

**STATEMENT OF
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ON

“CMS EFFORTS TO REDUCE IMPROPER PAYMENTS”

**BEFORE THE
UNITED STATES HOUSE COMMITTEE ON
OVERSIGHT & GOVERNMENT REFORM
SUBCOMMITTEE ON GOVERNMENT OPERATIONS**

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Hearing on
CMS Efforts to Reduce Improper Payments
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Chairman Meadows, Ranking Member Connolly, and members of the Subcommittee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) efforts to strengthen Medicare and Medicaid and to reduce improper payments. We share your 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 strategy.

CMS takes seriously our responsibility to make sure our programs pay the right amount, to the right party, for the right beneficiary, in accordance with the law and agency and state policies. It is important to remember that improper payments are not typically fraudulent payments. Rather, they are usually payments that do not include the necessary documentation, made for items or services that do not meet Medicare or Medicaid's coverage and medical necessity criteria, or that are incorrectly coded. Correctly recording and documenting medical services is an important part of good stewardship of these programs, and we strive to improve these practices among providers serving Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries. 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 of 2002 (IPIA), as amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA) and the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA.) This measurement and reporting process allows CMS to identify and address areas at risk for – and factors contributing to – improper payments.

Identifying and Addressing Improper Payments in the Medicare Program

CMS uses the Comprehensive Error Rate Testing (CERT) program to review a stratified random sample of Medicare fee-for-service (FFS) claims to estimate an improper payment rate. The

¹ <http://www.hhs.gov/sites/default/files/afr/fy-2015-hhs-agency-financial-report.pdf>

Medicare FFS improper payment rate decreased from 12.7 percent in 2014 to 12.1 percent in 2015. CMS's "Two Midnight" rule and corresponding educational efforts led to a reduction in improper inpatient hospitals claims, reducing the improper payment rate from 9.2 percent in 2014 to 6.2 percent in 2015, which contributed to the program's overall decrease in its improper payment rate.

The factors contributing to improper payments are complex and vary from year to year. In FY 2015, the primary causes of improper payments were insufficient documentation and medical necessity errors. While progress has been made, we know we have more work to do to sustain this progress and meet improper payment rate reduction targets.

Reducing Improper Payments in Durable Medical Equipment

The improper payment rate for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) has also decreased. Corrective actions implemented over a six-year period, including the DMEPOS Accreditation Program, contractor visits to large supplier sites, competitive bidding, and a demonstration testing prior authorization of power mobility devices, contributed to the reduction in the improper payment rate for these items and supplies.

CMS has also pursued additional prior authorization and pre-claim review models to help make sure other items and services are provided in compliance with Medicare coverage, coding, and payment rules before claims are submitted. Through these programs, a request for provisional affirmation of coverage is submitted for review before a claim is submitted for payment. Prior authorization and pre-claim review do not create additional documentation requirements or delay medical service. They require the same information that is currently necessary to support Medicare payment, but earlier in the process. Prior authorization and pre-claim review are effective ways to promote compliance with Medicare rules for some items and services and to help prevent improper payments before they occur while ensuring beneficiary access to medically necessary items and services.

In addition to certain power mobility devices (PMDs), CMS is now utilizing a prior authorization process in certain states for non-emergent hyperbaric oxygen therapy and repetitive scheduled

non-emergent ambulance transports.² Lastly, CMS published a final regulation on December 30, 2015 establishing a prior authorization program for certain DMEPOS items frequently subject to unnecessary utilization.³

The Medicare Prior Authorization of PMDs Demonstration was initially implemented in California, Illinois, Michigan, New York, North Carolina, Florida, and Texas. Since implementation, we have observed a decrease in expenditures for PMDs in the demonstration states and non-demonstration states. Based on claims processed from September 1, 2012 through June 2015, monthly expenditures for the PMD codes included in the demonstration decreased from \$12 million to \$3 million in the seven original demonstration states, without affecting beneficiary access to appropriate services. Subsequently, we expanded the demonstration to twelve additional states⁴ on October 1, 2014. These and other efforts have shown demonstrable progress in reducing improper payments in DME. The improper payment rate in DMEPOS has decreased from 73.8 percent in 2010 to 39.9 percent in 2015.

