STATEMENT OF

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ON

"CMS EFFORTS TO REDUCE IMPROPER PAYMENTS IN THE MEDICARE
PROGRAM"

BEFORE THE
UNITED STATES HOUSE COMMITTEE ON
OVERSIGHT & GOVERNMENT REFORM
SUBCOMMITTEE ON ENERGY POLICY, HEALTH CARE & ENTITLEMENTS

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U.S. House Committee on Oversight & Government Reform
Subcommittee on Energy Policy, Health Care & Entitlements
Hearing on
CMS Efforts to Reduce Improper Payments in the Medicare Program
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Chairman Lankford, Ranking Member Speier, and members of the Subcommittee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) program integrity efforts. Enhancing program integrity is a top priority for the administration and an agency-wide effort at CMS. We share this Subcommittee' commitment to protecting beneficiaries and ensuring taxpayer dollars are spent on legitimate items and services, both of which are at the forefront of our program integrity mission. We have made important strides in addressing improper payments and reducing waste, abuse and fraud across our programs and I appreciate the opportunity to discuss the priorities of CMS' Center for Program Integrity.

CMS is using a multi-faceted approach to target all causes of waste, abuse, and fraud that result in inappropriate payments by shifting towards prevention-oriented activities. We are working closely with law enforcement, states, private insurers, and providers in our efforts. CMS must strike an important balance while overseeing the Medicare program: limiting the administrative burden on legitimate providers and suppliers to preserve beneficiary access to necessary health care services while fulfilling our obligation to ensure taxpayer dollars are not lost to waste, abuse, and fraud. We have instituted many program improvements since the passage of the Affordable Care Act and other legislation, and are continuously looking for ways to refine and improve our program integrity activities.

In addition to CMS's ongoing program integrity efforts, the FY 2015 President's Budget reflects the Administration's commitment to strong program integrity initiatives, which includes investments that will yield $13.5 billion in gross savings for Medicare and Medicaid over 10 years. Such efforts targeting waste, abuse, and fraud have already helped extend the life of the Medicare Trust Fund, and are critical to protect Medicare for years to come.

Waste, abuse, and fraud can also inflict real harm on Medicare beneficiaries. Through prevention, we can decrease beneficiaries' exposure to risks and harm while preserving Trust

Fund dollars. For example, in the case of a Chicago-area dermatologist that was indicted in October 2012 for falsely diagnosing patients with skin cancer, patients endured the risks and trauma of unnecessary surgery. Using a proactive approach, CMS stopped payments to this provider in conjunction with law enforcement making the arrest and prosecuting the case.

Prevention

Provider enrollment is the gateway to billing the Medicare program, and CMS has put critical safeguards in place to make sure that only legitimate providers are enrolling in the Medicare program.

Strengthening Provider Enrollment

The Affordable Care Act required CMS to implement risk-based screening of providers and suppliers who want to participate in the Medicare and Medicaid programs, and CMS put these additional requirements in place for newly enrolling and revalidating Medicare and Medicaid providers and suppliers in March 2011. This enhanced screening requires certain categories of providers and suppliers that have historically posed a higher risk of fraud to undergo greater scrutiny prior to their enrollment or revalidation in Medicare. These new screening requirements resulted in an estimated additional 50,000 site visits, and in April 2014, CMS announced that upon notification, providers designated to the high screening level will be required to submit fingerprint-based background checks to gain or maintain billing privileges for Medicare.

The Affordable Care Act also required CMS to screen all existing 1.5 million Medicare suppliers and providers under the new screening requirements. Since March 25, 2011, more than 770,000 providers and suppliers have been subject to the new screening requirements and over 260,000 provider and supplier practice locations had their billing privileges deactivated for non-response as a result of these screening efforts.[1] Since implementation of these requirements, CMS has also revoked 17,534 providers' and suppliers' ability to bill the Medicare program. These providers and suppliers were removed from the program because they had felony convictions,

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[1] Deactivated providers could reactivate over time with updated practice information or after showing evidence of proper licensing.

were not operational at the address CMS had on file, or were not in compliance with CMS rules, such as licensure requirements.

