STATEMENT OF

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ON

REDUCING IMPROPER PAYMENTS IN MEDICARE

BEFORE THE

U.S. HOUSE COMMITTEE ON OVERSIGHT & GOVERNMENT REFORM, SUBCOMMITTEE ON GOVERNMENT ORGANIZATION, EFFICIENCY, AND FINANCIAL MANAGEMENT

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Chairman Platts, Ranking Member Towns, and Members of the Subcommittee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) efforts to reduce improper payments in Medicare. The Administration is strongly committed to ensuring that our programs pay claims in an accurate and timely manner and reducing the rate of improper payments.

Background on Improper Payments

Like other large and complex Federal programs, Medicare is susceptible to payment, billing and coding errors—called "improper payments." Estimates of improper payment rates are determined annually in an open and transparent process as required by the Improper Payments Information Act (IPIA) of 2002, and amended by the Improper Payments Elimination and Recovery Act (IPERA) of 2010. While improper payments represent a fraction of total program spending, any amount of improper payment is unacceptable and CMS is aggressively working to reduce these errors.

The IPIA uses the term "improper payment" to describe these errors, however it is important to clarify what these billing anomalies are – and are not. They can result from a variety of assorted circumstances, including: 1) services with insufficient documentation, 2) services provided that were not determined "reasonable and necessary," 3) incorrectly coded claims, or 4) services with no documentation. Further, improper payments do not mean an item or service was not needed. These payments are not necessarily fraudulent; rather, they tend to be an indication of errors made by the provider in filing a claim or inappropriately billing for a service. Most improper payments by providers are classified as such because they relate to claims where the information in the medical record did not support the services billed. Examples of common payment errors made by Medicare providers include services that were performed in a medically unnecessary setting[1], or were

[1] Medically unnecessary setting: Medicare claims fall into this category when services are provided in a more intensive (and expensive) setting than is considered reasonable and necessary by Medicare. For example, if a minor surgery is done in an inpatient hospital setting on a healthy beneficiary, instead of in an outpatient setting, the entire claim is classified as an "improper payment."

incorrectly coded.[2] Other payment errors result when providers fail to submit documentation when requested, fail to submit adequate documentation to support the claim, when Medicare pays a claim that should have been paid by a different group health plan or other liable party, or when a service is not medically necessary.

The Administration is committed to reducing waste and improper payments across the government. On November 20, 2009, President Obama issued Executive Order No. 13520, *Reducing Improper Payments,* calling on all Federal agencies to reduce improper payments by boosting transparency and accountability across Federal programs and CMS is working hard to carry out the Order. In addition, the President has issued a memorandum on intensifying and expanding payment recapture audits (March 10, 2010) and issued a memorandum to enhance payment accuracy by creating a "Do Not Pay" List (June 18, 2010). On July 22, 2010, the President signed IPERA into law to improve agencies' identification and estimation of improper payments and expand payment recovery audits to all types of programs and activities with $1 million in annual outlays if cost-effective.

Improper Payments in Medicare Fee-for-Service

The traditional, Medicare fee-for-service (FFS) program represents the majority of Medicare spending, with hospital and other institutional services representing the largest spending outlays. CMS administers the Part A and B programs through contracts with Medicare Administrative Contractors (MACs), which are private companies that process claims for Medicare beneficiaries.

In keeping with laws that require CMS to promptly pay Medicare claims, our claims processing systems were built to quickly process and pay the roughly 4.8 million claims that we receive each day, totaling an approximate estimate of 1.2 billion claims in fiscal year 2011. Due to the volume of claims processed by Medicare each day and the significant cost associated with conducting medical review of an individual claim, CMS relies heavily on automated edits to identify inappropriate claims. As such, most claims are paid by CMS without requesting or individually reviewing the medical records associated with the services listed in the claim.

[2] Incorrect coding: Claims are placed into this category when providers submit medical documentation that support a lower or higher code than the code submitted. (CMS Improper Medicare Fee-For-Service Payments Report, https://www.cms.gov/CERT/10_CERT_Reports_and_Data.asp#TopOfPage).

CMS uses the Comprehensive Error Rate Testing (CERT) process to sample and review Medicare FFS claims to estimate an improper payment rate. At the recommendation of the Department of Health and Human Services (HHS) Office of Inspector General, CMS applied a stricter and improved methodology for calculating the Medicare FFS error rate in FY 2009. As a result of this change, the FY 2009 and FY 2010 FFS error rates were higher than in FY 2008; 12.4 percent and 10.5 percent in FY 2009 and FY 2010 respectively compared to 3.6 percent in FY 2008. The Administration announced last year that CMS will cut the Medicare FFS improper payment rate in half by FY 2012, from 12.4 percent to 6.2 percent. CMS is making progress in meeting this goal, with a 1.9 percent point reduction in the error rate between FY 2009 and FY 2010.

