STATEMENT OF

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ON

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

BEFORE THE
UNITED STATES HOUSE COMMITTEE ON
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CMS Efforts to Reduce Improper Payments in the Medicare Program
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Chairman Mica, Ranking Member Connolly, and members of the Subcommittee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) efforts to reduce improper payments. The Administration is committed to reducing waste and improper payments across the government. On November 20, 2009, President Obama issued Executive Order 13520 calling on all Federal agencies to reduce waste and improper payments 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 on March 10, 2010; issued a memorandum to enhance payment accuracy by creating a "Do Not Pay" initiative on June 18, 2010, signed the Improper Payments Elimination and Recovery Act (IPERA) into law on July 22, 2010, and signed the Improper Payments Elimination and Recovery Improvement Act (IPERIA) into law on January 10, 2013.

Improper Payments in Medicare Fee-For-Service

Each year, CMS estimates the improper payment rate and a projected dollar amount of improper payments for Medicare, Medicaid, and CHIP.[1] These rates are determined annually in an open and transparent process required by the Improper Payments Information Act (IPIA), as amended by IPERA and IPERIA. CMS uses the Comprehensive Error Rate Testing (CERT) process to sample and review Medicare fee-for-service (FFS) claims to project an improper payment rate. In FY 2013, the Medicare FFS improper payment rate was 10.1 percent, or a projected $36 billion.

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

[1] http://www.hhs.gov/afr/2013-hhs-agency-financial-report.pdf

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.

Medicare 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. 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 home health policies regarding documentation. Although the policy change will ultimately strengthen 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 Efforts to Identify, Reduce, and Prevent Improper Payments

CMS is committed to paying claims in an accurate and timely manner and has a comprehensive strategy in place to address the improper payment rate, including strengthening provider enrollment to ensure only legitimate providers are enrolled, and preventing improper payments by using edits to deny claims that should not be paid. CMS also develops targeted demonstrations in areas with consistently high rates of improper payments, such as the prior authorization demonstration for the power mobility device benefit, and plans to test prior authorization with other high-risk items and services. CMS Medicare Administrative Contractors (MACs) conduct provider education to help providers avoid documentation errors and other sources of improper payments, in addition to their work reviewing claims. CMS also uses Recovery Auditors, as required by law,[2] to identify and correct improper payments by reviewing claims on a post payment basis.

[2] The Recovery Auditor demonstration project was required by section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and the Congress expanded the program in section 302 of the Tax

Provider Enrollment

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. The Affordable Care Act required CMS to revalidate all existing 1.5 million Medicare suppliers and providers under new risk-based screening requirements. Since March 25, 2011, more than 930,000 providers and suppliers have been subject to the new screening requirements and over 350,000 provider and supplier practice locations had their billing privileges deactivated for non-response as a result of revalidation and other screening efforts.[3] Since the implementation of these requirements, CMS has also revoked 20,219 providers' and suppliers' ability to bill the Medicare program as a result of felony convictions, practice locations that were determined to be non-operational at the address CMS had on file, or non-compliance with CMS rules, such as licensure requirements. CMS has demonstrated that revocations result in cost avoidance. For example, by revoking 48 providers identified by our advanced predictive technology, CMS prevented $81 million in improper payments.[4]

The success of our provider enrollment and screening efforts has demonstrated the importance of preventive actions to ensure that only legitimate providers are serving our beneficiaries. In April 2013, CMS issued a proposed rule that would provide CMS with additional authority to remove bad actors from the Medicare program. CMS proposed to permit denial of an enrollment application of a provider affiliated with a defunct provider with an outstanding Medicare debt, revocation of a provider for a pattern or practice of submitting claims for services that fail to meet Medicare requirements, and clarifying the list of felony convictions that may result in a denial or revocation enrollment.

Relief and Health Care Act of 2006, directing CMS to implement a permanent national recovery audit contractor program by January 1, 2010.

