system. This is all changing. We have put into place the automated providers screening system, the medical identities are being checked against a variety of databases now in an automated 21st Century manner that will allow us to identify people who don't belong in the program. By the way this will also conduct ongoing

screening of people while they're in the program, so that if they - oh, let's say they die or they lose their medical license, or they get convicted of a felony, we don't have to wait until the next time that we revalidate them, we have built the system to give us that information on an ongoing basis. This was implemented in its first phase at the end of last year. And it will continue to operate in this way going forward in a very efficient fashion. It will also give us alerts of various kinds that will feed into the fraud prevention system on the claims side that I mentioned before. We've already run licensure checks on a large number of providers who were in PECOS already and we've begun screening all of the Medicare enrollments and both the new enrollments and the revalidations. We are in the process right now of revalidating all 1.5 million providers and suppliers in the Medicare program and we started with the highest risk groups and we're progressing through to the lower risk groups.

So, this comprehensive strategy tied together will allow us to do the things that it will take to detect suspicious claims prior to enrollment, to get the bad actors out, to focus on risks, to keep people from enrolling who don't belong there, keep them from re-enrolling and to also - I mentioned at the end of this discussion about Medicare, to begin to work much more cooperatively with the states and to

share information with them as well as of course with our law enforcement partners.

So the net result is that our two pillars are coming together for our comprehensive strategy and that's the way that we are building our program at the Center for Program Integrity and very pleased to be able to talk to you about it. I look forward to our conversation later. Thanks a lot.

ED HOWARD: Great. Thank you. Thank you very much, Peter. Now we're gonna hear from Jim Frogue, who's the Co-Founder of the policy firm FrogueClark. Jim also has served on the Hill for several members of Congress. He worked with former speaker Gingrich at the Center for Health Transformation. He has edited the book, *Stop Paying the Crooks*, which seems relative to the current conversation. And we're pleased to have Jim with us this afternoon. Jim?

JIM FROGUE: Alright. Thank you very much, Ed. And thanks to the Alliance for putting this event together and thank you to Centene for sponsoring.

We first got interested in this topic about seven or eight years ago when there was a series in the New York Times about fraud in New York's Medicaid program. And there was a quote in there from an inspector for the state and he said he thought up to 40-percent of New York Medicaid claims were questionable. And at the time we thought that can't possibly

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be true. But it was something that sort of rattled around in the back of our minds, is this really right, is this - could this - if this is even close to right we're onto something that's in the hundreds of billions of dollars a year, and certainly in the tens of billions just in New York state alone. So after some research and looking around, and asking some people in the industry we decided to work on a book and we put that out in 2009 called *Stop Paying the Crooks*. It's available electronically for free, so if you want to see it you're welcome to. But it ended up being an issue that's a very, very big one. And as you look to things like, oh, for example SGR and how to fund that. The fraud abuse area would be a very easy place to start.

So the biggest question of course is how big is the fraud problem. Well in his speech to Congress in 2009, the President said, President Obama said, hundreds of billions of dollars a year in waste and fraud. And of course he was talking system wide, but he was still using the right numbers, he was using the right number of zeros to talk about how big this problem is.

In September of 2010 my former boss, Newt Gingrich and the CEO of AARP, Barry Rand had an op-ed in the Orlando Sentinel that said they thought about $100 billion a year was stolen from Medicare and Medicaid. Harvard Professor Malcolm

Sparrow, who in the 1990s worked for Clinton Administration and wrote a book called *License to Steal*, he testified in May of 2009, he said it's easily into the 100s of billions of dollars a year. And Professor Sparrow wrote two editions of his book. I happened to see him at a conference about two years ago and I said how come you haven't done any work on this in the last ten years or at least done a third edition of your book and his response was, because nothing has changed, which is a rather depressing comment. 60 Minutes said $60 billion a year in Medicare fraud alone. I'd highly recommend a clip of their piece from September of 2009 where they give you a real good flavor of how easy it is to steal from this program. And a guy with the full makeup and voice changed saying, yeah, I'm no genius and I was stealing $30,000 a day from Medicare and there are thousands of people like me. Institute of Medicine and Thomson Reuters have suggested that a third of all of our health spending is waste, fraud and various forms of inefficiencies.

A third of all spending is $800 billion a year. And then of course if you ask your average Americans who don't necessarily even know the difference between Medicare and Medicaid and don't follow these issues with any great detail, if you ask an average American using their own definition of the word wasted, what - what percentage of every federal dollar

spent is wasted, they say 51-percent. And the gap between democrats, republicans, independents is quite narrow. It was about mid-40s for democrats, and about low 50s for republicans and independents. So if you're at home trying to sell this topic, it's very fertile soil, your people are already there. They just instinctively know there's a problem and selling solutions, I think is a good place to be. So why is this problem not talked about quite as much as it needs to be. Well, for one providers aren't going to be particularly forth coming, very often they like to be protective of people in their industry.

And trade associations aren't gonna necessarily raise a hand and say, we have a lot of fraud over here, because it ends up drawing attention to them and it results in rate cuts and other things.

Academics, Professor Sparrow has a quote where he said, one of my deep regrets is discover that academia has paid almost no serious attention to this critical problem. And then at the health official level, we were speaking with a friend just earlier this week or earlier last week, and he said in his state they found $500 million in fraud, but the - over the last five years using a study they did. And their bureaucrats told them whatever you do, don't tell CMS, because the disallowances we can't afford, so imagine that. The people who are running

the programs find fraud and they're not allowed to talk about it, cause the [inaudible] is such that if they actually bring this up, CMS will disallow their percentage of the Medicaid spending. So I think the secretaries will talk about some other disincentives states have to speak to really go after this program, this problem aggressively.

So, just as a - as a quick sample of the fraud continuum, there's three different, fraud, waste and abuse, just so there's some distinction between the two. Fraud is just flat out bill for a wheelchair that wasn't delivered, black and white, no question about it. Abuse is a little different, abuse is up coating, bill splitting, excessive testing, things that's kinds of in a gray area legally, that's where actually you find most of the money, because it's a little hard to prosecute and we'll come back to that issue in just one second.

And then waste is coding errors, duplicate tests, very complicated things for people who work on the bills to work - to get right, prescription interactions, hospital infections, things like that. And then of course patients over using free care. And the New York Times specials, it's almost ten years old now, called, "Patients Lining Up for All that Medicare Covers", gave a very good flavor. First they picked on seniors in south Florida and how much they use Medicare even when

suddenly - sometimes they don't even necessarily have to, but I would recommend that article for just a what that looks like.

So, quick examples of fraud and we just picked these from 2012, just in the last couple of months. You probably all heard about the one last week, $375 million, a Texas doctor and five accomplices, $375 million over six years for Medicare and Medicaid. Medicare and you - right after I was supposed to send in my slides, there was a story that came out of Texas, the Undercover Grandma, which maybe some of you saw, where this older lady in - in McAllen, Texas, was taped and the physicians were over - over diagnosing her with all sorts of ailments she didn't have and she was in very good health. I mean this is the kind of thing that happens all the time, everywhere and almost no one catches it, because for a lot of seniors, there's not really much incentive to look at their EOB, their Explanation of Benefits that they get quarterly. And if they do, they're not necessarily responded to in a way that's timely.

So, especially if seniors are older and they may have, in some cases dementia, and the opportunity to take advantage of them with adding a few more diagnosis and other things on there happens all the time, all over the place that falls into the category of abuse, some of it flat out fraud, but certainly that's where you find the bulk of the - the money. So,

Medicare also has this new computer system that was launched in the middle of last year and it was $77 million, and it saved $7,591 in the first six months, which Senator Carper asked, did they leave out a couple zeros.

Medicare spending artificial feet, this was an Avalere Health study, despite the fact that amputations have gone down significantly in the last five years, spending on artificial feet had gone up 58-percent. Then even - even people, religious people are in on this too, there was a doctor in Los Angeles sentenced a few years in jail for bilking Medicare out of $14 million, so even ministers aren't above stealing from these programs.