Enrollment Moratoria

The Affordable Care Act also provides the Secretary the authority to temporarily pause the enrollment of new Medicare, Medicaid, or Children's Health Insurance Program (CHIP) providers and suppliers, including categories of providers and suppliers, if the Secretary determines certain geographic areas face a high risk of fraud.   In the last year, CMS has used this authority in seven metropolitan areas[2] to safeguard taxpayer dollars while ensuring patient access to care is not interrupted. In July 2013, CMS announced temporary moratoria on the enrollment of new home health agencies (HHAs) and ambulance companies in Medicare, Medicaid, and CHIP in three "fraud hot spot" metropolitan areas of the country: HHAs in and around Miami and Chicago, and ground-based ambulances in and around Houston.[3] In January 2014, CMS announced new temporary moratoria on the enrollment of HHAs in four metropolitan areas: Fort Lauderdale, Detroit, Dallas, and Houston, and on ground ambulances in the metropolitan Philadelphia area.[4] CMS also extended for six months the existing moratoria for HHAs in and around Chicago and Miami, and ground ambulance suppliers in the Houston area. CMS is required to re-evaluate the need for such moratoria every six months.

In each moratorium area, CMS is taking administrative actions such as payment suspensions and revocations of home health agencies and ambulance companies, as well as working with law enforcement to support investigations and prosecutions. In Miami alone, CMS has revoked the billing privileges of 101 HHAs in 2013, with 67 revocations occurring after the moratorium was put into place. Additionally, law enforcement made arrests in a $48 million Miami home health

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[2] The seven metropolitan areas where CMS has issued moratoria are: Miami, FL (Miami-Dade and Monroe Counties); Chicago, IL (Cook, DuPage, Kane, Lake, McHenry and Will Counties); Dallas, TX (Dallas, Collin, Denton, Ellis, Kaufman, Rockwall, and Tarrant counties); Houston, TX (Harris, Brazoria, Chambers, Fort Bend, Galveston, Liberty, Montgomery and Waller Counties); Detroit, MI (Wayne, Macomb, Monroe, Oakland, and Washtenaw Counties); Philadelphia, PA (Philadelphia, Bucks, Delaware, and Montgomery Counties in Pennsylvania and Burlington, Camden, and Gloucester Counties in New Jersey); and Fort Lauderdale, FL (Broward County)
[3] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-07-26.html
[4] http://cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-01-30-2.html

scheme, and secured guilty pleas against three home health recruiters in that scheme as well as guilty pleas from the owners of a clinic involved in an eight million dollar fraud scheme. In Texas, CMS has revoked the billing privileges of 179 ambulance companies in the last 12 months, and 92 revocations occurring after the moratorium was put into place in Houston.

Improper Payments in Medicare Fee-for-Service

Medicare fee-for-service has been deemed a "high risk" program by the Government Accountability Office in part due to the sheer size and complexity of the program. CMS pays 1.5 million providers for health care for 54 million beneficiaries under the Medicare program. The Office of Management and Budget has determined that Medicare is also a "high error" program due to its annual estimated error amount. Each year, CMS estimates the improper payment rate and a projected dollar amount of improper payments for Medicare, Medicaid, and CHIP.[5] While these improper payments represent a fraction of total CMS spending, any level of improper payment is unacceptable and we are working diligently to reduce these documentation, coding and claims processing errors.[6]

Improper payments are errors that are not necessarily fraudulent. The vast majority of Medicare FFS improper payments fall into two categories: 1) inadequate documentation to support the services billed and 2) the documentation as provided did not support that the services were medically necessary. Payments deemed "improper" under these circumstances tend to be the result of documentation and coding errors made by the provider as opposed to payments made for inappropriate claims. The most common error providers make is the failure to properly document the beneficiary's need for the service and most improper payments are made when information in the medical record did not support the services billed.

The factors contributing to improper payments are complex and vary from year to year. For example, a contributing factor to the FY 2013 Medicare FFS error rate was the implementation of new policies regarding documentation. Although the policy change will ultimately strengthen

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[5] http://www.hhs.gov/afr/2013-hhs-agency-financial-report.pdf
[6] The annual rates for all Federal programs that are deemed high-error are posted on the website www.paymentaccuracy.gov.

the integrity of the program, there is a change management aspect to implementing new policies. Since it takes time for providers and suppliers to fully implement new policies, especially those with new documentation requirements, it is not unusual to see changes in error rates following implementation of new policies.

CMS has designed its systems to detect anomalies on the face of the claims, and through these efforts, we are paying the claims correctly as they are submitted nearly 100 percent of the time. For example, CMS is using the National Correct Coding Initiative (NCCI) to stop claims that never should be paid in Medicare Part B and Medicaid. This program was first implemented with procedure-to-procedure edits to ensure accurate coding and reporting of services by physicians.[7] In addition to procedure-to-procedure edits, CMS established the Medically Unlikely Edit (MUE) program to reduce the paid claims error rate for Medicare Part B claims as part of the NCCI program.[8] MUE edits prevent payments for services such as hysterectomy for a man or prostate exam for a woman. NCCI edits are updated quarterly and, prior to implementation, edits are reviewed by national healthcare organizations and their recommendations are taken into consideration before implementation. Since October 2008, all procedure-to-procedure edits and the majority of MUEs have been made public and posted on the CMS website.[9] The use of the NCCI procedure-to-procedure edits saved the Medicare program $530 million in FY 2013, and the NCCI methodology procedure-to-procedure edits applied to practitioner and outpatient hospital services have prevented the improper payment by Medicare of over $7.5 billion since 1996 based on savings reports from claims-processing contractors.