The FY 2017 President's Budget also includes a proposal to expand CMS's authority to require prior authorization for additional Medicare FFS items and services, particularly those items and services at the highest risk for improper payment. By allowing prior authorization on additional items and services, CMS can ensure in advance that the correct payment goes to the right provider or supplier for the appropriate service or item, and prevent potential improper payments before they are made.

Reducing Improper Payments in Home Health

Medicare FFS home health services are another area of focus due to particularly high improper payment rates in recent years. In 2015, home health claims had a 59 percent improper payment rate, and a large proportion of the improper payment rate was because of insufficient documentation. Home health services are a critical part of the health care continuum and are

² For more information: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Prior-Authorization-Initiatives/Prior-Authorization-Initiatives-.html>

³ https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Prior-Authorization-Initiatives/Downloads/DMEPOS_6050_Final_12_30_15.pdf

⁴ Maryland, New Jersey, Pennsylvania, Indiana, Kentucky, Ohio, Georgia, Tennessee, Louisiana, Missouri, Washington, and Arizona.

instrumental in helping a patient with Medicare benefits recover after an illness or injury. The Medicare home health benefit allows beneficiaries who are deemed homebound to receive certain medically necessary services in their homes, which is a preferred setting for many beneficiaries.

To address the high improper payment rate in home health services, CMS has made changes to what providers need to submit in order to comply with our payment policies and clarified these policies for providers. CMS believes clarifying requirements will lead to a decrease in these errors and improve provider compliance with regulatory requirements, while continuing to strengthen the integrity of the Medicare program. To ensure providers understand the regulations and documentation requirements, CMS has implemented a probe and educate program for all home health agencies. This program reviews a small number of claims for every home health agency, identifies whether the reviewed claims complied with Medicare policies, and offers education to providers who require assistance in properly documenting home health claims.

Building on efforts to combat home health fraud, CMS recently announced a new pre-claim review demonstration to take place in five states - Illinois, Florida, Texas, Michigan, and Massachusetts. This demonstration will help CMS make sure that home health services are medically necessary without delaying or disrupting patient care or access.⁵ Under this demonstration, physicians and clinicians participating in Medicare will continue to make health care decisions in coordination with their patients, including creating a care plan for the types of home health services a beneficiary needs. Once home health services are ordered by their Medicare physicians, the eligible beneficiary should be able to receive Medicare's home health services immediately. The main change under this demonstration is that home health agencies will submit the supporting documentation for "pre-claim review" while beneficiaries are receiving care rather than submitting that documentation with the claim after care is completed. Pre-claim review does not change beneficiary eligibility standards or Medicare's documentation requirements for home health care. Rather, pre-claim review gives providers an opportunity to

⁵ The pre-claim review demonstration will begin in Illinois no earlier than August 1, 2016, and the remaining states will phase in during 2016 and 2017.

submit the supporting documentation earlier and to resubmit the pre-claim review request an unlimited number of times for re-review as long as the final claim has not been submitted. Absent evidence of potential fraud or gaming, the claims that have a provisional affirmation pre-claim review decision generally will not be subject to additional review. This new process should lead to a decrease in improper payments resulting from insufficient documentation, as well as reduce the need for home health agencies to appeal claims.

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 4.6 million Medicare FFS claims that we receive each day, totaling approximately 1.2 billion Medicare FFS claims in calendar year 2015. 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.⁶ For example, CMS is using the National Correct Coding Initiative (NCCI) to stop claims that never should be paid. This program prevents payments for services such as hysterectomy for a man or prostate exam for a woman. The use of the NCCI edits saved the Medicare program \$681.9 million in FY 2014.

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 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 encouraging providers to conduct self-audits, to targeting medical review of specific providers.

⁶ <http://www.hhs.gov/sites/default/files/afr/fy-2015-hhs-agency-financial-report.pdf>

Reducing Improper Payments in Medicare Advantage and Medicare Part D

CMS is also working to reduce improper payment rates in Medicare Advantage and Medicare Part D. To better address and prevent improper payments in Medicare Advantage, in December 2015, CMS issued a Request for Information (RFI)⁷ to solicit feedback on a proposal to contract with one or more Recovery Auditors (RA) to identify and correct improper payments in Medicare Advantage through a significantly expanded Risk Adjustment Data Validation (RADV) audit initiative. As a result of existing RADV audits and new regulations requiring Medicare Advantage organizations to report and return identified overpayments, during FY 2015, Medicare Advantage Organizations reported and returned approximately \$650 million in overpayments. We are also continuing to work on education and outreach with Medicare Part D plans and sponsors to correct improper payments, with a particular focus on long-term care medication orders, one of the primary causes of improper payments in Medicare Part D.