But just as a quick point, this is a map of all 3,000 counties in the United States and this is - this is MedPAC and the little ones in red, which is almost hard to see, south Texas, Louisiana, Oklahoma, Florida, 25 counties is where the majority of home health fraud exists. The home health is in many ways a good alternative to people being institutionalized. It's much less expensive, it's in an area that's been designated as rife with fraud, but the problem is very concentrated. It's in - it's in 25 counties out of 3,000, so the odds are pretty good it's not in your district, not in your state, not in your district, and it's happening somewhere, but your providers are the ones getting wacked, because the bad

guys are abusing the system and hurting everyone else. So this is just one example, there are so many examples of this problem being a targeted solvable one. And the 90, 95-percent of players, doctors, patients and everyone else involved are not the problem, but they do get tired and they do get targeted if their problem is not addressed accurately.

This slide shows - the administration a couple weeks ago announced that they had $4.1 billion in recoveries for 2011, which was a very impressive number and by far the best so far. But I think it's important to understand how you get to 4.1 billion. At the top of the triangle you can see and I put a question mark by it, let's say for arguments sake, there is $100 billion a year in fraud in Medicare and Medicaid every year. How much of that is actually detected? Well, the answer is a small minority actually. It's hard to know exactly what the number is, but very little of its detected. Steve Parente, who's at the University of Minnesota, and many of you know has done great work on this over the years. He came out with a paper for ASPE, Assistant Secretary for Planning and Evaluation a few weeks ago.

And the minute his paper went live there were an amazing number of hits on it from Eastern Europe. Now, that's not necessarily the non-academics at University of Warsaw trying to learn how to run their system better, it's organized

crime. And that was just a very talented - it wasn't our academics, it wasn't the Capitol Hill, it wasn't anyone else looking at [Inaudible] paper the moment it came out, it was criminals in eastern Europe. And a lot of that money is so far gone out of the country by the time the crimes committed and even found, that there's no way he could ever recover it. So, what is prosecuted then that narrows it further? Any prosecutor will tell you off the record, never on the record, off the record, that unless it's over a certain dollar amount they won't touch it. In south Florida that figure is in the millions.

For a lot of State Attorney Generals, if it's not at least $500,000 they're not gonna touch it. They just don't have the time. And so the message to criminals is if you're okay with a BMW and not a Ferrari, just keep your fraud a little bit on the - on the calm side and you'll be fine, and no one will ever prosecute you.

So, then what is convicted? Certainly prosecutors, because they have so much opportunity here to try and keep their cases to ones that are likely to win. So, instead of going after the ones with a 60-percent chance of winning, they go only after the ones with 100-percent and there's enough of those, so there's so much opportunities for fraudsters to get

in the program and not have to worry too much about getting tagged.

This is just a sense of some of the world class companies everyone has heard of and their supply chain management. There's no chance Federal Express delivers 500 fake packages anywhere in the world on a given day or on a given month. Visa the credit card fraud is less than 1-percent, where in healthcare fraud it could be 10, 20 or 100 times that much. The financial services is a great model for how to look at this issue. And some of the tools they've been using for decades are the ones that need to be brought over to healthcare.

Wal-Mart, Wal-Mart has about 400 stores in China now. They can tell you in Arkansas in real time, how many hammers they've sold that day in any of those Chinese stores. Yet the amount of fraud in our Medicare and Medicaid systems are just catastrophic. So, I give you this only as a flavor for what world class companies do with managing their supply chains.

And then just to wrap up, some of the legislation that's out there that Senator Carper and Senator Coburn have a building now of 35 co-sponsors fighting fraud and abuse to save tax payers dollars act, they've done some great work on this as Dr. Budetti said. Moving towards a more predictive modeling, which is along the lines of financial services industry

successes. That's where I think you can find a tremendous amount of money and stop the problem before it starts. Once a dollar is out the door, the recovery process is very difficult, stopping it before it happens is the way to do it. And how will you know when you're doing it right? When providers are banging down your door very angry. The first bill I ever worked on in this area was in the late 90s and it was on home health. And CMS wanted to introduce a surety bond. I didn't even know what it was. I could barely spell it for my constituent letters, but I know there are an awful lot of people banging down my door angry, because they were having trouble. And it gave me a flav - this is kind of what it looks like when you start to make progress on this issue.

And obviously Medicare spending will go down, because there's enough money here that's making a difference. Senator Grassley, Senator Wyden have done some great work on the transparency in this issue. And then Senator Wyden, Senator Kirk have an interesting bill as well. And then Congressman [inaudible] in the house has the Carper/Coburn version that he's introduced. So, this issue is getting more and more attention, as it deserves and I look forward to your questions after this panel. Thank you.

ED HOWARD: Perfect. Thank you, Jim. Next we hear from Doug Porter. Doug is the Medicaid Director in Washington

State, where actually he has been at that position for the past decade. Among other things there, he's brought his State's Medicaid program to a position leadership in program integrity efforts and we're looking forward to hearing from him. Doug? Thanks, be with us.

DOUG PORTER: Thank you, very much, Ed. A couple of messages from the state's perspective. States I think it's - it is a general statement, are very strongly committed to ensuring accurate Medicaid payments. In our state this past legislative session, there were not fewer than seven bills advanced to improve program integrity and increase our resources for fighting fraud, waste and abuse. We're very careful about what we do with the limited FTEs we have and in these tough budget times we undergo administrative cuts on a regular basis, so we try and focus on those areas that have the best return on investment. Our average is for every dollar we spend on our program integrity efforts we recover $7. We're all getting better at using technology.

I think about 25 states over the last five years have upgraded their MMIS systems, their Medicaid Management Information Systems, as did we. And we're - our staffs are getting better now that we don't have to collect - spend so much time collecting data. We're getting a lot better analyzing it and data mining. All this said there still are

challenges with maintaining our existing efforts and program integrity and meeting new requirements, several new requirements in the Affordable Care Act. And we're trying very hard to coordinate with our federal partners in a joint effort.

Here's a graph that tells you pretty clearly what technology can do. We started our payment review program in 2000 and ramped up our collections. You can see we hit our peak in 2008. There's a remarkable drop off here from 2010. That would be when we put our new MMIS system online. We had limited edit capability in our old claims payment system. The new system allowed us to stop paying and chasing and that's what you see there is that $12 million drop. Those are dollars that we were able not to send out on the front end. And I can - I can take a lot of confidence in this, because we also monitor our per member, per month increases from year to year. On average I think the Medicaid program grows, like over the last five years probably about between four and 6-percent, depending on the state. In 2011 our state increase and our per member per month was only 2-percent.

We do have some concerns. I would refer to you a recent Office of the Inspector General Report, HHS report that was issued in February of just this past month, February of 2012, which talked about some of the problems that states have and the feds have with the MSIS data. My deputy, who's the

head of our program integrity efforts likes to say MSIS is great if you don't mind it being incomplete, inaccurate and outdated. We also are a little grumpy that we didn't get any money under the Deficit Reduction Act or the Accordable Care Act to beef up and enhance our efforts as required by this new federal law. And compared to the Medicaid fraud control units that sit over in our attorney general's shop, where they get a 75/25 federal match, we only get an admin match of 50-percent on the state side for our program integrity efforts.

We have a few recommendations, few modest proposals. We think we should look to the feds to do what we can't do so well. They're better positioned to monitor interstate activity. We are very much interested in this new provider credentialing system that Medicare is adopting and we would like to oblige our Medicaid providers to have to go through that same process to be enrolled before we sign them up in our program. We're looking for access to better Medicare data, DEA data, we think that when we participated for about four years with the what was called the Medi-Medi program which is Medicare and Medicaid in partnership. And we thought that had a lot of potential for pay off in the Medicaid side. If we could compare our data to Medicare data, we spent over four years, so about $250,000 on staff time trying to coordinate with that effort and we finally withdrew after not collecting a

single dollar in response to that effort. So we would urge some of the existing programs like the payment error rate measurement system, program, the Medi-Medi program and the Medicaid integrity contractors be reviewed for either, you know, fix what's wrong with these programs or get rid of them and let's focus on - on things that really work.