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

[4] CMS, "Report to Congress: Fraud Prevention System Second Implementation Year," June 2014. Access at http://www.stopmedicarefraud.gov/fraud-rtc06242014.pdf.

Claims Edits and Medical Review

In keeping with statutory requirements to promptly pay claims in Medicare, our claims processing systems were built to quickly process and pay the roughly 3.3 million Medicare FFS claims that we receive each day, totaling approximately 1.2 billion Medicare FFS claims in calendar year 2013. 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 heavily relies on automated edits to identify inappropriate claims. 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 prevents payments for services such as hysterectomy for a man or prostate exam for a woman. The use of the NCCI procedure-to-procedure edits saved the Medicare program $530 million in FY 2013.

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 MACs develop 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 MACs reported that medical review resulted in $5.6 billion in savings for FY 2013.[5]

Prior Authorization

One area with high incidences of improper payments that CMS recently addressed was the Power Mobility Device (PMD) benefit; CMS found that over 80 percent of claims for motorized wheelchairs did not meet Medicare coverage requirements in 2011.[6] As result of these and other findings showing very high improper payment rates for PMDs, CMS implemented the Medicare

[5] http://www.hhs.gov/budget/fy2013/fy2013-other-information.pdf
[6] http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/MedicareFFS2011CERTReport.pdf

Prior Authorization of PMDs Demonstration in seven high-risk states in September 2012.[7] Since implementation, CMS observed a decrease in expenditures for PMDs in the demonstration states and non-demonstration states. Based on claims submitted as of April 4, 2014, monthly expenditures for PMDs decreased from $20 million in September 2012 to $6 million in December 2013 in non-demonstration states and from $12 million to $3 million in demonstration states.[8]

Based on this success, CMS announced plans to expand the demonstration to an additional 12 states.[9] CMS also proposed to establish a prior authorization process for certain durable medical equipment, prosthetics, orthotics, and supplies items that are frequently subject to unnecessary utilization. Through a proposed rule issued in May 2014, CMS solicited public comments on this prior authorization process, as well as criteria for establishing a list of durable medical items that are frequently subject to unnecessary utilization that may be subject to the new prior authorization process.[10] CMS will also launch two payment models to test prior authorization for certain non-emergent services under Medicare.[11] Information from these models will inform future policy decisions on the use of prior authorization.

The President's FY 2015 Budget also includes a proposal to give CMS the authority to require prior authorization for all Medicare FFS 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.

FFS Recovery Auditors

CMS uses Recovery Auditors to perform medical review to identify and correct Medicare improper payments primarily on a post payment basis. The Recovery Audit Program identifies

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[7] The seven states are: CA, IL, MI, NY, NC, FL and TX

[8] http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/MedicarePriorAuthorizationofPowerMobilityDevicesDemonstration_05212014.pdf

[9] The twelve states are: AZ, GA, IN, KY, LA, MD, MO, NJ, OH, PA, TN, and WA

[10] http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-05-22.html

[11] These services include hyperbaric oxygen therapy and repetitive scheduled non-emergent ambulance transport.

areas for potential improper payments and offers an opportunity to provide feedback to providers on future improper payment prevention. CMS encourages collaboration between Recovery Auditors and MACs to discuss improvements, areas for possible review, and corrective actions that could prevent improper payments. Educational efforts include articles or bulletins providing narrative descriptions of the claim errors identified and suggestions for their prevention, as well as system edits for errors that can be automatically prevented at the onset. In addition, CMS uses the vulnerabilities identified by the Recovery Auditors to implement actions that will prevent future improper payments nationwide. In FY 2012, the Recovery Auditors identified and corrected $2.4 billion in improper payments.[12] 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.

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.

Conclusion

CMS's goal is to ensure our 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, 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, and the systems controls and ongoing corrective actions that CMS is undertaking across our programs will address CMS's rate of improper payments. 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.

[12] http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/Report-To-Congress-Recovery-Auditing-in-Medicare-and-Medicaid-for-Fiscal-Year-2012_013114.pdf.