Identifying and Preventing Improper Payments in Medicaid and CHIP

Because Medicaid is jointly funded by states and the Federal Government and is administered by states within Federal guidelines, both the Federal Government and states have key roles as stewards of the program, and CMS and states work together closely to carry out these responsibilities. CMS uses the Payment Error Rate Measurement (PERM) program, which operates under a 17 state three-year rotation for measuring Medicaid and CHIP improper payments. The improper payment rates are based on reviews of the fee-for-service (FFS), managed care, and eligibility components of Medicaid and CHIP in the fiscal year under review. Like the Medicare program, it is important to note the error rate is not a “fraud rate” but simply a measurement of payments made that did not meet statutory, regulatory or administrative requirements.

Since roughly one third of the states are measured each year to calculate the Medicaid and CHIP improper payment rates, these measures are calculated as a rolling rate that includes the reporting year and the previous two years. The Medicaid improper payment rate reported in the FY 2015 Agency Financial Report was 9.8 percent. Similar to previous years, the primary cause was

⁷https://www.fbo.gov/index?s=opportunity&mode=form&id=83f1ec085c52a81a6a6ce7cba3ffbc5d&tab=core&_cvi_ew=0

related to state difficulties bringing systems into compliance with certain new requirements, including that all referring or ordering providers be enrolled in Medicaid, that states screen providers under a risk-based screening process prior to enrollment, and that certain National Provider Identifier (NPI) information be included on claims. While these requirements will ultimately strengthen Medicaid's integrity, it is not unusual to see increases in improper payment rates following the implementation of new requirements because it takes time for states to make systems changes required for compliance. CMS is committed to working with states as they work to improve their provider enrollment and screening processes, which will help to address the improper payment rate and make sure that only legitimate providers are serving Medicaid beneficiaries.

While states bear the primary responsibility for provider screening, credentialing, and enrollment for Medicaid, CMS has taken several steps to help states fulfill the enrollment and screening requirements created by the Affordable Care Act. For example, CMS has provided states with direct access to Medicare's Provider Enrollment, Chain and Ownership System (PECOS) enrollment database, as well as monthly PECOS data extracts that states can use to systematically compare state enrollment records against available PECOS information. CMS assigned staff to coordinate directly with each state and is providing extensive guidance and technical assistance to support states on their revalidation efforts.

In March 2016, CMS released additional guidance in the Medicaid Provider Enrollment Compendium⁸ to help states in implementing various enrollment requirements including the site visit requirements and provider ownership disclosure requirements. CMS also worked with the Federal Bureau of Investigation to publish guidance to help states implement fingerprint-based criminal background checks for providers in the high risk category.⁹

CMS also recently finalized a rule¹⁰ strengthening program integrity in Medicaid managed care by identifying minimum standards for provider screening and enrollment and expanding

⁸ <https://www.medicaid.gov/affordablecareact/provisions/downloads/mpec-032116.pdf>

⁹ <https://www.medicaid.gov/federal-policy-guidance/downloads/smd060115.pdf>

¹⁰ <https://www.federalregister.gov/articles/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered>

managed care plan responsibilities in program integrity efforts. Furthermore, CMS published several toolkits to help address some of the most frequent findings from state program integrity reviews in the area of provider enrollment, both in fee-for-service and managed care. The toolkits address a wide range of issues, including issues with provider disclosures of ownership and control, business transactions, and criminal convictions; federal database checks for excluded parties; and the reporting of adverse actions taken against providers to the HHS-OIG. The toolkits identify common issues observed and provide practical solutions that states can implement.¹¹

Conclusion

CMS's goal is to ensure our beneficiaries receive the right services, at the right time, for the appropriate levels of care, and for the right provider payment. While CMS has made progress in preventing improper payments, we continue to work to make further improvements. Reducing waste and errors in our programs will allow us to save more taxpayer funds to provide health care services for our beneficiaries, as ongoing corrective actions that CMS is undertaking across our programs work to reduce 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.

¹¹ <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/frequent-findings-toolkits-121714.html>