On the - that OIG report, a lot of good information there about the incompleteness of MSIS data. We had a lot of trouble with our good providers out there. When we were - our contractor was sending them notices saying, we would like all of the medical records on the following, you know 200 patients in your portfolio. And they gave them MSIS ID numbers, which providers don't have access to. So the providers have no idea who the patients were that were being asked about. And a lot of the data that was in there was not complete, so we think there's a lot of room for improvement there.

Another complaint I would raise is that the Affordable Care Act, basically for reasons that are probably more political than, than policy, gave a pass to managed care firms. And we think that there are still a lot opportunities out there to improve program integrity efforts in our MCOs. The other thing I would point out is that the Affordable Care Act also encourages states and Medicare and Medicaid to investigate more creative and more - a payment system that gets away from fee

for service, a lot of talk about bundled payments and about case rates. I think it's important that our program integrity efforts keep current with those kind - that kind of thinking, because if you apply your fee for service mentality in a program integrity model to a new payment system that departs from fee for service, I think there'll be a lot of unintended consequences.

And with that I'll conclude.

ED HOWARD: Doug, before I move on, just so everybody's on the same page, MSIS stands for? M - is it MSIS or...

DOUG PORTER: MMIS is the Management - Medicaid Management Information System.

ED HOWARD: Right.

DOUG PORTER: Which is the claims payment engine the states have.

ED HOWARD: Right.

DOUG PORTER: MSIS data stands for something that I don't - I don't know, Medicaid Statistical Information System.

ED HOWARD: Did you say MMIS data? We use to collect that at the hospital. [Laughs]. We have - we are in a data rich environment apparently. And we're gonna - we're gonna hear now more broadly from Dr. William Hazel, who is the Secretary of Health and Human Services in the Commonwealth of Virginia. He's an Orthopedic Surgeon by profession, a

profession he practice until 19 - in, I'm sorry, 2010, in a Northern Virginia group that he helped found some years ago. He's a former member of the American Medical Association Board of Trustees. And we're very pleased to have you visiting the northern part of Northern Virginia. Dr. Hazel?

WILLIAM HAZEL: I didn't realize that the northern part of Northern Virginia for the Potomac ocean, but the - thank you for having me. And if he says that I'm going to speak more broadly than the rest, it's probably because I'm a little less disciplined speaker than the rest and I tend to ignore my PowerPoints, you'll find that. And also after they've already said the basics it gives me free to be reactive, so that's what I'll do. And I can't help as I look at this to keep a provider hat on too.

Jim is absolutely right, the harder it gets for those of who - in real life and I've been in recovery now for about two years from the practice of orthopedic surgery, long enough to remember what it was like to have to jump through the hoops. And certainly that isn't where we want to go. I - I think it is important to recognize whatever we can do in healthcare cost is critical. When we look at the 16 plus percent of the gross domestic products spent in healthcare in this country. The next most expensive country in the world that I'm aware of is Switzerland, which is about 11.6-percent. And the difference

in the gross - the percentage of gross domestic product is equal to our budget for the Pentagon. And I never - I was never able to put that in perspective, but if you go look at gross domestic product military spending it's the difference in our spending and healthcare between U.S. and Switzerland's percentage GDP. It's huge. And to the extent that there is fraud and abuse in there we absolutely have to go after that. The question in the title of today's thing is how much money can be saved.

And I don't know how big the problem is. It's - one of the things - the hardest thing to know is what you don't know. We know it's a problem, we know it's in certain areas. And I asked Jim not to pick on Virginia and set expectations, because I sometimes think that the issue with fraud and abuse is if we could just solve the fraud and abuse problem, it's indeed 50-percent of healthcare spending is fraud and abuse, and waste. Boy, that's an easy way to get at the problem. And I would point out that there are some of us who think we have to fundamentally reform the delivery system to get the cost down. And that means reforming the payment system. And for those of you who are interested in federal issues, that only happens if we break up the RBRVS, it has to go away and be replaced with something else, and we have to break up the DRGs. We - as long as we're having the fee for service, I think we don't stand a

chance of - of getting away from this and getting the savings we need in the system. So I would bring to you - the first thought is that program integrity is a piece of the puzzle, but it will not be the salvation of healthcare in the U.S. if we can solve this, that's just my opinion.

And I will probably have some more opinions, because I'm an Orthopedic Surgeon and we are known to have several on almost any topic. But to speak of Virginia we have our 2-percent worth of the federal, the federal spending on healthcare in Medicaid. We have now probably 9,030 individuals enrolled in - between CHIP and Medicaid and we are expecting 40 plus percent increases with the PPACA, so we're looking at 1/1/14 as a huge challenge for us, because if we don't get that right, not only will we have to pay the cost of the newly enrolled that - the woodwork effect, we do have some concern with federal budget pressures that the promise funding for the non-woodwork effect may not materialize. And we also know that some here are looking at cutting the Medicaid budget and the max rates two to three percent for us in 2014 is looking to be $80 million. That - that's a lot, that's a lot for a state to absorb, especially when this year we don't actually have a budget yet. You may have heard that across the ocean here. We've been struggling with that.

So, it's a huge, huge challenge for us to get ready for it. And unless we manage the eligibility piece of it properly, the opportunity for fraud increases significantly. Now I believe you - they have some effort of the complexity of program integrity. And we run the gamut in Virginia. We do the provider in enrollment. I think last year we enrolled about 14,000 providers, newly enrolled again and that includes all the background checks and so forth h that we are supposed to do. We do find and Dr. Budetti may say, we - we do believe we send up our information. We sometimes find it's hard to get information back and I would share that with - with Doug that, that is the case. We don't always know who the bad guys are when someone else does.

Programs need to talk to each other. If we're gonna partner in this we got to talk to each other. We do extensive prepayment review. We have about - we have 1,349 procedures that automatically get prepayment review. We believe that, that saved us $130 million in the last vinculum, you know, we have an MMIS system, Medicaid Management Information System which is new. 1,550 edits and we also use a commercial software called Claim Check to try to look in advance. We - before we pay, so as opposed to pay and chase we really try to scrub the claims. And you've heard - referred to - or referenced the PERM, the error rates in Medicaid, where as our

eligibility rate in Virginia has been a tragic 16 percent. Our - our payment error rates is less than or is about 0.7 percent, which is - which is very, very low and we're pretty proud of that. We have - going through we have a number of contractors that do audits for us. If the feedback from our provider community is any indication they are fairly aggressive.

Jim, it does - it does get reaction. How audits typically are done on paperwork unfortunately, did you fill out the form properly, was it done in a timely fashion, things like that. Unfortunately most of what we audit has little to do with the ultimate quality of the care rendered. Which has to do with our payment system, which is if you fill out a claim that says you did it, we pay it. There's a problem there that we need to move away from. That being said, when we do have audits, we have a 97 percent success rate in supporting the claim when it's contested.

Now we mentioned the PERM rates, they are an issue. I'm gonna come to how we're addressing the eligibility problem in Virginia. We use the Medicaid Integrity contractors. Lots of state resources are required, which brings us to the issue of the match. AGs due get 75 percent, for IT was get 90 percent, for fraud effort we get a 50 percent match. If you're trying to prevent fraud that would make a lot of sense.