In addition to measuring the Medicare FFS error rate, the CERT program guides CMS in developing corrective actions to reduce improper payments in the future. CMS continues to analyze the improper payment data gathered from the CERT program and uses the results to manage and provide feedback to Medicare contractors to inform and enhance their medical review efforts, focus on high-risk areas, and improve overall operations.

To help reduce medical necessity errors, which occur when documentation submitted by a provider does not sufficiently establish the beneficiary's medical need for an item or service, CMS has developed an internal control called Comparative Billing Reports, which compare a provider's billing pattern for various procedures or services to their peers on a State and national level. Also, Medicare's automated systems can detect and reject payment for medical services that are physically impossible, such as a hysterectomy billed for a male beneficiary. Additionally, CMS has developed "medically unlikely" payment systems edits, which detects services when the quantity billed exceeds acceptable clinical limits.

Recovery Audit Program in Medicare FFS

The Recovery Audit program is another financial management tool in CMS' efforts to detect and reduce improper payments. The Recovery Audit program began as a 6-State demonstration project required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.[3] Congress expanded the Recovery Audit program in the Tax Relief and Health Care Act of 2006,

[3] CMS began this demonstration in Florida, California, and New York in 2005, and later expanded to Massachusetts, South Carolina, and Arizona.

directing CMS to implement a permanent national Recovery Audit program in Medicare FFS by January 1, 2010. Recovery Auditors work to identify overpayments and underpayments in previously submitted and paid claims; per the statute, these contractors are paid on a contingency fee basis. The permanent Medicare FFS Recovery Audit program, as of July 4, 2011, corrected a total of $685 million in improper payments, including $110 million in underpayments corrected and $575 million in overpayments collected.

More importantly, the Recovery Auditors help CMS identify areas where policy changes, systems changes, and provider education and outreach can help prevent future improper payments. CMS employs a robust system to identify patterns in the vulnerabilities identified by Recovery Auditors and to undertake appropriate corrective actions. During the demonstration, Recovery Auditors identified a number of improper payments in claims related to inpatient rehabilitation facilities (IRF). CMS recognized that the Agency's policy was outdated and published a regulation (CMS 1538-F) to update the policy and conducted extensive provider education to ensure that providers bill IRF claims correctly. In the national program, Recovery Auditors have identified several areas where edits can be helpful in preventing improper payments. CMS has implemented edits to stop the payment of claims provided after a beneficiary's date of death, to stop the payment of durable medical equipment while the beneficiary is receiving care in an inpatient setting, and to stop the payment for individual services that should have been bundled into another payment. In addition, the claim processing contractors have been able to implement local system edits to stop improper payments relating to durable medical equipment bundling (wheelchair and accessories and knee prosthetics) and drugs paid exceeding recommended dosages.

Some vulnerabilities cannot be fixed with automated edits and may require ongoing medical review and other more resource intensive activities. As such, the President's FY 2012 Budget Request includes a legislative proposal that would allow CMS to retain a dedicated portion of the funds recovered by Recovery Auditors. This would allow CMS to implement additional corrective actions and internal controls to prevent future improper payments, such as targeted prepayment review and provider education. Funding these financial management activities to prevent future improper payments is estimated to generate net savings of $230 million over 10 years.

<u>Improper Payments in Medicare Parts C and D</u>

The Medicare Advantage (MA) managed care benefit (Part C) and the prescription drug benefit (Part D) differ significantly from Medicare FFS and, as a result, require different approaches and internal controls to measure and address improper payments. Unlike Medicare FFS, CMS prospectively pays Medicare Part C and Part D plans a monthly capitated payment. Each per-person payment is based on a bid amount, approved by CMS, that reflects the plan's estimate of average costs to provide benefit coverage to enrollees. CMS risk-adjusts these payments to take into account the cost associated with treating individual beneficiaries based on health status. In addition, Part D payments are also reconciled against expected costs, and risk-sharing rules set in law are applied to further mitigate plan risk.