The main challenge with improper payments is that detection relies on evaluating the medical record – to identify whether the service was medically needed - for example – which is not submitted with claims. CMS and its Medicare Administrative Contractors (MACs) develop

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[7] Procedure-to-procedure edits stop payment for claims billing for two procedures that could not be performed at the same patient encounter because the two procedures were mutually exclusive based on anatomic, temporal or gender considerations.

[8] MUEs stop payment for claims that are beyond the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single data of service.

[9] Certain edits are not published because of CMS concerns that they may be used or manipulated by fraudulent individuals and entities.

medical review strategies using the improper payment data to ensure that we target the areas of highest risk and exposure. The review strategies range from issuing comparative billing reports that educate providers about their billing practices by showing the provider in comparison to his or her state and national peers, to encourage providers to conduct self-audits, to targeted medical review of specific providers. The Medicare Administrative Contractors reported that medical review resulted in $5.6 billion in savings for FY 2013.[10]

Prior Authorization

One area that previously had high incidences of improper payments was the Powered Mobility Device (PMD) benefit; CMS found that over 80 percent of claims for motorized wheelchairs did not meet Medicare coverage requirements in 2011.[11]

As result of these and other findings showing very high improper payment rates for PMDs, CMS implemented the Medicare Prior Authorization of PMDs Demonstration in seven high risk states in September 2012.[12] Since implementation, CMS observed a decrease in expenditures for PMDs in the demonstration states and non-demonstration states. Based on claims submitted as of September 30, 2013, monthly expenditures for the PMDs included in the demonstration decreased from $20 million in September 2012 to $9 million in August 2013 in the non-demonstration states and from $12 million to $4 million in the demonstration states.[13]

We believe the decrease in overall spending is due in part to national Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers adjusting their billing practices nationwide (not just in the demonstration states) and reflects suppliers complying with CMS policies based on their experiences with prior authorization in the demonstration states.[14] The decrease in spending can also be attributed to the continuous DMEPOS supplier education

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[10] http://www.hhs.gov/budget/fy2013/fy2013-other-information.pdf
[11] http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/MedicareFFS2011CERTReport.pdf
[12] The seven states are: CA, IL, MI, NY, NC, FL and TX
[13] http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/PMD_Demo_1yrUpdate_12182013_508Clean.pdf
[14] http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/PMD_Demo_1yrUpdate_12182013_508Clean.pdf

and outreach mechanisms implemented by the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and CMS as well as other initiatives to prevent fraud and reduce expenditures for medically unnecessary PMDs.

Additionally, overall the industry's feedback has been positive. Several DMEPOS suppliers have suggested prior authorization helps their business by providing a more predictable cash flow and improved relationships with the ordering physician. These suppliers have expressed support for the demonstration and would like it to be expanded to other states and items.

While the private sector widely uses prior authorization to control waste, abuse, and fraud, CMS is seeking authority to expand the use of this tool. The President's FY 2015 Budget includes a proposal that builds on the success of the Prior Authorization of PMDs Demonstration by giving CMS the authority to require prior authorization for all Medicare fee-for-service items, particularly those items at the highest risk for improper payment. By allowing prior authorization on additional items, CMS can ensure in advance that the correct payment goes to the right provider for the appropriate service, and preventing potential improper payments before they are made.

Fee-for-Service Recovery Auditors
CMS uses the Recovery Auditors to perform medical review to identify and correct Medicare improper payments primarily on a post payment basis. CMS uses the vulnerabilities identified by the Recovery Auditors to implement actions that will prevent future improper payments nationwide. Since full implementation in FY 2010 through the first quarter of FY 2014, the Recovery Auditors have returned over $7.4 billion to the Medicare Trust Fund.

Recovery Audit Program Improvements
CMS is currently in the procurement process for the next round of Recovery Audit Program contracts and plans to award these contracts this year. In February 2014, CMS announced a number of changes to the Recovery Audit Program that will take effect with the new contract awards as a result of stakeholder feedback. CMS believes that improvements to the RAC

program will result in a more effective and efficient program, including improved accuracy, less provider burden, and more program transparency.