RAC audits are something we don't care for in Virginia. I mean frankly in this - perhaps we didn't care for it before I was secretary and now that a provider is secretary, we do have some issues with bounty hunting and going after claims. We're not sure that, that is the best way to do it. We're not sure that the incentives line - we have not used it, but will under the new - the new rules. There's such a thing as a Medicaid Integrity Institute, your division of program integrity operates these. They work with our staff. There are regular trainings, our teams go to South Carolina. It's a great program. We think that, that, you all hit a home run with this one. We just hope that we can find ways to get more - get more individuals and the states exposed to that. It's - it's a very, it's an important sort of thing. Two more things that we are doing is we have set up a unit in our DMAS, our Medicaid program to look at fraud in managed care organizations. We agree that fraud exists there and there's been an assumption over the years, because it's - it's - we're just given a lump sum payment that the organizations themselves can manage it.

We look at this as a partnership with our plans, because certainly they don't want to be paying for fraud either, and so we are - we are looking at that. And then we also have audits out for data mining for prepayment review. We've not done a lot of that in Virginia, but as Dr. Budetti

points out that it's an area that we think we need to go. From an enterprise standpoint what we are trying to do is deal with the eligibility piece. And in Virginia we're using the 90 percent federal administrative match money to create a new eligibility system. Our social services offices in Virginia have handled the eligibility determinations for years. Medicaid itself has gone up, just in my tenure from about $835,000 to 935,000 recipients, SNAP has gone from 500 to over $900,000. These offices are overloaded and with the traditional enrollment, with paper-based products, without automated systems. We aren't getting the job done as well as we can on the application side and when a social worker's looking at people who are hungry, who need SNAP benefits or for energy assistance. Medicaid renewals tend to get down to the bottom of their list. So, we're trying to automate the things that can be automated. And we're spending a lot of time and effort in that. We're creating what's going to be called the Commonwealth Authentication Portal, so that individuals can come on - into the system. We will know that Bill Hazel who is in the Medicaid program is or is not the same Bill Hazel that's in behavioral health. We're working with the Department of Motor Vehicles who knows our citizenship better than anyone, so just areas that we're getting into to try to decrease the fraud

and the potentials for abuse and enrollment. We have a very strong relationship with [inaudible].

We've referred about 114 cases over there in the last two years. And I would agree with what Jim has said, the limitations they have are resources. It is hard to go after every little case. And you know, Professor Wilson just died this week and he had the broken windows theory, if you don't keep the windows replaced crime prevails. And we do not have the resources to fix the broken windows. And therefore we think that we let a lot go that shouldn't be going.

I will summarize with just a couple of recommendations. One is there is a maze of programs. There will be a MAC Pack report coming shortly and there is a maze of programs. And some of them are overlapping and some of them are redundant. And I do think that, that needs to be cleaned up. We do think the administrative match for fraud and abuse work needs to be increased. We think that communications, though not bad, I - I must say this is an area where a red state and a blue administration are doing just fine. We really are after the same people and the same reasons, and the team is a good one. That being said, I think we could more systematically do a better job of communications, particularly the bad actors could come back our way. We'd like to be able to use our own contractors, people who know Virginia and not necessarily those

that are federally assigned. And I would encourage you to look for the MAC Pack report when it comes out. I think it'll be - it'll be a very helpful one, so thank you.

ED HOWARD: Terrific. Thank you very much, Dr. Hazel. Peter mentioned partnerships and you've heard two Medicaid directors talk about the partnerships that they are forging and have forged with the federal government. On the private side, our folks at Centene operate programs in a dozen states and we've asked Glen Schuster to talk a little bit about the experience of Centene in this area. Glen?

GLEN SCHUSTER: Thank you very much. So, I wanted to start just a little bit with kind of outlining Centene. And we're obviously based in St. Louis, Missouri. And I wanted to start with a quote from our Chairman and introduce this concept of no compromise.

Okay, fraud and abuse is an area where there is no room for compromise. We cannot have any tolerance at all for this and I think the panelists here have made that point abundantly clear. This is an area where we need to work together collaboratively with our state partners, our physicians partners and our recipients to ensure that there is no fraud, waste or abuse in the program. And that's going to be a continued battle, you know the bad guys don't stand still. And

so we need to continue to invest in this area and continue to work together to make sure we knock these out.

As has been already talked about, we want to talk about a couple different methods, okay, of combating fraud. It is the conventional approach and I don't for a minute want to give the impression that conventional means legacy or old fashioned, or etcetera. More this is an area of continual investment and refinement. But it's really looking at some of those transactional type processes. But in addition to that as a managed care organization, we want to get out into the community and really take that preventative approach to make sure we can stop the fraud and abuse before it happens. So in the conventional space we start with the prepayment capabilities. We do work very hard to make sure that we are building a credentialed high quality network of providers that are local to the community, working with our FQHC partners, our rural health center partners in making sure we're building that high-quality network of providers that are capable of delivering the type of care that we want our members to receive. We also want to make sure that we are putting in place the system edits, so that we can stop things prepayment or frankly even before claims are submitted to stop fraud before dollars go out the door. And we leverage our strategic partnerships with our physicians, with our states, as well as

with nationally recognized authorities on [inaudible] to make sure that our algorithms are cutting edge and are really keeping up with the latest trends in this. We also do, as it was mentioned, post payment investigations. Sometimes it takes a while for the patterns to emerge.

And we have our [inaudible] intelligence capability, which is a data warehousing and business analytics capability, to really mind looking for those anomalous patterns. And really understanding, because find the discrepancies where, you know, this doesn't make sense. How can we dig in here and figure out what's actually going on. And then once we find a trend we're able to kind of isolate it, you know, stop future payments there and bring our state partners to bear in investigating and resolving the issues.

Also, making sure that the referrals are in place, so that we're giving the power to our medical home providers who actually have the day to day relationship with the members to ensure that they also have the ability to influence and control the system. Okay and then member reviews. We do unfortunately have some members who have drug issues, where they do doctored shopping. Might as well talk now, I'll talk a little bit more about that, looking for narcotics or the sharing of ID cards. And how do we make sure that we're able to isolate those as well and make sure we're able to crack down there.

Our capability is something we are continually investing in. We're very proud of the capabilities there and we continue to use it as a collaborative platform to try and deliver the best capabilities we can offer in - in the prevention of fraud and abuse.

So, now I want to talk a little bit more about our competitive approach. And four key things I want to talk about here. First of all health information technology. I am a technologist, so this area is of particular interest to me. But really this is that ability to use health information technology to minimize and prevent fraud and abuse. In this I just want to make a quick note, the elimination of paper from the system is something that would be incredibly advantageous to us in our ability to fight fraud and abuse. Paper transactions slow down the processing and thereby limit our ability to get on top of these issues quickly. The more support we have from you all in this room, from the folks here at the table here, to push electronic transactions in the marketplace. We can do a better and better job of making sure. Not only that our members get the timely and appropriate care that they need, but that we're able to jump on cases of fraud and abuse much more quickly and stop them.

Provider partnerships, we partner a lot with our federal qualified health centers, our rural health centers and

our other primary care physicians to make sure that we are creating a unified front and sharing the information back and forth, so that our physicians have the data at their fingertips to understand what's happening, coordinated care. We have case workers on the ground working day in and day out with our members, sometimes co-located in the physicians facilities themselves, talking to the patients, so we understand what the needs of the individual members are. This gives us a very good advantage, where if a claim comes in that doesn't make sense with the care profile of an individual member we're able to jump on that immediately. And then also incredibly important is our partnership with our state partners. The more we can share data, as was mentioned here, with our federal and state partners, near real time, and that goes to eligibility, provider data, sanction information, etcetera. The ability to get that information flowing electronically and quickly allows us to create a much more solid wall preventing the fraud and abuse that is occurring.

So, a little bit more into detail. Health information technology, EDI is the term that we use to talk about the electronic data interchange between many of the partners in the system. So when it comes to eligibility we receive electronic eligibility and best practices at least daily to get that up to date information. Okay, electronic health records are making a

big splash in the marketplace. We offer an electronic health record that our physicians can log into and see the full breadth of care. This is not to replace a physicians own electronic medical system, which has that depth of the individual episodes where that member is interacted with that doctor. But to give them the breadth to see where else is this patient going, is this patient going around to different doctors looking for that - those narcotics. Is this patient showing up inappropriately in the emergency rooms, etcetera.