The Part C error rate reported for FY 2010 (based on payment year 2008) is 14.1 percent, a reduction from the FY 2009 rate of 15.4 percent. Most of the Part C payment error rate is driven by errors in risk adjustment data (clinical diagnosis data) submitted by MA plans to CMS for payment purposes. Specifically, the risk adjustment error reflects the extent to which diagnoses that plans report to CMS are not supported by medical record documentation.

To reduce the level of Part C improper payments due to risk adjustment error, the President's FY 2012 budget includes a proposal to require CMS to conduct contract-level Risk Adjustment Data Validation (RADV) audits, and to extrapolate the sample results for each MA contract to all enrollees in that contract for a given year. That is, the payment error for a contract's sampled beneficiaries, which is based on diagnoses not supported by medical record documentation during the RADV process, would be extrapolated from the sample to all contract enrollees. Enactment of this proposal would result in increased collections of improper payments made to MA plans, and is estimated to save $6.16 billion over 10 years.

CMS has made strides in developing a Medicare Part D composite error estimate based on a series of payment error sources, and plans to report a Part D composite error rate beginning in FY 2011. For FY 2010 reporting, a total of four component error estimates were reported. The four components were: 1) a Part D payment system error of 0.1 percent, 2) a low-income subsidy payment error of 0.1 percent, 3) payment error related to Medicaid status for dual eligible Part D enrollees of 1.8 percent, and 4) payment error related to prescription drug event data validation of 12.7 percent. A significant portion of the prescription drug event data error rate was due to missing

prescription documentation from pharmacies. To reduce this error rate, CMS has provided Part D sponsors with additional guidance and addressed the timing of documentation submissions to assist them in improving collection of prescription documentation from pharmacies.

Recovery Audit Program in Medicare Parts C and D

The Affordable Care Act expanded the Recovery Audit program to Medicare Parts C and D and the Medicaid program, and CMS is drawing from the lessons learned from the Medicare FFS Recovery Audit program as we implement this new statutory authority. In January 2011, CMS awarded a contract to identify incorrect payments and recoup overpayments in Medicare Part D. Additionally, we sought public comment through a solicitation issued on December 27, 2010 in the Federal Register on innovative strategies for review of additional Medicare Parts C and D data, including the effectiveness of sponsors' anti-fraud plans. We are currently reviewing the comments we received.

New Efforts to Enhance Automated Provider Screening

Building on the results of a successful automated provider-screening pilot, in July 2011, we posted a solicitation for an automated provider enrollment screening solution. The successful pilot leveraged an external private sector database to test the added value of augmenting our internal data on provider enrollment with publicly available information on a rolling basis. CMS currently verifies and validates various data elements on provider enrollment applications using a multitude of websites available to the general public, however, this process of verification is somewhat cumbersome, and resource intensive. Additionally, maintaining provider data is currently dependent on providers self-reporting changes in information that is relevant to Medicare enrollment. When changes fail to be reported or are reported in an untimely manner, providers who are not or are no longer eligible for enrollment continue to bill the program. In the pilot program, which we intend to expand more widely, we found that linking an automated screening tool to our Medicare enrollment database significantly reduced the application processing time by providing "one-stop shopping" for enrollment relevant information. Continuous, automated monitoring and management of the enrollment database identified outdated provider records more quickly, and permitted the proactive confirmation of key information changes. We are excited about this new solicitation, which will provide us with another opportunity to save taxpayer money, particularly in

the area of monitoring license expiration, by timely identifying ineligible providers and taking appropriate actions to ensure they are not improperly billing.

We anticipate that this new screening technology will automatically verify information provided on an enrollment application for all Medicare provider and supplier types in all 50 States, the District of Columbia, and the five Territories. The screening will compile CMS data and appropriate external data sources, such as the National Plan and Provider Enumeration Systems for the National Provider Identifier (NPI), the General Services Administration (GSA) Excluded Parties List, and the Office of the Inspector General (OIG) exclusion database. The screening will also actively monitor compliance with requirements such as license status or changes in physical location. We anticipate awarding the contract in late September 2011, with implementation of the screening solution by the end of the year. All existing and new enrollments will be screened and validated by March 2013.