Zone Program Integrity Contractors Reviews

Zone Program Integrity Contractors (ZPICs) identify providers that have aberrant billing patterns and other behaviors that are indicative of fraud. The ZPICs use medical review on a pre- and post-pay basis to identify medically unnecessary billed services. In addition, CMS, in coordination with its ZPICs, uses a variety of administrative actions to stop payments, including payment suspension or revocation of billing privileges when there is a credible allegation of fraud.

Fraud Prevention System (FPS)

Under the Small Business Jobs Act of 2010, CMS is required to use predictive modeling and other analytic technologies to identify and prevent waste, abuse, and fraud in our Medicare fee-for-service program. Since June 2011, CMS has been using the Fraud Prevention System (FPS) to apply advanced analytics on all Medicare fee-for-service claims on a streaming, national basis. CMS designed the FPS to accommodate different analytic model types to address a variety of fraud schemes. The most important indicator of success is that the models in the FPS have led to administrative action – we have used our revocation authority to remove bad actors from the Medicare program, which is the surest way to protect Trust Fund dollars and beneficiaries, suspended potentially fraudulent payments from going out the door, and referred leads and cases to law enforcement.

Early results from the FPS show significant promise and CMS expects increased returns as the system matures over time. As reported in the FPS First Implementation Year Report to Congress,[15] in its first year of implementation, the FPS stopped, prevented or identified an estimated $115.4 million in improper payments. These savings are the outcome of activities such as revocations of provider billing privileges, the implementation of payment edits, the suspension of payments, and changes in behavior that result from CMS actions. The FPS

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[15] http://www.stopmedicarefraud.gov/fraud-rtc12142012.pdf

achieved a positive return on investment, saving an estimated three dollars for every one dollar spent in the first year; and CMS is expanding the ways that we are using the FPS to identify bad actors and improper payments that will enhance its success. For example, CMS initiated a pilot project with one MAC to determine whether providers flagged by the FPS are appropriate targets for medical review and education. CMS found that the early education by the MACs changed about half of the providers' billing behavior, while others required increasing levels of intervention. CMS is also working to implement edits directly into the FPS that would stop payment based on Medicare payment policy. CMS is expanding both of these efforts in the FPS.

Collaborating with law enforcement

Earlier this year, the Government announced that in Fiscal Year (FY) 2013, its waste, abuse, and fraud prevention and enforcement efforts in the Health Care Fraud and Abuse Control (HCFAC) program resulted in the record-breaking recovery of $4.3 billion in taxpayer dollars from individuals trying to defraud Federal health care programs serving seniors and taxpayers.[16] Over the last five years, the Administration's enforcement efforts have recovered $19.2 billion, up from $9.4 billion over the prior five-year period. Over the last three years, the average return on investment (ROI) of the HCFAC program is $8.10 for every dollar spent, which is an increase of $2.70 over the average ROI for the life of the HCFAC program since 1997.

As a result of these and other efforts, there has been a measurable decrease in Medicare payments for certain medical services that have also been targeted by the Medicare Strike Force.

DME Competitive Bidding

Finally, on January 1, 2011, CMS implemented Round 1 of DME competitive bidding program in nine areas, including Miami and CMS implemented Round 2 of the program in 91 additional areas on July 1, 2013. It is projected to save the Medicare program approximately $27 billion and beneficiaries $18 billion over ten years.[17] The program works by establishing Medicare's DMEPOS payments based on competitive market pricing, thereby reducing beneficiary out-of-pocket costs, program outlays, and suppliers' incentive to fraudulently bill Medicare for

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[16] http://oig.hhs.gov/publications/docs/hcfac/FY2013-hcfac.pdf
[17] FY 2015 Congressional Justification, Page 41.

DMEPOS. Moreover, CMS' monitoring revealed the competitive bidding program may have curbed previous inappropriate distribution of these supplies. Round 1 of the DME competitive bidding program is already generating significant savings for the Federal Government and the approximately 2.3 million Medicare fee-for-service beneficiaries residing in the areas where the Round 1 program is in effect. The competitive bidding program resulted in average savings of 35 percent below the fee schedule rates and saved more than $400 million in the first two years of operation while preserving beneficiary access to quality items in the nine Round 1 Rebid areas.[18] For the second round of the program, which started in July 2013, CMS is projecting savings of 45 percent below fee schedule prices for DMEPOS items, and savings for the national mail-order program are estimated at 72 percent below fee schedule prices.

Law enforcement activity combined with various measures taken by CMS, which themselves were prompted by enforcement activity, appear to have contributed to even further declines in Medicare payments for DME in Miami over time. Payments by Medicare for DME in Miami-Dade County alone hit an all-time high in the third-quarter of 2006, when payments exceeded $73 million, those payments have decreased over time, and in the first-quarter of 2013 payments were under $15 million.