Provider partnerships, we talked a little bit about putting our case workers in the physician facilities, allowing our members to talk directly with our case workers, as well as to make sure that there is that tight partnership between us and the physician.

Case management, making sure that our sickest members are getting the appropriate care necessary. And because our folks are on the ground, in the field, they're able to kind of see the care the member is receiving and therefore flag inappropriate care before it occurs. And state partnerships as we mentioned, the sharing of data electronically, making sure that we're getting the up to date information and are able to share that collaboratively.

I want to talk a little bit about some of the results we've seen. I talked a little bit about the shopping for

narcotics. This is a serious health issue in the field today. It is an unnecessary use of public resources. It costs real money, but it is also dangerous to the health of our individual members. Because of some of our capabilities in these real time collaborations, we were able to have a dramatic effect on our ability to reduce the overuse of narcotics in the marketplace. This is making sure that a patient who goes to see one doctor one day and gets an appropriate prescription for a narcotic, but then the next day goes to a different doctor and again presents with the same symptoms and gets the same prescription. Okay, we see this in our marketplace and it is obviously a waste of resources, as well as dangerous for that individual patient. Our system agents are able to catch these capabilities and where appropriate, working with our states, we're able to actually lock that member in to say, listen for this member, only this physician is able - will have the authority to issue appropriate prescriptions for them to make sure that we can stop that behavior quickly.

I also want to make sure, this isn't just a question of usage of resources. This is also about the safety and well being of our members. Over 70 percent of our members are under the age of 18. And we found a case where there was an ophthalmologist who was actually sending a bus to an apartment complex, picking up a group of kids, taking them to his clinic,

and day after day he would see them and then increasingly move up the scale, it's very culminating in unnecessary surgery on the eyes of these kids. We were able to identify this case, refer it to the Attorney General and make sure that not only we were able to stop these waste of important system resources, but make sure that this individual was put out of practice and stopped from performing this very dangerous procedure for our members.

So, in conclusion, these briefings allow us to kind of share some of the things we are finding in the marketplace. Making sure that we are able to bring some of the best capabilities that we can offer to our safe partners and to our communities.

At Centene we view fraud and abuse as a shared responsibility between our states, our physicians and ourselves, to bring these best in case capabilities, and make sure that together we can create a collaborative high barrier to fraud and abuse and get it stopped. Thank you.

ED HOWARD: Alright. Very good. Thank you. Thank you, Glen. We now have the opportunity for you to join this conversation. You will remember the green cards, you can see the microphones, and we will be pleased to have you address your question to whomever you would like. Please keep your question as brief as you possibly can and identify yourself.

KATHLEEN CHAN: Hi. I'm Kathleen Chan. I'm the Vice President of Public Policy at the Visiting Nurse Associations. And we represent nonprofit home health and hospice providers. This is a terrific presentation, I very much thank you. I would strongly encourage CMS to use the Moratorium Authority that they received under ACA. We're in the midst right now of writing a letter to encourage you to do that. We work very closely with Congress and with MedPAC. We actually have quite a few recommendations in terms of stopping waste, fraud and abuse.

I do want to say that in the home health arena it's not all of the gangsters that are out there doing that. There's quite a few quite poor profit corporations that have learned how to be very sophisticated and we saw that in the Senate Finance Committee report. They have an equal level of sophistication that they also can do some advocacy and lobbying under the guy's of - of coming up with solutions. But there are solutions which don't necessarily address all of the problems. So, we would - we'd love to work with - with all of your, particularly with CMS and I'll be sending a follow up email along those lines. But if you have the Moratorium Authority please use it.

ED HOWARD: Peter you want to -

PETER BUDETTI: Sure.

ED HOWARD: - just let people know what the Moratorium Authority is.

PETER BUDETTI: That's what I was gonna - one of the many very strong, powerful anti-fraud provisions in the Affordable Care Act is the authority for the secretary to impose a temporary moratorium on the enrollment of new providers and suppliers, not beneficiaries. This is moratorium on the enrollment of new providers and suppliers, where necessary to prevent fraud. We have been very - we - we - we agree that this is a very powerful tool. We are very much committed to using that tool. We also want to make sure that we're using that tool when it is the most appropriate tool to fight fraud, because there are certain problems that the moratorium can address and there are certain problems that the moratorium simply is not the appropriate tool, but there are lots of other tools that will work.

So, we have looking very thoroughly to look at the different ways that moratorium could be justified and identified, and where to put them into place. And it is a - it is an authority that we are very actively pursuing. And that's about all I can say about it. Thank you.

MALE SPEAKER: Ed, could - could I weigh in here just a - there was one thing I'm not sure that I would say that we see definitely, but there was sort of an insinuation, if not a

direct allegation, that this is about for profits and not for profits are more virtuous. I'm not sure whether the data would actually support that. And you may have some - there are examples certainly. But I would like to point out that we have to look for patterns of usage wherever they are. And we see a - we see a fair amount of it. It - it - I'm not sure whether it goes into the fraud category or the waste category, but what we've noticed in behavioral services in home care is that when we have sort of closed the door or - or - or created some disincentives for one type, another type pops ups with very high utilization. And it is not - it is not, I would say defined - definitely one, either for profit or not to profit that's going to be the key indicator there.

KATHLEEN CHAN: Yeah, I was referring basically to the Senate Finance Committee report which came out last year on therapy issues. One last - one last question is - or comment is that we'd love to talk to the OIG, because we know OIG is doing a lot of work and if there's a way that we can be helpful to them, we'd like to also be helpful.

ED HOWARD: Yes, go right ahead.

CAROLINE POPLIN: I'm Doctor Caroline Poplin. I'm an MD, JD like Mr. Budetti and my question is for him. A lot of this seems to - a lot of the work seems to be directed towards sort of pill mills and phony doctors and phony clinics, but how

is - how are you addressing situations like McAllen, Texas, that [inaudible] profiled in the New Yorker a couple years ago, where there's just a huge use of services and some of it - and the problem may be whether it's medically necessary, rather than whether it's, you know, using a service that was never provided.

PETER BUDETTI: We're looking across the board. We're looking at a variety of different kinds of data and - and using those to identify the patterns that we think are the most - the best targets for intervention. I have to say that it's - there are ways that you can identify hot spots around the country. Certainly data analysis has played a very strong role in the location of the strike forces under the healthcare fraud, prevention and enforcement action team that joint between DOJ and HHS.

As we build out the models in our fraud prevention system. We do take the findings from a variety of sources, as I mentioned, into account, and that's very useful to us. And that helps us identify what the best targets are for us to apply our resources. So, we're well aware of problems in certain specific areas. And we're doing things that will allow us to take a look across the country in a way that's really different than we have in the past.

CAROLINE POPLIN: Thank you.

ED HOWARD: Yes, Bill Hazel.

BILL HAZEL: To - to jump in, I think Glen hit on this earlier, but in Virginia, what we're trying to do is look at the issues with over utilization or inappropriate utilization, that don't fall so easily into the fraud category, but maybe their waste and abuse are much more subtle. And what we're looking at are things like coordination of care. How do we get - ensure that out high need individuals have some sort of coordination of care, whether that's involving second opinions when appropriate, ensuring that the services that they're getting are those that they need, not more and not less necessarily or may be different. We've added a second opinion program for behavioral services this year. It's called BICAP which we have our community service boards actually - essentially as part of the sec - the second opinion process, determining whether individuals could get a less restrictive environment of care. So I think that how we coordinate it and frankly this is an area, I know Matt Sale [misspelled?] was a meeting where he spoke. But this is where your physician, as well as I and Dr. Budetti, where we've fallen down on the job. There's a certain amount of - of, you know, we say we're the gatekeepers and we're ensuring it's happening, but it's not happening, and we have to look at our own profession a little bit harshly on that too.