Lessons Learned from the Private Sector

As we seek to continuously improve our internal controls and data systems to reduce improper payments, CMS is also examining the techniques used by insurance companies and other private sector entities. Though our Federal programs differ from private insurance in some significant ways, CMS is eager to learn from successful private sector efforts to reduce errors and improper payments. We are now using predictive modeling technology, which is similar to technology used be private industries, to assign risk scores to Medicare claims. Predictive modeling is an innovative technology that can detect potential fraud and improper payment by simultaneously analyzing multiple data sources, such as provider billing patterns and the distance between service location and a beneficiary's address, for a very large number of claims. Our new system is able to identify suspect claims prior to payment. Through this new technology, we now have an integrated view of Medicare FFS claims nationwide. This comprehensive view alerts us about potential problems as claims are submitted, instead of relying primarily on post-payment data. In addition to harnessing improved data analysis and predictive modeling to fight fraud, CMS is using these approaches to identify areas to target with additional medical review. As part of this effort, CMS will evaluate the accuracy of commercial products, whether the products are feasible to implement, and if they could reduce improper payments.

CMS is also examining other internal controls and processes, such as ways to link claims data and provider data within and across our various healthcare programs. The ability to identify trends sooner and link data is an important tool in preventing future improper payments. Additionally, CMS is exploring ways to leverage existing compliance programs within the provider community to inform and educate providers about payment vulnerabilities. Getting providers actively involved in the identification and prevention process will keep improper payments from occurring in the first place.

Conclusion

CMS' number one goal is to ensure our Medicare beneficiaries receive the right services, at the right time, in appropriate levels of care and at the right price. While CMS has made progress in reducing improper payments, we acknowledge that more work remains. Reducing waste and errors in our programs will allow us to target taxpayer funds to provide health care services for our beneficiaries. I am confident that the systems controls and ongoing corrective actions that CMS is undertaking across our programs will result in continued reductions in improper payments. I look forward to working with the Subcommittee to ensure that CMS has the necessary administrative resources and tools to continue our efforts to carry out this important work.

Michelle Snyder
Deputy Chief Operating Officer, Centers for Medicare & Medicaid Services

Michelle Snyder is the Deputy Chief Operating Officer (DCOO) for the Centers for Medicare & Medicaid Services (CMS). With the Principal Deputy Administrator and Chief Operating Officer (COO), she oversees daily operations, providing leadership in the implementation of Agency-wide program initiatives in the Central and Regional Offices. Ms. Snyder is also responsible for integrating Affordable Care Act (ACA) driven work into existing Regional Office workflows towards the objective of leveraging Regional operations ' expertise and capabilities to effectively integrate Affordable Care Act driven work from all centers while continuing operational support for existing Medicare and Medicaid programs. Reaching out across agency lines, she has led the charge for CMS' various improvement initiatives for the purpose of promoting excellence in operations. She is responsible for creating the concept of 'One CMS' geared towards enhancing more strategic tactical and coordinated efforts focused on achieving discrete communication goals and outcomes.

Michelle has partnered effectively and strategically with the Department around HIT priorities and initiatives including EHR and PHR projects, championed the Agency's Resource Analysis Project to ensure employees are appropriately carrying out the CMS mission, and is working to ensure the seamless transition of the Medicare Fee-for-Service workloads to a competitive environment to achieve long term savings to the Medicare Trust Funds. Ms. Snyder is leading the Agency's effort to build a new IT structure for CMS for the purpose of changing health and healthcare in the U.S. This includes efforts to reduce costs of operations and improving business intelligence to provide improved care for our Nation's beneficiaries.

In her prior role as Acting Deputy Administrator for CMS, Michelle continuously fostered collaboration among CMS senior leadership to ensure that the strategic goals and initiatives of CMS were implemented and managed successfully. Formerly, she was the CMS' Director of the Office of Financial Management and the Agency's first Chief Financial Officer. Under her leadership, the CMS achieved its first clean audit opinion, and developed its first comprehensive strategic plan on program integrity. During that time she also oversaw one of CMS' most significant efforts involving the integration of its financial and accounting systems to better manage Medicare Trust Funds.

Michelle's executive positions have spanned both administrative and program areas. At the Health Resources and Services Administration, she provided executive leadership to initiate the National Organ Donation Collaborative that in one year doubled the rate of organ donation in this country; worked to expand the number of health centers in this country that serve the Nation's most vulnerable citizens; and oversaw the Hospital Preparedness program under which states strengthened the ability of hospitals and other health care facilities to respond to bioterrorism attacks, infectious disease outbreaks, and natural disasters.

Michelle has also been a manager in the HHS budget office and had assignments with the Office of Management and Budget, the Congress, the Social Security Administration, and as a management consultant in the private sector.

She holds advanced degrees in Clinical Psychology and Legal Studies and Administration. Michelle has received numerous awards and honors including the Presidential Meritorious Service Award and the Presidential Rank Award for Distinguished Executive, which is selectively given annually to only 50 Senior Executive Service managers in the U.S. Federal government.