Working Across the Health System
CMS is coordinating a variety of efforts with Federal and state partners, as well as the private sector to better share information to combat fraud. CMS issued new compliance program guidelines to assist Medicare Advantage plans and prescription drug plans design and implement a comprehensive plan to detect, correct and prevent waste, abuse, and fraud. CMS also enhanced its data analysis and improved coordination with law enforcement to get a more comprehensive view of activities in Medicare Advantage and Part D. The Part C and D program integrity contractor, the MEDIC, identified vulnerabilities and performed analysis that identified over $105 million in improper payments. The MEDIC then sent notification to plan sponsors to delete the records associated with improper payments from FYs 2011 and 2012. To increase the impact of the proactive analysis, CMS proposed a rule that would provide CMS, the MEDIC,

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[18] http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2013-Fact-Sheets-Items/2013-10-31.html

and other agencies the ability to request and collect information directly from pharmacy benefit managers, pharmacies, and other downstream entities of Part D plans.

In July 2012, the Secretary of HHS and the Attorney General announced a historic partnership with the private sector to fight waste, abuse, and fraud across the health care system. The ultimate goal of the Healthcare Fraud Prevention Partnership (HFPP) is to exchange facts and information to identify trends and patterns that will uncover waste, abuse, and fraud that could not otherwise be identified. The HFPP currently has 36 partner organizations from the public and private sectors, law enforcement, and other organizations combatting waste, abuse, and fraud. In 2013 and 2014, the HFPP completed early proof-of-concept studies that have enabled partners, including CMS, to take substantive actions such as payment system edits, revocations and payment suspensions to stop payments from going out the door and improve our collective forces against waste, abuse, and fraud. Just last week, the Secretary and Attorney General announced a nationwide takedown by Medicare Fraud Strike Force operations in six cities that resulted in charges against 90 individuals, including 27 doctors, nurses and other medical professionals, for their alleged participation in Medicare fraud schemes involving approximately $260 million in false billings.[19]

Moving Forward

Our health care system should offer the highest quality and most appropriate care possible to ensure the well-being of individuals and populations. CMS is committed to protecting taxpayer dollars by preventing or recovering payments for wasteful, abusive, or fraudulent services. But the importance of program integrity efforts extends beyond dollars and health care cost alone. It is fundamentally about protecting our beneficiaries – our patients – and ensuring we have the resources to provide for their care. Although we have made significant progress by implementing important policies like prior authorization to prevent improper payments before they are made and utilizing technology and data to reduce coding errors and other billing anomalies, more work remains to be done.

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[19] http://www.hhs.gov/news/press/2014pres/05/20140513b.html

Going forward, we must continue our efforts to move beyond "pay and chase" to prevent fraud before it happens, provide leadership and coordination to address these issues across the health care system, and ensure that we take administrative action as swiftly as possible to stop suspected instances of waste, abuse, and fraud. We share this Subcommittee's commitment to protecting taxpayer and trust fund dollars, while also protecting beneficiaries' access to care, and look forward to continuing this work.

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Shantanu Agrawal is a Board-certified Emergency Medicine physician and Fellow of the American Academy of Emergency Medicine. He is currently serving as an appointee for the Obama Administration as Deputy Administrator for Program Integrity and Director of the Center for Program Integrity at the Centers for Medicare & Medicaid Services (CMS). His focus is to improve healthcare value by lowering the cost of care through the detection and prevention of waste, abuse, and fraud in the Medicare and Medicaid programs. Prior to this role, Dr. Agrawal served as Chief Medical Officer of the Center for Program Integrity, where he helped to launch new initiatives in data transparency and analytics, utilization management, assessment of novel payment models, and a major public-private partnership between CMS and private payers.

Prior to joining CMS, Dr. Agrawal was a management consultant at McKinsey & Company, serving senior management of hospitals, health systems, and biotech and pharmaceutical companies on projects to improve the quality and efficiency of healthcare delivery. Dr. Agrawal has also worked for a full-risk, capitated delivery system as the head of clinical innovation and efficiency. He has published articles in *JAMA*, *New England Journal of Medicine*, *Annals of Emergency Medicine*, among others, and has given national presentations on health care policy and the cost of care.

Dr. Agrawal completed his undergraduate education at Brown University, medical education at Cornell University Medical College, and clinical training at the Hospital of the University of Pennsylvania. He also has a Masters degree in Social and Political Sciences from Cambridge University. Dr. Agrawal has continued to work clinically both in academic and community settings and holds an academic position in Washington DC.