MALE SPEAKER: And one quick addition to that too is, Medicare and Medicaid don't talk to each other very well. If the highest cost people in the system are so-called dual eligible's, seniors, who are also poor. If you run a Medicaid program, you owe a lot to Medicare. If you are a secretary trying to run your program, Medicare doesn't give you all the information you need. Not only is that an open door for fraud, far more importantly it's an open door towards poor coordination of care and bad health for the most vulnerable people in our society. So if those programs aren't talking the way they should it's a real problem.

MALE SPEAKER: I - I would echo what he says and I'm hoping that we'll get some clarity soon on the dual eligible projects that are available in terms of the benefits, the cost sharing's, because we can invest at the state Medicaid level an awful lot and the return is all in the Medicare dollars that we don't see. And we see - we had one proposal in front of the general assembly this year for a very significant investment in the care coordination, it would be $56, $58 million investment on our part, and - and the return is - is not to us, so a problem.

ED HOWARD: Do you want to -

MALE SPEAKER: Yeah, let me just add to that, because I think you've touched on something that is absolutely critical.

When Secretary Sebelius has created the Center for Program Integrity, she moved together the Medicaid Program Integrity and the Medicare program integrity functions for the first time. And the Affordable Care Act presents a number of opportunities where there is to be quite appropriate overlap between the program integrity activities in both programs. We are of course, very conscious now that approaching 40 percent of the dollars in both Medicare and Medicaid are spending on the dual eligible population. And the fact that dual eligible's are both extremely vulnerable populations themselves medically, but also are vulnerable to exploitation in a number of ways. So we are now taking the opportunity of having the Medicare and Medicaid integrity programs together to build a true duals program integrity strategy within the center for program integrity. And that's going to take into account both the dual eligible beneficiaries and from their perspective - and all of the initiatives that are going on to serve them better. And the dual providers, the ones who are billing both programs and the opportunities they have to get away with things that the right hand hadn't noticed what the left hand was doing before. So, we're very much involved in building an overt, explicit, duals strategy within program integrity now.

MALE SPEAKER: Peter, Doug mentioned the Medi-Medi program and it seemed less than productive from his point of

view. And I wondered if that is still a viable piece of your armamentarium.

PETER BUDETTI: Medi-Medi is very definitely a valuable piece of our armamentarium, but - there I got through pronouncing that word. But - but we - we are certainly aware of the kinds of comments that Doug Porter provided and the feedback from states like his that didn't have the kind of positive experience in the past that we think we should get out of the Medi-Medi program. So Medi-Medi is actually very much integrated into our building a new approach to a true duals program integrity strategy and we think that there's great opportunities there to do things that really hadn't been accomplished before.

ED HOWARD: Glen, you had some -

GLEN SCHUSTER: Yeah - yeah, absolutely. So, I think - would also agree, I think duals represents a very tangible material opportunity for us. And we're very excited at Centene to kind of make sure that we are gathering the information from both sides of the program and are able to incorporate that into our fraud and abuse activities. You know, specifically we are looking forward, you know, we were recently given the privilege of expanding some of our programs into some of these areas of Texas. And so are looking forward to bring some of the managed care capabilities that we offer into those regions and

hopefully changing the color on some of those counties on Jim's map.

ED HOWARD: Yes.

FEMALE SPEAKER: Hi. I just wanted to clarify, before I ask my question that the -

ED HOWARD: Identify yourself.

BARBARA: Oh, sorry, Barbara Cornblau [misspelled?], the Coalition for Disability, Health Equity. But the duals also includes people with disabilities who are poor, not just senior citizens. But I think there's someone missing from the table and that is consumers. And I think that whoever said earlier that people, older people don't read those EOBs, they do, especially in south Florida, because they don't have a whole lot else to do, so they sit there and they read those and they call me, because my mother's advertised me as her daughter, the lawyer who works in Washington and does policy stuff. And I can tell you that my mother's first bill that was $8,000 for a wheel chair and three months of physical therapy for an accident that she never had. No one would take that to prosecute it, but she's not the only one. If they're doing it for her, there are hundreds of them. So they call the 800 number and they say, don't worry, honey, you don't have to pay the co-pay. I see that's changing a little bit with what's on the OIG webpage, but how we, you know, how can we capture

consumers like that and take one case and make it the hundred cases that it is.

MALE SPEAKER: I couldn't agree with you more. One of the things that we have done is to - I don't know if any of you have read any of your EOBs in the last few years, but -

MALE SPEAKER: I've tried, but I can't understand mine.

MALE SPEAKER: Thank you very much. I'm not the only one. So, we actually have embarked on a project that's coming to fruition soon, to redo the Medicare summary notices to make them much more consumer friendly and readable and to highlight areas of specific concern. And the new MSNs will be coming out soon. These were built on focus groups with Medicare beneficiaries, actually telling us what the issues were the old approach to the EOBs and also the kinds of things that we thought needed to be changed.

The second thing I'd point to is we have invested heavily in the Senior Medicare Patrol Program, the SMP program that's operated by the administration on aging and partnering with them to - to train seniors. I think that we still have a long way to go in terms of getting the full potential of, you know, 45 million people, most of whom would love to help us with all of this. And the third thing is that the calls to 1-800-MEDICARE, we have actually changed the response dramatically in the last couple of years.

But particularly, recently in terms of telling - when people call up with a possibility of fraud, we now have a new - a new interaction with the - with the caller to work through what their issue is, because the vast majority of the time it's a discrepancy that can actually be worked out. They don't understand that, you know, XYZ Company is actually a subsidiary of the healthcare system that they went to and it was a legitimate bill, all that sort of thing happens all the time, but last year we had something like 45,000 of the calls that did make it through to a higher level of investigation, because they did - they did raise suspicion. So we've taken that information and we've actually put it now into a sophisticated database that feeds into our fraud prevention system. So that's one of the sources of the kinds of information that we're getting. And I just very recently saw input on a provider who had potential fraud calls coming in from 300 different beneficiaries.

Now, I'm not prejudging that person, but that does - that does raise our index of suspicion. So - so I agree with you totally, I think getting the consumer more involved is very important. And I will say we've also engaged in a campaign, a parallel campaign, it's just about to get started for Medicare - for Medicaid beneficiaries, because most of our work has been with the Medicare beneficiaries.

FEMALE SPEAKER: Is - is there a way to flag those, because if you get a wheelchair you can't get another one for five years, so for five years we kind of prayed that my mother wouldn't break her hip, because it was on record that she had a wheelchair that she didn't have. So, I think that's another concern that -

MALE SPEAKER: So, what she's saying is that the victims here of - of different kinds of fraud often include the innocent beneficiaries, because if somebody has in their record that they got a wheelchair, even though they didn't get it, somebody else - actually probably nobody got it, all we did was get a bill for it. And - and - and it appears that - so, yes, we do flag those, that's our compromised numbered database that we have set up, which now has a quarter of a million Medicare beneficiary identities in it. And so that's integrated into our system as well. And that's something that we want to know about. By the way, we've also set up a new system to deal with provider identity theft as well.

FEMALE SPEAKER: Thank you.

MALE SPEAKER: Let me just suggest one additional angle as this also is, in Medicaid in particular, our members generally do not have a lot of patient responsibility in terms of co-pays, co-insurance and stuff, these are people that are at the lower end of the income scale. And so if the topic is

financial and the members don't have a financial stake, you know, certainly we have many citizens who step up and try and report this, but if we can engage them in a healthcare discussion. And so what we do is we put out a personal health record for the member to empower them to take control of their own care.

And if something shows up on their personal health record they will generally alert us, because this means that we are not properly putting them in the correct, the appropriate care, and so making that a healthcare discussion where they can talk about it with their doctor, they can talk about it with their case worker, etcetera, we can also flag things that way. And so that way we're engaging them in a conversation that they really care about, which is obliviously their own health. And making sure that we are able to leverage those conversations in our efforts to combat fraud and abuse as well.

MALE SPEAKER: And just a quick add, that bullet was in my presentation. And I think even though we spend a lot of time talking about technology and federal state governments, incentives, and all that, there's just not a whole lot of incentive on behalf of the patient to look at that bill in the first place and certainly report it, but I know over the years, AARP has done some good work with trying to get people to look at EOBs, understand them, report things that look anomalous,

but ultimately there's not a whole lot of incentive, and as - and even Dr. - Secretary Hazel, can't understand his EOB, certainly older seniors can't understand theirs and my patients are on Medicare, they - I looked at theirs when I was home at Christmas, and I don't understand it either.

So, [inaudible] another kind of inverted triangle like I had for the fraud to recoveries, you know, all the fraud that's out there and how do you get somebody who actually reports something and it gets acted on, and it gets recovered. But I think community activists and teaching people how to do that in senior centers and others is extremely helpful. But ultimately if there's not any - as Glen said, any financial incentive on behalf of the patient to do it, you're just really doing to have a hard time getting to the core of the problem.

MALE SPEAKER: I feel I need to put out a disclaimer. I'm not looking at Medicare EOBs quite yet.

ED HOWARD: I am and I can't understand them, although they're getting better, they're getting better, yes. Let me just say, we've got 20 cards here with really good questions. We have folks at the microphones. If you really want your question to be asked you've got a much better chance up there than you do here. So, and the other thing I would say is that as we move through the Q&A I would ask that you pull out the

blue evaluation forms and start filling them out before you get caught up in this fabulous conversation. Yes, go right ahead.

AMY: Thank you. My name is Amy Zettle [misspelled?] and thank you. This has been a very helpful panel. I have two questions for Dr. Budetti, if you have the time. The first one is related to the prepayment review demonstration. And I'm wondering if you could give us an idea of what level of savings you're expecting through that demonstration, especially as the DRGs are supposed to expand this year. and then secondly if you could speak a little bit more to the predictive analytics as it relates to corporate abuse. So, can we expect the predicative analytics to start looking at up coding and over utilization beyond just looking at fraud?

PETER BUDETTI: Let's start with the prepay review. There is an announced demo that will look at a specific number of DRGs on a prepaid basis in a limited number of states. I actually don't have the numbers at my fingerprints for what - for what the projections were. I'd be happy to dig them out for you and share them with you.

On the second question which has to do with are we going beyond fraud, our focus in program integrity has definitely been on fraud. I think the answer to the question posed today is a lot. That's the most quantitative answer that

I think we can actually give to that question. But I do think that there's a substantial amount of savings.

Having said that, we also recognize, as we put this system into place, that while the way that our system operates, it generates alerts that are at a great extreme of triggering not just one or two or three, but many different kinds of - of - of pointers towards there being a problem with fraud. So the things that we're directing our resources to are not likely to be - and especially as we expand and our system continues to grow and learn. Those things are not likely to be in the gray zone of waste and abuse or even normal practice under certain circumstances. But I have to say that one of the things that we're doing is planning for that arena, that when we get to an area that is not as clearly, likely to be fraud, not something that we necessarily need to turn over to our investigative resources, but never the less looks a little funny, we're talking to the provider community about ways to deal with that, about self audits or - or asking the providers to, in a non-threatening manner to explain the situation, because we genuinely believe that there may very well be explanations for stuff, not at the extremes, but - but into the vast bulk of what we're looking at. I drive my Center for Program Integrity staff completely crazy by repeating my goal for our - our activities which is zero false positives. That's a goal that

reflects the fact that the vast majority of our providers are legitimate and honest ones and we're focused on that, but there's a lot of bad stuff out there too, and so that's the direction we're going in, but we're very conscious of directing our resources, especially right now to the truly problematic end of the spectrum on the fraud side.

ED HOWARD: And if you believe and there's no reason not to, the chart in Doug's presentation, the better you are at this, the less you end up recovering, because the less there is to recover.

PETER BUDETTI: Yes, that's the true throughout medicine, it's very hard to measure the effects of prevention, but we're - we're working on that.

ED HOWARD: Yeah.

MARSHA THOMPSON: That's good, very true. I like that. My name is Marsha Thompson, I'm with Sash Institute [misspelled?] and I'm going to generally direct this to Mr. Porter and to Secretary Hazel. In Washington State you've had some wonderful results using technology as it relates to fraud, waste and abuse, particularly in the workers compensation area. And my question and commentary would be that fraud, waste and abuse from a technology standpoint can become something that would go across disciplines, go across departments. And I'm - so that's my commentary, it does. And I'm looking as the

states are seeing tremendous budget deficits and we're sitting here today talking a particular, you know, segment of the government. How are you looking at leveraging your expenditures in various areas, so that you get a direct return, a very high return on the technology that you're putting in place. So again I'll use Washington right now. I know workers comp is a great return to you. Are you using the technology to go across the various agencies?

DOUG PORTER: We've had our new system in place now for almost a year and I think we've got all the kinks worked out of it. And we are now starting to make that technology available to the Department of Corrections who does not have any automatic claims payment system possible. And I was shocked to find out how much healthcare DOC actually purchases. So, we're gonna be partnering with them and getting them a lot of information that they've never had before about what they're spending their money on. We've had a close working partnership with LNI [misspelled?] and our workers comp program, particularly around efforts to moderate the use of pain killers and narcotics. LNI buys kind of a different brand of healthcare than we do. They do a lot of backs, and knees, and hips and stuff like that. We do a lot of labor and deliveries, but we're looking at those areas where we can find some overlap to share information about our common providers out there.

They're currently using our legacy code in their claims payment system. And we've just opened up conversations with them to tell them about the functionality that our new provider one MMIS system has, so I foresee in the very near future a renewed and strengthened partnership with worker's comp in our state.

FEMALE SPEAKER: Excellent, excellent, that's what I want to hear, you know, as a citizen. And we look at how we spend money and we see that this is a prevalent problem across all the agencies that we'd like to leverage investment. Thank you very much.

DOUG PORTER: Thank you.

ED HOWARD: Alright, did you want to add anything to that?

BILL HAZEL: Only to the extent that, you know, our focus in technology is a little different. We are creating a unified IT architecture for the entire health and human services area. And we've created - we were - are building it off of what would have been the [inaudible] program now in social service need. We are creating the data standards, we have the service bust, the rules engine, the EDM products. And what we would ultimately like to do is have all of our legacy systems communicate then we can gather the data and determine who the individuals who really are getting into our system at higher levels, you know, so medicine it would be - you divide

your folks up into your cases that are your most expensive cases. Some you can't do anything about, some you can. And we want to pick those out in the social service, as individuals where we can actually really do case management. And we want to use data from a variety of agencies in the process of doing that, child serving agencies or social service, behavioral health, whatever, so this is the direction that we are embarking on. And frankly with the 90-percent, the rules that were 90-percent Medicaid in the OMB circular last year, it's allowed us to use some of the Medicaid money to make those investments. And we think there's a lot of promise there.

ED HOWARD: If I can ask you to defer for just a minute, there's a related question that came in on a card that promptly worth putting before the panel. And Jim Frogue, you mentioned, you said, Malcolm Sparrow's book, License to Steal. They quote - this questioner quotes Malcolm Sparrow from the book, saying that electronic claim submissions make it easier to submit fraudulent claims and I wonder - the questioner asks, if you think that electronic claims are more susceptible to fraud that the paper and ink variety. And you don't have to defend that anymore than any of the other panel members do.

JIM FROGUE: Well, I think the organized crime in Eastern Europe that was reading Parente's on the first day would probably agree that their lives are made easier and their

job is more lucrative by electronic remittances. One of the biggest problems though and I mentioned this earlier, is - is a point of entrance. I mean any willing provider issue makes it very easy for people to become part of the system and then if they're smart - and this is why the smart criminals are reading the most recent stuff, just to keep their billing in sort of a statistical norm. So, they don't - average billing practices actually are relatively findable and fixable, but getting into the system and then staying in sort of a - sort of a middle range, once you do that it's actually kind of hard to kick people out. But the any willing provider makes it very easy for people to get in that don't belong there and there's been some reforms there, but there's a long way to go. I mean one of the simplest ones and [inaudible] I guess it's been about two years now, is you know, you could simply add something to the DME enrollment form that says under penalty of prudery, that wouldn't cost a penny to add that and prosecutors will tell you that, that makes a crime a lot worse. So, there's a lot of little things that could make it a lot better, but any willing provider, that's the really key thing that needs to be addressed, because it makes it too easy for these people to get in the system that aren't even necessarily in the country.

MALE SPEAKER: So, a couple things and I absolutely agree with the any willing provider clause, we want to make

sure that the providers in our network are the best and are the highest quality. But to the direct point on EDI versus paper. The fact is now a days there are dozens, if not hundreds of vendors out there that will take an electronic claim and kick it out to paper, which means it comes in our door to paper. Those - it slows down the process, it also eliminates the key tagging information that comes on those electronic information that allow us to trace back these electronic transactions to their source. Needless to say, if we see a claim coming in through our website and we can tell somebody from Eastern Europe is accessing our website, that's gonna raise a red flag and we're able to stop those.

We can basically use the electronic tagging that the systems are putting on there to figure out where these claims are coming from. So, first of all that allows us to bring other information to bear, to allow us to better find these claims. But in addition we can then better go after whoever submitted them, as opposed to a paper envelope showing up on our doorstep where we can't really tell where it came from other than the postage stamp on it. The electronic claims have that electronic tagging going all the way back to the source. We can find where this data is coming from and we can stop it. And for example, we routinely review our web logs and say, you know what, we're not going to take anything from this IP range,

because we know that whoever is attacking our website is fraudulent. So the electronic actually gives us additional tools to more rapidly and more effectively stop these types of attacks.

ED HOWARD: Okay. Yes, go ahead. Thank you.

KELLY EMERICK: Thank you. Kelly Emerick with the Secure ID Coalition. And actually this is a great lead in to my question. Dr. Budetti, we are very excited that CMS is going through and verifying providers and will continue to do that. We think that is a critical element in knowing who is actually eligible to bill Medicare, so that we know who those people are. I think the question that I have is, taking it to the next step though, we know that I'm a legitimate provider, but how do we know that I'm actually the one doing the transaction. And when we look at other programs around the world, when we look at Germany, we look at Slovenia, we look at Taiwan, they're actually using smart cards as that token to verify that not only is it a legitimate provider, but it is actually the person that was issued that credential billing the system.

And I just was curious if you have looked at those types of programs and if you think that a authentication token is going to start some of the fraud that we're seeing happening

from organized crime and other places where they're able to steal provider numbers and then use those [inaudible].

PETER BUDETTI: Well, since we've gone over to smart cards to access our computers as CMS, it's been a - it's been a transition, I'll put it that way. So the first step of course is to get things - is to do it electronically. The second step is to have a, you know, multi factor verification or however else we're gonna go about doing that to make sure that it's the right person sitting at the other end of the terminal.

There has been some work to look at the use of other technologies, including smart cards. There are a number of issues that have been raised in terms of the initial investment in doing that. I think that we do need to look very carefully at what the payoff could be from - from doing that, not just at the costs of doing it. But that - that's something that is very much - has very much received attention, but it's not where we are at the moment, but we're certainly aware of that and we certainly have been interested in looking at what the benefits, as well as the costs might be.

MALE SPEAKER: Ed, if I could?

ED HOWARD: Yes?

MALE SPEAKER: At the state level, we are - we're developing - or we have in place now, early on, a child care portal and we are using smart cards for them to swipe for

billing purposes and child care, so I can see that being a technique we use down in the future. I mentioned earlier that we're creating a commonwealth authentication service. That would not just be for individuals, but we can use - put providers in that authentication service too, and then when they come in to sort of a multi facture, sort of validation of who they are, as they do business, you know, electronically with the commonwealth. Now, whether it gets to cards, how - beyond that, we're not that far yet.

MALE SPEAKER: I would just add that Senators Wyden and Mark Kirk from Illinois have a smart card that's for beneficiaries. It's based on what's already being used in the Department of Defense where there are millions of those things issued. There's some expense issues to work through, but there's a model out there for millions of people. But again the financial services industry is a good one, because there's - to look at as a model, because there's hundreds of millions of credit cards in circulation in the United States.

There's millions of millions of vendors and there's countless products. And there ability to find and authenticate and keep fraud far, far below 1-percent, I think is a model that needs to be considered when looking at best practices to migrate into that system.

FEMALE SPEAKER: Just a quick update on that front. Actually Visa and MasterCard have announced they will issue smart cards starting in 2014 to all U.S. credit card holders. Specifically to prevent fraud, because there is so much fraud that's coming here from overseas.

ED HOWARD: Very good. Yes, sir, yes.

CHRIS: I'm Chris Wadely [misspelled?] with the Counsel of State Governments. And I just wanted to say that I think on the state level, one of the big challenges is this is, you know, technically obtuse and often politically invisible. And to really drive the state level reform you've got to get all three branches of state government working together, right, and even constitutional officer. You've got these citizen state legislators who have to kind of work through this same complexity, figure it out, create a legislative and enabling environment, and then fund these program integrity efforts. And then you got attorney generals and governors who have to work together on the fraud control and the program integrity level. They're often from different parties, unlike in Virginia, they often don't get along. And just kind of catalyzing that state reform I think is gonna require a lot of, you know, incentivizing and hand holding from CMS. And then we're gonna have to look at other successful efforts like, you know, the two great Medicaid directors we have on the stage.

So, if you have any reaction to that, I'd be very happy to hear it. Thank you.

MALE SPEAKER: I'll respond -

MALE SPEAKER: Please do.

MALE SPEAKER: - since he pointed out Virginia. What's interesting in Virginia is that the current governor was the attorney general for the previous governor and now he's having to live with some of the decisions he's made, so it's interesting. You know, we are, by in large, pretty fortunate in Virginia. It seems that the legislature, AGN, and the Executive Branch seem to be on the same page and that is not really a party issue for us at this point.

ED HOWARD: Anybody else? Okay, by the way you see on the screen yet another request that you fill out that pretty blue form that you see. The 50-percent and the 100-percent are unattainable, it's really 35-percent and 50-percent. The one person who walked out did not deprive the community of hope of 50 bucks. I've got a final question here that I think is sort of appropriate, because it's forward looking. Other than home health what other healthcare providers are on your radar screen for closer scrutiny. And I assume that would be at either the federal or the state level?

MALE SPEAKER: Durable medical equipment providers.

ED HOWARD: There's a quick answer.

MALE SPEAKER: We've had a lot of issues, at least we think we're finding them in the behavioral health arena.

ED HOWARD: Behavioral health. Peter?

PETER BUDETTI: Well, when we - when we put into effect the provisions in the Affordable Care Act to do risk based screening, we did pick - we did establish as the highest level, the new home health and the new DME suppliers, but a number of other providers and suppliers were put into the moderate risk, doctors and hospitals in the lower risk. I think the answer is, we have to look everywhere all the time, but I think we do need to be sensible about to try and figure out where the highest risks are.

ED HOWARD: Okay, well listen, this has been - for one poor - I'm sorry I only have a doctorate in law, it's not in medicine, but for me I've learned an awful lot. Thanks to Centene for its participation in and support of this briefing. Thanks to you for asking a lot of good questions and my apologies for not getting to some of them. And ask you to thank the panel with me for what I found an incredibly useful conversation.

[END RECORDING]